

# My Croatian Experience with General/ Family Practice

Alan Mem Aba

Royal College of General Practitioners, London, UK

## ABSTRACT

*Despite the differences in organizational level and training of the new generation of family physicians general practice between the United Kingdom and Croatia shows many similarities. This article highlights some of these similarities and differences. It is written after a visit to the Family Medicine Department at School of Public Health »Andrija Štampar« and observations in various clinics in multiple locations including rural area in Croatia. Each primary care team in Croatia consists of only a doctor and a practice and a public health nurses with no availability of administration staff. As in the United Kingdom they have very heavy workload both clinical and nonclinical. In Croatia the lack of availability of commonly used community services in the United Kingdom brings extra challenges for Croatian colleagues. In Croatia presentation of patients with chronic disease and multiple co-morbidities and overall their management is not significantly different from the general practice of the United Kingdom.*

**Key words:** general practice, family medicine, organization, service provision, Croatia

## Introduction

One of the best outcomes of my attendance at the WONCA Europe region 2014 conference, held in Lisbon in July 2014 was to establish many international networks. Having an active approach to talking and exchanging ideas with colleagues from diverse primary care experiences made it easy for me to organize a trip to Croatia for a week as a clinical observer. I had always wanted to join an exchange programme during my training years but somehow could not organize it for various reasons, including the formality of the process itself. Of course having a chance to meet professor Mladenka Vrcić-Keglević<sup>1</sup>, founder of the Foundation for the Development of Family Medicine in Croatia, whose passion for family medicine and support for junior doctors has not changed in anyway even after her retirement, was also a great advantage. After exchanging e-mails and engaging in discussions about how best I could use my time effectively in Croatia, the Professor kindly organized a draft time-table for me and finally I was on my way to Croatia, a country that had recently gone through turbulent times but managed to become the twenty-eighth member state of the European Union.

When I set off on the Saturday, knowing that I would be collected from the airport by colleagues and also hav-

ing accommodation already booked gave me a sense of security and pleasure. As was planned, Dr. Miro Benčić drove us to School of Public Health »Andrija Štampar«<sup>2</sup> where I spent my six nights at the faculty's accommodation.

The next day at 10 am Professor (Vrcić Keglević) was already at the school to collect me for the 'city tour orientation'. Walking down the town with the Professor made me feel as though I was the luckiest tourist in town as she explained not only the general history of Kaptol, and its difference from other parts of the city, but also the history of the buildings we passed. It was fascinatingly informative. After 2 ½ hours of walking we were joined by two other colleagues who would be hosting me in the days to come. At this stage the Professor left, leaving us »youngsters« to continue with the city exploration and further our talks about primary care in the UK and Croatia. Of course our day ended with a meal in a typical local Croatian restaurant with delicious food and rakija<sup>3</sup>. While tasting it I learnt how rakija is used not only as an appetizer but also to treat various ailments from sore throats to pains in the knee. This added further taste to our dining experience.

## **Familiarization with the Family Medicine Specialist Training**

The next day was the »official« start day of my exchange programme. I was with Professor Vrcić Keglević again and, after a faculty tour, the picture became clearer in my mind as to the significance of Andrija Štampar and the School that was named after him, not only for Croatia but also internationally. Finally we were in the Professor's room. You may be wondering now: »isn't she retired?« Yes, she is. However, it is a Croatian academic tradition for retired members of the institution to have an allocated room. Our main topic was the GPVTS programme in Croatia. The three year specialty training in Family Medicine, which is quite an intense programme<sup>4</sup> has recently been increased to 4 years. It starts with six months theory based at the Family Medicine Department of the School of Public Health »Andrija Štampar« Faculty, during which time the trainees have no clinical commitments for service provision and also need to do research, after which clinical rotations start in hospitals. They undergo multiple rotations usually of a few weeks duration. During these rotations trainees have a logbook and need to perform a certain number of rotation related tasks. For example in dermatology they need to do a certain number of skin prick tests. Their final year is based in a General Practice clinic under the supervision of a »mentor«. The final assessment is very vigorous. Not only do they undergo an MCQ and portfolio and essay assessment but also OSCEs and a final oral examination. The numbers of OSCEs are between twenty and twenty five and the oral exam is conducted by three professors at which the trainee meets the trio for the final hurdle to obtain the title: Specijalist Obiteljske Medicine<sup>4</sup>. There is also another class of general practice doctors who just complete their basic medical degree and start working in health centers as General Practitioner. According to Professor Vrcić Keglević a number of doctors who underwent the specialist training since it re-started in 2003 were already doctors who had been working for many years in the health centers after their graduation from the medical school. All the Specijalist Obiteljske Medicine colleagues I met had had in fact experience as General Practitioners for between two-ten years before joining the programme. The Croatian training as a specialty was established in 1960 but unfortunately due to the war and some other factors/politics had been interrupted. The current training programme is planned to last until 2015 when it will be reviewed.

On our way to the inner-city teaching practice, I asked the Professor: »Don't you think this programme is a bit too intense and could possibly deter people from joining it?« Her answer was rather surprising but honest: »we wanted this specialty to be respectable«. This answer made much more sense after I talked to many colleagues and realized the high degree of tension there is between the primary care specialists and the secondary care service providers. My impression was that the main cause of this tension stemmed from the insurance based payment system. The more I talked to colleagues the

more I could not help thinking how lucky we are to practice in the NHS as gate keepers.

The inner-city teaching practice is based at a health centre. The health centre accommodates a total of two clinics but four teams as the teams run am and pm clinics in rotation. Each clinic is run by a Specijalist Obiteljske Medicine or a General Practitioner. Like any other single-handed clinic these health centre based teams consist only of a doctor, a nurse and public health nurse. As we entered the clinic from the common waiting room we found ourselves in the reception/nurse room which led to Professor Hrvoje Tiljak's room who was not wearing a white coat. It was about 1 pm and Professor Tiljak had already let all three of the trainees go as they were approaching their final exams. I noticed that there was no extra room for the trainee doctors. They saw patients with their mentors in the same room and did not have their own list of daily booked patients. As Professor Tiljak was very busy and he needed to vacate the clinic for the pm team we needed to leave and visit the clinic opposite. Dr. Vlatka Topolovec Nižetić, a Specijalist Obiteljske Medicine doctor in her white coat, was happy to see us. After a few minutes of welcome and introduction we talked about how I had made a comment about her poster in Portugal. Dr. Topolovec Nižetić was also very busy and highlighted the length of time that she needed to allocate to tasks that probably did not need a doctor's direct input.

As we left the clinic and Professor Vrcić Keglević drove towards »Andrija Štampar« I paid attention to a remark of hers: »Only Professor Tiljak and I do not wear white coats, you will see the rest of the doctors you visit all in their white coats; we could not get them to see patients without coats«. It made me think of what could be the reason for this. Is it status or infection control? Of course the literature has very interesting articles relating to white coats citing, for example, reasons such as »to be recognized by the colleagues« or »psychological barriers«<sup>5</sup>. Unfortunately, and to my regret, within my busy schedule I did not have real reasonable time to ask my Croatian colleagues why they prefer to wear white coats.

## **Small Clinic in Brdovec and Health Centre in Zaprešić**

On Tuesday I visited a clinic in Brdovec a small town in Zaprešić. Zaprešić is a city in Zagreb County, located eleven miles to the northwest with population of about 20,000. Dr. Benčić, a Specijalist Obiteljske Medicine doctor, had already started at 7 am with a phlebotomy service, taking blood from nearly twenty patients. He provides this service twice a week and takes the blood himself. The clinic in Brdovec is very clean, newly done up, and owned by a local health centre. Despite providing a single-handed service Dr. Benčić is not an independent contractor (the UK equivalent of a Partner) but actually works for the local health centre (something like a salaried GP in the UK). Given the chance, of course, Dr. Benčić would prefer to be an independent contractor. Be-

fore joining the GPVTS programme a doctor needs to be employed, or to have a contract with a health centre and after qualifying needs to work for the centre to which they were contracted. Some centres allow their qualified Specijalist Obiteljske Medicine doctors to work as independent contractors using the centre's facilities or to move out and establish themselves in their own premises. Unfortunately despite working very hard Dr. Benčić was not granted to be an Independent Contractor. One reason for this might have been the fact that he was generating a good income for the health centre as a result of his hard work.

Before the next patient arrived we had very little time to have coffee and look around the surgery. Dr. Benčić's nurse practitioner was very experienced, including having years of experience in working in an oncology unit. However, Dr. Benčić thinks that a large part of his nurse's daily task was administrative activity which would eventually lead to deskilling. After observing them in action for a week I think this is a view that it would be hard to disagree with. Dr. Benčić not only does some of the routine minor operations but also undertakes acute minor surgical inputs such as suturing. He is also fully equipped to catheterize patients, and in fact after seeing his second patient he popped out to the minor operation room to change a long-term urinary catheter of a patient with prostate cancer with multiple metastases. I quietly sat in a corner of the consultation room to observe. Luckily no patient objected and in fact some of them made good eye contact with me and their body language was very welcoming. Judging by their body language every patient who entered the room showed great respect for their doctor. They all entered with a file containing their medical information and letters from the hospitals, apart from one middle-aged gentleman with multiple co-morbidities who, according to Dr. Benčić was not a great fan of the medical establishment and tablets in particular. Unfortunately as the health centre had not provided any scanner for Dr. Benčić to scan his letters one aspect of his consultation was to write relevant information and do certain codings based on the written information that the patient provided. Consultants in secondary care do not send relevant correspondence to the patient's GP but hand the letters to the patient to deliver themselves. Dr. Benčić's patients' profile is not very much different from UK patients in terms of the conditions they present with such as HTN, DM, IHD, OA, medication review, URTI and other usual primary care problems.

Of course all the patients are Croatian speakers and Dr. Benčić does not need to worry about language barriers. In fact during my one week observation I did not see any ethnic minority patients who might bring challenges to the consultation due to a language barrier which is something we often face in London. Dr. Benčić has 2,083 patients on his list which is just below the upper limit of 2,125 patients that a single practitioner can have. The lower limit is 1,250. However, the system is not rigid and I was told that variations could be accepted depending upon the regions/populations demographics.

After his clinic Dr. Benčić kindly asked me if I would like to see the ER (Emergency Room) in Zaprešić where he had worked for many years before joining the GPVTS programme. Within ten minutes drive we were in the ER room. It is a mini Emergency Department with three fully equipped rooms. After being whisked through the rooms (luckily there were no casualties at this time), and very briefly meeting the sister in charge, we moved to the other parts of the complex. It is a reasonably size polyclinic building that accommodates not only an ER room but also primary care gynecology and pediatric rooms, basic laboratories, physiotherapy and some other community clinics/services. Like the majority of European countries they have primary care gynecology and primary care pediatrics where the relevant group of patients attend.

In Croatia primary care pediatricians usually look after children aged 0–8. However, where a service is not available (mainly in rural area) the GP steps in and provides this care. Dr. Benčić seemed to know everyone in the complex. He led us to the primary care pediatrics clinic where we met the community pediatrician who was happy to show me her clinic. The first room was the office/nurses station. The next room was the unwell child clinic, the third room was for the well child clinic and immunization, and there was also a play/waiting room area. A much smaller room, with its own entrance for cases that need isolation such as meningitis, chicken pox etc, was at the rear side of the clinic. I realized the time pressure but managed to get the specialist's perspective on how effective it is to have such a clinic run by a pediatrician. She is strongly in favor of it and says she has known all her patients since birth and this makes it easy for her to provide care. I did not express my own thoughts to her but could not help thinking that, this is what we GPs do on a daily basis for any age group of our patients.

## A Suburban Clinic in Zagreb

On Wednesday, I visited in a suburban Zagreb clinic. Dr. Renata Pavlov is an experienced Specijalist Obiteljske Medicine practicing in a health centre similar to the clinic we visited on Monday pm. She was very keen to know about the NHS and general practice in the UK. We used all the available time in between seeing patients to talk about the NHS and General Practice in Croatia. Before we headed off to a home visit in a nursing home, Dr. Pavlov's last patient came in to have her methadone. Apparently Directly Observed Therapy for substance misuse is one of the services they provide if it has been prescribed by a psychiatrist and there is no extra income for providing such a service.

Our home visit was to an elderly woman with a pancreas cancer living in a nursing home. Dr. Pavlov does her home visits with her nurse. I learned from this visit that there is no real easily accessible support available for palliative care patients. Dr. Pavlov had prescribed analgesic patches for this terminally ill patient but not all the medications to control the symptoms were in place

and she had no facilities for a syringe driver. After leaving this home visit I thought about my last terminal retroviral disease patient whom I visited a few days before flying to Zagreb. His medications were already prescribed after liaising with a local hospice and he had a HIV specialist nurse, district nurses, the hospice, dietician, and GP input while as well the district nurses were going to inform the tissue viability nurses to come and check his ulcer. It made me think how lucky we are to have a local hospice and Sutton Merton Community services<sup>6</sup>.

## Experience from Međimurje

On Thursday morning I got up early to go to Zagreb Coach Station to take a coach to Čakovec where a colleague, Dr. Ivana Babić was waiting to collect me. Dr. Babić's clinic in Sveti Martin na Muri is a rural clinic based in a pleasant farm house. It was, as with all the other clinics I had seen so far very clean, with white the dominant color, and spacious for a sole practitioner. Her medicine cupboard with its glass doors revealed how heavily it was loaded with medications for analgesia through to some for serious cardiac conditions and intensive care. Interestingly that was also the case for the inner city surgeries. It gave me the impression that IM and IV medication use is far too often compared to the UK general Practice.

Dr. Babić is a local Specijalist Obiteljske Medicine doctor. She practices where she was born and where both her parents also practiced as GPs. It serves a few local villages of close-knit communities. Having not lived in any one place for more than a few years since the age of nine, let alone working in my birth place, made me wonder how it must feel to treat your mother's friend who has known you since you were a little child as was the case in Dr. Babić's clinic later on that day. Patients continued coming in. Nearly every one of them entered with a well organized file while some presented their letter and other written instructions from the hospital consultants even before their opening statements. Dr. Babić in her white coat was trying to multitask, scanning the paper whilst talking to the patients, while in between consultations popping out to the next room to see how the unwell patient, who was with the nurse, was doing, etc. Her next patient was a young gentleman with a knee pain, who came in with the result of his knee X-ray. She receives her patients' blood results via a directly linked computer system but not the X-rays. She knew the patient well and organized an appointment via choose and booked him to see a consultant. The appointment was booked for 01 October 2014 (the date I was there being 11 September). I asked her what imaging modalities she had access to and was surprised to know that she was able to organize any CT and MRI but accepts that they are not commonly used by GPs. She had a severe COPD case who apparently did not like going to hospital and was attending with an exacerbation to have his aminophylline injections.

Her next case was a gentleman who was clinically showing any possible signs of liver failure but denied heavy drinking apart from the occasional homemade local alcoholic beverage. Another patient was an urgent presentation from another surgery (neighboring surgeries cover for each other in their closed hours during the day as they operate am and pm shifts alternately and after 7 or 8 pm patients attend ER). Her next patient was a woman who came in for repeat medications. Dr. Babić entered the relevant details on her computer for the repeat prescription and handed the patient's health card for her to go and collect her medications from any pharmacist in the country that she chose.

Every patient in Croatia has a health card, something similar to a credit card with a unique number on it. In all access to health care this card is used and can also be used to collect their electronically submitted prescriptions from the pharmacy of their choice. During my one week observation I did not see even a single paper prescription; in fact doctors' printers are prescription paper section free machines. I cannot help but think how difficult it might be to apply a similar scheme in the UK.

The next day I was with Dr. Vlatka Hajdinjak Trstenjak. She is also an enthusiastic Specijalist Obiteljske Medicine whom I met in Portugal at the European WONCA congress. She was my host for the whole day at two different clinics. In the morning she was covering a colleague's clinic. Covering each other for annual leaves, sickness and other reasons, and being paid by clinical activity rather than money, is the UK equivalent of locum cover. On our way to Dr. Hajdinjak Trstenjak's own clinic we were suddenly faced with an unexpected traffic jam, which was very unusual from what I had observed before in this town. Some 200 and 250 yards ahead of us people had gathered around a lorry and it looked as though someone was lying on the floor. Dr. Hajdinjak-Trstenjak used the incoming traffic's empty lane to bypass the traffic and parked straight next to the accident scene. A middle-aged woman was on the floor motionless but verbally responsive. The front tire of her bicycle was severely deformed and lying an inch away from the lorry's massive front right tyre. Soon after Dr. Hajdinjak Trstenjak's initial assessment a mild head injury was identified and the ambulance arrived even before we had put her in a recovery position. The ambulance driver went for the stretcher while the doctor and her assistant (an emergency care assistant, called a technician here in Croatia) in their whites, knelt around the patient and took over. Soon after leaving the scene we were back in Čakovec's more usual calm traffic talking about ambulances and the number and qualifications of their crew. I expressed my thoughts to my colleague: »did this woman need three people to attend?«.

Dr. Hajdinjak Trstenjak's clinic is one of the newest looking and the whitest clinic I have ever seen. The consultation room, nurse's room, waiting area, kitchen, and particularly the patients' rest room, all looked as though they had just been completed yesterday. All the clinics and health centers I visited in Croatia were extremely

clean, tidy, provided easy access for patients, and were all very well looked after. In the UK apart from my salaried job of six sessions I also sometimes do locum work in various clinics in London. I have seen clinics where carpets are worn and dirty, kitchens which would deter you from making a cup of tea, and old house-based clinics that are very inconvenient for patients to access and to walk up and down the stairs. I have also seen a clinic where the BP measuring cuff was so filthy that the patient objected to putting his arm in it. Yes I saw them all in London and in fact reported one of them to the CQC<sup>7</sup> I think a message to GPs from the Chairman of the British Medical Association General Practitioners Committee Dr. Chaand Nagpaul<sup>8</sup> informing GPs about GMS contract changes in 2015/16 tell it all: »We have secured agreement with NHS England to establish a working group to explore a strategy for the development of GP premises and primary care estate. This has been a much neglected area since the 2004 contract, which has in effect fossilized the state of GP buildings for most practices«. I hope the »working group« is going to find the »strategy« to bring the »premises« and »estates« to the level of the Croatian ones.

Dr. Hajdinjak Trstenjak's clinic is in a semi-rural area clinic and various patients were attending: For example, a woman with DM on triple oral anti diabetic agents, a child with URTI, an ex-soldier with PTSD, an elderly woman for her repeat prescription, and so on. One of her 90 year old female patients, who had been assessed by the orthopedics for possible arthritis related leg pains which were then thought to be vascular in origin due to her varicose veins, had been referred internally to a vascular surgeon. After her vascular assessment she came in to see her GP to have her Doppler done as instructed by the vascular surgeon. Then there was a haemodynamically stable urticaria case whom Dr. Hajdinjak Trstenjak moved to the next room for her nurse to administer IM antihistamine and steroid to. Apart from Dr. Hajdinjak-Trstenjak also having to scan the letters that patients

brought in with them, often going in and out of the nurse's room, and doing minor operations in between clinics, it was pretty much »a human body is a human body« type of clinic and no different from what we do in the United Kingdom.

## Conclusions

At one stage in my one week observation, I was taken back to a conversation I had with my brother in my second year of high school. He was a visitor from Germany and trying to help me find my path to university. He asked me what subject I had in mind to study and when he found out that I was undecided between a subject in social science or medicine he looked me in the eyes (of course having had not only the experience of needing to move from one place to another but also the experience of being an immigrant in a different country) and said something like: »think carefully, think about where you might end up, go for medicine; in the end wherever you go a human body is a human body, as long as you are a good doctor you will be able to deal with it«. I think my brother was right. Decades later I am now witnessing how depression, metabolic conditions, rotator cuff tear, COPD, and other various ailments do not discriminate in terms of geography, language, physical features in the way they attack the human body. I also realize once more how the approach to the treatment of these conditions is global with a local touch in trying to make the human body better. It is hard not to feel proud to be a member of such a global entity, a general practice.

## Acknowledgements

My visit to Croatia was supported by the Foundation for the Development of Family Medicine in Croatia ([www.zzrom.org](http://www.zzrom.org)). I like to express my gratitude to Professor Mladenka Vrcić Keglević and all the colleagues who kindly accommodated me in their clinics.

## REFERENCES

1. ZAKLADA ZA RAZVOJ OBITELJSKE MEDICINE, accessed 4.9.2014. Available from: URL: <http://www.zzrom.org/fullpage.aspx?PartID=170&PageID=1>. — 2. SVEUČILIŠTE U ZAGREBU, Medicinski fakultet, accessed 7.9.2014. Available from: URL: <http://www.mef.unizg.hr/eng/druga.php?grupa=020600000000>. — 3. RAKIJA, guide trough the universe of Rakija in Croatia, accessed 7.9.2014. Available from: URL: <http://www.croatia-expert.com/rakija-croatia/>. — 4. EUROPEAN ACADEMY OF TEACHERS, EURACT, accessed 8.9.2014. Available from: URL: <http://www.euract.eu/specialist-training/croatia>. — 5. FARRAJ R, BARON JH, J R, Soc Med, 84 (1991) 43. — 6. SUTTON AND MERTON COMMUNITY SERVICES (SMCS), accessed 8.9.2014. Available from: URL: <http://www.smcs.nhs.uk/>. — 7. CARE QUALITY COMMISSION, accessed 8.9.2014. Available from: URL: <http://www.cqc.org.uk/>. — 8. INDEX OF / VISAGEIMAGES / FILES / City\_and\_Hackney, accessed 9.9.2014. Available from: URL: <http://www.lmc.org.uk/visageimages/files/Londonwide/Letter%20to%20GPs%2030%209%2014.pdf>.

A. M. Aba

Royal College of General Practitioners, 30 Euston Square, NW1 2FB London, UK  
e-mail: [aba.m@doctors.org.uk](mailto:aba.m@doctors.org.uk)

## **MOJE HRVATSKO ISKUSTVO SA OPĆOM (OBITELJSKOM) MEDICINOM**

### **S A Ž E T A K**

Unatoč razlikama u organizacijskoj razini i obuci novih generacija između obiteljskih liječnika opće prakse iz Velike Britanije i Hrvatske, nailazimo na mnoge sličnosti. Ovaj članak ističe neke od tih sličnosti, ali i razlika. Napisan je nakon posjeta Katedre za obiteljsku medicinu Škole narodnog zdravlja »Andrija Štampar« i opažanja u raznim klinikama iz više mjesta u Hrvatskoj, uključujući i ona ruralna. Svaka jedinica primarne zdravstvene skrbi u Hrvatskoj sastoji se samo od liječnika, zdravstvenog tehničara i medicinske sestre, bez dostupnosti administracijskog i upravnog osoblja. Takvo je osoblje u Velikoj Britaniji pod vrlo teškim opterećenjem, kliničkim i nekliničkim. Nedostupnost društvenih služba u Hrvatskoj, uobičajenih za Veliku Britaniju, donosi dodatne izazove za hrvatske kolege. U Hrvatskoj se prezentacija bolesnika sa kroničnim bolestima i različitim oboljenjima, kao i njihovo upravljanje, ne razlikuje značajno od opće prakse u Velikoj Britaniji.