A week with a French country doctor

R. V. H. JONES, M.A., M.R.C.G.P.
General practitioner, Seaton, Devon

WITH Britain now a member of the Common Market, and discussions being held about the mutual recognition of medical degrees, it is possible that British doctors will, within the foreseeable future, be able to practise in France, Germany, and other member countries, and their doctors will be able to practise here. In Britain during the past ten years much information has been gathered about the scope and conditions of general practice (Wright, 1968; Royal College of General Practitioners, 1973). However, little is known about the content of general practice in other European countries, particularly France.

In November 1973, I spent a week living with a general practitioner in South-west France, sitting with him in his surgery and going with him on his visits. In order to make reasonably valid comparisons, it was like our practice with three partners, it was a semi-rural practice, and it was in South-west France isolated from industry and close to a holiday area, while our practice is in South-west England, with little industry, but having a large influx of summer visitors.

During the week I asked about the organisation of the practice, the method and amount of payment. I made a note of each consultation, the time taken, the diagnosis, and the method of treatment. Similarly the reason, time, diagnosis, and the nature of each visit was noted.

Organisation of care

In France a patient has freedom of choice to consult any general practitioner. In the practice I visited the practice numbers quoted are those of the number of patients who habitually go to a particular doctor. The reverse side of the coin is that as the doctor has no contract to provide medical care for any particular patient, no patient has the ' right ' to medical attention from any particular doctor.

Payments are made to the doctor both by the patient and the State.

The practice

The three doctors in the partnership, aged 47, 42 and 39, all live in the same village, which has about 1,200 inhabitants. The practice extends for a radius of about five miles. The nearest doctors are in villages seven and eight miles away.

Each of the three doctors practises from his own house, the one I stayed with had a consulting room (with examination area), a lobby, a waiting room, and a hall with a separate practice entrance at the back of his house. One of the other two doctors lives 200 yards away, the other 300 yards.

There are two branch surgeries. One in a room behind a café in the village about three miles away in one direction, the other in a room behind a grocer's shop four miles in another direction. These branch surgeries are used once a week by the senior partner, and once a week by another partner.

The approximate number of patients looked after by each partner are as follows:

Partner A: 1,100.
Partner B: 1,700.
Partner C: 1,100.

One week's work

The routine for the doctor with whom I stayed was as follows:

Monday: Consultations from 0900 hours until finished.
Tuesday: Visits until midday.
Wednesday: 0900 until 1000 hours, branch surgery. No visits.
Thursday: Visits 1400–1500 hours.
Friday: 1500 hours available in consulting room.
Saturday: 1500 onwards—visits.

The week's work was:

	Consultations			*Visits*	
	Patients	*Drug firm representatives*	*Certificates only*	*Acute*	*Chronic*
Monday	20	—	2	4	4
Tuesday	2	—	3	6	6
Wednesday	—	—	1	—	—
Thursday	12	5	3	6	6
Friday	3	—	2	4	3
Saturday	2	—	—	2	4
	39	5	11	22	23
Total for week	55			45	

Comments

(1) Excluding drug representatives and patients who came solely for certificates, there were slightly more visits than there were consultations in the surgery.

(2) There were the same number of ' chronic ' visits as ' acute ' visits.

Clinical

(1) *Content.* Of the 39 consultations, any one could have been seen in our surgery in Devon, e.g. upper respiratory tract, sciatica, sprained wrist, influenza injections, and so on. The numbers were too small for analysis.

(2) *Visits.* The chronic visits were mainly geriatric, and presumably did not vary much throughout the year, e.g. for hypertension, arthritis, and varicose ulcers.

Of the 23 acute visits there were two clinical conditions not often seen in England. One, a farmer's son, aged ten years, with tonsillitis, had an enlarged liver, said to be due to overeating (presumably in the same way that the geese in the farmyard produce *foie gras*); the other a young woman with an upper respiratory infection had the previous year had a fasciola infection of her liver.

(3) *Remedies.* Prescriptions for 108 items were given:

Medicine	24
Tablets	35
Suppositories	21
Injections	15
Ampoules	6
Ointment/lotions	7

In addition three patients were put on a diet.

Suppositories were popular for: phenylbutazone and indomethacin; antispasmodics, e.g. aminophylline theophylline; expectorants, e.g. eucalyptus; analgesics of all sorts from aspirin to morphine.

Ampoules such as ' Parenterovite ' were largely vitamin preparations for oral use.

Injections comprised: 12 prophylactic influenza injections, one desensitisation, one diphtheria/tetanus/pertussis inoculation (second) and one ' Depot medrone.'

(4) *Referrals.* Referrals of the patient by the general practitioner may be to: the local nurse, a physiotherapist, a laboratory for blood test, x-ray, or to a specialist, either privately or in hospital, or to hospital for admission.

Payment

Payment to the doctor by the patient is made at each consultation or visit (with various exceptions). At each consultation (or visit) the doctor signs a form (*feuille*) on which he writes the patient's name, date of consultation, amount due (and paid) for the consul tation, with any mileage payment for a visit.

The form comprises three parts—the first for the doctor, the second for the chemist, and the third for the laboratory. The patient takes the form and prescription to the chemist who fills in on the form the items prescribed and their cost. The patient pays the cost in full at this stage. Should any laboratory tests be needed again the laboratory fills the charge in on the form and the patient pays.

At the conclusion of the episode the patient sends the form to the Government which reimburses 75 per cent of the total cost.

In addition many patients are insured (usually through their work, e.g. farm workers, teachers) for the remaining 25 per cent, and if so the doctor signs further insurance forms at the consultations or visit.

The exceptions to payment by the patient at the time of service are: accidents at work, and some specified complaints such as arteriosclerosis, which in effect amount to chronic conditions particularly of the elderly.

For these cases payment is made direct to the doctor by the State on presentation of a different form.

Rates of payment

The rates of payment at November 1973 were as follows:

(1) Standard consultation 21 francs (about £2).
(2) Standard visits 32 francs (about £3).
(3) Mileage payments 50p to £1 for two–five miles.
(4) Night visits, additional 60 francs (£5·50).
(5) Reduced rates (accidents, specified diseases) 17 francs consultation, 28 francs visit.

Other payments

(1) By regulation all employed workers in France have to have an annual medical examination. Any abnormalities discovered are reported to the general practitioner of the patient's choice. These examinations are carried out by doctors appointed by the Government. The doctor with whom I stayed is the official examining doctor for agricultural workers for an area of South-west France measuring about 25 by 15 miles. The examinations take place at the three local hospitals within this area. The examinations of all the workers involved takes him every Friday afternoon from January until about October.

Payment for these examinations is by session: 110 francs for a three-hour session, during which he sees 10–15 patients. Mileage payments to the hospital where the examinations are carried out are also paid.

(2) In order to draw children's allowances each mother has to have a doctor's certificate to say that the child has been medically examined. These certificates have to

be produced each month between birth and one year old, at 18 months and at two years. These examinations are paid at the normal consultation rate of 21 francs.

Payments for other services

Nurses are not employed by the state, but are paid by the patient in the same way as the doctor. Similarly for the physiotherapists, a form is signed and the patient claims reimbursement. For consultations with a specialist the system is the same, and whether a patient sees a consultant ' in his rooms ' or at the hospital the costs are covered by the same scheme of state reimbursement.

Discussion

(1) *Contract*

There is no contract between patient and doctor for continuing care, the patient is free to choose any doctor he wishes to go to for any particular illness. This has several direct consequences:

(a) Because the doctor has no legal obligation for continuing care, he and his family are not tied to the house and telephone (or involved in deputising services) as they are in this country. He is free to take time off, leave the house unattended, and go on holiday without arranging cover if he so wishes (although where there is competition for patients there are obvious financial disadvantages).

(b) Because a patient is free to choose, the doctors appear to be more at their patients' beck and call. Certainly during my week about half the ' acute visits ' could well have come to the surgery. Furthermore ' second opinions ' and investigations appear to be more frequent—if the patient does not think enough is being done he is liable to go elsewhere.

(2) *Forms*

With having to fill in a government form so that the patient can claim reimbursement for each consultation and visit, and with having to fill in additional claim forms for insurance companies, and with various other certificates, the French general practitioner seemed to spend considerably more time each day on ' official ' paper work than I do.

(3) *Records*

The records kept by a general practitioner are his own affair and property. The doctor I visited had a trolley with four drawers which contained ' family folders ' arranged in order of villages. In these he filed consultants' letters and x-ray reports. He did not make a note during the week I was with him, and explained that with the small number of patients involved he did not need an aide-memoire for diagnosis and treatment.

Income

For a country general practitioner with two partners in a village covering a radius of about five miles the approximate numbers of patients and incomes were:

Including all payments last year (1972) income was approximately:
Partner A (1100 patients) 100,000 F.
Partner B (1700 patients) 150,000 F.
Partner C (1100 patients) 100,000 F.

By partnership agreement this was adjusted three monthly and gave a final payment in 1972 of:

Partner A 106,000 F.=about £10,000
Partner B 138,000 F.=about £13,000
Partner C 106,000 F.=about £10,000

Expenses

Each partner bears his own expenses (car, telephone, rooms). The only shared expense is a part-time secretary who works from his own home and organises the accounts. With the small work load the only ancillary help is a maid (Partner A) who, as well as her domestic duties, answers the door and the telephone when the doctor is not in the surgery.

Workload

By the standards we have grown used to over the past 25 years the workload was light and leisurely.

Was my week typical?

To calculate whether the workload for the week I was there was typical, the income for the week can be compared with the income for the whole year.

The total sums collected by the doctor on the days I attended were as follows:

Monday	673 F.
Tuesday	503 F.
Wednesday	Nil
Thursday	712 F.
Friday	331 F.
Saturday	199 F.
	2,418 F.

With 48 working weeks this would, if earned each week, produce a total of 116,064 F; as his income was 100,000 F, presumably the doctor worked slightly harder than usual during the week I was there.

Impressions

When comparing a week spent with a French country doctor with my own practice I may seem to be unduly concerned with his organisation and income. This is inevitable, because it is the outstanding difference between the two practices. The relationship between doctor and patient, the clinical content of consultation and visits, and the remedies used are all broadly similar. It was interesting to see that there was no embarrassment involved in direct payment to the doctor by the patient. Both are used to the system. The outstanding advantage that this method of payment appears to have is that it puts a value on the doctor's services. A direct result of this is that with a smaller workload (which produces a very adequate income) there is a lack of rush or hurry. The doctor has that one commodity which we too often lack—*time* to spend with each patient.

It would be very interesting to spend a similar period in a busy urban practice in France. I suspect the disadvantages of the system might be more apparent under these circumstances.

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