"... patients seem to value above all a specific diagnosis for a particular pain, rather than considering, as has become our way of thinking in the UK, how that investigation might change the outcome of that condition."

Italian lessons: exploring general practice in Italy

The mere mention of Italy, for most people, conjures images of beautiful scenery, culinary delights, and magnificent architecture. Having thoroughly explored these particular avenues in the past, I was keen to delve into the Italian world of medicine to understand how my chosen profession works there. This was made possible thanks to funding obtained by the RCGP for 30 UK GP trainees to travel to Europe this year to spend 2 weeks observing a GP in their chosen country, with the main objective to broaden professional horizons and encourage interest in the healthcare systems of our European counterparts.

As a current ST3 trainee, for whom QOF and NICE have always existed, without a doubt the most striking difference I noted was the relative lack of financial restrictions in Italy with regards to the prescribing and ordering of investigations. Medications are almost always prescribed by brand name, first because there is little pressure to prescribe generically, and second because patients have a longstanding wariness of generic medications which, I was told, has been propagated by the media. I wondered why there appears to be no such suspicion in the UK, but perhaps this is a battle that was waged on my behalf prior to my qualifying.

It struck me as a shame that money was being spent on more expensive versions of the same medications, while physiotherapy was unavailable on the Italian NHS. Also of note was the significantly higher rate of investigations and specialist referrals. Again, this was due to a combination of fewer restrictions and greater patient expectations. Often patients would attend specifically to request a test or consultant opinion, rather than to discuss a particular symptom. MRI scans are particularly popular, and patients seem to value above all a specific diagnosis for a particular pain, rather than considering, as has become our way of thinking in the UK, how that investigation might change the outcome of that condition. Of course, it is easy to see why it would be desirable to have a diagnosis for diagnosis' sake, but our necessarily careful allocation of resources means that this is a luxury we can rarely afford in the UK.

Single-handed GPs are still the norm in Italy, but the concept of the group practice is becoming ever stronger. This is largely due to the growing burden of chronic disease, and the emergence of incentives and targets in relation to the care of these patients. It is only with the pooled financial incentives of several GPs that sufficient funds can be raised to employ, for example, a practice nurse, and in the past GPs have carried out the role of both doctor and nurse, and often receptionist. The clinical advantages of having a close network of colleagues are also increasingly recognised, and young Italian GP trainees are consistently expressing their desire to work in a group in their future careers. Interestingly though, GPs within a group will normally retain their own fixed list of patients. It may be difficult to see how this would work in the UK, as patients are used to having access to any doctor within their local surgery during working hours, but there were clear advantages in the Italian approach, as the GP knows each patient and family member by name and is able to tailor their service more effectively. This, to me, seemed to bring the benefits of a group practice while still retaining the essence of family medicine, which does seem to be becoming more diluted in the UK as the current trend swings in favour of ever growing practice sizes and GP-led health centres.

GP training in Italy also struck me as being very different to our own. Although the training is 3 years, there appears to be more emphasis on theory and observation rather than learning 'on the job' as is the case in the UK. Following qualification as a GP, the young doctor must wait to receive the *convenzione*, or allocated fixed post. To obtain this, points are accumulated through various criteria that include the number of years of residency in the area and the number of out of hours locum shifts worked. Many GPs will, therefore, work for more than 10 years as locums before being allocated their fixed post, and the equivalent of a partnership for a newly qualified GP in Italy is a distinct impossibility, as is even the prospect of a retiring GP handing on his business to his offspring or valued colleague. As young GPs in the UK, therefore, we must be mindful of the great opportunities available to us after completing our training.

Of course, during the 2 weeks I spent in Italy there was something different to note from every consultation; but my lingering thought was what a great shame it is that we have not spent more time learning from each other until now.

Nicolle Green,
GP, Wilmslow Health Centre, Wilmslow.

DOI: 10.3399/bjgp12X636155

ADDRESS FOR CORRESPONDENCE

Nicolle Green
Wilmslow Health Centre, Chapel Lane, Wilmslow, Cheshire SK9 5HX, UK.

E-mail: nicollegreen@yahoo.co.uk