Principles of family practitioners and nephrologists collaboration

Steciwko A, Kurpas D

Family Medicine Department, Medical University of Wrocław, Poland

Abstract

There is a need to establish clear standards of cooperation family doctors with specialists and arrange specialist service for family practitioners to improve a care for patients with urinary system diseases.

Our paper presents attempt on the estimation of medical care system reform and state of general practitioners with specialists cooperation level as well as draw conclusions regarding possibilities of specialist and primary care contacts improvement and by this – increasing of comprehensive patients care quality.

Family doctor never tried to replace with a specialist. Only constructive and professional cooperation specialists with family doctors can secure proper care for patients.

Key words: general practitioner, nephrologist, collaboration.

Health Care System (HCS) in Poland is in continuous process of transformation. Before 1989 we had a system based on hospital, near-hospital specialist centers and local specialist units. There were no Family Medicine/General Practice specialists at all – the role of GPs was replaced by a team of internal medicine specialist and a paediatrician (sometimes with laryngologist, gynaecologist, dentist etc.). Patient was assigned to the nearest health care unit and couldn't choose a doctor. Almost all health care units were a public property [1-4].

ADDRESS FOR CORRESPONDENCE:
Family Medicine Department
Medical University of Wrocław
ul. Syrokomli 1,
51-141 Wroclaw, Poland
Tel/Fax: + 48 71 325 43 41

Received 14.05.2004 Accepted 10.06.2004

The growing number of non-public primary care practices especially family doctor practices originated from the transformation of the National Health Care system in Poland which started in 1998, giving independence to health care practices, and forming and strengthening the structure of the health care organizational body. This meant structures health care system could negotiate contracts with public and non-public practices. Further stages of health care system reforms aimed to strengthen the role of family medicine and put the focus on the promotion of family doctors who were able to bid competitive offers for providing health services [4].

The aim of reforming the Polish National Health Service is to improve the general health of the population and run effectively polish care system. The target number of GP in Poland is 20000 for 40 mln population.

Pharmacies, dental practices and a quite a lot of primary and secondary care units are private. Most of the hospitals are still public (local government's) property [1-4].

Primary care in Poland is to be provided by family medicine specialist. The insured patient chooses a doctor (signs a declaration). Family doctors are contracted on capitatation fee and they are responsible for population reported on their list (max 2500 patients), differently from specialists who have fee for service system. Family doctor signs one year contract with Regional Department of National Health Fund (public health insurance unit) and gets capitation fee monthly.

For now we have no certification/recertification system in family medicine [4].

Family Practice is open five days a week (from Monday to Friday) with working hours between 8 a.m. and 6 p.m. Out of hours patients usually report to Emergency Care Unit.

The out of hours services vary in different parts of our country. There are 3 general models:

a) services provided by emergency units,
b) services provided by family doctors/specialists on additional contracts with other family doctors in special "out of hour" centers,

c) services provided by GPs themselves at their own practice.

There is a document, written by College of Family Physicians in Poland which describes all duties of family practitioners – it leaves a wide range of competences in the hands of family practitioners. A reference document for constructing of undergraduate and postgraduate training program in family medicine has been written. But, in fact, the real duties of GP depend on a signed contract [1-4].

There is the referral system to specialist's care in Poland. It is required for the patient to be referred to the specialist excluding the following: ophthalmologist, dermatologist gynaecologist (obstetrician), oncologist and psychiatrist. Cooperation between GP and specialist is rather difficult because of low availability of specialist care, long waiting list for consultation, lack of a good system of information exchange concerning referred patients.

There are three levels of secondary care – provided by local specialist care, provided by specialist centers (mainly situated in large specialist hospitals) and university/medical school centers [4].

Specialists also sign contracts with public Fund – they have "fee for service" payment system (but there is a maximal number of medical procedures during a contracted period) [4-6].

Patient who has obtained a referral from GP can choose any secondary care unit to take care of her/him. The most expensive procedures (e.g. cardiosurgery, chemotherapy) are paid directly from central budget of Ministry of Health.

Choosing one doctor as your primary health care professional is your best insurance for better health care. By letting this doctor coordinate health care needs, the patient can be assured of the highest quality care. This means the doctor will know the complete health history, what kinds of medications the patient is on, how a new medication might interact with existing medications, and, if necessary, what kinds of specialists he may need. With this knowledge, the doctor will be better equipped to make the best recommendations when the patient need care especially – specialist consultation or diagnostic [2].

There is still a need to establish clear standards of cooperation family practitioners with nephrologists during diagnostic and treatment of kidneys' diseases [2,7].

The family practitioner should be able to conduct diagnostic and treatment:

- acute and uncomplicated urinary system's infections
- nephrolithiasis
- acute glomerulonephritis
- polycystic degeneration of kidneys
- uncomplicated anomalies of kidneys
- chronic renal failure (first stage, second – after the nephrologist's consultation)
- primary hypertension
- secondary hypertension (after the specialist consultation)
- gouty diathesis
- asymptomatic bacteriaemia
- complications of glomerulonephritis (between the nephrologist's consultations)
- the stage between haemodialyses (acute conditions)
- the stage during peritoneal dialyses (acute conditions).

The family practitioner has following diagnostic tests at disposal to fulfill the competences during collaboration with the nephrologist:

- urine analysis
- urea and creatinine concentration
- creatinine clearance
- electrolytes: Na, K, Ca, PO_4, Mg
- Fe concentration
- ESR, morphology
- ASO, complement-binding test
- urine culture with antibiogram
- abdominal scout film
- USG of abdomen
- concentration of cholesterol, HDL, LDL, triglyceride
- proteinogram
- gasometry
- concentration of GOT, GPT, GGTP
- concentration of bilirubin
- concentration of glucose
- markers of HBV and HCV infections.

The main tasks of the family practitioners are:

- knowledge of symptoms and diagnostic tests in kidneys' diseases
- follow-up of specialist recommendations
- knowledge of nephrotoxic medications
- doses modification due to creatinine clearance
- health promotion and prophylaxis in kidneys' diseases.

The proper functioning family practitioner should:

- start early diagnostic and therapy of urinary system diseases
- continue the therapy started by nephrologist
- know when and with which diseases to refer the patient to a nephrologist
- know which diagnostic tests are indispensable before a nephrologist consultation
- know principles of water balance and creatinine clearance estimation
- know principles of nutrition of patients with urinary system diseases
- know causes of urinary system diseases
- avoid anomalies of kidneys
- propagate the health promotion and prophylaxis of urinary system diseases
- collaborate with nephrologists during comprehensive care for patients with urinary system diseases.

There are very few relationships as important as those which bind a physician with a patient. To find a qualified doctor worthy of the patient confidence, requires time and effort. It is worth while, since this will give years of quality life, or even sometimes save the life. In addition to a great integrity, several factors and qualities must be joined together so that you will be completely satisfied with the choice [1].

A good doctor (a family practitioner as well as a specialist) is personally concerned with regularly advices on preventive medicine, including an anamnesis (personal history), i.e. personal medical history, a physical examination, and done with respect, confidence in a doctor who prescribes paraclinical examinations (laboratory tests, radiology), without having initially made anamnesis and physical examination, physical examination whose extent depends on anamnesis result [1].

A family practitioners and a nephrologists are partners in the care of patients: their duty to the patient comes first. They works for the good of the patient, not that of the government, an insurance company, or a managed health care bureaucrat.

Generally, any physician (a family practitioner and a specialist), officially agreed or not, knows extremely well that he is not a recipient in the contract which binds the policy-holder and the insurer and he is not co-signatory. In fact the physician does have and can have only one master: his patient especially during the care for the patients with so complex problems that urinary system diseases are.

The aim of reforming the Polish national health service is to improve the general health of the public and the effective running of the health service, as experience from western European countries and Poland shows, it is advantageous for the development of family medicine [4-6].

There is still a need to establish clear standards of cooperation family practitioners with specialists and arrange specialist phone service for family practitioners.

Family doctor never tried to replace with a specialist. Only constructive and professional cooperation specialists with family doctors can secure proper care for patients especially with the urinary system diseases.

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