Family Practice — World Perspective

American And French Family Physicians: A Comparative Profile

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An organization of physicians in France called UNAFORMEC invited 22 academic and private practicing family physicians, 18 from the United States and 4 from Quebec, Canada, to serve as consultants to the organization at a meeting in Paris on 22–24 May 1992. UNAFORMEC, which exists for the purpose of providing and promoting continuing medical education, comprises representatives from all specialties, although 70 percent of the members are general practitioners. We met with our French counterparts to compare the medical careers and the medical educational systems (undergraduate, graduate, and continuing) in France and the US. Our observations and comparison of the two systems are presented.

In recent years French physicians have come to realize that the body of knowledge and skills necessary to serve as the point of access to the medical system for families and to provide continuing comprehensive care go beyond the education currently attained by the French generalist physician. In short, they are realizing, as did medical educators in our nation in the 1960s, that family practice is a specialty in its own right and thereby requires its own unique graduate medical education to prepare its specialists for medical practice.

Hindered by negative stigmata of several origins (e.g., low pay, low patient volumes, and usually lacking hospital privileges), French general practitioners are undergoing self-examination before formatting a long-range plan to improve the medical educational system, the general practitioner's career, and the quality of primary care in their country.

Undergraduate and Graduate Medical Education

Following completion of high school, students in France take an examination called the baccalaureat.[1] Those who pass the examination and are interested in becoming physicians can register with a medical school to begin their first cycle of training, which lasts 2 years. Approximately 27,000 students enroll yearly. At the end of the first year, students take a comprehensive examination that must be passed to continue their medical education. Approximately 3000 students enter the 2nd year of training. The curriculum during the first 2 years addresses the basic medical sciences. A second cycle lasts 4 years during which students study clinical medicine, pathology, and professional skills. In addition to the regular medical school curriculum, many students also attend conferences at considerable personal expense to prepare themselves for a qualifying examination at the end of medical school. This examination allows students who pass to choose specialty training if they desire; if they fail, they are relegated to general medicine. Students can sit for the examination twice. Estimates are that 80 percent of students wish to enter specialty training, but only 50 percent of this 80 percent pass the examination.

Those students who either desire to practice general medicine or who have failed the examination enter 2 years of training similar to American graduate medical education. Most of the training is conducted in the hospital setting supervised by specialists. There is limited preceptorial ambulatory training (about 30 half-days) with private general practitioners who have been approved by the faculty to participate as teachers.

Understandably, because failing the test is the primary route into general practice, a negative

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image is created for those physicians who chose or were forced to enter a general medicine career.

In contrast, in the United States physicians have a great deal of freedom to choose to become a family physician or to pursue another specialty. In fact, American physicians even have the option to change careers midlife if they desire. There is no such avenue available to French physicians. This inflexible system eliminates the opportunity for interdisciplinary training, which can be of great value to academic medicine and medical practice.

Practice Characteristics

There is considered to be a glut of physicians in France, both specialists and generalists. Approximately 50 percent of French physicians are general practitioners, whereas in the United States family physicians (and general practitioners) account for about 12 percent of the physician population. France currently boasts more than 50,000 general practitioners, a number not greatly exceeded by the United States with a population nearly five times that of France. We were informed that French general practitioners see about 10 to 12 patients each day on average, which compares with a range of 93 to 127 patients seen each week by family physicians in the United States. The variability in the United States relates to the geographic region of the country, urban versus rural practice, and whether the physician is residency trained.[2]

The average French general practitioner earns the equivalent of $35,000 to $50,000 per year. There is a wide range of compensation in the United States for established family physicians based on geographic diversity, practice characteristics (e.g., obstetrics, procedural skills), and type of practice (solo, two-person, multispecialty). The American Academy of Family Physicians reported that the mean individual income before taxes in 1989 for a random sampling of active members was $103,300; the median was $90,000.[2]

In the United States, as a result of great patient numbers, reimbursement issues, medicolegal concerns, and a high standard of technical practice, house calls are rare and usually involve interventions for social situations or the treatment of chronic illness of shut-in patients. In contrast, our French counterparts see up to 40 percent of their patients through house calls and consider this personal contact with patients and families in their homes to be of great value. French families are reluctant to bring elderly patients, in particular, to the physician's office. The house call is not only mandated by custom and the lack of uniform access to suitable transportation to physicians' offices, but also to some degree by the competitive market. As one physician noted, if he declined to provide a patient home care, another physician would. Interestingly, this practice seems to be decreasing somewhat in France, whereas there is some trend toward increasing the number of home visits in the United States as family practice residencies increasingly include home visits in their curriculum.

Another major difference in practice characteristics of family physicians in the two countries is the lack of presence of the French general practitioner in the hospital. In the United States, 90 percent of members of the American Academy of Family Physicians responding to a 1990 survey reported having hospital privileges. Ninety-four percent of these members were satisfied with the extent of their privileges.[2] There is, in addition, an apparent absence in France of appropriate ongoing communication between the specialist in the hospital setting and the generalist in the ambulatory setting, which would appear to be an impediment to optimal patient care.

Continuing Medical Education

There are considerable differences between the continuing medical education (CME) processes in the United States and France. No mandatory CME is required in France, unlike the 150 hours every 3 years required for membership by the American Academy of Family Physicians or the 300 hours every 6 years required by the American Board of Family Practice as one component of the recertification process. As well, many US states require CME as a condition for licensure.

The French government is by far the major payer of medical care, although it is a fee-for-service payment system. It is interesting that a high value is placed on continuing medical education to the extent that physicians are paid the equivalent of income generated from 10 patient visits per day for their attendance. Validated activities, most lasting 2 or 3 days, are provided, and physicians are paid for up to 10 days each year for participation in these CME programs.

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The French social security system (comparable to Medicare) sets the topics of such validated CME programs based on predetermined national needs and priorities. In addition, local physician groups regularly convene to identify educational needs. French CME offerings are intentionally structured to favor smaller audience size to promote greater interaction of participants. Small-group interactions and discussion groups of general practitioners and specialists at the local level are especially promoted and well attended.

Conclusion

Definite parallels exist between the current state of general practice in France and the situation in the United States in the late 1960s, when family practice was emerging as a specialty. Although the percentage of general practitioners in France is much larger than was (and is) the case in the United States, the extent and appropriateness of their training appear deficient and in need of change. Many familiar issues will be faced by our French colleagues as they strive to revise their educational system. We are hopeful that the dialogue we have established and the knowledge we have shared will be of mutual benefit to the specialty of family practice and patients in both countries.

References

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