International Perspectives

Family Practice in France and Spain

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Historically, the renaissance of family practice (still known in Europe as general practice) found its inspiration in Britain in the 1950s and was carried through the written word or by immigration to Canada and the United States of America, where similar attempts at change were already beginning to occur. Each country, embracing the new ideas of family dynamics, patient relationships, and the physician's own role as a therapeutic agent and support system, developed an individual style of family practice based on its medical culture, social structure, availability of funds, public support, and the character of its professional leaders.

The advent of international family practice, demonstrated by the existence of WONCA (World Organization of National Colleges, Academies, and Academic Associations of General Practitioners/Family Physicians) indicates the increasing interest shown by family physicians from non-English speaking countries in the new directions the discipline has taken in the past few years. In Europe, language barriers still block the exchange of information and views, characterized particularly by the minimal cross-referencing noted between journals of English speaking countries and those of Latin countries.

In order to support the understanding between family physicians on the international level, this communication describes two medical systems in Europe (France and Spain) through the experience of two physicians. The first, Jacques Morineaux, from Rennes, France, is about to go into family practice and could be termed a "resident." The second, Dr. Llinas Pozas of Barcelona, Spain, is a well-established practitioner.

France

Jacques Morineaux is 30 years old and has just completed six years of medical school at the University of Rennes. As in other countries, there is considerable competition to become a doctor, although initial entry into medical school is quite easy. The first year class consists of about 1,000 students, 650 of whom are culled out at the end of 12 months. Because the classes remain huge, the students often are frustrated with the educational environment. The first two years of training consist mainly of instruction in the basic sciences. Physical diagnosis is taught in the third year. The fourth, fifth, and sixth years consist of three-month rotations on various services with certificates of competence awarded at the end of each session. Students also go through a three-month rotation in which they specifically study and ob-

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serve nursing skills, but in general they have poor direction and little practical experience. There is minimal instruction on human behavior, interviewing skills, family diagnosis, and none in psychology and sexuality. There is no exposure to primary care in family practice. Once the student has graduated after presenting and defending a "thèse" (a specific medical study), there is no legal requirement to undertake a year's internship. The new physician can immediately enter practice. Some do, but most spend a year as an apprentice with a practicing physician—or they train themselves in primary care by moonlighting.

Training for family practice is nonexistent in France; there are no residencies, except a pilot program in Paris. There is a growing surplus of physicians of all categories which is causing increasing conflicts between various specialists who provide primary care and "generalistes" (the family physicians). Jacques Morineaux is planning to practice in a rural area to avoid these problems. Because of the increasing unrest among students and physicians, the "Commission Fougère" has recommended a complete reform of medical education which would include a three-year specialized training program in primary care. In spite of resistance from archiac medical institutions it appears that the commission's findings may be implemented.

Solo practice is still very commonplace in France, although younger physicians prefer to work in groups. The average physician sees between 30 to 60 patients a day. If he works alone, his wife will act as the receptionist and will take calls at home every night. A group will tend to have a combined receptionist-secretary. However, family physicians rarely undertake their own laboratory work, but obtain services from private laboratories. The physician usually works from eight in the morning until eight in the evening. Patients have varying types of health insurance, and social security covers the medical costs of the poor. Patients have 70 percent of medical fees and drug costs reimbursed by governmental agencies, and there are 40 conditions (including diabetes, cancer, and heart disease) that are treated at no cost to the patient. The family physician earns on average 20,000 francs a month ($4,000); an office visit costs 33 francs ($7); home visit, $9.50; night visit, $21; Sunday visit, $17. Little is known about the morbidity and content of French general practice and data collection systems hardly exist in primary care in that country.

Spain

Dr. Llinas Pozas has been in practice for over 20 years. He graduated from the University of Barcelona and practiced surgery for five years before turning to endocrinology, pediatrics, and finally general practice. His practice is located in Barcelona, where he undertakes both private and social security work. The social security system is the biggest provider of health care in the country, with a widespread system of hospitals, outpatient centers, and primary care clinics. It is a complex, intensely bureaucratic, grossly inefficient, and frequently corrupt institution. Dr. Llinas works for the social security clinic in his district on a rota basis with other generalists. He attends the clinic between 8 and 10 AM every day, seeing between 40 to 80 patients in the two-hour period. Two nurses and an administrator provide assistance but the physician acts more as a prescription writer than as a clinician. Dr. Llinas states that it is difficult to tell who is ill since patients are constantly seeking sick notes to get off work or demanding expensive laboratory workups in order to get "value" for their social security payments. One thousand families in the area are assigned to Dr. Llinas by the social security system, although the children have to be seen by a separate pediatrician. Strangely enough, children are defined as people below the age of seven years only. Those above seven years are considered as adults. From 10 AM to approximately 4 PM home visits are undertaken at the behest of the clinic administrator who provides the physician with a list of sick patients. Dr. Llinas works in his private practice from 4 to 9 PM. He cares for about 1,500 private patients and spends about half an hour with each patient. He uses an appointment system, a nurse, and a fluoroscope. He also serves four small factories as an industrial medical officer, checking on health risks and factory regulations and providing medical attendance for an hour a day.

The availability of medical services in Spain is extremely haphazard. A significant proportion of the population is treated by a social security health-care system which is inadequate and riddled with bureaucratic tangles. Patients can receive free

care only in their own district. In order to do so elsewhere, they have to obtain certificates from the local health office for which waits of up to 5 hours may be necessary. Physicians are afraid of going into general practice because of the social security duties which destroy enthusiasm and clinical standards. An additional factor is the lack of technological support systems. There is a great scarcity of paramedical staff, such as public health nurses and social workers, to assist the family physician out in the community. Free care is given up to the age of 21 years and to the elderly, although the very aged are not eligible for social security, having been born before the inception of the system. Psychiatric and psychotherapeutic health care is not covered by social security payments at all.

There is an urgent need for general practitioners throughout the country, yet the trend is towards increasing specialization away from the jungle of primary care. There is no research undertaken on primary care in Spain, nor are there any specific general practice training programs. The recent change to a democratic government has allowed a liberalization of medical thinking and the creation of the first Ministry of Health whose initial task will be the restructuring of the health-care system to provide equitable facilities to the mainly rural population of Spain where infant, perinatal, and maternal mortality, malnutrition, infectious disease, and access to care remain serious problems.

Comment

In terms of the development of primary care, the concept of continuity, and specific physician training, both France and Spain have much to gain from an exchange of knowledge and skills with the English speaking nations. There is a need to overcome some nationalistic and chauvinistic attitudes as well as the barriers of language in order to allow family physicians from these different countries to learn from one another. It is possible that WONCA, or some form of international family practice journal could be the best initial method of achieving this aim.