A month at the Hôtel-Dieu: a reversal of perspectives

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International medical graduates (IMGs) account for more than 30% of the first-year positions filled in US psychiatric residencies (Nation Residency Match Program, 2007). At the time of writing, the first author was 4 months away from finishing his residency at the University of Connecticut (UCONN) when the opportunity arose to turn the tables and use his fluency in French to complete a month-long elective in France. During this period, he spent time as an observer in the psychiatric service of a Parisian hospital, l'Hôtel-Dieu. The realisation of this elective was helped by the fourth author, who knew various members of World Psychiatric Association. This paper presents some comparative observations of the clinical milieus at UCONN and the Hôtel-Dieu.

History

Created around 650 AD, Hôtel-Dieu – Hostel of God – is Paris's first (and smallest) hospital and France's oldest (Abecassis, 1993). Its 14 centuries of history have included grim periods, such as the insanitary conditions that led to public criticism by Voltaire in 1768, as well as proud ones, like the production of such notable physicians as Laënnec, Dupuytren and Paré (Abecassis, 1993). Today, Hôtel-Dieu enjoys a reputation not just as a historical monument but as an institution among France's top hospitals, particularly in ophthalmology and thoracic surgery. Its psychiatric service is noted for being the first in France to move away from the free-standing asylum and into a general hospital.

Academia

French medical education begins after high school and consists of two cycles of roughly 3 years each (Segouin *et al*, 2007). A ranking examination determines the residency location and choice of specialty for the graduates. Psychiatric residency lasts 4 years, with the option of an additional year dedicated to either research or specialisation in child and adolescent psychiatry. Medical students are called *externes*, and residents, irrespective of year, *internes* – the term *internes* originated in the 18th century under Hôtel-Dieu's head-surgeon, Jean Mery, in reference to students who lived in the hospital (Abecassis, 1993). Residency rotations each last 6 months and their allocation is dependent on an *interne*'s seniority and results achieved in the national examination – *internat* (Segouin *et al*, 2007). The daily patient load and academic responsibilities of the *internes* at Hôtel-Dieu parallel those of UCONN residents. The *internes* have a maximum case-load of six patients each, compared with seven for UCONN residents. Though the *internes* cover the emergency department until 6.30 p.m., they do not have overnight calls, nor are they expected to manage out-patients, both of which are requirements for UCONN residents. In contrast, even under supervision, *internes* tend to be more clinically independent, even when it comes to administering electroconvulsive therapy.

Clinical approach

Much as in the USA, the clinical approach in Paris is based on a biopsychosocial model. The team is led by a psychiatrist and includes ancillary staff. Morning report takes place at 9.00 a.m. and that is when nurses report the latest information on every patient. In contrast to UCONN, where every day of in-patient stay needs approval by an insuring entity, with universal healthcare in France there is a relative lack of urgency in the discharge planning for patients at Hôtel-Dieu. Collateral information, social history and developmental facts are gathered judiciously. As the teams get to know the patient, days may pass in establishing a diagnosis before medications or other treatments are started. In 1999, the mean duration of an in-patient psychiatric stay in France was 32 days (Verdoux & Tignol, 2003). Given the relatively slow process of psychiatric treatments, this setting provides any psychiatrist in training an excellent opportunity to witness the natural course of psychiatric disease and its management.

Though medications and other approaches are similar to how care is delivered in the USA, traditional psychoanalytic theories have a prominent influence on French psychiatry, even on in-patient services. Many patients routinely receive psychoanalytic out-patient therapy and a large number of French private psychiatrists restrict their practice to psychoanalysis only (Verdoux & Tignol, 2003). The clinical usefulness of psychodynamic principles becomes especially evident when the team tries to engage a patient's family. Biologically, communication with other medical specialties is emphasised and French psychiatrists seem exquisitely well trained in the principles of internal medicine and neurology. French patients seem to recognise and revere their psychiatrists, the same way they do with physicians in other specialties.

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In terms of boundaries, a mandatory white lab coat, worn by all hospital staff, makes the distinction between patient and doctor inescapable. On the other hand, classical French culture, with its routine greetings, pleasantries and ways of respecting others, makes being empathic that much more automatic and that much easier.

French psychology plays an important role in the diagnosis of patients, with the application of both traditional – Rorschach – as well as neuropsychological testing modalities. When a specific mode of psychotherapy is desired, psychologists with the necessary expertise are available. An in the USA, the title 'psychotherapist' is ill-defined and various professional backgrounds serve as qualifiers for the trade (Verdoux & Tignol, 2003). In contrast to the USA, in France the idea of psychology expanding into medication management is as absurd in reality as it is in theory.

Mental health organisation

In 1998, mental disorders accounted for 9.4% of France's total health expenditure (Verdoux & Tignol, 2003). In the USA, this proportion declined from 8% in 1986 to 6% in 2003 (Mark *et al*, 2007). French psychiatric in-patient units are centralised under the direction of the Ministry of Health (Verdoux & Tignol, 2003). These units are responsible for a catchment area or *secteur*. Community clinics – *centres medico-psychologique* (CMP) – will refer a patient who needs to be admitted to the in-patient facility serving that *secteur*. The set-up at Hôtel-Dieu is unusual in that, since it is the only institution in Paris that provides forensic psychiatric care, the service cares for patients who are referred from all over the city.

Regardless of locality, it is standard practice for a physician evaluating a patient in crisis to call the local CMP, which, based on the psychiatrist's recommendations, assists in the management and possible transfer of the patient. Unfortunately, since the homeless do not have a primary place of residence, they are at risk of falling through the cracks in the system. In cases of discharge or consultation without CMP involvement, a handwritten clinical letter is always sent to the primary psychiatrist or physician – private or public – who is always kept abreast of the patient's developments. This standard of communication between physicians, and the centralised structure of the system, makes the care of patients with acute and chronic psychiatric illness very effective.

Hôtel-Dieu's in-patient service is an open unit – *unite libre*. Individuals admit themselves and leave when they wish. Once in-house, patients are expected to follow rules that pertain to the care that they will receive. If a psychiatrist gives them permission, patients are allowed to leave the premises for a certain predetermined period. Patients use this leave, which can last up to 48 hours, to go out for strolls and meals with friends and family. Patients also continue their out-patient visits with their therapists, who then communicate their findings to the in-patient team. Though patients are allowed to smoke, they are prohibited from self-intoxication with alcohol or drugs of misuse. For high-risk patients, to ensure security and safety, privileges for leaving the premises are withheld and the patient is put under close observation in anticipation of a transfer to a closed unit. This open philosophy is in stark contrast to the closed-unit model at UCONN. Evidently, the severity of psychopathology at Hôtel-Dieu tends to be of a mild to moderate degree for patients to enjoy such liberties. Regardless, in terms of adherence to the recommended regimes, this open philosophy puts the responsibility on the patients to exercise a choice in their willingness to participate in their care. It is not that the hospital is not responsible for the welfare of patients, but that French common law is strict in its protection of civil liberties (Abgrall-Barbry & Dantchev, 2007). In comparison with the USA, where the brunt of the burden is on the hospital to ensure safety for patients, it was refreshing to see psychiatry practised in a setting that is not dictated by adherence to knee-jerk, risk-aversive management protocols, but that of true collaboration between patient and psychiatrist.

In France, involuntary admission is rare, since a signature from a 'concerned third party' such as a friend, family member or a social worker familiar with the patient is necessary for admission or discharge (Abgrall-Barbry & Dantchev, 2007). For example, a floridly manic patient with paranoid thinking was discharged because her partner opted for her release in the face of recommendations to the contrary.

In a minority of cases, with behaviour that is dangerous or disruptive, the police become involved and the patient can be admitted without a consenting third party.

Conclusion

The goal of this experience was to view psychiatry from a different perspective. The opportunity gave the first author a particular appreciation for the effectiveness of the centralised structure and governmental support of French psychiatry, the clinical usefulness of psychodynamic principles in acute settings, as well as the chance to observe the natural course of psychiatric disease and its management. This has inspired other IMG residents in the department to look at opportunities in other countries, such as China, India and Colombia. Given the number of IMGs within the US psychiatric workforce, it seems that the field is ripe with opportunities for global communication, education and progress.

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