French general practice

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SUMMARY. Five British general practitioners spent a week with French colleagues in various parts of France. We report results of the observations which we agreed in advance to make about some aspects of clinical practice in France.

Introduction

WITH the UK now firmly established in the European Common Market, and free exchange of medical practitioners within the Common Market a reality, more and more interest is being shown in the nature of general practice within our neighbour countries. Several British general practitioners have visited France within recent years, and several reports have been written (Harris, 1974; Jones, 1974; Horder, 1975; Wright, 1975).

Following an exchange visit in April 1975 which was co-ordinated by the Royal College of General Practitioners and the *Syndicat des Omnipraticiens,* in which five British general practitioners each spent between two and four working days with five French colleagues, we discuss some clinical aspects of general practice in France and try to draw conclusions which might, with benefit, change certain British and French medical habits. Other writers, for instance Maynard (1975) and Vickers (1975), have detailed the differences in organization and finance.

Concerning finance, it is sufficient to say that the French system is based on payment per item of service at the time by the patient, reimbursed in total, or in large proportion, by the State.

Method

We decided to examine clinical practice in France in five ways:

1. We collected information from 413 doctor/patient encounters, comparing statistics from the UK where possible.

2. We recorded the distribution of morbidity in the same 413 doctor/patient encounters and compared it with figures from the National Morbidity Survey (RCGP *et al.*, 1974).

3. We wished to test the hypotheses that there is much unmet medical need in France and that as a consequence of direct payment to the doctor, doctors see fewer 'trivial' cases and can thus give more time to their patients.

4. We observed the management of six specific disorders.

5. We observed the prescribing habits and referrals of our French colleagues.

Results

1. Analysis of workload

Six doctors in widely scattered parts of France were observed for an average of 2·66 working days each (Table 1).

2. The distribution of morbidity

This is shown in Figures 1 and 2. The French figures are derived by direct analysis of the diagnoses made in the 413 doctor/patient encounters observed.

The UK figures are derived from Table 10 of the second National Morbidity Survey (RCGP *et al.*, 1974). There was a great difference in the size of the populations compared.

3. The hypotheses

Our joint impressions confirmed that there is much unmet medical need in France. The French general practitioner is mainly concerned with routine examination and prescribing. Little attempt to take a psychological or a social history was noted. There was little co-ordination of different disciplines and agencies. Some problems were not noticed: for instance, depression in the elderly, a battered baby, and marital disharmony.

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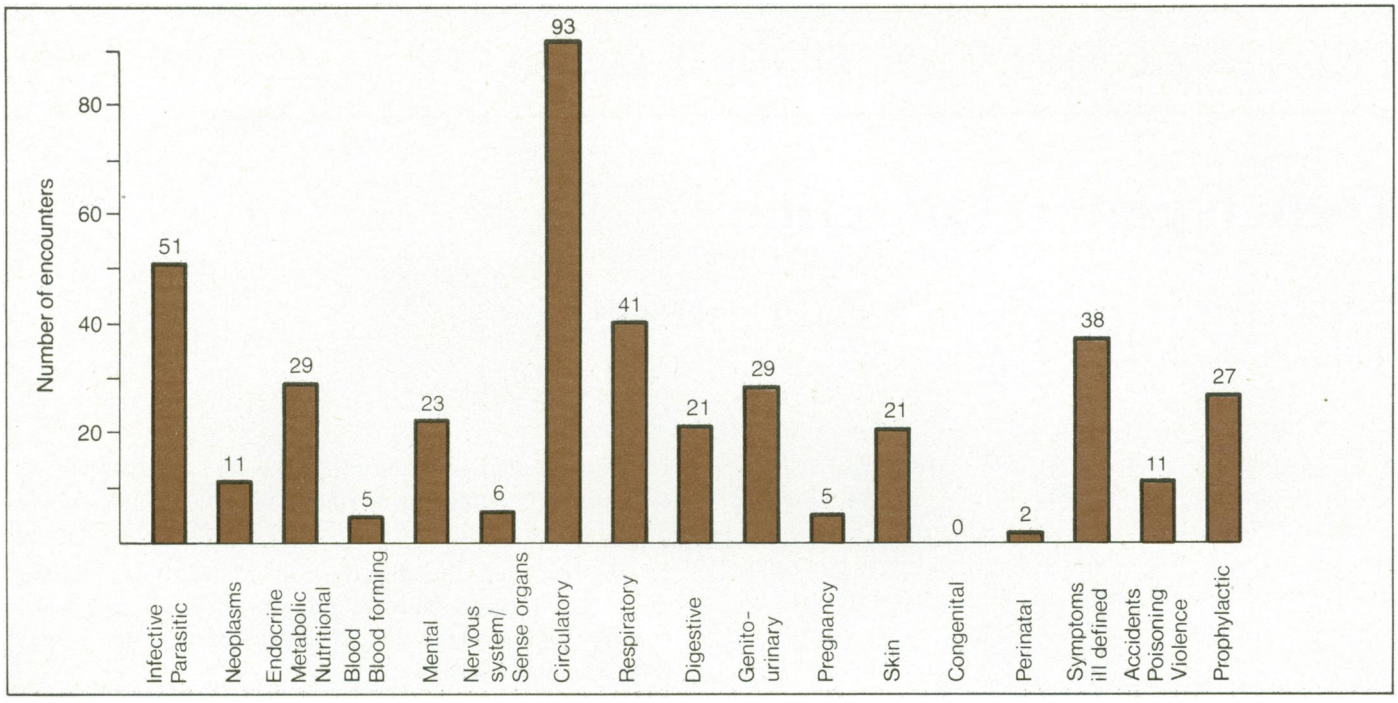

Figure 1. *Analysis of content of 413 doctor/patient encounters.*

Payment for each item of service was thought by some of the visiting doctors to dissuade the aged and impoverished from consulting (but not the very poor, who have 100 per cent reimbursement of their fees). Figure 2 shows that mental, psychoneurotic, and personality problems were grossly under-represented, as compared with experience in the UK.

Table 1. Analysis of workload (percentages in brackets).

	France	UK*
Total number of doctor/patient encounters (i.e. consultations)	413	
Total number of:		
home visits	140 *(33.9)*	*(16.6)*
office encounters	273 *(66.1)*	*(83.4)*
Mean duration:		
home visits (including) travel)	19.8 minutes	12.7 to 17.7 minutes
office encounters	10.1 minutes	5.7 to 6.6 minutes
Average number of doctor/patient encounters per day:		
total	25.9	35
home visits	8.8	
office encounters	17.1	
Total night visits during observation period (all doctors)	2	

*The right-hand column derives comparable figures from the National Morbidity Survey (RCGP *et al.*, 1974) and *Present State and Future Needs of General Practice* (RCGP, 1973).

There was no agreed view about the hypothesis that as a consequence of direct payment to the doctor, he sees fewer trivial cases and can thus give more time to his patients. One English doctor felt that, as payment was on an item-of-service basis, every request to the doctor was responded to in person (lest the patient go elsewhere) and that therefore no attempt was made to screen visits or consultations. Another felt that the doctor with whom he stayed had to do more unnecessary calls and consultations than he did himself. A third felt that consultations for minor ailments appeared to be discouraged, but suggested that perhaps the French pharmacist might be treating many of them.

4. *Specific disorders*

Hypertension. The treatment for this condition appeared to be similar in the two countries, for example, the use of reserpine, methyldopa, and beta-blockers. Practolol was used, but its side-effects were not mentioned.

Recording the blood pressure and commenting on the figures to the patient was an almost invariable part of each consultation, whatever the presenting symptoms or diagnosis.

Depression. Not enough cases were seen for conclusions to be drawn. This observation in itself seems important.

Alcoholism. A high intake of alcohol is part of the culture in France, and therefore accepted. This is one reason for the high prevalence of alcoholism, but another is economic; alcohol is the cheapest source of calories available for many of the poorest people. One English doctor noted that livers were frequently

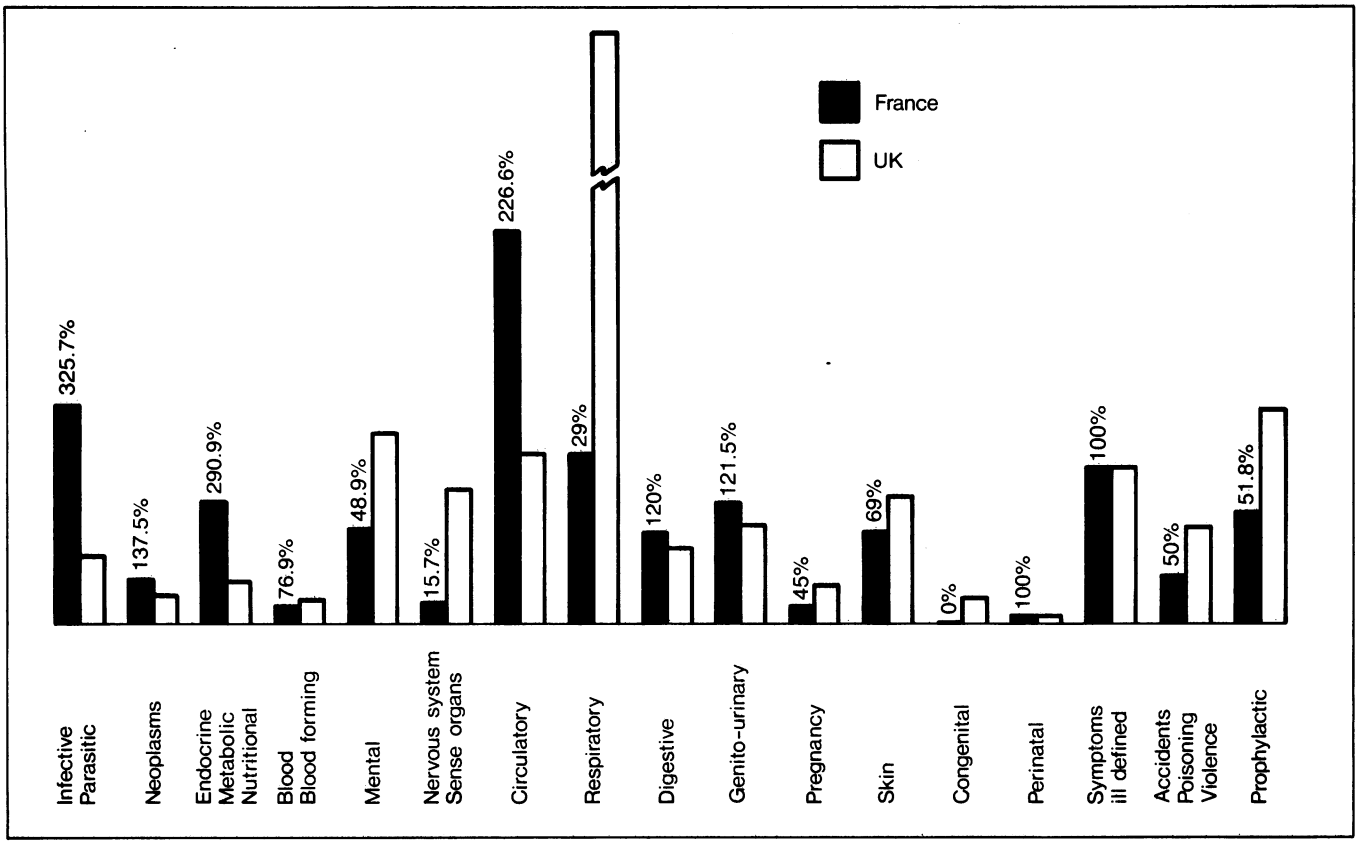

Figure 2. *Number of French consultations expressed as a percentage of UK consultations. (Second National Morbidity Study 1970-1971 — whole year).*

examined by his French colleague. The patient was advised to stop drinking if liver function tests were abnormal. This happened five to seven times a year in this practice—a much higher rate than in his own practice.

Contraception and abortion. Oral contraceptives were widely prescribed, but examinations in relation to them were often incomplete.

Abortion is available on request up to the eighth week of pregnancy, after the patient has appeared in front of a panel of three doctors. It was said that agreement for termination, following this appearance, is a formality.

Otitis media. Antibiotics were used, and also multicomponent nasal and oral decongestants. One doctor observed a case of otitis media seen at night, not treated, but referred to an ENT specialist the following morning.

Chronic bronchitis. Few cases were seen. One was treated with daily injections by the doctor (tetracycline, 'Neutraphylline', and 'Bisolvon', all in the same syringe). Another was noted to be treated with tetracycline, 'Synacthen', and bacterial de-sensitization.

5. Prescribing habits and referrals

All the doctors commented on the differences between the two countries. French prescribing seemed to be geared to the perceived wishes of the consumer rather than to logic, science, or economy. There is no equivalent to the *British National Formulary, Prescribers' Journal,* or the *Drug and Therapeutics Bulletin.* The French equivalent of *MIMS (Le Dictionnaire Vidal)* is 6cm (2⅜ in) thick. Drugs were not prescribed by generic name. Tablets, medicines, injections, and suppositories were usually multiple in composition. Many vitamins and vaccines were prescribed which appeared unnecessary to the doctor trained in the UK, and they were often used in combination with more logical choices. The actual prescription rarely contained fewer than three items, approximately twice the average for the UK.

This seemed surprising, since re-payment from the State is often delayed for some weeks. Drugs for peripheral vascular disease were widely prescribed, although they are believed in the UK to have little effect. Repeat prescriptions in answer to request by letter or telephone were not seen and one English doctor speculated that he would be struck off the French Register for the habits he has adopted in the UK.

As the system in France is on a competitive basis with payment per item of service, patients may consult someone else at any time. This includes medical specialists, other general practitioners, and nurses. As a

consequence, the general practitioner may not know who else the patient is seeing, and this is reflected in the inadequacy of record keeping (with the exception of the *Carnet de Santé,* which is a record of immunizations and medical examinations up to adult life, kept by the patient). Records seemed extremely incomplete. When referrals to consultants were made, the patient was seen within days, and any inpatient treatment was equally rapid.

All the British doctors commented on this difference from our own system, so often defective in this respect. However, as with prescribing habits, there is little attempt to limit demands from the consumer and there seemed little doubt about the cost effectiveness of British medical care in comparison with the French.

Discussion

Although our visit lasted only one week, detailed observations were made, and some tentative conclusions may be drawn which could be validated by a longer visit with more limited specific objectives.

The most important observation to be drawn from Table 1 is the mean duration of office encounters: 10·1 minutes. Criticism has been laid at the door of the British general practitioner because his average surgery consultation time is six minutes. Some French doctors make critical assumptions from this difference concerning the aims and quality of primary care in the UK. The time spent by our French colleagues includes time spent in completing claim forms for direct repayments, in ushering the patient in and out of the consulting room, and sometimes in answering the telephone. Moreover, the consultations recorded were carried out in the presence of a visiting doctor. These points may reduce the difference between the consultation times in the two countries.

The number of night visits—two per 413 doctor/patient encounters—was very much less than that in the UK. The reason for this may be that the French doctor is under no obligation to do night work, compared with the British doctor's terms of service and agreed responsibility for a list of patients.

The most noteworthy feature in the clinical content of the doctor/patient encounters (Figure 1) was the marked under-representation of mental, psychoneurotic, and personality problems compared with the work of the general practitioner in England. One reason for this may be the emphasis in undergraduate and postgraduate medical training on anatomical and physiological rather than behavioural factors. Another reason may be the system of payment. Giving an injection is a precise item of service; giving psychotherapy is not.

Our testing of the two hypotheses had mixed results. The wide range in the quality of concern and care among general practitioners in France makes it difficult and unreliable to generalize. We did find evidence of unmet medical need, but it was not clear whether or not the method of giving primary care discouraged trivial cases. The system of payment makes French doctors less often 'annoyed' than their UK counterparts. The use and abuse of the general practitioner is determined partly by the cultural demands of society, but also by the way the doctors have 'trained' their patients.

In the case of specific disease processes, hypertension was treated in much the same way, depression was seen too seldom for comment, and alcoholism was considered to be inbuilt in the French way of life and hence rarely presented to the doctor. Contraception was much the same as in the UK, but the management of abortion differed. Otitis media was treated in much the same way, and chronic bronchitis was seen seldom in this visit.

The good general practitioner responds to his environment in the way most appropriate to the needs of the patient he serves. This response is influenced by his basic training and the continuing process of postgraduate education. In France, medical thinking appears more anatomically based, and therefore more importance is given to examination than in the UK, where perhaps we are relatively more concerned with the psychosocial aspects of disease, and therefore with the history. Recent work by Hampton and colleagues (1975) confirms the relative importance of history taking in diagnosis. We felt that there was a tendency for some examinations to be ritualistic and of doubtful value in France.

The scarcity of organized postgraduate education, and the relative isolation of the general practitioner in a single-handed practice (of 85,000 doctors in France, only 20,000 are organized into groups; Vickers, 1975), seem likely to produce a particularly wide variety in the quality of care. The general practitioner has to make a very real effort to keep up to date and it is easy to slip behind in medical knowledge.

Relative isolation also relates to what we saw as the fundamental difference between our systems. The French doctor feels, from the moment he is consulted, that it is his sole responsibility to diagnose, treat, and supervise the recovery of his patients. Unlike British doctors, he does not expect his patients to make health decisions. He *supervises* care, while the British general practitioner *advises* his patients. These attitudes lead to more visits and examinations and very much longer working hours, often 14 hours per day, with more home visits in proportion to surgery consultations. Many of these, the British felt, could have been delegated to others, but because of the fixed relationship of income to work performed and the risk of losing patients to other doctors (there is a higher proportion of doctors to population in France than in the UK), delegation did not occur. One result, however, was that French colleagues live somewhat better than their counterparts in the UK. The English doctors saw the French as industrious entrepreneurs, while the French saw the English as *chefs d'équipe* (team leaders).

Conclusion

What are the best and what are the worst features of French primary care?

The best feature for the patients is the rapid referral to hospital specialists and the ease with which this can be arranged. There is also a high degree of respect for the patient and his illness.

For the doctor, the best might be the item-of-service payment, certainly in terms of income achievement, which rewards intensive effort and provides incentive at all levels of patient care.

The worst feature for the patient was the necessity to pay the doctor directly and then reclaim the fee from the *Securité Sociale.* However, there was no evidence that this reacts adversely on the doctor/patient relationship. The worst features for the doctor were the lack of support from a team, isolation, lack of continuity of care, especially in record keeping, and the poor facilities for postgraduate education.

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Addendum

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