RESPIRATORY MEDICIN

Section 3- Elective Objectives Robert Shine. (May 2012)

1) Describe the pattern of health provision in relation to France and contrast this with the UK ?

The contrast between the two systems did not strike me as being particularly significant and most likely relate to financial arrangements made at the time of the creation of the respective national health/insurance services. The French system has been classified as Bismarckian following the initial nineteenth century German example. It is an insurance based system where the 3 parties involved are firstly, the population who are compelled to participate through their employment; secondly the providers who are a mixture of private and public organisations and finally the contribution collectors who act independently from healthcare providers. The UK system is based on Beveridge's ideas from the 1940s with a taxation funded service where financing and provision are controlled by one central organisation for the entire population. Both systems aim to provide extensive medical support for the whole population and both systems are grappling with similar cost problems. These include an expanding elderly population who require more care and who are already retired so are not contributing to insurance or taxation. Also, the increased sophistication of medical equipment and techniques raises costs at a time of global recession when these two western European welfarist countries are trying to compete economically in a global competitive market.
Are there major differences in inputs and outcomes? As a percentage of GDP France spends 11 % against 8.4 % in the UK and has higher life expectancy and lower infant mortality. It regularly gets rated very highly in comparative studies but these studies are inherently very crude and deal with huge organisations that are extremely difficult to compare effectively.

2) Improve understanding of respiratory disease.

I encountered patients with a range of respiratory illnesses at the day hospital department at the Arnaud de Villeneuve Hospital. These included patients with bronchiolitis obliterans, COPD, idiopathic pulmonary hypertension, granulomatous disease, asthma, fibrotic lung disease and more rare diseases associated with a compromised immune system. I joined with the medical students to take histories and examine these patients in between the times when they were having formal tests undertaken like CT scans, PFTs, cardiovascular tests (echography, exercise test and ECGs). The information the students were trying to illicit from the patients was just as it would be in the UK focussing on current control of the pathology, day to day function, effectiveness of medication and patient understanding of their situation. Examination was based on assessing air entry, presence or absence of vesicular breathing and any added (abnormal) sounds. Each morning before the arrival of patients a senior doctor would brief the junior staff and students on what to look out for that day and discuss the theory behind some respiratory conditions. Areas that

were discussed in more detail included the underlying cause of hyper-reactive airways as seen in the asthmatic patient; the lung volumes of obese patients and the problems that decreased reserve volumes can create; the aetiology and prognosis of allergic bronchopulmonary aspergillosis and finally the stepwise medical therapy for asthma.

3) Describe your experience a different health culture, a different language and reflect on your experience.

I do not think that the French health culture is very different from that of the UK. These are two western European neighbours whose medical professionals work on the principal of best evidence and have powerful regulating authorities. A more interesting health culture comparison would be a western against a non-western or third world country. The revolution in communication and dissemination capabilities in the last 30 years in the form of the world wide web has meant that news of any new medical findings is almost immediately made available to the community of web users. This mitigates further against the possibility of big differences between modern western states' health cultures, particularly in regard to management of conditions. For example, if a new asthma drug has consistently outstanding results in one country then it is only a matter of time and cost management before it is used in another country.

The different language made things more difficult but also more interesting and challenging for me. The French abbreviations used for respiratory conditions like BOOP and HTAP took time to adapt to and the speed with which colleagues spoke meant that it was hard work to process what they were saying. At a crude level interactions with patients were more easy as I could ask direct questions (requiring yes/no answers) and perform physical examinations that did not require conversing. However my experience of 6 years of being a medical student in the UK has taught me that when taking histories the devil is often in the detail and there is a skill in teasing out key diagnostic information from a patient . This absolutely was not possible for me in Montpellier although my general ability to speak French improved quite considerably during the course of the time I was there.

Outside of medicine, I made sure that I enjoyed the rich culture, lifestyle and weather of the south of France which was the perfect antidote to the stress that had surrounded the period of final exams the month before in London. I made a deliberate effort to try and have the best time possible knowing that a very demanding job awaits me in July where my free time will be considerably curtailed. I hope that this experience will help me in the future as I intend to perfect my French and one day work in a francophone country in whichever field of medicine/surgery I end up in.