*Conference **4***

Dr *Étienne ROBIN (F)*
09/08/2023
Translation: Kathy WEBB-PEPLOE

REQUIEM FOR CONTINUITY OF CARE – ONLY TEMPORARY?

As the title of this talk suggests, continuity of care is an aspect of medicine that seems to me to be in decline.

This does not mean, however, that in the past, continuity of care was satisfactory: let's remember that a few decades ago, it was not great:

- We didn't often call the general practitioner, because it was expensive and poorly reimbursed.
- A specialist was rarely called upon because they were few and far away.
- Nurses did not do home visits very often.
- Surgery was effective, but medicine did not have drugs for most chronic diseases.
- Care was sparse. There couldn't therefore be continuity of care.

Continuity of care then reached a kind of optimum, when many of us were in the middle of our careers:

- You could be seen by a doctor without an appointment in a few hours: all you had to do was go to the waiting room.
- When the doctor asked for hospitalization, the hospital immediately found an available bed, even if it was sometimes a trolley.
- All requests for radiological examinations were performed within the day. There was no waiting list for surgery.

It was at this time that Medicine of the Person developed, which generally implies continuity of care.

But the system has gradually seized up. Today, it is possible to get treatment, but it is slower, poorly co-ordinated, not very effective. Why this decline in continuity of care? I will give you my point of view, which is a pessimistic one.

This will be a largely personal point of view. I am not a researcher who produces incontrovertible statistics. I don't have the tools of a medical historian. Nor those of a sociologist who studies changes in behaviour within society. I am not a philosopher capable of distinguishing between what is wise and what is disastrous.

No, my vision is narrowed by the inherent limits of my identities:

- I am a caregiver,
- I am French,
- I am a supporter of scientific medicine,
- I am convinced that relationship with others is the crux of existence:

All these personal affiliations mean that my opinion of continuity of care is partial. A sick person would present you with a different point of view. The same with a surgeon, an Englishman or an aromatherapist: all face different realities of care to mine. My point of view will therefore be incomplete. What is incomplete is always inaccurate. I apologize for that. We will have the small group discussions to complete, correct and contradict my observations.

This is a medical issue. So, I'm going to follow a plan that is familiar to medical students. It will make us feel young again:

I. DEFINITION

In the program for our meeting in Northampton, Kathy gives this definition: "What is continuity of care? For me, it's about seeing the same person again."

Kathy provides us with a very simple and clear definition of continuity of care: the best definition, in my opinion.

This clinician's definition indicates that continuity of care implies a personal relationship over time. Let us note that this is the very condition of the medicine of the Person, with its two components which are generally indispensable to the patient, as Paul Tournier indicated:

- the medical intervention
- And human support.

And more than that: sometimes continuity of care is limited to the second part only: I routinely go to the hospital on Sundays to see my inpatients. One in two visits are useless on a purely technical level, because the current illness does not require any intervention on the Sunday. It's a courtesy visit. But isn't this courtesy a therapy, and moreover a versatile therapy? Thanks to my visit, with a little luck, the patient will sleep better on Sunday night than if I had prescribed a sleeping pill. He will be better protected against a stress ulcer than by his antacid tablet. He will have less pain and variation in blood pressure.

Going to chat "unnecessarily" with a sick person on Sundays, and sometimes with his family who have come to visit him, that's continuity. The same is true for the old-style home visit, which is hardly ever practised anymore: general practitioners who have seen their patients' dining room are an endangered species like the white rhinoceros. Except that currently, there are people working to save the white rhinoceros, but there aren't many people to keep up home visits: continuity of care is diminishing because its advantages no longer seem obvious.

Of course, continuity does not mean that a patient is constantly cared for by one and the same caregiver: it is common for a patient to need a general practitioner, a few specialists and several nurses at the same time. The plurality of practitioners is a good thing for the quality of care, when it is a plurality of roles and a plurality of skills. The situation deteriorates:

- When the general practitioner is only available sporadically,
- When the specialist you see for your illness is never the same,
- And when the nurse or caregiver changes every day.

II. INTRODUCTION

In care, in a few decades, we have gone from great continuity to great discontinuity. This discontinuity is sometimes deliberately planned. But more often than not, it is endured (fatalistically) and regulated (as best we can): you could say that we have passed, at least in France, from the medicine of Claude Jacob to the medicine of Pierre Carnoy (who, appropriately, is a doctor who is involved in drawing up regulations!). Both of them, of course, doing the best they can, but each in a radically different context.

Almost all of you know Claude Jacob. You may remember that he was working as a general practitioner in a mountain region. In his early days, there was no other doctor nearby, except for his wife Geneviève. Group practices did not exist. Emergency medicine did not exist either. There was no accident and emergency department. There was not even an arrangement for the doctors in a region to share on-calls. Claude's patients saw only him, both during the day for a consultation or a home visit, and at night in case of emergency; both during the week (every day of the week) and at the weekend (every weekend). Except when Claude went on holiday.

We can see that professional activity encroached greatly on private life. This has become inconceivable, of course, in today's society. But alongside this disadvantage, you have to imagine the effectiveness of such a system:

- When you called THE doctor, he had usually known your body and soul for years. He remembered your background, your vulnerabilities, your psyche and even the characteristics of your home.
- The diagnosis was safer, faster, and had less need for additional tests.
- Familiarity with each other facilitated the correct assessment of symptom severity and the urgency with which the patient needed to be treated.
- It also reduced the patient's anxiety, and we know that this trust, this comfort, is a more or less important part of the treatment in many diseases.
- The monitoring of the evolution of the illness was done in favourable conditions for the patient, because he was sure to always be able to contact a familiar caregiver, well informed about his case, without delay; don't you dream today, when you are sick, of such accessibility?
- This clinical follow-up was also carried out in good conditions for the doctor: he could personally observe the results of his therapies: without this continuous observation, it is difficult to acquire professional experience.

Today, continuity of care has become uncertain: this is what I have called Pierre Carnoy's medicine. But be careful, this is just a manner of speech: in the first place, Pierre has nothing to do with it, it is the current era that is responsible. Secondly, doctors like Pierre still provide a good deal of continuity, if we compare it with what is happening elsewhere, in particular with my current work as a very part-time nephrologist! Nevertheless, how things have changed compared to Claude Jacob's rural medicine:

- Today, we are only received by appointment. It is not possible to go to your GP's office when you need to and wait in the waiting room.
- Almost no doctors are available every night for their usual patients. Nor on weekends.
- In general, the doctor cannot be reached after the practice closes, often at 5pm, either.
- Most doctors go on holiday several times a year.
- A good number of doctors work part-time, sometimes only two days a week.
- A number live far from where they work.

For the patient, we have therefore moved from an era when the doctor was a familiar, stable and accessible person to talk to, to the current system, where the doctor is a kind of rare, changing, and unpredictable commodity.

In an editorial in the journal Annals of Family Medicine, an author from the University of Amsterdam notes the decline in "continuity of care in family medicine" in the United States and Great Britain "for several decades." [1] He deplores this decline: continuity, he writes, is indeed correlated with:

- a reduction in mortality
- a better quality of life
- a decrease in admissions to the Emergency Department
- a decrease in hospitalizations
- better levels of satisfaction in patients and doctors.

An article in the same journal tells us that in Canada, in the province of Alberta, continuity of care decreased in 2015, with all the negative effects listed in the editorial. As a solution, the authors recommend developing teleconsultation, which seems paradoxical to me.

It should be noted that this regrettable change does have some advantages. For example, doctors have a better private life, while patients have a broader, more specialized, and more efficient range of care: the ra-

[1] Otto R. Maarsingh : "The Wall of Evidence for Continuity of Care : How Many More Bricks Do We Need ?", *The Annals of Family Medicine,* May 2024, 22 (3) 184-186; DOI: https://doi.org/10.1370/afm.3116

diologist with his ultrasound machine makes diagnoses of kidney cancer that a clinician would never have been able to make with manual palpation.

Let's start by listing the causes of this loss of continuity of care.

III. AETIOLOGY

*** OUR POPULATIONS NEED MORE CARE:**

The number of acts of care to be performed is increasing for several reasons:

First reason: The population is ageing because life expectancy is improving sharply[2]. To simplify, let's only look at male life expectancy in France:

1950	63 year old
2000	75 year old
2022	79.3 years

We can see that since the birth of many of you, life expectancy has increased to an extraordinary extent (and yet, France is only seventh in Europe). It is impossible to ensure continuity of care with finite resources, with such a big increase in the population to be treated! An older population generally needs more care... therefore more caregivers.

A little aside: life expectancy is slightly better in France than in Great Britain. This leads me to doubt that the ban on alcoholic beverages in Northampton is conducive to English longevity.

The second cause of the increase in care is the recommendations, or guidelines, or good practice: they force us to multiply the acts of care. Not only for a given disease, but also for people with no apparent disease: as Aldous Huxley (1894-1963) jokingly said, "Medicine has made so much progress that no one is healthy anymore."

Thus, in the case of diabetes, the patient must be monitored at regular and precise intervals by the ophthalmologist and the nephrologist. Therefore, all patients who have low creatinine clearance are referred to me. Sometimes, this biological abnormality reflects real kidney disease, and my consultation is possibly beneficial. But other times, the decrease in creatinine clearance is only due to the patient's low muscle mass. His kidneys are in perfect condition. In this case, a nephrological consultation is unnecessary. But the protocol makes it mandatory: the protocol imposes itself as a dogma These kinds of superfluous consultations overwhelm the outpatient clinics and prevent us from taking care of the real patients, those who have real kidney failure. Too bad for continuity!

In all specialties, such useless activities are multiplying.

*** THE DURATION OF TREATMENT IS GETTING LONGER.**

Of course, fortunately, modern medicine is sometimes more effective and faster. A fracture of the femur used to lead to hospitalization for one or two months with the lower limb in traction. Today, the surgeon

---

[2] Life expectancy in France:

"In view of the data studied, France appears to be a good student in Europe in terms of health. Between 1990 and 2019, life expectancy in France rose from 77.2 years to 82.9 years, which places France in 7th place in Europe, behind Iceland, Italy and Spain but ahead of Sweden, Germany and the United Kingdom.

France's performance is even more notable in terms of healthy life expectancy, which has risen from 67 years in 1990 to 71.5 years in 2019: France is in 4th place in Europe, with only Iceland, Israel and Spain achieving better results than us. »

inserts a hip prosthesis, and the patient can leave the hospital after a few days. GI bleeding no longer entails a long and debilitating laparotomy: it is stopped endoscopically, by quickly placing clips.

In my specialty:

- The duration of a dialysis session is steadily decreasing, thanks to more efficient purification techniques. In 1960, a session lasted 24 hours. In 1980, eight hours. At the beginning of this century, only four or five hours. In 2024, our dialysis patients are only connected for four hours, or even less.
- Two months ago, the first kidney transplant was performed in the USA without general anaesthesia. Epidural anaesthesia was sufficient. The transplant recipient returned home after 24 hours of hospitalization. Thirty years ago, our transplant patients stayed three days in a sterile room, then in a hospital room for at least a month, when there were no complications. Which was rare.

Such progress is important. It has allowed us to reduce the number of hospital beds.

Nevertheless, the opposite often happens; that care takes longer than in the past, because the techniques are more complex, and the precautions infinite.

At the time of Louis Bergouignan (one of the founders of Médecine de la Personne in France), appendicitis was a problem that was quickly solved: no additional test was done. The appendicectomy was performed without delay. The operation was brief: 10-20 minutes.

Today, care is extended because it has become more sophisticated:

- Inflammation is assessed by means of blood tests.
- The morphology of the appendix is evaluated radiologically.
- We willingly choose to temporize, by giving ourselves a period of clinical observation, rather than making an incision without delay. In any case, financial imperatives mean that we try as much as possible to postpone the operation to an economically favourable time: there is no question of opening an operating theatre at the end of the day, it is too expensive.

Including in case of emergency? I fear so: for example, we know that an intestinal obstruction should normally be operated on before the sixth hour to limit the risk of necrosis. I recently saw a patient who was dear to me wait more than 23 hours, to optimize the operating schedule of a private hospital.

A remark in passing concerning medical efficiency today, because it has to do with the availability of doctors, and therefore with continuity of care: in several countries, including France, the organization of healthcare is inadequate. Increasingly inadequate. Doctors at the end of their careers commonly note that to replace them, three young doctors are needed. In nephrology, this seems to be true almost everywhere: young doctors are competent, and yet they do a job that is in some respects inferior: it is particularly continuity of care that is deficient. Why? It is difficult to distinguish the cause of this real shipwreck of efficiency. Apparently, the inefficiency is not the result of a lack of money or a lack of doctors, or a lack of competence. It is a general defect in the organization of our societies. Maybe an excess of organization! I see an argument for this in the fact that our patients do not suffer from a lack of continuity only in care, but also in medical transport, and in home care.

But what exactly is causing this organizational problem?

- Is it the excess of power held by the administration?
- The excessive demands of the patients?
- Excessive regulation?
- Insufficient profit?
- The immaturity of computerization?

So far, in the face of this deterioration of the healthcare system, no one can agree on the diagnosis of the cause, and therefore no one has found the solution. In any case, the result is obvious: the effectiveness of care is poor, caregivers are exhausted, patients are dissatisfied, and continuity of care is waning.

*** THE TIME DEVOTED TO WORK IS DECREASING EVERYWHERE, INCLUDING AMONG CAREGIVERS**

Each man has multiple identities: he has a profession, a family situation, a political standpoint, a spiritual aspiration, a favourite hobby, a personal talent, etc. All these activities are important, but they all compete: if you are passionate about sport, you will have less time to devote to your family or your job. In the past, someone's main identity was the profession that they practised. In the interrogation of our patients, we never omit to ask what his profession was.

Devoting oneself to one's profession took up a lot of time in a day, and throughout one's life. Work impinged on other occupations. Why? On the one hand, work was seen more as a value and a duty. On the other hand, social mores did not allow idleness.

Like others, doctors in the past didn't balk at working 70 hours a week. They accepted that they could be disturbed at any time. This is now less true: in 2015, male general practitioners worked an average of 59 hours per week, and women 53 hours.

Thus, personal fulfilment is now in competition with the duty to work in solidarity with one's colleagues. One of our left-wing political figures, a candidate to be President of the Republic, declared in 2022 "Work is a right-wing value", which meant "Let's work as little as possible!". It is as if a good number of French people share this singular conviction: deliberately and without any guilt, they only work intermittently, made possible by many factors. Really very numerous and widely seen:

- For example, from 1988 to 1996, the administration paid private doctors to stop working at the age of 60 and retire immediately. From 1996 to 2003, they were even paid to retire at the age of 56!
- Even today, regulations encourage salaried caregivers to work less: the nurse's hour of work is paid more when she works part-time than when she works full-time.

This reduction in working hours mechanically disrupts the continuity of care. In some hospital departments, every day of the week, from Monday to Friday, it is a different senior doctor who visits hospitalized patients. This dance (waltz in French) is the same for young doctors: when I was an intern, we were present in our department five and a half days a week. Currently, the interns are only present three days a week, because of their lectures and because of the mandatory rest after their shifts. In community medicine, waiting times for an appointment are so long that sometimes patients do not consult their usual doctor, but a stranger: the one who will give them the fastest appointment. It's zero continuity.

*** THE MEDICAL PROFESSION IS BECOMING MORE FEMINIZED.**

Nowadays, young doctors are mainly women. This is a recent, rapid and profound change:

	Men	Women
1985	75 %	25 %
2000	64 %	36 %
2008	60 %	40 %
2020	49.5 %	50.5 %

This change is going to be accentuated, because among the young people who want to study medicine, there are a majority of girls. A majority of women are also among those who pass the entrance exam. This is surprising since we learned in anatomy that the volume of the male brain is 1500 ml on average, compared to 1400 ml for female brains... But it is as if the girls are using this smaller brain much better. So that soon the overwhelming majority of doctors will be women, especially in the category of young doctors.

Does this sociological change make a difference to continuity of care? Yes, because it is mainly women (until now...) who are sometimes have to be absent for maternity leave. There is absolutely no provision to replace them, even when they hold an important position. You could end up concluding that for management, the diagnosis of pregnancy is impossible before seven and a half months. In my hospital, when a young female doc-

tor is absent before and after giving birth, there is only a foundation doctor to replace her as best they can. In any case, even a replacement constitutes a break in the continuity of care.

*** PROFESSIONAL LIFE STARTS LATER.**

The majority of young doctors who have just graduated are delaying applying for a permanent position. For several years, they practise medicine in small pieces (in breadcrumbs in French). Some are doing locums, one day a week, in three or four different places.

Others go to work, for more or less short periods, in hospitals in various regions, to try out what will suit them best. The consequence for patients is that they constantly see unknown and temporary doctors. All the more so since these roving doctors deliberately work very little, for example six months a year. And this carries on for about ten years, before they settle in one place.

*** DOCTORS CHANGE WHERE THEY PRACTISE MORE OFTEN.**

Geographical instability does not only exist at the beginning of a career, as we have just said.

There are 230,200 doctors in France. Among them, more than 23,000 are not French. To this figure must be added more than 10,000 doctors whose diploma is foreign, but who have acquired French nationality. These figures are constantly increasing, because the flow of foreign doctors who come every year to practise in France is impressive, fortunately for us: they represent 48% of the new registrations[3]. The proportion of doctors with foreign degrees is particularly high in public hospitals: more than a third[4]. In my own hospital, it's 71%.

We are witnessing a kind of globalization of care. It provides great services, but it is not exemplary in terms of continuity of care, because doctors with foreign degrees are particularly geographically mobile. Whether they come from Romania, Syria or Algeria, they have no territorial ties in France. Having no reason to settle in a city or a hospital, they often move from one region to another.

I will give you a particular illustration of this: there is a serious shortage of ophthalmologists in the isolated mountainous region where I work. To remedy this shortage, we have set up a collaboration with a better developed nearby country, Switzerland: Every month, an ophthalmologist from Zurich comes to our hospital for a day to operate on our patients and leaves the same evening. He does not meet patients before operating on the cornea, the lens, or even a retinal detachment. Equally, he does not meet them the day after the operation. He explains to me that this way of organizing things is satisfactory:

- He studies the patients' files remotely before coming to operate on them.
- In the event of a post-operative problem, he sees them by teleconsultation from Zurich.

Since patients accept this system, it can be inferred that they approve of it. Without this solution, they would have difficulty finding the specialist they need. No doubt they are grateful for this Swiss ophthalmologist. If there are Swiss doctors in the room, I salute their commitment to this underdeveloped country that is France, just as the Gabonese were grateful to Albert Schweitzer for coming to operate on them in Lambaréné.

But still: having an eye operation is always a source of anxiety for the patient. Not recovering full vision the day after a phakectomy is a common situation, where formerly, patients would have really needed to see their surgeon in order to receive a reassuring explanation. Can we be satisfied with the doctor being present so little — one day in thirty — for those he treats?

*** SOCIAL CONFLICTS DISRUPT CONTINUITY OF CARE.**

---

[3] 2013 figure: 48%

[4] 2008 proportion: more than a third.

In the last ten years, France has experienced eleven major street protests. They went far beyond demonstrators going on a march. Rather, they were insurrections, with looting, pillaging, and setting fires lasting several days or nights. At least 18 people have been killed and hundreds injured. On these days of tumult, on the one hand, travel can be dangerous, and most importantly it is made more or less impossible: traffic is deliberately blocked by rioters, or forbidden by the police. It is difficult for patients to go to the hospital. When they need a dialysis or chemotherapy session, this loss of continuity of care is dangerous. It can be fatal.

In a dialysis department, concern rises when the dialysis patients we are waiting for do not arrive at the scheduled time, because their taxi is immobilized by a barricade or by a motorway being blocked: will this dialysis patient die of hyperkalaemia or pulmonary oedema?

I don't know of any cases that have occurred in metropolitan France, but there have been several deaths in these circumstances in Guadeloupe, where the demonstrators are particularly determined. It is feared that the same tragedy has occurred in recent months in New Caledonia: this French overseas island has been paralyzed by deadly riots. The roads were completely impassable, unless you wanted to risk being shot at. There are 700 dialysis patients on the island. At the time, we knew that they were all in danger of dying, as they were not able to go to their dialysis centre. We still don't know what the death toll of this dangerous break in the continuity of care was.

*** DOCTORS'S TIME IS TAKEN UP BY TASKS OTHER THAN CARE.**

You all know it, and you all suffer from it: doctors now devote a large part of their time to activities other than care.

What takes us hours?

- The phone
- The administrative documents to be filled out,
- Prescriptions which take forever because of computerization,
- Meetings,
- Writing business plans,
- Handovers,
- Keeping meticulous records of every interaction with the patient and their relatives (to ensure traceability).

When we have a little time left after all of this, we take care of the sick. It's absurd. This absurdity makes not only doctors, but other caregivers less available and ineffective: when a nurse dresses a wound, she sighs, "It takes longer to write in the patient's record what I did, than to do the dressing itself."

In these conditions, continuity of care falls by the wayside: when a dialysis session is tricky, I should in principle take a look at the dialysis machine every hour to observe the variations in the patient's hydration. Instead, I assess the situation all in one go, knowing that I won't have time to come back. Then I have to spend the rest of the morning in my office. As a result, the dialysis patient ends his session with less fluid taken off than is ideal. This is harmful in the long term for his blood pressure, his arterial compliance and his cardiac function. Without the availability of caregivers, continuous monitoring is not possible, and the quality of care becomes imperfect. We end up resigning ourselves to this mediocrity.

*** THE DEMANDS OF ECOLOGY COMPROMISE CONTINUITY OF CARE.**

How can ecological concerns negatively impact continuity of care?

The planet is warming dangerously, because of CO2 emissions. It is imperative to sequester as much as possible of this harmful carbon that we emit. We must therefore preserve the forests, and to do this, reduce our paper consumption.

The quest to reduce the use of paper has therefore become an obsessional activity in the world of care:

- Using a computer is seen as a sign of virtue,
- Using pen and paper borders on recklessness,
- Making a copy of results is a sin,

- Printing a document is a crime against humanity.
- The secretaries are ordered by their fanatical superiors to do away with the patients' paper files. The only solution left to the doctor is to go to the computer when he wants to explore the patient's extensive records. All the information you need is there.
  But in practice, they are largely impossible to find!
  We know that. We therefore give up on time-consuming research, which will not improve the health of the patient, but rather damage that of the doctor. We treat more or less blindly, without really knowing what the patient's history is or what medication he is taking. Unless you have the memory of an elephant, you feel like you're starting from scratch with each new consultation. Hello continuity of care...

*** WHEN RACIAL OR CULTURAL DIVERSITY IS AN OBSTACLE TO CONTINUITY OF CARE.**

For a dialysis patient, the ideal continuity of care is to be <u>transplanted</u> one day, to escape the painful constraints of dialysis.

In the case of Miss Fatima G. (the surname and first name are changed, as well as certain details which could allow her to be identified. The same has been done later in the text), this ideal solution is particularly desirable. She is young: 37 years old. She worked as an assistant in a nursery school. Suddenly, in December 2023, her kidneys were destroyed by thrombotic microangiopathy (a rare haemolytic disease).

Other than this renal failure, she is in perfect health, full of life and projects. The transplant would restore her to a normal social and professional existence. A month ago, she asked me how long she might have to wait before being transplanted.

I don't have a precise answer — it's impossible — but I provide her with two insights:

- First, being healthy, she will probably wait <u>less</u> than average.
- Secondly, being of Tunisian origin, she will probably wait <u>longer</u> than average. Indeed, even if Tunisians are white, they do not have exactly the same HLA genes as other so-called "Caucasian" whites [5] : the native French. Finding a graft in France compatible with the genotype of a Tunisian woman is statistically less likely.

In other words, for genetic reasons — one could also say: racial — it is better, for the continuity of some types of care, to be cared for medically in one's own country.

This is also true for reasons that are not racial, but cultural: people of Muslim culture are generally opposed to organ donation. Or more precisely, they agree to receive an organ, but they don't want to be donors. Such is the case of the family of Miss G. None of her brothers and sisters are willing to donate a kidney to her. People who study communities consider this behaviour to be a respectable cultural fact. Nephrologists hate it. They are indeed faced with a particularly absurd therapeutic impasse when viewed rationally:

- Kidney donation would be the easiest solution in Muslim families, because siblings there have many more brothers and sisters than among the native French.
- But it is in these families that the refusal to donate is most culturally anchored.

Elsewhere too, culture has a huge impact on the possibility of a transplant:

- Africans are reluctant to donate organs.
- The Japanese too.
- In Iran, misogyny means women donate and men receive.
- In China, kidneys from death row inmates are removed and traded by the thousands every year.

*** ACTIVITY-BASED TARIFFS ENCOURAGE THE FRAGMENTATION OF CARE.**

---

[5] The term "Caucasian" is vague: in France, it refers to the populations of Europe, the Levant and North Africa. In the USA, it refers to Europeans.

In a not-so-distant era, when a multimorbid patient was admitted to a hospital bed, he or she enjoyed a kind of (relative) comfort: he or she could stay in the same bed, be cared for by the same doctors, talk to the same intern, be injected by the same nurses, be mothered by the same nursing assistants, for the whole time their heart failure, diabetes, COPD, and even multiple sclerosis or myocardial infarction were treated.

But nowadays, the comfort of this relational stability no longer exists. Why? Partly because doctors have become more specialized, which can improve competence. But also, because the tariffs for care have changed, and impose their absurd and harmful regulations. We have implemented, first in the United States, then in France, " activity-based tariffs": for each of the diseases we have just listed, a specific remuneration is allocated to the department that provided the care. As a result, care is lucrative only on the condition that the patient described above goes from one department to another: he will move from a cardiac bed to a diabetic bed, then a respiratory bed, then a neurology bed, etc. This is the only way for the hospital, caring for a patient, to make the most money.

Naturally, the patient suffers because of this sequential care, which resembles a game of ping-pong. He finds a little stability, perhaps, only in the geriatric wards: do we have a geriatrician in the room, the last remnant, perhaps, of continuity of care?

IV. CLINICAL EXAMPLES

A) THE CESSATION OF CONTINUITY OF CARE DUE TO THE SARS-COV-2 PANDEMIC.

The pandemic has had the effect on continuity of care of a hyperthyroid elephant introduced into a crystal factory.

The virus appeared in China in the Autumn of 2019. It entered Europe through France.

- On January 27th, 2020, 3 cases were diagnosed in France.
- A month later, on February 29th, exactly 100 people were infected.
- But two months later, on March 31st, it is a catastrophe: 52,827 French people are infected. 21,000 are hospitalized, with 80,089 hospital beds in the country. 5,565 covid patients are in intensive care, which means that 100% of our intensive care beds are occupied. Already 3,523 people have died.
- Two weeks later, the change in the numbers is mind-blowing: the virus has killed 1,438 people in a single day[6].

A health bomb has just exploded. No health care system can withstand this tsunami. One would need to double the number of intensive care beds. That's impossible! … And yet it was achieved in two weeks: 10,707 beds on the 15th of April.

On the other hand, the hospital has almost stopped caring for the sick, except for patients with covid. Inpatient wards are either shut or hastily transformed into infectious disease wards. In surgery, very few operations are performed. Fortunately, thanks to the lockdown, there are no more road traffic accidents or accidents at work.

On the other hand, when it comes to continuity of care, there will always be cancers to be operated on. There are also general medical patients to be treated: cardiac patients, diabetics, cancer patients. All this is considerably slowed down. Continuity of care is well finished. And for a long time: it was only on December 27th, 2020 that the first dose of vaccine was administered in France.

Three remarks on this break in continuity of care:

- For those who we were not able to treat, we never totally catch up. For example, diabetics have lost their sight. Early cancers have only been diagnosed late. It is estimated that cancer mortality will be abnormally high in the next five years.
- Previously, it was sometimes thought that a break in the continuity of care was beneficial: when caregivers went on strike, mortality decreased. This observation had allowed for some ironic

[6] In ordinary times, 1,700 people die in France every day.

remarks on the reality of the services we render to the sick. But the cessation of care in 2020 because of a Chinese virus shows that it is not good to stop treating, screening and operating.
- Will a new paralysis of care occur because of a novel variant of the coronavirus?

It depends on two things: the mutations of the virus, which are not predictable; the protection of the population by the vaccine, which is unfortunately well-known: the vaccine is poorly accepted. In France, elderly or frail people are currently advised to get a booster every six months. But last autumn's vaccination campaign was a bitter failure: only 1.5% of the people who were targeted received the vaccine. France is doing little better than the African countries which, in 2021, had banned the administration and even the import of the vaccine, even though it was offered to them free of charge, for an indefinite period. It is as if the French prefer curative medicine to preventive medicine. However, they claim the opposite. But they have apparently forgotten the 61,000 deaths in 2021 and the 38,400 deaths in 2022.

B) THE CESSATION OF CONTINUITY OF CARE DUE TO THE UNAVAILABILITY OF MEDICINES.

This is a new phenomenon, which we might call "the syndrome of the unobtainable drug". It is disastrous for continuity of care.

Continuity of care is not only the possibility of access to the doctor you know well. It is also the possibility of having one's usual medication. This is going badly, for several reasons.

One of the reasons is, in France, the very low price of medicines. Indeed, France is among the world champions in health spending, but, among developed countries, it is also a country where the State imposes lower tariffs on pharmaceutical companies than elsewhere. However, the drugs are sold to several countries. There is competition between the different countries buying the drugs. In this situation, it often happens that manufacturers prefer to sell elsewhere rather than in France: the same box of pills can be four times cheaper in France than in Switzerland.

- In 2019, there were 1,504 official alerts in France for drugs that were "in short supply" and were at risk of becoming unavailable. This count only concerns "drugs of major therapeutic interest".
- In 2022, 3,721 drugs were in short supply.
- In 2023, the figure jumped to 4,925[7]. The situation is getting worse.

A solution is found 9 times out of 10, sometimes by asking pharmacists to make their own home-made formulations, known as 'master' formulations! But there were still about 500 occasions where a drug was unobtainable for a while. This may involve

- pain medication (paracetamol),
- Essential medicines (Flecainide),
- Or essential supplies such as surgical equipment (intubation tubes), resulting in procedures being postponed.

In my hospital, every time a drug is missing, the pharmacist fights like a lioness to find a stock or a supplier somewhere. It happened recently for my dialysis patients: we could no longer get a thrombolytic drug that is absolutely essential for unblocking the dialysis catheters. On this occasion, I learned that this pharmacist spends almost "one hundred percent of [her] time, twelve months out of twelve, phoning and travelling to find a solution for stock shortages" in order to help patients and doctors.

Despite her efforts, one of my dialysis patients was still forced to travel 50 kilometres to procure an anti-tuberculosis drug for herself that had become almost impossible to find in all of France. This is a pitiful example of caregivers' energy being neutralized.

Running out of stock, a serious obstacle to continuity of care, can edge towards tragedy: oncologists have run out of peginterferon, a drug essential for the treatment of certain leukaemia's and cancers.

---

[7] Zeliha Chaffin, *Le Monde*, January 27, 2024

C) THE DISRUPTION OF CONTINUITY OF CARE DUE TO INTERNATIONAL TRAFFICKING IN PATIENTS

For a foreigner, being treated in France can be a source of great suffering:

A month ago, a nurse told me about the distress of a dialysis patient. He is 39 years old. He comes from a poor country where violence is rife, Bosnia.

He has entrusted his future to a multinational organized crime company. This mafia network smuggled him into France a year ago. The human traffickers promised him, in exchange for I don't know what awful deal, that in France he would be dialyzed for free, automatically housed and transplanted quickly. Both taken care of and deceived by these unscrupulous smugglers, he agreed to be parted from his wife and children.

Despite his courage, a year later, this separation weighs heavily. On his smartphone, he shows me the photo of his two children. He makes me understand that he misses these two smiling kids terribly. He wipes his eyes. The way he looks away is pathetic. We can understand each other, but not talk to each other: for me, Bosnian is a language as difficult to master as English.

It's poignant: I can't help but think of one of my daughters. The analogy is disturbing: she is the same age as this young father, give or take four days. Like him, she has two children, of a comparable age. Like him, she suffers from a chronic illness. But she profits from satisfactory continuity of care. She will never have to leave her country and be separated from her family to be treated.

I can't help this Bosnian dad. The break in continuity of care seems tragic to me in his case:

- In Bosnia, he was on dialysis. Good or bad? I don't know.
- Did he have a chance of being transplanted? I guess not: Muslim culture, as has been said, is reluctant to donate organs, and even to donate blood.
- Will he be able to be transplanted in France, and thus be reunited with his children in Bosnia? It is uncertain: I doubt that the Bosnian health care system is capable of providing post-transplant monitoring.
- This man contributed to the prosperity of a network of scoundrels. In our country, he has also appeased the conscience of kind-hearted humanitarians who believe, simplistically, that they are doing good by helping unfortunate migrants who are looking for a better life.

So, would it have been preferable for this man if the continuity of care had not been broken? I ask you the question. It's a shame you can't see the photo of the two young children deprived of their dad.

This "clinical form" of discontinuity of care is becoming commonplace: in my small department of about forty dialysis patients, there are one or two more foreign patients every year, always brought in by organized crime gangs. Here is a second example, to illustrate another aspect of our subject: the international traffic of patients worsens the continuity of care for "our" native patients:

In what is called "chronic kidney disease", the care pathway has precisely defined successive steps, in order to provide ideal continuity of care:

- 1st step: identify people with kidney disease There are about 6 million of them in France. They have kidney failure of varying severity.
- Thanks to nephroprotective treatments, a minority reach end-stage renal disease, requiring dialysis to survive. We have about 55,000 dialysis patients, to which are added more than 12,000 new dialysis patients [8] each year.
- Among these dialysis patients, the least frail want and ardently hope for a transplant: about 16,000 are on the waiting list.
- But there are not enough transplants for everyone: we only transplant 3,500 people [9] per year. The waiting list is constantly growing. The wait is prolonged, it is a cause of great suffering.

---

[8] In 2016 : 10,590 new dialysis patients. In 2019 : 11,437 new dialysis patients

[9] Kidney transplants in 2016 = 3,615, in 2018 = 3,567, in 2022 = 3,376, in 2023 = 3,525

This ideal of continuity is undermined mainly by the lack of donors in France, but also by the arrival in France of additional recipients in the context of human trafficking. We will see that this is doubly dramatic.

Mrs. C. is on dialysis in Bosnia, like the previous young father. One Monday, she arrives at the hospital without warning.

She is 55 years old. She only speaks Serbian. The same goes for her husband who accompanies her. With the papers she brings, or by guessing things in the light of past experience, the social worker and I reconstruct her journey:

Experienced smugglers organized her illegal crossing of the various borders. in Europe. They are organized to perfection to find a dialysis place in France. They know exactly which centres are able to receive foreigners.

They probably continue to keep an eye on Mrs. C. now that they have transported her to the Haut-Jura. For her, they had all the Bosnian documents that they know to be useful translated into French before the trip, because they are professionals. For example, a certificate establishing that Mrs. C.'s son, then two years old, was killed in 1999 in a Serbian bombing: a certificate that is undoubtedly valuable in supporting an asylum application. There is also a document that mentions "Rekomandohet transplantimi veshkes", in other words which mandates permanent asylum in France since in Bosnia, it is neither possible to perform a transplant nor to ensure the medical follow-up of a transplant recipient. Well advised by her smugglers, Mrs. B., although she did not speak a word of French and knew nothing about France, asked us for her Vitale card as soon as she arrived. It is the French document that allows you to be treated.

Let us come to the worst part: Mrs. C left behind her four daughters, aged 12, 17, 21 and 30, in Bosnia, under the "protection" of the smugglers. What suffering! But also how awful: these girls are a guarantee, a means of pressure, and if necessary, a source of income to pay for the passage to France. How are the girls going to pay these wretches? We tremble for them.

And the husband? He too will have to earn money in France, well supervised by mafiosi who are involved in the international trafficking of weapons, drugs and fresh blood. We can only guess what kind of work he will be asked to do. He will accept the contract, otherwise it is "A bullet in the knee, to begin with". He has just spent two nights outside in the cold, but what awaits him is much worse.

We hurry to organize the care and accommodation of this unfortunate couple. Mrs. C. has a good chance of being transplanted quickly, because she is younger and in much better general condition than most of our dialysis patients waiting for a transplant, elderly, diabetic and vascular. Good for her. Too bad for our elderly dialysis patients: their interminable wait for a transplant, which is a form of torture, will be lengthened in their case. Or it will never come to an end: 16,000 registered on the waiting list, 3,500 lucky ones chosen each year...

We, the caregivers, are unwittingly complicit in this terrible injustice, and the horrors that are linked to it. We are the last link in a well-oiled criminal chain. It is an essential link. The criminals know it well, know us well. They know they can count on us. Reluctantly, we give them satisfaction, trying not to think too much that it is to the detriment of the continuity of care for our patients.

All the same, let us put this tragedy into perspective: today, because of the criminal globalization of transplantation, some patients will certainly end their lives on dialysis without ever being able to be transplanted. But about fifty years ago, the obstacles to continuity of care already existed, in another form, and it was even more tragic: there were not enough dialysis places for all kidney patients. We triaged the sick people we were going to save and those we were going to allow to die. For example, priority was given to patients who had children.

D) THE INTERRUPTION OF CONTINUITY OF CARE DUE TO REGULATIONS.

1) Generics

80% of the medicines manufactured in France come from abroad, often China, India or Israel. In most cases, these are copies of drugs that are already on the market. They are called "generic medicines".

In France, as no doubt elsewhere, the Ministry of Health does not hesitate to financially punish doctors, pharmacists, and even patients who would like to use, not generic drugs, but original drugs (called "brand-name drugs"). It is true, generic drugs have a big advantage: they are much cheaper.

They also have a big disadvantage: they provide manufacturers with low profit margins, which quite often become zero. It can even happen that, for a company, the price of manufacturing the drug becomes higher than the sale price[10]. Why? Because of endless competition between manufacturers, since, by definition, a "generic" can legally be copied by anyone who wants to. There is nothing virtuous about this unbridled competition because it is a question of copying and it creates a lot of chaos and unpredictability: it is common for a manufacturer to stop production of a drug that has become unprofitable. Patients are thus deprived, more or less abruptly, of a useful medicine.

In addition, generics are sometimes abruptly banned from sale because they are faulty. There is nothing surprising about this: while a branded drug is only authorized after numerous studies, generic drugs are exempt from proving their effectiveness. Only one test is required: to check that a generic tablet contains approximately the same dose of active substance as a branded tablet. Often unable to carry out this specialist test themselves, manufacturers of generics entrust the operation to a subcontractor who is not very rigorous. The result is not good. In May 2024, the European Commission asked its members to withdraw 400 "problematic" drugs from the market because they had been poorly tested: these are anti-cancer, antiviral, antiepileptic drugs, etc. manufactured by an Indian manufacturer of generics[11].

2) Administrative tardiness

In May 2024, a flu vaccine, Efluelda, was withdrawn from the market, at the request of the manufacturer. This flu vaccine is not like the others: it contains four times the dose. We know that it is much more effective in protecting people over 65 years of age. But this progress is still not recognized by the health authority, an administrative body (the Haute Autorité de Santé or HAS) that is on occasions not very scientific. Because of

the HAS, strangely, the high-dose vaccine is still sold in France at the same price as the standard vaccines, which are less effective. As a result, its sale price is lower than the cost of production. For this reason, the manufacturer has decided to stop distributing it in France: another blow to continuity of care, if we consider that traditional vaccines are not able to guarantee this continuity.

V. EVOLUTION: CONSEQUENCES OF CONTINUITY OF CARE (AND THE LACK OF IT)

A) CONTINUITY OF CARE IS ALSO GOOD FOR CAREGIVERS

Two years ago, a surgeon had no hesitation in saving my life, because he could not have foreseen that it would one day result in you having an interminable presentation inflicted on you.

After the operation, he paid me a flying visit. Visibly in a hurry, he did not take the time to sit next to the bed, nor to put down the motorcycle helmet he was holding in his hand. He only said to me: "Sir, it is useless my seeing you again. No point: you would only come and tell me that you are fine... »

No doubt he was rightly satisfied to have given an old man a few more years of life. This pleasure, which we know well, was enough for him. But I allow myself to think that our man in a hurry deprives himself of a deep satisfaction, by thoughtlessly deciding not to see again those he has operated on: in a sort of manual of therapeutics written two thousand years ago, we can read "Man does not live by bread alone". This is also true for the surgeon: he does not live only by skilfully and smoothly carrying out successful operations. His life is much more interesting if he also gives himself the opportunity to go on a part of the journey with patients who are not only grateful to him, but also have something to teach him.

[10] Zeliha Chaffin, *Le Monde*, January 27, 2024.

[11] *Quotidien du Médecin,* June 20, 2024.

Yes, our patients have something to teach us. But this is not possible if there is no continuity of care: without it, the fleeting relationship is highly likely to remain superficial. When it deepens, it enriches us. The elderly, in particular, are a living library. But it is not at the first consultation that they turn the pages of the book of their lives, adding their reflections. With their stories, my patients teach me a piece of universal human history.

Our patients are giving us an invaluable gift: <u>a world which is livable</u>, if I am to believe Paul Tournier, who wrote: "A world where we can live would be, I think, a world where there would be a real contact between people." [12]

In this sense, the profession of doctor is an opportunity. Claude Jacob used to say, "In the theatre of humanity, the doctors have a front row seat." Nurses may be even luckier. In addition to their technical virtuosity, they are confidantes. You may think that I am exaggerating when I speak of "technical virtuosity", but that is because you have not seen a nurse rush down a corridor towards a patient whose fistula is bleeding profusely: she leaps, she flies, while grabbing a pair of gloves in one hand, a thermostatic product in the other, and a packet of swabs in the third. In a few seconds, she is bent over the patient and pressing the bleeding point. The performance is dazzling. It is a pleasure to see. That's why I'm sharing it with you. But what is more relevant to our subject is that this flying female James Bond was, also, an hour earlier, a confidante for the same dialysis patient. When you spend ten minutes at the bedside of a dialysis patient several times in a morning, you talk to each other.

I think that the beautiful depth of humanity in many nurses comes from this dialogue. They are lucky to have it. I am also fighting to promote it: I opposed certain executives obsessed with performance: they came secretly with their stopwatches, to measure exactly how long it took to connect and disconnect a dialysis patient. They would have liked nurses to spend less "dead time" at the bedside, using sprung forceps, which could have eliminated the "wasted" time manually compressing the fistulas. This "lost" time, which is in reality time for dialogue, that constitutes continuity of care.

Let us keep this opportunity for interpersonal relationship. In other professions, it is threatened. In my opinion, teleworking is one of these threats.

B) MEDICAL DESERTS

The difficulties of access to care have taken on a pictorial name: "medical deserts". This is an undeniably worsening phenomenon, because it can be quantified: in 2024, a French person lives on average, 19 minutes from a general practitioner and 13 minutes from a pharmacist. But if you live in the countryside, the figures are 30% higher than these averages: it's starting to be a long time. To make matters worse, this distance is compounded by the impossibility of getting an appointment. As a result, in these medical deserts, there is much more recourse to hospital emergency services for care that is not urgent: + 54%.

It is a vicious circle: the lack of continuity of care causes an ever-greater deterioration in continuity of care!

C) DESPERATELY LOOKING FOR A DOCTOR (the rejected patients)

In France, everyone must choose a "general practitioner" and declare it to their health insurance company. If this is not done, various steps are impossible, for example the administrative recognition of so-called long-term illnesses.

A growing number of French people are turned away when they ask the nearest doctor to be their official "treating doctor", often for themselves and their children. They are told: "I don't want to take on any more patients". They are then condemned to call an emergency department for every little health problem, whatever the problem, whether it is a child with a fever, the flu, or a flare of multiple sclerosis: situations in which it is absurd to keep resorting to seeing an unknown emergency doctor, different every time, and moreover without the training to treat these pathologies, whether banal or on the contrary too specialized.

---

[12] Paul Tournier, *Guérir*, éditions Ouverture, Le Mont-sur-Lausanne, 1986.

D) TSUNAMI IN A/E: THE UNBRIDLED USE OF EMERGENCY SERVICES

The growth of A/E departments is impressive. In an average hospital, forty years ago, an emergency department had one or two rooms. It operated with a few cubicles, a medical foundation doctor, a surgical foundation doctor, and not a single senior doctor. Few of the city's patients knocked on the door of the emergency services. Most of them arrived after taking the advice of their G.P.

Everything has changed in twenty or thirty years: the patients, infinitely more numerous, come because they have not been able to contact their general practitioner, or because the latter has not wanted to take care of them. The emergency department of the above-mentioned average hospital now operates with ten cubicles (but the patients are crammed into the waiting room), with fifteen short-stay hospital beds (but several patients sleep in the corridor on trolleys), and with about twenty full-time emergency doctors (but that's not enough: half of the emergency departments in France have periods of closure because of lack of staff). Continuity of care is obviously in tatters: when you come to consult an emergency department, not only is the doctor a stranger, but he changes during the hours you are waiting in the department.

It's harmful: a recent study [13] studies a common reason for going to the emergency room, which will interest most of us, given the age of our vertebrae: what is the best way to treat low back pain in the emergency room?

Oral NSAIDs? Topical NSAIDs? Both? It seems to me that this study is not of much use, because according to a 2020 Cochrane review[14], we already know that NSAIDs have only a minimal effect, probably not enough to justify their side effects. But that is not our topic. Useful or not, this study was carried out <u>in the Emergency Department</u>, and that is what is of interest to us.

The <u>main</u> conclusion is that oral NSAIDs are useful (humm, Cochrane...), and that topical NSAIDs are not. But this is an <u>incidental conclusion</u> that touches on our subject: the most important "treatment" remains <u>the exchange</u> between the doctor and the person with low back pain, an interview focused on reassurance: it is necessary to reassure the patient with low back pain by explaining that recovery will occur no matter what we do, by patiently emphasizing that bed rest is harmful, and by being attentive to "psycho-social factors". In other words, anxiety, family life, professional constraints, in short, the patient's psyche and quality of life. How is this achievable with an unknown doctor?

VI. TREATMENT

For many years, we have been looking for solutions to curb the lack of continuity of care. Here are some of these "therapeutic" attempts:

A) INCREASE THE NUMBER OF CAREGIVERS

In France, the number of doctors is increased in two ways: by multiplying the number of medical students, and by bringing in doctors from abroad.

Number of active doctors in France:

Year	Doctors
1968	59,000 doctors
1979	112 066
1990	173 100
2000	194 000
2011	199 987
2023	230 200

[13] Khankhel N, Friedman BW, Baer J, et al. <u>Topical Diclofenac Versus Oral Ibuprofen Versus Diclofenac + Ibuprofen for Emergency Department Patients With Acute Low Back Pain: A Randomized Study.</u> *Ann Emerg Med*. 2024 Jun; 83(6):542-551. doi: 10.1016/j.annemergmed.2024.01.037.

[14] Van der Gaag WH et coll.: <u>Non-steroidal anti-inflammatory drugs for acute low back pain</u>. *Cochrane Database Syst Rev*. 2020, 16 avril; 4(4). doi: 10.1002/14651858.CD013581

Number of doctors with foreign degrees in France:

1990	8 000
2002	10 000
2007	17 000
2017	26 805

B) INCREASING THE ATTRACTIVENESS OF THE CARING PROFESSIONS

As far as salaried doctors and nurses are concerned, salaries have significantly increased in recent years. Despite this increase, there are still quite a few people who are leaving the public hospitals: 32.8% of hospital practitioners leave their posts for a reason other than retirement[15]. The poor continuity of care is therefore not due to insufficiently attractive salaries, but to the tough working conditions.

C) SOME SOLUTIONS WHICH ARE POPULAR IN FRANCE:

Teleconsultation is being developed: the patient comes into contact with a caregiver by means of a telephone and a camera. Sometimes he knows this caregiver. Sometimes it is a stranger who is thousands of miles away.

Curiously, only a few years ago, teleconsultation was banned! It was considered malpractice to give diagnostic or therapeutic advice over the phone. Sanctions were imposed, especially when remuneration by insurance companies was involved. Going forwards, instead of being prohibited, teleconsultation is encouraged. In the department where I was born, the Meuse, where young doctors do not want to practise, about 1,600 teleconsultations are carried out per year[16].

Hospitals are short of doctors: 24% of full-time doctors' posts are not filled. **Locum caregivers** are therefore called upon, who are officially called "interim doctors" and pejoratively "mercenary doctors". On average, these locum doctors come to work for 3.6 days[17]. The salaries are sometimes extravagant: up to €2,700 per day. In 2022, we needed 17,000 of this type of locum to bail us out.

In addition, there are slightly more stable doctors recruited "temporarily" on contract. Many change hospitals from one year to the next. There are currently 12,500 of them, out of about 45,000 hospital doctors. These doctors on temporary contracts make the continuity of care mediocre.

Replacing regular staff by locum or temporary doctors is not a solution: it poses an additional problem.

Health centres: they are built with departmental or municipality funds, to attract doctors.

Aeroplanes to get medical activity off the ground: we have heard in the past about these bush doctors, who travel by plane to give care in a distant dispensary. Typically, it takes place in an under-medicalized African area; the doctor is an adventurer who pilots his own small plane; He is as skilled at avoiding a collision with a giraffe on landing as he is at operating on a strangled hernia in the village chief's hut.

Well, this airborne medicine is being practiced again nowadays, except that we are no longer worried about seeing giraffes crossing the landing strip: every morning, in Dijon, the city where I live, a small plane takes off. Eight doctors from Dijon hospital are on board. Half an hour later, they landed in Nevers. Nevers is not a bush village, but a prefecture of 32,800 inhabitants which has a modern and well-equipped hospital... but

---

[15] CNG : https://www.cng.sante.fr/sites/default/files/media/2022-03/Synth%C3%A8se_PH_2022_VF.pdf

[16] Loan Tranthimy and François Petty, In search of doctors, the departments play their own score, *Le Quotidien du Médecin*, June 21, 2024.

[17] Arnaud Janin, Medical interim, short contracts: "worrying and poorly controlled abuses" for the Court of Auditors, *Le Quotidien du Médecin*, 3 June 2024.

is insufficiently provided for with doctors. To keep providing care, we have found no other way than this surreal air shuttle in a developed country.

Mobile medical practices: A medical office is set up in a van. We put in a doctor and his driver. This consulting room on wheels goes from village to village, like bakers' vans in the past.

From the point of view of continuity of care, it is not a success. From the point of view of the quality of care, it may not be any better: sometimes the doctor considers himself a makeshift troubleshooter: he renews old prescriptions but refuses to deal with new symptoms.

Re-establishing medical slavery in France: this is currently only in the planning stages. It is astounding, but serious. It underlines the extent to which continuity of care is deficient in certain places in France, in this case Brittany: Guingamp is a Breton municipality of 7,000 inhabitants, which has a hospital with almost 300 beds. The region is so devoid of doctors that it has asked the Cuban embassy for help. Havana immediately gave its approval, knowing it to be doable since the Cubans have already sent doctors to Italy.

We know that the Cuban state has a unique specialty in the world: it has trained tens of thousands of doctors with the sole purpose of sending them to countries that lack doctors (there are currently 50,000 of them, in about sixty countries). These are generally third world countries, and politically close to Castroism, such as Angola, Brazil, South Africa, Venezuela and Haiti.

These thousands of doctors are not all sent against their will: most are volunteers, for economic reasons. But they are deprived of all rights. 85% of their salary is confiscated. Their families must remain in Cuba because they are being held hostage to ensure their cooperation. The Cuban dictatorship created this system, not for humanitarian purposes, but to obtain foreign currency. Unfortunately, this is not a simple business transaction. It is slavery: this is the description used, after an investigation, by the NGO Prisoners Defenders. They believe that the constraints suffered meet the definition of slavery and have filed a complaint with the International Criminal Court[18].

Given that the Cuban regime has a considerable number of doctors at its disposal (10,000 of them worked in Brazil alone in 2018), councillors in Guingamp want to use this archaic solution to treat their medical desert. Patients would finally have a doctor to talk to, but we guess that this would not be a solution conducive to continuity of care.

European solidarity in the event of a shortage of medicines: when a major medicine is in short supply in a country and continuity of care is very seriously threatened, an exceptional mechanism is set in motion, the "European Voluntary Solidarity Mechanism". It is a "distress mechanism".

France has only used it once. The drug that was lacking was methotrexate.

The shortage threatened the lives of patients treated for cancers such as osteosarcoma, lymphomas, etc. Two countries had stocks of methotrexate and were "volunteered" to help France: Slovenia and Great Britain.

Lists of doctors for writing death certificates: this is a technocratic solution devised to deal with a discontinuity in care that may seem anecdotal, but which seems to me to be terribly inhumane.

What's the problem? When you're sick, it's hard to find an available doctor. When you die, it can also be difficult to find a doctor to sign the death certificate, which is administratively essential to organize the funeral: the attending physician is unreachable. The on-call doctor has more urgent things to do.

This has caused painful situations for families. To resolve these particularly difficult situations, the doctors in my region and the administration [19] have recruited 108 doctors who agree to be called on an emergency basis for this work.

When I was doing locums in general medicine, all the doctors were committed to fulfilling this last duty for the patients they had looked after until their death. The quarter of an hour they spent with the family was

---

[18] Angéline Montoya, Complaint before the International Court of Justice for slavery against Cuba, *Le Monde*, 15 May 2019

[19] The scheme was co-created in Burgundy by the ARS, the Order of Physicians and the URPS (Regional Union of Health Professionals): François Petty, Drafting of death certificates: the URPS Bourgogne-Franche-Comté is looking for volunteer doctors, *Quotidien du Médecin*, 20 June 2024. The drafting of the certificate is compensated €100 plus mileage expenses.

a time that was essential on the humane level. It was so sacred that we used to refuse remuneration. Today, the doctor who comes to sign the death certificate probably brings comfort and does a great service. But he is a complete stranger, and the price for his service shows a different conception of decency: it amounts to three times that of an ordinary consultation, plus travel expenses.

VII. FORECAST

For a patient, the care pathway is a zig-zag road where, too often, the caregiver changes at every turn.

This discontinuity is the new face of medicine: We have reviewed many causes. When you look at them, it's hard to see how it might improve. Hence the title of this presentation: "Requiem for continuity of care".

VIII. CONCLUSION

Is it <u>also</u> a requiem for Médecine de la Personne ?

For Paul Tournier, as we recalled in the introduction, the person who suffers needs the caregiver to provide them with two kinds of help: therapeutic skill which is generally scientific, and human support. The diseased organ needs a repairer, the vulnerable human being needs a comforting interpersonal relationship.

Where can this comfort come from? Four or five ingredients:

- kindness,
- compassion,
- interest in the person in front of you,
- sense of humour,
- love, if we can dare to use this word.

These ingredients have a little trouble being delivered when care is discontinuous, and caregivers are intermittent!

This is the current trend: so, requiem !

But not requiem aeternam! Indeed, as our exchanges in Northampton testify, continuity of care remains rooted in many practices. As far as I am concerned, I am in awe of what I see in the dialysis service: the patients we treat three times a week for years are very familiar to us. The bonds they sometimes forge with doctors, and often with nurses, are continuous and lasting, until death. What a chance!