

Out of Hours

International primary care snapshot:

academic primary care in Italy

AN ITALIAN DILEMMA

Family medicine (also known as general practice or primary health care) has undergone substantial growth accompanied by academic development in Western countries during recent years. In Europe, however, the situation is not uniform: although in Northern European countries family medicine is established in both the national health system (NHS) and the universities, and academic general practice looks promising in post-Communist Eastern European countries, in Southern European counterparts it is still considered a minor medical discipline. Even within Southern Europe the pattern of family medicine is not homogeneous, because several countries such as Croatia, Portugal, and Greece do include some academic curricula in family medicine. Yet this is not the case in Italy, where general practice is completely devoid of any academic features.

In fact, Italian universities have no primary care departments at all, and general practice is not even included in the undergraduate curriculum of Italian medical schools. Only private foundations conduct primary care research in Italy.

Italian GPs do not have the opportunity to pursue a PhD programme in family medicine, nor are academic positions in primary care available to them. In December 2010 the Italian government passed a law allowing for simultaneous registration for postgraduate medical training in a clinical specialty, and PhD studies for doctors wishing to pursue an academic career in clinical medicine. This is quite an advanced milestone for Italy, a country affected by an excess of 'incompatibilities' (vetoes against doing another job, even outside working hours) in public administration, which most often has little to do with real conflict of interest issues.

All in all, a very long period of training is an issue in medicine, because it implies a later entry into the work world. In view of this, some Northern European institutions have started MBBS/PhD programmes combining simultaneous undergraduate medical studies with PhD schemes. Unfortunately, the previously mentioned Italian law applies only to doctors training in hospital specialties governed by university authority; moreover, GP trainees are banned from registering in any sort of PhD programme during their 3 years of training.

Italian GP trainees complain they do not receive appropriate standards of education and do not feel they are adequately supervised during their training rotation in hospital wards. GP trainees are in fact considered 'simple' postgraduate students and can only rely on a taxable monthly stipend, which is half the salary of Italian hospital specialty trainees. Hospital trainees, being in charge of university governance, have a proper work contract. Despite the obvious financial discrimination, Italian GP trainees are also not allowed by law to do any extra self-employed medical work during their low-paid training in primary care.

As a result of the above, the reputation of general practice in Italy is somewhat low and this accounts for the tendency of some of the best medical students to opt for a hospital career, with GPs and specialty doctors now being in competition. The primary care establishment is independent from the academic world and seeks to protect privileges by providing better salaries and quality of life (flexibility and limited opening time of solo GP practices) than hospital doctors who are underpaid and work longer hours because their respective unions are not as strong in negotiations with the Italian government. This socioeconomic gap could be eliminated if primary care schools fell within the university domain.

There is a widespread opinion that responsibility for these poor standards of general practice are intermingled with politics. GP unions, in fact, are represented in the provincial medical councils and are therefore in the position of wielding political influence. Protecting the interests of a professional category may have detrimental consequences though, not only for junior doctors in training, but also for society as a whole. For example, the opening time of Italian solo GP practices is normally half a day or even less, and thus more limited than elsewhere in Europe.

Four sensible steps could be useful in improving the reputation of family medicine in Italy, establishing primary care research, and forming better qualified GPs:

- introducing external quality control into general practice and its training;
- abolishing the local medical councils in favour of one single national regulatory body;



The old anatomical theatre in the University of Padua, Italy.

- introducing primary care in the undergraduate curriculum of medical schools; and
- establishing primary care departments at universities and making academic positions available to doctors with a PhD thesis in family medicine.

The Italian medical system has not, so far, been sensible enough to consider these kinds of measures, perhaps due to the persisting influence of GP unions. In some cases this political influence is exploited, on the one hand, to mark the independence of family medicine from university governance, and, on the other, to set up advantageous professional regulations for GPs.

Rather than being predominantly controlled by the interests of unions, the medical profession should try to modify its view, focusing on best practices to comply with appropriate standards of care. In this way it could gain a higher level of competencies instrumental to real political autonomy. Improvement of primary care would in fact not only have a positive impact on the medical treatment of individual patients but also on the population, and society, as a whole.

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