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Participant report
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The vast differences in healthcare between countries often reflect cultural, historical and political differences. It is the problems we share that stick out and require our European if not global attention.

It was with a sense of adventure that I disembarked from my flight to Spain. I was there to seek out the truths and the myths of the Spanish healthcare system. Where could the NHS improve? Could I offer any advice? How could I influence local policy with all that I had learnt?

I was in the last two weeks of my GP training (in Brighton) and filled with both enthusiasm and wonder at the opportunity I had been given. The RCGP had arranged for me to spend 2 weeks shadowing a Spanish GP in a town just outside of Castellon. I was a little intimidated, as my Spanish skills are only passable. This intimidation grew as the news arrived that the primary language of the region was Catalan. This meant I had been swiftly relegated from 'almost hopeless' British tourist to 'hopeless' British tourist. Fortunately, I have adopted this role many times before and 'kept calm' and managed to 'carry on.'

What saved me was my host, a well-spoken GP who shared certain commitments to doing the right thing rather than the expedient thing. He was both well versed in English and acutely aware of the dangers posed by political and pharmaceutical corruption within healthcare.

I was stationed in a town outside Castellon of about 5000 people, known for its beach, a past generation of party goers and regular bull runs. Yes, that is a spectacle by which shops (and the GP practice) put metal fencing down to protect the windows. This allows for bulls to chase people though the streets for the amusement of onlookers. Thankfully for my colleague the government funds an extra doctor on call whilst this takes place.

The differences began with the building, a multipurpose health centre containing staff with white coats. Here they had GPs, midwifes, nurses and pediatricians all working in the same place. They have on call rooms to sleep and an abundance of coffee machines although no kettle (unbelievable.)

The day job seemed similar enough, although I saw significantly less mental health problems in Spain. It appears they benefit from a population that still values community and family ties over the consumption of goods or experiences. The data on prevalence of mental health problems support this (Europa.eu) The doctors are paid less but seem happier, they work more hours yet seem happier, they have less QOF, less targets, less paperwork and less to think about that isn't seeing patients. They also have less patients and a strict continuity of care. Their patients are happier with the health system as they can see their own doctor regularly with little access issues this also makes for a nicer working environment. The GP centre covers the out of hours service for their area and the nurses who work in the building are nurses for the 5000 patients.

We recapped the bureaucratic structure of both the NHS and the Spanish health system. This was a stark difference. I think from the head of health in the whole Valencia region there were 3 or 4 doctors directly above my colleague and little else. I attempted to explain NHS England, HEE, CGGs, foundation trusts, PCNs, NHS improvement, DOH, but even with the help of the kings fund it was tough.

The primary care system is mostly public, this results in fewer managers, less bureaucracy and fewer private companies. This means less money is taken away from the system towards profit, however there is also less innovation, less culpability and perhaps less motivation to ensure efficiency. It is near impossible to fire someone, productively and output are not measured and you do not apply for jobs directly but rather you apply to the government and they choose a spot for you.

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Most of these differences have developed over many years and lie in our different cultural and historical backgrounds. So, whilst interesting to observe, I don't think it would be wise to focus our efforts on either the NHS becoming more like the Spanish system or visa-versa. We must instead turn our attention to the problems we share as health professionals and societies. There are perhaps two exceptions. The first is that they use an integrated computer system which hospitals and GPs enter onto the notes. This allows for much better continuity of care as well as reducing admin time for many. The other I just wish to raise the question as to why we are using the expensive DOACs whilst Spain uses the cheap acenocoumarin? I understand there are slightly more side effects with the latter, however the cost saving is huge and could to be used for prevention of health problems rather than the treatment. I am sure there are good arguments either side, but as similar health systems, both attainting for excellence and wise resource allocation it seems strange we are at odds here.

Despite these differences it is clear that the doctors I know in England and the ones I met in Spain are professional and dedicated to their patients. Given the time to observe and reflect took my attention to larger problems than just the patient in front of me. It led me to realise that the problems facing modern medicine are likely pan-European, perhaps even global. There were many problems we shared. However, I want to focus on three main ones; drug company corruption, over medicalisation and the current confusion over the GPs role within society.

I had thought that the UK and US were the most affected by big business and ergo the manipulation of a populace's behavior. I was surprised to find out that pharmaceutical sales and influence extends throughout the EU and perhaps more so to Spain. In the UK we have CCGs keeping an eye on prescribing. We also have stricter rules preventing the more obvious type of persuasion. From what I learnt in Spain these things are less strict. Almost weekly the medical centre would be visited by drug reps and no one would particularly scrutinise GPs prescriptions. They still funded dinners, events, and travel to teaching. It is also likely that the more

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underpaid and over worked your healthcare professionals are, the less they are going to find the energy to fight these problems.

Most of doctor's education (post training) is funded by industry (Goldacre 2013) who also highlights the money drug companies spend on marketing, developing new versions of old drugs and ensuring doctors who support their views are well looked after. This is a huge problem for patients and for governments. Learning that these problems are endemic throughout the EU has highlighted the scale of the problem. Exchanges like the Hippocrates can help us design new ways to challenge this and avoid the damage from bias research and overuse of pharmaceuticals.

In a similar vein, I noticed parallels in patients with 'overmedicalisation syndrome.' This idea that everything in life has a medical problem. No doctor I know believes a patient's social background, current mental health or social situation is irrelevant in disease. However, we practice and teach medicine in positivist way, often ignoring this. If doctors continue to treat social and psychological factors with modern medicine (investigations, GP appointments, drugs) then patients with social problems will continue to visit their GP to solve these problems. It is not an easy problem to address, although it's another pan European issue that we can help address together. It was with dismay as I peered at patient's drug lists combining an anti-psychotic, an anti-depressant, a mood stabiliser and a benzodiazepine. This idea that these medications combined are beneficial in the long tun is a questionable one. As is the idea that these pills can 'cure complex social problems' (Goldacre 2009.)

This nicely leads us onto our final similarity. Which is the existential angst often felt by GP's, as to the confusion of their role within a society. As a society we need to be clear as to what role we want our GPs to play. Are we OK with taking the village priest role away? Are we life coaches? Nutrition experts? Psychotherapists? Social workers? Gateways to specialists? Human cancer screening machines? A soothing parental figure helping people cope with the tragedies of modern life? Have we replaced drug dealers by medicating society with neuropharmacological agents? Or are we the curers of the sick, those who diagnose and treat disease? This

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fundamental question needs discussion so that we know what's a doctor's responsibility, and so we know how to train our new GPs.

There were other similarities, patients were as reluctant to accept lifestyle advice as in the UK. I also found because of this; doctors were reluctant to give it. There were high 'did not attend rates,' as well as the detrimental impact that healthcare has on the environment. It is unclear who is tackling these issues despite their importance.

I appreciate I have offered a lot of problems rather than solutions. This is a common technique employed by young members of any profession. The difference here is that I believe increased awareness of such problems is part of the solution. As are the forming networks of doctors who understand such problems and are not happy with the status quo. To this end, I hope the Hippocrates program continues.

To conclude I will repeat how grateful I was to be given such an experience. I had a wonderful time and met some lovely people. It gave me the time to reflect about the difficulties in running a health service and the problems that we all face. Many differences are caused by deep differences in culture and governmental structure. This makes comparisons interesting and challenging. The similarities in the problems we share should be a warning that as doctors and society we need to work together to solve them. Exchange programs like this can act as a building block to create networks of doctors with the desire for improvement.

References

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