

WONCA News

An International Forum for Family Doctors



CONTENTS

From the Wonca President : The uneven climb – part 2 3

From the CEO's Desk : Wonca 2013 conference planning committee meets in Prague 7

From the Editor : A global issue 8

FEATURE STORIES 9

- Wonca president interviewed in Spain
- Entrevista al presidente de Wonca en España
- NCD opinion piece published in The Lancet
- Confrontando las ENT: es necesario un enfoque diferente
- Comment aborder le problème des maladies non-transmissibles: une autre approche est nécessaire.
- The first Montegut scholar – Dr Maltezis Kyriakos
- Wonca Warsaw in photos

WONCA REGIONAL NEWS 22

- Profile: Daniel J Ostergaard - President Wonca North American Region
- APR president dines with Margaret Chan
- SAR: Wonca Mumbai final preparations
- EMR: Wonca Dubai programme now online
- APR to meet in Jeju, Korea, in 2012
- Wonca Europe 2012 in Vienna
- Africa conference dates change

WONCA WORKING GROUP NEWS 27

Working party on research update

MEMBER AND ORGANIZATIONAL NEWS 27

- Myanmar celebrates World Family Doctors' Day
- Caribbean news and profile of Andy Shillingford
- Philippines book with a cause
- New office bearers in Fiji and Saudi Arabia
- Pakistan nutrition update

RESOURCES FOR THE FAMILY DOCTOR 34

- Dutch position paper: Core Values of General Practice/Family Medicine
- Journal of Medical Case Reports

WONCA CONFERENCES 2011-2013 AT A GLANCE 36

GLOBAL MEETINGS FOR THE FAMILY DOCTOR 37

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South Asia Conference of Family Doctors

WONCA-WORLD ORGANISATION OF FAMILY DOCTORS South Asia Region

December 16-17-18, 2011:

Renaissance Convention Centre Hotel, Powai, MUMBAI, INDIA

Hosted by: Federation of Family Physicians' Associations of India [FFPAI]

Organised by: General Practitioners' Association-Greater Bombay[GPA]

Theme:

Only Family Doctors Can Provide Accessible, Cost-beneficial and Equitable Healthcare

*In Collaboration with:
Academy of
Family Physicians of India*



*Pre-conference Program for
Young & Future Family Doctors*



*CME Program
for Family Doctors*

FROM THE WONCA PRESIDENT :

THE UNEVEN CLIMB – PART 2

In the previous issue of *Wonca News*, I contrasted Family Medicine in Denmark and Romania. Danish family doctors stand tall atop their health care system. Romanian family physicians have a challenging ascent up a very steep slope. In this issue, I reflect on Spain and Brazil – two countries where the national health care systems have been re-built over the past two decades on a foundation of Family Medicine. A fiscal crisis (Spain) and a change in government (Brazil) now threaten the continued climb of Family Medicine in those nations.



Prof Roberts with a groups of trainees in Spain

Zaragoza en junio

After three flights, two taxi rides, and one high speed train from Madrid, I arrived in early June in Zaragoza, Spain. Built along the Ebro river, Zaragoza is located in a valley between the Pyrenees Mountains to the northeast and the Iberian System to the southwest. It is the fifth largest city in Spain, with a metropolitan population of about 800,000. Zaragoza has a 2000 year history



Prof Roberts with the semFYC Board of Directors

of diverse rulers. It was founded by Caesar Augustus, captured by the Goths, ruled by Muslim emirs, and governed by the Kingdom of Aragon before becoming part of modern Spain.

My travel to Zaragoza was to attend the annual conference of semFYC (Sociedad Española de Medicina de Familia y Comunitaria). The Spanish Society has just under 10,000 members. There were about 3,000 in attendance at the meeting. The Spanish make a special effort to reach out to medical students through a pre-conference meeting. I participated in a lively panel that discussed the future of Family Medicine in Spain. Several of the professors and deans acknowledged that the Spanish medical school curriculum needed to become more student-centered and relevant to primary care.

During the course of the conference, there was much concern about potential cutbacks because of the government’s financial crisis. Another issue was the effort to create a specialty of Emergency Medicine, which was viewed as a threat to Family Medicine. The relative absence of Family Medicine in academia was also a subject of much discussion.

I spent a portion of one day watching an experienced and skilled family doctor at work in his health center. Averaging about 5-7 minutes per person, he sees about 40-60 patients each day. His practice was limited to those over age 14, which is the norm for Spanish family physicians. A government established electronic health record provided easy access to information for each patient’s history, lab results, imaging studies, and so on. The range of patient concerns was familiar: musculoskeletal complaints, multi-system problems in the aged, infections of various sorts.

My overall impression is that the family doctor plays an important role in the Spanish health system. A heavy volume of visits (40 per day compared to 25 per day for other specialists) makes it difficult to address the range of problems that patients present, or to know the patient as well as the doctor would like. Part of the solution will be to raise the visibility and status of family doctors in Spanish society in general and medical schools in particular.



Prof Roberts visits the clinic of Dr Jose Carlos Perez Viarruya of El Centro de Delicias Sur

Brasília em junho

Several weeks later, I traveled to Brasília for the annual meeting of SBMFC (Sociedade Brasileira de Medicina de Família e Comunidade). Built in the 1950s as a planned capital city to connect the country, Brasília consists of broad boulevards and futuristic government buildings. Growing at a rapid rate, Brasília now has more than 2.5 million inhabitants.

With more than 4000 registrants, the SBMFC meeting was a reflection of Brazil – big, enthusiastic, and on the rise. I was kept so busy that I did not have the chance to visit a family doctor’s practice in Brasilia, although I have had the pleasure on previous trips to observe family doctors at work across much of Brazil.

One of the most interesting portions of the meeting consisted of sessions with new officials from the Health Ministry. The previous federal government pledged to have all 180 million Brazileiros connected to 90,000 Family Health Units has been slowed by a lack of qualified family doctors. With only 30,000 Units established thus far, the new government had concluded that there was a gap between the promise of the highly touted Family Health Program and the current reality. There is a desperate need for more qualified family doctors. The new government, eager to leave its own imprint on the

health system, has begun to talk about allowing more local flexibility, including a reversion back to the old polyclinic model with care provided by specialists or general doctors without primary care expertise.



In Brazil (from l to r): Joao Sequeira Carlos (Portugal), Inez Padula Anderson, Juliana Oliveira Soares, Sandro Rodrigues Batista, Gustavo Gusso (all from Brazil), with Rich Roberts (USA), Wesley Schmidt (Paraguay).

The wavering by the government generated a great deal of discussion on the part of the SBMFC members who have worked hard to make the Family Health Program successful and to achieve and maintain qualification as experts in Family Medicine and primary care. People lined up at the microphones to confront government representatives and share their concerns that the health system was taking a step backward. The family doctors were quite vocal in expressing their worries about losing many years of effort to build a better Brazilian health system.



Dining with Prof Roberts in Brazil is Dr Salman Rawaf (Gp and researcher from the UK) and his wife at left: Dr Viviane Santos Sach (Brazilian family doctor now living in the US); Sister Monique (far right) (Canadian family doctor who has been working in Sao Paulo for the past years).

On my return home, I thought about what I had learned in Spain and Brazil. These are two countries that had expressed commitment to, and invested heavily in, health systems built on a foundation of family doctors. Yet, when economic times became difficult (Spain) or a new government wanted to be credited with a new

system (Brazil), the support for family doctors weakened. These examples reminded me that we need to become more than the friends of any one government – we need to be embedded in the fabric of our cultures. In the end, it is our patients and communities that must be our most dependable allies.

Climbing skills

Leaders of both semFYC and SBMFC asked me for suggestions on how to strengthen the position of Family Medicine in their countries. Following are some of the strategies I offered to both Societies, which are built around three questions they put to me.

How do we respond to proposals by the Health Ministry that do not support Family Medicine?

There are 3 possible responses: “we do not agree,” “we agree,” or “we agree with some of your concerns and goals, and offer the following better ideas.” Let’s examine each of the 3 options:

“We do not agree” – outright disagreement with the Ministry is a risky proposition since most family doctors work for the government and the government has very substantial resources and media access to persuade the public of the correctness of its position.

“We agree” – agreement with the Ministry will maintain the important alliances built up between the Ministry and the Society, but puts the Society in the position of endorsing policy proposals that weaken support for family doctors, and risk the loss of confidence of family doctors in the Society.

“We agree with some of your concerns and goals, and offer the

following better ideas” – this is the best option. When the Ministry expresses concerns about costs or the need for local flexibility where there are not enough family doctors, the Society should agree with the government about these real concerns. The Society should then show the data it has that total costs will go up and outcomes will worsen if they use other health care workers (nurses, general doctors) or other specialists as the entry point into the health care system. The Society should also develop a proposal to deal with those local situations where there are limited numbers of family doctors, but more workers or specialists of other types. For example, in communities without enough family doctors, their mayors could be brought together in a local summit with family doctors from their areas to discuss better ways to cover all of the population. It can be helpful to look to others to help you make your case for a new and better strategy for access – enlist health services researchers who are sympathetic to your cause and know the data; also ask for help from researchers and others outside the country who can assist.

How do we identify and reach our targeted audiences with our message?

Your target audiences are: governments (federal, state, municipal); influence leaders, media; and patients (the general public).

Governments:

Use the government’s own data, which show that Family Medicine is the best way to provide health care that is lower cost and better quality than traditional basic health units. Many times, public officials look only at the direct costs (a family health unit costs more to set up than a traditional basic health unit), but do not consider all the costs (there are fewer referrals to hospitals or other specialists through a family health unit, which becomes much more expensive overall than the direct costs of the family health unit). In discussions with governments, the Society must speak to the issues and not to political parties or politics. If the Society is seen as linked only to one side of the political spectrum, such as the left, then the Society will be ignored when the other side (the right) comes into power. The focus should be on what’s best for patients and family doctors, not to serve anyone’s specific political agenda. There may be some (or many) Society leaders who had good friends in the old Ministry and who are not good friends with the current Ministry officials. It may therefore be necessary to have other family doctors step into their place when representing Society concerns to the current Ministry.

Influence leaders:

Every community has many influence leaders, some of whom are formal (mayor) and some of whom are informal (TV talk show hosts, business leaders, religious leaders). Ask family doctors to begin to discuss your concerns with the influence leaders they know in their communities. Develop presentations for Rotary, the Chamber of Commerce, church groups, and other organizations that make it easy for family doctors around the country to tell the successful story of Family Medicine and the need for the country to continue to invest in Family Medicine.

Media:

Reach out to the media by offering ideas (even write scripts and suggest actors!) for soap operas (novellas), talk shows, or newspaper articles written by the Society. A story idea: "The secret patient": journalists with a hidden camera pose as patients and go to different specialists and show the different advice, outcomes, and costs they experience.

Patients/public:

Take an active role in the local health councils. Patients who benefit from your services are your best form of advertising. Reach out to all social classes. Even if a wealthy owner of a business gets his care through private insurance and other specialists, show him that his workers will be healthier and miss less work if they get their care from a family doctor.

How do we move forward?

It is crucial that the Society develop a specific action plan with achievable goals and actions to reach those goals.

1 – Set your goals:

What is your dream or vision for family medicine? The Society must set specific goals to achieve. Examples: "We want primary care spending to go up by 20% each year." "We want qualified family doctors to be paid at 100% of the average pay of all doctors." "We want the number of new Family Medicine practices to increase by 1000 per year." Your ultimate focus should be on what is best for the people and for society.

2 – Offer better changes.

The Society is in the difficult position of having to defend the status quo (the current Family Medicine-based strategy), which is associated with the old government. Politicians – and the public – always

want a sense that things are changing for the better. Offer them a new and improved strategy that addresses their concerns about the current system.

3 – Promote your position.

Develop good relations with all your stakeholders. Train your members (especially residents and young family doctors) how to develop those relationships and to present well before groups and the media. Create a Speakers Bureau, which identifies, trains, and supports family doctors who are good spokespersons across all of the country.

4 – Network with others.

Activate people who know people. Develop a list of influential people that Society members know – it might be relatives, patients, school mates, and so on. Ask them to help you with your cause. Even other specialists can help you. Many of them support Family Medicine and can support you in the media and with other influence leaders. John F Kennedy once said, "we have no permanent friends, we have no permanent enemies, we have only mutual and shifting interests." Understand and appeal to the interests of others that you would like to bring over to your cause.

5 – Reframe the debate.

Ask yourself: why is the Ministry proposing a change? Is it because of money? (you can show them that Family Medicine is less expensive overall) Is it because of unhappiness with the current program? (for every mayor or patient who expresses unhappiness with the current program, you can bring forward 100 who are very happy) Is it because as a new government, they feel the need to offer change, any change? (you can agree with the need to make the current program better and offer specific recommendations for

improvement, thereby allowing the new government to feel like they've accomplished something new and good).

6 – Keep the faith.

These kinds of challenges are exhausting and require time, money, and energy. Support each other. Know that you are not alone. When necessary, bring in others from the outside (outside your specialty, outside your community, outside the country) to help you when needed and to boost your energy when needed. The stakes are high. The country should not step back from its ambitious goal to have every person with access to a family doctor. This is more important than any one country – many countries, especially in Latin America, have listened to the excitement and good results of the Family Medicine programs in Spain and Brazil. If either country backs away from Family Medicine now, it will decrease the reputation of the country (Why are you changing directions? Were you wrong before? Are you wrong now?) and it will jeopardize similar reforms in other countries.

Why make the climb?

Much of the world (re)discovered Family Medicine with the new millennium. Intoxicated by these expressions of support, many of us in Family Medicine assumed prematurely that it would just be a matter of time before we climbed to the top of our health care systems. We have learned that the climb can be arduous and is not assured. But then, no one promised us that the climb would be easy, only that it was important.

Professor Richard Roberts

President

World Organization of Family Doctors

FROM THE CEO'S DESK:

WONCA 2013 CONFERENCE PLANNING COMMITTEE MEETS IN PRAGUE

The Wonca 2013 world conference planning committee (CPC) met for their first meeting in Prague, for two days, in early September 2011. The CPC consists of the chair of the Host Organizing Committee (Bohumil Seifert), the Wonca liaison person (Dan Ostergaard) and the Wonca CEO (Alfred Loh).

On the first day of the meeting, the CPC was given a briefing of the conference preparations by various members of the Host Organizing Committee (HOC) and also by GUARANT International, the professional conference organizer appointed by the HOC. This briefing was held at Castle Zbiroh which will be the venue of the Wonca Executive committee meeting prior to the conference itself. This venue is about an hour's drive outside Prague and provides a pleasant and quiet environment for the Wonca Executive committee to meet for the three days set aside for its business.

Preparations for the World Conference appear to be well thought through, with the HOC keeping to the various deadlines, for key issues to be settled. The plans for the 2013 conference promotion were also discussed with the CPC and advice sought on how best to promote the 2013 conference at the larger Wonca member organizations' annual scientific meetings (AAFP, CFPC, RCGP, RACGP). A considerable amount of time was spent by the CPC and HOC on the issue of the scientific content of the conference, and the geographical and regional distribution of the chairs and speakers for the plenary sessions, workshops and free papers. The conference theme is *Family Medicine - Care for Generations*.

The conference opening ceremony is planned to take place on the evening of Tuesday, June 25, 2013. The Conference will be for three and a half days with the closing ceremony taking place at noon on Saturday, June 29, 2013. On each day of the conference, there will be two plenary sessions; the one in the morning will cover the global perspective of the conference theme whilst the afternoon plenary sessions will have a more European slant. Altogether there are plans to have seven plenary lectures with one keynote lecture at the opening ceremony; up to 150 parallel sessions or workshops; about 600 oral presentations/ free papers and over 500 posters.

The HOC is keen to encourage the participation of members from different Wonca Regions and from countries with different levels of family medicine development in the various scientific programs of the conference.

On the second day, the CPC visited the Prague Congress Palace, the venue of the conference and looked at the facilities. The registration area, plenary hall, parallel session/workshop rooms, poster area and exhibition hall are all sufficiently large and well co-located for the smooth flow of the large number of participants anticipated. The Congress Palace is also very well served by the underground train system, as there is a station just adjacent to the building. This will ensure easy access to all delegates staying in the different parts of the city. To encourage participation and facilitate travel by delegates within Prague, the mayor of the city has agreed to issue free travel passes to all delegates of the conference which will entitle them to travel free on all trains, buses, trams and boats throughout Prague city for the duration of the conference.

The CPC also visited the two main conference hotels which are located just next to the Congress Palace. These are the Corinthia Prague Hotel and the Holiday Inn Prague. The Corinthia Hotel will be the venue for the Wonca World Council meeting and also regional council meetings, and is the larger of the two hotels. The CPC toured the various categories of guest rooms available and also the large hall needed for the Wonca World Council. The room rates provisionally quoted for 2013, do not appear to be excessive and the various categories of room types will fit the budgets of most delegates. Facilities offered by the Corinthia Hotel appear adequate for the various social functions that are usually held in conjunction with a world conference.

I feel that the preparations for the Wonca World Conference in Prague in 2013 are in good hands and I'm reassured that the HOC has made it a point to keep to the deadlines which it has set itself to ensure that the various aspects of the conference are all given due attention.

The 2013 Wonca World Conference in Prague should turn out to be a good and interesting conference.

Dr Alfred Loh

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FROM THE EDITOR:

A GLOBAL ISSUE

NCDs remain on the agenda

Non communicable diseases are not likely to be off the agenda any time in the foreseeable future – truly a global issue. This month we reprint in three languages, an article published in *The Lancet* on NCDs. The authors include a range of our Wonca leaders including the present, immediate past and next presidents. The Wonca CEO has recently put out a call to member organisations to action the World Health Organization recommendations on NCDs. *Wonca News* looks forward to receiving information from its members as to how this has been achieved in their country.

Warsaw

In September, I have been privileged to attend the Wonca Europe conference in Warsaw. It was some 32 years since I first (and last) visited Warsaw, so of course there were many changes to take in both outwardly and inwardly. Buildings had sprouted upwards; cars, shops most things looked as they do in innumerable other countries. The Polish language was still the challenge I remember, but this time I did manage to learn a few more words.

Our Polish hosts were warm and hospitable and they ran a conference which certainly appeared, to participants, to go off very smoothly. My enjoyment was increased through renewing old acquaintances and making new contacts with colleagues in the European region. My take home learning was the very innovative techniques for teaching empathy, in Turkey!

The conference is too recent to have many reports available for publication in this issue, so a pictorial report is included with the written items to arrive for our December issue.

One report that is in this issue, is that of the first Montegut scholar, Dr Maltezis Kyriakos from Greece. He is the first to benefit from this generous program to aid attendance at Wonca conferences. (Full information on the Montegut Scholar's program was included in the August 2011 issue of *Wonca News*.)

The president's travels

As many of you have realised by his engaging and interesting columns, our Wonca president, Prof Richard Roberts, travels to many and varied countries in a gruelling schedule. This month we continue his article of the August issue, moving on from Denmark and Romania of the August report. Also in this issue, is an interview of Rich, done when he was in Spain by eminent Spanish GP, José Miguel Bueno. The interview is reproduced in English and Spanish.

Member organisations participating

I am pleased to be able to provide news from a number of our Wonca member organisations. Those featured this month are Myanmar, the Caribbean, Pakistan, Fiji, the Kingdom of Saudi Arabia and the Philippines.

All member organisations are welcome to send their news and a couple of relevant photos to *Wonca News*. The more exchange we engage in, the more we learn from each other.

From the regions, there are a number of coming conferences to consider and I personally would love to be able to attend them all, but alas cannot! The Wonca CEO, Dr Loh, reports on a planning meeting for the next world conference, in Prague, in 2013.

The Wonca working party on research, chaired by Prof Waris Qidwai reports on its activities and plans.

Reports from such diverse countries and authors make *Wonca News* a truly global production and give us all some insight into the work and activities of our colleagues across the world.

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FEATURE STORIES

WONCA PRESIDENT INTERVIEWED IN SPAIN

Internationally renowned Wonca President, Professor Richard Roberts, is probably the best person to know the status of Family Medicine worldwide. His constant travels and studies, in addition to his role as President of Wonca, afford him a unique overview of the world situation.

At the 31st Congress of the Spanish Society of family and Community Medicine (semFYC), held from 8–10 June, 2011, in Zaragoza, Professor Roberts took time to share his knowledge and experiences; to speak directly with members of Congress; and to be interviewed by Dr José Miguel Bueno of *News semFYC*. The status of Wonca and Family Medicine around the world; the situation of Family Medicine in a time of global economic crisis; and the possible creation in Spain of the specialty of Emergency Medicine are just some of the topics discussed in this interview.

1. *What should members of semFYC know about Wonca?*

It is the only organisation that brings together all the family doctors in the world. It will be as powerful and effective as we family physicians decide it should be.

2. *The economic crisis has put health services generally and Family Medicine specifically in a key position. What model of health services best supports Family Medicine?*

I think our health systems should enable family doctors to do as much as we can for as many patients as possible. The more our availability to our patients is limited (by hours, gender, age, or presenting complaint), the more their care is fragmented across an assortment of other professionals who are strangers to them, with the risk that more errors will occur and they will be harmed.

3. *You know many of the health systems of countries around the world. What is your opinion on the situation in Spain?*

Many of us see Spain as a country that made the difficult and important decision in the 1980s to commit to a Family Medicine model, instead of continuing with the previous model of ambulatory care provided by general physicians with no post-graduate training in primary care. Spain quickly discovered the benefits of rebuilding the system with family physicians - improved outcomes and decreased health care costs.

4. *In Spain, the economic crisis is leading to cutbacks in the public health system. What do you think should be the response of family doctors?*

Innovate, be creative. Create novel ways to be more accessible to your patients and community (SMS, e-mail, group visits, etc.). Go to your patients and your community to share your concerns, and ask their advice. Prove your worth by obtaining and presenting the results of your improvements in care that give better outcomes and save money. Be consistent in your messages – you will need to communicate your messages many times to the Ministry of Health, other leading Spanish stakeholders, and the public.

5. *In Spain, we are having a lively debate on the creation of the new specialty of Emergency Medicine. We know that your country, the United States, was one of the first to have this medical specialty. Based on the U.S. experience, do you think Spain should create this new specialty of Emergency Medicine?*

If it does, I feel sorry for Spanish citizens, because it represents a further fragmentation of the health system. In the U.S., the literature shows that a considerable portion of emergency services are still being provided by family physicians. About half of our family physicians continue to provide emergency services.

My sense is that when a specialty of Emergency Medicine is created in a country and separates from Family Medicine, it is usually because one or more of the following happened.

- the accessibility of patients to their family doctors was considered inadequate.
- the academic reputation, financial position, quality improvement, and research of Emergency Medicine were advancing slower than desired.
- the work life of family physicians who provide emergency care and those who provide more comprehensive care became very different.
- communication between doctors providing emergency services and those providing more comprehensive services deteriorated or ceased to exist.

The model I like best is that of Canada, where doctors begin as family physicians and then develop an interest in emergency medicine. They are still considered family physicians. If there is a different specialty in a country, it is vital that emergency physicians and family doctors work in close collaboration for the benefit of the patient.

6. *As you know, the role of Family Medicine at Spanish universities is under-developed. What are the contributions and status of Family Medicine in academia, as perceived by professionals and the public?*

It is essential that Family Medicine is viewed as a respected member of the academic community. Each medical school should have a department of Family Medicine and an adequate number of family physician faculty. Those academic departments should serve as a connecting point between the research community and primary care, and should provide support for research (e.g., statistical and study design expertise) for those doing primary care research. These conditions are necessary to increase the interest of medical students in Family Medicine; to promote research that is useful for family physicians; and to demonstrate to other professionals and the public the importance and complexity of Family Medicine.

7. *What impressions of Family Medicine in Spain will you take home, after attending the 31st Congress of semFYC?*

Spanish family physicians and semFYC have accomplished much and should be proud of those accomplishments. You have gone from having no family doctors to having thousands in a short space of time; you have improved the health of the Spanish people and the outcomes of the Spanish health system. You have the respect and attention of the Ministry of Health and Social Policy. Most importantly, you are reaching out to young doctors and medical students to encourage, support, and help them develop their leadership skills. I think the greatest challenge you face in these trying times is to keep faith: you must maintain your confidence in your ability to live up to the challenges of these difficult times. Engage in more dialogue with the media so that they and the public better know who you are and what you value. Consider the creation of a TV series about the daily life of a family doctor, use social media to get out your messages, and so on. Finally, you must achieve your place in medical schools to enhance the status of family physicians and advance the discipline of Family Medicine.

8. *Professor Barbara Starfield has recently died. What you think her greatest legacy has been?*

Barbara's legacy has been to show the world the value of primary care and the dangers and cost of care that is fragmented and focused on specialists. She did this by meticulous research, by consulting with many governments, and by mentoring numerous young researchers. Her main message was that the people benefit most when their health system is centred in a relationship with one family doctor whom they trust and who does all he/she can do for them.

10. *In your column in the June 2011 issue of Wonca News, you reflected on your recent attendance at the World Health Assembly, which was focused on non-communicable diseases. You were concerned that the increased visibility of primary health care achieved in recent years may be overshadowed again by an excessive focus on specific diseases and that we should support the initiative "15 by 2015." What do you hope members of Wonca and semFYC will do?*

Contact your health ministries and foreign affairs departments. Ask to join your country's delegation to discuss these issues at the UN Summit on Non-Communicable Diseases in New York City on 19–20 September. Remind them of our three key messages: (i) integrate health care and do not fragment it further; (ii) remember that the strength of each health system depends on the strength of its primary care system; (iii) support the "15 by 2015" initiative which seeks, by 2015, that those who fund health care and research should dedicate 15% of their funds for targeted diseases (vertical programs) to the support of the primary care infrastructure (horizontal programs).

11. *In your lecture during the student day at the semFYC Congress, one of your final slides was "More important than knowing the disease is knowing the person with the disease". Why did you decide to end your speech with this message?*

I believe that technical knowledge, such as which medication to prescribe for a specific disease, is easier to obtain than the knowledge of the patients being treated (their unique biology, preferences, values, etc.). Patients expect that we know and treat them as unique individuals, and not merely as some abstract statistical average from a population study. For example, we can prescribe the "best" medication for a condition, but unless we know the patient well there is a good chance that the medication will not be used at all (because of lack of trust in our prescription) or not used correctly (because we do not know the barriers to using the medication as prescribed). What good is our knowledge of the disease and the "best" medication if we are unable to persuade the patient of the importance of using it as prescribed?

www.semfy.com

ENTREVISTA AL PRESIDENTE DE WONCA EN ESPAÑA



Wonca president Prof Rich Roberts in Spain

Richard Roberts, presidente de la Wonca: *“Los médicos de familia españoles y la semFYC tienen mucho de lo que estar orgullosos”*

Con un reconocido prestigio internacional, el presidente de la Wonca, Richard Roberts, es probablemente la persona que mejor conoce la situación de la Medicina de Familia en todo el mundo. Sus constantes viajes y estudios, además de su papel como presidente de Wonca le permiten tener una idea global de la situación. En el 31º Congreso de la semFYC -celebrado del 8 al 10 de junio en Zaragoza- Roberts tuvo tiempo para transmitir sus conocimientos y experiencias, pero también para hablar directamente con los congresistas (ver la noticia sobre las actividades en las que participó) y dedicarle esta entrevista al Noticias semFYC. La posible creación de la especialidad de urgencias, la situación de la Medicina de Familia ante la crisis económica y la nueva legislación de EEUU para tratar a los pacientes crónicos, son solo algunos de los temas que Roberts analiza en esta entrevista.

1. *¿Qué deberían saber los miembros de semFYC de Wonca?*

Es la única organización que pone en contacto a todos los médicos de familia del mundo. Será tan potente y efectiva como nosotros, los médicos de familia, decidamos que sea.

2. *La crisis económica ha situado a los servicios sanitarios y a la Medicina de Familia en particular en una posición clave. ¿Qué modelo de servicios sanitarios debería apoyar la medicina de familia a partir de ahora?*

Creo que debemos posibilitar que los médicos de

familia hagan cuanto puedan por el mayor número de pacientes posible. Cada vez que limitamos nuestra disponibilidad (en horario, por género, por edad, por presentar una queja), fragmentamos el cuidado a nuestros pacientes y aumentamos el riesgo de error del sistema sanitario y el daño que provocaría.

3. *Usted conoce la mayoría de los sistemas sanitarios los distintos países del mundo ¿Cuál es su opinión sobre la situación de España?*

Muchos de nosotros vemos a España como un país que en los años 80 tomó la difícil e importante decisión de comprometerse con el modelo de Medicina de Familia, en vez de continuar con el modelo previo ambulatorio de médicos generales. Se constataron rápidamente los beneficios de reconstruir el sistema con médicos de familia: los resultados mejoraron y el gasto sanitario disminuyó.

4. *En España la crisis económica está conduciendo a recortes presupuestarios en el Sistema Sanitario público ¿Cuál cree que debería ser la respuesta de los médicos de familia?*

Innovad, sed creativos. Crear métodos novedosos para ser más accesibles a vuestros pacientes y comunidad (SMS, e-mail...). Acercaos a vuestros pacientes y a vuestra comunidad, compartid vuestras preocupaciones y pedidles consejo. Demostrad vuestra valía obteniendo y presentando los resultados de las mejoras que conseguís y el dinero que ahorraréis. Sed constantes, necesitaréis comunicar vuestro mensaje muchas veces al Ministerio de Sanidad y a otros líderes españoles influyentes.

5. *En España está teniendo lugar un intenso debate sobre la creación de la nueva especialidad de Medicina de Urgencias. Sabemos que su país, EEUU, fue uno de los primeros que contó con esta especialidad médica. Según la experiencia de EEUU ¿Cree que España debería crear esta nueva Especialidad de Urgencias?*

Si esto sucediese, sentiría pena por los ciudadanos españoles, porque representa una fragmentación más del sistema sanitario.

En EEUU, tal y como demuestra la bibliografía existente, una parte considerable de los servicios de urgencia continúan siendo atendidos por médicos de familia. Alrededor de la mitad de los médicos de familia continúan ejerciendo en un servicio de urgencias. Mi experiencia me dice que cuando se produce esta división (separación de la Medicina de Urgencias de la Medicina de Familia), previamente había ocurrido algo de lo siguiente: (i) Se consideraba inadecuada la accesibilidad de los pacientes a sus médicos de familia. (ii) El prestigio académico, la situación financiera, la calidad y el estatus investigador de la Medicina de

Urgencias estaba avanzando más despacio de lo deseado. (iii) El día a día de los médicos de familia que proveen cuidados de urgencias y aquellos que proveen cuidados más amplios se hicieron muy diferentes. (iv) La comunicación entre ambos grupos dejó de existir. El modelo que me gusta más es el de Canadá, donde los médicos comienzan como médicos de familia y posteriormente pueden canalizar su interés en la medicina de urgencias. Son todavía considerados como médicos de familia, con los que permanecen en contacto.

Si existiese una especialidad diferente, sería de vital importancia que los médicos de urgencias y los médicos de familia trabajasen en estrecha colaboración por el beneficio del paciente.

6. *Como sabrá, el papel de la Medicina de Familia en la universidad española está por desarrollar. ¿Cómo está la Medicina de Familia en otros países y cuál es la aportación de la Medicina de Familia al mundo académico, tanto a los profesionales como a los ciudadanos?*

Es primordial que la Medicina de Familia sea considerada como un miembro respetable y de pleno derecho de la comunidad académica. Cada Facultad de Medicina debería contar con un departamento de Medicina de Familia y un mínimo de prácticas en Medicina de Familia. Los departamentos académicos deberían servir como punto de conexión, tanto para la investigación comunitaria como para la investigación basada en la consulta de Atención Primaria proporcionando apoyo investigador, estadístico y de diseño de estudios.

Estas condiciones son necesarias para fomentar el interés de los estudiantes de medicina en la Medicina de Familia, promover investigación que sea útil para los médicos de familia y cambiar la percepción de los profesionales y de la ciudadanía sobre la importancia y complejidad de la Medicina de Familia.

7. *¿Qué impresiones se lleva de la Medicina de Familia en España después de asistir al 31^o Congreso de la semFYC?*

Los médicos de familia españoles y la semFYC tienen mucho de lo que estar orgullosos: han pasado de no contar con ningún médico de familia a disponer de miles en un corto espacio de tiempo; han mejorado la salud de los españoles y los resultados del sistema sanitario español. Cuentan con el respeto y la consideración del Ministerio de Sanidad y Política Social. Y lo más importante, están tendiendo la mano a los médicos jóvenes y a los estudiantes de medicina para animarles, apoyarles, y ayudarles a desarrollar su capacidad de liderazgo.

Me parece que el mayor reto a que os enfrentáis en estos tiempos es el de mantener la fe, debéis mantener la confianza en vuestra capacidad de estar a la altura de los desafíos en estos tiempos difíciles. Dialogad más con los medios de comunicación y cercioraos de que saben quienes sois y de que os valoran. ¿Qué os parecería una serie de TV sobre el día a día de un médico de familia? Finalmente debéis conseguir un lugar en las Facultades de Medicina para mejorar el prestigio de los médicos de familia y potenciar el estudio de la Medicina de Familia.

8. *La profesora Barbara Starfield ha fallecido recientemente. ¿Cuál considera usted que ha sido su principal legado?*

El legado de Barbara ha sido que demostró al mundo el valor de la Atención Primaria y los peligros y coste de los cuidados fragmentados y centrados en los especialistas. Lo hizo mediante una investigación meticulosa, consultas con innumerables gobiernos, formando muchos alumnos y dirigiendo a muchos jóvenes investigadores. Su mensaje principal fue que la ciudadanía se beneficia más cuando su sistema sanitario está centrado en una relación con un médico de familia en quien confían y que hace todo lo que puede por ellos.

9. *En el número de Junio de 2011 de la revista Wonca News la editorial del Presidente se denomina "Reflexiones desde Génova (Suiza), enfermedades no transmisibles en la Asamblea Mundial de la Salud". En ella nos comenta que se fue preocupado porque el aumento de la visibilidad de la Atención Primaria conseguido en los últimos años puede ser eclipsado otra vez por la focalización en enfermedades concretas y que deberíamos apoyar la iniciativa "15 en 2015". ¿Qué espera que hagan los miembros de Wonca incluido semFYC?*

Contacten con sus Ministerios de Salud y Asuntos Exteriores. Soliciten formar parte de la delegación que debatirá estos asuntos en la ciudad de Nueva York los días 19-20 de Setiembre. Recuérdenles los tres mensajes clave: (i) integrar los cuidados sanitarios, no dividirlos; (ii) la fortaleza de los sistemas de salud depende la fortaleza de su sistema de Atención Primaria; (iii) apoyen el proyecto "15 en 2015": en el año 2015 los países donantes deben invertir el 15% de los fondos para investigación o sistemas sanitarios concedidos a cualquier programa vertical (por ejemplo HIV-SIDA) a servicios de Atención Primaria e investigación.

10. *En el Congreso de EQUIP de 2011 impartió la conferencia denominada "En busca de una ciencia de mejor calidad: conociendo la importancia de lo que estamos*

mediendo” y en la conferencia que pronunció la Jornada de Estudiantes del Congreso semFYC 2011 las dos últimas diapositivas fueron: “Más importante que conocer la enfermedad es conocer a la persona con la enfermedad” y “es la relación”. ¿Por qué decidió finalizar su intervención con este mensaje?

Creo que el conocimiento del contenido técnico (por ejemplo, qué medicación prescribir para cada enfermedad) es y será más fácil que conocer a la persona (su biología única, sus preferencias, sus valores). Sin embargo el paciente espera -y de hecho demanda- que lo conozcamos y lo tratemos, y no simplemente lo consideremos como una mera media estadística abstracta de un estudio poblacional.

Por ejemplo, podemos prescribir la mejor medicación para un caso, pero si no entendemos al paciente, existirán muchas ocasiones en las que el paciente no se tome la medicación como le indicamos e incluso que ni tan siquiera no la tome. ¿De qué nos sirve nuestro conocimiento de la enfermedad si no somos capaces de persuadir al paciente de la importancia de que siga nuestras recomendaciones farmacológicas?

Muchas gracias por su amabilidad y su tiempo.

José Miguel Bueno

NCD OPINION PIECE PUBLISHED IN THE LANCET

The debate on non communicable disease continues with the following opinion piece being published recently in The Lancet with the authors including well known primary care leaders Prof Jan de Maeseneer and Prof Charles Boelen, together with the Wonca leaders: president, Prof Rich Roberts, president elect Prof Michael Kidd, immediate past president Prof Chris van Weel and Wonca executive member at large Prof Iona Heath.

*The article is printed here without references in English, Spanish and French but is also available on request in Portuguese, Dutch and German. A full references version is available from The Lancet website.
<http://www.sciencedirect.com/science>*

De Maeseneer J, Roberts RG, Demarzo M, Heath I, Sewankambo N, Kidd MR, van Weel C, Egilman D, Boelen C, Willems S. **Tackling the NCDs: a different approach is needed.** *The Lancet* Vol 378 Number 9791 Aug 13, 2011



Lead author Prof Jan de Maeseneer

The worldwide attention on NCDs is timely, but the NCD Alliance seems to offer a conflicted strategy. On the one hand, a vertical and disease-oriented approach is recommended, such as developing a multidrug combination for people at increased risk of cardiovascular disease. On the other hand, the NCD Alliance calls for strengthening of health systems, particularly primary health care. Yet their vision of primary care is limited and ambiguous. Primary care is seen as an opportunity for “case finding” (for the disease-oriented programmes), but is overlooked as the source of comprehensive care that integrates and coordinates care for all health problems and engages individuals, families, and the community. It is here that the real added value lies for health care and the health of people.

Much has been learned from vertical disease-oriented programmes. Evidence suggests however that better outcomes occur by addressing diseases through an integrated approach in a strong primary care system. An example is Brazil where therapeutic coverage reaches almost 100%, much better than in HIV/Aids programmes in other countries with less robust primary care. Vertical disease-oriented programmes for HIV-AIDS, malaria, tuberculosis, and other infectious diseases foster duplication and inefficient use of resources, produce gaps in the care of patients with multiple co-morbidities, and reduce government capacity by pulling the best health-care workers out of public health sector to focus on single diseases. Moreover, vertical programmes cause inequity for patients who do not have the “right” disease and internal brain-drain of health professionals. The “lessons learned” from a vertical disease-oriented approach for select infectious and neglected tropical diseases should inspire us to rethink the strategy for NCDs.

In 2009, the World Health Assembly’s Resolution WHA62.12 urged member states “to encourage that vertical programs, including disease-specific programs,

The NCD Alliance aims to put non-communicable diseases (NCDs) on the global agenda to address the “NCD-crisis”. Improving outcomes in morbidity and mortality by 2015 will clearly depend to a large extent on tackling the burden of NCDs, especially in developing countries.

are developed, integrated and implemented in the context of integrated primary health care". Horizontal primary health care provides the opportunity for integration and addresses the problem of inequity by allowing focus on NCDs while providing access to the care of other health problems, thereby avoiding "inequity by disease".

Describing the rising prevalence of NCDs as a crisis makes for good drama, but misleads us into thinking that this problem is amenable to a quick fix. NCDs represent a set of chronic conditions that will require sustained effort for many decades. Thus, the focused "selective solution" pursued for infectious diseases must give way to a comprehensive and enduring strategy that affects and reflects the fabric of health-care services and research.

Integrated primary care is essential for tackling NCDs. Chronic conditions, much more than infectious diseases, are influenced by patients' perceptions and behaviour. Effective management of NCDs will require a shift from problem-oriented to goal-oriented care. The long-term management of chronic conditions requires more than "access to affordable essential drugs in primary health care". It requires the empowerment of patients, a reduction of barriers to healthy lifestyles, and care that reflects the values of the individual patient. There is consistent evidence of the effectiveness of primary health care in reducing hospital admissions related to NCDs; multi-morbidity among those with NCDs has been shown to be better tackled in primary health care.

It is not sufficient to exhort policy makers and health-care workers to promote synergies between existing programmes for NCDs and other global health priorities. We must

fundamentally rethink the way we address complexity in health problems, in both developed and developing countries. This will require that we put people and their values at the centre of the process, rather than specific diseases.

The best answer to the challenge of NCDs is to promote people-centred care through investment in integrated primary care, including sufficient numbers of well-trained health professionals. At least 50% of all health professions graduates should be trained for primary care. The NCD Alliance calculates that a global commitment of about US\$9 billion per year will be needed to pay for the priority interventions. Our advice is to add another \$9 billion to strengthen local primary health-care services in the same countries. As a result, millions of people will be able to have access to affordable, accessible, comprehensive, and quality primary health care that addresses all conditions, including infectious diseases and NCDs.

We are at an important moment of reflection and we should learn from previous mistakes, however well intended. It is time to respond to the aims of Resolution WHA62.12 and to put it into practice. We invite all stakeholders to participate in this fundamental reflection and to weave focused expertise into a broader tapestry of more effective and relevant health care and research.

CONFRONTANDO LAS ENT: ES NECESARIO UN ENFOQUE DIFERENTE

De Maeseneer J, Roberts RG, Demarzo M, Heath I, Sewankambo N, Kidd MR, van Weel C, Egilman D, Boelen C, Willems S. Tackling the NCDs: a different approach is needed. *The Lancet* Vol 378 Number 9791 Aug 13, 2011

La Alianza ENT apunta a poner las enfermedades no transmisibles (ENT) en la agenda global para tratar la "crisis-ENT". La mejora de resultados en morbilidad y mortalidad para el 2015 dependerá en gran parte de hacer frente a las ENT, especialmente en los países en vías de desarrollo.

La atención mundial hacia las ENT es aun oportuna, pero la Alianza ENT parece entregar una estrategia en conflicto. Por una parte, una orientación vertical y un acercamiento orientado solo a la enfermedad, como por ejemplo el desarrollo de una combinación de fármacos para la gente en riesgo creciente de tener enfermedades cardiovasculares. Por otro lado, la alianza de ENT pide fortalecer de los sistemas de salud, particularmente la salud primaria pero su visión de esta es limitada y ambigua. La salud primaria es considerada como una oportunidad para "el descubrimiento de casos" (para los programas orientados a la enfermedad), pero pasa por alto la idea de que es un cuidado ampliado y que integra y coordina el cuidado para todos los problemas de salud de los individuos, las familias y la comunidad. Este es el verdadero valor que tiene el cuidado de la salud y la salud de la población.

Se ha aprendido mucho de los programas verticales orientados a la enfermedad. Sin embargo, la evidencia sugiere que los mejores resultados se dan cuando la enfermedad se aborda dentro de un sistema de atención primaria integrada y bien consolidada. Un ejemplo de esto es el Brasil, en donde la cobertura terapéutica alcanza casi al 100%, mucho más que los programas de VIH/Sida en los otros países que tienen una menor consolidación en la atención primaria. Los programas verticales orientados a la enfermedad para el VIH/Sida, la malaria, la tuberculosis y otras enfermedades infecciosas fomentan la duplicación y el uso

ineficaz de los recursos, producen brechas en la atención a los pacientes con múltiple co-morbilidad y reducen la capacidad del gobierno al quitar a los mejores trabajadores del sector primario de salud público para centrarse en solo en las enfermedades particulares. Más aun, los programas verticales promueven la inequidad para los pacientes que no tienen la enfermedad “correcta” y sufren de la fuga interna de cerebros profesionales en salud. Las “lecciones aprendidas” de un acercamiento orientado a la enfermedad solo para algunas infecciones o enfermedades tropicales descuidadas debe inspirarnos a repensar la estrategia para la ENT.

En el 2009, la Resolución WHA62.12 de la Asamblea Mundial de Salud impulsó a los estados miembros a “fomentar que los programas verticales, incluyendo los programas específicos de enfermedades, a ser desarrollados, sean integrados y ejecutados en el contexto de la salud primaria”. El cuidado de la salud primaria horizontalizada facilita la oportunidad de integración y afronta el problema de la inequidad permitiendo enfocarnos en las ENT al proporcionar acceso al cuidado de otros problemas de salud y evitando la “injusticia de la enfermedad”.

La descripción de un incremento crítico y prevalente de las ENTs ayuda al buen drama, pero nos engaña al hacernos pensar que este problema tiene una solución rápida. Las ENTs representan a un conjunto de condiciones constantes que demandarán un esfuerzo sostenido por muchas décadas. En consecuencia, el enfoque de la “solución selectiva” buscado para las enfermedades infecciosas debe llevar a una estrategia ampliada y resistente que afecte y refleje la estructura de los servicios de salud y de la investigación.

La atención primaria integrada es esencial para abordar las ENTs. Las condiciones crónicas, más que las enfermedades infecciosas, son afectadas por la percepción y el comportamiento del paciente. La gestión eficiente de las ENTs requerirá entonces un cambio de orientación de problemas por un cuidado orientado por objetivos. La gestión de las condiciones crónicas en el largo plazo requiere más que solo el “acceso a las drogas esenciales en la atención de salud primaria”. Se requiere el empoderamiento del paciente, una reducción de las barreras a las formas de vida sana y el cuidado que refleje el valor del paciente. Hay evidencia sólida sobre la eficacia de la salud primaria en la reducción de admisiones hospitalarias relacionadas con las ENTs; la multi-morbilidad entre aquellos que tienen las ENTs puede examinarse mejor a partir de los servicios primarios de salud.

Ya no es suficiente exhortar a los responsables políticos y a los trabajadores en salud a promover sinergias entre los programas existentes para las ENTs y las otras prioridades globales de la salud. Debemos repensar la manera en que tratamos los problemas complejos de salud tanto en los países desarrollados como en los países en vías de desarrollo. Esto demandará que pongamos a las personas y a sus valores en el centro del proceso antes que a las enfermedades específicas.

La mejor respuesta al desafío de las ENTs es la promoción del cuidado centrado en la gente a través de la inversión en la atención primaria integrada, incluyendo a un número adecuado y bien entrenado de profesionales en salud. Por lo menos el 50% de todos los graduados en la rama de medicina debería estar entrenado para la atención primaria. La alianza de ENT calcula que una dedicación global de 9 mil millones de dólares por año sería necesaria para pagar las intervenciones prioritarias. Nuestro consejo es agregar otros 9 mil millones de dólares para consolidar los servicios locales de salud primarios en estos mismos países. Y como resultado, millones de personas podrían tener acceso al cuidado de la salud de forma que pueda ser pagada, ser accesible, ser amplia y de buena calidad que además incluya tanto a las enfermedades infecciosas como a las ENTs.

Estamos en un momento importante de reflexión y debemos aprender de nuestros errores previos, a pesar de todas nuestras buenas intenciones. Es hora de responder a los objetivos de la resolución WHA62.12 y de ponerla en práctica. Invitamos a todos los que toman decisiones a participar en este momento fundamental de reflexión y que converjan su experiencia hacia un enfoque más amplio del servicio de salud y de la investigación.

COMMENT ABORDER LE PROBLÈME DES MALADIES NON-TRANSMISSIBLES: UNE AUTRE APPROCHE EST NÉCESSAIRE.

De Maeseneer J, Roberts RG, Demarzo M, Heath I, Sewankambo N, Kidd MR, van Weel C, Egilman D, Boelen C, Willems S. Tackling the NCDs: a different approach is needed. *The Lancet* Vol 378 Number 9791 Aug 13, 2011

La «NCD-Alliance» a mis les maladies non-transmissibles (MNTs) à l'agenda de sorte que l'on puisse affronter la «crise-MNT». Améliorer les résultats au niveau de la morbidité et de la mortalité en 2015, dépendra largement de la façon dont on va s'attaquer aux MNTs, spécialement dans les pays en voie de développement. L'attention mondiale pour les

MNTs vient à temps, mais la «NCD-Alliance» semble offrir une stratégie contradictoire. D'une part, une approche verticale est recommandée, orientée vers les maladies, p.ex. en développant une combinaison «poly-pilule» pour les personnes à risque élevé pour les maladies cardio-vasculaires. D'autre part, la «NCD-Alliance» demande de renforcer les systèmes de santé, notamment les soins de santé primaires. Mais la vision des soins de santé primaires est assez restreinte et ambiguë. Les soins primaires sont perçus comme une opportunité de «recherche de cas» (pour les programmes orientés vers les maladies spécifiques), mais pas comme la source des soins intégrés qui coordonne l'approche de tous les problèmes de santé et engage les individus, les familles et la communauté. C'est précisément là que les soins de santé primaires réalisent une valeur ajoutée pour les systèmes de santé et la santé des populations.

Nous avons beaucoup appris de l'expérience avec les programmes verticaux, orientés vers des maladies spécifiques. Or, l'«évidence scientifique» suggère que les résultats sont meilleurs si on approche les maladies de façon intégrée dans le cadre d'un système solide de soins de santé primaires. Un exemple est le Brésil, où la couverture thérapeutique pour le sida atteint presque 100%, beaucoup mieux que les programmes de sida dans d'autres pays où les soins de santé primaires sont moins développés.

Les programmes verticaux, orientés vers les maladies spécifiques comme le sida, le paludisme, la tuberculose et d'autres maladies infectieuses, stimulent la duplication et l'utilisation inefficace des ressources, produisent des écarts dans les soins des patients avec des comorbidités multiples, et réduisent la capacité du gouvernement en extrayant les meilleurs travailleurs de

santé du système de santé publique en les orientant sur des maladies isolées. En outre, les programmes verticaux causent des inégalités pour les patients qui n'ont pas la «bonne» maladie et conduisent à un «exode interne des cerveaux» des professionnels de la santé. Les leçons apprises des expériences avec les programmes verticaux orientés vers des maladies infectieuses spécifiques et des maladies tropicales négligées, devraient nous inspirer de reconsidérer la stratégie pour les MNTs.

En 2009, la résolution WHA62.12, de l'Assemblée Mondiale de la santé, sollicitait les états membres «à encourager la mise au point, l'intégration et l'application dans le contexte des soins de santé primaires intégrés, de programmes verticaux, y compris de programmes axés sur des maladies particulières». Les soins de santé primaires horizontaux créent l'opportunité d'une intégration des soins et évitent le problème de l'inégalité en offrant un accès à tous les problèmes de santé, évitant l'«inéquité par maladie» («inequity by disease»).

Décrire la prévalence croissante des MNTs comme une «crise» a un aspect «dramatique», qui nous met sur la mauvaise piste, quand nous pensons que ce problème peut être réglé en un tour de main. Les MNTs représentent des conditions chroniques, qui nécessiteront un effort durable pour les décennies à venir. C'est pourquoi, l'approche «sélective» qui a été suivie pour les maladies infectieuses devra être remplacée par une approche intégrée et durable, qui réoriente l'organisation des services de santé et de la recherche.

Les soins de santé primaires intégrés sont essentiels pour affronter les MNTs. Les maladies chroniques, beaucoup plus que les maladies infectieuses, sont influencées par

les perceptions et la conduite des patients. Une approche effective des MNTs requerra un «shift» du «problem-oriented to goal-oriented care». L'approche à long-terme des maladies chroniques requiert beaucoup plus que «l'accès aux médicaments essentiels dans les soins de santé primaires»¹. Cela nécessite d'éduquer les patients, de réduire les obstacles aux styles de vie saines, et nécessite des soins qui reflètent les valeurs des patients individuels. Il y a une évidence scientifique d'effectivité des soins de santé primaires p. ex. en réduisant les admissions hospitalières relatives aux MNTs. La multi-morbidité chez les patients avec une MNT, peut être mieux affrontée dans le cadre des soins de santé primaires.

Il ne suffit pas de demander aux politiciens et aux travailleurs de santé de promouvoir des synergies entre les programmes existants pour les MNTs et d'autres priorités de santé globales. Nous devons reconsidérer fondamentalement la façon dont nous approchons la complexité dans les problèmes de santé, et ceci autant dans les pays en voie de développement que dans les pays développés. Ceci implique que nous mettions les personnes, leur contexte de vie et leurs valeurs au centre du processus, et non les maladies spécifiques.

La meilleure réponse au défi des MNTs est de promouvoir les soins orientés vers la population en investissant dans les soins de santé primaires intégrés, y inclus un nombre suffisant de professionnels bien formés. Au moins 50% des professionnels de santé gradués, devraient être formés pour les soins de santé primaires. La «NCD-Alliance» calcule qu'un engagement global d'environ US\$ 9 milliards par an sera nécessaire pour payer les interventions prioritaires. Notre avis est d'y ajouter encore \$9 milliards

afin de renforcer les structures locales de soins de santé primaires dans les mêmes pays. Il en résultera que des millions de personnes auront accès aux soins intégrés et que les soins de santé primaires de qualité pourront traiter toutes les conditions, y compris les maladies infectieuses et les MNTs.

Nous sommes actuellement à un moment de réflexion important et nous devons apprendre des erreurs du passé, si bien intentionnées qu'elles soient. Le temps est venu de répondre aux objectifs de la résolution WHA62.12 et de les mettre en pratique. Nous invitons tous les acteurs concernés à participer à cette réflexion fondamentale et à intégrer leur expertise dans une approche plus effective et pertinente des soins de santé et de recherche.

THE FIRST MONTEGUT SCHOLAR – DR MALTEZIS KYRIAKOS

At the Wonca executive committee meeting, in February 2011, it was agreed to accept the generous offer by the American Board of Family Medicine Foundation (ABFM-F) to establish the Montegut Global Scholars Program (MGSP). The MGSP was established to foster international education, research and collaboration, in the specialty of family medicine. It aims to support the attendance of one family physician from each of the seven regions of Wonca, to their regional meetings, or to the international meeting, in the year when it is held.



Dr Maltezis Kyriakos watched by Wonca President, Prof Rich Roberts, responds with gratitude after receiving his award in Warsaw.

The first Montegut scholar is Dr Maltezis Kyriakos, of Greece, who has been supported to attend the Wonca Europe conference in Warsaw in September 2011.

About Dr Kyriakos

Dr Maltezis Kyriakos graduated from the University

of Athens, in 1999. He trained in general practice in the General Hospital Sant Panteleimon in Piraeus, Greece and he works in the public sector as a GP. He is also in the final year of a Masters in Family Medicine and Science Methodology in Primary Health Care through the University of Crete. He has authored a number of papers published in international journals and in Greek Journals. He is involved in teaching undergraduate students in the University of Athens, in medical physiology and general practice.

He also has participated as a volunteer in international missions, in Africa, since 2005, providing primary care services in Uganda and Tanzania. He received an honorary award from the National Blood Donor Organization for his voluntary participation for four years in organising missions for blood collections in district areas all over Greece.



Dr Kyriakos in Africa.

Dr Kyriakos says “I very much appreciate and like international collaboration and interactions. This was the reason that urged my attention in order to apply for this wonderful global scholar program dedicated to Alain Montegut.”

“I was really touched to learn that Dr Montegut devoted his career to the quality of practice in primary care.” Dr Kyriakos believes that his own short experience doing humanitarian missions, in Africa, has given him a truer understanding of the meaning of the word “global” and made him realise that we have to offer our services as family doctors to our “global family” wherever this family has needs and expectations.

Dr Kyriakos has been blessed with a number of various inspiring mentors. He acknowledges Dr Kyriaki Sofroniadou, Dr Serafim Nanas, and Wonca identity Dr Christos Lionis. Dr Lionis has taught him about quality in primary care and how teaching knowledge and experience passes from the older to the younger doctors, effectively.

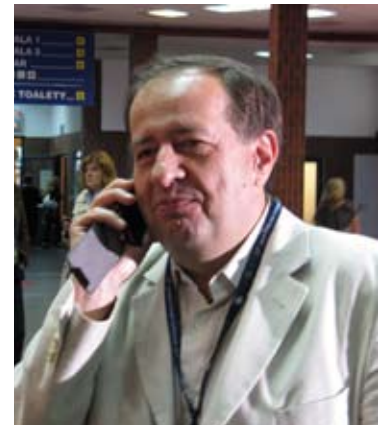
Dr Kyriakos’ final words are to “express my real acknowledgement to the American Board of Family Medicine Foundation and personally to the President James C Puffer, MD for offering me such an educational chance and experience”.

WONCA WARSAW IN PHOTOS

The 2011 Wonca Europe conference, in Warsaw, was successfully held from September 8-11. Few reports and papers are available at the time of going to press, so Wonca News is publishing a pictorial record of the conference. Reports will feature in the December 2011 issue of Wonca News



'Wonca Square' at the convention venue. The statue seems destined for the Department of General Practice in Krakow, where Prof Adam Windak can be reminded of Wonca on a daily basis! (photo courtesy of Dr Solomon Begg)



Chairman of the scientific committee, Prof Adam Windak, busy at the conference.



Wonca Europe president, Dr Tony Mathie, declares the conference open.



Young doctor and Vasco da Gama movement secretary, Dr Sven Streit of Switzerland, delivers the closing address at Warsaw reminding us to "think globally, act locally".



Professor Wienke Boerma, opening keynote speaker, on The state of the art of primary care in Europe.



Wonca Europe president, Dr Tony Mathie of the UK (left) and secretary, Prof Job Metsemakers of The Netherlands (right) with Wonca Europe administrative secretary, Barbara Toplek of Slovenia.



A relaxed moment for Kees Esser and Arno Timmermans



Dr Maria van den Muijsenbergh of The Netherlands, during her workshop on migrant care, international health and travel medicine.



RCGP leaders, President, Iona Heath and Chair, Clare Gerada



At the IPCRG seminar were Prof Jim Reid of New Zealand, Dr Jana Bendova of Slovakia, and IPCRG president Dr Miguel Román Rodríguez of Spain



Nordic group enjoy the sights of Warsaw (from l to r) Prof Jóhann Ágúst Sigurdsson, Dr Gisle Roksund; Lilja Thorgeirsdóttir; Dr Hálfðán Pétursson; Prof Steinar Westin.



Prof Job Metsemakers (centre), secretary of Wonca Europe relaxing with his colleagues from Maastricht in The Netherlands.



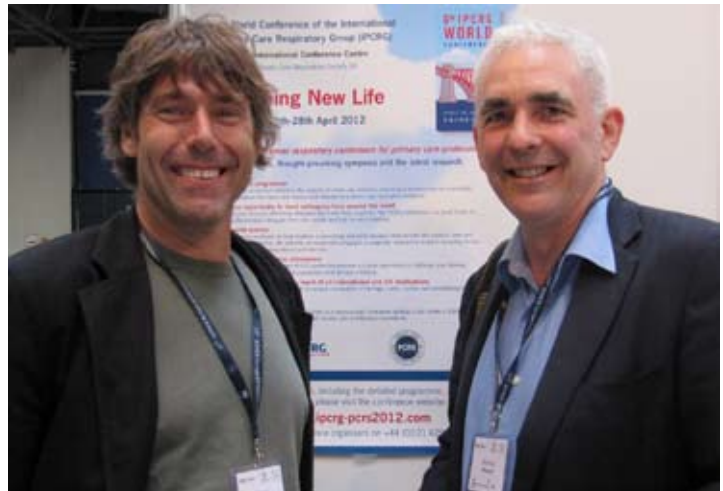
Dr Karen Kinder, executive director of ACG International with Wonca president elect Prof Michael Kidd.



Spanish delegates (l to r) Xavier Cos-Claramunt, Raquel Gómez Bravo, Anna Maria Pedro Pijoan, and Josep Maria Vilaseca



EURIPA representatives Cristina Galvão of Portugal and John Wynn-Jones of the UK



Dr Miguel Román Rodríguez of Spain with Dr Rod Peace of Australia.



Prof Amanda Howe, of the UK, presenting to the Wonca Working Party on Women in Family Medicine.



Young doctors from the Vasco da Gama Movement at their promotional booth.

WONCA REGIONAL NEWS

PROFILE: DANIEL J OSTERGAARD, MD - PRESIDENT OF THE WONCA NORTH AMERICAN REGION

Dr Dan Ostergaard became President of the Wonca North American Region, in May 2010, and will serve through June 2013. As such, he is a member of the World Wonca Executive Committee and he was previously as chair of the Wonca Bylaws & Regulations Committee from 2001-2010. He has been actively involved in Wonca since 1995, having served as chair of various committees and subsequently as an unpaid organizational development consultant to the Wonca Executive Committee.



Daniel J Ostergaard MD

Dr Ostergaard has been a professional employee of the American Academy of Family Physicians (AAFP) for over 30 years. His current position is vice president for health of the public and interprofessional activities, and he previously served in other vice president capacities including that of vice president for education and science.

As vice president for health of the public and interprofessional activities, he has oversight responsibilities for health of the public, scientific and research activities of the AAFP as well as the AAFP's relationships with other medical organizations in the United States and abroad. Through these relationships, he helps facilitate the continued development of family medicine globally and coordinates AAFP international activities. Professional staff in his area work to involve family physicians in targeted public health activities, including tobacco, obesity, exercise and immunization. Related responsibilities include development of clinical policies and development and dissemination of practice-based primary care research.

As vice president, Dr Ostergaard also helps direct organization-wide strategy and policy development activities in addition to participating actively in the activities of the AAFP Board of Directors. He is based in the AAFP's headquarters office in Leawood, Kansas.

In his travels to more than 60 countries, he has presented a wide variety of papers in multiple countries and has served in many international consultative capacities. He has numerous publications to his credit and has served as visiting professor in several states. Among his awards are: the 2000 Gabriel Smilkstein Memorial Award of the Society of Teachers of Family Medicine for outstanding contributions to the growth and development of family medicine education throughout the world; and the 2001 AAFP Humanitarian Award honoring his extraordinary and enduring humanitarian efforts both within and beyond the borders of the United States. In 1998, he was awarded honorary life membership in Wonca. In 2005, Heart to Heart International awarded him its Heart for Humanity Award.

Dr Ostergaard received his Bachelor of Arts degree in natural sciences and psychology from the University of North Dakota. He received his medical degree from the University of Texas Southwestern School of Medicine in Dallas. In addition to clinical practice in the United States Public Health Service in New Mexico, Dr Ostergaard served as director of the Family Medicine Residency in Duluth, Minnesota and was a faculty member of the University of Minnesota School of Medicine.

APR PRESIDENT DINES WITH MARGARET CHAN

Dr Donald Li, president of Wonca Asia Pacific region reports that he recently dined with World Health Organization Director General, Dr Margaret Chan. She is very pleased with Wonca's enthusiastic help to her, in enhancing primary care around the world. She is particularly committed to increase the role of primary care workers in the management of non communicable diseases and chronic diseases, especially diabetes.



WHO director general, Dr Margaret Chan with AP region president Dr Donald Li.

SAR: WONCA MUMBAI FINAL PREPARATIONS

Wonca Mumbai at a glance

Venue: Renaissance Convention Hotel Mumbai, India.
Date: 16-18 December, 2011
Last Date Abstract submission: October 15, 2011
Web: www.woncasar2011.com
E-mail: woncasar2011@gmail.com

Dear friend and colleagues

During December of 2011, we expect over 1000 Indian, Asian and international family physicians to visit Mumbai to attend South Asian Conference of Family Doctors. We extend a warm invitation to you to join us in this important event which will unfold before you what is the future of medicine and family practice.

For students of medical science future has arrived much before time! With genome mapping almost completed, changing disease patterns, newer fertility treatments born daily, and the world taking notice of the benefits of primary care physicians' significance in making healthcare accessible and affordable to all family practice will change drastically than ever before. Are we ready to meet these challenges and to create a strategy to adapt to the change? We hope to tackle these and many more burning issues, which family practice faces today.

The city of Mumbai, the capital of the state of Maharashtra, nestled on the western shores of the Arabian sea, is also considered the commercial capital of India, as is witnessed by hustle and bustle of the teeming millions of office goers, wending their way to their places of work, single-handedly contributing to almost one third of the GNP of the country. It is also a film city producing reams of fine cinema and television serials, attracting hordes of histrionic talent to the city from different parts of the country and the subcontinent.

India has a very diverse industry. About 65% of its people work in farming, but India is also one of the largest developers of computer software in the world. It exports manufactured goods and has a growing tourist industry. India is also part of the international economy and tries to get other nations to invest money in Indian businesses.

India will start growing faster by 2013, says a Morgan Stanley report. The primary reason it cites is the demographic dividend, supported by continuing economic

reform and globalisation. India will see a declining trend in the share of non-working dependents (children and the elderly) in the population, and contribute 136 million people to the workforce over the next 10 years, more than any other country of the world.

The Spice Route Movement for young and future family physicians of South Asia was launched at Kathmandu at SAR Conference in Nepal in December 2010. This will be the very first Preconference meeting of young South Asian Family Doctors. We are already receiving overwhelming response! We invite members of Vasco da Gama and The Rajakumar groups to attend this event and share their views.

Your active participation will add value to yourself from the deliberations of the world leaders of the speciality. You may also inform your progressive friends to join you to attend the event, which comes infrequently. We recommend that you register early and take advantage of the early bird discount.

Hosted by: Federation of Family Physicians Associations of India (FFPAI)

Organised by: General Practitioners' Association-Greater Bombay (GPA)

EMR: WONCA DUBAI PROGRAMME NOW ONLINE

Wonca EMR Dubai at a glance

Dates: December 17-19, 2011
Venue: Dubai International Convention and Exhibition centre
Web: www.wonca-dubai2011.com
Email: pco@wonca-dubai2011.com
1 Dec 2011 final program available and second early bird registration deadline

The 1st Wonca EMR conference and exhibition is organised by the Wonca EMR branch in collaboration with the Emirates Medical Association and Sheikh Hamdan Award for Medical Science. The meeting is also supported by the Dubai Convention Bureau.

Key-note speakers

Keynote lectures are planned from a wide variety of local and international speakers. Wonca leaders speaking include:

Prof Richard Roberts, Wonca president: *The family doctor in the twenty second century*

Prof Van Chris Weel, Wonca immediate past president: *Accreditation in primary health care and family medicine*

Prof Michael Kidd, Wonca president- elect: *Ensuring quality in primary care*

Prof Nabil Al Kurashi, Wonca EM region president: *Primary care doctors as owners of primary care: a trend of change in the Middle East*

Prof Waris Qidwai, Chair of Wonca working party on research: *Research strategies to reduce disease burden from non-communicable diseases in developing world*

International key-note speakers include:

Dr Alaa Alwan, Switzerland: *Integrating the prevention and control on NCDs into primary health care: challenge and opportunities in the region*

Dr Tesfamicael Ghebrehwet, Switzerland: *Home health care*

Prof Salman Alrawaf, United Kingdom: *Continuity of care as pillar PHC*

EM region speakers are:

Prof Faisal Al Nasir, Bahrain: *Family medicine in the Arab world. Is it a luxury?*

Prof Tawfik Khoja, KSA: *Accreditation in primary health care and family medicine*

Dr Naeema Algasseer, Bahrain: *Preparedness of family physicians and nurses to respond to emergencies as a team*

About Dubai



Photo courtesy of Dubai tourism - a spectacular skyline.

Safe, clean and ultra modern, Dubai is an ideal destination for conferences and events.

Dubai is a business city that enjoys a taste of traditional Arabic hospitality, immersed in a warmth and generosity of a bygone Bedouin era that still lives on in the spirit of the people today.

Citizens, expatriates and visitors alike, enjoy a relaxed and pleasant lifestyle. There is virtually no crime, the city is clean and there is a wide choice of modern and spacious accommodation. In addition, Dubai has a choice of cuisine to suit any palate and all pockets. Arabic is the national language. However, English is widely spoken throughout Dubai, so delegates will have no problem getting around.

Dubai is secular and tolerant, freedom of worship is allowed to all religions and Christian churches have existed in Dubai for many years. Alcohol may be consumed at home, in hotels and on licensed club premises. Women can drive and move about freely unaccompanied.

Nationals of the following countries do not require Visas prior to arrival to the UAE:

Andorra, Australia, Austria, Bahrain, Belgium, Brunei, Denmark, Finland, France, Germany, Greece, Hong Kong, Iceland, Ireland, Italy, Japan, Kuwait, Liechtenstein, Luxembourg, Malaysia, Monaco, New Zealand, Netherlands, Norway, Oman, Portugal, Qatar, San Marino, Saudi Arabia, Singapore, South Korea, Spain, Sweden, Switzerland, United Kingdom, United States of America, Vatican.

All other nationalities require a visa prior to arrival to UAE. (Kindly note that visa assistance will only be provided for registered and paid delegates who book their hotel accommodation through the WONCA 2011 professional conference organizing company)

For any further inquiries, please contact Mrs Lina Alaa Al Deen: lina@wonca-dubai2011.com

ASIA PACIFIC REGION TO MEET IN JEJU, KOREA, IN 2012

Wonca Jeju at a glance

Venue:

Date: May 24–27, 2012

Early bird registration closes: December 30, 2011

Second early bird registration closes: February 29, 2012

Abstract submission closes: December 30, 2011

Web: www.woncaap2012.org/

E-mail: admin@woncaap2012.org

Note: Jeju has reduced visa requirements and a number of direct international flights



Dr Jung Kwon Lee (left) overall chair of Jeju organising committee in Cancun in 2010 with (from l to r) Wonca leaders Dr Alfred Loh and Prof Rich Roberts.

Dear Colleagues

It is a great pleasure to inform you that the 19th WONCA Asia Pacific Regional Conference will be held from May 24th to 27th in Jeju, Korea. As an overall Chair of Organizing Committee, I am truly honoured to host one of the most highly acclaimed meetings in the field of family medicine on the beautiful site - Jeju Island.

This year, the organizing committee has chosen "*Evidence-Based Approach to Primary Care*" as the main theme of the conference, with a focus on the latest developments and trends, as well as the future outlook of the field of primary care and family medicine.

The organizing committee is gearing up for an exciting and informative conference program including plenary lectures, symposia, seminars, workshops on a variety of topics, poster presentations and various social programs for over 2,000 participants from around the world.

I hope you will join us at the WONCA Jeju 2012 and have a meaningful time with all the global experts. All members of the Organizing Committee and the Korean Academy of Family Medicine look forward to meeting you in Jeju, Korea.

Sincerely,

Jung Kwon Lee

Overall Chair of Organizing Committee Wonca Jeju 2012

WONCA EUROPE 2012 IN VIENNA

Dear colleagues, dear friends,

It is a great honour and pleasure for the Austrian Society of General Practice and Family Medicine to invite you on behalf of Wonca Europe to come to Vienna for the 2012 Wonca Europe regional conference which will be held on July 4–7 2012.

Wonca Europe Vienna at a glance

Dates: July 4–7, 2012

Venue: Vienna, Austria

Web: www.woncaeurope2012.org

Email: wonca2012@medacad.org

Abstract submission deadline:

December 15, 2011

"Last week results" submission:

March 15, 2012

Early Bird registration deadline:

February 29, 2012

The main theme of our conference will be *The Art and Science of General Practice and Family Medicine*, a title which comprises important and fascinating aspects and principles of our work as general practitioners and family doctors. The skilful integration of scientific knowledge and evidence based medicine in daily work has many aspects of an art and can help to make the work of a family doctor more efficient. Medicine and art have always been in tight relationship and there are many examples in music, literature and fine arts. The central image for our conference serves as a symbol for this theme. This image shows one of the world-famous anatomical wax models of the 18th century which are situated in the Josephinum, the foundation site of the first medical school in Vienna in 1786. These elaborate figures document a perfect synthesis of exact knowledge of anatomy and the art of transforming that knowledge

into beautiful and accurate models, which were ideally suited for teaching. Vienna, a city with a great medical and cultural tradition, many historical places and famous cultural highlights should be the ideal location to explore our conferences' theme in depth.



Vienna conference promotion team, in Warsaw, in front of the conference poster of an anatomical wax model (from l to r) Christian Schiller; Gustav Kamenski and Christian Linzbauer.

Wonca conferences are the most appropriate place where experienced general practitioners and family doctors can meet with young and enthusiastic members of the Vasco da Gama Movement and medical students to discuss their specific problems, attitudes and opinions. As many colleagues visiting our conference may be interested how Austrian GPs and family doctors work in their surgeries, the conference schedule will also offer a "Meet a Doctor" program.

An additional reason to come to Vienna is our attractive social programme. This consists of typical Viennese and Austrian music, an exhibition of works of art created by our physician colleagues, various tourist tours to explore the medical history of Vienna and a carefully selected post-conference tour.

We warmly invite you all to join us for an exciting conference in a fascinating city in the heart of Europe. We are looking forward to meeting you in Vienna and to your contributions to the conference program!

Dr Gustav Kamenski
Conference President

AFRICA CONFERENCE DATES CHANGE

Due to the number of conferences taking place in October 2012, Wonca Africa region has had no choice but to change their dates to November 19-21, 2012. The conference will be followed on November 22-24 by a Primafamed conference.

Wonca Africa at a glance

Venue: Elephant Hills Hotel,
Victoria falls, Zimbabwe
Date: November 19-21, 2012
First early bird registration
closes May 31, 2012
Last Date Abstract
submission: June 30, 2012
Second early bird registration
closes August 31, 2012
Web: [http://
3rdwoncaafriaregionconf.org/](http://3rdwoncaafriaregionconf.org/)

The conference will be followed on November 22-24 by a Primafamed conference.

WONCA WORKING GROUP NEWS

WONCA WORKING PARTY ON RESEARCH UPDATE



Prof Waris Qidwai, of Pakistan, chair of the Wonca Working Party on Research

At the meeting of Wonca Working Party on Research (WWPR) at Cancun, Mexico, in May, 2010, a work plan was developed to increase capacity building in primary care research methodology; to hold workshops and meetings at all Wonca Regional meetings; and to initiative a networking project to bring members closer together.

In brief, progress to date has included:

- A website for the WWPR was developed as part of Wonca website
- A list server has been up-dated for better communications between members.
- Capacity building workshops were held at regional and local meetings of Wonca and its member organisations.
- Meetings were held of the members of WWPR at regional Wonca meetings.
- A networking project was successfully completed titled, *“Equity in Health Care and Family Medicine*

as the most suited specialty for its promotion”.

We unfortunately lost our prime leader in Primary Care Research Dr Barbara Starfield, who died in June 2011. WWPR renewed pledge to carry her work forward. It is proposed to designate "Starfield" Lecture at each 3-year Wonca world meeting and initiate a "Barbara Starfield Primary Care Research Award".

A number of reports and work plans have been received from member organisations and these can be viewed online.

<http://www.globalfamilydoctor.com/IndexArchive.asp?view=fv>

Some of our new objectives for 2011-12 include:

1. Hold capacity building workshops on primary care research methodology and manuscript writing/critical appraisal of medical literature.
2. Initiate research projects.
3. Application of PCAT in different regions/countries
4. Combined projects with other Wonca working parties.
5. Work through regional presidents/national colleges.
6. Debate and agree upon research themes for Wonca Working Party on Research.
7. Developing a reporting format for annual reports and work plan for members.

Prof Waris Qidwai

MEMBER AND ORGANIZATIONAL NEWS

MYANMAR CELEBRATES WORLD FAMILY DOCTORS' DAY

Myanmar Medical Association – General Practitioners’ Society (MMA-GPS)

On July 22, 2011, a day of heavy monsoon rains, general practitioners from various parts of Myanmar were gathered in an auditorium of the Myanmar Medical Association (MMA) for the national mid-term meeting of the Myanmar Medical Association – General Practitioners’ Society (MMA-GPS) and award presentation ceremony of the “1st World Family World Family Doctor’s Day Essay and Standard Primary Care Clinic Competition, 2011”

Of the representatives from the General Practitioners Societies of 33 districts, almost all are senior general practitioners or family physicians. A few new young faces were also present.

The opening speech was delivered by the President of the MMA, Prof Kyaw Myint Naing, followed by Dr Tin Aye, Chairman of the General Practitioners’ Society. The speeches were an inspiration and strength for GPs, as they provided guidelines for community health services with an appreciation of the role of GPs are playing in the Myanmar Health Care system, CME activities and Quality and Safety practices.

The Master of Ceremonies, Dr Win Zaw, then invited the chairman of selection committee of the “Essay and Standard Primary Care clinic competition”, Dr Win Lwin Thein, to inaugurate the prize presentation ceremony for the award winners. The



Myanmar GPs at the historic meeting

chairman explained the background of the competition, selection criteria for the six prizes and the total number of senior GPs, young GPs and the medical students who took part in the competition. The ideal requirements for the prize for the Standard Primary Care Clinic were also clarified. The list of the award winners was announced. There was a huge applause from the audience when the winners stepped on to the stage, one by one, to receive their prize.

This was followed by the presentation of a USD 1,000 personal donation by Dr Alfred Loh, CEO of Wonca. The money was designated to help with GP education activities in Myanmar. Dr Tin Myo Han, secretary of International Relations MMA-GPS made the presentation on Dr Loh's behalf.



Dr Tin Myo Han presents Dr Alfred Loh's personal donation to the MMA-GPS chairman Dr Tin Aye Chairman, while the MMA-GPS Executive look on

After a sumptuous lunch, the national mid-term meeting was continued in the afternoon. The meeting was especially memorable as it was the first time Myanmar General Practitioners were commemorating the first World Family Doctors' day activities in Myanmar.

Standard Primary Care Clinic Competition winners



Winners of the Standard Primary Care Clinic prize, Drs Tin Oo Lwin & Myoe Myoe

Drs Tin Oo Lwin & Myoe Myoe, Royal Clinic, Dawei township (southern Myanmar). After winning they said that they had never dreamt of getting the prize for their clinic. They are trying to equip the clinic to provide the needs of patients as much as they can and have achieved a clinic of international standard, complete with an e-record system, proper dispensary services, emergency care and a minor operations room.



The selection committee of the competitions in a group photo with the prize winners

Essay writing competition winners

Senior GPs / Family Physician (over 35 years) wrote on the topic *The role of Family Physicians in providing Quality Health Care Services*: 1st Prize to Dr Soe Aung, Minbu township, Central Myanmar; 2nd Prize to Dr Nwe Nwe Aung, of Yangon.

Young GPs (under 35 years) wrote on the topic *A family physician is essential for a family*: 1st Prize to Dr Sai Thi Ha of Yangon; 2nd Prize to Dr Htoo Htoo Kyaw, of Yangon. Dr Sai Thiha said “I got the information about this competition from *Health Digest Journal (Myanmar)*. I understand more about family physicians because of this easy competition. I will try to become a family physician.”



Dr Tin Ayem, Chairman of MMA-GPS awarding the 1st prize of essay competition for young general practitioners to Dr Sai Thiha.

Medical Students wrote on *Learning family medicine since undergraduate day*: 1st Prize to Mg Phyo Zaw Wai and 2nd Prize to Ma Thinzar Win, both from the University of Medicine, Yangon.

To Dr Win Zaw, our General Secretary of MMA-GPS, our thanks for his effort in arranging the national mid-term meeting in conjunction with World Family Doctors’ day activities.

Dr Tin Myo Han
Secretary of International Relations MMA-GPS

CARIBBEAN NEWS AND PROFILE OF ANDY SHILLINGFORD

Some will remember that the Caribbean College of Family Physicians (CCFP) met in Barbados, in late 2009, and held a strategic planning meeting, its fourth since the first CCFP meeting in Jamaica, in 1987. From these deliberations, the CCFP has developed a Regional Corporate Strategy for the next five years, 2011 to 2015.

Following a SWOT analysis, where the views of members from across the region were fed into the loop and frank discussion encouraged, and many online meetings thereafter, a list of strategic goals was drawn up. They are grouped under four headings which were identified as being of highest priority:

1. Organisational development
2. Research in GP
3. Education
4. Advocacy in Family Medicine

The CCFP is aware of the many and sometimes almost insurmountable challenges it faces in achieving its stated aims and objectives: its diversity of cultures, languages, political administrations and agendas; plurality of approaches to health care management across the region; difficulty and expense in travelling from territory to territory; lack of funding, lack of personnel, lack of time and commitment and many times the lip-service that is paid by the policy-makers in the Caribbean to family medicine and primary care.

However, the CCFP is also aware that many of the challenges can also be seen as opportunities and it is in this spirit that CCFP is preparing its next five year onslaught, in the Caribbean region. One of its strengths is its commitment to democracy and gender equity.

A proposal for mandatory postgraduate CME, for all doctors wishing to be registered as independent medical practitioners in the region, has been submitted to the regional Ministries of Health and the Medical Councils and this seems to be finding favour in a number of the larger territories. CCFP continues to build relationships and strengthen ties; encouraging individual participation in CME activities for general practitioners, as the CCFP works towards revising its Curriculum for Family Medicine, towards awarding the Membership in CCFP (MCCFP).

CCFP was able to hire a fulltime regional administrator for the first time and this will inevitably improve communication and organisation of the CCFP's affairs. The CCFP website is also being strengthened with the addition of a dedicated webmaster.

<http://www.caribgp.org>

The CME agenda has continued with monthly meetings beamed to members across the region using *Illuminate* technology; and quarterly family medicine workshops continue to be carried out in the more active territories like Jamaica, Bahamas and St Lucia.

A conference hosted by the Jamaica Chapter, in February 2011, with the theme *Family Physicians Taking Charge of the Wellness Revolution* was so successful that it has been decided that this will be an annual feature.

Additionally, the tradition of a Triennial Pan Caribbean CCFP Family Medicine Conference will be continued when

this returns to Port of Spain, Trinidad, in 2012. Our guests who attended the inaugural conference, in 2000, tell us that they cannot forget how they learned to "storm a fete" and "buss a lime".

Plans are in train to further bridge the gap between the English, Dutch and French speaking territories and as well to increase communication between colleagues in the larger islands, the smaller less developed islands and the mainland territories.

Our influence in the region continues to solidify; as our members are given more responsibility as academics within our regional University Faculties of Medicine, are called to serve as senior officers within our Public Health departments and Ministries of Health and are recognised and honoured as good clinicians and service-oriented doctors, in family practice.

CCFP is an important partner alongside the University of the West Indies in preparing applicants for the Caribbean Association of Medical Councils examination (CAMCE) which is the qualifying examination for doctors who apply to be registered to practice in the jurisdiction of CARICOM (the Caribbean Community). CAMCE is the Caribbean equivalent of the PLAB(UK) and the USMLE.

Current Officers

The CCFP has a large board and we are still enlarging it to include representatives from all the territories. This makes for inclusion and democracy. Since we meet online it works fairly well. We plan at least one face to face meeting per year. Our new executive is:

Regional President: Dr Wilmoth 'Andy' Shillingford (Dominica/ Cayman Islands)

Immediate Past President: Dr Pauline Williams-Green (Jamaica)

1st Vice President: Dr Cherilyn Hanna-Mahase (Bahamas)

2nd Vice President: Dr Dorothy Pietersz-Janga (Curacao)

Honorary Secretary: Dr Monika Asnani (Jamaica),

Honorary Treasurer: Dr Henry Blythe (Jamaica/ Turks & Caicos Islands)

Members-at-Large: Drs Kristen Campbell-Smith & Tomlin Paul (both from Jamaica)

Regional Administrator: Ms Hyacinth Coy (Jamaica)



Members of the Board of the CCFP

Directors: Drs Marlene Byrne-Joseph (Antigua-Barbuda), Myles Poitier (Bahamas), Colin Alert (Barbados), Johanne Perez (Belize), Jennifer Japal-Isaacs (Grenada & Carriacou), Ruth Der Kenne (Guyana), Jennifer Ludford-Reid (Jamaica), Glenville Liburd (St Kitts-Nevis), Christopher Beaubrun (St Lucia), Miriam Sheridan (St Vincent & the Grenadines), John Goedschalk (Suriname), Paula Nunes (Trinidad & Tobago).

Committee chairs: Drs Monika Asnani (Jamaica), Sonia Roache-Barker (Trinidad & Tobago), Peter Adams (Barbados), Colin Alert (Barbados), Henry Blythe (Turks & Caicos Islands), Rohan Maharaj (Trinidad & Tobago)

In the months of July and August, which was the ‘summer’ break for our schools, the Caribbean celebrated Emancipation (freedom from slavery of the people of African descent); started its fasting for Ramadan amongst those of the Muslim faith to end in Eid ul Fitr; held the annual Carnival celebrations for Antigua; Kadooment (crop over festival) in Barbados; and Independence celebrations for Jamaica and Trinidad & Tobago - a busy time.

Cherish Freedom, Happy Emancipation
Sonia Roache-Barker



Dr Pauline Williams-Green of Jamaica, immediate past president of the CCFP in the College gown

Profile: Dr Wilmoth 'Andy' Shillingford CCFP Regional President, 2011-2012

Dr Wilmoth Shillingford MBBS (UWI), MRCP (UK), or "Andy" as he prefers to be called, is the ninth Regional President of the Caribbean College of Family Physicians (CCFP). He was elected, in February 2011, at a Special General Meeting of the College to replace Dr Pauline Williams-Green who had resigned prematurely for urgent family reasons.



Dr Andy Shillingford, new CCFP regional president

Andy graduated MBBS (class of 1996) from the University of the West Indies (UWI), at the Mona Campus, Jamaica. He entered UWI, in 1990 on scholarship from his home country, the Commonwealth of Dominica, the nature island of the Caribbean, described as the most ecologically unspoiled.

After graduation, he was chosen to intern at the University Hospital, where internship posts are usually given to the top in the class. Thereafter he was recalled to Dominica, to serve as a Medical Officer. About three to four years after qualifying, he was assigned to his hometown to serve as the lone District Medical Officer – the district of St Joseph, on the Caribbean south coast of Dominica. He served in this

capacity for two years; working within a short distance from his home and birthplace; and with persons who had known him all his life.

His grandmother was one of his patients, his head nurse was his aunt and most of his staff would have known him, as they say in the West Indies "before he was born". He describes this period of his life as comforting although challenging. He speaks of "knowing nothing yet knowing everything; of being in a place where you did not know what you did not know but you did what you could and you did your best."

His clinic was situated about eleven miles (18km) from the nearest District Hospital where the radiology department, the laboratory and a surgeon and other specialists were housed. He was the only doctor in residence and he could safely be described as the quintessential country family doctor. The population entrusted to his care numbered approximately 5000. He was on call 24 hours a day, seven days a week, with alternate weekends off when he would be replaced by the Nurse Practitioner.

Dominica has spawned many important people, one of whom is Dr Carissa Etienne, then Head of Primary Care, now Deputy Director General of WHO, assigned to Geneva. Andy says she was one of his mentors. He decided to enroll in the UK-MRCP programme and go to the UK to "join a British friend who showed up in Dominica that summer". This friend whom he had met first when they were thirteen or thereabouts at a Church Youth Camp, in Dominica, happened to be Angeline, who he married in 2002, one year after going to England.

After three years, Andy switched to the MRCPGP programme. He took to GP training like a duck to water,

becoming a GP Registrar and then actually working as a salaried GP in the UK.

During this time, a daughter, Ashley, was born. Angeline, a pharmacist, is again responsible for what he claims is to date the most rash decision of their lives - the move back to the Caribbean. She applied for a vacancy in the Cayman Islands and was hired. Simultaneously, the Cayman Islands Health Service told them that a vacancy for a GP had just opened up, and Andy applied and was hired. What was the UK and Dominica's loss had just become the Cayman Islands' gain.

Andy is now a Senior Medical Officer in the Cayman Islands, one of the most prosperous and modern of all the territories in the English-speaking Caribbean, enjoying one of the highest standards of living in the world. It is a protectorate of the UK, with a population of less than 60,000, a GDP per capita of USD40,000: a far cry from the beautiful and tranquil island of Dominica, the least developed of all the British islands but independent and self governing.

Andy is a young man of potential, bright and accomplished, with special IT skills which he shares freely with the CCFP, having made his mark as a fledgling member when he rescued and reconstructed the College's website. He is focused, principled and creative; given to brevity and order; self-confident but open and willing to learn. He is devoted to his family, his wife and his two daughters.

PHILIPPINES BOOK WITH A CAUSE

The University of the Philippines Manila (UP Manila), School of Health Sciences (SHS) celebrated its 35th Anniversary on 28 June 2011.

They commemorated the following accomplishments:

1. pioneer work on ladderized curriculum for midwifery, nursing and medicine.
2. strong community partnership from recruitment of students to return service after graduation, making SHS a model for retention of health professional in rural areas.
3. opening of extension campuses in Northern Luzon and Mindanao, replicating its mandate.
4. internationalization through membership in "Training for Health Equity Network," co-hosting the Wonca Working Party for Rural Health Meeting in February 2011, and assistance to Timor Leste as it develops its own ladder program.
5. Launching of the book on SHS entitled "Bringing Health Care to Rural Communities."

To mark the occasion, UP Manila is publishing a book entitled "*Bringing Health To Rural Communities: Innovations Of The UP Manila School Of Health Sciences.*" Vice Chancellor for Academic Affairs, Dr Josefina Tayag, one of the editors of the book, has initiated "Book for a Cause" to help raise funds for SHS.

The book is a testament to the beginnings of SHS, how it survived the first 35 years, with reflections from students, graduates and faculty - it is all of 450 pages of heart warming testimonials and historical accounts.

The SHS has students coming from underserved areas and poor communities. By virtue of its admission criteria, students come from families which are below or just above the poverty line. UP Manila waived the tuition fees and miscellaneous fees of students. That foregone income could have been used to augment the operating expense of the school.

Communities are supposed to provide allowances for the students but sometimes students do not get the full allowance or none at all. There are very limited scholarships available for the students.

The staff at UP Manila SHS are hoping to attract donors of as little as USD125 to much larger sums. Donors are being given a copy/copies of the SHS book in appreciation. Monies are begin raised for

1. Augmentation funds for operation of the 3 SHS campuses of Palo, Leyte, Baler Aurora and Koronadal City, South Cotobato;
2. Seed money for student loans, when allowances are delayed—to be repaid;
3. Financial assistance for the very needy as attested by the Dean of the School of Health Sciences; and
4. Additional funds for a learning resource centre.

For further information on the book, or this initiative please contact

'Dada' Zorayda E Leopando
 Email: dcmdada@yahoo.com;
 zleopando@mail.upm.edu.ph

NEW OFFICE BEARERS IN FIJI AND SAUDI ARABIA

Fiji

The new office bearers, from 11 June, 2011, of the Fiji College of General Practitioners are:

President: Dr Rosemary Mitchell;
 Vice President: Dr Shanita Sen;
 Honorary Secretary:
 Dr Keshwan Nadan;
 Wonca Liaison Officer:
 Dr Wahid Khan
 email: awkhan55@gmail.com

Kingdom of Saudi Arabia

The Saudi Society of Family & Community Medicine (SSFCM) has a new Council which includes a newly elected president and vice president. The SSFCM also has a new Secretary General, Dr Shaher Alshehri. The new council is:



New president of the Saudi Society, Prof Sameeh Al-Almaie

President: Prof Sameeh M Al-Almaie

Vice President: Dr Mohammed H. Al-Doghether

Council members are: Prof Adnan Albar, Dr Shaher Z Alshehri, Dr Mohamed Al-Rukban, Dr Abdulaziz M Sebiyani, Dr Ali F Al-Amri, Dr Hadi S Al-Enazy, Dr Yahia M Solon.

PAKISTAN NUTRITION UPDATE

The College of Family Medicine Pakistan (CFMP) conducted a two day nutritional educational program for Family Physicians titled *Integrating Nutrition in Clinical practice* on 26-27 June 2011 at the Pakistan Medical Association (PMA) House, a 130 year old heritage building synonymous with learning in the Doctors community of Karachi.

The course faculty included: Prof Iqbal A Memon, president elect of the Pakistan Paediatric Association Centre; Nazra Huda, an eminent clinical nutritionist; Dr Aziz Khan Tank, consultant family physician and secretary-general CFMP; Dr Shehla



Attendees at the nutrition event

Naseem, consultant family physician and joint secretary CFMP, who was also the course director.

The program was a very well attended event with the course audience comprised of more than 60 eminent GPs from Karachi, Hyderabad, Nawabshah and Larkana. The course was very interactive and interesting for the audience who participated wholeheartedly in this learning activity, including pre and post tests, lectures and case study workshops. The program ran very successful judging from the number and interest level of audience. The speakers were also highly knowledgeable in their field and kept the audience captivated throughout the two days.



Certificates of attendance are distributed

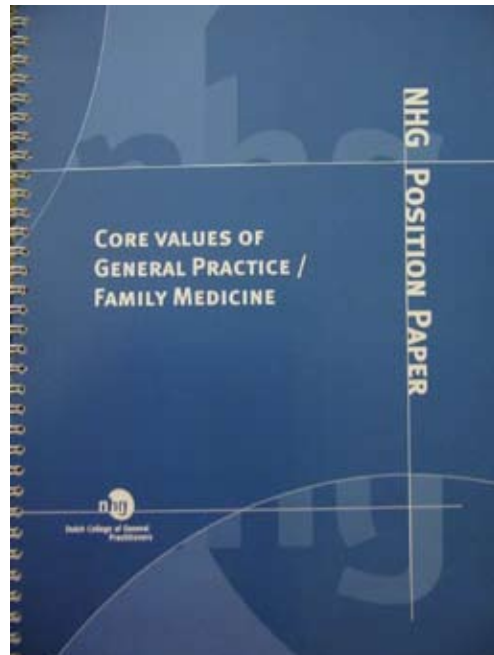
Country Head Abbott Nutrition, Mr Ayub Siddiqui, congratulated the College and the participants for their commitment and devotion to the quest of knowledge and promised his continued support for such endeavours in future.

Dr Shehla Naseem

RESOURCES FOR THE FAMILY DOCTOR

DUTCH POSITION PAPER: CORE VALUES OF GENERAL PRACTICE/ FAMILY MEDICINE

The Dutch College of General Practitioners has produced their *NHG Position Paper Core Values of General Practice/Family Medicine* which is freely available online.



The paper states that general practice medicine is generalist, patient-oriented, continuous care. These core values are inextricably linked to each other. The quality of general practice/family medicine can only be described by viewing these core values in their mutual connection. The GPs actions at the practice are based on these core values. The core values of general practice/family medicine are not new and have long been the foundation of general practice care. However, the context in which these core values are implemented by GPs in practice are constantly subject to change.

To access the paper enter the search term "*position paper*" in the search box of the Dutch college website.

<http://nhg.artsennet.nl>

JOURNAL OF MEDICAL CASE REPORTS

The editor of Wonca News received a copy of some articles from this interesting journal when recently attending the Wonca Europe conference in Warsaw. Professor Michael Kidd AM, president-elect of Wonca, is the editor in chief of this journal, so finding out more information proved easy.



Prof Michael Kidd, president-elect of Wonca is also editor of the *Journal of Medical Case Reports*

As doctors we learn something new about human existence, health and disease every single day. And, as Sir William Osler once wrote, “The best teaching of medicine is that taught by the patient.”

For example, in the past week, what did you see in your own clinical practice that made you stop and think: “This patient has taught me something new” or “I haven’t seen that before” or “Today I have added to my medical knowledge”.

This is why in 2007, with a group of colleagues from around the world, we founded a new medical journal, the *Journal of Medical Case Reports*. We were surprised to discover that this was the world’s first medical journal devoted to publishing case reports from all clinical disciplines. We decided to publish only those case reports that are the first of their kind to be published in the English language medical literature. We also encouraged authors to include patient perspectives where the patient describes their own experience of the disorder and their treatment. And we decided to publish open access, which means that the content of the journal is available free of charge through the Internet, to ensure that our case reports are easily accessible to clinicians in every nation of the world.

Since the launch of the journal we have published over 2,000 case reports and, in 2010, case reports were downloaded from our journal’s web site over 1,000,000 times.

The rationale for the journal is easy. In this era of evidence-based practice, we need practice-based evidence. The basis of this evidence is the detailed information we obtain from each person that we see in our clinics; the reports about individual people that inform both our daily clinical care and clinical research. Our aim is that every case report published in our journal adds valuable new information to the world’s medical knowledge.

We have received many case reports from family doctors. One of the most important categories of case reports from family medicine has been reports of previously unreported or unusual side effects or adverse interactions involving medications. Case reports can serve as an early warning signal for the adverse effects of new medications, highlighting problems that were not uncovered in the original clinical trials of new medications. We have also received a number of case reports related to patients presented with new and re-emerging diseases. For example we have recently published a series of case reports from the H1N1 influenza pandemic.

We hope that the case reports in our journal will assist our colleagues in their daily clinical work and also serve as a source of inspiration for clinical researchers seeking ideas about new research directions. It is a motivation for our authors to know that what they observe and report today may contribute to the well being of other people in the future. The *Journal of Medical Case Reports* is published by BioMed Central and can be accessed at www.jmedicalcasereports.com

Professor Michael Kidd

WONCA CONFERENCES 2011 – 2013 AT A GLANCE

Information correct as of September 2011.
May be subject to change.

**Wonca Direct Members generally enjoy lower conference registration fees.
The level of discount is determined by the Host Organizing Committee of the conference.
See Wonca Website www.GlobalFamilyDoctor.com for updates & membership information

2011			
16 – 18 December	Wonca South Asia Regional Conference	Mumbai INDIA	Only Doctors Can Provide Accessible, Cost-beneficial and Equitable Healthcare
17 – 19 December	Wonca East Mediterranean Regional Conference	Dubai UNITED ARAB EMIRATES	A Family Doctor with you in all stages of Life
2012			
24 – 27 May	Wonca Asia Pacific Regional Conference	Jeju SOUTH KOREA	Evidence Based Approach to Primary Care
4 – 7 July	Wonca Europe Regional Conference	Vienna AUSTRIA	The Art and Science of General Practice
9 - 14 October	Wonca Rural Health Conference	Thunder Bay ONTARIO	Joint Conference with The Network towards unity for health
16 – 19 October	Wonca African Regional Conference	Victoria Falls ZIMBABWE	Roles and Responsibilities of African Family Physicians
2013			
26 – 29 June	20 th Wonca World Conference	Prague CZECH REPUBLIC	Family Medicine: Care for Generations

GLOBAL MEETINGS FOR THE FAMILY DOCTOR

MEMBER ORGANIZATION AND RELATED MEETINGS

RACGP GP '11 conference

Host : The Royal Australian College of General Practitioners
Date : October 6–9, 2011
Venue : Hobart, Australia
Web : www.gp11.com.au/

EGPRN autumn meeting

Host : European General Practice Research network (EGPRN)
Date : October 13–16, 2011
Venue : Krakow, Poland
Web : www.egprn.org

RCGP annual national primary care conference

Host : Royal College of General Practitioners
Theme : Diversity in practice
Date : October 20–22, 2011
Venue : Liverpool, United Kingdom
Web : www.rcgp.org.uk

IAHCP 46th joint medical congress

Host : International Association of Health Care Professionals (IAHCP)
Theme : Progress in Medical Practice, Primary Care and Education in the 21st Century
Date : October 24–27, 2011
Venue : London, United Kingdom
Web : www.ahcpuk.org
Email : ahcpconference@ymail.com

Family Medicine Forum / Forum en médecine familiale 2010

Host : The College of Family Physicians of Canada. Le Collège de médecins de famille du Canada
Date : November 3–5, 2011
Venue : Montreal, Quebec, Canada
Web : <http://fmf.cfpc.ca>

40th EQUIP Assembly Meeting

Host : European association for quality in general practice/family medicine
Date : November 3–5, 2011
Venue : Zagreb, Croatia
Web : www.equip.ch

3rd Asia Pacific Primary Care Research conference

Theme : Bridging the gaps: doing research in the real world
Host : Academy of Family Physicians of Malaysia & Malaysian Family Medicine Specialists Association.
Date : December 3–4, 2011
Venue : Kuala Lumpur, Malaysia
Web : www.afpm.org.my

Mental health and family medicine

Date : February 8–11, 2012
Venue : Granada, Spain
Web : www.thematicconference-granada2012.com

6th IPCRG world conference

Host : International Primary Care Respiratory Group
Date : April 25–28, 2012
Venue : Edinburgh, Scotland
Web : www.ipcrg-pcrs2012.com

AAFP annual scientific assembly

Host : The American Academy of Family Physicians
Date : October 17–20, 2012
Venue : Philadelphia, USA
Web : www.aafp.org

EGPRN spring meeting

Host : European General Practice Research network (EGPRN)
Theme : Quality improvement in the care of chronic disease in family practice
Date : May 10–13, 2012
Abstracts close: January 15, 2012
Venue : Ljubljana, Slovenia
Web : www.egprn.org

EURIPA invitational forum

Host : European rural and isolated practitioners association
Theme : Education and Training for rural practice
Date : May 11–13, 2012
Venue : Porto, Portugal
Web : www.euripa.org

RNZCGP conference for general practice

Host : The Royal New Zealand College of General Practitioners
Date : September, 2012 (exact dates to be confirmed)
Venue : Rotorua, New Zealand
Web : www.rnzcgp.org.nz

RCGP annual national primary care conference

Host : Royal College of General Practitioners
Date : October 4–6, 2012
Venue : Glasgow, United Kingdom
Web : www.rcgp.org.uk

AAFP annual scientific assembly

Host : The American Academy of Family Physicians
Date : October 17–20, 2012
Venue : Philadelphia, USA
Web : www.aafp.org

EGPRN autumn meeting

Host : European General Practice Research network (EGPRN)
Theme : Research on patient-centred inter-professional collaboration in primary care.
Date : October 18–21, 2012
Abstracts close: June 30, 2012
Venue : Antwerp, Belgium
Web : www.egprn.org