The World Book
of

Family Medicine

-

European Edition

Published on the occasion of the 20th Anniversary
of

WONCA Europe

Istanbul, October 2015

Wonca
World family doctors. Caring for people.

EUROPE

Design: Carl Steylaerts

This book uses British English as the language for carrying thoughts.

Proofreading was performed by Ms Naomi Uludamar.

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In close collaboration with our networks

Vasco da Gama Movement
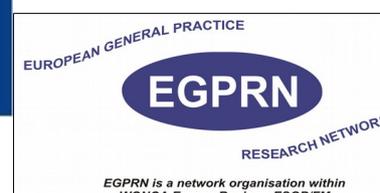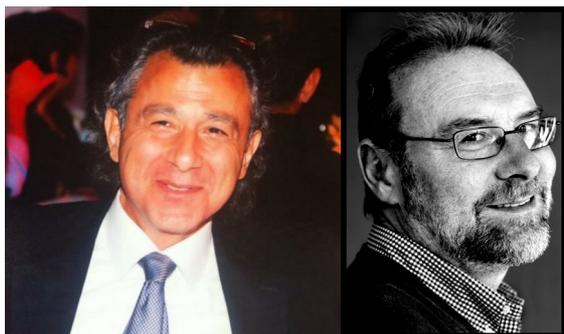
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Prologue

Conceiving of a World Book of Family Medicine is easy. Actually making one is a lot harder.

We started in 1995 and 20 years later, we present you this present in the present.

It contains a lot of history and the roots for a lot of future plans.

We leafed through 20 years of abstracts, including those presented at World Conferences, made a long list, selected a jury who then made a short list of 100 titles that best represented our job. During this process, it became obvious that we had selected mostly European titles, hence, this is the European Edition of the World Book. We do hope that other regions will follow, and also hope that a following generation will create **The** World Book of Family Medicine. Time will tell.

In the process of finding the original authors, some were lost due to natural causes – death, illness, retirement. We then went to find body-doubles, and it will be no surprise that a lot of the youngsters of the Vasco da Gama Movement are authoring themes that were researched almost before they were born – offering a splendid proof that memory is a living organism that is constantly recreated and growing.

We owe a lot to the 100 authors who finally drafted their 1000 words, selected take home messages and showed us the sources of their thoughts, with references.

They were put under time pressure, some had to redraft, and then everything was being proofread by our outstanding Miss Naomi Uludamar. We owe her so much.

All the authors joined us in a journey towards … a growing body of evidence that WONCA and WONCA Europe inspire, teach and learn.

We show them our eternal gratitude and honour them. Thank you all!

While editing this World Book, it became also obvious that there is no such thing as one kind of General Practice or Family Medicine. There is only a local answer to local needs. And though General Practice/Family medicine is mostly a clinical specialty, you will find none of this in this book. For then we should have taken 1000 titles. The chosen titles should be regarded as "generic", applicable in every country – or at least most of them.

This book is a starting point.

WONCA (Europe) is the terrific place where knowledge about our field of experience, expertise and interest is exchanged. Youngsters come for a try out, PhD students lecture from their research, post docs idem, seasoned professors tell us their stories, and key note speakers from various fields come to inspire us.

Hypes come, hypes go. Some stay, as evidence based medicine – not as a golden bullet, but as an enrichment. The past 20 years brought us a lot of change and some of that wisdom changed our daily work.

To be true, this book is about people. The people that we care for, our patients, and the people that we care for, our colleagues. The reason why we make the journey to the different places, mostly terrific as well, where the Conferences take place. The more you go to a conference, the less you learn, but the more people you get to know. And their

stories, which is why every Conference is a rich environment.

Then bad news arrived. Soon after she finished her contribution, Professor Fusun Yaris died, a lost battle. A few weeks later, another author, Professor Janko Kersnik had an appointment with the Great Reaper as well.

It makes us aware of our mortality. And the legacy that this book bears.

The myth of Zeus and the birth of Athena comes to mind. A quantum of solace for us, earthlings.

Fusun and Janko went early, we will follow one day. Theirs and ours and your energy however will not disappear. Our genes live in a trans-, inter- and intragenerational environment.

And as we now know, both Darwin and Wallace were right. So it is important to keep digging for ideas, knowing that they will mutate and differentiate as well.

It is in that great tradition of creating fora for exchanging ideas that we found the inspiration for this World Book. One author referred to the famous words of Margaret Mead:

Never underestimate the power of a few committed people to change the world. Indeed it is the only thing that ever has.

Take home messages

- The proof of the pudding however is in … the reading.
- We hope you enjoy this World Book – European Edition.
- And that we inspire others to follow and do even better.

Ex Oriente Lux!

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Istanbul, October 2015
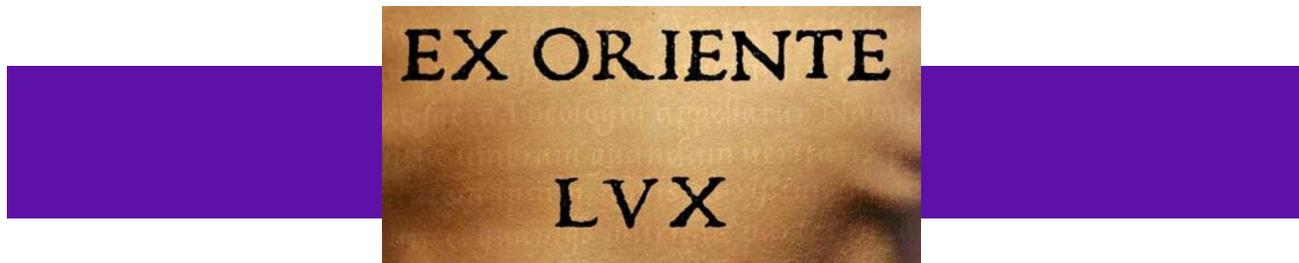
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1 – Patient Empowerment for Patient Self-Management
Wonca Europe 20th Anniversary Project 2015

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With thanks to members of the
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and thanks to Project Special
Advisers: Ernesto Mola (IT), John
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At the European Council meeting of WONCA Europe in Warsaw in 2011, Patient Empowerment was adopted as the twelfth characteristic of general practice in the European definition of family medicine (FM) by WONCA Europe, and categorised within the core competency of person-centred care. Core competencies of the FP doctor mean competencies essential to the discipline, irrespective of the health care system in which they are applied.
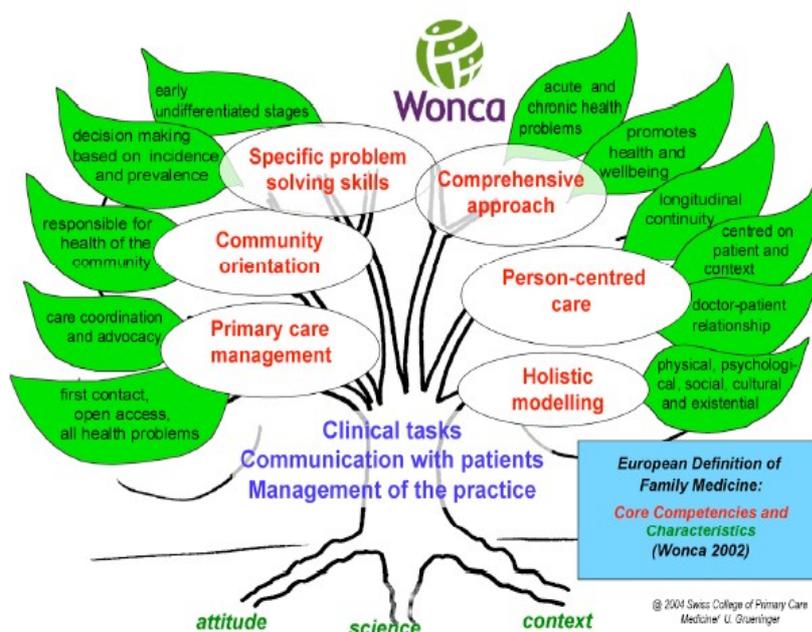
Fig 1 The WONCA TREE – as produced by the Swiss College of General Practitioners (Revised 2011) – Reprinted with permission

WONCA Europe: The European Definitions of the Key Features of the Discipline of General Practice 2011

The 2011 revision of the definition of FM gives recognition to the new dynamic between doctor and patient. As social values and healthcare systems continue to change, patients' expectations are to make choices and decisions in keeping with their autonomy. This recent revision of the definition of FM gives the FP in Europe a new role to harness this patient autonomy and develop the expertise of patients in managing their own health and illnesses.

Empowering patients is officially acknowledged as a responsibility of family medicine, which provides an appropriate

environment to promote patient empowerment for self-management of chronic conditions.

In 2012 WONCA Europe sought to fund a project with the aim of having a lasting benefit for FM in Europe, and in order to prepare its report for the 20th Anniversary of WONCA Europe in 2015. The successful bid was submitted by EQuiP, The European Society for Quality and Safety in family medicine, along with three project partners; the Irish College of General Practitioners, the Finnish Medical Society Duodecim, and the Department of Family Medicine at University of Jena, Germany.

The project partners sought to explore one aspect of chronic disease management, namely, patient empowerment in self-management of chronic disease. The EQuiP group initially named the project PECC-WE; Patient Empowerment in Chronic Conditions - WONCA Europe, and the project was initiated with the definition of "patient empowerment" (PE) as defined in the European Journal of General Practice (EJGP) article by Ernesto Mola:

> Patient Empowerment is an educational process to help or support the patient
> to develop knowledge, skills, attitudes and self-awareness,
> and to assume effective responsibility for health-related decisions.
> Definition of Patient Empowerment (E. Mola, EJGP 2008)

The value of investing in empowering patients to help themselves seems obvious; however the brainstorming sessions in our project research group revealed that we still have questions about which specific skills, attitudes and behaviours can be taught to primary care clinicians to promote positive patient behaviours and attitudes that improve patient outcomes in chronic conditions. The project partners agreed that the best use of project funds would be to explore whether the education of clinicians in FM to improve patient empowerment for self-management of chronic conditions would improve outcomes for patients compared to patients of clinicians who were not educated in that particular skill.

The WONCA Anniversary Project 2015

The role of the family physician (FP) has changed over the last twenty years. Patients' attitudes to health and healthcare have also changed. The revision of the European definition of general practice is a response to these changes.

Patients are more informed now and have access to the same sources of information as medical doctors. Patients in 2015 are less likely to be passive recipients of healthcare and are more likely to have expectations and demands that reflect the psychology of consumer-based societies. 21st century patients expect *to receive* high quality, safe care. However, as all members of society are either patients or potential patients, there is an obligation on all citizens *to participate* in their care and actively manage their own lifestyle factors for optimum health.

Once established, chronic diseases are by definition not curable. Multimorbidity and polypharmacy are escalating as people live longer with chronic conditions. Public services funded by taxpayers and privately funded healthcare services, voluntary organisations and charities all contribute finance and other resources towards the management of chronic conditions. These challenges of healthcare provision are intensifying as costs, demands and expectations are apparently infinite, while resources remain finite.

Our research shows that one path for assisting patients to improve their health outcomes is through primary care health professionals who are educated and trained in the skills of motivation, goal setting and communication skills appropriate for change management.

There are of course many pathways to patient empowerment, and several factors influence patients' motivation and capacity for self-management. We have evidence that patient self-management has a positive impact on health outcome, though we must acknowledge that incorporating self-management support in routine healthcare is in itself challenging.

In conclusion

There are a number of findings of this project which will be formally presented at the WONCA Europe Conference in Istanbul, 2015. These include the systematic review report, the online educational tool for health professionals and its evaluation, and the launch of an online hub of resources on patient self-management for health professionals, patients and those who care for them.

Our research findings can be regarded as a successful starting point for primary care-based multidisciplinary interventions with capacity to implement quality improvement in management of chronic conditions for the benefit of

both patients (improved self-efficacy and better outcomes), and for health professionals (improved self-efficacy and job satisfaction).

The future post 2015

This project will add to the growing evidence-base for integrating patient self-management into routine healthcare. In general practice we recognise the need to intervene earlier, even before chronic disease is established, when the person has risk factors like smoking, alcohol consumption, obesity, or cardiovascular risk due to a combination of several moderate risk factors.

We hope this will prompt a fresh multifaceted interest in managing lifestyle risk factors for chronic disease in European general practice / family medicine, to reappraise our various models of chronic condition management and to ensure best practice models are disseminated.

Exploring this complex topic has highlighted global issues which have an impact at grass roots level in routine general practice / family medicine. It would be encouraging to see GP/FP from all WONCA regions collaborate to develop a global team player approach in addressing the important role of the patient in determining their own health outcomes.

Take home messages

- Patients have capacity to improve their own health through patient self-management.
- Patient empowerment for self-management is a core element of patient-centred care.
- Primary care health professionals with training in patient self-management support can help to empower patients for change.

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2 – Communicating with Patients

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Patients want:
- Factual, authoritative information
- Both sides of the story
- Language they can understand
- Advice they can follow

This presentation, from Western Australian GP Dr Michael Jones, was aimed at encouraging GPs to use a practice newsletter. The talk illustrated the benefits, to both patients and doctors, of using this form of communication. The speaker reminded the audience that "doctor" used to mean "teacher" and that GPs need to focus on their role as educators about health, as well as dealing with the specific issues raised at any given consultation.

In 1991, frustrated by some of his patients making unwise decisions based on what they had read in the popular media, or seen on TV, Dr Jones decided to produce a newsletter for the patients of his practice. The purpose of the newsletter would be to give patients accurate information on topical medical issues, remind them about preventative health matters, and give general advice about nutrition and other health-related topics. At the same time, the newsletter would keep them informed about current activities in the practice, such as details of new doctors, practice policies, staff leave, etc.

He rapidly realised the enormity of this task and hit on the idea of producing a 'generic' newsletter which could then be personalised for individual subscribing doctors or practices. As a result, the concept of the practice newsletter 'Your Doctor' was born.

With the help of an experienced journalist, Dr Jones produced the first edition in February 1992. It is a monthly 4 page A4 newsletter (one page of A3 paper folded once) with articles of general medical interest, plus reminders about preventive health measures such as pap smears, mammograms and immunisations. One segment – Good Health on the Menu – contains nutritional advice plus a recipe relevant to that month's topic.

Doctors need to:
- Show that they care
- Tell patients about themselves and the services they provide
- Make patients feel they 'belong'
- Improve their business

Areas on the front and back pages are left blank in the initial print run and then overprinted with information provided by the individual subscribing practice. Practices pay a fee which depends upon the number of copies required. The practice can change the content of its personalised section each month at no extra cost. The concept was promoted to GPs as a useful tool, benefitting both patients and doctors. Patients benefit from getting reliable information from a source they trust – their family doctor.

Doctors benefit because in the competitive small-business environment of Australian general practice, where patients are free to see GPs from any practice, patient loyalty is critical for financial survival. Patients appreciate their doctor doing that little-bit-extra to keep them informed and healthy.

The presentation demonstrated the often sensational, out-of-perspective, manner in

Using the newsletter:
1. Hand it to patients
2. Keep it topical
3. Include personal bits and pieces

which the popular media broadcasts medical information. This may lead to patients making unwise decisions such as stopping their medication through fear of highly publicised (although rare) side-effects.

Dr Jones reported on positive feedback from patients, including a lady in Victoria who had read an article about angina, recognised her symptoms, saw the GP and soon after had a triple coronary by-pass operation. She wrote and thanked her GP for "writing the article that saved my life".

He also emphasised the importance of doctors including some personal information in the practice-specific segment. This shows their human side, which patients like. When, in his own practice's newsletter, he advised readers that he would be away for a month, as he was going to the UK for his mother's 80th birthday, numerous patients got in touch to wish her well, despite never having met her.

Another tip was for doctors to keep the newsletter on their desk and personally hand it to patients saying "have you had this month's newsletter?" or similar, rather than leaving it among the piles of other help-yourself brochures in the waiting room. Research shows that people are more likely to read something when it is given to them personally by a doctor. Dr Jones told of a patient coming to the reception desk and saying "I don't need to see the doctor, but is this month's newsletter out yet?".

In 1994 the Australian government introduced an accreditation scheme for general practices. One of the criteria for accreditation was that the practice should have a patient-information brochure. 'Your Doctor' was approved as a suitable means of meeting that requirement.

The initiative has proved to be a great success. By the end of 2004 it had been used in over 700 Australian general practices, plus practices in New Zealand, Hong Kong and Fiji. The annual print run was about one million copies.

Original Abstract

Figure 1 The first edition of Your Doctor was produced in February 1992. My 2004 it had been used in more than 700 practices with an annual print run of almost one million copies.

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3 – Ethical Dilemmas in Family Medicine - a Workshop

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Background

At the WONCA Europe Conference 2000 in Vienna, Austria, the programme included a special symposium entitled "challenges to our professional attitudes- past and present". This full day symposium covered areas and time periods from the past to the present where the medical profession in general or individual colleagues have been or were involved in developments based on unique political situations: the Holocaust in Europe, the Apartheid in South Africa, torture of prisoners in areas of war or the death penalty in the United States. Experts and eyewitnesses of these developments gave stunning insight into the circumstances whereby physicians could get involved and sometimes were even eager to do so.

This symposium attracted a full auditorium and resulted in the founding of a Special Interest Group (SIG) on ethical issues in Family Medicine by WONCA. In 2002 the group gathered to formulate the terms of reference: "to attempt to illustrate the nature of ethical issues encountered by WONCA and its members and to explore the principles, values and beliefs which inform decisions". Thus, the aims of SIG were formulated:

1. To identify common principles of ethical dilemmas
2. To consider circumstances which favour the development of ethical dilemmas
3. To raise awareness about ways to solve some of these ethical dilemmas
4. To develop an instrument useful to assess professional attitudes

Since that time, the proceedings of the special symposium from WONCA Europe Vienna 2000 have been published (1); a list of interested colleagues has been established and the group has tried to identify Family Doctor's working groups on ethical issues around the globe. In addition, the group has reviewed the teaching situation for professional attitudes worldwide, has introduced a forum for discussion on ethical issues and tries to motivate colleagues to initiate similar activities in their associations or back in their home country. These activities are promoted at almost every WONCA Europe conference and all WONCA World conferences by organizing a workshop on "ethical dilemmas in FM" and a special symposium on "challenges to our professional attitudes" addressing selected topics such as inequalities in health, conflicts of interests, end of life care, electronic health records, etc.

So far, the activities of the group, which became a Working Party (2) at the WONCA World conference 2010, have attracted a very interested crowd - at times it has been difficult to accommodate all participants in the room provided!

The Workshop

In the workshop, practical situations involving regularly occurring ethical dilemmas in Family Medicine are presented

and their background and possible consequences for the patient, his/her family and the physician are discussed. Typically, the group work starts with short presentations by the workshop participants, demonstrating situations involving ethical dilemmas.

The participants then select 3-4 situations out of those presented, split into small groups and discuss the following issues:

1. The patient's history and other factors, which resulted in the development of the particular ethical problem presented
2. The possible consequences of the situation for the patient and the physician
3. Possible solutions
4. What are the basic ethical principles demonstrated and challenged by this situation?

The aim of this workshop is to increase awareness in ethical standards, attitudes and global differences in the legal context of clinical practice applicable to future medical graduates and Family Doctors. Here are a few examples of the difficult situations presented:

- Both a woman and her husband are patients with the same family doctor. The woman receives Diazepam for anxiety and depression due to metastatic breast cancer; her husband is in early retirement and in a consultation with his Family Doctor complains about his sleepiness. Previously, the woman told the Family Doctor that in the evening she puts some of her pills into her husband's wine so that he would not sexually approach her.

- A patient with a haemoglobin level of 2.4 refuses both diagnostic procedures and therapy suggested by his Family Doctor.

- A sixteen year old boy suffers from heavy injuries and tetraplegia after a car accident; it turns out that he had too much alcohol in his blood. His father requests the Family Doctor to delete this information from the medical record for reasons of disability insurance coverage.

- A 54 year old woman with diabetes and diabetic nephropathy needs kidney transplantation. According to the legal situation she is not entitled for a kidney transplant in her country. However, for a large fee, she is offered the kidney of a prisoner in China who is facing the death penalty. She approaches her Family Doctor for advice.

- An elderly lady first refuses diagnostic clarification and therapy of her hip fracture; a few days later she agrees with the suggestion by her Family Doctor to be treated in the hospital and dies there following surgery. The Family Doctor feels guilty.

- In a given country, influenza vaccination at the Family Doctor-level is obligatory for every citizen and those who refuse are punished with a 400 Euro fine; moreover, Family Doctors are legally obliged to report every patient who refuses to comply.

Among the questions quite often discussed and exchanged among participants are those related to the respective health care system, the respective legal framework, the needs and demands of patients in the country concerned, the expectations of patients and society, conflicts of interest, options for support and advice in these situations, the need for efficient communication, how to react in the particular situation, etc. Finally, the principles and responsibilities of medical professionalism (3) such as the principle of respect of patients´ autonomy, priority of patients' welfare and of promoting social justice and equity are identified and their value and possible discrepancies in political or market reality are discussed. Despite these principles and guidelines however, the family doctor is more often than not alone in his/her decision regarding an individual situation.

The WP on ethical issues in FM plans to raise awareness of the importance of professional attitudes at every level of medical education and training and supports the idea to establish Family Medicine as the leading discipline in teaching medical ethics/professional attitudes to students and colleagues.

This will be accomplished through promoting widespread dialogue within the profession, initiating and supporting research and disseminating information throughout the WONCA community, the international academic community, healthcare organisations and government agencies.

Take Home Messages

The WP workshops on Ethics described aims to:

- identify common principles of ethical dilemmas as they occur in daily practice
- discuss circumstances which favour their development
- to raise awareness about ways to solve and prevent some of these ethical dilemmas

Original Abstract

http://www.woncaeurope.org/content/192-ethical-dilemmas-general-practice-workshop

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4 – Health Consequences of Emotional, Physical, and Sexual Abuse

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Abuse is widespread across all ethnic, cultural, and socio-economic groups. In the US population, 30 - 40% of adults report some type of abuse during childhood. Different forms of abuse often co-occur. Rates of abuse in other countries are variable, but comparable. Clinicians who believe abuse does not occur in their patients are just not looking for it.

Childhood Abuse – Mental Health Impact

A history of childhood abuse correlates strongly with mental health symptoms. A dose-response effect exists between multiple types and severity of abuse with magnitude of symptoms, and number of diagnoses. Post-traumatic stress disorder (PTSD) is extremely common in victims of abuse; symptoms may persist for years. Complex PTSD in response to multiple severe traumas combines prolonged symptoms of PTSD with those of other psychological conditions. Anxiety disorders, various eating disorders, and repeated episodes of major depression are common sequelae. Survivors also suffer from difficulty with relationships and trust, long-standing shame and guilt, poor self-esteem, and anger. Dissociative identity disorder is also a potential outcome when a young child experiences multiple severe abusive episodes for which adult memories may be elusive. In this condition, a more complex walling off of memories of abuse allows the person to develop more normally, free from memories of the abuse, although the boundaries between memories often start breaking down later in life. While controversial, the syndrome clearly exists and is more common than generally recognized.

Long Term Physical Health Effects of Sexual and Physical Violence

Abuse survivors commonly experience multiple physical symptoms, especially abdominal and pelvic pain, genitourinary symptoms, fatigue, and headaches. Although medical conditions may explain some symptoms, many remain unexplained despite extensive evaluations. Whenever studied, women with unexplained symptoms often give a history of childhood and/or adulthood physical and sexual abuse, and women with sexual symptoms are likely to have a history of sexual abuse or assault.

The Adverse Childhood Exposure Study found that adverse childhood experiences (including physical and sexual abuse and witnessing abuse of a parent) were strongly interrelated and that the number of categories of adverse exposures had a graded relationship to later adult diseases, including ischaemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. Diseases associated with four or more categories of exposures included ischaemic heart disease (OR=2.2), cancer (OR=1.9), stroke (OR=2.4), COPD (OR=3.9), diabetes (OR=1.6), fracture (OR=1.6), and hepatitis or jaundice (OR=2.4).

Application of the strictly medical model to abuse survivors with chronic abdominal and/or pelvic pain, gastrointestinal symptoms, and dyspareunia may lead to multiple investigations and surgeries. Such painful, costly, and often re-victimizing interventions can lead to complications, including adhesions and more chronic pain. Since previously abused women are more likely to be overweight, smoke, drink, use drugs, engage in risky sexual behaviours, and not get pap smears, they also are more prone to sexually transmitted disease, HIV/AIDS, unintended pregnancies, and various chronic diseases. Violence tends to perpetuate itself with repeating patterns in subsequent generations. Mothers with childhood or adult abuse experiences may be less able to protect their daughters from an abuser. Helping patients to break such patterns is challenging, and most physicians are not trained, skilled, or comfortable in identifying and assisting with survivors of abuse.

Identification and Management

Victims of abuse seldom volunteer information about their abuse to clinicians but are generally willing to talk about their abuse histories when asked directly. Building trust before asking questions will enable patients to disclose abuse, even on a first visit, if asked in an appropriate manner. Using the "generalized other" technique can facilitate the inquiry, i.e., "Many of my patients have been threatened or hurt by others, as children or adults. Did anything like this ever happen to you?" If the patient answers yes, establishing safety for the patient and any children still vulnerable to the abuser is crucial. Another approach is to ask about abuse as part of the standard review of systems or as part of family history. Asking about a family history of alcohol and drug abuse can lead easily into questions about physical abuse of the patient and family members, followed by a question about sexual abuse. A subsequent question might be, "Since then has anyone ever tried to or made you have sex when you didn't want to?" Another screening strategy is to ask the patient about to disrobe, "Is any part of this exam difficult for you?" - enabling disclosure before the vulnerability of being undressed.

Clinicians should ask these questions when they have time to listen and respond appropriately. When adequate time is not immediately available, the clinician should schedule early follow-up, indicating the importance of prior abuse to the patient's medical care. Empathy is critical. The clinician must state that the abuse was not the patient's fault and should never have happened. Discussing abuse with a supportive clinician can be very therapeutic, but referral to counselling with a therapist skilled with abuse survivors is often the best approach when the patient is ready. In the meantime, the clinician should explore how the patient would feel most safe and comfortable receiving medical care.

Clinicians need to consider the abuse history in the patient's ongoing management, allowing survivors control over the timing and conduct of referrals and investigations. A complex, necessary task is helping survivors make the connection between the abuse and their physical and emotional problems, while not implying that symptoms are "all in their head." Another task is acknowledging how ordinary health care can be frightening for abuse survivors; that exams and procedures considered part of routine care can easily re-traumatize them. Careful explanations and explicit consent for each aspect of disrobing and touch are critical. Because betrayal of trust is often a key source of trauma for abuse survivors, clinicians must continuously demonstrate honesty and trustworthiness for these clinical relationships to succeed. Giving patients control through attention to safety, and always allowing the patient accompaniment by a chosen safe person can facilitate the conduct of necessary and potentially empowering health care.

Take Home messages

- Abuse survivors commonly experience physical and psychological symptoms and syndromes.
- The only way to find out if a patient has been abused is to ask.
- Always affirm that the abuse was not the patient's fault and should never have happened.
- Recognize that ordinary health care can be frightening for abuse survivors.
- Allow patients the maximum possible safety and control.

Original abstract

http://www.woncaeurope.org/content/4376-health-consequences-emotional-physical-and-sexual-abuse

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5 – The Role of Family Medicine in Undergraduate Medical Education

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Introduction

General practice / family medicine (GP/FM) is defined as "an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical speciality orientated to primary care". Although primary care is widely perceived to be the backbone of a rational health services system, medical education is widely based on disciplines other than family medicine. There is a discrepancy between the place of practice of medical graduates and the place where medical education is based: despite nearly 60% of the medical graduates being employed there, only less than 10% of the training happens in primary care facilities (Figure 1).
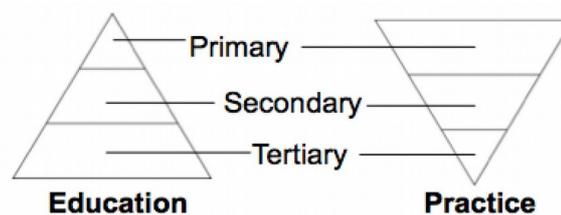
Figure 1: The mismatch in the balance between education and practice platforms.

Aim

The aim of this paper is to describe the potential contribution of family medicine/general practice to undergraduate medical education (UME).

The Past: During the early days of the discipline, it was discussed and suggested that family medicine should contribute to UME. However, it was not an easy task. There were even arguments that general practice is not 'scientific'. In Turkey, we had to wait more than another 20 years to see family medicine engaged in UME: in 2001 there were only seven actively lecturing family practice departments throughout 47 medical faculties (15%). That same year, Trakya University commenced UME of class one medical students with objectives such as "to teach the principles of primary healthcare, and basic procedures used in medical practice".

The Present: Over time, the contribution of family medicine to UME increased significantly. The discipline improved in all areas including service provision, management, research, and educational content. Today, almost 90% of European universities have GP/FM curriculum, the duration of clinical rotations ranging from 1 to 12 weeks. In Turkey 55/83 medical schools (66%) have a GP/FM curriculum.

Some of the authors of this article joined a one-day workshop (http://www.ktu.edu.tr/dosyalar/17_02_15_769b1.pdf) where participants presented

a literature review on the curricula of different schools. A summary of the suggested family medicine content was presented at the end of the workshop. As a result, the authors suggested family medicine should be taught during all three years of the pre-clinical phase in the six-year medical education as well as throughout the internship period (Table 1).

Table 1. Topics suggested to teach for undergraduate medical education.

Lecture name	Topics
Basics of family medicine 1	1. Clinical case presentation 1 2. Primary care medicine 1 3. Internationalization 4. Continuous professional development 5. Time management 6. The effects of family on health 7. The family life cycle 8. Genograms 1 9. Quality in health care 10. Basic quality improvement tools 11. Observation of hospital departments 12. Effective communication and body language 1 13. Definition and basic features of family medicine 14. Oral health 1 15. Humanities in medicine 16. Science philosophy
Basics of family medicine 2	1. Primary care medicine 2 2. Morbidity patterns in family medicine 3. Genograms 2 4. Clinical case presentation 2 5. Contextual care 6. Comprehensive care 7. Continuous care 8. Coordination of care 9. Access to care 10. Effective communication and body language 2 11. Patient empowerment 12. Patient adherence 13. Medical malpractice 1 14. Home accidents 15. Professionalism 16. Behavioural change 1 17. First contact with the hospitalized patient
Clinical family medicine	1. The biopsychosocial approach 2. Consultation and referral 3. Effective communication and body language 3 4. Patient education

	5. Behavioural change 3
	6. Adolescent health
	7. Care of the elderly
	8. Simulation of common health problems
	9. Health life styles counselling 1
	10. Breaking bad news
	11. Periodic health care
	12. Periodic health care guidelines
	13. Integrative medicine 1
	14. Domestic violence
	15. Pre-conceptional care
	16. Pregnancy follow up in family practice
	17. Healthy child follow up in family practice
	18. Social responsibility projects
	19. Care of the disabled person
	20. Equity in health care
	21. Patient interview and clinical examination
Family practice application	1. Medical records
	2. Medical malpractice 2
	3. Legal responsibilities of the health personnel
	4. Forensic medicine services in family practice
	5. Sick leave in family practice
	6. Low prevalence medicine
	7. Evidence based medicine
	8. Coding in medicine
	9. Health life styles counselling 2
	10. Integrative medicine 2
	11. Management of co-morbid conditions
	12. Polypharmacy
	13. Medical literature review and guidelines
	14. Laboratory use in family practice
	15. Obesity follow up
	16. Home visits and home care
	17. Pregnancy follow up in family practice
	18. Rational prescription
	19. ECG reading in family practice
	20. Direct chest X-rays in family practice
	21. Oral health 2
	22. Rural medicine
	23. Family practice in extraordinary conditions and disaster medicine
	24. Payment systems, insurance organizations and family practice
	25. Community oriented family practice
	26. Community based medical education
	27. Duties of family physicians and family practice management

Conclusion

UME curriculum should be composed of topics predominantly related to primary and thus preventive health care services. However, it takes time for this fact to become a reality in its application within the UME. Over the last 40 years, there has been an extended gap in the discipline, and the recent developments and improvements are promising for the future. We believe that the WONCA working parties (http://www.globalfamilydoctor.com/groups.aspx) have contributed much to this success. Of special value are the activities of EURACT (www.euract.eu/) and EGPRN (www.egprn.org). Improvements are especially remarkable in the number of academic departments and staff. However, most of the contributions so far are via lecturing and interactive teaching inside the medical school facilities. Family medicine is a comparatively new medical speciality, but it is probably the oldest medical discipline. Hence, there is still a long way to go to involve clinical family practice in UME.

Take Home Messages

- Although most medical graduates practice in primary care, most of the training is based in hospital settings.
- Even in the earliest documents of family medicine it was suggested that family medicine should be included in undergraduate medical education.
- Today almost 90% of European universities have a GP / FM curriculum, the duration of clinical rotations ranging from 1-12 weeks.
- Being a relatively new medical speciality, but probably the oldest medical discipline, family medicine should play a much greater part in undergraduate medical education.
- We suggest family medicine play a part in all preclinical phases plus the internship period of the undergraduate medical education.

Original Abstract

http://www.woncaeurope.org/content/63-role-family-practice-undergraduate-medical-education-experiences-trakya-university

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6 – Developing National Curricula for the Education and Training of Family Doctors

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As a GP trainee, I sometimes feel like an endangered species. Many of my peers from medical school have chosen hospital specialties, and non-medical friends find it hard to understand that I have chosen to be '*just a GP'*. Across Europe the proportion of doctors who train as specialists is rising (1). In the press General Practitioners face regular denigration, even from some specialist colleagues in hospital who have warned that '*GPs are part of the NHS's problem, not the solution*' (2). Yet the evidence suggests the opposite, that countries with strong primary care infrastructures have healthier populations, reduced health inequalities and greater cost-effectiveness (Starfield et al 2005). As a result, in 2008 Iona Health called for '*A GP for every person in the world'* (3, 4). Yet before this can be achieved we need high quality general practice training schemes for every country in the world.

Currently, even in Europe, general practice training varies considerably, and not all countries require a qualification in family medicine to work as a family doctor (4). In order to achieve improved training in family medicine for all, we should be looking at what already works, in countries with well-established training, using an evidence-based approach.

WONCA provides an ideal forum for sharing innovation, knowledge and experience and at the annual Vasco da Gama preconference for new and future GPs, the topic of training is regularly discussed. Enthusiasts debate the relative merits and disadvantages of their countries' training systems, highlighting areas for improvement. How can this shared learning and communal knowledge be captured, drawn out and used to benefit training throughout and beyond Europe?

Various initiatives to compare training schemes in Europe have grown already from WONCA conferences. One initiative from EURACT was to develop a dynamic interactive database with information enabling comparisons between training schemes throughout Europe (2). Another approach which grew from the grassroot enthusiasm of trainees themselves was to create a motivation and satisfaction questionnaire, with the aim of exploring differences in motivation, satisfaction and workload across these very different vocational training schemes of Europe (5). Results showed high levels of satisfaction amongst family medicine trainees, and demonstrated that 'positive' motivators such as 'challenging medically broad discipline' are the main reasons for a career choice in family medicine. 'Negative' motivators such as 'it remained after I ruled out other options', 'non availability of another specialty training' and 'did not get specialty training because of my grades' were chosen by a minority, challenging some negative preconceptions of family medicine.

Other more formal work arising from WONCA Europe has been highly influential in the development of family medicine training, such as the European Definition of Family Medicine (5), which describes the core competencies of family doctors. This

has been used in negotiations with policymakers, educators, media and physicians, and formed the basis of national family practice curricula such as the UK Royal College of General Practitioners GP curriculum. Following on from this, more recently the WONCA Working Party on Education has produced WONCA global standards for postgraduate family medicine education (6), which will provide further thrust to drive quality improvement, new program development and recognition of family medicine training globally.

However there is a balance and equipoise to be reached in the efforts to develop global standards and curricula, which need to be comprehensive enough to be relevant to all family doctors, without producing overly burdensome bureaucracy, which may hinder rather than help learning.

So what about Alternative Blue Sky Thinking, to Help the Development of Family Medicine Training?

A thought experiment by Bernard Lietaer, a professor of economics, might suggest an option (8). The slogan would then be "*to master your topic, you should teach it*". This means that everybody becomes a student as well as a teacher, an apprenticeship model running right through from graduation to retirement. At entry to family medicine specialty training (after 6+ years of basic medical education) every doctor would be given a sum of 1000 Sabers. For 1 Saber you can buy one hour of teaching or coaching by an elder colleague. The elder colleague can only get Sabers by teaching or coaching. After 3 years, the time of getting a Master degree, there is an appraisal by a senior assessor. If you can pass this appraisal and demonstrate that you have earned 1000 Saber, you are rewarded with time and money. You get a sabbatical leave of 3 months and the money you would normally get in those 3 months. An extra free month a year. Every year.

If it seems hard to imagine how this could be implemented in countries with well established training then imagine how this sort of cascade effect might be beneficial in countries without well established family medicine training in place. In these countries an educational voucher system could set in motion a 'learning multiplier', providing educational opportunities despite a lack of available funds for formal teaching. The incentive of extra money and sabbaticals could help recruit and retain doctors in countries where family medicine can be seen as 'low prestige' and where there is often a significant 'brain drain' of qualified medical staff to other countries.

Perhaps another way of thinking of it is that this is just a modified version of the cascade of learning which already happens each time a group of family doctors is brought together. As Margaret Mead famously said:

> *Never underestimate the power of a few committed people to change the world.*
> *Indeed it is the only thing that ever has.*

This cascade of learning is hard to quantify but is something which is felt by family doctors each time they attend a WONCA or Vasco da Gama conference and meet with a group of committed and inspired family doctors who share their visions and goals. The ripples from this learning cascade back as ideas and innovations which are applied in the home countries of doctors all over Europe and beyond.

Take Home Messages

- In order to achieve a 'GP for every person in the world', we need family medicine training in every country in the world.
- WONCA initiatives and collaborations can help drive development of national curricula.
- Thought experiments can help us think outside the box.
- Never underestimate the power of a few committed people.

Thank You

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Original Abstract

http://www.woncaeurope.org/content/3553-developing-national-curriculum-education-and-training-general-practitioners-united

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7 – Transient Illnesses

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Within the context of mental illnesses, Ian Hacking talks about 'transient illnesses', in that certain illnesses are typical for certain eras. (Hacking, 1998). By this, he does not state that an era determines its illnesses and therefore illnesses can be reduced to it; instead, he analyses why certain illnesses are more prevalent in certain eras than in others. ADHD, depression or bipolar disorder for instance, are diseases of our era.

One can ask why we are limiting ourselves to mental illness? Obesity can also be described as a 'transient illness': it is a basic characteristic of our era, far more than it was before. Obesity is particularly a problem of contemporary society. Everywhere in city streets, you can drink coke or eat burgers and all of us are on a daily basis faced with a battery of advertisements, influences which can hardly be overestimated. Listen to the radio, watch television or walk on the streets: we all are bombarded with advertisements appealing us to enjoy our life via the consumption of food and beverages. (Minkler, 1999)

The concept of transient illnesses opens up the forum for discussion on health and illness in today's society. When discussing so called lifestyle diseases, many people consider individuals responsible for their health condition and people are even blamed for being sick (Wikler, 1987, 2002). Consequently, in many countries the pursuit of a healthy lifestyle has or is expected to become a criterion in the allocation of healthcare services. One of the crucial questions is what the consequences of this evolution would be for health care policy, for individuals and for society in general? If we consider individuals as autonomous and regard the way they live as largely a matter of their own free choice, it seems 'logical' to hold patients personally responsible for making (un)healthy life style choices when they try to obtain insurance or enter healthcare facilities. And if the individuals are unwilling to change their risky behaviour, could they then also be denied health care services? In short, the discussion about lifestyle also concerns responsibility and the amount of control that others should be allowed to exercise over an individual's choice for a particular way of living. Critics of paternalism talk about control and tyranny, while defenders point out the importance of public interest. (Cosner Jr, 2008)

The idea of transient illness has the potential to make a breakthrough in this debate and can be of help to general practitioners in facing patients with lifestyle diseases. It explains why people, at the very moment they make autonomous decisions, decide for things which are obviously analogous to the main characteristics of society, i.e. enjoyment of your personal life, putting your desires first, etc. Despite the fact we are often very aware of the possible consequences of our decisions for our health, a lot of us keep on making unhealthy choices – it is for instance hard to say we are not informed about the dangers of smoking and yet many people continue smoking (Devisch I & Dierckx, 2009).

Can we blame these people for making choices which result in consequences they have not opted for? Of course people are responsible, but societies do 'produce' illnesses as well. An old 'Marxist'

thesis would argue that the 'system' is responsible for everything. However, it is not that our choices are determined solely by social circumstances; it is not because our particular social context offers us fewer opportunities for physical activity that we are destined to live our life as obese. In as much as we should stop 'blaming the patient' because of his risk behaviour, we cannot simply shift the responsibility of the individual's lifestyle to society.

Therefore, we suggest the counter-intuitive thesis: there are aspects of our behaviour for which no one is responsible. By this we mean that many of our choices are developed as a strategy for living our lives or – similarly to what Carl Elliott writes about in his 'A Philosophical Disease. Bioethics, Culture and Identity' – "the result of cultural factors beyond our reach"(Elliott, 1999). As long as lifestyle is considered to be based solely on independent, conscious and deliberate choices, be they taken individually or collectively, we will never solve the question of why people are 'choosing' one thing or refusing another.

Beginning with the idea of transient illness, people should be viewed in a societal context which makes their individual freedom and choices a relative and not an absolute matter. To be free is more a question of 'are the terms of the choice' fair? If the available alternatives to a healthy choice are less attractive than they can/should be, maybe the terms of the unhealthy choice are unfair. For example, working in a coal mine; you know it is risky, but sometimes, there is no alternative. These people need to be protected, not punished.

Take Home Message

- General practitioners should be fully aware of the idea of transient illnesses and make use of it in supporting patients struggling with lifestyle diseases. Rather than blaming the victim, people deserve support and understanding for the context in which they live and the choices stemming from it.

Original Abstract

http://www.woncaeurope.org/content/36-theory-general-practice-concepts-illness-and-paradigm-general-practice

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8 – Cooperation Across the Interface of Primary and Secondary Care

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Battle Zone

Starting with a citation: "cultural interfaces are said to be like battle zones between the fronts of two armies facing each other: the situation creates uncertainty and fear, there are no rules, the one part trying to impose power to suppress the other part" (1).

The primary secondary care interface is a clearly defined demarcation zone, and it has changed very little during the last 20 years. It is similar in different European countries (2). The patient seems too often to be caught in a "no mans-land" where they suffer from care fragmentation, not knowing what to do, what is to happen next, or who is coordinating (3). These days, the patient has become more like a consumer and customer, a tendency that is boosted by social media spreading messages about which services to demand. Competition is turning health care services into suppliers of health care in a market, and the family doctors find themselves often in an unexpected role to shop secondary care services for their patients, based on expectations or needs. Increase of cost in health care is by many attributed to inappropriate use of care at the interface (4).

Different Cultures

Primary care and secondary care represent different cultures, and their interface represents the biggest hindrance for smooth care processes in modern health care systems (5). One important reason is fragmentation of secondary care as result of higher professional specialization, technology and focus on pathology, with the risk that persons are more often seen as organs or diagnoses than individuals. At the same time, family doctors struggle to keep a broad and patient-centred perspective in a jungle of new knowledge, patients' increasing expectations and demands while coordinating complex diagnostics and treatment. Iona Heath has described the basis for these differences in an eloquent way: "In family medicine, patients stay and diseases come and go. In hospitals, diseases stay and patients come and go".

Working in separate medical realities may diminish understanding and even respect for the concerns of others. To be able to smooth patient journeys, professionals themselves must cross the interface to learn about the other side, share perspectives and seek mutual understanding and goals. However, little effort has still been devoted to bringing professional groups together to enable them to understand that their work is complementary with that of others in a single healthcare system. The probably best approach so far is a Danish model where family doctors act as advisers in hospitals (6).

Improving interface problems has gradually caught the interest of professionals and leaders of health care (7). We all agree that seamless care is an important goal for

quality improvement, but when it comes to broaden our perspectives and changing behaviour, we resist and regress.

Important Perspectives

Four important perspectives of the quality of care at the primary/secondary care interface:

1. The system perspective: A system approach to better co-ordinated care implies that we should understand and discuss division of tasks across boundaries within the health care system. This can improve process-flow, reduce waste of resources and diminish patient risk.

2. Perspective of medical quality: Patients must be given an interpretation of symptoms and findings within a holistic framework where biological, psychological and social aspects of health care are considered and weighted. They have the right to make choices for diagnostics and intervention (8). To achieve this, the professionals must cooperate. The alternative is obsolete: fragmented and uncoordinated care resulting in poly-investigations, poly-interventions and poly-pharmacy.

3. Patient perspective: Patients expect coordinated chains of investigation, treatment and follow up. It is important that professionals and leaders use patients' experiences to improve quality of care on a systematic basis. Understanding patient perspective is an assumption for narrowing the "expectation gap", where needs and expectations clash with offers.

4. Provider perspective: Modern health care systems are complex with multiprofessional providers. There needs to be capacity within the system to prevent and settle conflicts between specialities and professions. Competition should give way to mutual understanding of roles and skills.

Targets for Change

Based on complexity and perspectives, in 2001 the EQuiP listed ten targets for quality improvement of the interface (2). They are still valid.

*   Develop leadership with a defined responsibility for improving the interface
*   Develop a shared care approach for patients treated in both primary and secondary care
*   Create consensus on explicit task division and job sharing
*   Develop guidelines that describe quality problems at the interface and seek solutions to such problems
*   Develop an interface that contains the patient perspective
*   Develop systems for appropriate information exchange to and from family medicine care
*   Reinforce interface improvement through education
*   Facilitate team building across the interface
*   Establish quality monitoring systems at the interface
*   Establish a broad understanding of the need for cost effectiveness at the interface

The work required in different countries must be based on national needs, resources and priorities. Improvement of leadership is probably the most important target. So is bringing family doctors and specialists together to develop personal and group relations and understanding. Bridging the expectation gap by informing and empowering patients will also be a strong drive to improve communication and cooperation across the interface. The ten targets can help redesign health care systems in order to deliver care that is perceived by patients as seamless.

Working towards these targets can help leaders to make care systems work as a whole. In Norwegian hospitals there is a new trend assigning family doctors with public health experience to the leadership. The Danish model for family doctors as advisers in hospitals is a multi-potential method to promote cooperation (6). Studies of patients' expectations and experiences can help professionals to act in accordance with guidelines for medical practice and cooperation.

Improving care across the interface is a continuous process that must be based on principles for quality improvement. Shared perspectives and common goals can lead to behavioural and system change. Both carrots and sticks are needed to accomplish the task.

Take Home Messages

- The interface primary/secondary care represents major obstacles for seamless care
- The culture gap between primary and secondary care needs closing by sharing perspectives and goals
- The subject must be addressed both by leaders, family doctors and specialists
- Improving care across the interface must be based on principles for quality improvement
- Patient experiences must be monitored and listened to

Original Abstract

http://www.woncaeurope.org/content/24-interface-between-primary-and-secondary-care-continuity-shared-care

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9 – Complexity and Primary Care

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Complexity comes from the Latin word complexus; com- "together" and plectere "to weave" or "braid". By studying complexity, we aim to understand how things are connected, and how these interactions relate to one another.

Complexity also entails a particular way of thinking, a change in world view, away from understanding the whole based on knowledge of its individual parts towards an appreciation that the parts exhibit different properties to those they display in the context of the whole. In complex science lingo; the whole is different and more than the sum of its parts (Fig. 1). Furthermore, the behaviour of system components varies depending on context; changing context may result in "unexpected" changes in the component's and therefore the system's behaviour [1].
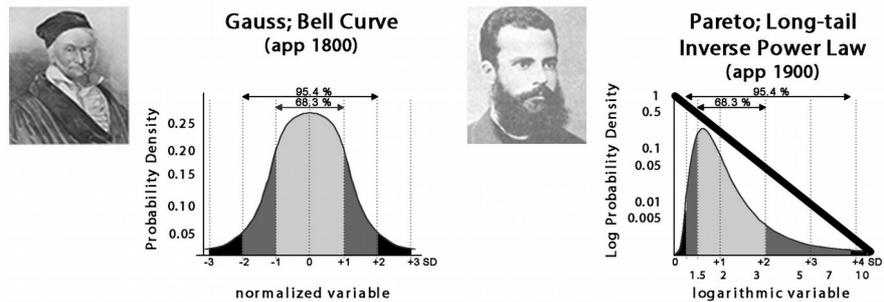
Fig 1: Gauss and Pareto distributions, the basis that define the key differences between simple and complex world views. Note: the long-tail frequency distribution and its log-log equivalent are superimposed – modified from West. (2010) Homeostasis and Gauss Statistics: barriers to understanding natural variability. J Eval Clin Pract. 16(3):403–8)

Complex systems consist of many different parts (agents) contained within a boundary separating it from other systems. Hence every system is part of a supra-system and itself contains many sub-systems. Systems have permeable boundaries, providing output and receiving input from their external environment. A system's agents are interconnected, interacting in multiple ways; each agent influencing others and in turn being influenced by

their responses resulting in feedback which gives the system its unique non-linear behaviour. Most importantly, systems behaviour is non-deterministic, its behaviour will change in major ways with even the smallest change in its agents' initial condition (or starting value) (Fig. 2) [2].
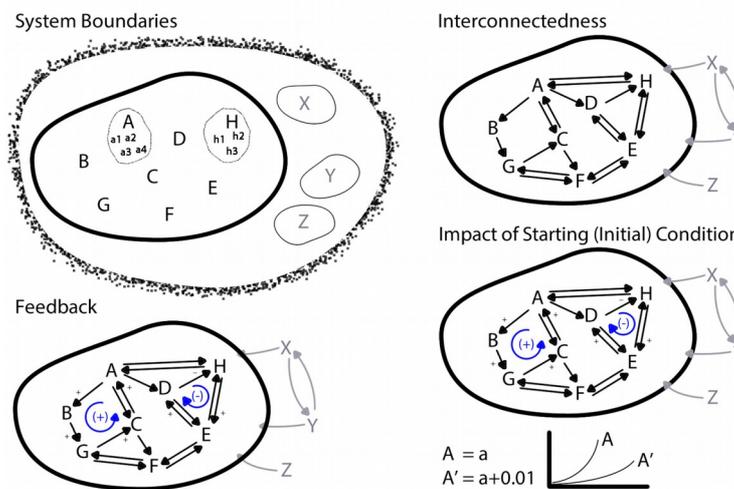
Fig 2: Complex systems and their core characteristics: the boundaries of a system and its supra- and sub-system context (top left), interconnectedness of agents (top right) resulting in feedback (bottom left), and the impact of initial condition (or starting value) on its behaviour (bottom right)

Primary care exhibits all the characteristics of a complex (adaptive) system [3, 4]. Structurally, primary care is part of the wider healthcare system; its agents are members of the community and various health professions. Each agent within the primary care system consists of members of its respective craft group. Important agents outside the primary care system, like teachers, public services, employers etc., receive outputs and provide inputs to the primary care system. Dependent on the size and the number of agents involved, their interactions lead to unique behaviours, and the behaviour can vary markedly between various local settings, no more so than in light of the socio-economic conditions of the local area.

How can you implement complexity thinking into problem solving in primary care? The following examples illustrate and explain some system and system-dynamic approaches for everyday practice.

Most frequency distributions in nature show long tail or non-linear (log-log normal, power law, 80:20 split or Pareto) distributions. Health in the community has long been known to be distributed that way – most people are healthy most of the time, and most people with a health concern have conditions amenable to primary care treatments. Only 3.2% of the community require secondary and 0.8% tertiary care. Many physiological parameters, like blood pressure, cholesterol and BMI, show non-linear distributions. These distributions highlight the gross over-classification of patients as abnormal, not only mathematically but also pragmatically. Physiological variables operate within a homoeostatic range, i.e. they show threshold behaviour in regards to outcomes, like blood pressure in relation to morbidity or income to life-expectancy [5].

Multiple cause diagrams provide a means to fully appreciate the dynamic changes underpinning a person's illness trajectory as illustrated by John, a patient with multiple problems known by any primary care provider anywhere in the world (Fig. 3). Changing disease-specific parameters more often than not result from influences of factors distant to the disease processes (the "real reason" for the deterioration of disease markers). Failing to see the whole picture easily results in unnecessary and/or inappropriate management, overlooks the patient's real needs and results in less than the best possible health outcomes [6].

In primary care, multiple agents interact with people with usually multiple, less-defined illnesses that typically exhibit more unpredictable dynamics and outcomes, i.e. they deal with greater complexity. In situations of high complexity health professionals have to rely on improvisation, using multiple different approaches to adapt to seemingly "similar problems" in a patient at different points in time, or different patients or patients in different environments. Katerndahl demonstrated that primary care physicians deal with far greater complexity and greater uncertainty compared to focused physicians like cardiologists and psychiatrists. Not surprisingly working in a more complex environment creates greater stress and is associated with a higher error rate, both being outcomes of the system's dynamics [7].
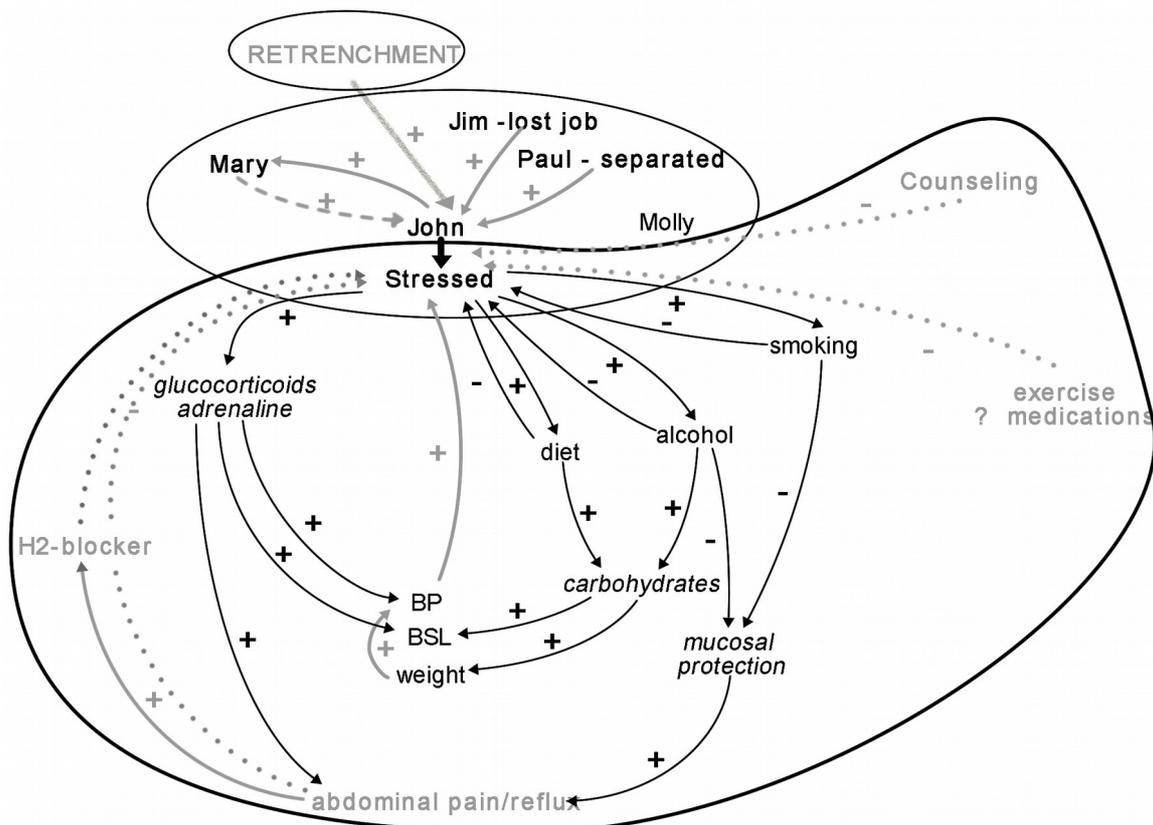
Fig 3: Multiple cause diagram of patient with multimorbidity – the multiple cause diagram shows that John is part of at least three subsystems. John's central problem is stress. His retrenchment, marital problems and worries about his sons all increase his stress and stress response. The causal loops are self explanatory from their physiological and pharmacotherapeutic perspective. Of note are the synergistic effects caused by the input of multiple variables, e.g. increased alcohol consumption and smoking both cause a decrease in mucosal protection which in turn increase ulcer/reflux symptoms and stress (Sturmberg. (2007) Systems and complexity thinking in general practice. Part 1 - clinical application. Aust Fam Physician 36(3):170-173)

The whole health system can be understood by the healthcare vortex metaphor which visualises the interconnectedness of all agents at the various organisational levels of health care. The metaphor highlights a core feature of complex adaptive systems; its interconnected function depends on sharing a common value or focus that in turn generates common simple rules to operationalise each agent's behaviour. This model creates a space in which primary care can lead the discourse for healthcare reform that meets all the various needs for which people require the help of a health professionals (Fig 4) [4].

To succeed in primary care we have to acknowledge and embrace its underlying complexities and uncertainties. There are now a variety of accessible tools that can help us to better cope, learn and act. Using these tools is of paramount importance as they help to overcome our brain's limited capacity to simultaneously process more than a few things (on average 7 ± 2) at a time, to easily detect connections between seemingly unconnected objects or facts, and to easily anticipate – especially nonlinear – behaviours more than a step or two ahead. Acknowledging our limitations in dealing with complexity can easily be compensated for by adopting the science's foundations and tools; it will make us better problem solvers and decision makers [8].

Systems and complexity-orientated primary care offers patient-centred, individualised, health-focused healthcare that integrates the best solutions with regard to each person's needs.
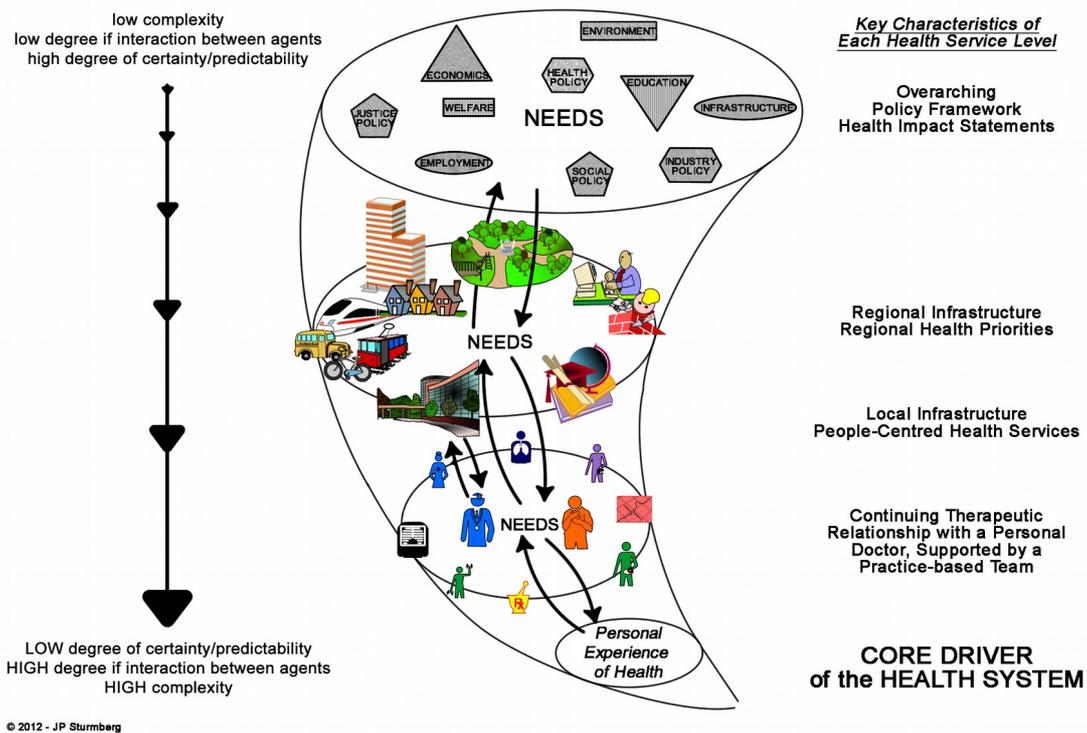
Fig 4: The health vortex as a metaphor for the health system. Note the changes between certainty and complexity at the various levels within the health vortex.

Take Home Messages

- Complexity and uncertainty are core characteristics of primary care
- Variables in "living systems" have non-linear (long-tail) distributions
- Small changes in a single system variable can result in largely divergent system behaviours
- Applying system tools helps to understand complex problems and guides the development of solutions
- Simple rules arising from a shared common focus (value) provide the operating principle for all system agents

Original Abstract

http://www.woncaeurope.org/content/56-complexity-and-primary-care

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10 – Motivational Interviewing in Family Medicine

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"People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the minds of others."

Blaise Pascal

When we, as family doctors, have to deal with physical ailments, we can offer explanations, good advice and healing treatments and, for the most part, there is a successful outcome for the patients. However, we are often faced with more challenging situations. When the issue relates to dangerous behaviour, such as smoking, alcohol abuse, drug abuse, excessive eating, lack of exercise, not adhering to prescribed treatments etc., we can be faced with a resistance to our best efforts at advice and treatment - where people continue to behave in self-defeating ways.
In this situation, our helper role often proves ineffective: when we have given our best advice and stressed the importance of a change in behaviour, we are often left with the frustrating feeling of failure.

Patients can react in unexpected ways. They sometimes resist our advice and, indeed, argue against it. They can get angry and defensive, thus provoking feelings of frustration in us. We may even think that he/she "has bad will or is too silly to follow our advice".

Motivational Interviewing (MI) was developed more than 30 years ago in the setting of alcohol dependence treatments. The approach to counselling advocates is particularly relevant in the above context (2).
We doctors are trained to use what can be called the "Deficit Model" which implies that "my patient lacks something (insight, information, understanding) and my role is to give him what is missing. The word "docere (to teach)" which is the origin of "doctor" is the basis for this "deficit model".

In MI the approach is different and has to do with "E-ducere (to draw out)". That means search and draw out what is already present which includes what the patient himself may know. With this approach, the doctor and the patient search together, for a solution. Instead of focusing on the failings of the patient (which may be important) we focus on his/her resources, possibilities, wishes, hopes, strengths and capacity to change.

Our efforts are twofold

- First, we encourage our patient to find arguments himself/herself, in favour of change.
- Second, we listen carefully to every element of "change talk" the patient expresses, we support his/her ideas for change and help develop them into a strategy that he/she will be able to apply.
  Ambivalence about the problematic behaviour is the starting point for MI

intervention. Possibly, our first goal is to reveal this ambivalence. To get to understand the specific nature of our

patient's ambivalence, we need to avoid a directional and "expert" driven style. Instead, we should adopt an empathetic, reflective, listening style in order to communicate understanding of the patient's inner world of conflicts.

Reflective listening involves the following skills:

- Using Open Questions.
- Making reflections aloud to show empathy and to test whether we have understood what the patient meant.
- Affirming the strengths and qualities of the patient.
- Summarising to check that both doctor and patient have the same understanding of what has been said and/or agreed.

Studies show that these skills are easy to understand, but difficult to use in a fluid and easy manner during a consultation. Like the game of tennis - easy to understand, but not so easy to master well! A lot of training and supervision is necessary (3).

The Spirit of MI, is defined essentially by our will to collaborate with the patient and activate his/her own expertise. It means Unconditional Acceptance, Empathetic Reflection and support for the patient's Autonomy and this can be summed up as: "I'm here to help but it's up to you to decide where to go and what to do".

An important element of Acceptance is affirming the qualities and strengths we can observe in our patient. This is linked to Compassion which is another important element of the spirit of MI and implies "I want the best for my patient".

MI usually starts with Engaging: "Do I understand this person's perspective and concerns? "How comfortable is this person in talking to me?" This is followed by Focusing which is to look for the "goals for change" and questions "Are we working together with a common purpose?" "Does this feel more like dancing or wrestling?"

Next comes Evocation which means: "What are this person's own reasons for change? Is his/her reluctance more about confidence or the importance of change? What change talk am I hearing? Am I steering too far or too fast in a particular direction? Is the reflex "to be right" making me the one to be arguing for change?"

The last element is Planning which takes in: "What would be a reasonable next step toward change? What would help this person to move forward? Am I retaining a sense of quiet curiosity about what will work best for this person?" (1 - p.311).

MI is described as a style of being with people, an integration of particular skills to foster motivation for change. It is essentially a collaborative partnership that honours the other's autonomy, seeking to understand the patient's internal frame of reference. Compassion is added to the spirit of MI precisely to emphasise that MI is to be used to promote the patient's welfare and best interests, not one's own.

There are currently a lot of studies showing the efficacy of MI (4, 5, 6,7,8).

The most powerful change catalysts operating in MI include empathic listening, the capacity to strengthen change talk, and the therapists ability to refrain from counter therapeutic responses (1 - p.386).

One last word: there is a benefit for the family doctor himself in MI. My experience in adopting this style of interaction with my patients is that, not only is there a greater degree of satisfaction in the doctor/patient relationship, but it is also an effective preventative measure for 'burnout'.

Take Home Messages

- When patients resist the doctor's advice, it's time for MI
- MI gets much better results than blaming or criticizing
- When patients hesitate to consider behaviour change, it's time for MI.

Original abstract

http://www.woncaeurope.org/content/ws216-applications-motivational-interviewing-hypertension-treatment

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11 – Quality Circles

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The Phenomenon

Ongoing quality improvement (QI) is fundamental to modern family medicine; it is about providing person-centred, safe and effective care, and efficient use of current resources in a fast-changing environment. There are diverse methods, tools and approaches to QI and structured small group work has been shown to contribute to an individual's increase and use of knowledge. The terms peer review group (PRG), quality circle (QC), CME/CPD (continuous medical education/continuous professional development) group, practice-based small group work (PSGW) and small group work (SGW) are used interchangeably in different European countries.

QCs are groups of 6 to 12 professionals usually working in general practice, who meet regularly to consider their standard practice. QCs select the issues they want to deal with and decide on their data-gathering method and on ways of finding solutions to their problems. Practitioner-participation, certain topics and thematic frameworks may be mandatory for accreditations or for reimbursement by health insurance companies. The groups provide a social context for reflective practice and allow the dissemination of knowledge to the work practices of the participants (1).

QCs consist of more than one educational step and are best described as a multifaceted intervention which uses various predisposing, enabling and reinforcing methods (2). They use educational material which is discussed in a workshop-like atmosphere, contact with local knowledge experts, audit and feedback with or without outreach visits, facilitation and local consensus processes. The groups are led through the circle of quality by facilitators who seek to keep the members focused on the issue without controlling them, respecting the contribution of each individual and taking into consideration the group dynamics. Rhetoric and didactic techniques such as debate, consensus discussion, brainstorming, reflective thinking, self-observation and role play, among other practice, appear to keep QCs active.

Origins of the Approach

QCs are based on two concepts: the framework of Knowledge-To-Action-Cycle (KTA) and the social context the group provides for its function. In 1924, Walter Shewart created the first table depicting a circle for continuous control of the process and QI. The US statistician Deming enhanced this and introduced the Plan Do Check Act (PDCA) cycle as a method of QI. QI spread from manufacturing to service industries and then to medical service providers. Donabedian introduced the basic aspects of quality and QI in health care using the same terms as the manufacturing industry. This concept was first implemented in in-patient settings and secondary-care clinics in the Netherlands, where Problem Based Learning (PBL) first influenced the health care sector. In 1979, PBL was implemented experimentally in Nijmegen, in the

Netherlands, where small groups of family physicians met voluntarily on a regular basis, using their peers to

continuously and autonomously improve their knowledge.

Gradually, the learning cycle transformed into a cycle of QI as the focus changed from knowledge gain to QI and implementation of knowledge according to the KTA framework (Fig 1)(3).

PBL added didactic techniques and industrial QCs added communication skills and knowledge about group dynamics to these small primary health care groups. QCs spread rapidly to many European countries. A parallel development could be observed at Mc Master University in Canada in the Eighties.
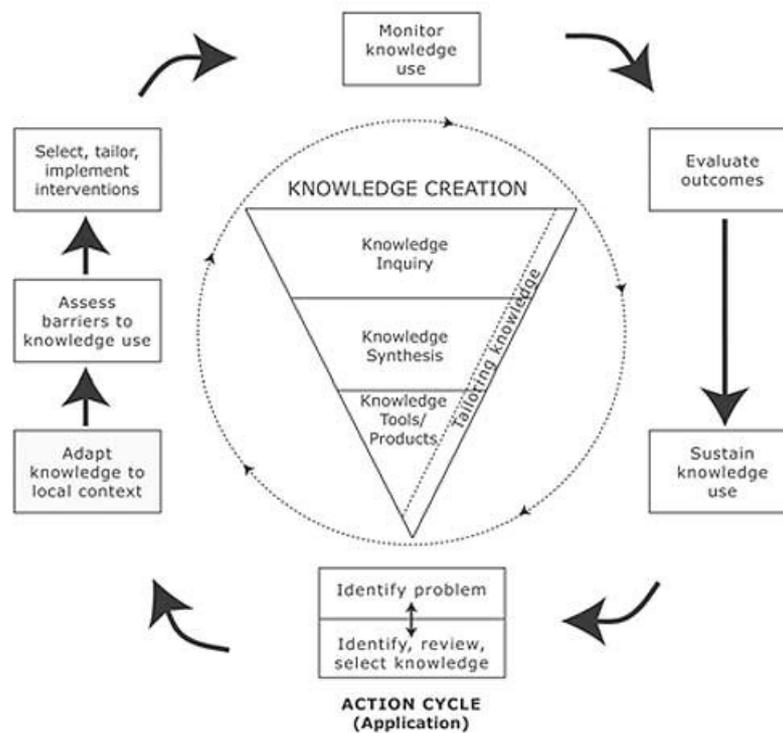
Fig 1: KTA Framework

Significance of the Phenomenon and its Development

According to a survey performed by the European Society of Quality and Safety in Family Medicine (EQUiP) presented at the WONCA Conference in 2000, of the 26 European countries which participated, QCs had been established in Austria, Belgium, Denmark, Germany, Ireland, the Netherlands, Norway, Sweden, Switzerland and the UK. The main objectives of QCs in primary health care being QI, CPD and CME (4).

Numerous Dutch, German and Scandinavian studies conducted in the following years suggest that QCs improve both individual and group performance in terms of costs, ordering of tests, prescription habits and adherence to clinical practice guidelines, thus resulting in better patient outcomes, measured in changes in performance indicators (5). As the QC programme uses several, though varying sequential interventions, it is tempting to judge the programmes according to the results each component generates. Several systematic reviews (SR) of high quality show that elements of QCs have a positive impact on behaviour (6, 7).

In the Netherlands and Ireland, QCs have become inherent in QI where family physicians are supported by their colleges. In Germany, they are often mandatory as part of integrated or selective contracts in health care. Overall, approximately 50% of all family physicians participate regularly in QCs. In Switzerland, currently, 80% of all primary health care physicians who answered surveys, regularly attend QCs. QCs have developed rapidly in Scotland and England and over 25% of all family physicians in Scotland regularly meet in groups. There are no current data for other European countries about how common QCs are and what features they have. However, literature reviews and contact with European key stakeholders suggest that QCs also play an important role in Austria, Belgium, Denmark, France and Sweden.

Future Prospects

QCs are assumed to work because they bring people together to identify key issues concerning the quality of health care and they involve people in exploring solutions where there is a need for improvement. However, understanding of the QC components that act independently and interdependently to optimize the programme has to be improved. The influence of the context should be taken into account and studied since it affects both participants and their motivation. Basically, it is about unpacking the black box to see what variations of QCs work for whom and under what contextual features, by looking at the numerous projects that are being undertaken (8). An EQuiP meeting on this subject is planned in Spring 2015 and an updated survey on QCs in European countries will be conducted to discover how common they are, what contextual features they display and to identify optimal conditions for their success.

Take Home Messages

- Quality Circles are commonly used in primary health care in Europe to consider and improve standard practice over time.
- They represent a complex social intervention that occurs within the fast-changing system of primary health care.
- Quality Circles work according to the Knowledge-To-Action Framework
- Numerous controlled trials, reviews and studies have shown small but positive effects on behaviour change.

Original Abstract

http://www.woncaeurope.org/content/20-s-quality-circles

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12 – Pathology and Minor Surgery in Primary Care

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Since last century, family doctors have played a varying role in the management of skin lesions. While family doctors traditionally played an important role in handling skin lesions, this changed in the second half of last century when minor surgery performed by family doctors declined as a result of limited funding and the growing wish of patients to be treated by specialists. The increasing costs of this led to the insight that minor surgery primarily belongs in family medicine, and financial incentives were created for family doctors to perform more minor surgery. Since then, the role of family doctors in the management of skin lesions has gradually increased, illustrated by a significant increase in the volume of minor surgery performed in primary care in the UK. This largely involves skin lesions that may be malignant, and thus there has been discussion about the appropriateness of clinical management decisions in family medicine with several issues of concern:

- The quality of the clinical diagnosis by family doctors
- The need for histological confirmation of the clinical diagnosis
- The cost-effectiveness of histological confirmation
- The technical quality of the surgical procedures performed by family doctors
- The cost-effectiveness of minor surgery in family medicine

Pathology applications in Family Medicine can concern cytological or histological investigations. Histology is also of great importance in Family Medicine, in terms of skin excisions, biopsies and curettings. Skin diseases are a major part of the workload of the family doctor, reflecting about 15% of daily consultations. Skin cancer incidence rates have increased steadily, leading to a growing demand for healthcare services to inspect suspected lesions and treat patients. In The Netherlands, lifetime risk of skin cancer is 1:6 and of melanoma is 1:50. In many countries, including The Netherlands, family doctors are the portal to healthcare and therefore play an important role in handling skin lesions. Nevertheless, the role of family doctors in these matters is not without controversy. Family doctors are criticized because of their lack of diagnostic accuracy and quality of their surgical technique.

To have clear insight into this process it is important to know how family doctors handle skin lesions in daily practice and to know what the role of histopathological investigation is following skin excisions.

We evaluated the yield of histopathological investigation of a large group of 5105 skin excisions performed by family doctors and sent to a family doctors' pathology lab in Utrecht (Saltro), with special emphasis on discrepancies between clinical and pathology diagnoses of malignancy. The total yield of (pre-)malignancies in this large group of skin excisions was about 5%. These (pre-) malignancies were often serious and unexpected.

Table 1. Comparison of clinical and final histological diagnosis in 5105 skin biopsies and excisions by family doctors.

		Final histological diagnosis				
		benign	premalignant	malignant	unknown	total
Clinical diagnosis	benign	4302 (96.6%)	34 (0.8%)	100 (2.2%)	16 (0.4%)	4452
	premalignant	12 (42.9%)	13 (46.4%)	3 (10.7%)		28
	malignant	66 (50%)	11 (8.3%)	54 (40.9%)	1 (0.8%)	132
	unknown	441 (89.5%)	12 (2.4%)	35 (7.1%)	5 (1%)	493
	total	4821	70	192	22	5105

In the group of benign clinical diagnoses we found 3% (pre-) malignancies. The malignancies occurred over the whole spectrum of clinical diagnoses including epidermal/trichilemmal cyst, seborrhoeic keratosis, naevocellular nevus, verrucous wart and fibroma. This indicates that clinical assessment of skin lesions by family doctors may be insufficiently reliable in allowing some skin excisions to be exempt from histopathological investigation, and that all skin excisions by family doctors deserve to be routinely investigated by histopathology in order not to miss serious malignancies.

We compared melanomas excised by family doctors with those excised by dermatologists and surgeons in an academic practice to identify the nature of melanomas missed by family doctors, which may be translated into better clinical practice for family doctors. Of the family doctor melanomas, 64% were clinically considered to be a benign nevus in contrast with 38% of academic melanomas. This does not necessarily mean that family doctors do worse in diagnosing melanoma, since family doctors will usually refer patients with highly suspicious lesions anyway, and the low index of suspicion lesions will be treated by the family doctors (pre-selection bias). A low index of suspicion will usually lead to a narrow primary excision with a higher risk of an incomplete excision. The general consensus is to refer pigmented lesions with a high index of suspicion to a dermatologist or surgeon for a slightly wider local excision followed by re-excision and sentinel node biopsy if indicated.

In a study exploring whether the "ugly ducking" (UD) sign is sensitive for melanoma detection it was concluded that melanomas are generally apparent as UDs. It is a common observation that, in a given individual, all the nevi tend to show a similar pattern. A nevus that stands out, the ugly duckling, is suspicious. Translating this knowledge to Family Medicine it seems very important to let patients undress when assessing pigmented skin lesions in order to investigate the overall pattern of the skin moles and to detect the "ugly duckling" if present.

The safest approach to skin lesions is to excise them all and submit them for histopathology. However, this would lead to unwanted cosmetic side effects and low cost-effectiveness. Better diagnostic strategies could help family doctors to discriminate between benign lesions that can be left alone and high index of suspicion lesions that need to be excised properly. Dermatoscopy is widespread in secondary care and has been suggested as a tool to improve the diagnostic accuracy and therapeutic management by family doctors as well.

Take Home Messages

- The total yield of (pre-)malignancies in skin excisions submitted for pathology is between 5% and 10%, most of them unexpected, including serious malignancies.
- Unexpected malignancies in skin excisions performed by family doctors occur across all clinical diagnosis categories, and about 2% of clinically 100% benign lesions are malignant.
- Lowering the number of unnecessary excisions is a more fruitful approach to cost-saving than omitting histopathology of excised lesions.
- It seems very important to let patients undress when they present with a pigmented skin lesions to investigate the overall pattern of the skin and to detect the "ugly duckling" if present.
- Dermatoscopy may be a valuable addition for the diagnostic and management strategy of pigmented skin lesions by family doctors.

Original Abstract

http://www.woncaeurope.org/content/27-pa-minor-surgery-primary-care-team

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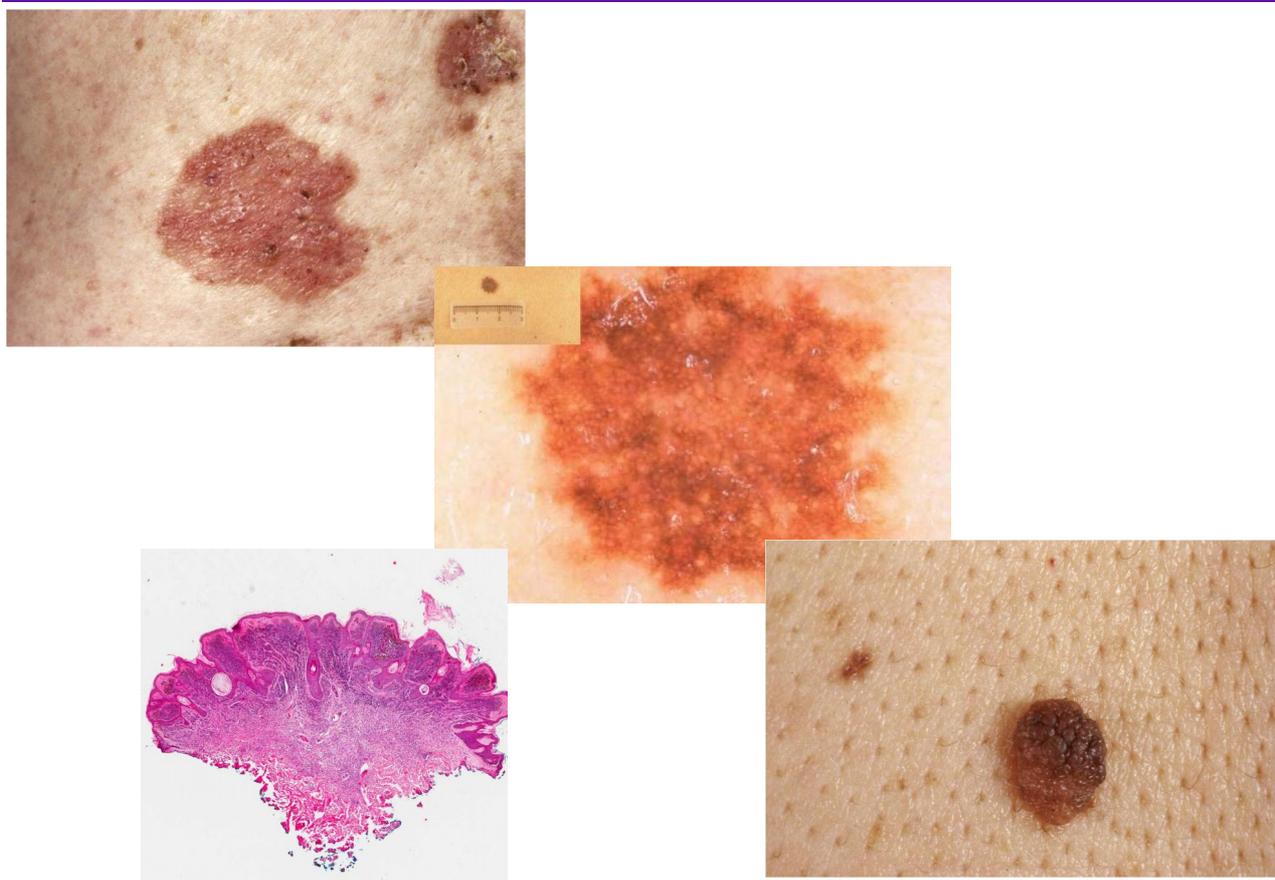
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13 – Developing Research Capacities in General Practice: the Croatian Experience

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Background

Vocational training or specialist training (ST) in General Practice / Family Medicine (FM) in Croatia started in the school year 1960/61. It was prepared by the experienced working general practitioners (GP), supported by the academics, public health and clinical teachers from the Zagreb Medical School. The vision was not only based on the development of FM as the primary health care discipline, but also on the academic development of the discipline, which included the development of research capacities. Therefore, ST was organised along three pathways; as a postgraduate course, clinical rotations and the FM practical experience under the supervision of the trainers. A postgraduate course was equal to other postgraduate courses organised by Zagreb Medical School, leading to the obtaining firstly, a Master of Science degree followed by a doctoral degree. At the same time, ST trainees in FM have had the opportunity to proceed toward doctoral degrees and becoming a specialist in FM. Many GPs took advantage of this and obtained Master of Science degrees, and several of them doctoral degrees. A doctoral degree is one of the prerequisites to becoming a FM teacher, in order to fulfil the same criteria as other teachers at the Medical School. It led to the early establishment of the Department of FM; in 1980, three prominent GPs with doctoral degrees were elected as a core staff of the Department of FM at Zagreb Medical School. The ST curriculum was changed several times, with particularly significant changes happening in 2003/04, but the vision remains the same; the availability of a postgraduate course with a special research module, clinical and FM rotations. The aim of this report is to present our experience in the developing research capacities and to evaluate the outcomes in terms of published articles written by the ST trainees.

Developing research capacities

Over 3 years of ST curriculum, out of a total of 900 teaching hours in the postgraduate course, 600 are devoting to direct teaching and 300 hours on individual task-based learning. In the research module, out of 100 hours, 40 are devoted to direct teaching and 60 to work on small research projects under the supervision of mentors with academic degrees. The final requirement is post-graduate diploma work, which should be written and defended in front of three members of a jury. The diploma work is a prerequisite to obtaining a postgraduate degree.

Generally, the research module is designed to develop the trainees' competencies in the posing of a research question, collecting data in response to the question, and presenting and answering the question (1,2,3). However, the entire educational process was divided in smaller modules. Generally the process is initiated with a discussion on the general nature of the problem, or rather, its context within the

research framework in Family Medicine. A group discussion is conducted regarding the importance of the research problem with relation to the ST trainees' interests and preferable outcomes from their working experience. Following this, a literature review is performed to identify flaws or holes in previous research, which provides justification for the study, and is done individually; each trainee undertaking their own literature-search relevant to his/her research inquiry. They learn that a gap in the current literature, as identified by them, will lead to the formulation of a research question which may be parallel to their hypothesis. In data collecting to test the hypothesis, special attention is paid to selection of appropriate research methods, quantitative or qualitative depending on the research question, as well as sampling methods. Knowledge and skills on the basic statistical methods, important for data analysis and interpreting, are standard content. The education process is organised in an interactive way through a combination of theoretical teaching (lectures, small group discussion) and practical work on the defined task, such as data collection. The last part of the module is related to the writing of diploma work, and different types of articles, including the rules on literature citations and publishing.

As mentioned previously, the direct outcomes of the research modules are small research projects completed by each ST trainees, published and defended as diploma work (4). Some of the projects are also published as research papers in different journals and have been presented at the European General Practices Research Network and other conferences (5, 6). Another advantage to such education is the further development of the individual's research capacity. Whe some of the ST trainees choose to go on to the doctoral study programme lasting three years, this module covers almost one year of the study; and brings him/her 40 ECTS of the 60 ECTS necessary to obtain within one year.

Evaluation

Two types of pilot evaluation were performed, one related to the post-graduate diploma works and another related to the number and content of published articles. We carried out analysis of 420 diploma-works (64.5% of total). 82.1% of them are designed as research, 5.2% as literature review, and 12.6% as case presentations. The majority percentage of the content are related to clinical themes (27.9%). 17.4% are related to organizational issues and methods of work in family practice. In 15.5% of them, specific family medicine themes were surveyed, such as co-morbidity, biopsychosocial aspects and palliative care. 10.7% were dealing with patients' and their health needs. Prior to the start of renewed VT in 2003, 42 articles were published in the official Croatian FM journal by the trainees and subsequently, 71 articles. This accounted for a 69% increase in published articles. 96 articles were published at the Congress Proceeding of the Croatian FM Association prior to renewed VT, and 165 subsequently; an increase in 71.9%. Most of the articles are related to clinical themes (65%), 21% related to FM issues, and around 14% associated with other themes.

Conclusions

The results of the pilot evaluation indicated that it was worth the investment of resources in the development of research capacities in FM. We presented Croatia's model in order to share experiences and to improve overall development of research capacities in Family Medicine consistent with the "Research Agenda for General Practice / Family Medicine and Primary Health Care in Europe" proposed by EGPRN (7).

Take Home Messages

- Research capacities are important for the development of FM as a scientific discipline
- It could be undertaken within the ST training
- The research topics should be relevant to the ST trainees' interest and preferably stem from their working experience
- The "active" educational methods are needed
- The effort is a valuable experience and bring success and satisfaction

Original Abstract

http://www.woncaeurope.org/content/research-general-practice-what-and-how-teach

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14 – An International Comparison of the Role of the Family Doctor in Different Countries and its Consequences on the National Health Outcomes and Expenditures: What has Changed in More than 10 years?

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In the 2002 WONCA Congress (London) Alberto Donzelli, Maria Enrica Bettinelli and I delivered the presentation "An International Comparison of the Role of the GP in Different Countries and its Consequences on the National Health Outcomes and Expenditures".

The authors are MDs, with clinical and organizational specializations, working for the NHS in the continuing education and management of >1000 GPs, in Milan, Italy.

We addressed some issues about the organization of primary care in industrialized countries, looking at the available evidence.

The GP is the health professional closest to the greatest number of citizens and the only professional who can provide personalized/comprehensive care, including prevention, at reasonable costs.

In order to fully accomplish this task, GPs must coordinate and filter the market-driven increasing technological suggestions, be the patients' advocate in order to avoid unnecessary medicalisation, as well as consider the community's needs and attempt to influence the physical/social environment components of the disease.

The main issues regarding the GPs' role, how to finance them and organize the health service are:

- GPs (mainly) gate-keeper vs. direct provider of services
- GPs paid by capitation vs. fee-for-service
- Public NHS vs Health insurance-based

We considered the economic point-of-view of the NHS and the community's wider opinion, highlighting the more effective and cost-effective options on the basis of the available health and economic indicators. We chose the reliable, updated Organization for Economic and Cooperation Development/OECD Health database (2001), comparing it now with the 2013 OECD database (1) and others (2).

To measure the effectiveness and cost-effectiveness in producing health, we chose some proxy health and economic available indicators. Health indicators were life-years lost before 70 years for avoidable mortality; infant mortality; and rates of selected surgical interventions. The main economic indicator was the percentage of the Gross Domestic Product/GDP spent for health in every country, as total and public expenditures. We differentiated the countries according to the different GPs' role, payment and health system model, with special interest for Italy, where the GPs are gate-keepers, paid mainly by capitation with some incentives, in a NHS. There is still political pressure towards more market and privatization, supposedly more cost-effective.

In 2002, with the exception of Portugal, the USA had the highest quantity of life-years-lost before 70 among the

examined developed countries; in 2013 their life expectancy is still lower than the average of the 34 OECD countries (78.7 vs 80.1 years) and much lower than Italy, second-best within the whole evaluation (82.7 years).

The infant mortality pattern has not changed, with Nordic countries experiencing the lowest rates (2/1000 live births) and around 4/1000 in the other Western European countries and 6.1/1000 in the USA. The reduction in infant mortality has been slower in the USA than in most other OECD countries, with socio-economic/ethnic inequalities playing a significant role.

In 2002 the rates of some surgical elective procedures showed regional variations not consistent with any epidemiological pattern, but strongly correlated with the different method of payment of doctors and with the health systems' organizational structure. This is still valid today.

We addressed the question whether a GP is more effective and efficient when he/she is mainly a gate-keeper or a direct provider of services, even when these functions are compounded in the work of European GPs.

The Total Health Expenditure was higher in countries without a gate-keeping GP and with direct access to the specialist (i.e. USA, Switzerland, France, Belgium…). The countries with gate-keepers (i.e. Italy, UK, Spain…) spent less and achieved better health results. Since 2002 the European economic situation has deteriorated and health expenditure has abruptly decreased in some countries (Greece), but the main findings seem still valid.

If the main source of income and gratification comes from the direct provision of services, especially if highly technological, this could divert GPs from the fundamental role of gate-keeping. Under these circumstances, they must question the appropriateness of many prescriptions or suggestions coming from hospitals or university specialists. The gate-keeping task often makes the doctor-patient relationship problematic, especially if it has not been included in the education and training and is not seen as important or valued by the health system and community. The public should be educated on the value of the gate-keeping function and its ethical significance for a better use of available resources.

The direct provision of additional services is usually linked to fee-for-service payments and where they are used the per-person total and public expenditures are higher than where capitation or salary are preferred. Doctors seem to provide the best rewarded services, even if they are aware of their questionable health value (3).

The capitation payment should also be preserved for ethical reasons, being more suitable to comprehensive care, prevention included, according to the patient's needs. It should evolve towards an age-weighted capitation formula with a progression by age, weighted more towards the elderly (and infants) than the young (4). It could be integrated by incentives based on results/levels-of-result, especially in crucial areas such as the anti-smoking and breast-feeding counselling in Italy.

The General Medical Contract/GMS for GPs with its related Quality Outcome Framework/QOF, introduced in 2004 in the UK and continually readjusted, showed that the P4P was more expensive than expected because most GPs have reached the fixed goals, concentrating their efforts on the targeted areas only. Our model with a strongly age-weighted capitation is more comprehensive and should avoid the latter.

The role of GPs is also preventative; increased financial reward for older patients should encourage every evidence-based preventative efforts to ensure a healthy old age for their patients, avoiding unnecessary diagnostics and treatment, recently defined as "quaternary prevention" (5). To sum up: "A system that pays for health and not for disease".

Comparing Insurance–based and NH services, the *total* health expenditures are obviously not contained by the former, and such systems are not able to contain the *public* expenditure, both in the non-profit version ("mutuel", "Krankenkassen"…) and in the profit ones (private insurance companies) which also have the worst health outcomes.

Take Home Messages

- National health services are still the more effective and efficient health systems
- Within them, GPs should have a strong role as gate-keeper
- GPs should be paid by a weighted capitation system, integrated by outcome-based incentives
- Fee-for-service payments and other systems paying for disease (disease management…) and for processes (pay-for-performance/P4P…) should be dismissed in favour of a system paying for health (and for a long healthy life of the citizens)

Original Abstract

http://www.woncaeurope.org/content/419-international-comparison-role-general-practitioner-gp-different-countries-and-its

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15 – Tackling Health Inequalities: the Role of Family Medicine

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The late Barbara Starfield left us her wisdom, "Inequity is built into health systems-especially health systems that are based on a view of health needs disease by disease. Therefore, the benefits of primary care, which is in person- and population- rather than disease-focused, are under-appreciated. Data provide evidence not only of its benefit to populations but also of its preferential benefit to the socially disadvantaged." (1)

Introduction

Health inequities occur in different socio-economic classes (2), and span across a wide range of socio-cultural characteristics (2-3). Health inequity refers to differences in health that are not only unnecessary and avoidable, but are also unfair and unjust (4). Research consistently shows that gaps in health and health care persist, and are even widening (5). Research has repeatedly shown the strength of a country's primary health care system and its primary care attributes significantly improves populations' health and reduces inequity (6-7). Starfield *et al* identified the primary care attributes that contribute to population health, including first contact access, greater focus on prevention, provision of person-focused comprehensive care, with greater continuity and coordination (7). Such attributes are of special importance to inequity reduction as the socially disadvantaged have a greater likelihood of occurrence, severity, and adverse effects in multiple illnesses for which a comprehensive, coordinated, person-focused primary care (rather than a speciality driven, disease-focused) view of morbidity can be more effective (1).

Recent evidence also supports the above conclusions showing that primary care can reduce inequity in developed as well as in low and middle-income countries. A review that assessed the contribution of large primary care initiatives to a broad range of health system goals in low and middle-income countries concluded that primary care-focused health initiatives had improved access to health care, including among the poor, at reasonably low cost and primary care programs had reduced child mortality and, in some cases, wealth-based inequity in mortality (8).

Current Health Inequity Issues Faced by Primary Care Practitioners (PCP)

As a foundation step for the establishment of WONCA's first Health Equity Special Interest Group, The World WONCA held a workshop on health equity during its bi-annual meeting in Prague on 26-30 June 2013 with the aim of exploring how a better understanding of health inequities could enable PCP to adopt strategies that could improve health outcomes through the delivery of primary health care. It was attended by 120 delegates from across the globe, including developed as well as low and middle-income countries. Following the presentations, workshop attendees were asked to participate in small group discussions and were asked to rate on thirteen possible inequity reduction activities

on a 1-5 Likert scale in an anonymous survey.

In the small group discussions, they recognized in their own setting how uneven distribution of social determinants of health could have affected poor health outcomes such as life expectancies and risk behaviours, and how health systems that had operated in different countries could have systematically affected people's affordability as well as access to healthcare services and fundamental rights to good health. They identified health workforce shortage, lack of communications between primary & secondary care, low political incentive and priority for marginalized populations as well as low health literacy and expectation of the patients as contributions in meeting the health equity agenda. They believed signposting for how to navigate the healthcare system and training should be provided to leaders of vulnerable groups since community awareness should be provided to the public as well as the patients. Furthermore, they believed that training in inequity should be provided to medical students as well as PCP on how to improve health equity through primary care.

Overall, the participants rated the degree to which their country currently had utilized the various mechanisms to reduce health inequity as "moderate" (mean: 2.85, standard deviation (SD): 1.12). The results indicated that the types of mechanisms most commonly utilized included: promoting access to primary care (mean: 3.63, SD: 1.24); initiation of public health programs to promote health equity (mean: 3.17, SD: 1.01); and, promoting access to care by increasing coverage (mean: 3.12, SD: 1.36). The activities least practised were: engagement in cross-national collaborations to promote health equity (mean: 2.12, SD: 0.99); promoting research on health equity (mean: 2.40, SD: 1.04); and, reforming medical education to incorporate health equity and cultural competency training (mean: 2.44, SD: 0.96).

On average, participants rated the degree to which they had believed the items representing priority areas which countries should be engaged in as "high" (average: 3.85, SD: 0.88). Practices most commonly viewed as useful were: promoting the availability of primary care services (mean: 4.68, SD: 0.63); and, initiation of primary care programs to promote health equity (mean: 4.42, SD: 0.76).

How Could PCP Help in this Movement?

In view of these findings and enthusiasm within the profession, the Health Equity Special interest group (SIG) was proposed and approved by the WONCA Executive in early 2014 bringing the essential experience, skills and perspective of interested PCP around the world to address the differences in healthcare that are unfair, unjust, unnecessary but avoidable. It is hoped this group will use WONCA as a platform for exchange of ideas, advice, support and advocate for better equity in health.

The WONCA Health Equity SIG plans to contact and work with existing centres on health equity; to provide news updates and events related to health equity; to conduct/facilitate literature review on research gaps; to collaborate/identify/set up a resource centre on health equity; to organise regional/international workshops/ seminars to keep up with the health equity agenda; and, to formulate a framework within a medical curriculum on health equity. Interested parties should visit:
http://www.globalfamilydoctor.com/groups/SpecialInterestGroups/HealthEquity.aspx for further information.

Take Home Messages

- Despite evidence of the contribution of the core attributes of primary care to populations' health and reduction of inequity, inconsistencies are found in implementation of primary care features in different countries, with greater emphasis on the provision of easily accessible primary care and less investment in promoting programmes to improve continuity or coordination.

- Health equity workshop participants expressed similar assessments regarding their countries' priorities, indicating that promoting access (availability and coverage) of primary care services was more often performed than initiating tailored primary care interventions (mean score: 3.04-3.63, compared to 2.96, respectively).

- Importantly, survey respondents identified "promoting access to primary care services" as the most important priority that countries should engage in.

- Activities that have been previously cited as important for promoting equity in health i.e., reform in medical education, promoting research, and fostering cross-national collaborations, were identified by survey respondents as low current priorities in their own countries.

- Assessment of the gaps between current and preferred priorities showed that to bridge expectations and

actual performance, countries should engage in forming cross-national collaborations; incorporate health equity and cultural competency training in medical education; and, engage in initiation of advocacy programs that involve major stakeholders in equity promotion policy making as well as promoting research on health equity.

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Original Abstract

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	The level to which this activity **is currently** part of respondent's countries' key priority issues (1-5)[*], M±SD	The level to which this activity **SHOULD** be part of respondent's countries' key priority issues (1-5)[**], M±SD
Initiation of **advocacy programmes** to involve major stakeholders in equity promotion policy making	2.71±1.08	4.35±0.75
Reform of **medical education** to incorporate health equity and cultural competency training	2.44±0.96	4.19±0.83
Promote research on health equity	2.40±1.04	3.96±0.85
Initiate **public health programmes** to promote health equity	3.17±1.01	4.22±0.89
Initiate **primary care programmes** to promote health equity	2.96±1.04	4.42±0.76
Promote **access** to care – availability of primary care services	3.63±1.24	4.68±0.63
Promote **access** to care- increased coverage of services / health insurance	3.12±1.36	4.20±1.12
Promote **access** to care- point-of- service free care	3.04±1.06	4.08±1.08
Promote the **collection** of socio-demographic data on patients in a routine and standardized way	3.07±1.46	3.82±1.31
Write **guidelines** for physicians for health equity promotion	2.70±1.23	3.74±1.13
Promote the development and implementation of tools to **measure and monitor** inequity in health	2.73±1.12	4.11±0.70
Promote **diversity** in medical workforce	2.96±1.19	4.04±0.84
Engage in **cross-national collaborations** to promote health equity	2.12±0.99	4.08±0.91

[*]1=Currently **not** a priority; 5=Currently a **top** priority.

[**]1=SHOULD **not** be a priority; 5=SHOULD be a **top** priority

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16 – Using the Internet to Answer Clinical Questions

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"Medicine has built on a long history of innovation […]
Doctors have embraced each new technology to advance patient care.
But nothing has changed clinical practice more fundamentally
than one recent innovation: the Internet."
- Pamela Hartzband and Jerome Groopman (1)

Evidence-based Medicine became widely accepted at the same time that the World Wide Web was rapidly expanding and the development of online databases was making information easily available. Nowadays, healthcare professionals are increasingly using the Internet to obtain current health and medical information, and access journal articles and synthesis of evidence-based information.

However, there is relatively limited research on the healthcare professionals' online searching methods and behaviour, especially in real-world settings, beyond the academia's strict models (2). The plethora of information readily available on the Internet has gradually shifted the focus to how well we are able to search, filter and appraise the most relevant, accurate and reliable information and how efficiently and appropriately we are able to handle and apply it in clinical practice.

Retrieving information from the Internet necessitates specific skills and the outcome depends on the user's ability to access catalogues and databases, and employ an effective search strategy. Besides the essential digital literacy which is considered to be commonplace among young physicians, healthcare professionals are also required to be trained in order to translate their need for information into a properly structured and "answerable" query (3). Systems using natural language and semantic tagging are under development and promise to change the way we seek and obtain information.

Although almost three out of four physicians who seek out medical information on the Internet state that they begin their research with a generic search engine, such as Google (4), other research suggests that healthcare professionals prefer more specific resources, like Pubmed and WebMD (5).

There are still a significant number of online resources that require paid subscriptions, restricting the fair dissemination of medical knowledge.

Time also represents a major constraint: healthcare professionals have very little amount of time available to search the Internet for the current best information. With medical knowledge and literature expanding rapidly, there is a negative impact on how healthcare professionals are seeking and managing information, leading to misinterpretation of the evidence, acceptance of lower-quality information and resignation (3).

Social Networks

Despite the exponential growth of medical information available on the Internet, many healthcare professionals still turn to colleagues and trusted experts as their first resource (2). With the advent of the 2.0 era, these resources are being replaced by global networks, where information-seeking and appraisal can be crowd-sourced.

Although social networking should function as a companion in the search for the best available evidence, by investing in the development of a trustworthy network, healthcare professionals can reach out to the world and have information at their fingertips. Besides employing generic-purpose social networks, they can also use those relevant to the medical sector, such as Doximity, Sermo and doc2doc, which offer more controlled and possibly safer environments. What is more, in this era of brewing participatory culture they are also given the opportunity to curate content themselves and open up to a dialogue not only with their peers, but also with professionals from various settings and with different backgrounds and expertise.

Information Seeking and Healthcare Users

As health information is becoming widely accessible and growingly reliable, patients are increasingly interested in learning about their conditions, their prevention and treatments, and sharing their experiences. They seek online health information, connect and collaborate with the others and take advantage of the Internet not only for decision-making and management of their own condition, but also for education and advocacy purposes. In fact, according to the Pew Research Centre, 7 out of 10 Internet users in the United States searched for health-related information in the span of a year and one in three adults looked online to diagnose a condition (6). Remarkably, 30% of the older people sought health-related information as well.

For the first time, as Eric Topol mentions, the medical world is getting democratized (7) and the flow of information is leading to a paradigm shift of the patient and healthcare professional roles.

As patients face the overwhelming and often conflicting body of available information, it is becoming common practice for them to bring such information to consultations in a quest to analyse and comprehend it. Patients in fact, are increasingly relying on their physicians for the interpretation of the online information (5). It is therefore becoming increasingly essential that not only should healthcare professionals embrace this need and accept this behaviour, but they should also guide their patients and refer them to reliable online resources.

Take Home Messages

- Healthcare professionals are increasingly using the Internet to obtain current medical information and are gradually focusing on how well they are able to search, filter and appraise the most relevant, accurate and reliable information and how efficiently and appropriately they are able to handle and apply it in clinical practice.
- Information-seeking and appraisal can be crowd-sourced with the use of social networks, where physicians can also curate content and converse with professionals around the globe.
- As patients seek online health information, and connect and collaborate with others on the Internet, healthcare professionals should be able to help them interpret such information and guide them to reliable online resources.

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17 – Threats to Patient Safety in Primary Care: A Review of the Research into the Frequency and Nature of Errors in Primary Care

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This WONCA Conference presentation was based on a literature review that had been sponsored in 2001 by the Department of Health in the UK. Several databases were systematically reviewed, the key findings of which showed that medical error occurred between five and 80 times per 100,000 consultations, and these errors were mainly related to the processes involved in diagnosis and treatment (1). Prescribing and prescription errors were identified to occur in up to 11% of all prescriptions, and these were mainly related to errors in dose.

An important aspect of this review was to highlight firstly, the wide variety of definitions of the various threats to patient safety that were used to identify the frequency and nature of these threats and secondly, the different methods used to identify threats to patient safety. These findings are of great importance if a comprehensive understanding of the frequency and possible causes of threats to patient safety is to be obtained. This understanding is essential for making appropriate interventions, including policies and protocols, to reduce threats to patient safety, with the ultimate aim of improving patient care.

The main approaches to identifying threats to patient safety are incident reporting, systematic identification (such as by observing clinical practice), and medico-legal and patient complaint databases and qualitative interviews. All of these approaches reveal different aspects since some of the events may, or may not, have caused actual harm and the identification may only be through mandatory reporting, with greater emphasis on the less common but more serious events. Overall, the variety in the reported frequency and type of threat to patient safety depends on the different perspectives obtained from family physicians, primary health care workers and patients. A recent study has confirmed these findings, noting that patient surveys identified the highest number of events and pharmacist reports for the lowest number (2). Many of these events reported by patients are likely to have caused minimal harm but can be regarded as an indicator of potential causes of more serious threats to patient safety.

The causes of threats to patient safety are usually a combination of inter-dependent factors (3). A study in primary care found that about half of the threats to patient safety were due to "situational" factors and that these events were often linked to serious potential consequences. The most frequent contributing factor was the organisation of work in primary care, including the excessive demands of working in a complex clinical environment, as well as the fragmentation of healthcare across the variety of different health care providers in primary care (4).

Dealing with complexity is typical of the work of primary care and it is not surprising that this factor is a major contributory cause of threats to patient safety. A recent

study in the UK found that there was a risk of eight adverse events per 10 000 consultations, and that the highest risk were in patients aged 65–84 years, in patients who frequently consulted, patients who had five or more emergency admissions and in those patients who had the most diseases recorded (5). It is also interesting to note the findings of a review of international malpractice claims (6) .The most common reason for a claim was associated with failure to, or delay, in diagnosis, especially missed or delayed diagnoses included cancer and myocardial infarction in adults and meningitis in children. Medication error was the second most common reason for a claim.

Threats to patient safety continue to be a priority for all healthcare systems, including primary care. The increasing recognition over the last 20 years that these threats are associated, and probably to some extent inevitable, when working in a complex clinical environment should turn attention of all stakeholders to the important "situational" factors. The approach should be to minimise the impact of these factors on the process of healthcare, such as ensuring doctors recognise when they feel under stress, developing clinical decision-support systems and empowering patients to speak out during the process of their care.

Take Home Messages

- Estimates of the frequency and nature of threats to patient safety in primary care vary widely due to differences in definition and method of identification, with patient surveys identifying the highest number of threats to patient safety
- The most common causes of threats to patient safety in primary care are related to making a diagnosis and using medication.
- Recent research highlights the importance of factors associated with the complexity of providing primary care, such as elderly patients with co-morbidities and early diagnosis of serious diseases, to threats to patient safety in primary care.
- The importance of "situational" factors, such as work-load stress and fragmentation of care across different healthcare providers, is increasingly recognised as contributing to threats to patient safety in primary care.
- Reducing threats to patient safety in primary care requires an awareness of the different inter-related factors that occur with the complexity of the provision of primary care and requires a variety of appropriate interventions, including empowering patients to speak out during the process of their care.

Original Abstract

http://www.woncaeurope.org/content/53-threats-patient-safety-primary-care-review-research-frequency-and-nature-errors-primary

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18 – Teaching and Learning about Uncertainty in Family Medicine

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Uncertainty is a fact of life. We face many kinds of uncertainty in medicine: uncertainty about diagnosis, tests, treatments, and outcomes. There is financial, political, and organizational uncertainty in health services. All this is in addition to uncertainty in our daily lives.

Acceptance of uncertainty can help us develop coping strategies in the low-tech, high-touch world of Family Medicine. We can teach this to our students and trainees and hone this throughout our careers. Does uncertainty make us ask more questions, order more tests, prescribe more treatments, make more referrals, and do more surgery? Does it lead us to take time for personal reflection and discussion with colleagues, patients and their families? It is worth exploring this field and considering new directions for research.

Attitudes to uncertainty have shifted from attempts to master or diminish uncertainty to efforts to cope with it. Many accept and celebrate that things remain uncertain.

Uncertainty can be tolerated (1). By sharing responsibility with the patient we can make it easier on ourselves. Long-term relationships in family medicine and close follow-up allow us to use time as a diagnostic and therapeutic tool. This may reduce anxiety in both doctor and patient from the initial visit.

Uncertainty arises in primary care at the point of first contact with the medical care system (2). Patients appear with undifferentiated symptoms. A patient-centred approach, focusing on understanding the patient's reasons for consulting, may help. The doctor-patient relationship is an important tool for managing uncertainty.

Shared decision-making affects doctors' feelings of uncertainty and their willingness to disclose this to patients (3). Anxiety may be related to gender and be more prevalent among younger doctors. Willingness to learn about shared decision-making increases comfort through sharing uncertainty with patients. Training can help people to cope with the inevitable uncertainty of practice.

Consider a 30 year-old man who comes to the family doctor with low back pain of three days' duration, after heavy lifting at home. The neurological examination is normal. When doctors are asked how certain they are of their diagnosis and that their usual treatment would help the patient in this scenario, figures are high on both counts. When they subsequently learn that this patient had a history of successful treatment with radiotherapy and chemotherapy for Hodgkin's disease ten years earlier, assessments of certainty fall. Context is everything.

Uncertainty also plagues our patients. Patients with chronic obstructive lung disease face ambiguity, defined as a lack of understanding of symptoms, and complexity, defined as lack of understanding of treatment (4). Criticism from family members increases uncertainty while participation in patient support groups helps patients by decreasing uncertainty. Research into patient self-help groups and their effects on uncertainty and self-efficacy might be useful.

Uncertainty may represent hope to patients. We need to recognize and validate uncertainty in our patients concerning

breast self-examination (BSE) (5). BSE increases anxiety without decreasing morbidity or mortality from breast cancer.

Teachers also feel uncertain (6). They may ask: how much do my students know and understand, how effective is my teaching, how can I best use the limited time I have with students and what intellectual and social authority do I have to teach? Too much uncertainty in the classroom can lead to anarchy while too little uncertainty can lead to dogmatism.

Medical students appreciate that we can't know it all, we don't know everything, and we can't even agree on what we think we know. We help our students by listening to their concerns, helping them to ask questions, strengthening their healthy coping mechanisms, providing information they need, and simply by being there for them.

Are evidence-based medicine and computers sufficient to lift the smog of uncertainty (7)? Technology and data are not enough. We work in complex systems on the edge of chaos (8). Strategies for coping with uncertainty may include shared reflection of narratives in Balint groups.

Research may tell us how much uncertainty plays a role in our clinical encounters and describe the ways patients and doctors cope. We should assess the consequences of uncertainty, including costs. We need to understand the meaning of uncertainty in the unique context of family medicine. The results of research in this field will certainly be helpful to us.

Take Home Messages

- Uncertainty is a fact of life in Family Medicine.
- We can tolerate, accept, manage, and even celebrate uncertainty.
- A patient-centred approach and long-term relationships can help us cope with uncertainty.
- Patients may value uncertainty because it gives them hope.
- Research will help us understand how we cope with uncertainty and what this means to medical care.

Original Abstract

http://www.woncaeurope.org/content/73-teaching-uncertainty

Conflict of interest:

None reported

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Dedication

It is dedicated to the memory of Dr. Ivar Ostergaard, the original co-author of the workshop on uncertainty presented at the WONCA 2001 conference in Tampere.

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19 – Home Visits: are they Useful or Necessary in Family Medicine?

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Introduction

In most European countries home visits form part of the family doctors' (FD) normal routine. However, the chance of receiving a home visit by a family doctor varies widely across Europe. In the Nineties, the percentage of home visits was high in several European countries, such as Belgium, Germany and France (1). But also in East European countries, such as Moldavia, the percentage of home visits varied from 35 to 40 %, taking up the majority of the doctor's time (2). However in health care systems with a patient list system and payment by capitation, there were fewer home visits. Especially in Scandinavian and Mediterranean countries, family doctors had a low frequency of home visiting (1).

Necessity of Home Visits – Their Added Value, Disadvantage and/or Benefit Versus an Office Encounter

There is a debate about the value of home visits and the appropriate rate.

Patients seemed to like home visits more than family doctors did, and it is likely that this is often the deciding factor , as stated by several authors (1, 2). There is little debate about the family doctor's role in performing a home visit when patients are restricted in their mobility, especially for the elderly and very ill patients. But there are constraints. Home visits are time-consuming (double time compared to office consultation), less efficient (because of less favourable clinical situations for diagnostic and therapeutic interventions) and not always safe to realise, especially in the evening and night.

Quantitative research revealed that doctor-related factors, the organisation of the healthcare system and to a lesser extent, patient characteristics were explanatory factors for the high number of home visits (3).

In Belgium, qualitative focus group research was conducted with family doctors, patients and representatives of health insurance companies, in order to list all added values, disadvantages of home visits by family doctors – and to explore the factors in determining the request and performance of home visits (4). In total, 77 items were identified, classified into 8 categories of a theoretical framework. Besides different patient groups/illnesses, health care organisation and doctor-related factors, other factors were also revealed – such as patient related factors (convenience for the patient), practice organisation (waiting times, appointment systems), context and intimacy (closer relationship), medical/technical factors and economic factors (cost of a home visit). The additional value of home visits was reported as the understanding gained from meeting the patients on their own territory and the observation of the home situation.

Decreasing Rate of Home Visiting by Family Doctors

In order to change the rate of home visits, an analysis of the necessity of home visits in countries such as Moldavia and Belgium was a first step. This stimulated intervention at the level of practice organisation, for example, in providing an easily accessible appointment system, repeatedly asking patients to come to the surgery and reduction in waiting times. In addition, both patients and health care providers need to alter their view of home visits.

There has been a clear decline in family doctor home visits over the past two decades. The decrease of the number home visits performed was remarkable, for instance in Moldavia from 30 % in 2003 to 12 % in 2005 (2). Especially urgent house calls are increasingly delegated to the emergency services, whereas home visits to nursing homes are often characterised as emotionally stressful (5). The question arises whether these changes have really had a positive influence on the quality of medical services.

When asking family doctors, they are convinced that they have to ensure quality home care but they are unable to suggest how this might be achieved (5).

Home Visits in the After-hours of Primary Medical Care

Furthermore, the organization of after-hours primary medical care services in many European countries is changing. The development of out-of hours cooperatives combined with telephone triage seem to decrease the home visiting rates (6), while deputizing services seem to increase home visiting rates. The circumstances of after-hours primary medical care could possibly give inspiration to daily primary care.

Other Professionals

Since family doctors are increasingly working within multidisciplinary teams, home visits are not just performed by family doctors but are increasingly redistributed from the family doctor to other qualified members of the healthcare team such as nurse practitioners or specially trained nurses (7). Their role is important in improving, for instance, the safety of medication management among older persons- but also in (tele) monitoring for different chronic diseases. Multiple programmes have shown to be effective. Informal caregivers are also taking up roles, which were previously undertaken by health care professionals and/or family doctors. They look after and provide help and support to family members, friends and neighbours because of their long-term physical or mental ill health/disability or problems related to old age. Collaborative approaches and redistribution of tasks could probably be the response to the challenging demand for ensuring quality home care in future.

Conclusion

Despite the increase of chronically ill and elderly patients, the home visiting rate by family doctors is declining in all European countries. Home visits remain a central element of primary care, especially for the increasing vulnerable patient group. Primary care should reflect on how to ensure this essential service, regarding changing contexts.

Take Home Messages

- Although the home visits rate has declined over the past two decades, home visits remain an important component of family doctors' routine and workload.
- Many factors influence the request and performance of home visits by family doctors: doctor- related factors, practice organisation, contextual information and patient-related factors are the most important reasons to perform home visits.
- Family doctors have an important role in performing a home visit when patients are restricted in their mobility, especially in relation to the elderly and the very ill.
- Other healthcare professionals and informal caregivers have to take up roles in home care for and home visiting to the disabled and elderly, in order to ensure quality home care in future primary care.
- Collaborative approaches and redistribution of tasks are good answers to the challenging demand for ensuring quality home care in future.

Original Abstract

http://www.woncaeurope.org/content/cf73-home-visits-medical-necessity-or-simply-service

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20 – Promoting the Health and Well-being of Family Doctors -Guerilla Tactics for Family Doctors

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Physicians are well known to be very reluctant to have a family doctor –but every GP needs a GP! They don't feel the need to have a competent medical "second opinion" or just a routine monitoring of their health. They know it all – and who would trust another doctor?!

We decided to tackle this issue as a Military Operation –the doctor as his own enemy and feeling surrounded by enemy colleagues.

Sometimes when your day was fully packed fighting infectious and non-infectious diseases, fighting against insurance companies' bureaucracy, struggling with technical problems in your computerized office, never finding the right specialist at the right time when you need him/her, then one can feel forsaken from the protecting crowd of medical doctors.

In your Forward Command Post, with limited low cost armaments, as near as possible to your entrusted patients, that´s where your graduate and postgraduate Training someday comes to an End. Once you realize that the people are the key to be secured and defended rather than the conquest of new Scientific Territory, you will seek new strategies to carry on.

Guerilla Tactics for Family Doctors focuses on low-cost strategies to guarantee one's own healthy survival. These Guerilla Tactics were surely never taught at any medical College, or at the University…

Strategies for Survival

Acquire Dogs & Training

Since scientists left their Offices and followed Timber Wolves to the woods, we begin to understand why dogs are the most successful companions of Mankind. They developed a rich Body Language or "Calming Signals", easily understood by any Dog worldwide, and by humans! If you want something to be done by a dog, it´s mostly a question of motivation! Dogs immediately show their Feelings and Emotions to the pack and seem to balance Signs of Stress and Discomfort very quickly in order to avoid stress (Turid Rugaas). A Dog wants to get out no matter what the weather and enjoys your sporty companionship very much. Communicating with this species focuses on the understanding of Body Language and a few Words. And by looking at the dog, you know who's boss ('What the Dog Saw', Malcolm Gladwell).

Photography

A doctor should have fundamental knowledge of taking a picture. As doctors, we are obliged to focus on Light, to help People out of their unknown Darkness of their Complaints: The more you see, the more you learn, the more you learn, the more you see (Aldous Huxley). Go buy a good Camera! Reframe your Picture of yourself as a GP on a regular base. Be aware that you only get the inside-out

view. Once in a while, you should also practice the art of looking outside-in (Kahneman).

Try to relax and condense a moment of time, freeze a movement, a notion, catch an emotion with your lens. Then store it and refresh every bit of these pictures. You might try some photoshopping once in a while. Delete what you don't like, sharpen the edges, give a little more contrast when it's lacking, be the director.

Dancing

Dancing offers Family Doctors a whole new world of a worldwide fully accepted Concept of Interaction with our Patients and Fellow Colleagues of other Disciplines.
The Euract "Bled" Courses in Slovenia offer Family Doctors dancing lessons!
In our daily consultations we mostly perform a Pas de Deux. Compliance and Adherence are about Leading and Following, and getting into ones Stride. It´s a fine School of humour in our attempts to follow the Rhythms of Life.

Sometimes you're invited for a Quickstep, the next patient is in for a Tango, the next one likes to Waltz you around and a day without a Rumba is a day not lived. All this dancing can exhaust you, and at the end of the day all you want is to skip along Fandango on a Whiter Shade of Pale with your life partner.

Haute Cuisine

Some Principles in Cooking are compatible with our prescriptions /interventions: please take a close Look at the local Food Traditions. Exchange Recipes! Ask your patients in which season and how to prepare the Fresh Food when you are rewarded with it at your Office.

Train your Nose and your Senses of Taste for the Joy of Life not only for the cure of illnesses.

Lucky you when your dog is under-the-table to protect you from: Medicus Medico Lupus est!

Sailing

Some principles of sailing are also very useful.
If the wind is coming straight from behind, just go straight out – if that is the direction you want to go.
If the wind is from one of the sides, you can still go straight out without manoeuvring a lot.
If the wind is opposite to you, and you decide not to go with the flow, then you need to tack.
If the wind is changing a lot, you need to adjust your course and tacking.
Always know your goal. Tides and winds are just as easy to play with as coping with life and its doings.
In your Network it's the knots not the mesh! Sail fast and live slow in the seas of Love!

Symphonic

Symphonic thinking is an art that is very useful in your daily life as well as in your daily practice.
A symptom or a complaint might be a note, it might be a tune, it might also contain a whole song or harmony. Train your ears in discerning what you hear – or don't.
Think of remedies or solutions as of symphonies: there is more than one music player at work, although the solo of an instrument can do wonders – if it is well timed and perfectly orchestrated.
All players are equal, as equal as the slowest or worst or atonal player. See to it that you know what you are directing – and to what it should lead: a wonderful piece of Bach or Beatles. Engage yourself in the way of lateral thinking and listening what´s between the lines due to celestial strings!

Conclusion

Lucky you living in the countryside, if you´ve found a wonderful Partner for Dancing, a Dog as your Personal Fitness Trainer, and a friendly Photographer/ friend who takes your picture and lets you look outside in. Lucky you if you can sail on symphonic thoughts.

The Art of practising these touches of Guerilla Tactics in Dog Training, Cooking, Dancing, Sailing and Taking Pictures while playing music is taught in the University of Life, and patients, partners and students help us in developing skills, motivation, feedback and in maturing together.

Take Home Messages

- Try to be in a good physical condition / shape.
- Learn from other species how to teach on the basis of motivation rather than of paternalistic, maternalistic, pillistic ways.

- Reflect your Life with Friends and professionally with Balint Groups.
- Be sure that your partner supports your wish to become a real good (rural) GP

Original Abstract

http://www.woncaeurope.org/content/37-pa-education-promote-health-and-well-being-family-doctors

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21 – Prevention and Health Promotion in Clinical Practice

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Primary health care is a suitable setting for interventions to identify and reduce behavioural risks factors and recommend preventive activities (including immunisations, screening for cardiovascular risk factors and cancer, and counselling).

A survey carried out in the year 2000 among 2082 GPs from eleven European countries showed that significant gaps persist between GPs' knowledge and their practice in the use of evidence-based recommendations for health promotion and disease prevention in primary care (1). To complement this GPs' survey, and in order to explore patients' views and beliefs on the importance of lifestyle and preventive interventions, another survey was carried out in the year 2008-2009, involving 7947 patients from 22 European countries (2).

The results of this survey showed that alcohol drinkers do not see, or fail to admit, that alcohol use is a risky habit that needs to be modified. Less than one third of risky drinkers would like to receive advice concerning alcohol intake from their GPs. It seems that patients are much more conscious about the risk of tobacco, unhealthy diet or sedentary lifestyle than the risk of alcohol. Also, patients reported that they had received less advice (in a discussion initiated by GPs) for alcohol than for tobacco, diet and physical exercise. In another study done in Sweden, only 18% of patients reported that they had received advice at least in one area, with a four-fold variation between the most common type of advice (exercise in 16%) and the rarest type (alcohol in 5%) (3).

The view of patients that GPs initiated a discussion on smoking in 63% of cases, eating habits (59% of cases), and physical activity (55%) shows some correlation with the views of GPs in Europe as surveyed in 2000 (1). At that time, GPs declared that they advised smokers to quit in 61 – 71% of cases, and counselled overweight and sedentary patients in 59 – 62% and 54 – 57% of cases respectively. However, in this study patients identified as risky drinkers said that their GPs had only initiated a discussion regarding their alcohol use in 42% while the 2082 doctors participating said they would advise heavy drinkers to reduce consumption in 57 – 64% of cases. Thus while patients and doctors seem to agree regarding the frequency of their discussions on smoking, healthy eating/weight and physical activity, patients seem to have a more negative viewpoint on how often doctors give advice on alcohol use. Table shows the views of patients regarding optimal interval for screening for cardiovascular risk factors and cancer and for vaccination.

More than 80% of women think they should be checked for cervical cancer yearly or every two years. However, revised guidelines recommend Pap test screening every three years for women age 30 and older (4). These findings reflect overuse of Pap test screening, which is expensive for the health care system and may result in unnecessary follow-up testing and increased risk for colposcopy-associated illnesses and adverse birth outcomes, as well as distress for patients (5).

The survey also showed that 43% of women aged 30-49 thought that screening for breast cancer should be done

yearly or more often and that 30% felt that screening should take place every two years. This recommendation is a direct challenge to the strong message from massive campaigns aimed at women in some countries over the last two decades advising they undergo yearly screening starting at age 40, and this is also reflected in the results of our study. Other studies have also found that opportunistic mammography screening in excess of the recommendation is common and persists despite explicit advice about recommended screening frequency (6).
Health professionals should be conversant with the recommended testing intervals for cardiovascular risk factors and for cancer screening in order to better educate patients in the judicious use of such tests.

Table. Views of patients regarding the optimal interval for screening for cardiovascular risks factors and cancer, and for vaccination.

How often do you think it would be appropriate to have…,% (95% CI)	Not at all	I don't know	Yearly or more often	Every 2 years	Every 3 years	Less often than every 3 years
Blood pressure check (n=5085) 1	1.2% (0.8-1.7)	15.5% (13.7-19.7)	75.1% (72.0-78.0)	5.2% (4.3-6.3)	1.1% (0.7-1.7)	0.9% (0.5-1.6)
Blood sugar check (n=6865) 2	1.1% (0.8-1.6)	16.7% (14.5-19.3)	66.0% (63.3-68.7)	12.4% (10.9-13.9)	2.3% (1.7-3.0)	1.5% (1.1-2.2)
Blood cholesterol check (n=5805) 3	1.3% (0.9-1.8)	17.5% (14.8-20.5)	62.6% (59.6-65.5)	14.3% (12.5-16.3)	2.7% (2.1-3.4)	1.7% (1.2-2.5)
Flu vaccination (65 years old and over) (n=928)	14.4% (10.9-18.7)	15.2% (11.7-19.5)	67.6% (61.1-73.5)	2.0% (1.0-3.7)	0.6% (0.2-2.4)	0.2% (0.0-1.1)
Cervical smear test (only women) (n=4007) 4	1.9% (1.2-2.8)	8.5% (7.1-10.3)	58.2% (54.9-61.5)	23.3% (20.8-26.0)	5.9% (4.6-7.6)	2.2% (1.6-2.9)
Mammogram (only women) (n=3650) 5						
30-49 years (n=1919)	1.4% (0.7-2.8)	14.4% (12.0-17.1)	43.1% (38.9-47.4)	29.7% (26.5-33.3)	6.6% (5.0-8.7)	4.8% (3.5-6.5)
50 years or more (n=1731)	2.8% (1.7-4.5)	8.2% (6.2-10.6)	41.7% (38.3-45.2)	40.6% (37.1-44.2)	4.5% (3.2-6.1)	2.3% (1.5-3.6)

1 Excluding patients diagnosed with high blood pressure
2 Excluding patients diagnosed with high blood glucose
3 Excluding patients diagnosed with high blood cholesterol
4 Excluding women diagnosed with cervical cancer
5 Excluding women diagnosed with breast cancer

Take home messages

- A high proportion of patients attending primary care with unhealthy lifestyles (especially risky drinkers) do not perceive the need to change their habits.
- Half the patients reported not having had any discussion on healthy lifestyles with their GPs.
- Patients overestimate their need to be screened for cardiovascular risk factors and for cancer.
- Further studies are needed to investigate the reasons behind these perceptions so that suitable strategies may be devised to tackle them.
- Health professionals should be conversant with the recommended testing intervals for cardiovascular risk factors and for screening for cancer in order to better educate patients in the judicious use of such tests.

Original abstract

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22 – Determinants of Multimorbidity

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Introduction

Multimorbidity, often defined as the co-occurrence of two or more (chronic) diseases within a patient, without an index disease being specified (1), is the rule rather than the exception in daily clinical practice. In Western countries the prevalence of multimorbidity in the general population ranges around 20-30% when the whole population was considered, and ranges between 55-98% when only older persons were included (2), with Asian studies showing similar results.

Risk Factors Associated for Multimorbidity

The main risk factor for multimorbidity seems to be age: in older populations the prevalence of the most common diseases, such as heart failure and dementia, is much higher than among younger patients, resulting in frequent co-occurrence of diseases. Multimorbidity is therefore often positioned as a condition of older patients. This is confirmed when looking at relative numbers, but increasingly it is recognized, that in absolute numbers the majority of patients suffering from multimorbidity is less than 65 years of age, with Barnett et al (3) reporting just over half of the people with multimorbidity to be 65 years of age or less.

Secondly, women and persons from low social classes consistently appeared to be more prone to multimorbidity across Western and Asian studies (2, 4). In a Brazilian study, Andrade et al (5) reported that somatic and mental disorders also frequently co-occur in a population sample of a developing country. The results suggest that substantial proportions of both chronic medical and psychiatric morbidities are not attributable to disorder-specific risks but rather to a few generic liability factors associated with many disorders, like lifestyle and distress. This supports the notion of general disease susceptibility (6).

Thirdly, ethnic, educational and cultural differences seem to play an important role: Black Americans had significantly higher initial levels of multimorbidity relative to white Americans in a national representative sample of US adults (7). The same study by Quinones et al. showed that higher education is associated with fewer reported diseases.

Methodological Influences on Prevalence Estimates

Already in the late 1990s it was recognized that many of the choices related to design of the study, definition and operationalisation of multimorbidity strongly influence the reported prevalence and incidence of multimorbidity (8). The influence of methodological decisions on the reported amount of multimorbidity is considerable. Starting with the various definitions of multimorbidity, where the minimum numbers of diseases differ (two vs three or more chronic conditions), or where multimorbidity is defined as the simultaneous presence of diseases/symptoms, cognitive and physical functional limitations, or the

unit of counting is organ systems instead of diseases. Furthermore, the number of conditions studied is of major importance for prevalence estimates: the higher the number, the higher the occurrence of multimorbidity.

Apart from a disease count there are a number of validated indices, such as the Charlson Index and the Cumulative Index Rating Scale. Although some indices cover only a limited number of diseases, they all aim to weigh the presumed impact according to illness burden. As chronic conditions widely differ in terms if severity and effects on survival and functioning, the mere number of chronic conditions do not necessarily have a major impact on outcomes. We can reasonably hypothesize that disease severity, disease duration and interactions between acute and chronic conditions are probably much more important than the mere count of chronic morbidities in increasing mortality risk. On the other hand, all studies agree on the fact that persons with multiple diseases have significant medical needs, which raises issues of resource allocation, equality and prioritization (2).

There is a serious distinction between data collection based on physician-diagnosed diseases (chart, paper files, EMR), administrative data, or patient self-reported diseases (questionnaires, interviews). The agreement between physician-diagnosed and patient-reported diseases is limited. Based on availability / feasibility, data choices made should be optimally adjusted to the research question.

In general, it can be stated that the more specialized the care setting the higher the prevalence of multimorbidity. Going from the general population to people in the waiting room in primary care, to a hospitalized population, the prevalence of multimorbidity is likely to increase gradually.

Future Research

It has been argued that future studies must begin to investigate multimorbidity across life course, to enable the distinction between real longitudinal changes and cohort effects. Furthermore, overlooking the field, knowledge on determinants of multimorbidity is still lacking for the greater part.

Key Points

Population prevalence of multimorbidity is 20-30%; with a sharp increase above 55 years; in absolute numbers of all patients with multimorbidity, more than half are over 65 years of age.

Older age, female sex and lower level of education are apparent determinants of multimorbidity.

Different definitions of multimorbidity and other methodological decisions have an influence on the reported multimorbidity.

Take Home Messages

- Population prevalence of multimorbidity is 20-30%; with a sharp increase above 55 years; in absolute numbers of all patients with multimorbidity more than half are older than 65 years.
- Older age, female sex and lower level of education are apparent determinants of multimorbidity.
- Different definitions of multimorbidity and other methodological decisions have an influence on the reported multimorbidity.

Original Abstract

http://www.woncaeurope.org/content/determinants-multi-morbidity

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23 – When Chronic Care Becomes End-of-Life Care: Bridging the Gap

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Population ageing remains a global phenomenon and it is not only a triumph for society but a huge challenge for health care systems.

Advances in health care have transformed our society and as a result fewer people today die of infectious diseases, and more people live longer. In addition however, more people are living longer with serious and chronic illnesses characterised by fluctuations in trajectory, uncertainty in prognoses, extended disease timelines and stress.

Helping someone that is living with a chronic condition can be challenging and sometimes the transition to end-of-life care is introduced too late to be fully effective.

The Key Question Is "When Does End-of-life Care Begin?"

The point at which end-of-life care begins depends on patients' needs. End-of-life care may last a few days, or for months, or years, beginning and ending when the patient needs it.

Often doctors focus on curing the disease but few have the time to explore all the wide-ranging solutions that can address symptoms and restore people to normal life as far as possible.

The current evidence suggests *various gaps in care, as reported by patients, their families, GPs and other health care providers.*

Identified gaps in the end-of-life care include problems in areas such as:

- patient's quality of life
- quality of care
- physical or psychological distress of caregivers
- cost-effectiveness of care.

Quality of care incorporates a great variety of aspects related to structure and process of care such as:

- physical aspects of care which hide many underwater stones in the management of pain, other symptoms and side-effects of treatment
- psychological and psychiatric aspects of care which involve trained professionals working as a team and special attention given to delivering bad news
- social needs, spiritual, religious and existential aspects of care which are often underestimated
- not respecting cultural preferences of patients and family
- disregard for the end-of-life concerns, hopes, fears, and expectations of the imminently dying patients
- and finally, key ethical and legal issues for terminal patients

A great variety of initiatives are needed to bridge the gaps in the current practices of care and achieve a better quality of life. Providers who care for chronically ill patients should be supported with evidence-based guidelines, specialty expertise, and information systems.

This vast subject would require a much more comprehensive approach beyond the health care system as it concerns other areas such as employment and the environment - "health in all policies". Another consideration is "What are the patient's desires and wishes?"

There is a need for an approach that focuses on the individual who has specific needs related to provision of prolonged and continuous care. These needs can be:

- medical; with regard to pain control and prevention of complications, etc.

- psychological; associated with the need for information or emotional support

- social aid in patients' daily life and involvement in the community

- spiritual; searching for a meaning.

All these needs relate to the organisation of healthcare, accessibility of services, and coordination between care settings.

The key being "Patient gets the right care at the right time in the right setting by the right health care providers."

In the search for effective and efficient solutions for the management of long term care, scientists are developing different programs.

The Chronic Care Model by Ed Wagner describes the necessary components for a delivery system that encourages and sustains productive interactions between patients and providers.

Improving Chronic Illness Care's Chronic Care Model brings together the best in research and practice for chronic illness care interventions.

The KCE report from Belgium in 2012 proposed a draft of an optimal-idealised-system, with the characteristics for the optimal management of chronic diseases that is needs-based, personalized, goal-oriented, planned and services are provided in a high quality, efficient, sustainable, accessible, culturally competent and patient empowering manner in the least complex environment that is clinically appropriate.

Palliative care offers an alternative perspective. Palliative care is a new, supportive, compassionate and integrative approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain, and other problems. Palliative care can be provided in hospitals, nursing homes, outpatient palliative care clinics, other specialized clinics, or at home. Palliative care teams help patients manage their new circumstances and relieve some of the physical and mental stress of internal illness. Ultimately, palliative care helps individuals live as well as possible for as long as possible. It is focused on timely identification of patients in need of palliative and end-of life care, assessing and agreeing how to meet people's needs and preferences, timely referral to palliative care experts, collaboration between patients, family and the medical team, the use of guidelines and appropriate working procedures, and knowledge of palliative care and symptom management on the clinical wards using advanced care planning, and delivering high quality services.

The end of a person's life can be one of the most important moments in that life. Meeting end-of-life care gives rise to ethical issues. Voluntary euthanasia and physician-assisted suicide bring about many ethical issues regarding a patient's death and have been the focus of great controversy in recent years. Some physicians claim that euthanasia is a rational choice for competent patients who wish to die to escape unbearable suffering. Others feel that aiding in the patient's death goes against a physician's duty to preserve life that is morally unacceptable. Some forms of voluntary euthanasia are legal in Belgium, Luxembourg, the Netherlands, Switzerland, and some states in the USA.

Primary health care, provided by GPs, is to a great extent the cornerstone of eliminating some of the gaps previously mentioned. High quality training for family doctors is vital to ensure the delivery of quality chronic disease management and a smooth transition to palliative care.

Patient-centred care is an option to help patients and families in various ways. Good doctor–patient communication leads to various positive aspects both for patients as increased satisfaction, better health outcomes, improved understanding, increased adherence to treatment and for doctors - decreased job distress and less emotional stress and burnout.

Take Home Messages

- Proactive and holistic thinking
- Attention to patient and family as unit of care; patient-centred approach
- Education and support for the patient and family, and continuing medical education for care providers
- Effective communication
- Interdisciplinary team approach

Original Abstract

http://www.woncaeurope.org/content/4325-when-chronic-care-becomes-end-life-care-bridging-gap

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24 – What is Universal in Primary Care? Challenges for North/South Co-operation.

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Introduction

A cursory examination of the way Primary Care is practised in the Northern and the Southern hemispheres gives the impression of vast differences in orientation, settings and operations. With the advent of the global focus on Primary Health Care heralded by the Alma Mata declaration of 1978, the focus of Primary Health Care in the South was predominantly Community oriented. Emphasis was on disease prevention through immunization, provision of water and environmental hygiene (1).

The operation was driven by Community Health Extension Workers and other Physician assistant personnel. On the other hand, in the North, the orientation has traditionally been based on physician-led individual person-centred care often with strong Private Public Partnership.

Over the years, there has been a convergence in the approach to Primary Care with more integration of both models to varying degrees. However, differences still exists in broad terms. The apparent differences often give the impression that there is nothing in common in Primary Care between the North and South.

The impression is further accentuated by the vast array of ethnic, cultural, social, economic and technological diversity in which Primary Care operates in both settings. The apparent differences give the impression of a parallel paradigm with no meeting point, nothing in common and nothing to learn from each other. This is misleading.

What is Universal?

Within the midst of the array of ethnic, cultural, social and economic diversity is the universal cord that ties us all together – the humanity in us. At the most basic level, man's needs are the same irrespective of the circumstances, location or situation of our birth – the need for self-preservation, safety and security, love and self esteem.

Primary Care is at the heart of the most basic of these needs - the instinct for self preservation. Forging alliances with people and their families to promote optimum health, prevent disease, and when necessary make prompt accurate diagnosis and implement /coordinate effective care to our patients in the most dignified manner possible. The basic elements of Primary Care - accessibility, comprehensiveness, continuity and coordination apply universally (3). The attributes of good primary care - compassion, patience, love of people, love of communication and care are universally demanded and appreciated(4).

Perhaps the strongest articulation of the universality of the quest for Primary Care is that of Margaret Chan, the Director General of WHO in her introductory remarks to the World Health Assembly 2008 World Health Report:

"A primary care approach is the most efficient, fair, and cost effective way to organise a health system. It can prevent much of the disease burden, and it can also prevent people with minor complaints from flooding the emergency wards of hospitals. Decades of experience tell us that primary health care produces better outcomes, at lower costs and with higher user satisfaction" (5)

The entire report titled "Primary Care; Now More Than Ever" underscores the urgency of concerted universal efforts to give thought to rekindling attention to the development and sustenance of Primary Care (6).

However, Primary Care has many different faces, depending on the context and geographical location where it is practised. Whereas in one location it may be normal to perform a surgical procedure for appendicitis on the kitchen table, it is highly irregular to perform the same procedure in another place. Though both doctors work in Primary Care, their task description is very different – modified by several factors.

The moderating factors include the economic environment, the level of social and technological development and the effectiveness of the Health Systems in place. Even within Regions, there are differences. Health Systems in the United States and Canada for example are quite different from those in Brazil or Cuba. These factors are dynamic and undergoing continuous evolution. This has resulted in evolutionary continuum with the North predominantly at one end and the South at the other in different fronts.

These factors of socio-economic and cultural realities impart on how Primary Care is implemented. The implementation of Primary Care is in the context and place where it is practised. Therefore, there is no such thing as a unique form of Family Doctor.

North/South Co-operation

The peculiarity of the circumstances and situations under which Primary Care is practised from North to South offers unique challenges to the practitioner. The mastery of these challenges builds valuable experience for the practitioner whether practising in the North or the South. The experiences in a geopolitical zone at a point in time are potential sources for learning for others. The examples of Brazil and Cuba's models of Primary care are veritable examples which offer lessons for Countries in both the North and South.

Most of the time, North-South co-operation is seen as a one – directional way of assistance. But as described above, the time and place of delivering Primary Care are so different, that there is no real mirror of the circumstances.

Therefore, bi-directional co-operation in which experience are shared between the North and South is what is needed.

The vital questions should be: What can each of us contribute to each other? What can the North learn from the South and vice versa? There is a lot we can learn from each other - From National Health Systems, how Primary Care is delivered at practice level to epidemiological disease prevalence, pattern and treatment.

Challenges

Implementing such bi-directional co-operation has its challenges:

Living in a world where Malaria and Ebola are prevalent is quite different from a world with largely lifestyle problems as challenges. Hypertension is a Northern problem, Dengue and Malaria are Southern problems.

Cancer and Diabetes Type 2 are ubiquitous; but one has to live long enough to get them. To add to the complexity, in the dynamic societal evolution and globalization, what was exclusively a Northern problem yesterday is gradually becoming a universal problem today and vice versa. This is why co-operation is inevitable.

Take home messages

- Primary care offers the opportunity to forge an alliance with people and their families to promote optimum health, prevent disease, and when necessary make prompt accurate diagnosis and ensure effective care to our patients in the most dignified manner possible.
- The peculiarity of the circumstances and situations under which primary care is practised in both the North and in the South offers unique challenges to the health care practitioner.
- We need bi-directional approaches and co-operation, in which experiences are shared between the South and the North.
- The best way to co-operate is to learn from one another – and that is why WONCA is so important. It offers the opportunity through its Conferences and other activities to exchange experience and ideas.

Original abstract

http://www.woncaeurope.org/content/291-what-universal-primary-care-challenges-northsouth-co-operation

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25 – The New Consultation: The Doctor in the Electronic Age

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The New Consultation: developing doctor-patient communication, (Pendleton et al 2003), and it's predecessor The Consultation: an approach to learning and teaching (Pendleton et al 1984) both described:

- the current literature on Doctor Patient communication
- the ideas, concerns and expectations that patients bring to their consultation
- the opportunity that each consultation has to develop the patient's understanding
- the potential to develop the relationship between the doctor and patient over time.

  Based on this "Cycle of Care" we were able to describe Tasks to be achieved in the consultation, which in summary are:

  Understanding the patient's problem

  Understanding the patient

  Sharing understanding

  Sharing decisions

  Sharing responsibility, and

  Developing a relationship that helps to achieve the other tasks.

Are these still relevant in "The Electronic Age" characterized by the emphasis on Evidence Based Medicine and Shared Decision Making, by new technologies, and by developments in health care systems?

Evidence based medicine aims to improve the quality of the evidence on which clinical decisions can be based. However most evidence is derived from populations, while the clinician is dealing with an individual patient, and that the approach can generate a "right" answer, with which the clinician, and in turn the patient, is encouraged to comply.

Shared decision making, or Evidence Based Patient Choice (Elwyn et al 1999), responds to these criticisms by an approach where clinicians and patients make decisions together using the best possible evidence. This involves presenting the evidence about diagnosis, options for treatment and it's benefits and harms and uncertainties, in ways that are fully comprehensible to patients, and encourages and enables patients to make choices about their own care.

There is evidence that shared decision making can produce better informed patients who are less passive, who adhere better to treatment, and who sometimes make more conservative decisions about treatment. There is strong professional and institutional support for the implementation of shared decision making. (The Salzburg Declaration 2010).

Another major technological change is the almost universal presence of the Computer in the Consulting Room. This

has transformed record keeping, particularly in primary care. They can provide structured records and templates for the management of chronic conditions, for results and for screening and prevention. The patient's record can be shared with other team members, and across sites, and in some settings patients can access their own records, and become more involved in their own care.

Computerization of the consultation can also bring problems. It can interfere with maintaining eye contact with the patient, and can influence the doctor's agenda to be more structured and task orientated in response to the templates and prompts of the computer. Bensing et al in 2006 found that in two sets of recorded consultations with patients with hypertension separated by 10 years, the technical quality of care by the doctors improved, while the patients spoke less, asked fewer questions, and expressed fewer concerns and worries. She speculated that this reflected the shift towards more evidence based protocol driven care, as well as the influence of the computer in the room.

Computers also allow doctors and patients to access information, guidelines and decision aids either in the consultation, or for patients to consider afterwards. This can also include examples of patient experiences on sites such as Healthtalk (Ziebland et al 2013).

The telephone is being used increasingly as a means of communication with patients in many settings. It can improve access and follow up, it can be convenient for patients, and can be a more efficient use of doctors' time. On the other hand a telephone consultation does not involve face to face contact, omits visual cues and physical examination, and both the doctor and the patient may feel that it was a "second best" and riskier encounter.

Other modes of communication such as Email, Web sites and Social Media are less well established but offer opportunities for innovation, as does self-recording and monitoring using smart phones. All have the potential to help patients become better informed and more in control of their own health care. However it is face to face contact that builds mutual understanding and trust between doctor and patient.

Continuity of Personal Care is valued by many patients, particularly those that are older, have long term medical conditions or psychological conditions. Supporters of personal continuity argue that personal continuity leads to increased patient satisfaction, more trust, and better care (Gray DP et al 2013). However, in the United Kingdom the health care system has recently given greater weight to accessibility, which is also valued by patients. Changes in the contract with general practitioners, and increased shift working in hospitals, have made the delivery of personal continuity more difficult.

Per Fugelli in his James Mackenzie Lecture in 2001 defined Trust as the individual's belief that the sincerity, benevolence and truthfulness of others can be relied on, and that trust often implies a transfer of power to a person, or to a system, to act on one's behalf, in one's best interest. He described personal trust as the trust you have in an individual, such as your doctor, and social trust as trust in societal institutions such as the government or health care institution. He went on to describe the influence that trust, or the lack of it, has on the process of the consultation.

Take Home Messages

- Understanding the patient, their problems and their perspective remains an essential task in an effective consultation.
- Shared Decision Making can enable patients and improve their care.
- New technologies offer new opportunities for communication, but should not be a substitute for face to face contact.
- It is essential that we maintain the trust of patients in their doctor, the medical profession and the health care system.

Original Abstract

http://www.woncaeurope.org/content/466-new-consultation-doctor-electronic-age

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26 – How to Deliver a Successful Learning Package for Family Medicine Trainees?

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Like most learners, FM trainees are eager to learn to become competent professionals. It is the task of tutors and course organisers to guarantee the quality of learning. In order to be successful, learning programmes require a certain number of features. Family Medicine has been in the front line of innovation in designing learning and teaching programmes to fit the objectives and learning needs of trainees (1). Furthermore, it has published guidance and developed several courses to allow the development of teaching skills of tutors and teachers in family medicine (2,3).

What Makes a Teaching Programme Successful?

This text will review some of the characteristics of a teaching package that can include in-person learning, such as small group work modules combined with distance learning, mostly using problem based learning and integrating practical work in a real primary care setting.

Learning objectives and content can be adapted to work with small groups, individual learning or one-to-one teaching in a residency programme. We will consider the six key features that make such a comprehensive programme effective.

Content

In most countries, there is already a good syllabus defining the content of learning and teaching in the training phase (4). In the planning stage of each learning package, teachers have to define very clearly the purpose of the module that should be based in the assessment of the training needs, the skills and knowledge deficits of students and the learning objectives (5). The objectives have to be written in a clear way as measurable statements of what participants should know or be able to do. Ideally, the specific training needs of each trainee or group of trainees should be evaluated previously to the design of the programme, so that the teaching and learning package is tailored to the participants' knowledge or skills gaps (5,6).

The Human Factor

Training involves different people who agree to participate and need to be aware of their roles and tasks. Trainer and trainee have to be capable to build and maintain a continuing relationship. They should also be able to involve the practice nurses and staff and to obtain the consent from patients, who should be clearly informed of their rights and assured that their voluntary participation is important for the teaching programme and that any inconvenience should be minimised.

The Environment

Teaching and learning is facilitated by an adequate environment. Premises for group work should allow a distribution of seats so that all participants and the speaker can face each other. If a group sits in a circle without a table, communication is likely to be easier. Designing web based teaching requires certain skills and the support of a good technical team. In a teaching practice, the premises have to meet certain requirements such as a minimum number of consulting rooms and areas for meetings and presentations. Besides the normal clinical tools there should be equipment specifically dedicated for teaching, such as a fast internet access, data-show and screen, flip charts, and video cameras.

Types of Learning

Other important features that need attention are the types of learning required with relation to different aspects of education. Types of learning fall into three categories. The first one consists of the knowledge of specific facts, patterns, and concepts. The second category includes the skills that require practical abilities, manual skills measured in speed and / or precision, clinical reasoning and problem solving aptitudes. The third one contains the attitudes, realising feelings, values, and motivation (5).

Learning also requires adaptation of the program to individual trainees as people have different individual learning styles. Some persons learn quickly by listening, some others need to complete listening by reading and memorising; others have to repeat and correct the skill until they know it. This requires the tutor to take into account the trainee's preferred learning style and to consider the trainee's learning needs.

Communication

Good communication is essential for effective teaching and learning. Tutor and trainee should develop an adequate communication mode. This requires frequent interaction aimed at clarification, problem solving and course correction. Adult learning though, is a process that requires independent learning and the role of the tutor is more of a facilitator and organiser coaching the trainee through the learning process. Qualities such as openness, networking, and proactive communication are important ingredients in the process of personal and organisational change (7).

Assessment

Assessment is important because it drives learning, allows measures of individual and programmatic progress and assures the public that providers are competent. It is fundamental to outcomes or competency-based education (8). Assessment methods have to be adapted to the type of learning. Common methods of assessment such as multiple choice questions, simulation tests, and objective structured clinical examinations (OSCEs) target the lowest levels of the learning pyramid (7,8), while work based methods of assessment target the highest level of the pyramid and collect information about doctors' performance in their normal practice and should be preferred in a more comprehensive teaching program.

Miller's Pyramid of Competence. (8)

Conclusion

Delivering a successful learning package for FM trainees requires a certain number of skills. Family Medicine teachers and tutors should be aware of this and undergo some of the available training programmes in order to master the

basic features of adult education. This will be a key element in assuring the quality of future family physicians.

Take Home Messages

- Learning is a process that you have to learn.
- Teaching is a skill that you have to learn and train.

Original Abstract

http://www.woncaeurope.org/content/11-w-teaching-science-learning-care-how-deliver-effective-learning-package-gp-trainees

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27 – The Integration of Mental Health into Primary Care: International Perspectives

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According to an evaluation in 2012, approximately 38% (1) of the European population suffer from a mental disorder at some time in their life. The WHO predicts that by 2020, significant psychiatric disorders will make a major contribution to the burden of disability and suicide (2)(3). This is even more pertinent with regard to the current economic crisis and the consequent reduction in resources and services. The message delivered to European nations at the Helsinki Conference of 2005 was that there is no health without mental health (3). Nine years later, one wonders if European states have kept their commitment to promote mental health policies with respect to public health, adoption of a life course approach targeting all age groups, making structural changes, community transformation and respect for human and civil rights of people with mental disabilities. If they had, perhaps today's outcomes may have been different. In recent years, the international economic crisis has had an important psychosocial impact on individuals and families through the reduction of available resources. It has resulted in increasing social marginalization, unemployment and higher risk of exposure of the individual to stressful life situations, with negative repercussions through the increased risk of developing psychiatric disorders and by making treatment and recovery more difficult.

In high income countries there remains a lack of social inclusion for those people with mental health problems including a fragmentation of family and social structures, poor housing, lack of employment opportunities and loss of spiritual framework. Against this background;

- Family Physicians are in a position to provide leadership in the health care system (5)
- it is important that this role is supported by national governments.

Family Physicians should be carefully consulted before the development and implementation of new policies and processes in order to achieve the goal of health care cost containment and improvement in the management of mild and moderate psychiatric disorders, in order to avoid the stigmatization of mental health patients with all the negative consequences that this may carry. Family Physicians must have leadership roles in managing the delivery of health services because the Family Physician is one of the medical professionals best placed to demonstrate the full range of qualities necessary to drive change including; (6) trust and doctor-patient relationship, expertise in diagnosis and prognosis, expertise in complex decision-making process, the beginnings of a multidisciplinary approach to health care, professionalism, leadership and management skills in delivering comprehensive primary health care to large populations and skills in the training of medical students and doctors.

In the early 2000s, care delivery to patients with mental health difficulties was driven through a lens of ethics and morals (7). Today the choice is not only based on these ideals but also on the wise use of

limited economic resources to deliver quality interventions with a reduction in health care costs.

The vision that I'm proposing, could be interpreted as reductionist but it is better at maintaining quality of care and treatment interventions ethically whilst reducing costs. To achieve this goal, Family Physicians need to become more skilled in the foundations of psychiatric diagnosis and therapy, not to become pseudo-psychiatrists but to play a pivotal function in delivering mental health services to a broader range of the primary care population.

By adopting this suggested approach, the role of the Family Physician becomes the constant filter and support at the primary/secondary care intersection. We might say that there is nothing new under the sun. From my point of view there is a great difference between the former vision and the current situation. In the 1980s there was a simple proposal designed to streamline the psychiatrist's work, making him/her responsible for interventions for the most severe and high-risk cases. The current economic stagnation dictates that there should be less waste and demands that the majority of interventions are delivered in primary care (8). Moreover, it has broadened the horizon to a world of "emerging needs" of mental health for primary care including adolescents and young people who require early intervention, the elderly, people suffering from common emotional disorders or with complex co-morbid somatic conditions and a whole population who attend family practice as the first port of call when faced with medical needs. Alongside the responsibility of delivering more treatment for newly presenting mental health problems, Family Physicians are also expected to sustain the goal of a more inclusive society by supporting the reintegration of patients with severe mental disorders. Family Physicians are called upon to promote societies' ability to understand and tolerate the complexity of individuals and the variety of different ways of being in the world. They are also expected to avoid the temptation to make superficial changes by evading the right but difficult decisions and ignore the evidence base for political expediency and 'short-termism' or by merely attending to the risk associated with mental suffering and disorder.

I would like to propose the following goals:

Mid- term goals:

A reduction in the numbers of people with mental health problems followed up by secondary care mental health services
An increase in the number of patients with mental health problems managed by Family Physicians
More appropriate use of the resources offered by psychiatrists in Secondary Care
More rational use of nursing resources to address mental health problems

Long- term goals:

An improvement in the quality of interventions offered in mental distress
Evidence based and appropriate consultations
Evidence based clinical and therapeutic interventions
Evidence based nursing interventions
A decrease in hospital admissions
A decrease in relapse rates
Efficient management of resources

In my view this is the future challenge for the Family Physician who, as a result of the nature of the role, deliver assessment and treatment to large numbers of the population within a defined geographical area, and in a broader social context, informed by the Family Physician's depth of knowledge of the family and social contexts of his/her individual patients. Therefore, the Family Physician remains the pivotal figure of future health systems.

Take Home Messages

- Family Physicians encounter covert and sub-clinical psychiatric disorders
- Family Physicians manage psychiatric disorders with reduced costs
- The stigma related to mental disorder is decreased in the general practice context
- Family Physicians are in a unique position to provide comprehensive management of the patient's mental and physical disorders
- Family Physicians also implement social interventions for their patients

Original Abstract

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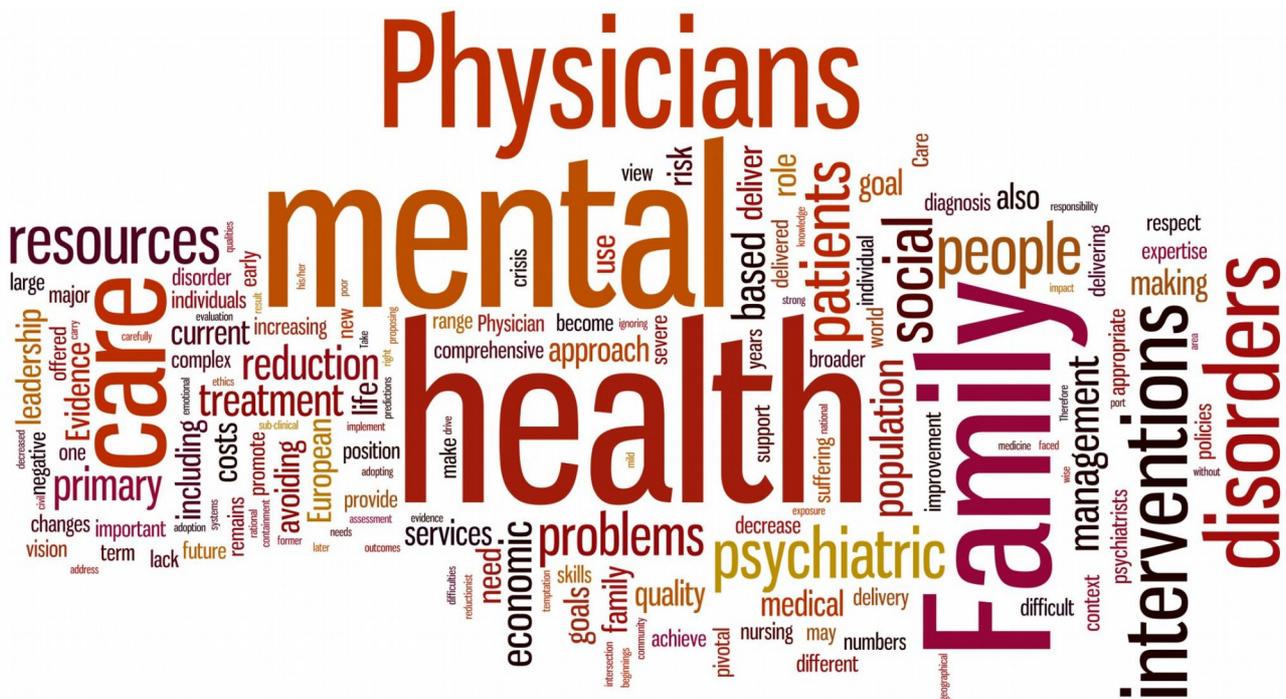
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28 – WONCA and the Cochrane Primary Health Care Field: opportunities for a synergetic collaboration

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The Cochrane Collaboration is a global independent network of more than 31,000 dedicated people from over 120 countries. It constitutes an equal partnership between health practitioners, researchers, health care providers and patient advocates. Its mission is to promote evidence-informed health decision-making by preparing, updating, and promoting the accessibility of Cochrane Reviews, published online in the *Cochrane Database of Systematic Reviews*, part of The Cochrane Library (www.thecochranelibrary.com).

Cochrane Reviews are systematic reviews of primary research in human health care and health policy, and are the highest standard in evidence-based health care. The abstracts and plain language summaries of all Cochrane Reviews are also freely available on Cochrane Summaries (http://summaries.cochrane.org/), thus ensuring equal accessibility to anyone interested in evidence informed health care.

In January 2011, the World Health Organization (WHO) awarded Cochrane a seat on the World Health Assembly, the decision-making body of the WHO. This provides Cochrane an opportunity to promote evidence-based health care at the highest levels of international health care policy-setting.

The Cochrane Primary Health Care Field (CPHCF) and its Achievements

The Cochrane Collaboration (www.cochrane.org) is organised by 'entities' called 'groups' or 'fields'. *Primary Health Care* became the first registered field in October 1993. While the Cochrane Review Groups focus on production and promotion of Cochrane Reviews, Fields advocate the representation of certain interests in the Cochrane Reviews (for example a focus on setting, e.g. primary care, or patient groups, e.g. children). Furthermore, fields promote and enhance dissemination and implementation of evidence from systematic reviews in the area they represent.

Thus, the CPHCF aims to ensure that the primary care perspectives are adequately represented within the Cochrane Collaboration. Moreover, the field promotes and stimulates the development of Cochrane reviews which are more relevant and accessible to primary care (Van de Laar 2007).

Means to achieve these goals are, for example: introducing, supporting or linking primary care peer reviewers, or authors with Field-relevant expertise to Review Groups editors. In addition, the CPHCF tags existing reviews and review-protocols with ICPC-codes in order to make them more accessible to workers in primary care. This enables the products of the Collaboration to be accepted and adopted into practice.

We have developed two important 'tools' to assist us achieve our goals. Firstly, we have created the concept of PEARLS (Practical Evidence About Real Life Situations) which are very concise summaries

of (Cochrane) reviews focusing on one Clinical question for direct implementation in practice (Arroll 2011). PEARLS are disseminated through the CPHCF website and Newsletter, The Cochrane Library, the WONCA website and the website of the New Zealand Guidelines Group. PEARLS have also been published in the Dutch Journals of *Huisarts en Wetenschap* and *Modern Medicine* and also at conference presentations.

Furthermore, we have developed the website www.cochranegetinvolved.org in which we welcome new collaborators in primary care research. Accordingly, this network is integrated into the formal Cochrane ('Archie) network and enhances (future) collaboration with primary care research and practice. The current focus is to expand this network and link it to the activities of the various Cochrane Review Groups.

Another spearhead of the CPHCF is the development of a register of studies on the development, validation and impact of Clinical Predication Rules in primary care. This project is coordinated by the Dublin branch of the CPHCF and is supported by the HRB Centre for Primary Care Research (www.hrbcentreprimarycare.ie). So far, a register of over 700 CPRs have been identified. A reproducible search strategy to identify relevant CPRs has been developed that is enabling regular updating of the register. A searchable, web-based register is being developed and would form part of the Cochrane Primary Health Care Field activity. Other developments include assessment of CPRs in relation to their use in clinical practice guidelines, and a systematic review of randomized trials that assess the impact of CPRs in clinical practice in primary care.

Global Family Medicine and PHCF

WONCA and the Cochrane Collaboration share many important objectives. Both WONCA and the CPHCF aim to foster high standards of care in general practice. With this in mind, the Cochrane Collaboration produces high quality and accessible systematic reviews for the promotion of evidence –informed health decision making. Both organizations aim to promote health equity. Cochrane strives to achieve this by making the vast amounts of evidence generated through research useful and available to everyone (both practitioners and patients) interested in human health care. In addition, both WONCA and the CPHCF are academic initiatives which aim to collect, collate and disseminate information concerning the research aspects of general practice. And finally, both WONCA and Cochrane provide a forum for exchange of knowledge in the field of health and medical care.

WONCA has already important, established links with the Cochrane Collaboration. Cochrane output such as the Cochrane Library and PEARLS from the CPHCF are incorporated at the WONCA World website as important resources for general practitioners. Cochrane is also represented in WONCA through many individual members. We sincerely hope that Cochrane and WONCA will continue to collaborate in the promotion of evidence-based primary care.

Is Cochrane Helpful in Everyday Practice?

For some colleagues The Cochrane Collaboration may seem an academic initiative with only a distant association to every day practice. We believe that the opposite is true (Fahey 2013). Firstly, an efficient way in applying Evidence-based principles for your patients is searching, reading and using systematic reviews. Compared to primary studies, the information-density that comes from systematic reviews is enormous. The Cochrane systematic review aims to reduce publication bias. Moreover, the latter's structured format makes them easily accessible for readers whore are interested in part of the information only. And for those who like to cherry pick, there are many easy-to-read structured summaries available through the Cochrane summaries website, in particular for those primary care people who wish to receive the PEARLS that are distributed through the Primary Care Field. So do not hesitate and subscribe for the Field on www.cochraneprimarycare.org .

Take Home Messages

- The Cochrane Collaboration publishes Systematic Reviews in order to support evidence based decision making in Health Care
- The Primary Care Health Care Field is the entity within Cochrane that represents family medicine and primary care in the Collaboration and vice versa
- The Field produces PEARLS which are concise and easy-to-read abstracts of Cochrane reviews aiming at specific clinical questions
- WONCA and Cochrane share many important values and further future cooperation between the primary care field and WONCA seems promising

Original Abstract

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29 – Do you Understand how Your Health System Works? From Beveridge to Bismarck; a Whistle-stop Tour of European Health Systems

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As family doctors we should be thinking about how our healthcare system works and how we can shape it. We share responsibility for the distribution of limited resources not only as healthcare professionals, but also as patients and taxpaying citizens. But how much do we know about how the system works, and in particular how it is financed?

Healthcare Systems' Goals

In order to understand a healthcare system the first requirement is to think about its policy goals. The 'final' goals ultimately are; to improve the health of the population; to be responsive to the needs of healthcare service users and citizens; and to ensure protection among citizens from the burden of financial hardship due to healthcare payments.

There are also 'instrumental' goals; to be transparent and accountable; to deliver high quality healthcare services; to be efficient; and to ensure equity across the healthcare system. Equity exists in several forms, such as equity in access or use of the service, equity in coverage of the type of services provided to the local population, and equity in how financial risk is redistributed.

With the final and instrumental goals of a health system in mind, there are three key questions that help to determine the financing structure of a health system; (1) Where does the money come from? (2) Who collects the money? (3) How is the money spent?
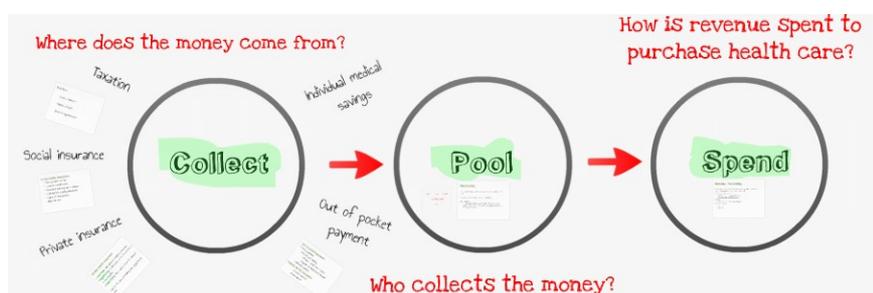
Where Does the Money Come From?

There are several ways to collect funds for healthcare. Options include taxation, compulsory social health insurance, voluntary private health insurance, individual medical savings accounts or out-of-pocket payments. In the case of lower income countries, funding can also come from international donations.

The archetypical European models to collect funds for healthcare are the tax model, named after the English

economist William Beveridge (1879-1963), and the social health insurance model more commonly known as the Bismarck model, named after German Chancellor Otto von Bismarck (1815-1898). In 1942 Beveridge laid the foundations of the National Health Service (NHS) in the United Kingdom in which free healthcare at the point of delivery was paid through taxation collected by the government. Bismarck passed the sickness insurance law in 1883 in an effort to improve economic growth through employees' well-being in Germany. In his model employers contributed one-third and workers two-thirds into locally managed funds that paid for medical treatment and sick pay.

In general terms, taxation and social health insurance are considered the most 'progressive' methods of paying for healthcare, in other words, they enable the most equitable forms of collecting and pooling funds. On the other hand out of pocket payments are 'regressive' or the least equitable, hitting the sickest and poorest the hardest. Every method has of course its own variants, advantages and disadvantages, as well as its ethical, moral and ideological arguments. Thinking about taxes, for example, differences can arise in whether taxes are collected directly (e.g. income tax) or indirectly (e.g. tobacco tax) or whether those who earn more should contribute a higher proportion of their earnings.

Who Collects and Redistributes the Money?

The second question points to how the money is pooled and (re-)distributed. Fund pooling is the accumulation of prepaid healthcare revenues on behalf of a population and facilitates the pooling of financial risk across the population. Collection agents can either be public or private, for profit or not-for-profit. The size of pools can vary (e.g. national versus regional). If multiple pools are available a risk-adjusted re-distribution of funds according to the risk profile of the population (e.g. age, sex, etc.) covered by each pool is preferable. This, in addition to regulation, is important to prevent cherry picking of patients in competitive health insurance systems, as well as to reduce the risk of healthcare funding bodies becoming insolvent.

How Is the Money Spent?

The third question explores how money is used to purchase healthcare. The range or package of services can be agreed upon in several ways, for instance by decree in the Netherlands or by negotiation in Germany. A single organisation can undertake both the purchasing and provision functions, or these may be divided up between different organisations. In the English NHS in the 1990s for example, a purchaser–provider 'split' was introduced to encourage provider competition in healthcare markets.

How healthcare professionals are paid can vary and this can affect the healthcare system's ability to contain costs and deliver high quality care. Thinking specifically about primary care, for example, family doctors can be salaried, paid through fee-for-service or by capitation – or a blend of all three payment methods. In the most basic sense, salary and capitation payments are often less costly than fee-for-service and in particular in the case of capitation may promote preventive work. However they can lead to doctors over-delegating and under-providing services. Meanwhile fee-for-service places the financial risk on the payer and may potentially increase 'unnecessary' activities.

Performance-based pay is also often used, which involves paying doctors or groups of doctors for achieving targets on quality indicators. This may lead to improved attention to quality domains, but can also lead to surrogate end points, neglect of non-quality indicators and may disturb the doctor-patient relationship. There are, of course, more incentives than just money. Providers can be incentivised by professional development, clinical guidelines, utilisation reviews, targets, public disclosure, ethics and of course an intrinsic desire to do good! Payments can modify behaviour, but mechanisms to create more incentives generally have greater administrative costs. Their merits depend on the context in which they are made.

Take Home Messages – Finding the Right 'Blend'

- Archetypal models and methods generally ignore the complexity of healthcare system financing and conceal similarities and differences. It is unlikely to find a system that, for example, uses tax contributions solely to fund healthcare and reimburses providers using solely capitation-based payments. Most systems in Europe now blend methods to collect, pool and spend healthcare funds.
- In order to achieve the policy goals of any healthcare system blended methods of financing are needed to balance the drawbacks of purist methodologies and to align incentives. The input of family doctors as advocates for their patients and as front-line health professionals is important to help find the right blend in each context to meet the desired goals of their healthcare system.

Original Abstract

www.woncaeurope.org/content/ws07-do-you-understand-how-your-health-system-works-beveridge-bismarck-whistle-stop-tour-2

WONCA Europe Vienna 2012

In a packed room during the 2012 WONCA Europe conference in Vienna, this workshop set out to provide participants with a framework to compare their own healthcare systems. It was picked up in a column by RCGP chair at the time, Prof Claire Gerada (1), reported in a blog for the London School of Economics and Political Science (2), and the full presentation (available on Prezi) has over 3000 views (3).

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30 – The Transition from CME to CPD - Fostering Good Practice Through Education

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Introduction

The College of Family Physicians of Canada is a voluntary organization of Family Physicians, which makes CME/CPD mandatory. Over ninety percent of its members have obtained Certification, which is an indicator of special competence in the discipline of Family Medicine. In 1997, the CFPC introduced Mainpro-C activities, which aim to have more of an impact on practice than traditional CME, by encouraging physicians to reflect on the impact of the learning on their practice. It is well recognized that the determinants of good practice go far beyond disease management and the role of clinical expert. We utilized eight identified physician roles:

- medical expert,
- communicator,
- collaborator,
- health advocate,
- learner,
- manager (gatekeeper),
- scholar,
- and "physician as person",

as a model consistent with good practice and meeting societal needs. Currently, Medical Regulatory authorities in Canada are reviewing the integration of a physician's CPD/CME portfolio as a component of revalidation of licensure. In this study, we will review the past Mainpro-C activities of our members based on the identified physician roles.

From CME to CPD in a Regulatory Context of Physician Practice Improvement

The College of Family Physicians of Canada is responsible for the accreditation of postgraduate residency programmes in family medicine in each of Canada's 17 faculties of medicine. It is responsible for the creation and administration of examinations leading to Certification in Family Medicine and a Certificate of Special Competence in Emergency Medicine. It is also responsible for setting the criteria for Maintenance of Certification, and for supporting all family physicians in their commitment to lifelong learning. Since 2007, most medical regulatory authorities are mandating that physicians demonstrate such commitment through participation in an accredited programme of continuing Professional Development (CPD) by either the CFPC or the Royal College of Physicians and Surgeons of Canada (RCPSC) for specialties other than family medicine.

Context

Several factors have stimulated reflection and evolution regarding CFPC's maintenance of certification programme: 1. Team based care; 2. Greater importance of work-based learning; 3. The need for reflection about impact of learning on practice, given the evidence to support the importance of this step to support practice improvement; 4. Regulatory context in which increasingly physicians will need to demonstrate maintenance of competence and a commitment to practice improvement.

Action

The CFPC will be introducing an enhanced programme of maintenance of Certification, Mainpro+, in July 2015. It aims to support family physicians better in assessing their learning needs, to help them to capture the many ways in which they further their learning in all spheres of practice, and to reflect on the impact of each learning activity on their practice. Mainpro+ has three categories of CPD activities: Group Learning, Self Learning, and Assessment, with sub-categories (Certified and Non-Certified) within each group. There will continue to be a yearly minimum requirement of credits for each five year Mainpro cycle. CPD activities that stimulate learning in all the roles expected of physicians (Collaborator, Communicator, Manager/Leader, Professional, Scholar, Health Advocate, Medical Expert-Definitions based upon CanMeds-FM) will be encouraged and incentivised, and recognition of the learning needed to excel at teaching, research, and administration as well as clinical work. All participants will be encouraged to develop a learning plan at the beginning of their cycle. For those family physicians who have acquired enhanced credentials in a focused area of practice, there will be a minimum number of credits required to address that practice domain.

The CFPC, along with several other medical professional organizations, will build upon the Future of Medical Education in Canada (FMEC) project, to be part of a consortium working towards a CPD system that can consistently address evolving needs and priorities. The 3-year planning phase will be co-chaired by CFPC and the Royal College of Physicians and Surgeons of Canada. Describing and bringing these future directions to life will be accomplished through commissioning a series of collaborative projects to address important questions that will have a bearing on the future of CPD and the role(s) of a future Consortium (e.g. How will CPD activities be funded? What will be the role of patients and the public in setting priorities? How will team-based care be reflected in the setting of learning? etc.). The FMEC-CPD project will leverage the high degree of collaboration and conjunction of interest that already exists across the many organizations involved in CPD to construct a future pan-Canadian system with an appropriate governance structure that can respond more completely to the diversity of physician, provider, and societal health care needs.

We have good evidence that clinicians who commit to lifelong learning perform better in practice. Mainpro+ aims to facilitate such engagement. The FMEC-CPD project will include a robust evaluation agenda to confirm collaborative priority-setting to support this learning.

Take home messages

- The context of practice is evolving: team based care, workplace based learning, and increased accountability expected of our profession. Our CPD system needs to evolve to support physicians in their engagement in lifelong learning
- CFPC's new Mainpro+ programme will better support physicians in assessing their learning needs, developing a plan, and measuring the impact of learning on all aspects of their practice. The CFPC is part of a consortium to build upon the Future of Medical Education in Canada (FMEC) project, to build a Pan-Canadian Planning Consortium for CPD. The initial phase of this work will unfold in 2015-2017

Original abstract

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31 – Factors Associated With Adherence to Drug Therapy

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It is well known that lack of patient adherence is of major importance in the success of a prescribed medical treatment. Lack of adherence may result from patient-related factors, or be related to the provider. Various measures to promote adherence have been proposed, ranging from pill counts and use of trace elements to interviews and questionnaire-based methods.

Adherence varies with diseases and across methods used. It has for instance, been found that following an acute coronary syndrome, 8–20% of patients discontinue their medication within 6 months. In many chronic diseases, 40–50% of patients do not adhere to the initial treatment beyond 12 months and in women given hormone replacement therapy, as few as 50% still adhere to their medication after one year.

Most adherence studies focus on one drug or one type of disease and are typically run only in patient groups. Few have taken a wider perspective. To this end, we carried out a study on medication adherence, defined as persistence of medication or stopped as prescribed, and some of its determinants in middle-aged women in the general Swedish population.

The study was carried out in the Uppsala-Örebro Health Care Region in mid-Sweden with a population of approximately 2 million. The study was performed by means of a postal questionnaire and comprised 2991 women willing to participate. The age distribution of respondents and non- respondents was similar. The questionnaire had two parts, the first containing questions on marital, occupational and educational status, tobacco use, and height and weight. The second part of the questionnaire contained questions on drugs prescribed during the past year. For each prescription, information was sought on drug trade name, dosage, duration of medication and whether the drug was currently being taken as prescribed, was ceased as prescribed, was ceased by the woman against prescription, whether the prescription was filled but the medication not started or whether the prescription was not filled at all. If more than five prescriptions were received during the study period, information on drug number six and onwards was given in a free format, but with the same type of information as for the first five.

The study population constituted 1406 women who reported having received at least one prescription . Adherence was considered to be satisfactory if the medication was taken or stopped as prescribed; in all other cases it was considered to be unsatisfactory, since the purpose of the study was to study general adherence to prescribed medication, not the occasional loss of individual drug doses.

Information was also sought on scheduled check-ups, perceived necessity of the medication (coded from low (=1) to very high (=7)), concerns about medication safety (yes/no) and prescribing physician's sex and type (general practitioner, hospital physician, private practitioner or occupational health physician).

Mean age was 51 years, mean BMI was 25, 27% had a college or university education. 79% were married or cohabiting,

68% were gainfully employed, 26% were smokers.

The number of prescriptions per women ranged from 1 to 15 drugs, with a median of 1.5.

Based on 3067 prescriptions among the 1406 women, 85.6% reported satisfactory adherence, with 78% of the medication being currently taken and 7.6% being stopped as prescribed. In 10.7% medication was stopped prematurely, in 1.8% it was never taken and in 1.9% it was not filled at the pharmacy. A total of 207 (14.7%) women reported mixed adherence, satisfactory for some medications and unsatisfactory for others. With relation to 62% of the prescriptions a follow-up appointment with the prescribing physician was given. In 68% the women regarded the medication as important to their health. Seventeen per cent of the women had concerns about the safety of a particular medication. The majority of the prescriptions were for one dose per day or less, 66.6% were issued by a male prescribing physician, in 71% of the prescriptions the confidence in the prescribing physician was reported as high. Most of the prescriptions were issued either by general practitioners (41%) or by hospital physicians (38%).

Patient age, a scheduled follow-up appointment, perceived importance of medication, concerns about medication safety, taking respiratory disease medication and taking cardiovascular disease medication remained significantly related to adherence as was seen in a multivariate analysis (Table 1). Among other drug groups the best adherence was found in the groups taking hormonal medications, such as insulin and thyroid hormones, not including hormone replacement therapy or contraceptives. The lowest adherence was found in the women taking musculoskeletal medications, such as non-steroidal anti-inflammatory drugs.

Table 1. Factors associated with adherence to medication in multivariate logistic regression with backward elimination of non-significant factors, listed in order of importance. Odds ratios greater than 1.0 indicate that presence of the factor increases adherence, and odds ratios less than 1.0 that adherence decreases. (1) odds ratio, (2) 95% confidence interval

Factor	OR (1)	95%CI (2)
Age, years	1.04	1.02-1.06
Check-up appointment scheduled, yes/no	2.51	1.85-3.40
Importance of medication score, 1-7	1.94	1.77-2.12
Concerns about medication safety, yes/no	0.50	0.35-0.73
Respiratory disease medication, yes/no	2.16	1.13-4.14
Cardiovascular disease medication, yes/no	1.80	1.05-3.10

Adherence also varied with various combinations of significant factors in the multivariate analysis. An example is given in Figure 1. Among women 35 years old, who regarded their medication as unimportant and who had no follow-up appointment scheduled, adherence was approximately 15% while among women 65 years old it was 35%. A scheduled follow-up appointment increased adherence by 15–20% units. The change in perceived importance of a medication from unimportant to moderately important increased adherence by 40% units. The best adherence, 95% or more, was found among those who regarded their medication as important and who had a follow-up appointment scheduled, almost regardless of age.

Compliance is associated with information giving and positive talk. Patient-centred consultations, when the patient's points of view are sought by the physician result in higher reported compliance rates. Our findings of high adherence in the group of women with a follow-up appointment is supported by prior findings, where following patients in care is seen as one of the most important adherence interventions.

It seems that the patient-provider relationship, when communicative and concordant aspects are developed, may further improve adherence. One way to optimize this relationship is to train the medical providers and students in

communication skills, in order to improve their abilities in creating an optimal consultation within the given time constraints.

Figure 1 Adherence (%) according to patient age, perceived importance of medication, and given scheduled check-up appointment.

Take home messages

- Arrange for scheduled follow-up appointments to assess the effects of the medication.
- Discuss the medication and the importance of taking it as prescribed during the consultation.
- Ask about the patient´s concerns with the medication.
- Explain disease severity to the patient.
- Provide training opportunities for medical students and practitioners to improve communication skills.

Original abstract

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32 – Improving Practice Questionnaire - A Patient Feedback Tool for Clinical Governance, Practice Accreditation and Recertification: Where Are We Now?

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Introduction

The voice of the patient is becoming increasingly recognized as a significant indicator of quality. The patient is envisaged as an important part of developing new services, and ensuring quality improvement across the various levels of the health care system. A recent systematic review published in the BMJ showed that patient experience is linked to clinical effectiveness and patient safety (1).

So how can practices gather robust, valid and reliable data on patient experience? And how can this data be helpful in supporting the practice to improve its quality? The Improving Practice Questionnaire (IPQ) is a patient feedback instrument that combines both the general issues around primary care, such as access, availability of information, preventive care and health promotion, as well as the patient's experience of the clinician's interpersonal skills in the consultation (2).

Spread

The IPQ was extensively used across UK primary care practices (over 4,000) as part of the evidence required for the Quality Outcomes Framework (QOF) (3). In Australia, the IPQ is called the Practice Accreditation and Improvement Survey (or PAIS) and has been approved by the RACGP as part of its 4th Edition Quality Standards (commencing 2011) for practice accreditation (4). Over 3,500 Australian practices are involved in using the tool. Several other countries have adopted the tool including New Zealand and the Republic of Ireland.

However, just undertaking a valid and reliable patient survey is not enough. The real challenge begins when healthcare organisations receive their results and reflect on their significance. Research evidence shows that these organisations do better when they build action plans around their results of patient feedback, and even more so, when patients are involved in the proposed improvement strategies. This process has been referred to as 'Critical Friends Groups' (5).

At the individual level, clinicians can receive feedback on their interpersonal skills. In the UK, doctors are using this evidence as part of their requirements for Revalidation (6). In Australia, where revalidation does not yet exist, the IPQ is being utilised by doctors for their CPD requirements. Increasingly, the tool is being linked to Multi-Source Feedback (MSF) which is becoming more widely adopted across health practitioner recertification/revalidation (7).

So What Next?

Although several countries are now embedding systematic patient feedback into their

quality requirements, there is still little known about how practices reflect and respond to their feedback. More research is needed in the area of what actions, based on patient feedback, lead to improved outcomes.

Another issue is that systematic patient feedback has been largely adopted by medical organisations because of quality requirements. However, there seems to be little uptake among other primary care providers such as dentists, pharmacists, physiotherapists and other allied health professionals. This apparent neglect of patient feedback is beginning to change. For example, the Pharmacy Guild of Australia has recently engaged their pharmacies in patient feedback as part of their Quality Care Pharmacy Program (8). However, to ensure further uptake by allied health professionals, more needs to be done to incentivise them in not only measuring patient experience, but also embedding such feedback into their quality review processes.

Take Home Messages

- Patient experience and its measurement is key for providing evidence of quality and safety across healthcare organisations.
- The Improving Practice Questionnaire has been extensively used in the UK, Australia, Ireland and NZ.
- It provides feedback at both the organisational and individual levels of performance to help provide evidence for practice accreditation and practitioner recertification/revalidation.
- Approximately 4 million questionnaires have been analysed across 10,000 organisations, however more needs to done in other allied-health professions.
- More research is needed on the impact of the tool in terms of improving quality at both organisational and individual levels.

Original Abstract

http://www.woncaeurope.org/content/221-improving-practice-questionnaire-patient-feedback-tool-clinical-governance-practice

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33 – Health Promotion In European General Practice – Opportunities and Challenges from a Research Perspective

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Background - Health Promotion in General Practice: the Project

The project "Health Promotion in Primary Health Care - General Practice and Community Pharmacy", commissioned by the European Commission, brought together professional associations of general practice/family medicine (GP/FM) and community pharmacy from all participating EU member states. Conceptually developed and coordinated by the Ludwig Boltzmann Institute for the Sociology of Health and Medicine in Vienna, WHO Collaborating Centre for Health Promotion in Hospitals and Health Care, and supported by a European expert group, this project aimed to contribute to the development of quality assured patient-/user-oriented health promotion in GP/FM and community pharmacy in the - then - 15 member states of the European Union (http://www.univie.ac.at/phc/e/tx_1020_85.htm).

The main objectives were to strengthen health promotion perspectives in professional health care settings, and to further European exchange and mutual learning. Based on a systematic literature search, consultations with project participants, and country reports, we provided an overview of the state of health promotion in these two settings. In a further step, the partners of the project formulated proposals as to how the European Commission could support the further development of health promotion in both settings.

Our literature review revealed that health promotion in GP/FM was an under-researched topic. However, health promotion was explicitly recognized as an integral part of the professional role of the GP in several policy statements both at the European and the national level. Nevertheless, health promotion and relevant skills and competencies did not figure very prominently in professional education and training. As to reported health promotion activities, we identified several models and initiatives, albeit with only very few systematically designed and evaluated intervention studies; research on interventions and their effectiveness mostly referred to risk-factors and disease-oriented interventions. Health promotion and prevention activities provided in routine GP/FM had an emphasis on individually oriented interventions, including health-checks, opportunistic screening, and lifestyle counselling, vaccinations and participation in national cancer screening programs.

Opportunities

General practitioners (GPs) are considered well positioned to provide health promotion and preventive interventions. GP/FM is usually the point of first and low threshold contact for a large segment of the population and deals with a wide range of health issues. Given the nature of problems presented in GP/FM consultations, Gps are responsible for longitudinal continuity of care, often have established trusting relationships with their patients over

time, and develop a person-centred approach (1). Furthermore, patient attitudes towards lifestyle advice by GPs are positive, specifically regarding advice on dietary habits, physical exercise and smoking (2).

Research suggests that brief lifestyle advice by primary care physicians can be effective, such as advice to promote smoking cessation, reduce harmful drinking, or improve nutrition behaviour, especially when offered to patients at risk of chronic conditions rather than to an unselected healthy primary care population. Interestingly, evidence also shows that more intensive interventions do not result in additional health benefits (3-5).

Challenges

Despite all these opportunities, wide-ranging implementation of health promotion, especially of more communication-intensive interventions, as well as prevention in routine GP/FM practice still seems to remain low. Patients report low rates of lifestyle advice and counselling by physicians in primary health care and often perceive their GPs not sufficiently interested in delivering such interventions. Research exploring barriers to provide health promotion as perceived by primary health care physicians identified the following factors: perceived lack of time or competing work load, insufficient reimbursement, doubts about patients' acceptance and willingness to receive lifestyle counselling, low self-efficacy, insufficient skills and training, doubts about effectiveness of interventions, and health promotion perceived as outside professional role (6).

As these perceived barriers may differ, ranging from factors associated with the individual practitioner to factors dependent on organizational or systems' context (7), strategies to address these barriers and to influence professional practice will also vary. They include interventions to enhance professional competencies (i.e. professional education, audit and feedback, or quality assurance projects), financial incentives and improved regulatory contexts, or organizational measures for physicians (explicit inclusion in occupational roles, skill mix changes, integration of GP/FM in multidisciplinary teams, integration of different providers/services).

Current and Future Perspectives

While we were unable to carry out an update of our review, we found indications that the aim to better integrate health promotion in today's GP/FM has not been fully achieved. Thus, how can evidence-based effective health promotion interventions successfully be implemented in routine GP/FM? Results from implementation research call for a structured and multi-faceted approach: so-called tailored implementation interventions, i.e. strategies designed to achieve desired changes in professional practice based on an assessment of relevant determinants, are needed. There is evidence that efforts to change professional practice have a higher likelihood of success when relevant barriers are identified in advance and taken into account (8). So far a majority of the tailored interventions investigated has been oriented at the individual provider, predominantly as educational interventions, while other strategies, like skill-mix development or multidisciplinary teams, have not been equally explored.

Future activities as to how health promotion interventions can be better integrated in GP/FM should move beyond the traditional linear "from research-to-practice" approaches to more collaborative and flexible ones. More consideration should be given to actively involve patients and health care practitioners in designing research interventions and, research designs should more carefully address local and socio-cultural contextual factors in order to increase acceptability and sustainability. Before transferred into routine practice, such innovative strategies should then be tested using an appropriate methodological framework.

Take Home Messages

- General practitioners are considered well positioned to provide health promotion and preventive interventions.
- Implementation of health promotion and preventive interventions in routine GP/FM practice still remains low.
- Multiple barriers to health promotion implementation in GP/FM have been identified.
- Tailored implementation strategies with collaborative and flexible approaches should be explored to better integrate health promotion interventions in GP/FM.

Original Abstract

http://www.woncaeurope.org/content/279-health-promotion-european-general-practice-%E2%80%93-overview

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34 – How the UK Discovered Europe

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Background

In the United Kingdom over the last 15 years arrangements for the provision of specialty training for general practice and its supervision have undergone several reorganisations, and one of the major changes has been the development of a general practice curriculum. Specialty training for general practice lasted for three years, in six month training posts, two years in hospital and one year in an approved general practice placement.

It may surprise you to know that until 2005 there was no comprehensive GP curriculum in the UK. Although there was high quality practice-based teaching, the governance and supervision arrangements were fragmented and inconsistent. The approval of hospital posts for GP training was vested in Royal College of the specialty concerned rather than the general practice college. The Joint Committee on Postgraduate Training for General Practice (JCPTGP), a statutory committee of the RCGP and the GP Committee of the British Medical Association (BMA) was responsible for approving general practice trainers, training placements and the issue of certificates of satisfactory completion of the training programme.

The Joint Committee on Postgraduate Training for General Practice (JCPTGP), a statutory committee of the RCGP and the GP Committee of the British Medical Association; this committee was responsible for approving general practice trainers, training placements and the issue of certificates of satisfactory completion of training, given by an approved trainer. To add to this chaotic mix, the supervision of hospital training for GPs rested with the specialty college concerned. All medical colleges except general practice were supervised by a different national body, the Specialty Training Authority (STA). All these bodies were responsible to the overarching supervisory body in the UK, the General Medical Council (GMC). The GMC was also separately responsible for the undergraduate curriculum and performance matters of working doctors.

As a result of some major governance issues in the UK involving patient harm (for example Harold Shipman) the government decided that the whole governance process was in need of reform, to avoid duplication and possible confusion of roles and responsibilities, not helped by the number of acronyms! The STA and JCPTGP were to be abolished and replaced by a single body, the Postgraduate Medical Education and Training Board.

One of the strangest anomalies of the former system was that the RCGP had a very good final assessment exam but this was not approved for use as the national outcome assessment and a different system of assessment ran in parallel.

My Input

In 2005 the RCGP was given the responsibility for developing a national curriculum for GP training, including assessment. It is at this point that I joined in the fun, having been invited to join the RCGP curriculum group, as I had some knowledge of work going on in Europe on curriculum development.

The curriculum group was running a symposium on curriculum development at a WONCA conference entitled:

"Developing a National Curriculum for the Education and Training
of General Practitioners in the United Kingdom"

This symposium looked at the process the Royal College curriculum group were undertaking in designing a new GP curriculum. The RCGP prides itself on the quality of its work and set about its task with its customary academic rigour and energy; it had already started this process when I joined, having started a programme of focus groups, trainee and educator surveys, presentations and workshops at national and international meetings. It had commissioned a literature review and was starting a process of considering other general practice curriculum models that had been developed elsewhere – one from the Oxford region in the UK, and nine from other countries: Australia, Canada, Denmark, Ireland, the Netherlands, Norway, Portugal, Spain and the USA.

The observant will have noticed that four of the countries are native English speakers and that the remainder are from the WONCA European region (Ireland fits both categories). Even so the RCGP group were having difficulties in finding a good match for a comprehensive training curriculum for GPs in the National Health Service.

As a newcomer to the group I was puzzled (I was often puzzled anyway). The Royal College of General Practitioners was an active member of WONCA Europe and its network organisations which had produced the 2005 European Definition (1) which contained a list of the core competences required to be a GP. EURACT had worked further and developed the European Definition into its Education Agenda (2). This document developed the list of competences into a full blown curriculum statement for European general practice ready for adaptation to the needs of individual countries. But the College did not appear to have considered the European Definition or the Educational Agenda. As we are part of the European Union and as a college have worked hard with our WONCA Europe colleagues, I suggested to the group that we should consider these models. This they did and discovered that with some modifications these documents would be a good basis for the new UK curriculum. With very little dissent, which was possibly related to the fact that the British only speak one language (and that rather badly) the WONCA definition, with its six core competences and three essential features became the basis for the UK curriculum in 2005, and remains so today. The EURACT Educational Agenda is the basis of the core curriculum statement "Being A GP", and all of the RCGP curriculum statements use the six core competences and three essential features - see for yourself on the RCGP curriculum web site: http://www.rcgp.org.uk/training-exams/gp-curriculum-overview.aspx .

Take Home messages

- Until 2005 there was no comprehensive national GP curriculum in the UK.
- Governance of GP training was by a number of bodies, with overlapping roles. GP and hospital training were supervised by different organisations.
- The national GP curriculum in the UK has now been developed, and is based on the WONCA Definition of General Practice and the EURACT Educational Agenda.

Original Abstract

http://www.woncaeurope.org/content/3553-developing-national-curriculum-education-and-training-general-practitioners-united

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35 – Health Needs Assessment

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What is a HNA?

"Health needs assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities" (NICE, 2005). It is not only the process of identifying the health needs in the community but also an exploration of all the resources involved - how they are used and how they could better be used - and where they are lacking. It is used to inform decision making and should lead to change which benefits the health of the target population, usually within finite resources – it is therefore necessary to be realistic about what you are capable of achieving from a practical, clinical and economic position. It is important to consider that many factors influence health and therefore numerous individuals, groups and institutions/bodies have a role to play in the health arena.

It is accepted that a HNA will produce benefits on multiple levels; these may include:

- strengthening community involvement in decision making
- improved public/patient participation in planning services
- improved team and partnership working
- professional development of skills and experience
- increased understanding of local health issues
- improved patient care/improved health of people in your community/practice
- improved communication with other agencies and the public
- demonstrate the reasons for decisions about health care
- better use of resources, services and people.

What Does a HNA Involve?

The steps involved in a HNA are outlined in many toolkits – Figure 1 outlines the five key steps from one of these (NICE, 2005).

In brief, data collection in a HNA in primary care will likely include existing practice data, routinely available local statistics, a patient/public consultation exercise, and a mechanism to obtain public and professional perspectives on need. The latter two may include such activities as questionnaire surveys, interviews, focus groups, casework information and observations.

It will most likely be necessary to determine need priorities in consultation; questions which may help this process relate to the numbers affected (absolute or comparatively), equity, impact, changeability, availability of effective and appropriate interventions, the provision of adequate services, the existence of expertise, local and

national priorities/strategies, acceptability and resource feasibility.

Planning and implementing actions is the most important part of a HNA and involves setting clear aim(s) and objectives, agreeing a shortlist of potentially effective interventions or actions and specifying the resources required (people, space, time and equipment).

Evaluating successes and failures and continuous monitoring are part of the process. Effective outcome evaluation requires setting indicators (measures against which to monitor progress) and targets (the level of outcome you want to achieve, for whom and by when).

Guiding Principles and Notes for Primary Care

The many authors who have written on the subject take different theoretical perspectives and propose diverse approaches. Furthermore, a HNA may be conducted at different levels (European, national, local, individual etc). However, the guiding principles when conducting a HNA are:

- Be clear about your aim(s) from the very start as this will determine your approach.
- The negotiations leading up to a needs assessment are important to determine what sort of evidence of 'neediness' you will have to demonstrate to convince decision makers.
- There are many different concepts of 'need' e.g. felt need, expressed need etc.
- Different information sources and methods of investigation tell you about different aspects of 'need' – a mix of sources/methods will build a broader picture of need.
- The way you undertake a needs assessment is important and ideally you should use a method that allows you to start to work on the solution to a problem while you are assessing it.
- The needs assessment should be owned by the people who will have to implement the actions.
- Health needs assessment should fit in with the appropriate decision making/planning system e.g. team, local, regional etc.
- Health needs assessment is not an end in itself but a means to help plan the future.
- Health needs assessment is a part of a cyclical process and should include an evaluation of how the needs have been met and not met by the actions taken.

Kilduff et al (1998) highlight the need for primary health care teams (PHCTs) to understand their stage of development and how this will directly affect any health needs assessment, and discusses the place of health needs assessment within the general processes and systems of the PHCT. A diagnostic and development tool, which links together the intimate relationships between five stages of development needed for effective primary care-oriented health needs assessment work, is outlined. The BMJ has produced a series of six articles on HNA which give a useful overview and direction, and contain many useful references for further and directed reading. Of particular interest for primary care is the first of these articles which points to the importance of distinguishing between individual needs and the wider needs of the community in the planning and provision of local health services; ignoring these needs can lead to a top-down approach to providing health services, which relies too heavily on what a few people perceive to be the needs of the population rather than what they actually are. The third article moves HNA from theory to practice; it notes that the assessment of individual's needs may form part of the assessment of a population's needs and outlines the circumstances favouring individual needs assessment for planning purposes. The fourth article in the series focuses on HNA in primary care (albeit in the UK) and identifies the different levels at which a HNA might be conducted and the related approaches and methods. The fifth article in the series highlights the importance of and scope for greater consultation with the general public and with current users about needs and priorities. It points to a need to acknowledge limitations to professional knowledge as well as to respond to inequalities in health (BMJ, 1998).

Step 1
Getting started
What population?
What are you trying to achieve?
Who needs to be involved?
What resources are required?
What are the risks?

Step 2
Identifying health priorities
Population profiling
Gathering data
Perceptions of needs
Identifying and assessing health
conditions and determinant factors

Step 5
Moving on/review
Learning from the project
Measuring impact
Choosing the next priority

Step 4
Planning for change
Clarifying aims of intervention
Action planning
Monitoring and evaluation strategy
Risk-management strategy

Step 3
Assessing a health priority for action
Choosing health conditions and
determinant factors with the most
significant size and severity impact
Determining effective and acceptable
interventions and actions

Figure 1: The five steps of health needs assessment

Take Home Messages

- HNA is an approach that helps plan services that tackle 'needs' rather than just reacting to demands.
- HNA is a multidisciplinary and multisectoral activity and consultation is a key component.
- HNA is not only about assessment but also about taking action to improve the health of the population.
- Aim for small, achievable, measurable goals; this increases the chance of success.
- HNA is not an end in itself.

Original Abstract

http://www.woncaeurope.org/content/theme-b-needs-assessment-general-practice-family-medicine

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36 – The Balint Experience

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The Early Days of Balint

Balint groups are named after the psychoanalyst Michael Balint (1896-1970). In the late 1950s, Michael and his wife Enid began holding psychological training seminars for GPs in London. This work was first described in the book The Doctor, his Patient and the Illness (1957). There were no lectures and the doctors' education was based on case presentation and discussion in a small group of nine or ten with a psychoanalyst leader. To begin with, Balint encouraged the group members to hold 'long interviews' with their problem patients. This helped the doctors to concentrate on becoming good listeners. Subsequently the focus changed to studying the relationship between doctor and patient in the context of every day ordinary-length consultations. The groups met once a week for a number of years so that patients and their progress could be followed up. The continuity also enabled group members to feel at ease with other. Since those early days, Balint groups have spread across the world and in 20 countries there are national Balint Societies whose aim is to foster and develop the Balint approach.

Balint Groups Today: What Happens?

The group members and the leader sit in a circle and the leader (or one of the leaders if there are two) asks 'who has a case?' Someone volunteers to talk about a patient who has been on her mind. The problem may be that the patient has been emotionally disturbing or just difficult to understand or to engage in treatment. The group listens to the story without interrupting. When the presenter has finished, the leader invites the group to respond to what they have heard. Responses take various forms. There may be questions, advice to the doctor, emotional reactions induced by the patient's story and speculations about what else might be going on. The group leader will gently discourage too much interrogation of the presenter, as the aim is to get the group members themselves to work on the case. In a variation of the group process, the leader asks the presenter to 'sit back' i.e. to push his chair back a little and to remain silent for the next 20-30 minutes.

This effectively prevents the group from asking any more questions and throws them back on their own resources. The presenter is allowed to have her say and respond to what she has heard when she is invited to join in again later.

The Role of the Leaders

The leaders' first aim is to make the group a safe place, where confidentiality is observed and members feel free to talk about their feelings and their work (including their mistakes). The leaders will discourage unwanted and intrusive questions about the presenting doctor's personal life and history. Personal anecdotes are sometimes volunteered and can be helpful. The leaders will allow this provided there is no pressure. The group is not a therapy

group although its effects can be therapeutic.

The leaders' second aim is to keep the discussion focused on the doctor patient relationship. They may ask how the patient has made everyone feel. Do we feel angry or sad? Do we like the patient and want to help him? Or would we prefer to keep him at a distance? The group may be invited to consider how the patient is feeling or what sort of doctor he wants his doctor to be. A group that dislikes or fears the patient may be unwilling to engage and will try to 'escape' by talking about generalities: 'these patients are always untreatable' or recommending referral to an expert whom somebody knows. In this situation the leaders will try to bring the group back to the work, perhaps by representing the patient ('If I were this patient I would be feeling terribly alone and abandoned right now…')

If there are two leaders, they will be trying to work in sympathy, picking up cues from each other. One may steer the discussion while the other watches for people trying to get a word in. Often, the presenting doctor finds herself behaving like the patient, while the group members mirror her own reaction in the consultation.

Ending the Session

The session ends, like a therapy session, when time has run out. At least one leader will be keeping a discreet eye on the clock. There may be one or two presentations (including follow-ups) in a ninety-minute session. The leaders may ask for a follow up and thank everyone. They do not attempt to tie the loose ends or give a reassuring summary.

Benefits of Balint

What does participation in a Balint group do for a group member?

The first and most easily obtained benefit is to have a safe place where you can talk about interpersonal aspects of your work with your patients. The group will be sympathetic and they will all have been in similar situations themselves. This is a great relief and usually means that when a dreaded patient turns up again he or she will cause less anxiety. We believe that the Balint group experience helps to avoid professional 'burnout'. Are older Balint doctors still enjoying their work? Try asking them!

Secondly, the Balint group encourages doctor to see their patients as human beings who have a life and relationships outside the consulting room. They become more interesting to listen to and easier to help.

Thirdly, the group members may gradually reach a deeper level of understanding of their patients' feelings and their own. They may realise that certain patients or emotions may resonate with what is going on in their own inner and outer lives. This may be causing problems which the doctor can learn to avoid or even to turn to therapeutic advantage.

Take Home Messages

Taking part in a Balint group can help a doctor to:
- find a safe place to discuss doctor-patient issues
- see patients as human beings
- reach a deeper level of understanding of the feelings of both patient and doctor

Original Abstract

http://www.woncaeurope.org/content/25-balint-group-experience

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37 – Environment and Health in Family Medicine

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How is the environment that my patient lives in, affecting her health? It is an interesting question, and one most family doctors seldom consider. I will discuss this question from a number of perspectives.

Is it important, i.e. how big is the burden on health as a result of environmental factors? There have been a number of estimates of the burden of environmental impacts on health, noting that these impacts are preventable. However, the scope of the definition of environmental health and the methods used vary from study to study, making interpretation difficult. Table 1 lists a selection of the studies. It is clear that the morbidity and mortality from environmental factors is significant.

Study	Jurisdiction	Scope of Study	Health costs
WHO (1)	Globally	A broad scope of factors, including chemical and biological pollution in air, water and soil, UV and ionizing radiation, noise and electromagnetic fields, occupational risks, climate and ecosystem change and the effects of the built environment.	24% of DALYs (Disability Adjusted Life Years) 23% of all deaths 36% of deaths in children aged 0-14
WHO (1)	Developed countries	As above	16% of DALYs
Boyd (2)	Canada	Restricted to environmental burden of disease from respiratory disease, cardiovascular disease, cancer and congenital affliction	Annually: 10,000–25,000 deaths, 78,000–194,000 hospitalizations, 8000–24,000 new cases of cancer; and 500–2500 low birth weight babies, costing between $3.6 billion and $9.1 billion

Developed countries are less affected, as the burden in developing countries includes water contamination, and the large numbers affected by indoor burning of coal and biomass for home heating and cooking, which is responsible for 1.6 million premature deaths and nearly 3% of the global burden of disease in 2000 (3), as well as the suffocating outdoor air pollution of cities like Beijing and Delhi.

So let's consider a case. A 14 year-old girl presents in the emergency department with an exacerbation of her asthma.

She had been previously well controlled, on a LABA and Inhaled Corticosteroid combination. What might have precipitated this exacerbation? It could be due to a viral upper respiratory infection, or non-compliance. But to consider possible environmental factors, we suggest taking an "exposure history" using the CHP mnemonic (4). She might be exposed in the following environments. (Table 2)

CHOP	Location	Examples
C	Community	Outdoor air pollution from traffic, industry, wood-smoke from a fire, crop burning or home heating/cooking
H	Home	Second-hand smoke; a new pet; cockroaches; House dust mites; water damage and mould; smoke from wood-burning or kerosene stoves or fireplaces; Outdoor air pollution infiltrating inside
H	Hobbies	Clay dust or glazes from pottery/ceramics; paint fumes; solvents; chemicals; baking flour
O	Occupation/ School	Exposures at work or in the school building
P	Personal	Smoking

So asking, or if a house-call is carried out, observation, might reveal the "upstream" provocative factors, which might otherwise not be recognised. And the treatment would be two-fold: treating the asthma exacerbation medically, but also intervening if possible in the environment. For example, community air pollution was increased that day, and the corresponding Air Quality Index was elevated. The family could be counselled that strenuous outdoor activity increases the intake of air pollutants into the airways, and should be reduced when pollution levels are high; and that she should exercise away from traffic as much as possible, because exercising near traffic increases pollutant exposure and reduces FEV1 (5).

Environmental health is by definition multidisciplinary, and many of these issues might overlap with Public Health, or other disciplines. For example, a 2 year-old child is found to have a high serum lead level. The source (H in the CHOP mnemonic) is hand to mouth activity so that house dust is ingested; and the dust is contaminated by deteriorating old lead-based paint around the windows. Lead was removed from paint in Canada in 1978. The intervention is to remove the child from the environment, and remediate the house dust/paint situation. Other sources of lead might have been from

- (H-Home) children's toys or jewellery, lead-soldered pots or glazed pottery;
- (H-hobbies) stained glass or pottery and
- (P-personal) folk remedies, Ayurvedic products or Asian eye-cosmetics.

But there is another aspect of the environment that, although less immediately clinically relevant, is important to family doctors; namely the health of the planet. Climate change is not just a physical issue; it is very much a health issue. Dr Margaret Chan, director-general of the WHO, called climate change "the defining issue for public health in the 21st century". The broader perspective of planetary sustainability (6) is being discussed more and more urgently in medical circles.

The health effects of climate change are described as direct (heat extremes; severe storms and floods) and indirect, which spans a number of pathways; increased range of vector-borne diseases (Lyme disease in Canada; Chikungunya in Europe and the Caribbean); food insecurity secondary to drought, with resulting malnutrition, water insecurity, and sea level rise which will all lead to the displacement of climate change refugees and the potential for international conflict.

What is the role of family doctors?

We should be checking and taking steps to reduce our own and our family's Carbon footprints:

http://www.nature.org/greenliving/carboncalculator/ .

In our clinics and hospitals, we should be leading by example, and doing our best to make them ecologically sustainable: "greening" our workplaces.

We are also teachers, and need to impress on the next generations of health care professionals the urgency of tackling these global health threats.

Finally, we could be advocates for our planet, advocates for the urgent transformations required by our societies, to gain control of carbon emissions, and reduce over-consumption and inequity. Family doctors are well-respected community based scientists. There is one of us in almost every community around the globe. We are uniquely placed to be effective actors (7). My hope is that we exert our well-deserved influence and credibility, as individuals, and also as medical organizations, in the name of redirecting our planet towards health and sustainability.

Take Home Messages

- Environmental factors are responsible for a significant burden of illness.
- Environmental causes of illness are "upstream", and often not recognized.
- An exposure history, using the CHP mnemonic, is a useful clinical tool.
- Climate change and planetary sustainability are pressing global issues.
- Family doctors have a role in greening their clinics and hospitals, educating the next generation of doctors, and advocating individually and in our organizations, for planetary health.

Original Abstact

http://www.woncaeurope.org/content/ws-013-environmental-medicine-family-practice

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38 – Mentoring – a Quality Approach to Professional Development

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The term 'mentoring' is derived from the character 'Mentor' in Homers Odyssey. In the story, Mentor was an old friend of Odysseus and was the respected advisor to Telemachus, the son of Odysseus and Penelope. Odysseus entrusted his Son and household to Mentor when he sailed against Troy. The goddess Athena took on the appearance of Mentor in order to guide young Telemachus in his time of difficulty, giving him prudent counsel. Since then, wise and trusted advisers have been called "mentors".

Appraisal is now an annual requirement of every doctor registered with the GMC in the UK in order to continue to demonstrate their ongoing fitness to practice. Revalidation occurs in a five yearly cycle enabling a doctor to continue the practice of medicine. Although the process of Mentoring has been around for a long time the advent of annual appraisal has meant that appraisers have identified 'doctors in difficulty' who need the advice and guidance of a mentor with increasing frequency.

So what is Mentoring?

"Mentoring is to support and encourage people to manage their own learning in order that they may maximise their potential, develop their skills, improve their performance and become the person they want to be." (Eric Parsloe)

Mentoring is a powerful personal development and empowerment tool. It is an effective way of helping people to progress in their careers and is becoming increasingly popular as its potential is realised. It is a partnership between two people. The MENTOR (the person doing the mentoring) and the MENTEE (the person receiving the mentoring) normally work in a similar field or share similar experiences. It is a helpful relationship based upon mutual trust and respect and is different to coaching an individual. It is for the mentee to find their own path rather than being told what to do.

A mentor is a guide who can help the mentee to find the right direction and who can help them to develop solutions to career issues. Mentors rely upon having had similar experiences to gain an empathy with the mentee and an understanding of their issues. Mentoring provides the mentee with an opportunity to think about career options, personal difficulties life hurdles and helps them to progress.

A mentor should help the mentee to believe in themselves and boost their confidence and above all do no harm in this relationship.

A mentor should ask questions and challenge, while providing guidance and encouragement. Mentoring allows the mentee to explore new ideas in confidence. It is a chance to look more closely at themselves, their issues, opportunities and what they want in life. Mentoring is about becoming more self aware, taking responsibility for your life and directing your life in the direction you decide, rather than leaving it to chance.

How is it achieved?

Usually there is an agreement between the mentee and the mentor for a number of sessions over a period of time. The session length and the number of sessions are predetermined so that dependence on the mentor does not occur. The mentor should have a proven track record of helping others and of continuing self development and continuing professional and personal development.

The sessions may consist of whatever the Mentee may bring but the premise of the Mentor is to get the Mentee to 'solve' the problems themselves through the use of powerful questioning and putting the mentee in the driving seat to re-frame the problem and approach it from a different point of view. Powerful questioning should take into account the learning styles of the mentee i.e. Honey and Mumford - Theorists, Activists, Reflectors and Pragmatists. The powerful questioning can then be tailored on these styles so that they are even more relevant to the mentee. This process often begins with the mentee producing a time line and looking at significant life changing events that have occurred that may influence behaviour, to get the mentee to understand why they behave as they do.

At the end of the sessions it is implied that the Mentee will have been on a journey of self discovery and been empowered to change their behaviour.

This process can be divided into the' five phase' approach to mentoring:

Phase One: Contracting and building the relationship: the mentor and mentee build an initial relationship, getting to know one another and building rapport. They establish what the mentee hope to gain from the mentoring and confirm what the mentor has to offer. They jointly agree the mentoring contract.

Phase Two: Understanding the Mentee: the mentee describes their current situation and how they would like things to be in the future. This looks at the mentees strengths and weaknesses, skills and experience.

Phase three: Analysis: the mentee and mentor work together to apply appropriate frameworks to help the mentee gain awareness and understanding, recognising the patterns of behaviour that are relevant.

Phase four: Action Planning: the mentor and mentee identify the options that will extend the range of possibilities for the mentee. This involves looking at problems in different ways and the possibility of acting as 'devil's advocate', to challenge the mentee to change and take a different perspective. This involves considering and comparing the options and helping the mentee to understand the implications of each option in order to work out the best option and create a detailed action plan.

Phase five: Implementation and review: this is where the mentee puts their action plan into practice. This is the result of the mentoring process.

The elements of this process are

Awareness - understanding what's going on in the here and now, not reacting in ways that are historical and redundant.

Alternatives- being able to identify and develop choices for any given situation and not having one way of responding.

Authenticity - being able to build genuine relationships with others.

Key to the success of mentoring is the relationship established between mentor and mentee, the formulation of a 'contract' between the two parties to reach a successful end point involving a changed behaviour to enable the individual to progress and continue in their career.

Take Home Messages

- The need for Mentoring is increasing.
- A contract is needed between mentor and mentee.
- The premise is 'Do no harm'.
- The mentee should be empowered.
- Effective change should be an action plan outcome.

Original abstract

http://www.woncaeurope.org/content/mentoring-quality-approach-professional-development

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39 – Pleasures of Doctoring in Family Medicine

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Every day family physicians deal with difficult patients and difficult diseases, with disability and death. In many parts of the world, they face crowded waiting rooms, little time for each patient, disrupting telephone calls and financial and administrative pressures (1). Other pressures are those related to the doctors' own personalities such as perfectionism, self criticism, fear of failure or making mistakes or discomfort about uncertainty (2) (3). Feelings of helplessness or guilt are common among them (4). Doctors often feel overworked and under-supported and feelings of loneliness are also common (5). When family medicine is practised in a hostile environment with the threat of malpractice, doctors adopt a defensive position where their personal and professional well being is jeopardized, nibbling at their ability to enjoy their profession.

But, in every simple day of work of any family physician, there are plenty of pleasurable moments, laughter, intimacy and closeness, moments of trust, compassion, love and warmth.

Based on a qualitative review of Balint groups with residents (6) and on focus groups of tutors and specialists in family medicine, three themes could be identified regarding the pleasures of doctoring: the professional, emotional and contextual gratifications.

Professional Gratification

Family physicians expressed their enjoyment in practising holistic medicine, their ability to deal with almost all aspects of medicine, from cardiology through infectious diseases and psychiatry. This diversity guaranteed a continuous interest in their work.

Some of the doctors expressed feelings of accomplishment when performing simple surgical procedures or actions that brought immediate relief from pain or disease. They described sharing the joy and prompt relief obtained after opening an abscess, excising an infected ingrown toenail or reducing a dislocated elbow. They expressed that there was no greater gratification than when the patient left the office without pain.

Gratification was also felt in making a precise diagnosis, at the right time. This would happen especially when a diagnosis led to a dramatic change in the patient's health, which further on, would also lead to a better doctor-patient relationship, recognition, respect and trust. To decide to treat difficult problems alone and succeed was also stated as immensely rewarding. The courage to treat difficult issues on one's own, with the cooperation and full participation of the patient in the decision-making process was another source of much joy.

Emotional Gratification

We found a second group of expressions of emotional gratification that brought comfort and pleasure.

One doctor described how good he felt when he examined a child who did not cry, even after forcing a wooden tongue depressor into his throat. He felt special pleasure in conquering his trust, and the trust of the child's parents accepting his explanations about him having "just" a viral infection.

Other doctors described their satisfaction in caring for their dying patients and their families, discovering the real meaning of assistance when easing the physical pain of the body, or the emotional anguish in a cancer patient. They felt at their best in their ability to break bad news and to handle the anxiety and depression that followed. The emotional price paid by the doctor in his involvement gave him a feeling of spiritual uplifting. They felt that this was family medicine at its best.

Many doctors shared the pleasure obtained through continuity of care, so characteristic of the profession, and the simple joy of knowing their patients. Powerful sources of pleasure were going out into the waiting room of the clinic, welcoming a patient-friend, calling him by his/her name, giving a strong and affectionate handshake, or a gentle touch on the shoulders while leading the patient from the waiting room to the examination room. Knowing precisely the appropriate opening phrase for each patient, from their last vacation to football, or directly addressing the patient's suffering were also pointed out to be most satisfying.

Physicians related to their feelings of affection that grew with time, while accompanying the personal, familial or health crises of their patients: "It's the mutual respect, trust and friendship that develop over time that I especially enjoy."

The awareness that one has the ability to care and feel positive feelings, like a mother who discovers her ability to parent and love, was, in itself, gratifying to the participants.

Contextual Gratification

Many rural doctors live and work in the same community as their patients, or have personal friends as patients. Although this situation may cause problems, most of the doctors reported more satisfaction than problems. Some doctors reported their joy and pride at being invited to the weddings of their patients or being treated with a special respect by the community grocer or by the car mechanic. These satisfactions may have been unwarranted, yet the pride and respect doctors felt from their special status in the community were sources of special joy to them.

With regard to the issue of professional status, the doctors, mainly the residents, reported that family doctors sometimes enter into competition with other profession specialists, wishing to win their collaboration and approval. While the disrespect some residents felt from hospital doctors was translated into indignation, earning the respect of colleagues was reported as a source of satisfaction. Hospital-based colleagues regarded the decision to become a family doctor as going down the easy path. Yet, most of the residents opted positively for a career in family medicine. Identifying and understanding the rewards and gratifications of their professional choice helped these family doctors overcome any insinuation that they took the easy option.

Conclusion

The joy we experience with our work radiates to the entire environment and to the patients in particular, fostering their well being and the well-being of the doctors as well. Pleasurable insights achieved in Balint groups or in workshops on the pleasures of doctoring can serve as another source of gratification and can help in preventing burn-out.

Take Home Messages

- Family physicians often deal with difficult patients, crowded waiting rooms, little time with patients and administrative pressures.
- Other pressures are related to the doctors' own personalities such as perfectionism, self criticism or fear of making mistakes.
- But, in every day of work of any family physician, there are plenty of pleasurable moments, laughter and intimacy.
- Three themes were identified regarding the pleasures of doctoring: professional, emotional and contextual gratifications.
- Pleasure in doctoring radiates to the entire environment, fostering both patients' and doctors' well-being.

Original Abstract

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40 – Measuring Effectiveness in General Practice / Family Medicine

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Context

Increasing patient involvement in their own care, and its evaluation, is an important feature of health service development. Donabedian has conceptualised effectiveness into technical and interpersonal aspects: the latter is explored here.

McWhinney defined general practice as working with undifferentiated problems, patient -focused, and stressed the importance of the doctor-patient relationship. All definitions of the role of general practitioner (The Leeuwenhorst Group 1974, the European Academy of Teachers in General Practice, EURACT in 2005) focus on a biopsychosocial perspective.

So core values in primary care include a holistic patient-centred approach. There has been much debate over the definition of patient-centredness and its measurement, but Stewart defines essential components as: exploring the patient's reason for the visit, including their information needs and concerns, seeking an integrated understanding of the patient's world, finding common ground on defining the problem and how to manage it, attending to health promotion and prevention, and enhancing the on-going patient-doctor relationship. This paradigm change from biomedical and disease-centred, is embodied in 'the patient-centred clinical approach'. Patient-centredness, although a widely recognized concept, is difficult to define, and measure.

The importance of communication

The consultation is the pivotal exchange in health care delivery. Silverman reports that during their working life doctors perform 200,000 consultations. Striving for quality in such a fundamental area is therefore a professional imperative. Research continues to show that doctors fail to determine why their patients *really* consult. Studies have shown how quickly doctors interrupt patients, how they fail to elicit half of their concerns and how important unvoiced agendas are. Doctors often consult in a directive doctor-centred style. Patients crave information and want to be involved in decisions regarding their care. Problematic communication has led to malpractice claims and dissatisfaction.

Pragmatic process and outcome measures

Time is used as a crude measure of consultation quality and studies have shown that longer consultations are associated with improved problem recognition. Studies have also shown that a "patient –centred" approach to the medical consultation does not always take longer -it is the interplay of factors that is important. Mechanic has pointed out the complexity of potential "active ingredients" in consultations which impact on time and quality (variability in problems, patients, doctors, the system).

Our understanding of effectiveness needs to be further developed.

Patient satisfaction surveys have flourished and many are now available. Baker defined satisfaction as "the patient's judgement of the quality of care". Both Ware (in the US) and Baker (UK) found that technical and interpersonal aspects of care are important for satisfaction. Patient satisfaction studies confirmed that remarkably few patients express dissatisfaction, which may be because satisfaction becomes a composite of overall attitude to health care and specific feelings. Framing may be influenced by methodological approaches.

In satisfaction studies there was downward drift over time, which could be linked to increasing patient expectations and staff demoralisation, so repeated surveys could become problematic. Calnan has investigated patient satisfaction with general practice in the UK (95%), Greece (87%), Yugoslavia (85%) and Russia (62%): all nominated the doctor-patient relationship, and professional skills as important. Another of his surveys reported that despite patient satisfaction being high, 38% of respondents felt unable to discuss personal problems with their GP, which casts doubt on satisfaction denoting quality of care. Satisfaction surveys have limitations as patients seem inclined to report satisfaction and the results of such surveys fail to provide detail needed for assessment of individual consultation quality. Patients may report satisfaction with their consultation, but have they been helped?

The Patient Enablement Instrument

The development of the Patient Enablement Instrument (PEI) aims to operationalise patient-centred consulting in terms of a patient-reported outcome. It represents over 20 years work by Howie (1) and was developed from literature review and patient focus groups: six questions were discriminatory (Figure 1).

The Patient Enablement Instrument

As a result of your visit to the doctor, do you feel you are …

	Much better	Better	Same or less	Not applicable
able to cope with life	○	○	○	○
able to understand your illness	○	○	○	○
able to cope with your illness	○	○	○	○
able to keep yourself healthy	○	○	○	○
	Much more	More	Same or less	Not applicable
confident about your health	○	○	○	○
able to help yourself	○	○	○	○

Scoring: much better/more: 2; Better/more: 1; Same or less: 0;
Total score: max 12, min 0, per consultation

Figure 1: The Patient Enablement Instrument (PEI)

Enablement builds on theories that adjustment and coping are important modifiers of patient outcome, and predictors of how patients feel and perceive life. Although enablement correlates with satisfaction measures, it represents a distinct concept. GPs who were more enabling were those who had longer consultation times, so both were regarded as useful measures of consultation quality.

It is known that continuity (how well the patient knows their GP) improves enablement (and is under attack by contemporary service development). Studies relate enablement and empathy (2) , and an analysis of verbal interactions in consultations (3) showed that socio-emotional interactions support enablement. Receiving a prescription when one is expected (4,5) is also associated with enablement. Mead et al studied a modified PEI (part of the General Practice Assessment Questionnaire (GPAQ 12) in the UK, with 190,038 consultations, 1031 practices) and found patients' evaluation of communication skills was associated with enablement. Patients with chronic illness and frequent attenders report lower enablement, and patients consulting in other languages report higher enablement (5). The PEI has been validated in Poland (5) Croatia, Thailand, Japan, China and Sweden with similar results. Howie's study reported PEI as independent of case-mix (4), but Mercer and Pawlikowska (5) have found that those with psychological problems are more difficult to enable.

A wide variety of issues impact on the consultation, given the influence of case-mix, the individuality of patients,

doctors and their relationships, it is clear that any quantitative measure of effectiveness based on the analysis of small numbers of consultations, will be unlikely to yield a reliable measure. Large numbers of unselected consultations are needed for the effect of influences to accumulate. PEI requires such conditions, which is both its strength and its possible limitation.

Patient enablement (the PEI) provides us with a way to investigate effectiveness in general practice, which is sensitive to patient, doctors and consultations. It encapsulates general practice core values and a patient-centred approach.

Take home messages

- Increasing patient involvement in the assessment of their own care is a 21st Century imperative.
- The medical consultation is pivotal to health care delivery, and the pursuit of excellence in consultations enables practitioners to activate their knowledge in the service of patients.
- There are many ways to approach the assessment of effectiveness, and patient centred outcomes are valued, but sometimes difficult to define and operationalise.
- The Patient Enablement Instrument (PEI): Patient offers an approach to investigate effectiveness in family practice, which is sensitive to patient, doctors and consultations.

Original abstract

http://www.woncaeurope.org/content/theme-c-measuring-effectiveness-general-practice-family-medicine

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41 – The International Classification of Primary Care: a Success Story

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1. Wonca International Classification Committee (WICC)
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(°) The first WICC working group consisted of Charles Bridges-Webb (Australia), Robert Westbury (Canada), Philip Sive (Israel), Derek Callagher (New Zealand), Donald Crombie (United Kingdom) and Jack Froom (United States). ICPC was first developed by Henk Lamberts, Maurice Wood and Sue Meads.

The Forty Year Story of ICPC

The WONCA International Classification Committee (WICC) was set up by the WONCA Council in Melbourne in 1972 on the occasion of the Fifth World Conference (1). WONCA recognized the need for classifying and analysing data derived from clinical encounters with patients that was quite unique to family medicine. This would become increasingly important with the advent of electronic health records.

From an initial small group led by Henk Lamberts and Maurice Wood (°), a tool which would become the ICPC was progressively developed and in 1987, the three existing classification systems, the International Classification of Health Problems in Primary Care (ICHPPC-2), ICPC-Process and Reason for Encounter - were merged into a single one; the ICPC. ICPC-2 was published in 1998 by the WONCA International Classification Committee, after several years of revision and cross-mapping with the International Classification of Diseases (ICD) – 10 (2).

ICPC-2 is maintained by WICC and an updated version is edited on the site of the Norwegian Centre for Informatics in Health and Social Care. WICC members meet each year in a different country and communicate through a very active mailing list.

ICPC and its Role in Primary Care

ICPC is a coding and classification system that reflects the distribution and content of the domain of family medicine, and also acts as its ordering principle. It was designed as an epidemiological tool to classify and analyse data about three important elements of the health care encounter: the reasons for encounter (RFE), the diagnosis or problem, and the process of care in family medicine. Novel features are the inclusion of patients' symptoms and complaints which allows the patient's reasons for encounter to enter a system of routine clinical data collection, the structuring of data into episodes of care, and the incorporation of the symptom as a diagnosis (3).

The collation and analysis can occur at the level of an individual patient for clinical care, and at the practice level for recall, clinical audit and activity analysis for health services research. Maps are maintained from other classifications such as ICD-10 so that ICPC may also be used as an organizing principle for data collected in other systems such as the clinical terminology, SNOMED-CT. Linkage of elements permits categorization from the beginning of the encounter with a health problem to its conclusion, as well as a dynamic arrangement of encounters into episodes.

ICPC-2 is available in more than 25 languages. It is compact, and the entire classification can fit onto two A4 pages. It is compatible with problem-oriented clinical records. In Norway, FDs are obliged to label all fee-for-service bills, sick-leave certificates and social security forms with an ICPC-diagnosis in order for them to be accepted by the health authorities. It is also used in referrals, e-Prescriptions and the

electronic ordering of laboratory tests (4).

ICPC Use in Family Medicine Research

ICPC has been used extensively for research in family medicine. In Australia, a version of ICPC is used in the BEACH database which contains more than 1,400,000 FD-patient encounter records (5). In the Netherlands and Malta, researchers are able to create reports from TransHis (6), an ICPC-based electronic health record, and the data have been used to develop the first public domain database of the predictive power of symptoms in making a diagnosis, for all relevant primary care diagnoses. ICPC is used by Danes conducting research in rural practice (7), as well as FDs who enter data into the Danish General Practice Research Database (8).

The Future of ICPC

A workshop on ICPC and other classification systems was conducted at the 2010 WONCA Europe conference in Malaga, Spain between WICC and the WONCA Informatics Working Party (WIWP). WIWP is primarily concerned with education in the field of family medicine informatics.

Meanwhile, WICC is developing the third version of ICPC. ICPC-3 has been in development for many years, using data collected with ICPC and other coding systems to allow expansion and modernisation of the classification without losing its core characteristics and values. Further information is available at www.ph3c.org , including the ICPC training module and an extended bibliography.

Take Home Messages

- Structured data in electronic health records are important not only for education but also for research and audit purposes
- Several classification systems are available, including the International Classification of Primary Care (ICPC) produced by WONCA
- Revising ICPC and getting more family physicians skilled in its use remain ongoing challenges

Original Abstract

http://www.woncaeurope.org/content/ws-17-international-classification-primary-care-icpc-and-hows-and-whys-classification

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42 – Physician Heal Thyself and then the World: Workaholism, Helpaholism and other Physician Conditions (Fraud Syndrome, Empathopoenia, Email-Overdose, MDeity Syndrome, Cell-phone-Otitis, etc) – Playful but Effective Medications for Serious Symptoms

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Most docs are workaholics or helpaholics -- especially Family Docs (1)! I am both. I still run workshops and a psychotherapy practice at 75. I love what I do, that's the problem!

I'm getting better! I read Barbara Killinger's "Workaholics: the Respectable Addicts; a Family Survival Guide" (2), often worse in its impact than alcoholism. Take the Workaholic Quiz at: www.cnn.com/interactive/2011/05/living/workaholic.test/ and find out if your case is serious!

I was fortunate to train with Virginia Satir, the "Columbus of Family Therapy", an enlightened lady way ahead of her time. Stone deaf for two years from mastoiditis at six, she noticed people looked very different when communicating, and planned to become a detective on parents when she grew up. Her mother, a **Placator** never spoke her own feelings, hid anger deep inside, never saying "No!"– like many family docs. Her father was a **Blamer**, hiding his helplessness and shame of alcoholism. Others looked like computers, the **Super-Reasonables** –- maybe she met some doctors (specialists particularly) -- hiding discomfort about feelings ("Just give me the facts. Don't bother me with this emotional stuff!"), quoting N.E.J.M or the Bible. Others were always joking or changing the subject, the clowns hiding despair, the **Distracters**. She later understood these four came from AND increase Low Self-Esteem (3). So one medication that helps stop the Performance-Based Self-Esteem of most physicians is the prescription of:

Congruence!

I remember being told to be congruent with patients in Med School, but nobody explained how! Congruence is being respectful, considerate and honest. Non-verbal signals match verbal content. If you're angry you may look and sound angry, but you don't blame or accuse, you try to understand the other's position.
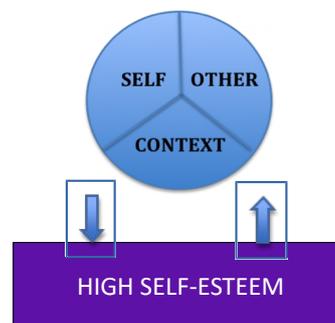
Every communication has three components: Self - one's thoughts, feelings and opinions, Other's thoughts, feeling and opinions, and the Context or situation. Picture a peace sign, without the bottom bar, and you have congruence - all three are expressed. When feeling safe and confident (high Self-Esteem), it's easy to be congruent AND it adds to the self-esteem of both parties. For example; "Mrs Smith. I see you are fed up with the side-effects, and I'm getting frustrated with you 'forgetting' the pills, because you really need them. Can we discuss this situation so we get unstuck?"

When you feel insecure or defensive you move to one of those Stances, which make you feel a victim, a jerk, a cold fish or a clown respectively, i.e. you feel even worse about yourself underneath the anger, apologies, quoting of studies or joking. They are "survival stances" as that's how you learned to survive in your family growing up.

Each coping stance ignores part of the picture:

Stance:	PLACATING	BLAMING	SUPER-REASONABLE OR COMPUTER	DISTRACTING OR IRRELEVANT
Each hides Feelings:	(ANGER)	(HELPLESSNESS)	(FEAR OF FEELINGS)	(DESPAIR)

LOW SELF-ESTEEM
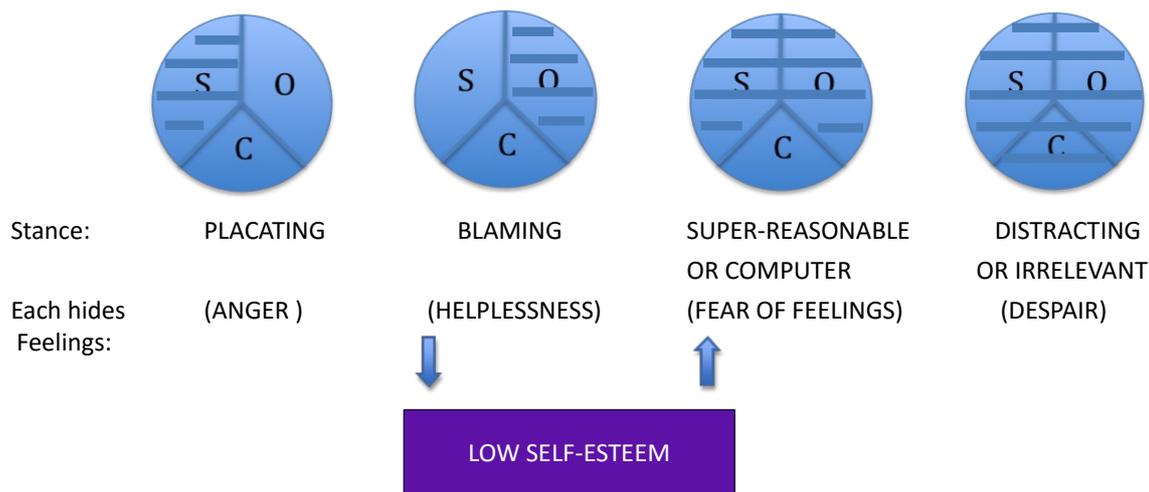
Icebergs

Virginia often said: "The problem's not the problem, it's the coping". What are we coping with? The insecure feelings the problem generates.

Behaviour is the tip of an iceberg (4) - the only part seen. It pays, especially for physicians to know the other layers. Humans, like icebergs are all unique and beautiful, but the layers under the waterline can be dangerous.

Below Behaviour, determining it, are the Coping Stances described above. Fuelling them are Feelings, especially feeling about ourselves – our Self-Esteem. We developed that from Perceptions of ourselves from childhood experiences. If we came to expect criticism and punishment, that's what we continue to dole out to ourselves -- what we in the Ottawa Satir Learning Centre call our Gremlin (from a wonderful little book: "Taming Your Gremlin:" (5)). The Gremlin loves Negative Self-Talk, and lives in the Expectation or "Should-ing" layer.

First homework: Draw your Gremlin (did he or she just say: "But you can't draw!" – a scowly-face or a cut out tiger from a magazine will do, but it should be visual on a piece of paper). Carry this around for several days, recording anything it says, like: "You're lazy / a fraud / way behind in your journals / etc". Beware; doctors' Gremlins are louder than most! Then, for another week, try elastic band therapy - wear one on your wrist - every time you hear the little fellow give it a flick – not too hard, this is NOT self-punishment! Under the Expectation layer is "Yearnings" – what we really want and need in life –to love and be loved, to be heard, to contribute. How often do you listen to yourself rather than patients? Have you ever talked to the kid inside you who longs to play, paint, dance or research something?

Second homework: dialogue with him or her, with a pen or a pencil in your non-dominant hand for the child. (When I tried I was startled at what I heard – from a three year old whom I'd told was not good enough! She loves painting! www.christie-seely-art.ca). Diving into Yearnings propels you into the Self or "I AM", your spiritual core. Good news! Here, your self-esteem is always high, and you can readily say: "The world is a better place because I am in it!" Try saying that to yourself now – without thinking in terms of your work contributions.

You can also get to Self through meditation, music, art, running – but if you go through the Iceberg you can learn to live there. It will improve your ability to heal the world!
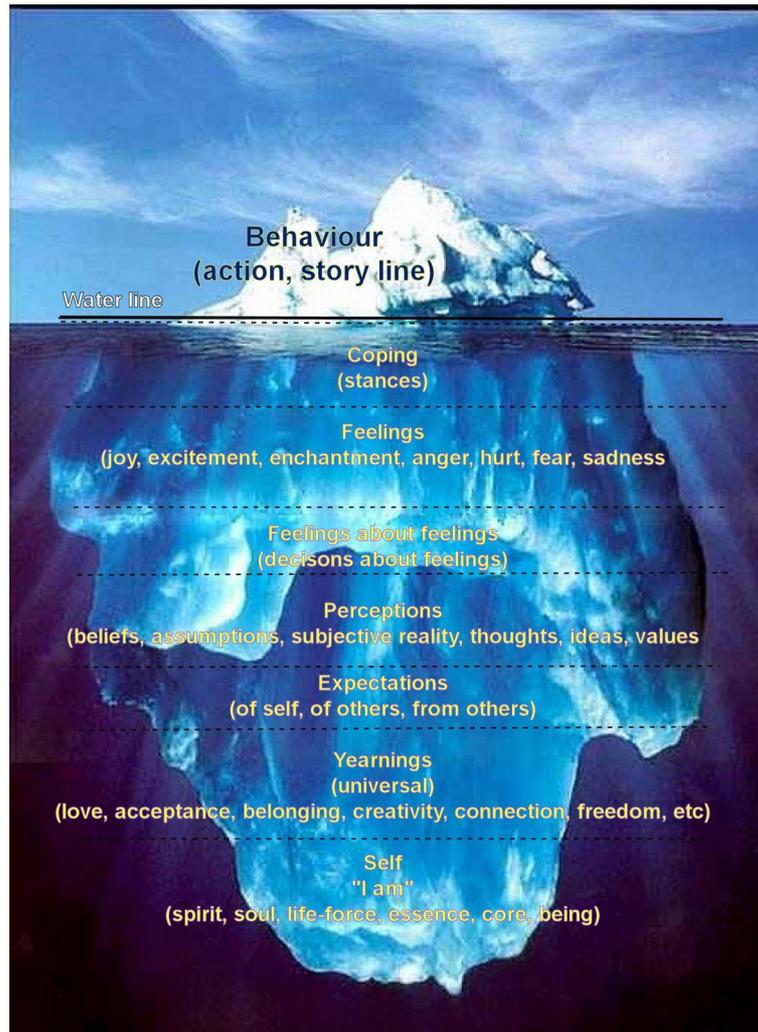
Good luck!

Take home messages

- True self-esteem is independent of performance.
- Congruence raises self-esteem of all concerned.
- Listen to your inner kid, don't berate him / her.
- Satisfy YOUR real needs, THEN help the world.

Original abstract

http://www.woncaeurope.org/content/3798-physician-heal-thyself-and-then-world-workshop-workaholism-helpaholism-and-other

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43 – Competency in Medical Record-Keeping: Development of a Scale and Assessing CME (CPD) Impact

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Poor medical record keeping is a commonly encountered deficiency when evaluating physician quality. Medical records that do not adequately or accurately capture what transpired between the provider and patient at the time of an interaction lead to poor communication, medical errors and lawsuits. The University of California, San Diego, Physician Assessment and Clinical Education (PACE) Program has been offering assessment and remediation of physicians in all specialties since 1996. Early in the course of our assessment program, it became clear that deficient medical records were a common theme for many referred participants. Further needs assessment work revealed that only a small minority of physicians ever received formal training in medical record keeping. A surprising finding since a medical record entry must be made for every patient interaction. PACE therefore developed the Medical Records Keeping Course (MRKC) and initially offered it in 1999. Similarly, PACE offers continuing education courses in prescribing, physician-patient communications, professional boundaries, anger management and customized courses.

A number of the ACGME/ABMS Core Competencies (Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems Based Practice) particularly interpersonal and communication skills, and professionalism address medical record keeping. It is an integral and necessary part of the practice of medicine. The medical record serves as a source of communication, is used to help determine the quality of patient care, is used to confirm proper reimbursement and is the key source of evidence in medical risk management matters.

The PACE MRKC content covers: an introduction to medical records and a brief history of the modern day record; the legal requirements and aspects of the medical record; coding, billing and compliance regulations; computer hardware and software information related to the record; information retrieval, information security, privacy and HIPAA ; and, the electronic health record. Acquisition of knowledge, skills or attitudes is the goal of any educational endeavour. To measure the success of knowledge acquisition, the PACE MRKC course has pre-tests and post-tests. Knowledge (competence) must be achieved prior to incorporating items into practice (performance). Knowledge, the precursor to practice, is easier to assess and became our initial objective.

The participants of the PACE MRKC were generally mandated to attend the course by a state regulatory board, hospital or medical group based on a disciplinary action. In the sample, one hundred seventy-two participants took the pre- and post-test. A comparison group/convenience sample of thirty-two non-disciplined UCSD Family Medicine residents and faculty were recruited. A thirty item multiple-choice test was devised covering the content areas of "legal/ethical, electronic health record and coding." Principle components factor analysis demonstrated a strong one factor

solution. An independent three factor solution was tested but there was weak statistical support for the three factor structure. Cronbach's alpha was 0.72, with 30 items indicating internal consistency.

The MRKC participants scored 21.2 on the pre-test and 24.7 on the post-test. The UCSD faculty scored 24.3 on the pre-test and 25.3 on the post-test and the UCSD residents scored 23.1 on the pre-test and 24.0 on the post-test (figure 1). There was significance difference between comparison groups with the MRKC physicians scoring significantly lower than the UCSD groups on the pre-test (p<0.01) validating that the MRKC participants should have been participants of the course. A 2x3 ANOVA (MRKC/UCSD (fac. and res.) & time) indicated significance with time and group interaction (p<.01)(figure 2).

Further analysis of scores looked at other MRKC participant factors including whether the participant was a foreign medical graduate, American Board of Medical Specialty certified and age. The only factor revealing a significant change in score was whether the participant was a foreign medical graduate or not (figure 3).

In conclusion, the pre-test and post-test for the PACE MRKC are reliable examinations. The physicians that were referred for the course did score significantly lower than those physicians not referred to the course indicating that their pre-course knowledge base was deficient compared to the UCSD faculty and residents. The PACE MRKC participants did significantly increase their knowledge through attending the course. Being a foreign medical graduate was a risk factor for a lower score but whether it was a language issue or an education issue could not be determined and remains an item for further study.

Figure 1
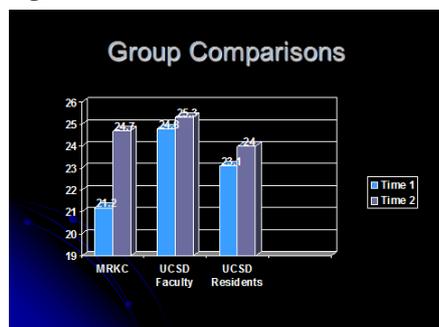
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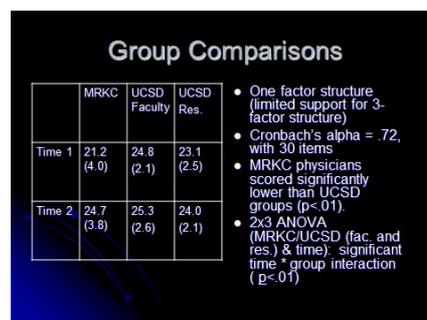
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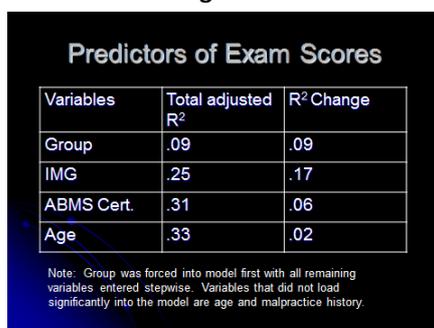
Take Home Messages:

- Adequate and accurate medical record keeping is important for delivery of safe and optimal medical care; and it's the law.
- Despite the extensive education that physicians receive, most have not had formal training in medical record keeping.
- The University of California, San Diego, Physician Assessment and Clinical Education (PACE) Program developed an accredited CME program, Medical Record Keeping Course (MRKC), in 1999 and educates approximately 200 physicians and other health care providers per year.
- Each participant completes a pre-test and post-test as a required component of the course. PACE has demonstrated statistically significant knowledge acquisition by course participants.

> - Knowledge in MRKC participants was statistically significantly less on the pre-test when compared to a university faculty and resident cohort confirming that the participants, almost exclusively referred to the course for disciplinary reasons, had a pre-course deficient knowledge base in medical record keeping.

Original Abstract

http://www.woncaeurope.org/content/4305-competency-medical-record-keeping-development-scale-and-assessing-cme-impact

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44 – The Health Needs of Hard to Reach Groups: Do We Know Enough?

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One of the most representative minority groups in almost every country in Europe are the Roma. The Roma (Gypsies) are a special ethnic community with multiple homelands, abundant cultural heritage, and a certain way of life. They are a special ethnic group of people who predominantly live in Central or Eastern Europe (CEE) (approximately 5.2 million of Roma live in CEE countries). It is estimated that about 10,000 Roma live in Slovenia, of which 3,000 live in Prekmurje. In Slovenia, the Roma are legally considered to be a minority at risk, and their status is partly regulated by the Slovenian Constitution. Their integration into the community primarily involves jobs and schooling (Roma children attend the same schools as non-Roma). The Majority of Roma in Prekmurje have built good relations with the non-Roma population. They are also very active in protecting and developing their cultural and ethnic specificity. They have their own radio and TV programme, publications in the Roma language, and they take part in investigating the needs and specificity of the Roma population.

Due to the problems researchers face when carrying out studies in Roma settlements, there is a lack of data on how public healthcare measures should be appropriately developed and implemented for this minority group. These problems arise because of the mistrust the Roma hold for the non-Roma researchers; they are afraid of being discriminated against and exploited, they have problems talking to researchers, and they are afraid of any consequences they might face within and outside their community if they participate or do not participate in these studies. Time-related and financial obstacles represent an additional burden in carrying out such studies.

The Roma have their specific material and spiritual culture, including health culture which determines their attitudes towards health, diseases and death. In the past, their strong superstitious beliefs led them to prefer visiting domestic healers rather than doctors and conventional medicine. The decision by Roma to seek medical care is affected by their culture. They equate health with happiness. They believed that certain diseases were outside the realm of their perception of health so they visited special Romani practitioners, and used herbal home-made medicines. However, most of those Roma beliefs have been abandoned over the past few decades. They have developed an increased trust in conventional medical methods but a lack of confidence in health-care workers and institutions. Since they are mostly poorly educated, and sometimes do not trust the non-Roma population, this often results in communication difficulties with healthcare workers. In addition, their low education level, poor mastery of the language of the non-Roma population, and cultural and ethnic differences contribute to poor health literacy. They often do not understand medical protocols, and have problems comprehending information material they are given in health centres. Due to the poor health literacy of the Roma, their difficulties understanding medical terminology or misinterpreting it, few publications deal with

the issue of healthcare in the Roma communities. In some cases, their culture still contains beliefs about health and healthcare with which health workers may not be familiar. Vivian and Dundes emphasized that health care workers frequently make the mistake of assuming that all Roma patients have basic medical knowledge and accept the standards of the country's medical system. The hierarchy of the Roma family and gender distinction in seeking out medical assistance plays a vital role in the communication with medical workers. Usually, the family elder makes conversation, decides on family decisions, and ensures that younger family members co-operate with doctors and other medical workers. An understanding of the culture, traditions, and values of the Roma is of great importance if health professionals wish to understand and assist these people. The general health of the Roma people is substantially worse than that of the majority population, with poor compliance with preventive activities and vaccinations. Different Studies show that the Roma have a high prevalence of a variety of diseases, for example: smoking, metabolic syndrome with type 2 diabetes, respiratory diseases, mental health problems and increased cardiovascular mortality compared with the general population. The health of the Roma is strongly related to their socio-economic situation, associated inadequate living conditions and infrastructure of their homes. Their health problems are also linked to inadequate hygiene conditions and poverty, which in turn leads to decreased lifespan, increased risk of illness, and chronic diseases. A Hungarian study that compared the health status of the general population with that of the Roma community and a Serbian study that examined sexually transmitted diseases identified the need for a specific public healthcare approach in the Roma community that includes health education and promotion of a healthy lifestyle. Similar findings have been established by Croatian researchers, who concluded their study by recommending the planning of a public healthcare approach in socially marginalized and economically disadvantaged communities such as the Roma.

However, overall life quality of the Roma has improved over the last few decades. Today the remaining problems of the Roma (including in Slovenia) include: socio-economic conditions (mainly affected by education and employment), social exclusion, and in some cases, misunderstanding with the local people. While health care is largely free in Slovenia, obstacles for the Roma population relate more to certain special medications and hospital-related fees, especially for those Roma who do not hold compulsory health insurance. As with any ethnic minority, the Roma need special consideration from the social and healthcare systems. It is important that the healthcare system recognises and deals with the requirements of this population. This is, however, difficult if the Roma attitudes and beliefs towards healthcare are not taken into account. Numerous studies have taken into account ethnicity and culture as important variables in the exploration of marginalized ethnic communities' relationship to health and healthcare. Considering inequalities and the special needs of the population, this variable is important in analysing attitudes of ethnic and ethnic minorities towards the health and healthcare services. Over the last few decades, numerous qualitative and quantitative studies have raised the issue of the Roma population and their attitudes towards health and healthcare services in the US, some West European countries, CEE countries, and the former Yugoslav republics including Slovenia.

Take Home Messages

- Culture, customs and socio-economic situations affect minority groups' relationship towards health and healthcare services
- Only with knowledge and improved communication, we can together develop the health for marginalized populations

Original Abstract

http://www.woncaeurope.org/content/40-pa-assessing-health-needs-hard-reach-groups

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45 – Is There Such a Thing as a Correct Diagnosis in Family Medicine? Learning Points from the Use of Consensus in Validating Diagnoses in Family Practice

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Background

A correct diagnosis is the basis for therapy in clinical medicine. Research in validation of medical diagnoses has however demonstrated disappointing results. Different doctors have been shown to make different diagnoses when presented with the same case history, and the same doctor makes different diagnoses when the same history is presented several times.

The author wanted to study the ability of experienced family doctors to make a diagnosis based upon a video recording of real life consultations in family practice, and to test the impact of subsequent information about the long-term outcome as well as a small group discussion on agreement or disagreement about correct diagnosis.

Setting and Methods

244 consecutive patients over the age of 15 presenting for consultations with the author in a group practice in northern Norway, were asked for informed consent to video recording of their meeting with the doctor. Immediately following each consultation the doctor decided whether the patient had presented a new problem that had not been discussed before. The doctor made a note of the new diagnoses that he had made by the end of the consultations. The patients were interviewed by telephone 3-6 months later. Three years later the medical records of the patients were scrutinised and the doctor made a final diagnosis.

Altogether, 69 video recorded consultations where the patients presented 90 new problems were included. In 20 problems a specialist had made the final diagnosis after referral. Among the remaining 70 problems, 20 were selected at random for validation by experienced FDs. Four patients did not consent to their video being shown to other FDs, which allowed the remaining 16 video recorded consultations with 16 new problems to be analysed further.

Five experienced family doctors were invited and each of them met three times in groups of three. The video recordings and the medical history of the patients were presented according to a step-by-step procedure:

1. The doctors were given a short written summary of the patient's previous history and presented with one new problem which they were expected to diagnose. They then watched the video recording of the whole consultation. After the video, the author answered clarifying questions and elaborated on his clinical findings during the consultation. The author then left the room. Each doctor was asked individually to write down the most likely diagnosis of this single problem (Diagnosis 1), without

discussing this with the other doctors in the group.

2. The doctors were then presented with a summary of results of subsequent tests, further examinations and the long-term outcome after three years. Each doctor then wrote down the most likely diagnosis at this point (Diagnosis 2), still with no discussion within the group.

3. The doctors were then presented with the final diagnoses that the author - who had performed the consultations - had made after three years, and they were asked to score whether they agreed or disagreed with these diagnoses.

4. Finally, the participating doctors were asked to compare their diagnoses and engage in a discussion in the group of three to try and reach consensus about the most likely diagnosis (Final diagnosis) in each case. The participants were asked to indicate the certainty of each diagnosis on a scale from 1 (most unlikely, but possible) to 5 (certain).

Results

For each of the 16 videos there were three doctors making individual diagnoses of the new problem, yielding 48 individual diagnoses altogether. The participating doctors reached consensus on the most likely final diagnoses for all 16 problems. For one problem the final diagnosis was that of a symptom (T 08 Loss of weight), whereas the diagnoses for the remaining 15 problems were clinical diagnoses (ICPC-code 70+). Details of diagnoses of the 16 new problems are presented in table 1. The results of the doctors' self-assessed feeling of confidence with his or her own diagnoses at each step are shown in table 2.

There was no major disagreement between the final diagnoses made by the author and those made by consensus between the FDs. However, two cases deserve commenting upon:

- In case no. nine the author stated R 78 acute bronchitis as the most likely diagnosis, whereas consensus among the other doctors as their first choice was R96 COPD. In view of the long-term outcome, the author did agree.

- In case no. three the author - having made an unexpected clinical finding - maintained a rare diagnosis for his first choice even following validation:
Case 3: A 65-year-old married woman presented with upper gastric pain. The pain gradually subsided spontaneously over three weeks and when palpating the epigastric area one month later the author had noticed a tender subcutaneous lump in the area where she had located her pain. He concluded that the most probable reason for her pain was acute necrosis in a subcutaneous lipoma with a probability score of 4. The participating doctors individually gave a probability score of two ("unlikely") on the 1-5 scale for this diagnosis, and found consensus that the most probable reason was biliary dyskinesia.

Discussion

The fact that all the FDs were able to find a diagnosis is in agreement with earlier findings that doctors are able to make a correct diagnosis in more than 90% of cases after taking medical history only.

The finding that the FDs initially had less confidence in their own individual diagnoses than the author is hardly surprising. What is surprising is that the doctors did not feel more confident with their diagnoses after having been presented with the long-term outcome.

Only after having discussed the case with other colleagues did they feel as confident with their own diagnoses as the doctor who had seen the patient in the flesh. This may be taken as an illustration of the strong normative power of consensus in professional judgement.

Take Home Messages

- Experienced FDs are able to find consensus about a correct diagnosis when given all relevant information and watching a video recording of the consultation.
- Only after having discussed the case with other colleagues will they feel as confident with their own diagnoses as the doctor who has seen the patient in the flesh.
- Unexpected clinical findings made by the doctor during the consultation may be decisive for the doctor to insist on a different or rare diagnosis.

Original Abstract

http://www.woncaeurope.org/content/there-such-thing-correct-diagnosis-general-practice

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Table 2: Participating doctors' self-assessed feeling of confidence in own diagnoses
Mean score and 95% confidence intervals on scoring on a scale from 1 (most unlikely, but possible) to 5 (certain).

		Diagnoses 1	Diagnoses 2	Final diagnoses
Author (n=1)	Mean	4.13	4.06	4.06
	95% CI	3.92-4.35	3.90-4.22	3.90-4.22
Participating doctors (n=5)	Mean	3.52	3.75	3.94
	95% CI	3.29-3.75	3.56-3.94	3.71-4.14

Table 1: Diagnoses based on viewing video recordings of 16 consultations in family practice.
Problems presented by the patient, the author's diagnoses before validation, and consensus by experienced FD's.
Most likely diagnosis first.

Case no.	New problem presented by the patient	ICPC	Author's diagnoses before validation	ICPC	Consensus by participating doctors	ICPC
1	Lump in the groin	S04	Lipoma Atheroma	S78 S93	Lipoma	S78
2	Pain in the left hand	L11	Tendinitis	L93	Tendinitis	L93
3	Pain in the stomach	D02	Necrosis in lipoma Biliary stones	S78 D98	Biliary bladder colic	D98
4	Loss of weight	T08	Depression Cerebral infarction Encephalitis	P76 K89 N71	Depression	P76
5	Pain under the right heel	L17	Pressure ulcer Fasciitis	S97 L93	Osteotendinitis	L93
6	Pain in right side of the neck	L01	Shoulder myalgia	L92	Myalgia of the neck	L83
7	Pain on micturition	U01	Cystitis	U71	Cystitis	U71
8	Reduction of medication	R50	Reduction of medication	R50	Reduction of medication	R50
9	Cough	R05	Acute bronchitis Chronic obstructive pulmonary disease	R78 R96	Asthma Chronic obstructive pulmonary disease	R96 R95
10	Difficulties in swallowing	D21	Functional problems with swallowing Thrush	P75 D83	Functional problems with swallowing	D21
11	Pain in the right shoulder	L08	Tendinitis Problems with sick child Problems at work	L92 Z18 Z05	Shoulder tendinitis	L92
12	Loss of weight	T08	No disease	A97	Loss of weight	T08
13	Pain in the chest	L04	Myalgia Angina pectoris	L99 K74	Intercostal myalgia	L99
14	Pain in the head, neck, back and chest	L01	Myalgia Fibroadenomatosis of breasts	L84 X88	Myalgia of neck and back	L84
15	Pain in both shoulders and hands	L08	Arthritis	L91	Arthritis	L91
16	Sore throat	R21	Upper respiratory infection (viral)	R74	Upper respiratory infection (viral)	R74

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46 – Family Medicine Facing New Challenges on a Global Scale.

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Introduction

In the second half of the 20th century, family medicine developed considerably, starting with the exploration of the different dimensions of the patient-centred approach, developing the bio-psycho-socio-ecological model, training appropriate consultation-models, underpinning clinical decision-making in the epidemiological context of primary care, front running in the development of Evidence Based Medicine, framing the profession in the broader concept of the primary health care-team, and serving patients and populations throughout their lives. Increasingly, the "experience" of family physicians became underpinned with results from both quantitative and qualitative research, strengthening the evidence base of the discipline.

Presently, the health of populations is facing two important challenges. The first is the worldwide epidemiological and demographical transition leading to the fact that multi-morbidity is becoming more and more the rule, rather than the exception in patient populations (1) while in the meantime, there are the new challenges of emerging infectious diseases (e.g. Ebola).

The second challenge has to do with the increasing social gradient in life expectancy, both within and between countries. In Belgium, the gap in healthy life expectancy for men at the age of 25 is more than 18 years between those having received only basic education and those with a university degree. How can family medicine and primary health care respond in order to face both these challenges?

The Epidemiological Transition and the Need for a Paradigm-shift.

Nowadays, 50% of those aged over 65 have at least 3 chronic conditions and 20% of those aged over 65 have at least 5 chronic conditions.

In recent years, not only Western countries, but also developing countries, have started "Chronic Disease Management Programmes". A recent survey of "Chronic Disease Management" in 10 European countries illustrated that disease-management programmes are mostly organized around a single chronic condition, e.g. diabetes, sometimes even focusing on sub-groups within a specific chronic disease, e.g. disease management programmes that only include people with type 2 diabetes. Although this approach has led to more providers adhering to guidelines, to task-shifting from physicians to nurses, dieticians and health educators, and to improved knowledge and skills of patients in dealing with their chronic condition, we actually face the growing mismatch between the needs of people living with multi-morbidity and the resources offered by a health system that increasingly focuses on disease-defined care. Vertical disease-oriented programmes produce gaps in the care of patients with multi-morbidity and cause inequity for patients who do not have the "right" disease (2) leading to "inequity by disease". There is a need to explore new generic ways and

paradigms. A goal-oriented approach that encourages each individual to achieve the highest possible level of health, which is defined by the individual instead of the health system (3). Family Physicians can be involved in the facilitation of "goal definition" by the patients and are well-placed to integrate these goals in clinical decision-making for multi-morbidity and build an individual care plan together with the patient. Continuity of care enables the family physician to be attentive to the fact that goals of patients can alter over time as the context changes. Such an approach will require more focus on the individual patient-provider interaction and on appropriate communication skills to facilitate goal definition and patient empowerment. It is obvious that this can only take place in the framework of an inter-professional team including other primary care providers (see: www.euprimarycare.org). Shared decision-making, starting from the patient's goals and involving the patient and other care providers, will avoid gaps in the process and encourage empowerment of the patient (4).

The Contribution of Family Medicine and Primary Health Care to More Health Equity.

In figure 1, we formulate a hypothesis about how family medicine, in the framework of a primary health care team can be a strategy for promoting health equity and intersectoral action (5). A first prerequisite is a high level of accessibility of the primary health care team (6). A second is: the team should deliver high quality care. Moreover, the team should interact with different networks (education, work, economy, housing,…) that are related to important sectors. Apart from an approach to individuals and families, the primary health care team should also address the community, utilizing the Community Oriented Primary Care Strategy (COPC) (7). The COPC, the direct action of the primary health care team and the intersectoral networking will enhance the social cohesion in the community. The actions of the primary health care team (preventive, curative, rehabilitative, health promotion,…) together with the increased social cohesion in the community will lead to empowerment of the people. This empowerment will decrease the vulnerability to factors that may contribute to health inequity. Moreover, as the COPC-action will address the living conditions of the local population, the exposure of the people to factors that may be a threat to their health will diminish and the differential vulnerability will decrease. Finally, a better education, improved working conditions, decreased unemployment, better housing conditions, and access to safe food and water will improve the structure of determinants that influences social stratification. In summary, the inter-professional primary health care team operating in a network with other sectors will promote health equity through increased social cohesion and empowerment. This is in line with Starfield et al who find a rationale for the benefits of primary healthcare in (1) greater access to needed services, better quality of care, (2) a greater focus on prevention, (3) early management of health problems, (4) the cumulative effect of the main primary care delivery characteristics, and (5) the role of primary care in reducing unnecessary and potentially harmful specialist care.
Examples of this kind of inter-sectoral action for health can be found in the International Federation of Community Health Centres (http://www.ifchc2013.org).

Family Medicine on a Global Scale.

Nowadays family medicine is operating in the context of primary health care all over the world. Recent developments of the profession of family medicine in Asia, Latin America, Africa, have illustrated the ubiquitous need for this discipline in order to build strong health systems. Important in this development is the continuous integration of personal and community health care. Interestingly, there is a two-directional evolution in the current developments: in Western countries practices that were mostly focusing on care for patients are becoming more and more "population-oriented", and in countries like Latin America, Africa, the challenge is to integrate the (vertical) population health programmes in a comprehensive primary care system (8).
Family Medicine and WONCA have an important role to play in the further development of an inter-professional learning community of primary health care practice.

Take Home Messages:

- In order to address the challenge of multi-morbidity a paradigm-shift from problem- to goal-oriented care is needed
- Accessible family medicine practices may contribute to health equity

Fig. 1: Primary health care as a strategy for promoting health equity and intersectoral action.

Original Abstract

http://www.woncaeurope.org/content/478-equity-human-rights-and-primary-care-national-and-international-perspectives-human
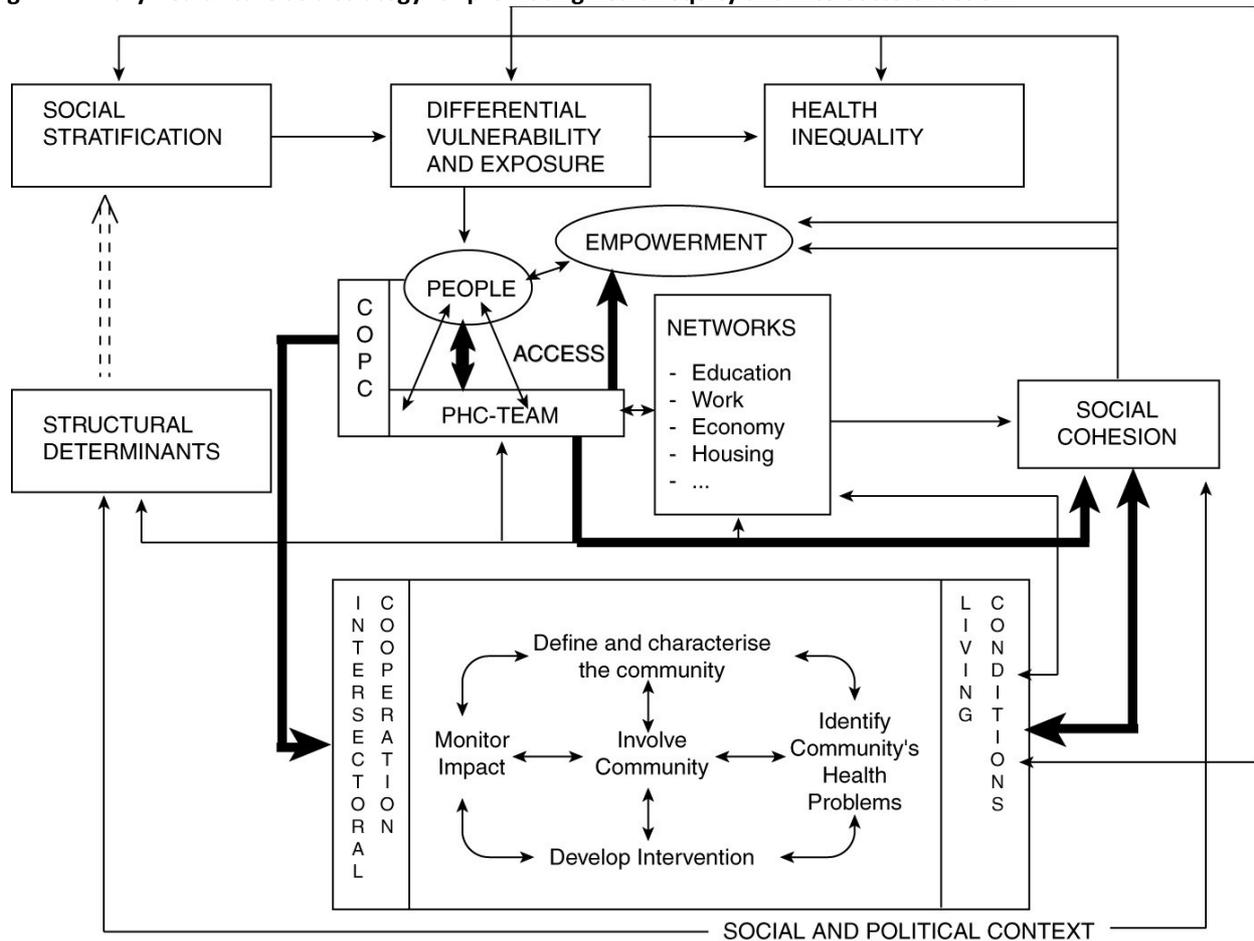
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47 – The EURACT Educational Agenda

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"General practice is the easiest job in the world to do badly, but the most difficult to do well."
Professor Sir Denis Pereira Gray

Introduction

The discipline of general practice/family medicine (GP/FM) should move away from time- and institution-based curriculum set-up to competence- and outcome-based learning. A relevant education programme that is mainly competence driven should be produced. GP/FM is best learned in a GP-setting, although specific competences and skills can be learned in environments of other disciplines. It should also be remembered that learning is a lifelong issue.

Specifically the discipline needs to establish:

• How family medicine is learnt best?

• Where should it be taught?

• When should it be taught?

• What should be taught?

• What should GP/FM be teaching learners from other disciplines?

Harmonization in Europe at the level of competency aims and learning outcomes

The European Union stresses harmonization of the content and level of the training in all areas. Since 1993 the European Directive on mutual recognition of medical qualifications (Directive, 1993) has been trying to complement the quality of GP/FM by harmonizing the length of specialist training, the setting where it takes place, and the national supervising authority. The Directive contains no descriptions of content or competence issues and is regarded as unsatisfactory in this regard.

EURACT Educational Agenda (EEA) (Heyrman, 2005) is a dynamic document, derived from the core competencies accepted by all European GP/FM academies during the WONCA Europe meeting in London 2002, (updated in 2005 and 2011) and presented at the WONCA Europe meeting in KOS-Greece 2005.

Its aim is to contribute to the harmonization of the learning outcomes of the different educational programmes all over Europe. It explores six core competencies and how the acquisition of these competencies can be converted into abilities to perform. In each of eight chapters the specific educational objectives, appropriate learning and assessment methods and the specific options for the setting and the time frame within the curriculum are identified. Six core competencies lead to the definition of 25 first level and 80 second level educational objectives. The implications of the EEA on education and research in family medicine have been profound. In this document the complexity of the real

practice was accepted as the main focus and complexity learning as the educational paradigm. Learning is seen as a process, highly dependent on pre-knowledge and on the learning context (Innes, 2004). Rather than the acquisition of a list of defined knowledge and skills, "Action in wisdom" (Harris, 1993) is the final aim.

The EEA involves the use of specialized knowledge, but central to this is judgement in specific situations with conflicting values regarding which problems need to be solved and how to solve them. It involves knowing-in-action, reflection-in-action, and reflection-about-action, using repertoires of examples, images, and understandings learned through experience. It involves using prototypes in memory of frequently encountered situations to construct interpretations of related situations. That is why "the tree of wisdom" became the final logo of the EEA.

The legacy of EEA?

EEA is a living document serving as a foundation for General Practice/Family Medicine teaching in general with a set of offspring documents necessary for the development of the discipline. For those involved in delivering general practice/family medicine education and in developing programmes of teaching in general practice, it is designed to provide a framework to teach the core competencies. Several countries have adopted the EEA framework and built it in their specialty training programmes. For those who learn the discipline, it aims to offer an educational framework for setting the learning aims, and monitoring their achievement. A Performance agenda developed on the foundations of EEA provides an opportunity for self-assessment on how the learning objectives have been used in everyday practice (Wilm, 2014). For those involved in curriculum building, it should be used to determine priorities in teaching and learning general practice/family medicine. A Framework for continuing educational development of trainers in general practice in Europe (CEDinGP) sets standards for teachers in general practice based on EEA (Alen et al., 2012). For healthcare developers, it is meant to contribute to national policy development.

With regard to the whole medical profession, it is conceived to define which specific competencies can be expected from the particular discipline called General Practice/Family Medicine as a crucial contribution to healthcare.

For the researchers, it defines the mile stones for the Research agenda related to these competencies (Hummers-Pradier, et al., 2009).

The EEA and future generations

What the future will bring to health care industry is almost impossible to foresee. The future of European General Practice/Family Medicine is set in stone in The European Definition of General Practice and supported by a series of documents based on it. Fortunately, the position of General Practice/Family Medicine and the level of incorporation of General Practice/Family Medicine in health care provision varied at the times when these documents were produced, meaning they are so generic that they will survive any turmoil of local health policy decisions. Through very well developed education and research in the majority of European countries, quality of General Practice/Family Medicine services has risen and can no longer be overlooked. A large number of recently qualified General Practice/Family Medicine physicians have been trained in the spirit of EEA and they are the best prophecy for future success. However, the leaders of the discipline at national and international level shall further strive for the implementation of the EEA in specialist as well undergraduate education. The General Practice/Family Medicine Agenda for undergraduate education is still one of the tasks remaining for future generations along with regular updating with regard to content and methods..

Take Home Messages

- The definition of the discipline of general practice/family medicine and of the specialist family doctor must lead directly to the core competencies of the general practitioner/family doctor.
- The interrelation of core competencies, and essential application features characterizes the discipline and underlines the complexity of the specialty.
- There is a need for harmony, equal quality standards and exchangeability in teaching general practice/family medicine.
- Rather than the acquisition of a list of defined knowledge and skills, "Action in wisdom" is the final aim.
- General practice/family medicine is best learned in a GP-setting, although specific competences and skills can be learned in environments of other disciplines.

Original abstract

http://www.woncaeurope.org/content/313-wo-educational-change-users-perspective-educational-agenda-gpfm

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48 – Continuity of Care

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Continuity of care is a cornerstone of family medicine and a key point for patients.

It has been included by EURACT (European Academy of Teachers in General Practice and Family Medicine), in "Person-centred care", and one of the "Core competences of GP/FM"(1), as the ability "to provide longitudinal continuity of care as determined by the needs of the patient, referring to continuing and co-ordinated care management". It can be interpreted as following the patient from birth (sometimes also before) until death (sometimes even after), throughout their whole life.

Continuity of care, also described as 'the ability to manage in continuity of time, in the individual, a series of multiple complaints and pathologies, both acute and chronic health problems' (3), enables doctors to promote health and well-being by applying health care and disease prevention strategies appropriately, as described in another core competence, the "Comprehensive Approach".

It is firmly bound to other core competencies, in the "Holistic Approach" (considering a biopsychosocial model taking into account cultural and existential dimensions), and "Community Orientation" (also taking into account the community in which the individual patient lives and trying to reconcile health needs of both individual patient and community in balance with available resources).

With continuity of care, it is possible to adequately handle risk factors by promoting self-care and empowering patients.

The family doctor knows the community's potential and limitations, health needs, epidemiological characteristics, interrelationships between health and social care, impact of poverty, ethnicity, and inequalities in health care. He also needs to have an understanding of the structure of the health care system, with its economical limitations, the correct use of its services by patient and doctor (referral procedure, co-payments, sick leave, legal issues etc.) in their own context. All this is possible through provision of continuity of care by GP/Family Doctor.

The multiple dimensions of continuity

Fletcher et al. (3) distinguish between "coordination" as "the degree to which various components of care bear a useful relation to each other", and "continuity" as "the existence of some thread - individual, practitioner, group, or medical record - that bind together episodes of care". But the term 'continuity of care' has been used to describe a great variety of relationships between patients and the delivery of health care. (4)

Record Continuity refers to availability of all the information about a patient's history, visits, tests, allergies, medications, and preferences, in a medical record or clinical database, easily shared by all the clinicians caring for the patient, whether in the same institution, between institutions, or between care settings. This can improve quality of care in the presence of increasing mobility of patients, increasing numbers of people involved in their care,

and increasing amount of information to remember.

Clinician Continuity, highly appreciated by patients, refers to maintaining a relationship with the same doctor over time (5). In medical education literature, this use appears in family practice, general internal medicine, and paediatric journals.

Both record and clinician continuity are used in the definition of primary care that describe it as accessible, continuous, comprehensive, family centred, coordinated, and compassionate, delivered or directed by well-trained physicians, both able to manage or facilitate essentially all aspects of care and linked to the patient and family in a relationship of mutual responsibility and trust with them. Of course nobody can be available 24 hours/day, but a GP/FD can usually manage the care of a patient with occasional intervention of nurses or other colleagues, ward or emergency doctors, or specialists, when not present. In various surveys, patients showed a preference for single doctor practices, or multi-practice where they can see their own FD, even in limited hours, than for "Polyclinics" with rotas of doctors and 24/7 visiting hours.

Clinician continuity is thought to be important, in that not all information is included in the medical records, and a clinician who knows a patient can recognize significant changes, with a period of reference to go by (the patient as his/her own control). Behaviour and body language compared to patients' previous visits may be as important as clinical findings in identifying a significant event.

A continuous relationship can promote trust, a core part of the clinician-patient relationship and possible part of the healing process. Trust and mutual respect facilitate patients divulging private information, or posing questions otherwise. This relationship is important not only to patients, but also to the clinicians, representing a valued part of medical practice.

Site Continuity means that patients have a "usual source of care" as opposed, for example, to unrelated emergency departments.

Continuity also appears in the literature as synonymous with accessibility or availability or even with compliance, such as following post-hospital discharge instructions or follow-up appointment keeping.

The Continuum of Care. In long-term care literature, continuity is used as a synonym for the continuum of care (7) which is defined as a client-oriented system composed of both services and integrating mechanisms that guides and tracks patients over time through a comprehensive array of health, mental health, and social services spanning all levels of intensity of care.

Continuity as an Attitudinal Contract. Finally, continuity has been described as a "contract of attitudes" (8). There is a "cornerstone caregiver" who is in charge of the patient's care and is the sole responsible for decisions and for communicating information to the patient and his or her family. If the previous uses of the term "continuity" could be considered retrospective (to what extent has it occurred), the attitudinal contract - whether called coordination, integration, or continuity - could be considered concurrent and prospective.

Continuity and Improved Outcomes of Care

Linking the degree of continuity, however defined, with improved clinical outcomes (e.g., for chronic problems, preventive care) has been reviewed by Starfield , concluding that continuity of care is "associated with more indicated preventive care, better identification of patients' psychosocial problems, fewer hospitalizations (in emergency and in general), shorter lengths of stay, better compliance with appointments and taking of medications, and more timely care for problems".

Take home messages

- Cornerstone of family medicine and key point for the patients.
- Present in core competences (person-centred; comprehensiveness, community orientation; holistic approach.
- Promotes health, well-being , empowering patients.
- Relationship with the same doctor over the time.

Original abstract

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49 – Where General Practice Meets Public Health: Surveillance and Prevention as Examples

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Introduction

Traditionally, general practice deals with individual patient care for people with illnesses and diseases or who are worried about their health. Public health deals with the threats potentially affecting the health of populations, e.g. through vaccination programs, sanitation, surveillance, or health education at population level. Public health is organized and financed as a governmental service.

Health systems vary with respect to the integration of general practice and public health from almost complete overlap (e.g. in Central and Eastern European countries) to complete segregation (e.g. in Belgium and in The Netherlands). However, the level of integration does not affect the potential contribution of general practice to public health. We argue here that the setting of general practice and the information available in general practices is very valuable for public health purposes. We illustrate this for two domains of public health: surveillance of common infectious diseases, notably influenza, and the prevention of chronic diseases.

Surveillance of influenza and other common infectious diseases

The importance of general practice in signalling the emergence and the course of influenza epidemics over the last 60 years is well recognized and sentinel practice networks have been established in numerous countries [Deckers et al, 2006]. Historically these networks were established to monitor various common infectious diseases (e.g. measles, mumps, rubella) many of which are now prevented through vaccination. In these practices, data on the number of patients presenting for each illness is collected and reported on a daily or weekly basis to public health authorities. This 'early warning' information provides insight into the periodicity, age specificity and severity of epidemics. In the example of influenza, virological surveillance has been integrated as part of clinical surveillance in many countries enhancing the interpretation of clinical surveillance data and providing virological determination at the earliest opportunity [Hannoun et al, 1989]. The virus strain-specific information obtained from general practice supports the choice of vaccine strain types to be included in the WHO recommendations for influenza vaccine manufacture. Associated patient-specific vaccination uptake information has also facilitated studies of influenza vaccine effectiveness [Hardelid et al, 2012].

Influenza is the best example of an illness with a significant public health impact which is predominantly managed in general practice. There are many other illnesses (e.g. chickenpox/herpes zoster, skin infections) for which data from primary care is essential for the evaluation of optimum and cost effective management strategies. In most countries sick persons usually visit a general practitioner as the first point of contact when they have significant symptoms, which makes general practice- based medical records a valuable source

of information on population health trends.

Over the last 20 years general practices participating in the surveillance networks have converted from a paper to an electronic record-based reporting system, opening up new opportunities for disease surveillance and its management; in particular therapeutic management such as antibiotic prescribing, which is, as a result of its association with antimicrobial resistance, an issue of particular importance for public health. More than ninety per cent of antibiotic prescriptions are issued in general practice and it is essential if we are to achieve more appropriate use of antibiotics that patient-specific antibiotic data are collected routinely on a continuous basis [Woodhead et al, 2004].

Prevention of chronic diseases

According to the Institute of Medicine's categorization of prevention, universal prevention is the domain of public health, and indicative and care-related prevention is the domain of health care, including general practice. However, selective prevention (identification of people at high risk and interventions aimed at reducing their risk) has no natural embedding, neither in public health, nor in general practice. Selective prevention is at the interface of public health and general practice: it addresses the general population without symptoms or diseases and it addresses general practice for individualized risk-reducing interventions. As general practitioners keep a medical record of their patients, information about their risk profile is available. This facilitates the identification of persons whose risk profile is not available or incomplete, and these persons can be invited selectively. This increases the efficiency of selective prevention when compared to a mass screening prevention programme.

Prevention of chronic diseases such as cardiovascular diseases, diabetes mellitus or chronic respiratory diseases often means intervening in the lifestyle of people (physical exercise, smoking, diet). This includes interventions on the individual level, but also at the level of their household and the community they live in. General practitioners are in the ideal position to tailor risk-reducing interventions to individuals, with regard to their social and physical environment. Therefore, close collaboration between public health professionals and general practitioners in the field of prevention of chronic diseases is warranted and will increase the effectiveness of preventive interventions.

Where family practice meets public health: the importance of linked information

The examples of influenza surveillance and prevention of chronic diseases illustrate the interface between general practice and public health. An effective link between the two is established through the use of individual patient data which is collected routinely in general practice. Exploitation of this link requires the collection of the raw data from primary care and its storage as coded data according to an agreed classification system. Ideally, the same classification system should be used in all healthcare domains thus maximizing opportunities for linking information from different sources. There is also a need for longitudinal linkage over time which is readily achieved in patient-specific medical records. However, reliable linkage of individual patient data across different health care providers requires the use of unique patient identifiers. Information stored in (electronic) medical records is primarily recorded for individual patient care purposes but it has an economic value for public health services, e.g. for determining the disease burden in populations [Fleming et al, 2004]. There is also a political perspective: aggregated information from medical records provides critical information about groups of people who are otherwise marginalized such as persons with minor mental illness, immigrants, and homeless persons.

Take home messages

- Information available in general practices is very valuable for public health purposes
- General practice is the ideal setting for real-time surveillance of common diseases
- Patient-specific data needs to be recorded and stored according to an agreed classification system
- Patient-specific information from medical records facilitates tailored prevention of chronic diseases
- Aggregated data from general practices provide insight into population health

Original abstract

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50 – Stages of Behavioural Change – a Helpful Concept for GPs?

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Stages of change originated from the field of counselling for addiction disorders. Instead of treating every patient in a one-size-fits-all fashion, a motivational diagnosis is made before doctor and patient embark on a treatment plan. A patient may have tried to stop smoking or drinking several times. Subsequently, a person probably does not have to be informed about the fact that smoking or drinking is bad for his health and perhaps even the health of others. There are others, however, who initially need to be informed that their weekly alcohol consumption is above safe levels. While the former may benefit from a precise plan for when to stop and how to manage the transition, the latter would be forced into resistance when confronted with a prescription of this kind. Instead, patient-communication should roll with resistance. Clinicians should only propose to the patient what he can realistically achieve at his current motivational stage (1). Stages of change implies that humans go through a sequence of defined stages of contemplation, preparation and observable action. For each stage, tailored interventions are available to help the patient move on to the next and, finally, to the aspired behaviour. Since they drew upon previous models, Prochaska and DiClemente coined the notion of a Transtheoretical Model (2).

Twenty years ago this approach became almost orthodox in the treatment of behavioural problems related to health. This happened despite the empirical evidence supporting the model being somewhat contradictory (3). Moreover, Stages of Change came under the attack from scientists proposing different models of behavioural change (4,5).

Despite this, Stages of Change has had a long-lasting appeal with General Practitioners (GPs) (6). While the scientific debate centred on the descriptive and analytical validity of the model, clinicians embraced it for its pragmatic utility. The model may not apply to all human beings in the process of changing their minds and their behaviours. But GPs find the model useful for distinguishing between those in which immediate intervention makes sense and those in which friendly waiting is to be preferred.

Counsellors in specialised clinics usually see those who have decided to seek help, their clients are at least ambivalent and perhaps even ready for change. GPs, on the other hand, see smokers not because they want to stop their smoking habit but because of their cough or other manifested illness. In primary care we are thus confronted with a much broader range of motivational stages than the specialist counsellor. While in a specialised clinic the stages of contemplation and preparation are more frequent, primary care more closely reflects the distribution in the general population. The latter is U-shaped with most people having no intention at all or being past the sequence of changes (maintenance).

GPs thus need a tool to decide where to invest their time and energy. The "Stages of Change" model provides exactly that. It helps identify opportunities for change but also the lack thereof.

Nowadays, clinicians are under pressure by their governments and the public to motivate their patients to adopt healthy behaviours. Their professional leaders may even stress the suitability of the setting for prevention by getting patients to change. Among busy clinicians already struggling with the narrow curative task this often results in feelings of guilt.

The simple question 'Have you ever tried to [give up smoking, stop drinking, exercise more, take your tablets regularly etc.]?' is often sufficient to understand where the patient is in the process (hopefully) of leading to healthier behaviour. There is no need to use lengthy questionnaires although standardised instruments have been developed for research purposes. The practical steps of taking a history and suggesting the next move are easy to learn. The longer one tries, the more one realises that "Stages of Change" is an attitude rather than a cookbook-like prescription. Ideally, the patient is given room to identify opportunities and barriers himself and to suggest the next step. In primary care, occasions are plentiful, they range from the most obvious addictive behaviours to lack of exercise and poor diet. Discussions regarding taking medicines regularly or attending for chronic disease monitoring may also benefit from this approach.

Against this background the "Stages of Change" approach can be likened to an internal gatekeeper. It can ease the tension between practice resources, with time being the most valuable, and the needs of the patient. "Stages of Change" has also been of tremendous benefit in implementing patient centred communication strategies in primary care.

Perhaps the most important and damaging risk factors for chronic diseases are behavioural. The moral overtones arising from this knowledge have often put a heavy strain on the doctor-patient relationship. Payment being linked to behavioural outcomes of care has only made matters worse. "Stages of Change" has helped GPs prioritise their tasks, avoid unnecessary guilt and maintain their feelings of respect for their patients.

Take Home Messages

- Before you suggest behavioural change to your patient, stop and ask whether he / she has already tried [to stop smoking, have more exercise, take his / her tablets regularly etc.].
- The answer will help you decide whether the patient is ready or not.
- Ideally, the patients formulates him / herself what the next step should be. Waiting is perfectly OK, but try to address the issue later.

Original Abstract

http://www.woncaeurope.org/content/7-pa-stages-behavioural-change-helpful-concept-gps

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51 – Future and Innovations in Family Medicine – in 2065

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Dr Monty Kent Hughes, the very first WONCA president, said in 1972: "the future of our professional discipline will depend on our ability to work together in the service of humanity." (1)

Fast forward to 2065

Who would have thought that the apparently least developed specialization, family medicine, would eventually end up as the only one? Cardiologists? There are still three in Europe. Emeriti, they are no longer active. Gynaecologists? None. No longer necessary since the breakthrough in cloning. Paediatricians? All retrained to avatarologues. Surgeons? Obsolete after the introduction of growing graphene and nanobots which turn every cancer cell in apoptosis. Falls and accidents have been eradicated: we use superconductivity to move now. What bliss!
Graphene, delineating and replacing the vessel wall, causing no more obstructions or bleeding, was a fine piece of nanotechnology. Extended life span by at least 200 years.

Moreover, everything that is somewhat based on medical technology is obsolete today. Technique killed technique. But family medicine has remained. Because of demand.

And thanks to symphonic thinking, our trade has survived. We were already strong through our holistic thinking, but this additional thinking step turned out to be the right one.

General Practice, General Practitioner, Family Medicine, Family Physicians ...

With the putting in motion of a quality train entitled "Validation of increase", the formerly flat and uninspiring trail of a GP career was transformed into an inspiring one. From GP to Personal Doctor to Family Doctor.

A first master after six years, second master after 9 years, third master after 12 years, and so on every 3 years, the family physician trained in the complex game of families, relationships and interactions with the new technology and unhealthy environment, proved to be just what the future needed: not more technology, but doctors trained in the inclusive approach of more or less healthy people and their relationships.

Because despite all the technological advances, 80% of people remained just that - people with their facts and failures, their joys and wishes and their hopes still to make it (2).
Family Doctor Art has remained a versatile specialty, with an eye for the totality, continuity, quality, and equality. As demanded.

How did family medicine become so successful?

Through Genius Forecasting a properly balanced accreditation system was developed along with the establishment of a WONCA Europe observatory. They turned out to be the strategic moves that kept the discipline up to date.

Accreditation became validation, mainly inspired by the British. Credere or validere? Belief or evidence based? The British knew for sure: evidence based. Confidence or control? Control and confidence!

Core values

A literature search on the website of WONCA Europe came up with the following titles:

1. Community-Oriented Patient-Centred Primary Care
2. Continuity and Comprehensiveness
3. Teaching Cross-Cultural Care
4. The Transition from CME to CPD - Fostering Good Practice Through Education
5. Physician Heal Thyself and then the World: on Workaholism, Helpaholism and other Physician Conditions - Playful but Effective Medication for Serious Symptoms
6. The Role of the College of General Practitioners in Developing Research Capacity and Capability in Primary Care
7. About quaternary prevention

All wonderful titles.

Let us zoom in on two phenomena the researchers unanimously selected as the first to start with:

- The Role of the College of General Practitioners in Developing Research Capacity and Capability in Primary Care
- The Transition from CME to CPD - Fostering Good Practice Through Education

They had also read other books

1. Michio Kaku, Journey to the Future, 2011
2. Michael Kidd, The Contribution of Family Medicine to Improving Health Systems, 2013
3. John Cleese, How to Survive your Family? 1983
4. Wilkinson, Pickett, The Spirit Level, 2009
5. Daniel Kahneman, Thinking Fast and Slow, 2011
6. Daron Acemoglu, Why Nations Fail, 2012
7. Jeremy Rifkin, The Empathic Society, 2009
8. Malcolm Gladwell, Outliers,
9. Leo Bormans, The World Book of Happiness, 2010
10. Michio Kaku, The Future of the Mind, 2014

From this additional literature they took a surprisingly simple principle: (s)he who knows his/her business is in the best position to teach it. To know your topic best you have to teach it. So everyone became both student and teacher concurrently.

Then WONCA got an Observatory

GPs measured, and therefore increased their knowledge-base. They started simple. Weight and height of each patient, at every consultation. The data entered into the Electronic Health Record were sent to the Observatory in real time. The aggregated data were sent to several city squares, where a local information display flashed the current average BMI of the city, updated by the hour. This followed a campaign launched under the title "Your BMI minus one!" Actions were developed in conjunction with several advertising agencies. Thus, even more people were encouraged to participate, and in no time the target was achieved: BMI – 1.
The yield was calculated as being 1000 million Euro per year, along with an increase in happiness.
And many more health benefits. For Europe alone.

Another added value: the general practitioners at that time asked their patients to join them in conducting research – inclusive policy, you know - through a kind of Galaxy Zoo project. All that now seems obvious, but then it was anything but: http://www.galaxyzoo.org/ .

Next, slightly more advanced parameters were recorded, and all the general practitioners of the scientific society participated, also encouraged by the success and a few incentives of course.
You know those historical targets, but I will repeat them, even though they are obsolete now.

From Wilkinson and Pickett: The Spirit Level

- Level of trust
- Mental health and drug use
- Physical health and life expectancy, child mortality
- Obesity: wider income gaps, wider waists
- Educational performance
- Teenage births: recycling deprivation
- Homicides
- Imprisonment and punishment
- Social mobility

When cloning became a trend, teenage pregnancies in particular disappeared. With the first rough version of the amnesia pill, addictions were treated successfully. They just forgot that they were hooked. But in the beginning they also forgot who they were, tabula rasa, and that decreased the pill's success.

Murder and suicide have been decimated, as there are hardly any drugs in circulation and those that exist have been legalized. The amnesia pill was truly an asset. Social mobility was simply no longer needed.

Next Came Educational Reform

CPD starts early today, about the 7th year of life, and this commenced in 2015.

Subsequently, in 2020, it was announced that anyone who wanted to study medicine with a specialization in family medicine (this really was its name) needed to have undergone at least 4000 hours of music lessons.

Indeed, it was scientifically proven that music education positively influenced language competence. And of course, the symphonic thinking. The 10,000 hour rule to form experts subsequently evolved.

Then the Bologna model was enriched and expanded. Your first Master was an MD, purely out of nostalgia, then became a Master of Arts, MA. The second master was a Master of Family Arts, the third master - here is where the divergence may have begun - was either a Master BioNanotechnology, BioCloning, Singularity, Symphonic Thinking or Photosynthesis, for those who wanted to keep themselves busy while repairing energy modules.

The sequential achievement of various Masters titles was a wonderful incentive. Not only lifelong learning, but the introduction of innovations could also be faster now.

But 'fine-tuning' was necessary – and they finally came up with 100 Master's degrees.

Change is not so simple. Especially when you are coming up for 450 years old.

I hope we will soon find the right flexibility with the switching of connectomes through reverse engineering. In order that the once pruned dendrites can redevelop and search, find and reconnect with new experiences.

And since the decimation of agriculture, much time is freed up to do the really important things: create beauty, and provide clean water universally. Still needed, because we have inherited quite a mess from our ancestors. But it must be said that our family doctor forefathers surely propagated this with insight.

Singularity

Years later the step to singularity became a fact. Gone is osteoarthritis, cancer, diabetes and pain. What is left is stainless steel, carbon fibre and an energy module based on photosynthesis. Food is not needed anymore. Pity.

A rising equality gave rise to fewer thefts and that along with fewer killers led to decreased numbers of prisoners and punishments. Inclusive policies, it can be a blessing.

The most difficult one to improve was the level of trust and confidence, because fear has always been an evolutionary advantage. The brave were trampled, the fearful in their dens survived and procreated.

Confidence was difficult to measure because of its variability with age and prone to bias and confounding. But family physicians found a solution, and the Edelman Trust Barometer has simply been washed away by means of a daily representative measurement. Exhibited daily in the town squares. Boosting trust.

What will the future bring next?

The achievement of the stages of Kardasjev's predictions.

People becoming gods, in the depths of their mind, it's something absolutely new. So they say.

Take Home Messages

- Symphonic thinking as a selection criterion
- Validation of increase
- In order to learn you have to teach
- WONCA enriched with an Observatory

Original abstract

http://www.woncaeurope.org/content/436-future-and-innovation-family-medicine-active-workshop-perspectives-discipline

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52 – Home Care at the Dawn of the 21st Century. Electronic Devices and Telemedicine Facilitate Safe Home Care for Acutely Ill Patients.

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Introduction

The current status of technology, which is available and affordable for widespread use, is already sufficient to permit advanced home care to acutely ill patients (1). However, ongoing technological evolution is even more promising and highlights a big change in healthcare provision (2). It seems that soon, the concept "hospital" will not continue to be considered so much related to the venue itself, but to an overall organization where sophisticated treatment and enhanced patient monitoring can be provided with safety regardless of the place, whether hospital ward or patient's residence, neutralizing distance barriers (3).

Continually increasing bandwidth in telecommunications, which permits fast and smooth video and data transmission, tablets, smartphones, portable analysers, imaging systems and other diagnostic devices, apparatuses such as electronic infusion pumps and ambulatory monitoring systems including high-tech sensors incorporated into "smart clothes", are the main contributors in this evolution.

Point of care diagnostic devices.

Portable palm-size analysers can perform a wide range of important measurements including blood gas analysis, basic chemistry, troponin, BNP and PT-INR, at the point of care, within just 2 minutes. There are also portable, small and lightweight automated 5-part WBC haematology analysers, which provide quantitative results in 3 minutes.

Ultrasound portable scanners are equivalent to the stand-alone ones in terms of capability, reliability and accuracy. There are also quite reliable pocket size scanners for prompt emergency testing.

Portable x-ray systems produce high-resolution images in seconds. We use fully equipped vehicles. Digital x-rays, which are performed in a patient's home, are subsequently developed in the vehicle outside the home. Images are transmitted to radiologists for diagnosis and, concurrently, to other physicians involved in the patient's treatment.

Telemedicine state of the art.

Digital sound archives which are captured by electronic stethoscopes and transmitted by means of Bluetooth protocol, can undergo frequency and waveform analysis. For example, when an additional tone is heard, graphs can show it's frequency, duration, time-distance from the 1st to 2nd tone and it's variation with respiration. This information, which otherwise would need a very experienced cardiologist's ear, can be recorded with accuracy through us of an electronic stethoscope and subsequently transmitted for remote

interpretation by a specialist.

Flexible cameras can capture images from inside the ear, nose, throat and vagina for evaluation by specialists through remote consultation. Teledermatology has been reported as being practised in various settings (4,5). Fundoscopy can now be carried out by professionals who are not expert cardiologists, with the use of an amazing digital ophthalmoscope.

Videoconference is now becoming progressively more available with the support of 3D, 4D and Wi-Fi technology . With the widespread use of tablets and smart phones, a team of health professionals including nurses, primary care physicians and specialists can virtually "team up" at any time regardless of distance and with considerable reduction in manpower cost.

Inspection is an essential part of physical examination. As a result, videoconference is very important for the remote specialists in order to gain a complete impression of a patient's condition. With the aid of the visiting health professional's hands and his or her cooperation, a remote specialist can also recognize abdomen guarding, tenderness, stiffness of joints, tendon reflexes and other signs, which are classified under "palpation". Percussion sounds can also be heard and evaluated by the remote specialist.

We use Ethernet cameras with pan, tilt and zoom functions to achieve 7/24 observation of very ill patients at home. This not only assists in the continuous monitoring of a patients' breathing and alertness, but also to monitor the carers' adherence to given instructions.

Infusion pumps.

In order to guarantee accuracy, safety and nurses' compliance to regulations, we use multi-functional infusion pumps. Multi-dose function allows administration of medicines in doses, even when a nurse is not present at the time of infusion. Often, a nurse stays with the patient and monitors vital signs, urine output and other parameters. He/she is able to change the pump's settings, either according to a given protocol, or after a remote specialist's consultation.

A view into the future.

Flexible technologies and smart clothing are highlighting a new era in the field of telemonitoring. There is ongoing evolution towards the development of miniature, soft and flexible non-invasive sensors, which are incorporated to clothes (6).

Many important parameters regarding metabolism, thermal comfort, skin blood flow, skin hydration, skin thermal conductance, skin infection, muscle activity, autonomic nervous system activity, respiration rate and amplitude, heart rate, blood pressure, position, circadian rhythm, pressure sore detection, heart point detection, etc., can be measured from skin, using non-invasive sensors. A personal area network (7) connects the distributed intelligence of all the items of smart clothing, transmitting data to a computer and a specialist monitoring station, where vital parameters are analysed (8).

Conclusion

Point of care diagnostic capabilities and telemedicine are essential parameters towards a safe shift of the care of acutely ill patients from hospital to home. Yet the treatment of an acutely ill patient also requires uninterrupted responsibility by a clinical team, regular clinical measurements including vital signs, bio-signals and water intake/output balance, frequent and rapid acquisition of testing results, prompt interpretation of the entire clinical information and decision making and high degree of alertness to effectively react in the case of any unforeseen complication or deterioration. Consequently, safe home care for acutely ill patients, apart from the availability of ambulatory testing equipment and telemedicine, also requires special and smoothly operating organizational structures.

Take home messages

- "Hospital" should not continue to be regarded as a venue, but as an organization, which combines concerted teamwork of health professionals, enhanced patient monitoring and sophisticated treatment.
- Point-of-care portable diagnostic apparatuses enable most of the frequently required diagnostic tests to be rapidly and reliably performed at the patient's home.

- A team of doctors, nurses and other health professionals can be at any time virtually near the patient regardless of distance barriers, with the support of information and communication technology.
- Ongoing technological evolution highlights a new era in the field of telemedicine, which promises to allow safer advanced home medical care in the near future.

Original abstract

http://www.woncaeurope.org/content/4478-home-care-dawn-21st-century-whats-difference-electronic-devices-and-telemedicine

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53 – "To Travel With Your Profession Is to Live and Learn"*: Educational Exchanges in Family Medicine Training - the Hippokrates Exchange Programme

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Since the beginning of western civilization travel has always been an essential part of the education of future generations. At first, there was the legendary Grand Tour, a rite of passage, which brought young British aristocrats in contact with the cultural legacy of classical antiquity and the Renaissance. Today, in times of standardized and mandatory schooling the Grand Tour is safer, often shorter, but equally valuable and enlightening; it takes the form of an exchange and it covers all stages of education, from lower and upper schooling to higher and post-graduate education (1).

In recent years, interest in international rotations has increased among students, at all levels and in every field of education. Correspondingly, many Universities around the world have acknowledged such a need and are now promoting exchanges and the internationalization of school curricula in the aim of preparing (their) students to a globalised world as well as work environment (2-4).

Exchange in General Practice/Family Medicine (GP/FM): The Hippokrates Exchange Programme

Hippokrates is an exchange programme for medical doctors specialising in GP/FM and junior GPs/FPs within five years of completing specialty training. It offers the possibility of undertaking an inspiring journey to discover different primary care systems and educational environments.

Now thriving and well structured, the programme was first presented at the 6th European Conference on GP/FM (WONCA Europe) in Vienna in 2000, under the auspices of the European Academy of Teachers in GP/FM (EURACT), which has always had an important role in shaping and enhancing medical education in Family Medicine throughout Europe. In 2008 the programme was entrusted to the then established Vasco da Gama Movement (VdGM) which reviewed the scheme two years later and established a database along with a standardised framework to guarantee a beneficial and verifiable educational outcome for every exchange.

The Aims of Hippokrates

The main objective of the Hippokrates Programme is to provide an enriched learning experience that promotes the acquisition of academic and clinical knowledge of another health system and encourages mobility among junior doctors. Thus it offers a broader perspective to the concepts of GP/FM at both professional and personal levels for future GPs/FPs.

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* One of the earlier restless Danes, the famous Poet and Fairy-tale-writer Hans Christian Andersen said: "To travel is to live" and he described the enhanced sensitivity that characterises you when you are on unfamiliar territory. Now if you travel with your profession you are up for a double bonus – living and learning.

Through these experiences, participants, visitors as well as GP/FP hosts, gain new perspectives that inspire them to undertake an active part in the development of GP/FM in their own country. In fact, the programme also contributes to enhance collaboration among national colleges of GP/FM and recruitment of young professionals to these important associations (5).

At the individual level, the benefits are numerous; some are open to any kind of exchange, while others are particular for an international clinical experience in a vocational setting. Most exchanges offer the opportunity to improve foreign language skills, challenge one's ability to adapt to new situations, developing an intercultural identity and establish friendships that are most likely to inspire throughout life (4). Moreover, the exposure to a different health system and GP/FM environment enhances professional skills, as well as improving academic knowledge and increase opportunities for subsequent employment (5).

The Hippokrates framework

Aimed at ensuring high quality educational content, the programme is set on a distinctive and standardised framework which entails a pre-exchange and post-exchange section.

Pre-exchange:

Before embarking on an exchange, participants must reflect on the potential educational benefits.

- Learning objectives should be guided by the Visitor's own learning needs, respect their national vocational training curriculum and comply with the WONCA Definition of General Practice (6). Such educational goals need to be realistically achievable within the Educational Programme that the Host is able to offer and therefore shared and agreed on by both parties.

- Educational programme: Hippokrates exchanges are normally 2 weeks long. During this time the visitor will be introduced to many aspects of the local Primary Care system, mainly by shadowing all the host practice activities such as consultations, house visits, practice nurse clinics, and collaboration with other caregivers as well as special services. The exchange should ideally also entail visiting local Family Medicine training and research departments to meet and exchange views with homeland trainees. Where applicable, visitors will be encouraged to gain insight into local resources and quality improvement activities as well as local healthcare structures, such as the management of emergencies in primary care by attending an out-of-hours service run by GPs/FPs.

Post-exchange:

Once back home the participant is asked to reflect on the experience and the professional and personal gains.

- Learning outcomes: participants are requested to reconsider the original learning objectives and discuss with the host the overall outcomes of the international experience.

- Final report: The participants are requested to make a comparison between their own country and that of their destination, considering different aspects of primary care and GP/FM, including the contextual, attitudinal and scientific ones. All participants are also encouraged to strive to present and publish their experiences locally, nationally and internationally (7).

Hippokrates in numbers

Over the years, the programme has grown extensively, from an initial pilot phase of five participating countries, the Hippokrates Programme today counts an extended network of hundreds of host practices in 26 European countries. The numbers of participants and completed exchanges has also increased consistently from 13 in 2010 to 83 in 2013.

Prospects

Further research on the impact of exchange programmes during GP/FM vocational training is needed to determine the actual educational value and outcomes of international rotations. However, the potential contribution of such schemes targeting future European FDs/GPs not only for personal development of individual participants but also to a greater collective professional identity of our profession is undoubtedly substantial. The authors believe that the Hippokrates Programme has contributed considerably to the formation of the VdGM and consequently to the vitalisation of WONCA Europe. It has also been the inspiration for similar programmes of vocational exchange like the FM360 and thus has created resonance throughout the global GP/FM community.

Hippokrates is very much alive and all European trainees/GPs/FDs are encouraged to participate.

Take home messages

- In a world of international travel and migration, educational institutions have been acknowledging the need for the internationalization of school curricula and the promotion of educational exchanges.
- Hippokrates is an exchange programme for medical doctors specialising in GP/FM and junior GPs/FPs within five years of completing specialty training.
- The Hippokrates Exchange Programme offers a standardised framework that helps deliver structured professional development to new and future GPs/FPs through international exchanges.
- Benefits are numerous at many levels for all participants, trainees as well as GP/FD Hosts.

Original abstract

http://www.woncaeurope.org/content/388-hippokrates-european-exchange-programme-medical-doctors-specializing-general

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"To move, to breathe, to fly, to float,
To gain all while you give,
To roam the roads of lands remote,
To travel is to live."
Hans Christian Andersen, *The Fairy Tale of my Life: An Autobiography*

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54 – Am I a good doctor? Education about Quality Assurance in Family Medicine in Croatia 15 Years On

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At the turn of the century, education on quality assurance (QA) in family medicine (FM) in Croatia was organized through several minor local projects. It was a time of primary health care (PHC) reorganization involving the privatisation of FM service. FDs who had worked in an already established network of FM teams were offered to run private practices as long as they remained under contract to the national health insurance fund (CHIF). This process was gradually introduced to eventually establish over 1000 privately run FM practices all over Croatia. During the process, several flaws appeared. One of the most prominent was the omission to define FM's vocational education financing framework. This problem resulted in delays and a diminishing number of FDs vocational training posts lasting for longer than 5 year periods.

Practising FM teams felt the need for additional education and under these circumstances, local educational projects started to expand in response. The "Am I a good doctor" educational programme for QA in FM was organized by local PHC centres supervised by experts from the Department of Family Medicine, University of Zagreb Medical School. The programme consisted of six to ten one-day workshops held monthly in the cities of Čakovec, Karlovac and Slavonski Brod. Topics of workshops were audit methodology, data gathering and registration, quality improvement options, malpractice prevention and sanction, etc. The programmes were well accepted by participating FDs and were certainly effective in raising awareness on the importance of QA in PHC.

Many changes have occurred since then. The most significant positive movement was reanimation of the FDs vocational training framework. The national project "Harmonisation of Family Medicine according to EU standards through introduction of Family Medicine Specialization" was introduced in 2003. The project offered in-service and regular vocational training and attracted almost 300 FDs to join specialised educational programmes in the first two years of its existence. One part of the educational programme consisted of a theoretical course organized by the Department of Family Medicine, University of Zagreb Medical School. The content and format of this course has changed over the last 10 years, but it has become a permanent component of specialization in FM. Topics for QA were incorporated into this course and by this time, the specific subject "Improving quality in FP" had been introduced as one of the mandatory subjects for FD trainees within the educational programme offered at the University of Zagreb Medical School. Based on previous experience, the educational programme consisted of basic information on QA and practising audit and peer review. Each student had to perform an audit of his/her practice and present it to his peers. This format allowed practical training in QA procedures. Aside from this, it also offered a broad database of Croatian FDs' practice due to the obligation of students to submit written audit reports. "Improving quality

in FP" was welcomed by trainees and resulted in the publication of many articles in national medical journals as well as two doctorate theses by FDs.

The next positive step was to establish a National Agency for Accreditation and Quality in Health Care in 2007. The Agency defined quality indicators (QI) for FM offering a variety of indicators covering common chronic diseases and prevention procedures. QI promoted by the Agency were largely based on international standards rather than on experience and research results produced in Croatia FM. The Agency has not yet succeeded in establishing any kind of accreditation scheme for FM and therefore weak affirmation of the Agency still exists among Croatian FDs.

Based on the mutual interest of FDs and the Croatian Health Insurance Fund (CHIF), a new movement was launched in 2012. The CHIF substantially changed its contract with FM teams by the introduction of a combined remuneration system which included performance payment and stimulation for practice quality improvement. In this way, quality of care became rewarded or related to contract obligations and payment systems as laid out by the UEMO statement in 2010. In the beginning, CHIF introduced Key Performance Indicators (KPI) and a '*five-star practice scheme*' in an annual contract with FM teams. KPI comprised issues of "created care" resulting from the FD's gate-keeping role: total prescription costs, sick-leave rate, referring rate etc. Five-star practice scheme comprised of the FDs' service offer profile: electronic and telephone communication friendly approach, possibility of taking blood samples in practice etc. It was evident that both innovations in the CHIF contract were not main-stream of quality improvement in FM. KPI aimed for optimization of CHIF costs and *five-star practice scheme* did not go further than proposal – did not concern performance quality. In the 2013 contract, CHIF introduced Quality Indicators (QI) composed of well-known QIs in the British Quality and Outcome Framework (QOF). Newly introduced QI by CHIF consist of a target population and values for defined health problems as well as stimulus for target achievement. Health problems covered by QI are arterial hypertension, diabetes mellitus, COPD and cardiovascular prevention. This aside, CHIF also recognised peer-review as part of the quality improvement process in FM. Peer-review performed monthly in groups of not less than three FDs and related to specific patient problems can be registered in monthly reports and rewarded by CHIF. At the same time, such peer-review is awarded continuous medical education (CME) points within the accreditation scheme covered by CME. It is important to note that CHIF did not support FDs in performing any kind of CME activity until 2013 and such a movement represents a small but important step in promoting QA and CME in FM.

Although the described process is not ideal, does not represent epic movements and needs refining, there are reasons to be satisfied when looking back on the last 15 years. In 2014, Croatian FM has a well-established structured education for QA as a mandatory subject in the specialization of FM, numerous QA activities throughout Croatia and the support of CHIF in performing QA activities and improving quality of PHC. Currently, Croatia is suffering from economic recession and achievements are expected to improve in the future.

Take home messages

- Family Doctors themselves feel a need for quality improvement.
- Family Doctors have a capacity to promote quality assurance.
- Basic educational package on quality of care is imperative for every FD early in their career.
- Quality assurance activities should be related to everyday work of FDs.
- Quality assurance activities should be rewarded and stimulated by health policy stakeholders.

Original abstract

http://www.woncaeurope.org/content/am-i-good-doctor-teaching-qa-general-practice

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55 – Evidence-based Primary Care Through Guidelines

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Sound knowledge about effectiveness and safety of diagnostic and treatment methods should form the basis of decisions in all health care. Finding such knowledge is particularly challenging for doctors in primary care, because they treat people of all age groups and with any illness. Guidelines can answer their information needs if they are appropriate to their working environment, easy to access and use, and up to date. Modern guidelines can also provide reminders and active decision support. Here, we describe the national guideline structure and their use in Finland as an example.

Guideline quality

High-quality guidelines are produced in a systematic and transparent manner. This means that best available evidence is searched for, evaluated and synthesized. Guidelines should be produced by content experts and presented clearly in a user-friendly format (1). With the AGREE instrument, guideline developers and users can assess the methodological quality of guidelines (2).

Not all well-produced guidelines, however, are useful in primary care. Those written by subspecialists may focus on patients in secondary care – a selected group – and may be irrelevant or misleading if applied to patients in primary health care. Not only are our patients different from those referred to hospitals; we also have different diagnostic and treatment resources.

Recommendations in quality guidelines are often based on systematic reviews of trials, most of which study patients with a single disease. FDs see patients who often have several diseases and key decisions may affect more than one of these. We apply the evidence while discussing with each patient what their own preferences are. General practitioners may need to check several guidelines in one consultation. The necessary information must be found quickly and in a clear format: How helpful is this treatment for these patients in achieving better health outcomes?

Best guidelines also offer links to supporting material, such as pictures, flow charts, references, evidence summaries, and materials for patients. The level of evidence and strength of recommendations is presented clearly and in a methodical fashion: Is this information likely to change with new research or not?

Using guidelines

Bringing guidelines to practice is a challenge. Doctors' habits change slowly and only to a small extent. Grimshaw and colleagues have reviewed the effects of guideline implementation strategies (3) and found improvements in performance from 6 % when using multifaceted interventions to 14 % for reminders.

Likewise, the MIKSTRA project in Finland produced evidence-based guidelines for six common infections and implemented these in a randomized trial (4). Patient versions of guidelines were edited and distributed. Primary care units received training and other support to change their care

pathways toward more evidence-based practices. The use of diagnostic tools became somewhat more systematic, and antibacterial prescriptions were 2 – 16 % better targeted. The study demonstrated that not only doctors but also patients need to change their attitudes regarding drug prescriptions.

For the busy general practitioner, the threshold for looking up information during a consultation is quite high. If guidelines are available in a compact source, covering many diseases, the task becomes easier. Guideline collections are preferable to single guidelines. Searching medical databases or googling for an answer to a patient problem during consultation is seldom feasible.

When a guideline collection for general practitioners was introduced in Finland, we studied how our colleagues consulted these guidelines (5). They made at best up to ten searches and on average three searches each working day, and found sufficient information in 71% of the searches. Another study found that general practitioners' compliance with guidelines was high: over 80% for use of laboratory, radiology, physical examinations, and referrals (6).

Any guideline starts getting outdated the minute it's published. Users should know how well guideline producers are able to keep the guidelines up-to-date. Medical Society Duodecim houses the national guideline organization in Finland, providing a stable framework for guideline production. This includes regular updates every two or three years: new searches are made on key questions in the guidelines and authors evaluate new publications, updating the information. If important new information (e.g. on new side effects of treatments) appear between regular updates, a partial rapid addition can be included in the guidelines.

Next step: Decision support

Good guideline collections are useful, but even better support is on its way. Linking guideline information to actual patient data can be used to create clever systems that provide guidance without request. Electronic decision support brings evidence into practice by means of context-sensitive guidance at the point of care. The national guidelines in Finland were used as the basis for creating a set of evidence-based, patient-specific reminders for 59 different health conditions embedded into the Electronic Patient Record (EPR) system (7). These reminders were shown to healthcare professionals when they opened and used the EPR during consultation. Typically, a reminder suggested timely action (e.g. "Long-term glucocorticoids—add calcium and vitamin D?") or gave a warning (e.g. "Serum potassium is dangerously out of range"). In addition, links to guidelines were shown in accordance with the patient's diagnosis list, and drug alerts were triggered on prescribing a medication that for example created a risk for interaction with existing medication.

The trial in primary care included more than 13000 patients randomized to trigger or not to trigger reminders during consultations (7). We had expected the number of reminders to decrease over one year, however, both in the intervention and control group, numbers of reminders increased. One possible explanation is that recording of disease codes improved during the trial. Implementing computer-based decision support is still problematic, but it is possible to build such systems based on sound guidelines. In this way, guidelines can fulfil their aim of improving quality of care and, ultimately, improving health (8).

Take-home messages

- Evidence based guidelines are essential for high quality primary care.
- Guideline collections are preferable to single guidelines.
- Patient versions of guidelines should be produced alongside full professional versions.
- Guidelines do not make decisions; patients and doctors decide together.
- Linking guideline recommendations to individual patient data can make GPs' work easier in the future.

Original abstract

http://www.woncaeurope.org/content/37-evidence-based-primary-care-through-guidelines

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56 – Developing Skills for the Developed World

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Undoubtedly, technological advances have improved health outcomes and quality of life. On the other hand, lifestyles have been significantly altered by this developing era. The purpose of this opinion piece is to identify potentials and skills, especially within family medicine that more traditional societies in the developed world use. Thus, it will be interesting to observe how primary health care physicians cope and manage to overcome obstacles and challenges encountered due to either the slow pace of or no development in isolated rural areas around the world, where certain hidden secrets may still prevail.

Life expectancy has increased in industrialized countries mostly as a result of reduction in childhood mortality and improved medical treatment, due to advances in medicine. Developing regions have poorer mortality rates due to limited biomedical and technological resources, although they may have skills and remedies to offer in complementary and alternative medicine through services provided by traditional practitioners and healers. Transcultural health care or indigenous healthcare may include, among others; acupuncture, herbal medicine, homoeopathy, yoga, meditation exercise training, and music and art therapy. It is always challenging to test alternative remedies within primary care in order to more flexibly manage several medical conditions such as chronic health problems, cardiovascular, respiratory, allergies, infections and other disorders.

Another approach is the concept of religiosity and spirituality that may also offer efficient ways for handling patients' problems, since they are well-integrated in the cultural identity of the world communities and can act as preventive or 'healing' mechanisms against a range of health problems. The appropriate use of indigenous knowledge available in traditional societies may also be a major source for developing natural products in improving health and curing illnesses. An example of the traditional 'secret' that has diminished in the fast pace modern world and can prolong life expectancy with higher quality of life is the so-called midday nap (siesta), and the well-known Mediterranean diet.

Due to the geographic isolation, emergency cases and workforce shortages, general practitioners serving rural and remote areas are often called upon to maintain a greater variety of skills, to provide a more integrated and patient-centred care approach for conditions due to limited resources. On the other hand, general practitioners serving urban areas often perform more advanced duties in improved conditions with regard to available facilities and special resources. Learning the indigenous healthcare practices is also an essential resource at the hands of GPs that it is expected to enhance their capacity in promoting self-management.

Another useful primary care practice 'tool' adapted by GPs in underdeveloped regions that is lacking in the developed world is their comprehensive role with the family and community caregivers, as their orientation towards the patient in the context of the family and local community may enhance their health outcomes. The role of family support in decision making and in caring in a more traditional structure, may be critical to manage different illnesses as

it promotes compassion and the sense of belonging. The involvement of the family in the decision-making process is also critical since such processes take into consideration not only the family's socio-cultural values but also the family roles and dynamics in the process of delivering a more holistic approach towards the patient.

Among special qualities that seem to have almost diminished in urban settings and developed societies is the cultural difference of the social interactions. Interpersonal relationships shaped within rural areas are more enduring and they are based on loyalty, not only to friends and relatives, but to the community and its members. On the contrary, relationships in urban settings are usually based on self-interest as they are forged in extremely competitive environments. Furthermore, social roles and function in rural settings are more likely to be connected to traditional and religious beliefs.

All these cultural habits influence GPs while also illuminating another great asset that can be of use in regions under development and that is the value of compassion, meaning the awareness of someone else's suffering and the will, effort and action to help and relieve it. Compassion is the fundamental element of the bond connecting a family especially in rural areas as urbanization and excessive technological development have altered the structures of the traditional pattern of families resulting in the loss of compassion and cohesion. Compassion in treatment served in rural and remote primary health care can strengthen the doctor-patient relationship, increasing trust, confidence and effectiveness, when traditional and cultural aspects or beliefs of health are taken into account. With this in mind, a recently published systematic review provides initial support for the discussion that doctors' empathy can be enhanced through targeted interventions.

Take Home Messages

- Developing societies can contribute to find effective solutions of health care for the developed world communities combining the 'wisdom' from the first and the scientific knowledge from the second. Community-based interventions and innovative strategies with regard to the socio-cultural differences mentioned could prove helpful in managing developed-society healthcare challenges.
- All lost 'ingredients' found in a complex web of social relations, cultural history and socio-political networks of the developing world, helping a general practitioner overcome barriers in the delivery of health care, should be revived and integrated into the modern primary health care services, especially now that society and humanity has to overcome many crises and challenges.
- Globalization always claims service cost reduction and communication flexibility. By learning the 'secrets' that have been embedded in underdeveloped societies, we can test and build additional skills for GPs with the aim of investing more efforts in the health and happiness of the people that they serve.

Original Abstract

http://www.woncaeurope.org/content/14-namibia-shetland-developing-skills-developed-world

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57 – Gut Feelings as a Guide in the Diagnostic Reasoning of GPs

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Introduction

General practitioners (GPs) all over Europe sometimes experience the feeling that something is wrong with a patient during a consultation, although they do not know exactly what(1, 2). This so-called 'sense of alarm' is a feeling of sudden heightened awareness alerting a GP and causing them to worry about the patient's health status. It is often accompanied by physical sensations in the abdomen (hence 'gut feelings') or the heart. Remarkably, the decisions of Dutch medical disciplinary tribunals indicate that the timely manifestation of this sense of alarm should be part of the professional standard for doctors(3). However, in the era of evidence based medicine (EBM), gut feelings sound slightly old-fashioned, and the question may arise as to how much gut feelings really contribute to a GP's decision making process. Ten years ago, an international group of GP-researchers started a study on the topic. This chapter reports on their findings.

Focus Groups and a Delphi Consensus Procedure

We explored the meaning and significance that GPs attach to gut feelings using a focus group method. Most of the participating GPs considered gut feelings to be a valuable instrument that they could rely on (4). They emphasized that besides the sense of alarm, the sense of reassurance also played a substantial role in general practice, i.e. when a GP is sure about the prognosis and therapy, even in the absence of a definitive diagnosis. The basis of gut feelings is a GP's knowledge, including medical knowledge, experiential knowledge and contextual knowledge, the latter defined as everything a GP knows about the patient apart from the symptoms and signs. Various determinants influence the process of arousing gut feelings, such as the doctor's personality, factors that fit the general picture, alerting triggers and interfering factors.

In order to find valid definitions of gut feelings, we conducted a Delphi consensus procedure and achieved consensus on precise descriptions of the sense of alarm and sense of reassurance(5) (See Text box 1).

Gut Feelings Questionnaire

Based on the consensus statements, we then composed a short questionnaire to determine the presence of gut feelings in the context of GPs' diagnostic reasoning. The gut feelings questionnaire (GFQ) was validated after a construct validation procedure(6). Consequently, we are now able to study the diagnostic value of gut feelings. We produced a linguistically validated English-language version, and the GFQ is now also available in French, Polish and German.

COGITA European Network

The European General Practice Research Network (EGPRN) gave us the opportunity to present the results of our study at several conferences, which led to the establishment of a network of FD researchers interested in the topic, called COGITA (www.gutfeelingsingeneralpractice.eu). Its aim is to share research findings and to prepare proposals for cross-border research projects. At yearly meetings, European researchers discuss research findings and advise on the implementation of new studies. A glossary of diagnostic reasoning terms related to the topic of our research was composed by the group and published on the COGITA website.

1. Statement 1: A 'sense of alarm' means that a GP perceives an uneasy feeling as he/she is concerned about a possible adverse outcome.

2. Statement 2: A 'sense of alarm' implies that a GP worries about a patient's health status, even though he/she has found no specific indications yet; it is a sense of 'there's something wrong here'.

3. Statement 3: A 'sense of alarm' activates the diagnostic process by stimulating a GP to formulate and weigh up working hypotheses that might involve a serious outcome.

4. Statement 4: A 'sense of alarm' means that, if possible, the GP needs to initiate specific management to prevent serious health problems

5. Statement 5: A 'sense of alarm' will decrease as the diagnosis and the right management become clearer.

6. Statement 6: A 'sense of reassurance' means that a GP feels secure about the further management and course of a patient's problem, even though he/she may not be certain about the diagnosis: everything fits in.

7. Statement 7: The 'sense of reassurance' and the 'sense of alarm' constitute a dynamic element in a GP's diagnostic process.

Text box 1. Consensus statements

Theoretical Framing

To explain how gut feelings arise and function in GPs' diagnostic reasoning, we reviewed the literature from medical, psychological and neuroscientific perspectives(7). Gut feelings are based on the interaction between patient information and a GP's knowledge and experience. We visualized this in a knowledge-based model integrating the two well-known reasoning tracks of medical decision-making and medical problem-solving, adding gut feelings as a third track. (See Figure 1) These three tracks fit well in dual-process theories, where analytical and non-analytical reasoning continually interact as two modes of knowing and thinking. The interaction enables GPs to use elements of all three tracks, depending on the task and situation. The role of affect as a heuristic within the physician's knowledge network explains how gut feelings may support GPs in navigating efficiently in often complex and uncertain diagnostic situations.

Skilled Intuition

Intuitive thoughts come to mind without apparent effort but their value is the topic of many scientific debates(8). Some researchers showed that intuitive judgements based on simplifying heuristics are often flawed. Others believe that intuition defined as the process of pattern recognition is trustworthy in some domains such as nursing, medicine, fire-fighting and accountancy. It is based on experience that recognises valid cues. E.g. medicine provides a high-validity environment where cues are stable and regular and can rather easily be recognized. In such domains prolonged practice and rapid feedback may enable students to develop a so-called skilled intuition which can be trusted. Gut feelings are based on skilled intuition and form a substantial part of the diagnostic reasoning process.
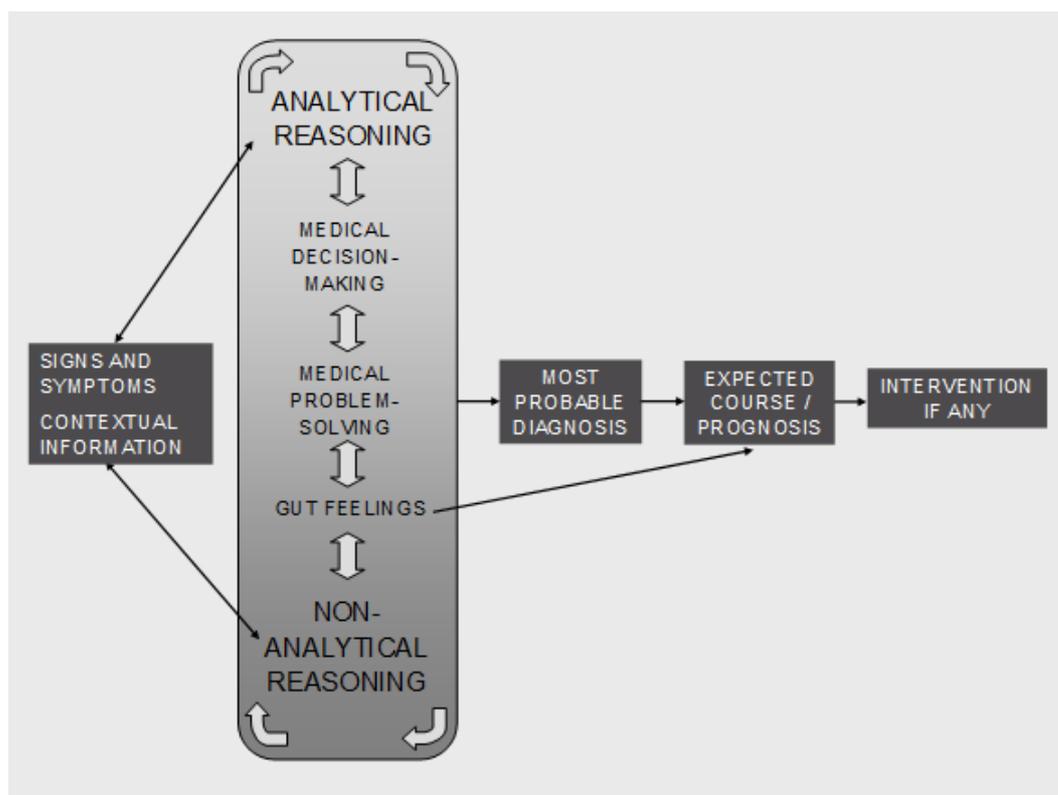
Figure 1. Knowledge-based model of GPs' diagnostic reasoning.

Evidence Based Medicine

Although evidence and skilled intuition may sometimes appear as irreconcilable opposites, the combination fits in very well with the EBM concept that is based on the integration of scientific knowledge, patients' preferences and physicians' expertise and skills. Doctors have to weigh up these three elements in their decision-making process, but it is remarkable that the literature offers no studies on how this integration process must be achieved or taught.

Future

We may conclude that the gut feelings concept exists and that they substantially contribute to GPs' diagnostic reasoning process. In the future, we will study them in greater depth, i.e. by investigating the predictive value of gut feelings, the influence of the determinants of experience and contextual knowledge, and the significance of gut feelings in the learning process for diagnostic reasoning in workplace settings. We welcome any researchers who would like to participate in our research.

For more information and contact please visit www.gutfeelingsingeneralpractice.eu .

Take Home Messages

- Gut feelings , i.e. a sense of alarm and a sense of reassurance, play a substantial role in the diagnostic reasoning of general practitioners.
- The sense of alarm stimulates a GP to formulate and weigh up working hypotheses that might involve a serious outcome.
- The sense of reassurance means that a GP feels secure about the further management and course of a patient's problem, even though he/she may not be certain about the diagnosis.
- Gut feelings can be considered a third track in general practitioners' diagnostic reasoning next to medical decision-making and medical problem-solving.
- Gut feelings are a kind of skilled intuition and fit well in EBM.

Original Abstract

http://www.woncaeurope.org/content/ws-061-gut-feelings-guide-diagnostic-reasoning-gps

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58 – Family Medicine Miles Programme: Getting Students Involved Where There is No Family Medicine in Medical School

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Brazilian Background on Family Medicine.

Since 1988, Brazil's public health system has tried to build a national health system that responds to the needs and expectations of Brazil's population. In 1994, the government created the Family Health Programme to help carry out this goal. However, the shortage of family physicians in Brazil—the central figures of this programme—limits the programme's effectiveness.

The lack of family physicians can be traced primarily to the medical schools in which medical training favours specialists and discourages generalists. Medical students seldom have family physicians acting as role models. If the academic knowledge of primary care is absent as a model in the undergraduate curriculum it will be difficult to promote family doctors among the students and to encourage them to choose family medicine as their future career (1,2,3).

SOBRAMFA Working with Medical Students

In 1992, a group of physicians (most of them specialist and some faculty from medical schools), inspired by other countries' associations of family medicine teachers, founded SOBRAMFA- Brazilian Society for Family Medicine, in São Paulo, Brazil. SOBRAMFA is an academic society established with the purpose of promoting the humanistic dimensions of doctoring and establishing the proper basis and scientific methodology for family medicine.

SOBRAMFA has developed a variety of initiatives involving more than 4,000 medical students in family medicine over the last 22 years. Thus: 1) The Annual Family Medicine Academic Meeting (up to the 18th). 2) Family Medicine Interested Groups 3) The Family Medicine Day bringing students from several medical schools along to share educational experiences. 4) The Young Doctor Monthly Meetings, where an innovative learning model is set (student-teaching-student) as continuous medical education course. 5) Participation in International Meetings and Conferences(STFM-Society of Teachers of Family Medicine Conferences and WONCA) where students present their academic work.

Students´ interest in family medicine has been increasing over these years through a continuous preparation process of a non-curricular nature, as a result of the realisation that they need these values to become better doctors. Besides seeing family medicine as their future specialty choice, family medicine provides students with tools to improve doctoring (4).

The Mini Fellowship in FM (MF2) and the Family Medicine Miles Programme

One of the most effective family practice exposures for medical students occurs in the Mini-Fellowship in Family Medicine (MF2) programme; an elective clerkship over one to two weeks (40 or 80 hours). Students see patients under supervision of SOBRAMFA's faculty and residents in a broad range of family doctors' private practices.

The MF2 started in 2004 and to date, 162 students from 46 different medical schools have participated in the programme. Students learn how to develop communication skills understanding the whole person and the family context; they also learn about continuity of care, solving complicated problems with inpatients, dealing with other physicians and facilitating health professional teams in order to provide better care. Finally, they address self-knowledge as a surprising outcome of the programme. The students gain respect for the specialty and spread this "discovery" to their colleagues.

The Family Medicine Miles Programme (5) was created to measure students´ participation in SOBRAMFA activities and in which students are rewarded with grades (miles). The Miles Programme allows an individual assessment of each student, offers balance between theory and practice, provides tutorial guides, and fosters leadership among the students. This "continuous medical education programme" fosters students´ interest in family medicine, and encourages those who will be able to apply for the residency programme currently under development by SOBRAMFA. The Family Medicine Miles Programme is managed by the SOBRAMFA web site, and students can track their own performance, as well as monitor specific guidance in order to improve their training.

Training Young Doctors through the Pacemaker Agenda

There is a growing diversity of opportunities for family doctors in private practice supported by Insurance Health Companies in São Paulo, Brazil. Patient's satisfaction, problem-solving while keeping costs low are the real basket of services companies ask for. The practising scenarios in private practice include: Geriatric Care, Managing Complicated Patients with co-morbidities in Hospitals, Palliative Care, Family Medicine Clinics and Ambulatory, Home Visits, Nursing homes and Hospices.

For a proper training of young doctors in such variety of practices, in a city with a population of 14 million people (São Paulo), SOBRAMFA has developed an innovative agenda in which several components are incorporated for pursuing excellence and expanding opportunities. This Agenda, required for all trainees and faculty members, has been ongoing for more than a decade and includes:

1. Scientific "pacemaker" - Weekly Scientific Meeting. A two-hour meeting. Case-based discussion, update with articles from the most relevant publications, case-decisions for specific patients supported by Evidence Based Medicine.
2. Construction "pacemaker"- Monthly Meeting, conducted as workshops and to include topics to promote reflective practice: professionalism, medical education, humanism, family medicine core values, personal development, teamwork, and leadership.
3. Cultural monthly Meetings - at dinner time and displayed as a familiar get-together and targeting an open-mind scenario, with acknowledged leaders in several fields (Philosophers, Journalists, Educators, Lawyers, Artist and Musicians, Entrepreneurs).
4. Young Doctor Monthly Meeting- case-based discussions lead by medical students and young doctors acting as facilitators, fine-tuning their teaching skills.
5. Mentoring and Evaluation- trainees are evaluated and giving feedback by their respective preceptors.

The Main Outcomes of the Pacemaker Agenda Are:

1. Effective Training- Clinical Competence - Trainees develop expertise in doctoring, skills in managing complicated patients and leading health teams.
2. Mastering Communication with patients, families and their peers.
3. Respect, Credibility and Happiness - They are recognized as good physicians by the patients they are caring for, by their peers in the clinical setting, and by the owners of the Insurance Companies.

Take Home Messages

- Family doctors as role models in the academic undergraduate curriculum are needed to promote FM among medical students.
- Students exposed to the real practice of a family doctor realize they need family medicine core values to improve their future doctoring.
- The Mini Fellowship in FM (MF2) and the Family Medicine Miles Programme are two successful initiatives which involve medical students in family medicine through a non-curricular process, allowing for concurrent involvement for students from different medical schools..
- The Pacemaker agenda is set for training young family doctors for the wide basket of services and the growing diversity of opportunities in private practice.

Original Abstract

http://www.woncaeurope.org/content/3434-family-medicine-miles-program-getting-students-involved-where-there-no-family-medicine

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59 – Improving the Prescribing of Antimicrobial Drugs in Primary Health Care: the Effect of Being Members of a Scientific Society

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Introduction

Unnecessary use of antibiotics plays an important role in increasing bacterial resistance and medical costs as well as in the risk of drug-related adverse events [1]. The most frequent indication for antibiotic prescription in Europe is respiratory tract infections (RTI) [2]. Clinical signs and symptoms are unreliable for distinguishing viral from bacterial RTI [3]. Diagnostic uncertainty increases the likelihood of inappropriate antibiotic prescription and, when in doubt, general practitioners (GP) opt for antibiotic prescription. Compared to other European countries, Spain has historically had a high outpatient antimicrobial consumption rate [4]. We presented an abstract in WONCA 2000 aimed at knowing if GPs who are members of task force groups on the rational use of antibiotics prescribe antibiotics more appropriately than GPs who are not involved in these study groups. The overall consumption of antibacterial drugs in 1997 was lower among the six GPs who were members of a task force compared with the mean prescription of all the GPs in Catalonia (10.1 DID vs. 14.8 DID, respectively). In addition, the former GPs prescribed more penicillins and fewer macrolides and quinolones than their counterparts. A prospective non-randomised controlled before-after study was performed in primary care clinics in 2008 and 2009. This study constituted part of the Happy Audit project, a study financed by the European Commission [5]. A total of 281 FDs throughout Spain participated in this study, with the inclusion of FDs in nine Autonomous Communities. Some of these GPs were members of study groups on the rational use of antibiotics in each of these areas, belonging to the Societies of Family Medicine. We wished to know if the antibiotic prescription of these GPs significantly varies from the remaining GPs in terms of the total amount of antibiotics prescribed for RTIs and the type of antibiotics used.

Methods

All the participants were instructed to fill out a template with all the patients with RTIs during a 3-week period in the winter months of 2008 (first registry) and 2009 after the intervention (second registry), covering a total of 15 working days in both periods. On this sheet the physician attending the patient noted different specific parameters of medical care, including the age and gender of the patient, the number of days of symptoms, presenting signs, diagnosis, performance of chest X-ray, rapid antigen detection tests (RADT) and C-reactive protein (CRP), and antibiotic treatment or not. The intervention consisted of discussion sessions of the results of the first registry, courses for GPs, guidelines, patient information leaflets, workshops on RADT and CRP and use of both rapid tests. A descriptive statistical analysis was performed and significant differences were considered if the p value was <0.05.

Results

Out of the 281 GPs, 42 were members of study groups on the rational use of antibiotics (14.9%). As shown in the table, the percentage of antibiotic prescribing was lower among the members of these groups than in the remaining GPs before the intervention (25.2% vs. 28.2%; p<0.001). This difference was slightly smaller after the intervention (18.2% vs. 20.1%; p<0.05), with a reduction of antibiotic prescribing that was slightly greater among GPs not involved in study groups, with a reduction of 8.1% in this group and of 7% among GPs involved in study groups (no significant differences were observed). After the intervention, GPs belonging to the study groups used the rapid tests more frequently: RADTs were used in 13.3% of the RTIs in this group of GPs compared to the 11.8% observed among the remaining GPs and CRP was also more commonly used by these physicians (10.6% vs. 7.7%; p<0.001). GPs involved in task forces percentually prescribed more penicillin V and amoxicillin than their counterparts and, conversely, they prescribed fewer macrolides, cephalosporins and quinolones. Even though the type of antibiotics prescribed improved after the intervention, this improvement was greater among GPs who were members of study groups on rational use of antibiotics (table).

Table. Total number and type of antibiotics prescribed by the participating FDs before (2008) and after the intervention (2009)

	Members of study groups (n=42)			Other FDs (n=241)		
	Number of RTIs	RTIs treated with antibiotics	%	Number of RTIs	RTIs treated with antibiotics	%
Before the intervention, 2008	2,194	552	25.2	12,879	3,626	28.2
Penicillin V		46	8.3		142	3.9
Amoxicillin		196	35.5		995	27.4
Amox/clav		148	26.8		1,447	39.9
Macrolides		45	8.2		414	11.4
Quinolones		44	8.0		307	8.5
Others		73	13.2		321	8.9
After the intervention, 2009	1,984	362	18.2	10,776	2,168	20.1
Penicillin V		76	21.0		233	10.7
Amoxicillin		111	30.7		646	29.8
Amox/clav		101	27.9		729	33.6
Macrolides		14	3.8		231	10.7
Quinolones		22	6.1		174	8.0
Others		38	10.5		155	7.2

Discussion

The results of this study should be interpreted with caution because of a series of limitations. Firstly, this is a study in which physicians participated voluntarily and, thus, their prescription habits may not be the same as those of general use which GPs globally follow [6]. It was not a clinical trial and the results of this study were based on the data reported by the GPs, and even though these data were not double-checked with the actual prescription, this bias is likely to have occurred in both groups of GPs. The greatest strength of this study is, however, the large number of physicians included. This study demonstrates that baseline antibiotic prescribing is more appropriate among GPs who are aware of the problem of antibiotic resistance and recommend the rational use of antibiotics. The results of this study also show that an intervention aimed at promoting more prudent use of antibiotics for RTIs is able to reduce the prescribing of antibiotics. However, this reduction is greater among general professionals than among physicians who prescribe the antibiotics more rationally at baseline, probably because there is more room for improvement in the first group of GPs, as some qualitative-based studies have pointed out [7]. We are unable to compare the results of this study with other studies, since there is a lack of studies focusing on the differential habits of prescribing depending on

the inclusion of GPs in taskforces that promote a more rational use of antibiotics. The fact that these GPs are more motivated to prescribe fewer antibiotics than other GPs seems logical since they are more aware of the threat of antimicrobial resistance.

Take-Home Messages

- GPs involved in study groups on the rational use of antibiotics are more aware of antimicrobial resistance.
- These primary care physicians prescribe fewer antibiotics and use more narrow-spectrum antibacterials than GPs not particularly interested in the rational use of antibiotics.
- These clinicians also use more rapid tests that can help GPs to better distinguish viral from the bacterial respiratory tract infections.
- An intervention aimed at promoting more prudent use of antibiotics for respiratory tract infections is able to improve the prescribing of antibiotics.
- However, strategies to improve the use of antibiotics seem to be less effective among GPs involved in study groups than in the general population of primary care physicians, mainly because the baseline prescription of antibiotics is much lower.

Original Abstract

http://www.woncaeurope.org/content/133-improving-prescribing-antimicrobial-drugs-primary-health-care

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60 – Comprehensiveness and Continuity of Care - Core values Necessary for the Survival of General Practice

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Frankly spoken, General Practice is especially appreciated by politicians because it is cheap and effective. And providing good care for little expense truly is a value - especially in poorer countries. But it is also true for richer countries where specialized care is becoming rapidly more expensive because of the sophisticated developments in diagnostics, treatments and pharmaceutics – even if this progress involves only very small steps of being "better" in diagnosing or treating. In other words, specialists are making care more and more cost-**in**effective.

General practice can still be cost-effective because not all the possible diagnosing and treating is actually carried out in all "cases". General practitioners (GP) decide on the "individual patient" and not on the "case", e.g. they are not doing the same in all patients with a similar problem. This is basically different from the specialist, who usually does not know the patient well and therefore follows, more or less, a guideline, i.e. is doing more or less the same in each similar consultation.

If one is not doing all that is possible, one is at risk to make mistakes, miss a diagnosis etc. There are two things reducing this risk: first of all, one has to reflect on all the possible things which can be done, but then decide on what can also be left out by following Bayes' theorem. This process needs sound medical knowledge as all possibilities must be known to become part of this reflection.

Secondly, there has to be good knowledge of the patient and his/her life-circumstances, his/her preferences and values and, last but not least, his/her way of handling/coping when being ill. Combining all these factors, a decision is a complex process and is made for just this patient in that particular situation and with these special findings – and often by discussing it with the patient.

This way of decision-making saves money – otherwise often spent on futile diagnostic or therapeutic procedures. And it decreases stress for the patient by reducing the proportion of false-positive results (Bayes theorem) and by reducing over-treatment.

What allows GPs to know their patients well? The GP is the only doctor seeing his/her patient over several years and under different circumstances of health and illness.

Additionally, an emotional relationship between doctor and patient is established through the length of their association which allows them to understand one another instead of simply knowing the facts about him/her. With this background, GPs are at an advantage in noticing even subtle differences in his/her patient - in the way of behaving, moaning, talking, looking and expressing him or herself. This knowledge can be employed in "interpreting" the patient and his problems and wishes – and hence finding an appropriate decision for a certain situation.

All this can only work if the doctor can see his/her patient often and under different circumstances. In other words, GPs have to provide comprehensiveness and

continuity in care – and society has to guarantee this. This makes continuity and comprehensiveness not only popular

with patients, but also an "essential" in the special way GPs work; as shown above.

If this is no longer possible or the number of contacts between GP and patient are reduced considerably (e.g. by shift work, special services for extramural care etc.), GPs would not know enough about patient's life-circumstances, values, and their coping ways of handling symptoms – and by this also lose their abilities to engage patients in shared decision-making based on understanding the patient.

If continuity of care and comprehensiveness are reduced considerably, as is happening in some countries, General Practice will lose its allure for society and the patient - due to a loss in the described special ability of General practice to provide cost-effective care as well as reducing overtreatment.

Should it be "personal continuity" or "institutional continuity"? Personal continuity is the only guarantor for obtaining optimal knowledge of a patient and a joint experience with each other, which is absolutely essential for a solid doctor-patient-relationship. Institutional continuity is only a second-best substitute because joint experiences of patient and doctor cannot be "transported" from one doctor to the next through writing notes. In most developed countries today, these core values of comprehensiveness and continuity of care are under pressure due to the developments in medicine bringing in sophisticated technical and analytical skills and knowledge on the one hand, and young doctors insisting on a limited number of working hours (including half-time work) on the other hand. Group practices and, within these, a division of functions also undermine these core values. "Emergency services" and "hotlines for health", supported by the health care system, are additional institutions reducing the number of contacts with the GP.

In some rich countries, like Germany, without a) a gate-keeper function of General practice and b) a work force of specialists as large as that of GPs, working full-time outside the hospital, the core values of continuity and comprehensiveness are seriously threatened. Additionally, patients are more and more attracted by the modern developments of technical medicine - which they expect to receive from specialists.

In countries with fewer specialists and less funding on health care, General practice has to face another threat: contacts to one GP are massively reduced by installation of shift-work in health care, hospital ambulances for immediate care, and several different paramedic professions doing some of the work previously undertaken by GPs.

Without the core values of comprehensiveness and continuity of care as well as an underlying solid patient-doctor-relationship, General Practice will, in the long run, lose any justification for its existence: Under such circumstances, specialists- with little information about the patient - would perform better because they are better educated for medicine of the "details". But knowing that often these "details" are not the real problem, and that the patient's complaints have to be interpreted in the context of the whole person, the time and circumstances of developing a symptom or illness, we have to fear about the quality of care in a future without GPs.

Take home messages

- General Practice is a very cost-effective way of caring.
- For this it is absolutely necessary to have detailed knowledge of and experience with the patient.
- Only a system allowing GPs to care comprehensively and in continuity makes this possible.
- Without these two core values General Practice will lose its base.
- And society its cost-effective health care.

Original abstract

http://www.woncaeurope.org/content/155-comprehensiveness-and-continuity-care-core-values-necessary-survival-german-general

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61 – Teaching Cross-Cultural Care

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The need for cross-cultural care and cultural competence

The need for cross-cultural care derives from the fact that modern societies are increasingly becoming multi-cultural and the observation that many cultural groups are not satisfied with health care, while medical practitioners say that some cultural groups are difficult to work with (Waxler-Morrison et al., 2005). On this note, Waxler-Morrison et al. (2005, p.6) argued that we need to adopt a cross-cultural care approach in order to deal with such "problems with health care". These problems with health care relate to the different philosophies and knowledge that medical practitioners and lay people have with regard to health, illness and the management of diseases. Waxler-Morrison et al. (2005) explained that when a medical practitioner and a patient do not share the same culture they may not understand each other and lead to what they authors called "clash of cultures" (p.2). Such a clash should be avoided when medical practitioners communicate with and treat their patients. But how can they avoid it? To answer this question, we should first look into the main source of the different understanding between medical practitioners and lay people. This difference is attributable to the distance between the biomedical model and social knowledge.

The biomedical model, which medical practitioners are trained to adopt, makes a distinction between the body and mind, and focuses on measurable characteristics of the body and identifiable symptoms, which represent distinct medical conditions (Helman, 2007). Furthermore, the biomedical model is concerned with causes of health conditions which can be observed in the physical world or inside the body, while it tends to attribute the development of certain diseases (i.e. heart diseases) to human behaviour, such as diet and lifestyle choices (Helman, 2007). Interestingly, biomedicine tends to underplay influential social forces, such as socio-economic status, occupation, migration and so forth. On the other hand, lay people rely heavily on socio-cultural knowledge to understand the causes and management of diseases. Such socio-cultural knowledge can result from cultural and religious values, such as the belief in the spiritual world or the evil eye. Moreover, lay people pay particular attention to the importance of social relations and the stress they experience in daily life (Helman, 2007). In other words, while medical practitioners are looking into the individual to find out the causes of diseases, lay people look at the outside world. To reduce the distance between these two regimes of knowledge we should not expect patients to acquire medical knowledge but medical practitioners should become "culturally competent" (Betancourt et al., 2005).

Cultural competence is increasingly considered an important skill for medical practitioners. Betancourt et al. (2003, p.297) explained that cultural competence refers to "understanding the importance of social and cultural influences on patients' health beliefs and behaviours". These social and cultural influences may relate to services, language barriers, belief systems, habits and so forth. If medical practitioners manage to understand the rationale of their patients' beliefs and

behaviour they can then develop their skills in how to work with their patients more effectively. But how can we make medical practitioners culturally competent? A multi-layered long-standing training may be very effective.

Methodology of teaching cross-cultural care

The *Cultural Competence Train-the-Trainer* Manual (2011) outlines a series of teaching methodologies in cultural competence. Drawing from this manual we propose a more simplified teaching methodology of cross-cultural care and cultural competence which should rely on situated learning and constructivism. Situated learning refers to contextualising learning by using examples or cases (Kaufman and Mann, 2010). Constructivism refers to the role the learners play in their own learning and to the process of constructing their learning by being active participants (Davis and Forrest, 2008). Both situated learning and constructivism have been used in modern medical education through adopting Problem-Based Learning (PBL) as the main method of teaching.

Based on situated learning and constructivism, we propose a pyramid of building competence in cross-cultural care (figure 1), which is a modification of Mehay's (2012, p.358) pyramid of clinical assessment. The proposed pyramid consists of three layers in order to train medical practitioners and students more effectively. The first layer is called "acquiring knowledge" and focuses on transferring knowledge to the learners through lectures. The second layer, "applying knowledge" could be enhanced by making the lectures case-based. Therefore, the learners learn the basic information in the social and cultural background of specific cultural groups and then they apply their knowledge to real life cases. The third layer, "practising knowledge" would train learners in how to perform their knowledge. In other words, the learners would be trained in the ways that they could use their knowledge in medical practice. To achieve this, teachers of cross-cultural care could construct cases and tasks for the learners to undertake based on these cases. For example, a scenario could describe a female migrant who cannot accept the medical diagnosis by her doctor and prefers attributing her condition to the act of the evil eye. The learners should then be taught how they should handle this patient. This third layer of practising knowledge could take the form of small-group role play sessions and reflection on work-based experience. Through the pyramid of building competence in cross-cultural care, medical practitioners can acquire knowledge, skills and attitudes to communicate with and treat their patients more effectively.

Conclusion

The need for cross-cultural care has increasingly been acknowledged as an important element in medical practice. Based on situated learning and constructivism, a three-layered pyramid of building competence in cross-cultural care can be implemented to help medical practitioners acquire knowledge, skills and attitudes to become more competent and effective in communicating with and treating their patients. Better cross-cultural care would thus mean better health care in general and improved medical practice.
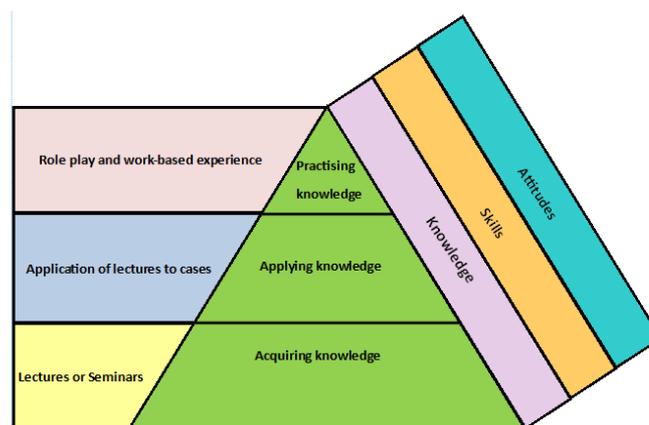
Figure 1: Pyramid of building competence in cross-cultural care. Modified from Mehay's (2012, p. 358) pyramid of clinical competence. Mehay based his approach on Miller's prism of clinical competence published in 1990 at *Academic Medicine*, 65(9): 63-67.

Take-home messages

- Medical practitioners need to be trained in how to become competent in cross cultural care.
- To improve their communication with and treatment of patients, medical practitioners should be trained on the basis of the pyramid of building competence in cross-cultural care in order to acquire, apply and practise their knowledge.
- Better cross-cultural care means better medical practice.

Original abstract

http://www.woncaeurope.org/content/1014-wo-teaching-cross-cultural-care

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62 – How to Recruit and Select Your Future Colleagues?

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Recruitment of new colleagues to general practice/family medicine is essential for the viability of the specialty. Selection of "the right" colleagues for training in general practice/family medicine is also essential in order to give the trainees a satisfying professional life and their patients excellent GPs/family doctors!

A survey conducted in 2004 by EURACT, the European Academy of Teacher´s in General Practice/Family Medicine, on specific selection processes for GP trainees in 28 European countries indicated different processes, even within the same country in 50% of the countries. The selection was done by course organizers in 75% and by universities in 25%, usually using interview and university scores. Training Programmes in other specialties sometimes gave credit in general practice programmes. The future trend was predicted to involve "more control by GPs in the process".

This issue was further explored at an interactive workshop at the WONCA Europe conference 2005 in Kos organized by EURACT. The aim was to strive to produce European recommendations for recruiting and selecting GP trainees.

Introductory presentations by EURACT-Council members (Table 1) gave insight into a very diverse situation in different countries in Europe, ranging from nearly no selection "who is volunteering for GP ?" to very elaborate selection processes. In some places non-GP-specialists were doing the selection – in other places GPs were leading the process. A clinical testing period and references on collaborative competences were sometimes included.

Table 1

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Dr Bernhard Rindlisbacher	Switzerland
Dr Dolores Forés	Spain
Dr Roger Price	United Kingdom

According to the literature review presentation, selection practices are relatively unsystematic (1) and also ineffective, uneconomical and unfair (2). The most important factors in selecting applicants have been reported as the personal interview and earlier performance on clinical rotations (3). Knowledge tests at the entrance are not suitable (4). Personal attributes need to be considered rather than academic and clinical competence alone (5,6). In addition, it is recommended to target on six competences essential for family medicine: empathy and sensitivity; communication skills; clinical expertise; problem solving; professional integrity and coping with pressure (1).

The UK was in the process of introducing a new application procedure: firstly a

"technical/formal" procedure, secondly a knowledge test, and if successfully short-listed in this part, the process continued to the third step: direct observation of behavioural competencies, a simulated consultation, and a group problem-solving exercise.

The Kos-workshop was successful with intense discussions. Many participants were very inspired by the elaborate system being used in certain areas of the UK. It became clear that different national settings have to influence the method of selection. It was also obvious that we might learn from each other and we should try to generate some general principles and recommendations.

Some unanswered questions were: Where should training start? (in general practice or in hospital). Introductory period? (to try out the GP-speciality). Who should undertake the selection? Written application? Standard criteria? Use of references? Personal interview? Who should be the interviewers?

Selection and recruitment relate closely to other aspects. EURACT has conducted further work, accessible on its website, on various issues believed to be useful to trainees, trainers, course organizers and also to policy-makers. Some examples are:

- http://www.euract.eu/resources/specialist-training:
  A database with information on "the European GP-training landscape"

- http://www.euract.eu/scientific-papers/finish/2-scientific-papers/96-funding-of-vocational-training-programmes-for-general-practicefamily-medicine-in-europe:
  How is GP-training funded? How are GP-trainees salaried? Overview and recommendations.

- http://www.euract.eu/resources/educational-research-presentations/finish/5-educational-research-presentations/226-selection-and-reaccreditation-of-st-trainers-in-general-practice-in-europe-brendan-oshea-for-euract-specialist-training-committee-11nov2011:
  On selection and re-accreditation of ST-trainers in GP in Europe

Since 2006 the UK has implemented a very elaborate and systematic selection process nationwide, which has been well researched, evaluated and published (7). Focus remains on assessed competencies - Communication, Empathy, Professionalism and context-based Problem solving, with no interview at all! There is a 3-stage process: a single Person Specification for entry to all Specialty training; a Machine Marked Test (8) with papers on Clinical Problem Solving and Situational Judgement; and a Selection centre including Written test and Simulations. It is an expensive but reliable process with evidence that the various elements are predictive of progress in training.

Other countries were also inspired by the workshop and the ongoing discussion within EURACT. For example, Denmark - where Multiple Mini Interviews are used, and in the near future, also simulated patients. Ireland is moving towards national selection with interviews looking at 6 competencies, assuming minimum criteria are met. GP teachers are central to this process which attracts the best candidates.

However the situation is still diverse. In Switzerland the GP-trainee has no clearly structured program, but many options and selection notably depend on the (hospital) posts found. Spain has an exam, consisting of the same Multiple Choice Questionnaire for all specialties. The best student is the first to choose specialty and place, usually a hospital. In Sweden some areas have too few applicants minimizing selection. Sometimes the trainee starts a supervised trial-period.

The recruitment agenda in GP/FM is a big and increasing problem in many countries and in some may even present a threat to the specialty.

Take home messages

- Selection of trainees to be done by GPs/FPs.
- Target competencies essential in GP/FM (empathy and sensitivity; communication skills; clinical expertise; problem solving; professional integrity and coping with pressure) to be evaluated.
- Systematic approach and selection process should be adapted to conditions within the country taking into account e.g. credits, funding issues, re-training.
- Selection of trainers.
- Recruitment of trainees in GP/FM of importance to the specialty, but also to other disciplines and the ability to meet the challenges of our changing world.

Original abstract

http://www.woncaeurope.org/content/275-wo-how-recruit-and-select-your-future-colleagues

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63 – Motivate Healthy Habits For Life: Coach Each to Change Before Helping Patients and Families

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Systems are perfectly designed to get the results that they get. Our toxic cultures have created epidemics of unhealthy habits. These epidemics have mass-produced premature deaths and diseases on unprecedented scales in the history of humankind. We are killing ourselves with unhealthy habits beyond all acts of war and terrorism combined. One billion people, or 1-in-8 persons, will die from smoking in the 21st century: never mind the impact of obesity, poor nutrition, alcohol abuse and sedentary lifestyles (1-3). Unhealthy habits shorten life expectancy by 10 years (4).

Our "disease" care systems face overwhelming demands, unmet needs, finite resources, regulatory reforms and time-pressured, short-term demands. There will never be enough practitioners and coaches to reverse these epidemics and reduce the mounting burdens of chronic diseases (5). These constraints combined with the dominance of the medical model stymie innovation for where population health improvement needs to go (6).

There are no saviours to solve these problems. We can only save ourselves. Closed mindsets are the greatest barriers to innovation and change. We must expand our closed professional systems constrained by finite resources to include peer coaching systems with exponential capacities and capabilities (See figure 1).

Our greatness lies not in remaking the world … but in being able to remake ourselves.

Gandhi

To do this, we must open, expand and align our mindsets to design health movements (6). Health movements are for the people and led by the people. To build such movements, we need catalytic innovations: scalable, sustainable and self-organizing solutions to:

- Go beyond the limitations of (1-to-1) clinical encounters and (1-to-n) group visits (8)
- Overcome the limitations of evidence-based guidelines and static brief interventions that address surface change
- Engage people in dynamic peer coaching activities to explore, make and sustain deep change
- Mobilize communities to help healthcare organizations break through the ceiling of their organizational performance

Catalytic innovations are inexpensive, convenient and accessible learning processes that radically change how we improve our health (7). Everyone can develop some level of health coaching skills. Taking turns, we can coach each other to improve our health. Social media and online courses can make these innovations widely available: anytime, anyplace and anywhere. Crowd-sourcing strategies using catalytic innovations can unleash the positive power (n-to-n) of our social networks.
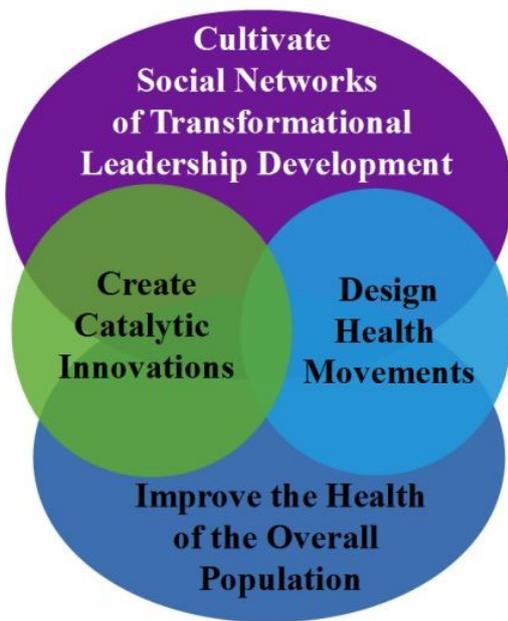
Figure 1: Transformational Leadership: Re-designing Systems

Figure 2: Design Exponential Health Movements

The Health Coaching Buddies (HCB) learning system helps people coach each other to motivate healthy habits for life. In other words, we develop health coaching skills for everyday life and create our own circles of health coaching buddies. To initiate this process, we invite our healthcare teams, staff and students to:

- Become Health Coaching Buddies (HCB) together
- Break the taboo and talk about deep change
- Develop healthier habits before helping our patients and families do the same

Lead Together

To create leadership, professional social movements, our leaders can implement the HCB learning system at all levels. Together, we can follow the seven simple "**C**" rules to lead exponential health movements (see figure 2).

- **C**onnect to **C**are
- Be **C**urious, **C**reative and **C**ourageous
- **C**ollaborate to **C**oach each other

"You must be the change that you wish to see in the world."
Gandhi

Become Health Coaching Buddies

Working together to go beyond surface change (increasing knowledge, setting goals with good intentions and making action plans), you can learn how to talk about deep change.

A. Explore Deep Change

- Clarify your issues for and against deep change
- Understand why you maximize your reasons to stay the same
- Understand why you minimize your reasons to change
- Identify gaps in your values between what you do and say

B. Make Deep Change

- Address gaps in your values between what you do and say

- Shift your perceptions in favour of healthy change
- Lower your emotional resistance
- Increase your motivation
- Enhance your confidence and ability to change
- Create commitment and passion to live a healthy life

C. Sustain Deep Change

- Develop the discipline to maintain deep change
- Become accountable to yourself and others
- Stay on track with the right motives
- Manage negative feelings and impulses effectively
- Overcome roadblocks to change and stop getting side tracked
- Keep focused on achieving your goals
- Learn from failures to prevent lapses and relapses
- Celebrate successes

The ten online modules (See Table 1) enable you and your health coaching buddies explore, make and sustain deep change.

Table 1. Learning Modules
1—Inspire Healthy Choices
2—Navigate Deep Change
3—Explore Goal-setting
4—Enhance Your Prospects of Deep Change
5—Get to the Heart of Deep Change
6—Lower Your Resistance
7—Increase Your Motivation
8—Enhance Your Skills
9—Use a Circular Process for Effective Action
10—Sustain Your Healthy Habits

Learn More

Experience this learning process for yourself. Go to www.HealthCoachingBuddies.com. Look over a decision balance of a woman who has unprotected sex with her HIV positive partner and understand why she sacrifices her health. Then use a decision on yourself to discuss your resistance and motivation to change with your health coaching buddy.

Host Your Own Webinar or Workshop: Lead the Next Health Movement for your organization and community

- Download the free e-book www.HealthCoachingBuddiesMovement.com for group discussion
- Access free online course to hear leaders, scholars, researchers and practitioners reviewing this e-book

Take Home Messages

Mission
- Implement the Health Coaching Buddies learning system at all levels.
- Create ever-growing social networks of Health Coaching Buddies

Vision
- Align leadership, professional and social movements
- Build exponential health movements
- Reverse the epidemics of unhealthy habits

Original abstract

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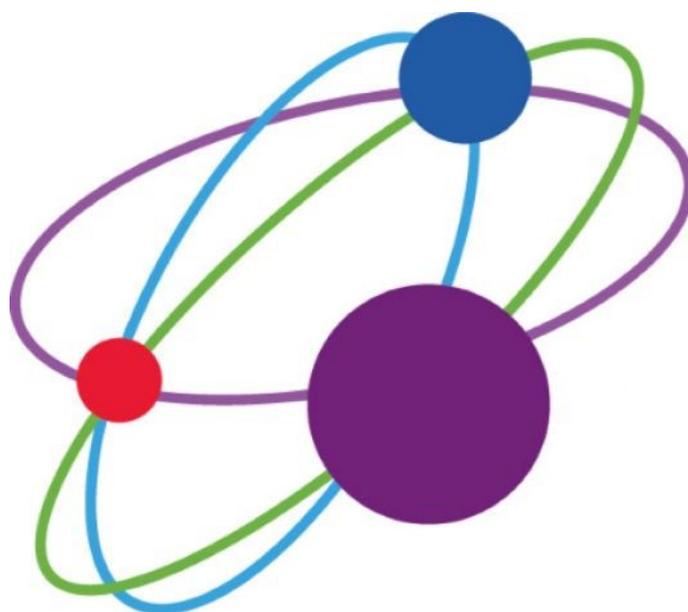
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64 – An Ideal Training for the Future Career Patterns of Family Medicine

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It has been fourteen years since the presentation of innovative training posts in the UK combining clinical experience in primary and secondary care education within the same working week (1). This chapter considers how far we have come since then in achieving the ideal education for family medicine. It uses the NHS in the UK as an example, but the principles apply worldwide.

What is the ideal educational environment? One in which the learner feels fully supported and encouraged to achieve their maximum potential. An apprenticeship, described by Dreyfus, in which they move through advanced beginner, to proficient and possibly expert in their future career choice; in this case, family medicine. A learning environment where they achieve Mintzberg's "shortcut to the acquisition of experience", on a daily basis in their future career choice. Learning from both formal education and informal education in the workplace environment, whilst caring for patients.

The vision outlined in the 2013 RCGP report "Enhanced GP training" is for a focus on community approaches and integration of care (2). To have primary care experience early on in training, to move to 24 months in primary care, with more child health and mental health experience, for all trainees.

The report describes a "spiral curriculum model where expertise in generalist medical care is built up incrementally over time" (2). Five educational themes are identified for the four year curriculum. These are relating to others, applying clinical knowledge, managing complex care, working in systems of care, and caring for the whole person. Opinion in the UK is moving towards more generalist training with capacity to adapt to future pluri-potential integrated care posts spanning across secondary, primary and community care (3, 4).

However the current reality of today is similar to the 1980s. Doctors training for UK family medicine still rotate through a range of separate specialties where the focus is predominantly on learning related to the secondary care specialty setting. There is considerable value and insights that continue to be derived from secondary care experience for doctors with careers in family medicine, but it does not appear that the full potential of GP training is being recognised.

In the GMC national training survey these secondary care posts were consistently rated lower by general practice trainees than their secondary care colleagues and also lower in comparison to training posts in the primary care setting (5). Part of this is the context of education, and the relevance of education to future career, but part of this may be due to the quality of education. Factors such as the ratio of learners to educational supervisors, the professional recognition of educators, the demands of service pressures, the lack of protected time and shift systems all play a part in the secondary care setting. Educators, as professionals, need the time to supervise, teach, review and improve their own practice.

Until now the focus for change has been on the proportion of time spent in primary care. Moving towards 18 out of 36 months, with regular one day primary care focused education once a month during hospital based posts. Change is happening around the basic structure of GP training rather than to the core of GP training.

Attempts to integrate secondary and primary care education in 2002 did move on from this current model by combining primary and secondary care experience each week in the same post (1). Satisfaction was high (1). Trainees gained insight into both sectors and had the opportunity to follow patients from primary to secondary care and back. Their learning was more focused on future career needs, even though doctors still experienced two distinctly separate learning environments. Looking back it is evident there is still room for yet greater integration of education with contributions to be made not only from secondary care specialist knowledge, but social care, community care and voluntary care as well as primary care.

However, the support for these basic initiatives to flourish was not present. For most of the UK the basic model of siloed secondary care education for the primary care doctor continues. It is possible that healthcare itself needs to integrate more effectively before education for healthcare becomes more integrated.

One current example of future integrated models related to future career needs is the rural medicine course in Scotland, which has a placement in a developing country. The course makes use of video-conferencing for both service delivery and education. There are rural attachments and additional training in medical retrieval, intubation and roadside care.

Since 2000 there have also been a selection of ST4 and clinical fellow posts across the UK emerging as optional add-ons to help get trainees up to speed for real general practice, following their core training. This gives them skills in a range of settings including management, research, leadership and integrated healthcare.

In addition, external factors such as technology are bringing about developments. Websites, apps, YouTube, podcasts, wikis, discussion rooms, twitter, and Facebook are moving on line education into the workplace and the learners' pocket. The difficulty is picking out what is really needed and retrieving it quickly, when required, within the consultation.

Simulation has also evolved. Examples now exist of manikin simulation running from the road side, through the emergency department to the wards and into intensive care, involving a range of multi-professional teams in the real life workplace, providing learning that is immediately relevant. Actors and actual patients, including children, now take on the simulated patient role. Trainees take exams with simulated patients, but there are, as yet, no simulations of the real life pressures of full-on, busy primary care.

In conclusion, education for family medicine has evolved by having proportionally more time in the primary care setting. However, there is a long way to go before we attain a shared NHS vision and plan to create the ideal integrated care education for future family medicine in the 21st century.

Take home messages

- Education for family medicine continues to be predominantly in the secondary care setting
- Education in secondary care is consistently rated less favourably than in primary care by trainees
- Technology is opening a range of new educational approaches
- The full potential of integrated care education for family medicine has yet to be recognised

Original abstract

http://www.woncaeurope.org/content/1-ideal-training-future-career-patterns-family-medicine

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65 – 'Burnout' and Family Practice

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Occupational stress has been recognized as a problem for family physicians. Relations with patients, colleagues, managers, satisfaction or dissatisfaction with the work, possible conflict situations in the workplace, insufficient education to perform work-related tasks, work overload, and lack of promotion opportunities at work are considered to be the most common causes of workplace stress. Many countries in Europe have been trying to transform their health care systems and implement health care reforms in recent years. Working with system changes, responsibility for the registration of citizens, financial responsibility, and other changes within the reforms are the most important reasons for the high prevalence of burnout syndrome among family medicine physicians. Burnout syndrome is defined as chronic work-related stress which includes three dimensions:

- feeling of emotional exhaustion,

- negative approach to the service provided (depersonalization)

- reduced sense of satisfaction and lack of professionalism (sense of reduced personal accomplishment)(1, 2).

These symptoms tend to be seen frequently among personalities which are characterised by the setting of unrealistic high performance goals, or unrealistic goals altogether, and ignoring warning signals from family and friends.
The Maslach Burnout Inventory Test is a validated diagnostic instrument.

One of the major research projects on the presence of burnout syndrome among physicians in primary health care was conducted by the EGPRN (European General Practice Research Network Burnout Study Group) in 12 European countries: Bulgaria, Croatia, France, Greece, Hungary, Italy, Malta, Poland, Spain, Sweden, Turkey and the United Kingdom (3). The research results were published in 2008 showing that 43% of the respondents had a high level of emotional exhaustion, 35% had a high level of depersonalization, and 32% had a low level of personal satisfaction/accomplishment. Burnout syndrome is seen as a common problem among family medicine physicians throughout Europe and it is followed with personal and work overloads, tendency to change jobs, and use/abuse of alcohol, tobacco and drugs. High burnout was found to be more likely in association with several of the variables examined, especially those relative to respondents' country of residence and European region, job satisfaction, intention to change job, sick leave utilization, the use/abuse of alcohol, tobacco and psychotropic medication, younger age and male sex. The strong relationships found in this study between low job satisfaction and burnout support the notion of focusing future research on improving job satisfaction rather than addressing burnout directly.

Surprisingly, little research has been conducted into interventions for burnout. Although research indicates that it is the organizational attributes that seem to have stronger associations with burnout, most interventions have in the past ironically been centred on changing individuals (4,5).

Paperwork; feeling undervalued; long waits for accessing specialists, diagnostic tests, and community resources; difficult patients; obligation to undertake night shifts at the emergency departments of hospitals and medico legal issues are well known stressors of family practice. Unfortunately, workplace violence caused by patients and their relatives are increasing and this is another demotivating factor for the physicians.

Measures to be taken

- improving skills and knowledge,
- improving conditions for work and rest,
- improvement of facilities and working conditions,
- increase in work motivation,
- changes in reward system,
- implementation of social programmes for self-protection,
- introduction of the system for psychosocial draining and stress relief after working day;
- improving organizational psychosocial atmosphere and recommendations to stop the development of burnout syndrome:
  ◦ introduction and implementation of new projects without waiting for the manager's consent,
  ◦ maintenance of good health habits including provision for adequate sleep and nutrition,
  ◦ acquiring meditation skills,
  ◦ developing a satisfying social life,
  ◦ establishing contacts with some friends possibly from other professions,
  ◦ desire to achieve results without expecting to be always the best,
  ◦ ability to lose without the feeling of self-underestimation and aggressiveness,
  ◦ ability of self-assessment without thinking about the opinion of others,
  ◦ openness to new experiences,
  ◦ ability to provide sufficient time to achieve positive results in business and personal life,
  ◦ ability to take responsibility,
  ◦ to read literature not related to the profession,
  ◦ participation in seminars and conferences where there is a chance to meet new people and share experience with colleagues,
  ◦ occasionally working together with colleagues with whom you disagree in professional and/or private life,
  ◦ participation in the work of professional groups and thus have the opportunity to discuss personal problems connected with recommendations on the work,
  ◦ nurturing hobbies which bring joy and satisfaction (2).

The American Association of Internist's proposed five basic measures which should be applied by every physician to prevent the development of burnout syndrome:
1. Care of yourself; first consider your own safety programme. Include fun or some other distraction in your work. When you are under stress, it is important to be with your family more than usual, and find time for your hobbies.
2. Define the boundaries/limits of your work, consider your practice and see where it is necessary to draw the line. Saying "no" to the patient and thus risk him leaving you and going to another doctor is healthier than constantly appeasing and satisfying unreasonable patient demands.
3. Determine methods for coping with stress. Select the person who you can confide in. If you don't want to discuss your problems with your colleagues, contact old classmates, former professors or mentors.
4. Analyse yourself, figure out what your values and desires are, what your skills are and what you like doing and what you do not like or hate doing. Burning often results from the imbalance between desires, assessments and interest on the one hand and job requirements on the other.
5. Overcome the complex that others are always better than you and that this happens only to you. The physician's job is very demanding and subject to constant changes. However, this happens in other professions as well. In order to be protected from the development of burnout syndrome the physician must develop skills which will help him/her to cope with constant change and to create the necessary defence mechanisms (6).

Take home messages

- Burnout syndrome is characterized by mental or emotional exhaustion, fatigue and depression, with a greater emphasis on psychological rather than physical symptoms
- Job satisfaction is an important element; it should be seen as an action point for further research and intervention
- Not only individual but also organizational interventions should be developed to overcome the problem

Original abstract

http://www.woncaeurope.org/content/or1337-burn-out-and-job-satisfaction-among-turkish-family-physicians

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66 – Assessing Patient Satisfaction in Primary Health Care – Reliable Information and Benchmarking

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Background

Health policy declarations emphasize the importance of patients' views and opinions in providing and developing health services (1-3). Patients´ opinions should be assessed regularly and used systematically as an indicator of the quality of health care (4, 5). We studied the feasibility and reliability of a questionnaire for data collection and as a benchmarking instrument in evaluating the opinions of Finnish primary health care patients. The aim was also to explore trends in patient satisfaction within primary health care.

Methods

A 15-year follow-up questionnaire survey was conducted among patients attending health care centres in the Tampere University Hospital catchment area during 1998-2013. The questions were based on international study findings (6) and adapted to the special characteristics of Finnish primary health care. There were originally 65 health care centres in this area, the total population being 1.2 million. Basic demographic data such as gender and age of participants were collected.

Data were always collected during the same calendar week in September. The reception staff distributed the questionnaire to patients visiting physicians and nurses due to illness from Monday to Friday between 8 a.m. and 4 p.m. Patients returned the anonymously filled questionnaires to a box in the waiting room after their consultation. The health care centres collected the questionnaires and sent them to the Department of General Practice at the University of Tampere where the data were recorded and analysed.

Patient satisfaction was assessed with the statement: "The service in the health care centre was so good that I can recommend it to my family and friends". The response alternatives were: "I totally agree", "I agree", "I disagree" and "I totally disagree". Since the objective in health service is complete satisfaction, we sought particularly to ascertain the proportion of respondents who gave the answer "I totally agree", this being considered to represent unreserved satisfaction with care.

In statistical analysis we used frequencies, percentages and cross-tabulation. The analyses were carried out with SPSS predictive analytics software.

Results

A total of 157 549 patients responded out of a sample of 363 464. The response rate varied yearly from 39% to 53%. Forty out of 65 primary health care centres participated in the study at least six times and 61 at least four times. Each health care centre was informed of its own results and also the combined results from the other centres.

The general patient satisfaction varied considerably among the centres (Figure 1).

There was a notable decreasing trend in patient satisfaction with care in Finnish health care centres from 1998 to 2013 (Figure 2).
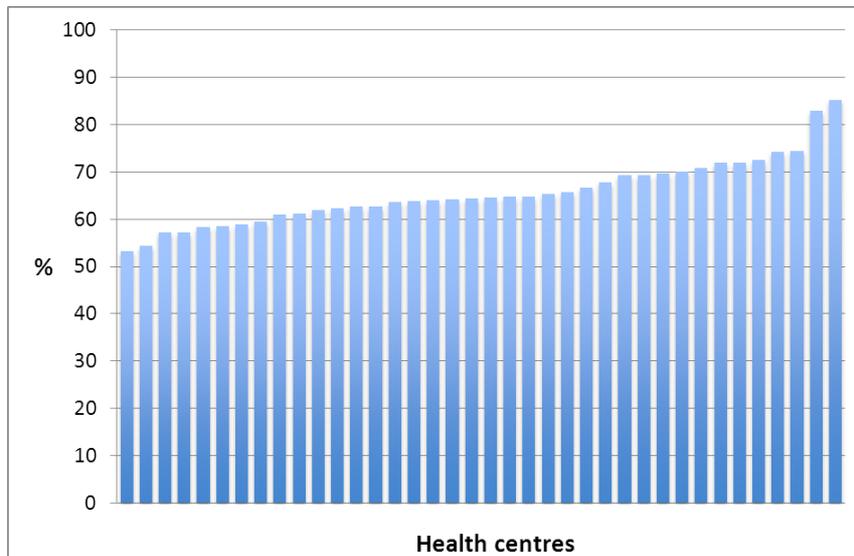
Figure 1. The variation of unreserved patient satisfaction (%) according to health care centre.
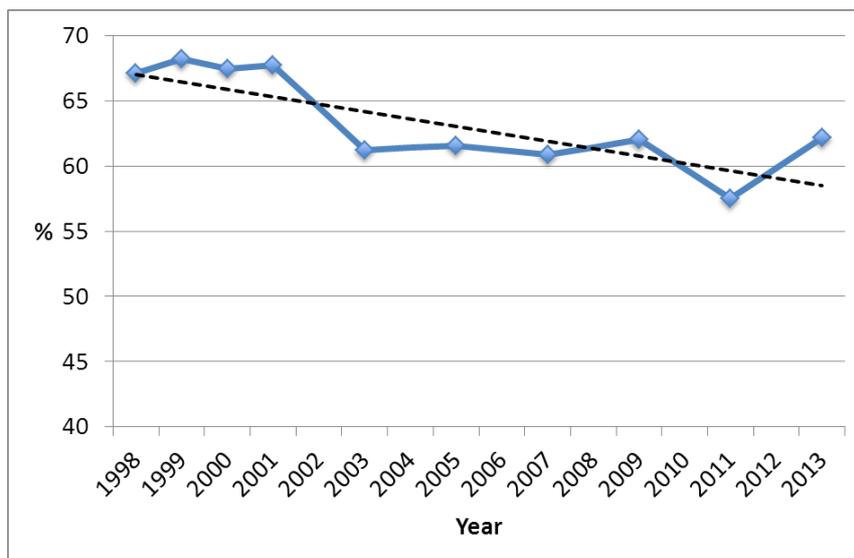
Figure 2. Linear trend line of unreserved patient satisfaction (%) by year.

There were no differences between genders in patient satisfaction. Sixty-year-olds or older were more satisfied (75% vs. 58%) than those under 60 years of age. On the other hand, satisfaction decreased most in the age group 60 years or older. Those patients who had a family doctor specifically appointed to them were more satisfied (63% vs. 57%) than those who had no specific doctor appointed by the health care centre for consultation.

Conclusions

The findings underline the importance of the patient in assessing primary care services in giving new and useful information on patient-related satisfaction within Finnish primary care.

We developed a feasible, reliable and comprehensive process for assessing patients' opinions in Finland. This process also provides a benchmarking instrument for primary health care centres.

Despite efforts by the authorities, in the past 15 years patient-reported satisfaction with primary health care has declined in Finland (7). In addition to a decreasing satisfaction, fewer patients have reported good access to and continuity of care. This fall-off in satisfaction is a matter for concern.

Finnish health care centres have undergone a number of changes during the study years. This may partly explain the falling trend in patient satisfaction with the services. Some of the changes in question were influenced by societal change, financial austerity and a lack of experienced primary care professionals (7).

The implemented and planned national health care programmes and legislation in Finland between 2000 and 2010 were designed to improve the health services. However the general strategic reforms with weak implementation methods might not have been able to resist the strong pressures within the service provision system (7).

The findings indicate that new means of coordinating and developing care in Finland are still necessary in order to improve satisfaction with primary health care. The authors also suggest that, at least those patients who need care most should be able to consult with a specific family doctor to enhance their satisfaction with and continuity of their care (8).

Take Home Messages

- Patients´ opinions can be assessed regularly and used systematically as a quality and benchmarking instrument in primary health care.
- Despite efforts by the authorities, in the past 15 years patient-reported satisfaction with primary health care has declined in Finland.
- Patients who need care most should be able to consult with a specific family doctor appointed to them to enhance their satisfaction with and the continuity of their care.

Original Abstract

http://www.woncaeurope.org/content/op-183-assessing-patient-satisfaction-primary-health-care-reliable-information-and

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67 – Risk, Uncertainty and Indeterminacy in Clinical Decisions

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Rationality, Science and the Legitimacy of Clinical Decisions

We present a typology of scientific uncertainty and discuss how uncertainty can inform patient-centred clinical decision-making.

The emergence of modern states in 18th and 19th century Europe came with a particular model of policy-making, the modern model (Funtowicz and Strand 2007). Within this model, the legitimacy of decisions is rooted in being based on scientific facts. The modern model captures the economic concept of rationality. Rational actors choose those policy options that, given the scientific facts, best meet their preferences.

Accordingly, if a patient can only survive if surgery is performed and he "prefers" survival, surgery is the unique rational choice. Rationality in this model has two distinctive features: The relevant facts are known with certainty (by science), and the preferences are also known (by the patient).

Gradually, the concept of objective probability replaced certainty in empirical science. Rationality and legitimacy were also claimed in the absence of certainty as long as probabilities could be quantified objectively in terms of frequencies, a procedure requiring formalization in risk-cost-benefit-analysis. Below we discuss several other forms of uncertainty. How can physicians and patients make rational decisions in the absence of quantifiable knowledge?

Risk, Uncertainty, Ignorance and Indeterminacy

"Risk" has many definitions. According to Knight (1921) uncertainty is reduced to risk when the frequencies of the outcomes are known. There is strict uncertainty when frequencies remain unknown. Ignorance is the lack of knowledge of relevant outcomes (incomplete knowledge of the event space).

The rationality of the modern model hinges upon the possibility of reducing uncertainty and ignorance to risk. Without probability estimates there is no unique rational choice. Bayesian concepts and methods cannot solve this problem because their subjective component compromises the original legitimizing force of the probabilities.

Finally, there is indeterminacy: no unique way of defining the system (Wynne 1992). Causal chains and networks are open and any choice of system boundaries has an arbitrary component (the neck, the person, the person and his colleagues, the person and his family). Moreover, any definition of system boundaries introduces its own sources of risk, uncertainty and ignorance.

Sources of Risk, Uncertainty, Ignorance and Indeterminacy in Clinical Contexts

There are numerous sources of incomplete knowledge in clinical contexts (Rørtveit & Strand 2001). The following questions may elicit some of them:

Risks: What frequencies are known for the prognosis of patients similar to mine, given this or that treatment?

Strict uncertainty: Is my patient representative for the group(s) for which I have risk information, or is he too different? Of which relevant peculiarities of my patient am I ignorant?

Ignorance: Which non-medical (or hitherto unknown) consequences of the clinical decision will feed back into health?

Indeterminacy: How did we define the clinical problem and system? If we had defined it differently, what would the relevant options and outcomes be, and which sources of risk, uncertainty and ignorance would they entail?

Jane, 71 Years, Slightly Overweight

The following hypothetical example is adapted from Rørtveit & Strand (2001): Jane (71) goes to her GP, allegedly for a "check-up". She is somewhat overweight, does not smoke and feels quite well. She walks the dog every day. On request she tells that her father died suddenly at age 55 "because of the heart", and her mother's brother "has angina". Blood pressure is 140/90 mm Hg. Clinical tests are normal except the cholesterol, being 8.5 mmol/l. Three months later, following changes to her diet, she presents with a cholesterol of 8.3 mmol/l. HDL 1.3 mmol/l and triglycerides 1.0 mmol/l. The GP is in doubt about what to do and whether medication should be prescribed.

Our point is not to indicate the correct decision. Indeed, there are several ways ahead. We shall begin by eliciting sources of risk, uncertainty, ignorance and indeterminacy.

Risk can be assessed by risk charts and risk calculators, also for this patient. Strict uncertainty is present, however, notably because the patient does not fit into the groups well characterized by existing epidemiology: she is a Norwegian woman >65 years without established disease, with unclear familial risk and living in a different country than those of most relevant studies (Selmer et al 2008, Cooper et al 2008, Petursson et al 2010). Although it is always possible to base the clinical decision upon the risk charts it is not necessarily legitimate, since the assumptions of the modern model are violated. Therefore, there might be other rational options.

Other options can be found by eliciting sources of ignorance and indeterminacy. This requires more knowledge about the patient, some of it quite reliable, some of it not. Will she continue to walk her dog if she is on medication? Will she think of herself as ill and will this have a (positive or negative) health effect? Did she only want a "check-up" and had nothing else on her mind (for example a small lump in her groin)? Why is she overweight, and is it a problem? What is important for this woman to be able to do in her remaining healthy years, and how can the GP help her accomplish her objectives? Such questions may clarify (a) other sources of uncertainty and ignorance with respect to the decision to medicate or not; (b) other options for action; (c) that the decision on whether or not to medicate, loses importance. Perhaps the GP should just give the medication to her without further ado and then concentrate his/her effort on Jane's other health aspects.

Conclusion: Creative Efforts May Be Rational

Knowledge is essential. We do not encourage unaccountable forms of judgement. However, when scientific uncertainty prevails, an approach where doctor and patient co-produce relevant knowledge about the patient may strengthen the knowledge base and the legitimacy of clinical decisions. Sometimes, this leads to a re-framing of the clinical problem in which uncertainties are less critical. Sometimes, uncertainties remain unresolved, actually giving GP and patient more autonomy to develop their own path ahead.

Take Home Messages

- Clinical decisions often have to be made in the presence of scientific uncertainty about premises and possible outcomes
- A model of rationality based on probabilities can be restrictive in clinical settings
- We present a typology of uncertainty and its application in a clinical example: risk (probability), strict uncertainty, ignorance and indeterminacy

Original Abstract

http://www.woncaeurope.org/content/ws-036-risk-uncertainty-and-indeterminacy-clinical-decisions

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68 – Do Practice Visits Have a Future?

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Assessment in visits in the various countries

Many countries have initiated some sort of visit programme depending on the level of commitment from the profession and on external pressure. In an individualistic culture of general practice more resistance to the introduction of practice visits can be expected. Practice visits require a culture of valuing feedback and reflection. Donabedian puts it succinctly with: "every defect is a treasure".

The UK had a first with the "What sort of Doctor" programme assessing GP performance, which included an extensive visit by three GPs as a requirement to become a "fellow" of the RCGP. It developed into a portfolio system requesting data to be entered in order to qualify for "revalidation" and re-registration.

The Netherlands' Practice Accreditation program was set up in 2001 by the Dutch College based on the validated VIP (Visit Instrument Practice management) to improve the quality of care in general practices. Each practice can voluntarily participate in the programme by meeting conditions regarding hygiene, telephone accessibility in emergency situations, use of electronic medical records and safety report incidents. The programme tests the practice on three aspects: practice organization, medical care and patient experiences.

European Practice Assessment (EPA)

The successful development with the help of EQUIP (European Quality Improvement Party, WONCA) of a European patient questionnaire (EUROPEP) led to much insight into the variation between countries. The next step was an attempt by Germany, Holland, The UK, Switzerland, France and Belgium to develop the Dutch VIP-method into a European approach. Practice organization/management was defined as: 'systems, structures and processes aimed to enable the delivery of good quality patient care', excluding clinical processes and clinical outcomes. 171 indicators within five domains of practice organization were identified, organized into 202 questions and allocated to specific questionnaires for the principal GP or practice manager, all GPs and all staff respectively. In addition, 30 patients completed the EUROPEP patient questionnaire. During a practice visit, an external visitor used an observer check-list and interview schedule for the principal GP or PM, and all data were entered into the computer. Thus the EPA-system was able to generate real-time practice feedback (provided by the AQUA-institute, Göttingen, Germany) to be discussed with the practice team. Developed in English the EPA visit-instrument was translated into relevant languages and adapted by each country.

Development worldwide

Many other countries started in the nineties to develop their own standards of care and practices were assessed against these standards. For example in Australia, Canada and New Zealand, practices

could increasingly provide their own data (internal auditing) to make independent, external visits more feasible. Meanwhile, Scandinavian countries have continued to value personal, formative mutual practice visits including observation of consultations using straightforward check-lists. The different countries and their respective colleges all appear happy with their approach to practice visits and agree it deserves a place in their CME-system and/or (re)registration. Almost no research, however, compares the methods on their effectiveness or uses the data for benchmarking. Also problematic is that the more selective the instrument becomes, the more local its use for research. Most methods appear to result in an improvement process using the quality or the Deming circle, but few of the methods provide benchmarking data.

Effectiveness of practice visits and accreditation or certification in Family practice

Practice visits mostly form part of accreditation programmes for healthcare providers (3). Accreditation affects the institution or practice and is more or less voluntary, while certification focuses on a specific norm that individuals or particular services should reach. In hospitals, accreditation and certification have proven more effective than 'no intervention', with accreditation scoring slightly better; but the results have to be interpreted cautiously (4).

A Cochrane review suggested that an audit and feedback system has a small positive effect on quality of care overall (5), but the added value of accreditation was not considered. In another systematic review Greenfield and Braithwaite found that accreditation can promote change, for example through the opportunity to reflect on organizational performance, and influence professional development. However, they reported inconsistent findings regarding quantifiable effects of accreditation on measures of clinical processes and outcomes.

Few rigorous evaluations of effectiveness of accreditation are available, particularly in primary care. This conclusion emerges from the review by O'Beirne et al. (6) on accreditation in primary care. Nevertheless, Szecsenyi et al. examined an accreditation programme (The EPA-program, adapted to Germany and Switzerland called Topaz) that focuses on practice management; they found improvements on several quality and safety measures regarding complaint management, analysis of critical incidents and quality development (7). A study with two cohorts including 138 Dutch family practices showed improvement of the quality of primary care for patients with chronic diseases, but few could be attributed to the accreditation programme (8). We conclude that there is growing evidence that accreditation has an effect, but we do not know at what costs and how much patients benefit.

Personal view on the coming of age of practice visits

Collins, an American anthropologist who visited 60 British practices in 1950, published a blistering report in the JAMA which was a turnaround for General practice. But visits can be a major, cumbersome enterprise. The profession has an obligation to make the procedure as "lean and mean" as necessary.

Practice visits were the first step towards accountability and transparency and ICT has increased the possibilities to make the visit more virtual and lean. Dutch practice visits shifted from internal audit and feedback to meeting standards. Consequently accreditation shifted more to certification and has become quite bureaucratic. Often GPs delegate required activities to their staff, which make you wonder whether visits may become more of a ritual to get protocols in place and to be able to tick them off rather than making an effort to change the culture of the practice. After 15 years, Dutch GPs are proud to have been assessed, feel safe to do so and take time to reflect in assessment/peer groups or quality circles. Ultimately visits could become obsolete, with mere data and patient feedback followed by reflection becoming sufficient to produce quality improvement and innovation. The future may be that practices have their own dashboard with data serving an ongoing improvement process.

Figure 1 Practice visit with auditors and FP

Take home messages

- Feedback and taking action on feedback have become an ethical imperative for a practice
- Practice visits with a validated tool can provide the necessary feedback on quality of care and patient safety and are complementary to self-assessments
- Consensus on framework and indicators for quality of care assist in benchmarking and comparison between practices, population/ regions and countries
- Practice visits / generating feedback should be lean and mean
- All GPs and staff always have to be engaged in the feedback and improvement

Original abstract

http://www.woncaeurope.org/content/175-practice-visits-controlling-doctors-or-improving-practice

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69 – Contribution of Drugs and Somnolence to Car Accidents with Victims: A Family Practice Study

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Somnolence at the wheel

- is a major cause of severe car-accidents
- is in most cases preventable
- Family practitioners can detect and prevent most cases
- therapy is expensive but cost effective.

In 2004 and 2010, the UN General Assembly and World Health Organisation (WHO) (1) reviewed the costs of traffic accidents, and unanimously approved a policy statement urging that in the years 2011 to 2020, increased attention be given to the issue of road safety. The road traffic injury fatality rates per 10.000 population were 16,6 in South-East Asia; 32,2 in Africa; 32,2 in Eastern Mediterranean; 15,8 in the Americas; 13,4 in Europe and 15,6 in Western Pacific. In Australia it has been shown that driver fatigue is responsible for 17% of all accidents, 30% of which resulted in deaths. In 2010, 41% of a sample of US drivers who responded to a telephone survey admitted to having "fallen asleep or nodded of" at the wheel. Road transport causes over 95% of travel accidents and 90% of travel fatalities in Europe (2). Obstructive sleep apnoea, excessive workload and lack of physical and mental rest are preventable causes of sleep restriction, driver fatigue, sleep attacks and falling asleep at the wheel. Run-off-the-road single car collisions and head-on collisions by failure to brake make up 16% to 20% of serious highway accidents (3). Drivers aged 18-22, nurses, medical residents, medical doctors and police officers are especially at risk. Of the medical residents who drove after a night shift, 29% reported falling asleep at least once while driving and 14% reported a motor vehicle accident (4). 61% of accidents and injuries and 36% of fatalities occur between 00 and 08 hours, most of these between 03 and 06 hours. Benzodiazepine hypnotics and zopiclone significantly impair next morning driving performance. Less than 6 hours nocturnal sleep is associated with increased risk of rear-end collisions and single-car accidents (5).

Maggie's Law in the state of New Jersey, US, is the toughest and most detailed law regarding driver fatigue. A driver who causes a fatal accident after being awake for more than 24 consecutive hours can be convicted of second-degree homicide, and sentenced up to 10 years in prison. People in the state of heavy tiredness drive emergency vehicles and take "controlled" risks (6). Doctors far too often turn a blind eye to impaired driving ability of young attention deficit hyperactivity disorder patients, and of patients with a severe depression or mania (no reference). Different studies performed in many countries show a remarkable similarity of 8% to 10% of psychotropic substances in the blood of injured drivers: benzodiazepines, Z-drugs, antidepressants, antipsychotics, Parkinson drugs, antiepileptics, sedative anti-histamines, antidepressants and thymo-regulators in people who were not warned at all of the well known vigilance deficits they create, especially in combination with alcohol and illicit drugs such as

cocaine, cannabis, designer drugs.

The Driving under the Influence of Drugs, Alcohol and Medicines project has the acronym DRUID.

Sleep apnoea syndrome has been identified as the major cause of habitual drowsy driving with a relative risk op six than can be reduced five times with continuous positive airway pressure and a major increase in health care expenses.

Restless legs syndrome, periodic limb movement in sleep, acute and chronic insomnia are preventable causes which cause dozing and micro-sleep at the wheel.

Focusing on these illnesses in primary care could reduce the toll of often very severe vehicle accidents up to 20 to 30%. The EQUINOX cross-sectional study was carried out by primary care physicians across ten countries. It highlighted the link between insomnia and domestic accidents, work accidents and car accidents. Karolinska Drowsiness Score and Karolinska Sleepiness score correlate well with on-board expert driving instructor's judgement of prematurely terminated night drive as a result of sleep-related imminent danger.

Open window or loud music have little effect. Two or three cups of coffee, about 200 mg caffeine, can delay drowsiness for half an hour after nil sleep and up to two hours following sleep restriction. Prophylactic naps are effective, especially during night work.

Figure 2. Distribution of the average number of fatigue-related road accidents and casualties (injuries + fatalities) on Poland's national roads (per year) by hour of the day in 2003–2007.
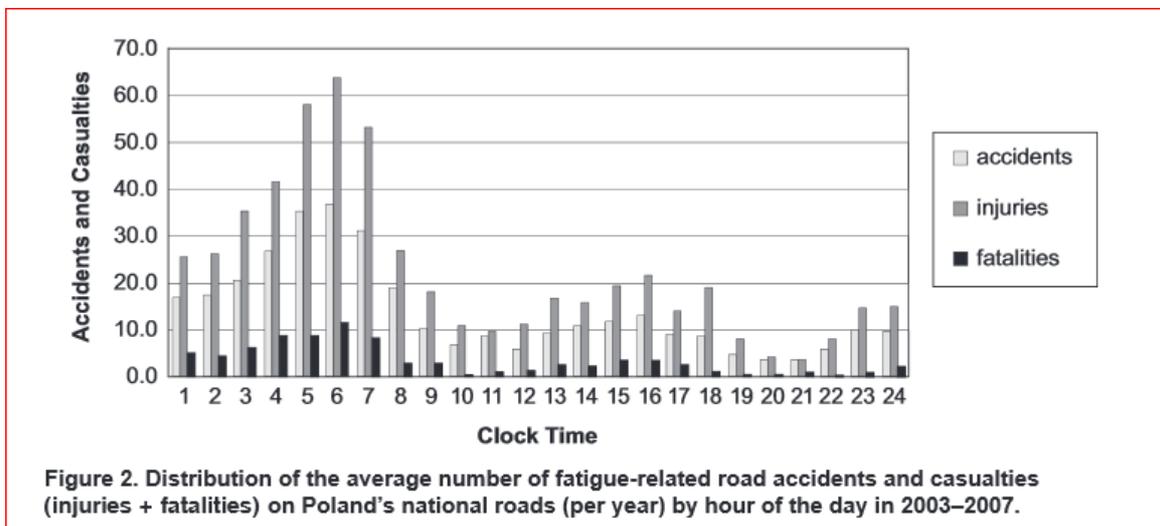
JOSE 2013, Vol. 19, No. 2 p.303

An additional but until now never published caveat: many countries introduce a driving licence with points. The younger generation who have caused a single car accident while intoxicated with cocaine, cannabis, designer drugs, alcohol and most often a cocktail of these can press elderly to declare they were drowsy drivers.

Take home messages

- Family Doctors, surgeons, and police-officers are especially at risk;
- Not all single car accidents are suicide attempts;
- Sometimes, elderly drivers declare having fallen asleep at the wheel to hide alcohol and drug use of youngsters;
- As obesity increases, sleep apnoea increases accordingly;
- Family practitioners should motivate people to use CPAP.

Original abstract

http://www.woncaeurope.org/content/293-contribution-drugs-and-somnolence-car-accidents-victims-family-practice-study

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70 – Talking about Medical Errors: the Bigger Picture

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Healthcare professionals involved in quality improvement focus more and more on active patient participation in the care process. The point is not patient satisfaction, but to get the patient involved as the central actor to improve outcomes in all quality dimensions, especially in safety.

The patient has a key-role in hospitals and even more so in primary care: When will he call and whom? How does he express and understand his illness? Will he/she observe the prescriptions?

These questions appear essential when dealing with the risk issue. Previous studies focused on adverse events (AEs) in primary care showed that some risks can be reduced if the patient is well listened to, informed and guided by the surrounding professionals.

At the 2014 Lisbon conference, we presented a French epidemiological study ESPRIT (1) collecting AEs in general practice and drawing up a typology. This study showed that AEs are frequent in primary care (1 every 2 days, detected by a GP in his practice), fortunately with no resulting consequence to the patient in 3/4 cases.

Some AEs' examples from this study suggest that the physician-patient interaction and the information given to the patient are important to the risk management in the outpatient health care system:

A 78 year-old patient, treated for glaucoma, consults her GP for a prescription renewal. By the end of the consultation, he proposes to substitute benzodiazepine for an anticholinergic drug. The glaucoma is listed in the patient's history but the software alarm does not work when writing the prescription.

This error resulted in no adverse consequence because the patient, being aware of frequent drug contraindications with glaucoma, read the notice and decided not to take it.

The key here was the patient's health literacy, her ability to draw a conclusion, and the relationship's quality enabling the patient to speak with her doctor about it.

While electronically composing a prescription, a doctor makes a slip in the alphabetical medication list and validates Temesta* instead of Temerit* just above on the list. Reading the prescription together, the patient observes she does not recognize this drug.

Joint reading of the newly-issued prescription is a secured practice and signals a good doctor-patient relationship.

Such good practices could be more widespread: a 2013 report from the WHO (2) gives the results of a Polish study exploring the knowledge and information the patients have at hand about their treatments: only 39% of the patients with chronic diseases knew the name and dosage of the

prescribed drugs, 2/3 had a talk about it during the consultation - mostly (93%) at their own initiative; only 6% reported that the physician mentioned or discussed the possible drug interactions.

Diagnostic procedures and investigations also require some information exchange at the right time with the right actors:

A 70 year-old patient consults his GP for diarrhoea associated with poor general condition. The physician orders a colonoscopy for his patient as soon as possible. An appointment is organized but two days prior to the exam, the endoscopy centre finds out that the patient had not seen the anaesthetist, and postpones the exam for a month. The patient was neither aware of the need for an anaesthetist consultation, nor that he had to make the appointment himself.

This was a near-miss: the patient informed the GP, who obtained the anaesthetist consultation in time for the initial endoscopy date.

Mr Y, 80 years old, consults for his anti-hypertensive treatment renewal. Some hours later, the pharmacist calls, wondering about the double treatment, duplicating the nephrologists', ordered two weeks before. The GP had not received any mail and the patient did not mention it.

Here, the pharmacist's mediation averted any harmful consequence. The communication between physicians is an issue; however the patient did not provide the link between them. What exactly did he know and understand about the treatment change?

Sometimes, the patient situation is awkward to explain, and tricky to understand:

A teenager, 14 years old, comes with her mother for a delayed period. In front of her mother, the girl declares she never had intercourse. The physician does not order a BHcg level. Some weeks later, the patient comes again and the diagnosis of pregnancy is made.

Communication between patient and physician is a key issue in this diagnosis delay, an incident most feared among GPs. However, one cannot assume that a face-to-face interview would have helped the teenager to speak out.

Obviously patients could significantly contribute to their own safety with better information and understanding of their disease and treatment.

The studies quoted suggest enhancing this new role for the patient, already applied in chronic disease management. However, practitioners often regret the constraints of time in training and educating their patients (3).

But patient safety, transparent communication and mutual patient-doctor trust, are not always easy to conciliate, when it comes to the inherent risks linked to care activities. A Danish qualitative study (2013) shows that in oncology, patients and physicians talk little about safety (4). Exchanges are limited to medication adherence and some drug side effects. According to the physicians, talking about risks, would add unnecessary anxiety.

With regard to the patients,, there is a large array of feedback, from the continuous demanding of information to keeping to the strictly necessary: not everybody "wants to know" …

Threats to the doctor-patient relationship become more obvious in the case of more direct involvement of patients in safety management such as error reports. Patients do not feel comfortable challenging a professional they trust. They may fear coming across as "difficult patients" and decreased quality and outcome of care.

Today general practitioners seem open to the idea of giving a larger and more central place to the patient (5), provided that such involvement does not detract y responsibility away from doctors (6).

Building a comprehensive action to facilitate AE reporting and their analyses in quality circles or other QI programs could promote real cultural change and good practices, improving patient-physician communication regarding medical errors and risks as well as preventing harm to the patient.

Take home messages

- Adverse events are frequent in primary care, mostly with no harm to the patient.
- Better informed and educated patients could significantly contribute to safety improvement.
- Let us get familiarized with preventing, reporting and analysing medical errors.

Original abstract

http://www.woncaeurope.org/content/333-system-medical-error-disclosure-promoting-quality-care-through-partnership-between

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71 – The Optimal Practice Size Revisited – a Critical Appraisal of a Topical Discussion in the Light of Academic Leadership in Primary Care

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Practice size has been an issue in general practice for as long as most of us can remember. Although the discussion apparently hinges on the provision of quality of care and maintaining clinical experience, more mundane conditions like the number of general doctors (GP) in relation to the population, or the GPs' ability to generate an income are never far away from the argumentation. There remain substantial differences in the numbers of GPs, proportional to the population [1], and this is also true for the performance of GPs in (primary) health care [2]. But there is no correlation between GP density and actual performance and never has been: in no way are the smaller or larger numbers of patients to be cared for a determinant of the care provided [3].

Against this background, a Workshop was run at the Kos WONCA Europe conference in 2005 on Optimal Practice Size. What To Preserve Of Single Handed Care? [4].The workshop reviewed the available literature and then moved to explore the personal experiences of participants in their own practice setting. The discussions amongst the universally proud GPs were animated, and yielded a diversity of views. And needless to say, that the exchanges were highly valued. But with full respect to the workshop instigators and participants, one might question the value of the exercise: posing the same question over and over again seldom leads to a new answer.

The occasion of this World Book of Family Medicine offers an opportunity to revisit this and explore alternatives to approach the core values of primary care. In this, four angles come forward from which to develop these alternatives.

Variation and value

Variation is a powerful input to examine practitioners' performance, trigger discussion on alternatives and effectuate change [5]. Variation appears to install feelings of unease, differing from one's peers is seen as a sign of underperformance. Yet, the very core of primary health care and general practice is in tuning to the needs of the individuals and the community that is served [6]. As communities' and individual needs differ, therefore general practice should differ in approaching these needs. Numbers of (general) practitioners per population is part of the variation in the context in which primary care operates. Not 'practice size' but how apt the practice is tuned to the needs of its patients and population should be the core of the discussion.

The lone ranger versus the leader of the pack

Single handed practice in the community has been the starting point of general practice, but for decades there has been an evolution in primary care from the

general practitioners to the general practice, from an individual to an institutional level. This is in line with the motor car replacing the horse and carriage as the practitioner's transportation, or the telephone with the knock on the doctor's door to invoke care in the middle of the night. Rather than redoing discussions of old, it might have been more appropriate to explore the innovation of practice organisation: how GPs can shape and lead the development of their practice to be able to respond to the challenges in nature and volume their practice environment poses.

General practice or primary health care

This orientation is the more important in the current development in which mono-disciplinary general practice is replaced by an integrated multi-disciplinary primary health care structure. Interconnectedness within primary health care, with hospitals, public health and with other sectors in society is required to fulfil the contemporary mission of promoting and securing health of individuals and populations [7]. This is a generic principle that has to be translated to the conditions on the ground in which GP and practice work and the numbers to consider have to be related to the multi-disciplinary team.

Experience and performance

A returning argument in the opinions about practice size has been the building and maintaining of clinical experience. It goes without saying that hands-on exposure to patients and their health problems are important in developing and shaping clinical reasoning. But exposure in itself does little to generate skills. For this, a process of critical reflection is required, and it is in the quality, not the quantity of these reflections that GPs' professionalisation comes about. This is the more decisive, as the most important clinical decisions may concern the most infrequent health problems. For this, no practice size will ever cater, and exposure alone can never secure the adequacy of clinical decisions. This presents in my view the most compelling reason to get away from the 'ideal' practice size, recognise the vast importance of building skills from clinical exposure and turn to more sophisticated methods to do so. Attributing critical decisions to experience or intuition [8] is mystifying, unhelpful and potentially dangerous. It is exactly in this line of thinking that discussions on practice size have focused. The engagement of experienced GPs in the workshop in 2005 might have made better use of their intellectual skills, by getting to the heart of decision-making in uncertain situations and with few available data – better than fixating on a number for the size of their practice.

Conclusions

Looking back objectively, the workshop in 2005 might have been better directed at the leadership role of GPs – in transforming the context of their practice setting from single-handed, mono-disciplinary to integrated multi-disciplinary teams; in exploring the nature of functional differences between practices; and in focusing on the inner-mind processes of how their decisions under real life circumstances come about – rather than fixating on an ideal number criterion. But GPs work with and in time to solve problems, and this makes 2015 the first opportunity to address these issues after all.

Take Home Messages

- Single-handed general practice is a feature of the profession's past, as a consequence of its ever more prominent role in health care.
- Size and disciplinary composition have to be determined by the needs of the practice community.
- It is not possible to build expertise and knowledge simply on experience from exposure to primary care health problems.
- As primary care has to direct and adopt the local needs and conditions, practice variation can be an indicator of quality as much as lack of quality.

Original abstract

http://www.woncaeurope.org/content/777-wo-optimal-practice-size-what-preserve-single-handed-care

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72 – Revisiting "Home Visits: Your Practice on the Road"

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Home visits have been a central part of medical practice and were once a standard of practice (1). The number of home visits made by physicians has consistently declined, being today less than 1% of all patient-physician encounters, with the average doctor conducting fewer than one house call per week in the United States (2). In most European countries, home visits are increasingly becoming an exception and common reasons cited for this decline are inadequate compensation, the time required, limitations of technological support and poor physician training and exposure in this area.

Today there are 174 million people aged 65 years or older, in Europe and North America. A further increase of about 93 million people is expected within the next 20 years; a fact that illustrates the acceleration of an ageing population (3) and that a considerable number of persons will live home-bound, reinforcing the need for home visits.

This reality requires a thoughtful definition of the rationale for home visits in order to improve efficiency of care and optimization of physician's time and community resources, as the effective use of home care services has become a core competency for family physicians (1).

Home visits: who and how?

The major types of home visits reflecting patient-related situations viewed as a priority by the general practitioner (1):

- patient assessment: polypharmacy, comorbidity, immobility, social isolation, frailty, suspected neglect;
- illness management: emergency, acute and/or chronic conditions;
- dying patients: palliative/terminal care, grief support;
- post hospitalization follow-up;
- and preventive house visits.

A cross sectional study (4) which meant to evaluate which older people benefit most from a comprehensive geriatric assessment, concluded that general practitioners should, at least, target older people with ≥ two chronic conditions, using ≥ five medications, being female of an older age, living alone and less educated.

An effective home visit implies developing a systematic approach that includes advanced planning, minimal interference with daily practice, establishing the reason and type of home visit, gathering the necessary equipment and establishing a formal hour for the visit.

The INHOMESSS mnemonic (1) still reflects the components of a holistic house call and helps the physician remember some items to consider in a possible check-list:

Impairments/ Immobility, Nutrition, Home environment, Other people, Medication, Examination, Safety, Spiritual

health and Services. In the majority of house visits only specific elements will be addressed, allowing the conciliation between patient needs and the physician´s agenda.

The equipment recommended for a house call should include: map, mobile phone, physical exam instruments and documentation as dictated by the patient and type of home visit. The technological evolution has made computers easily portable and internet connection widespread. This previously considered "optional medical equipment" has become fundamental for daily practice, allowing accurate record-keeping and access of important patient information and clinical tools for evidence-based decision making.

Overcoming barriers

Scheduling visits in geographic clusters and choosing a specific day/hour for home visits allows time optimization. The restricted diagnostic options available in the domestic setting are being overcome by the use of easily accessible technology, as the ever-expanding contents of the modern-day "black bag", which can include everything from a Blackberry to portable IV medications, keeps evolving. Concern about personal safety is reduced if the physician knows the community, makes daytime visits, carries a mobile phone or is accompanied by other health professionals.

The establishment of a "home visits curriculum" should be considered during medical training. The use of role models as well as mandatory and longitudinal clinical time provision of home visits and residential care will produce both challenges and opportunities. This will allow family physicians to become more confident when providing home care.

What does the evidence tell us today?

The number of home visits is continuously declining while the primary target group, older people with multimorbidity, is growing. These contradictory findings are sustained by several studies published in the last two decades, which have analysed the number of home visits from either quantitative surveys or practice data (5).

Since 2000, five English language systematic reviews have been published with conflicting results. Some reported that home visits and primary care programmes did not affect mortality, physical and psychosocial function, health status or health care use and costs; others concluded that these programmes reduced mortality, admissions to long-term care facilities and functional decline (6). Home visits were not consistently associated with differences in mortality or independent living; investigations of heterogeneity did not identify any programmes that were associated with consistent benefits, although the poor reporting of intervention components and delivery, did not allow for the possibility that some programmes may be effective (7).

Looking to the future

Quality of primary health care must be maintained while improving the quality of home visits. This modernisation implies designing effective and scalable programmes, developing education and training skills of general practitioners and their vocational trainees, investing in research and in continuous evaluation of the implemented programmes (5,6). Learning and adapting from specifically designed home-based primary care programmes can considerably affect patient, caregiver and systems outcomes; high-quality evidence from the Veterans Affairs System in the United States shows that these programmes can substantially reduce emergency department visits, hospitalizations, and long-term care admissions (8). Making theses outcomes reproducible would be critical to maintain the quality of life and function of the elderly and home-bound population, as well as to allow the sustainability of the health care system worldwide.

Take home messages

- The ageing population make home visits increasingly necessary and their rebirth must be seen as an essential part of a community integrated care programme.
- There are suggested economic benefits by eliminating unnecessary emergency room visits and by ensuring adequate health care for housebound elderly, although these presumed advantages must be critically addressed by further research.
- The challenge concerning home visits is making them cost and time effective, attractive, unthreatening and rewarding for family doctors.
- Continual medical education and resident training programmes are fundamental for providing physicians with the attitudes, knowledge and skills to conduct home visits effectively.

- Home visits may provide benefits to patients and physicians, with their potential to re-establish a more intimate doctor-patient relationship. The opportunity of taking care of patients in their own home allows the perception of their living environment, support system and overall safety which gives the family doctor an insight that cannot be gleaned from office or hospital visits.

Original abstract

http://www.woncaeurope.org/content/926-po-home-visits-your-practice-road

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73 – Re-training of GPs: A EURACT Survey

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Medical education's ultimate aim is to supply society with knowledgeable, skilled and updated professionals who put patient care above self-interest, and undertake to maintain and develop their expertise over the course of a lifelong career (1). Many areas of education and training bring together both functions within a learning experience. The two may be differentiated by thinking of: education as being about doing better, training as being about taking on new tasks (2). In recent years, major components of healthcare have been transferred out of the hospital and are now only found in the community. Chronic diseases are managed primarily in community. This experience is unique for the trainees (3).

At the postgraduate level, lectures are of even less value than at the undergraduate level, yet they are used just as frequently. Trainees gain far more from small group teaching sessions and on-the-job training than from, for instance, revision courses for passing membership exams. In the UK, primary care has tended to lead the way with its long-established one-to-one training relationship and regular group-based release courses, but effective education and training is also possible in secondary care and the training need not be one to one. It is common practice to train senior doctors, junior doctors and medical students concurrently (1) and training requires a multi-professional approach in primary care (2). Flexible training often has low priority in general practice departments (4). Doctors are eligible for flexible training if they have well-founded reasons such as young children or disability (4).

Educational needs assessment

Educational needs assessment tools have been developed to help primary care practitioners identify their learning needs (2). Comprehensive check-lists or organizational development tools can help any organization to identify its learning needs from individual practitioners' or the organizational perspective. The outcome should be to evolve learning culture while addressing these needs. Local coordination of the training programmes helps to reduce duplication of resources. In Turkey, during the first phase recertification programmes of primary care doctors, needs assessment was used for the planning of the second phase retraining programme (5).

Evidence based training

Best evidence medical education has been defined as the implementation by teachers in their practice, of methods and approaches based on the best evidence available (2). Guidelines can be used for this purpose and impact of training on the practice, prescriptions, and cost-effectiveness can be evaluated (6).

Educational Plans and Monitoring

Assessment of your training needs as a teacher, or other health professionals must take account of the differing priority areas of the government, your health organization as well as the influences on public. We need to decide how to balance the priorities (2). A supervisor works with the learner to develop and facilitate an educational plan that addresses their educational needs and monitors following training (2).

Teacher in primary care

A teacher does not only need sufficient knowledge, skills, but also the right attitude and understanding of the overall context and cultural environment to be able to make the teaching relevant to the learner's needs (2).

Assessment of learning in General Practice

Assessment is a measurement of achievement of progress towards meeting defined educational objectives. Formative assessment to give feedback to learners in order to guide progress may be used. Summative assessment can also be used. Programme evaluation and in-training assessment are necessary to be flexible in the primary care. Validity, reliability, educational impact, acceptability, feasibility, and efficiency are the characteristics of good assessment for general practitioners. Check-lists, rating scales, and portfolio may also be integrated. General Practice requires proficient team work, therefore team and the patients should assess the trainee (7). Objective structured clinical examinations can be used with simulated/standardized patients (8). Continuing professional development (CPD)

The aim of continuous medical education is to sustain the professional development of general practitioners and help them to provide high-quality patient care and to keep up to date with developments in general practice (4). The accredited professional development programme is designed as a new approach to CPD in order to offer ongoing support as general practitioners continue their professional development as part of their everyday practice (4). The process is a semi-structured process that will help general practitioners to collect all information and evidence that will be required for annual appraisals and revalidation over a five year period (4).

Lifelong learning

The structure of the programme is to encourage learning for the individual's needs. It is well focused on the day to day work of the average GP. This programme allows GPs to plan their learning and also provides evidence and documentation which will be useful for appraisals and revalidation in the future (4).

Turkey

In Turkey, physicians who choose to specialize in family medicine or other specialties have to pass a standard exam, which allocates them to a residency programme according to their score. The physicians who do not pass the specialty exam are also granted a certified family doctor position with a smaller salary than specialists in the National Primary Health Care System. Both family medicine specialists and certified family doctors work in primary care in rural and urban areas. In Turkey, family medicine is a relatively new specialty having been established through legislation in 1983. The first vocational training programme was started in 1985. Retraining is mandatory for certified family doctors, but not for family medicine specialists. Starting with pilot provinces, retraining of the 25 thousand certified family doctors has been ongoing since 2004 all over Turkey, based on needs assessment and guidelines for primary care (5).

Take home messages

- Training requires a multi-professional approach in primary care.
- Trainees gain more from small group teaching sessions.
- Educational needs assessment tools have been developed to help those in primary care identify their learning needs.
- Guidelines can be used for evidence based training.
- The aim of continuous professional development is to sustain the professional development of GP's and to keep up to date with developments in general practice.

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74 – Primary Care Based Case Management – Current Research and Implications for Daily Practice

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Disease, case or care management? A history of terms

What is meant by disease, case or care management? A variety of definitions behind these terms often hinders a cross-national or even a national comparison of effects of these care models on patient outcomes. We do not want to aggravate this problem by providing new definitions for these terms. In contrast, a short overview of the history of these terms and the concepts behind them will help to clarify things.

Historically, "case management" is the oldest of these terms first used during the de-institutionalization movement in psychiatric care in the 1970's. With shifting the focus from in-hospital psychiatric care to community based psychiatric care, concepts were needed that actively approach "complex", "critical" or "high-risk" patients in order to monitor their health status continuously. During the 1980's, case management was introduced nationwide in the USA, resulting in the foundation of the Case Management Society of America (CMSA) in 1990. The CMSA defines case management as a "collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes" [1] including social services and health services.

The term "Disease management", however, was invented and implemented by US pharmaceutical companies in the 1990's to foster evidence-based care (mainly medication) for specific chronic diseases. Besides its focus of single diseases, disease management programmes vary enormously by both intention and intervention.

Bodenheimer and colleagues [2] defined the term "care management" in contrast to "case management" to distinguish concepts focusing on patient (health) care from those focusing on social care. However, case management and care management share the same generic process of assessment, care planning, action/intervention and monitoring.

Case management – basic concept

The basic concept of case management (see figure 1) comprises of 5 steps:

a) Case finding

Evidently, the highly resource-intensive process of case management cannot be offered to all patients. Therefore, identification of patients most likely to benefit from case management, a process called "case finding" is crucial for the success of a case management intervention. The most common case finding methods are referral, patient survey/health assessment or predictive modelling of future adverse events (e.g. hospitalizations).

b) Assessment

A structured assessment of patients' needs and resources is the first step of case management. It is often performed by nurses or other non-physician health professionals.

c) Planning

Once needs and resources of a patient are evident, comprehensive care planning together with patients and caregivers is essential to focus case management on problems which could be addressed by the intervention. Long term goals and short term actions plans should be laid out explicitly. Planning often includes supervision by physicians, particularly if medication regimes have to be changed.

d) Action

In every case, specific actions have to be undertaken by patients, caregivers or health professionals (e.g. self-monitoring of symptoms by patients, modified medication regime etc.)

e) Monitoring

Ongoing pro-active monitoring of patients` symptoms, health status and progress in achieving his or her goals is crucial for case management. Monitoring is often performed by nurses via telephone on a monthly or bi-monthly basis. Thereby, clinical deterioration of patients can be detected early.
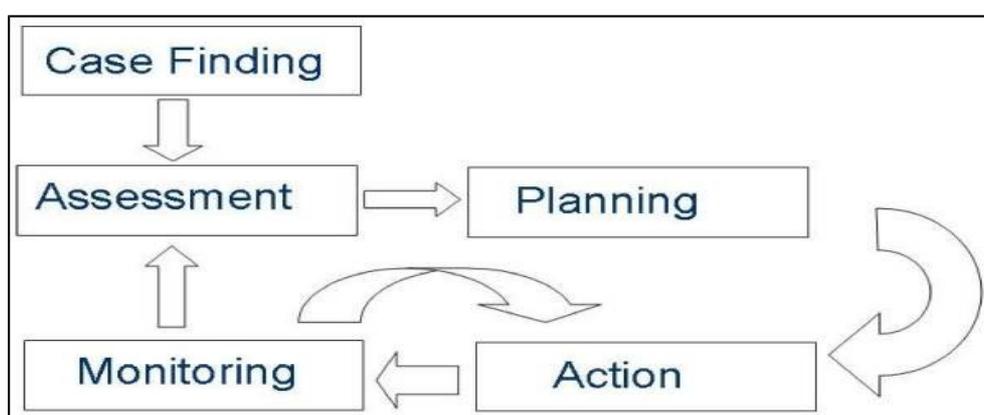
Figure 1: Basic concept of case management (3)
(Freund *et al. BMC Health Services Research* **2010 10:112   doi:10.1186/1472-6963-10-11**).

Case management should be primary-care based.

The basic principle of patient-centred, comprehensive care for the most vulnerable patients meets the core ideas of family medicine as defined by WONCA [4]. Therefore, case management is and should be part of primary care management of complex patients.

Case management can easily be provided by specially trained non-physician health professionals. Nurses are the most common profession providing case management in the US, the UK and in many other countries. But as case management is mainly focused on complex, high risk patients, health insurance companies have special interest in offering these programmes in order to improve health and to reduce costs. This has led to the development of vendor-supported, external case management programmes offered by a number of health maintenance organizations (HMOs) in the USA. However, patients' acceptance of these programmes is much lower when compared to case management programmes offered by "their" primary care clinics [2].

What does research say?

In 1998 the first literature review on primary care-based case management concluded that none of the programmes supervised by generalists showed a positive effect on resource use [5]. Since then, evidence on primary care-based case management has been expanded by a large number of studies. First results of an ongoing systematic review show positive outcomes of primary care-based case management particularly in high risk patients [3]. Core features common to many of the more successful models, include: systematic identification and intensive care management

(including frequent face-to-face contact) of high-risk patients; primary care physicians collaborating with on-site registered nurses and other staff (all working in redefined roles "at the tops of their licenses"); health information technology that facilitates coordinated care; engagement of patients and their family;

caregivers in evidence-based health education and self-management; easy 24/7/365 access to primary care for emerging problems; well-coordinated transitional care following hospital discharges; comprehensive medication management; and the integration of community-based support services into health care [6].

Future developments may include primary care based case management supervised by nurses [7] as well as more sophisticated ways of case finding including both prediction of patients' risk of adverse outcomes and their ability and willingness to participate in case management – a concept called "care sensitivity" [8].

Take home messages

- Person-centred, comprehensive management of vulnerable patients (i.e. "case management") is a core element of primary care.
- Primary care-based rather than vendor-supported case management is well accepted by patients and physicians.
- Case management should focus on high risk patients with sufficient "care sensitivity" (i.e. willingness and ability to participate).
- Case management is a multi-professional approach that engages non-physician primary care team members to work "at the top of their license".

Original abstract

http://www.woncaeurope.org/content/ws-03-primary-care-based-case-management-%E2%80%93-current-research-and-implications-daily-practice

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75 - How Would Citizens Develop the Health Strategy of Their Country?

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Introduction

Answering this question could give more importance to a bottom-up health strategy, allowing citizens the right to choose and decide the most appropriate health care system adapted to their needs. Is it possible in a health world dominated by centralized and top-down policies under the pressure of economics, which forget that Health is a value and not only cost-factor? Are there successful examples?

Individual behaviour

First of all we can assume that individual changes in lifestyle will improve health outcomes. It is not really «strategy» but it certainly does have an impact. An individual is able to do a lot to improve his well-being starting early in life. The health behaviour of a pregnant woman may influence the lifelong mental and physical conditions of her baby. Early, adapted and repeated interventions at school (1) regarding better nutrition and physical activities can improve the health status of children. Self responsibility at any age moving towards healthier behaviour (e.g. stopping tobacco) contributes to better health outcomes of a nation.

By interfering with the mode of urbanization, demanding a reduction in car exhaust emissions, decreasing air pollution, protesting against fracking, and other environmental acts, citizens can prevent ill health-related measures.

Actions against global warming, such as bringing fossil fuel consumption to an end and investment in alternative energy, are an emergency according to the latest report of the Intergovernmental Panel on Climate Change in March 2014 (2). Such actions are necessary to prevent increasing illnesses from food-, water- and vector-borne diseases. Citizens can thus individually and indirectly weigh on health policies.

Democracy and peoples' input

At national level, with a direct democracy system like in Switzerland, a group of citizens can modify a law or the direction of a policy. Facing an increasing shortage of primary care physicians and a loss of consideration in comparison to specialists, the Swiss Association of Family Doctors put forward a popular Initiative with 200,000 signatures in 2010 to change the Constitution, defining primary care as essential for the Swiss health system and demanding that the State assure better education and financial support for family medicine. When a minimum of 100,000 Swiss citizens put forward such a petition it obligates the Government and the Parliament to propose new laws or to apply the petition. Finally, all citizens have to vote on it. This took place on May 18th, 2014 in Switzerland and the new constitution was approved by the people with a majority of 88%. Nowadays, there is a directive in the Swiss health system clearly based on primary care and obliging the Authorities to legislate on

better education and financial incentives for family doctors. The first concrete achievement occurred in October 2014, with the provision of around 150 Million Euros from specialists' budget allocated to family doctors. Such an example proves that the mobilization of citizens can influence a national health strategy. Could the Swiss example inspire other countries? Every situation is different…

In England in 1996, randomly selected groups of citizens were questioned about their views on the current state of their country's health strategy and on their ideas for its development compared with the government's 1995 plan. In conclusion, citizens «should contribute to but not determine health strategy». Citizens may produce fresh ideas but perceive as inadequate the existing arrangements to screen certain types of cancer, although such screening is evidence based (3). This proves that individual points of view without a global perspective do not define a strategy.

The increasing complexity of health care organizations combined with the pressure of costs seems to anaesthetize individual initiatives. Or are the health care systems still comfortable enough not to mobilize the population?

In Canada in 2002 (4), dialogue sessions with members of the public were used to help define a new health policy. Twelve sessions of a full day of dialogue were held across the country, each with about 40 citizen participants aged 18 years and over, randomly selected to provide a representative cross section of the Canadian population. People working in the healthcare system were excluded. Combining their roles as patients, taxpayers and members of the community, participants reframed the healthcare contract, redefining both individual and collective responsibilities. This had an important impact on the ensuing debate, giving for example a stronger direction for primary care. In conclusion, such engagement of the public may be costly but an essential requirement when opinions are unstable and difficult decisions must be made.

An article published in 2004 by De Vos and colleagues (5) analyses the evolution of the European health systems. The authors demonstrate how, since the 1990s, the European Union has built a strict financial and political straitjacket, forcing these systems to carry out privatization and cutbacks. Reform measures can be divided into three interdependent categories: 1) the increasing influence of governments on health care organization, to enable restructuring; 2) measures aimed at reducing public expenses, including higher financial contributions by patients and restrictions on the range of services provided; and, 3) measures that establish competition and hide or open privatization of services and insurance systems.

The De Vos et al publication is already 10 years old, during which time the economical crisis of 2008 has taken place , with no change whatsoever to this trend.

Is this not a contradiction with the growing collective needs? Is it not a threat to health and social security? The defence of the European welfare state is one of today's most important challenges. Are citizens aware of the dangers and able to mobilize? Finally as voters, we all have a responsibility to elect or change our authorities if we do not agree with their strategies.

Future involvement

In a time when social media is creating new ground, can we imagine someone inventing an even more direct democracy than the Swiss model? Groups like Avaaz (6) gather clicks but also voices to get their opinion heard.

All forms are probably necessary bearing in mind that humanity has always used both the pioneers and the conservative power brokers in order to maintain the equilibrium in society.

Take home messages

- Individual changes of lifestyle improve health outcomes and can thus indirectly weigh on health policies.
- A direct democracy system or randomly selected groups of citizens can contribute to health strategy when difficult decisions need to be made.
- In a moving and increasingly connected world, new ways of mobilization are appearing, from citizen to netizen. For a better humanity?

Original abstract

http://www.woncaeurope.org/content/6-s-health-their-nation-how-would-citizens-develop-englands-health-strategy

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76 – Drafting A Practice Professional Development Plan: A Learning Exercise Using A Continuous Quality Improvement Approach

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Primary health care services are still provided in many GP single-handed practices around the world. However, primary health care is increasingly being delivered by practices with multidisciplinary teams that include doctors, nurses, health care assistants, receptionists, physiotherapists, psychologists, and social workers, among many others.

A team is, by definition, a group of people that have complementary skills and generate synergy through a coordinated effort, which allows each member to maximize their strengths and minimize their weaknesses. However, each team member has a specific set of knowledge, skills and attitudes, as well as personal values, experiences and ambitions. Teams are a highly challenging and enthusiastic environment to work in and to work with.

To be able to face the daily requests of patients and challenges posed by health administrations and primary care organisations, teams need to be open to change, to be innovative, multi-skilled and efficient, well managed and popular while respected in the community. Team members can only reach this high level of performance if they concentrate efforts while being coordinated by a leading member.

Leadership is nowadays recognized as an increasingly fundamental skill that needs to be developed and trained by every primary care doctor. However, only some will master the five skills defined by the Clinical Leadership Competency Framework:

- Demonstrating Personal Qualities
- Working with Others
- Managing Services
- Improving Services
- Setting Direction

The Working Party on Quality Improvement from the World Organization of Family Doctors (WONCA) defined quality in primary care as being "*the best health outcomes that are possible, given available resources, and that are consistent with patient values and preferences*". To achieve higher quality in primary care, leadership is seen as a crucial skill to help the entire team to understand the value of adopting a quality improvement approach.

One of the quality improvement strategies that teams can apply is the Practice professional development plan, or PPDP, defined as follows:

A Practice Professional Development Plan describes the developments planned, and the specific educational actions for individuals, groups and the whole team to enable the Practice to improve care, and which is reviewed annually.

The PPDP is a team-based approach for quality improvement that relies on the assessment of needs, together with planning and implementation of a collectively owned project, which should be

meaningful for the team, evidence-based and centred in patient care. The main purpose of the PPDP is to enable the primary health care team to focus on the objectives and priorities for future years and to identify continuing needs.

Through effective leadership, teams might allocate directed efforts and protected time for the development and implementation of their PPDP. Evidence shows that PPDPs can improve patient care, although results are sometimes only seen at a later stage.

Each PPDP should be structured according to the team's needs and goals, to be owned by the team and to be perceived as a collective effort. The following draft and its components can be used as a starting point for more complex and ambitious plans.

Topic	Goal	Strategy for improvement	Assessment methodology	Team members involved	Deadline
Colorectal cancer screening rates	To audit and improve colorectal screening rates in our practice population	Local protocol to be produced and implemented in January 2015 after team discussion	Screening rates are assessed yearly and published in the annual practice report in each January	AG, SL	July – December 2014
Internal communication	To develop and improve communication between team members	Outdoor team-work activities and inter-professional collaboration workshops	Working conditions appraisal by team members to be done at the end of each year	JMC, FA	January – December 2014
Prescription errors	To avoid harmful drug interactions in medical prescriptions	Learning activities and practical workshops	One week audit of medical prescriptions	AO	July 2014

The Plan-do-study-act cycle is one of the approaches available for quality improvement. It's a feasible strategy to be used in the implementation of the PPDP, although its effectiveness is quite variable. In the 'plan' stage a change aimed at improvement is identified, the 'do' stage sees this change tested, the 'study' stage examines the success of the change and the 'act' stage identifies adaptations and next steps to inform a new cycle.

Although a PPDP represents an efficient and simple tool for organisational quality improvement, it has considerable obstacles in its implementation and success. Teams need to be aware that PPDPs require protected time for its design, an enduring commitment for its implementation and a rigorous assessment of the proposed outcomes. Even if the achievement of the desired objectives might not be reached, this does not represent a defeat. In sum, it's the process itself of developing and implementing a PPDP that matters the most.

Take home messages

- Primary care teams are made of professionals that have complementary skills and generate synergy through a coordinated effort in order to provide high quality care for their local population.
- Leadership is an essential skill for family doctors and fundamental in quality improvement among primary care teams.
- A practice professional development plan is a team-based approach for quality improvement in consensualized topics identified by all team members, through structured collective efforts that are focused on accepted outcomes.
- The implementation process of the practice profession development plan is by itself an important strategy for the development of better relationships among team members and will lead in the long-term to better results of the primary care team.

Original abstract

http://www.woncaeurope.org/content/1003-drafting-practice-professional-development-plan-learning-exercise-using-continuous

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77 – European Practice Assessment (EPA): Practice Assessment and Quality Management With Indicators That Matter

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Quality management systems within healthcare aim to improve health outcomes, patient experiences, accessibility and efficiency of service delivery as well as the job satisfaction of all staff involved. EPA is an easy to use and self-explanatory system which can be used without specific training in quality management. With its educative and reflective approach, it has a high impact on the change of performance.

Objectives

The main objective of EPA is to develop an internationally validated tool for quality management for healthcare providers. It aims at enabling healthcare providers to assess and improve the quality of care they provide.

Quality indicators

Quality indicators play an important role in achieving these objectives. They are measurable elements of performance that can be used to assess the quality of care. Their development is based on evidence or consensus and they close the gap between expert knowledge and routine daily practice. Based on indicators, quality improvement starts with measurement according to the principle that you cannot change what you cannot measure. In order to assess the quality of care, indicators need to be well defined. They should be smart (specific, measurable, achievable, relevant and time-bound), valid, objective, and sensitive.

To assess the quality of care in general practice, indicators were developed that are comprehensive and relevant to general practice; to assure this, general practitioners and experienced researchers were closely involved in the development process. The current EPA version contains more than 200 quality indicators covering a wide range of quality issues relevant for practice management across Europe. Quality indicators are arranged thematically in 34 dimensions and 5 overarching domains covering all important aspects of practice management, like quality and safety, people, infrastructure, information and finances.

International development

The indicators used within EPA for general practice were developed in an international study in Germany funded by the Bertelsmann Foundation, Germany. Various countries like Switzerland, Austria, France, Great Britain, Italy, Slovenia and Israel took part in the project. The set of indicators was piloted in 50 general practices for each participating country. National implementation of EPA nowadays lies with the responsibility of the individual countries.

Methodology

The set of indicators used within EPA was developed with science-based methods and instruments. A modified RAND/UCLA appropriateness method was used as the scientific basis. An expert panel consisting of international scientists and experts from daily practice rated the indicators according to clarity and relevance to generate a usable set of indicators. Expert knowledge as well as patients' perspectives were included to generate practical indicators.

Assessment process

The process of EPA is based on an assessment where indicators are measured and results are presented to the participating healthcare provider. There are five steps covering the whole process of assessment with EPA. In a first, initial step of the assessment, all staff involved are informed about EPA and the assessment process. As a second step, the situation of the healthcare provider is analysed to evaluate performance using a self assessment questionnaire, a patient survey and a staff survey. All three instruments are based on the indicators defined previously. In a third step, the healthcare provider is visited by an expert facilitator who collects more data using a check-list and an interview guide. In a subsequent team meeting, the facilitator presents the result from the assessment to the whole team. The team thus gets feedback for every indicator of the assessment of the healthcare provider and can also benchmark its result against all participating providers. As a last step, the team of the healthcare provider itself plans activities and measures to improve the quality of care provided.

By working with quality indicators, improvements can be recognized exactly where they are necessary and useful. Figure 1 shows the overall structure of EPA and the results of an assessment as seen by the healthcare provider during the feedback session. Our unique software Visotool® visualizes the results of the assessment via a pentagraph and allows benchmarking against all other participating providers.

Figure 1: Pentagraph representing the results of the individual healthcare provider compared to the mean value of other participating providers in the five domains

The pentagraph shows;

• results of all indicators/data collected for an individual provider (continuous red line)

• mean value of all facilities which have so far taken part in the EPA process (dashed blue line)

• potentially best value to be reached by a provider and the benchmark group for this provider (black external line)

The closer the lines are to the edges of the five domains (the black external line), the better the results in each of these domains, dimensions and indicators. Each indicator is measured via items which are part of the instruments used during the assessment. To generate these lines, all indicators and items are transferred into degrees of goal achievement between 0% and 100% (e.g. yes = 100% and no = 0% goal achievement for a specific item).

Table 1: The overall structure of EPA shown with an example of the domain Quality and Safety

Domain	Quality and Safety
Dimension	Critical Incident Reporting
Indicator	There is a critical incident register
Item	Does the facility have a critical incident register? Instrument: Interview

Results

EPA has been successfully implemented in various European countries and is currently being tested in an international context. So far, the results have been encouraging. They show;

- improved quality of care and higher standards of service delivery
- increased transparency and competition among healthcare providers
- increased job satisfaction by staff

- improved confidence and experiences by clients/ patients
- motivation for practice teams for measurable change and improvement

Further perspectives

The strength of the EPA approach lies in the transparency it generates. A direct and detailed feedback and the possibility to benchmark against participating healthcare providers can be used in various settings and healthcare systems. It can be used to focus healthcare services provided by healthcare specialists or be tailored to illuminate health system aspects such as health financing, leadership, drugs, human resources as well as clinical areas. It may, furthermore, be adapted to special fields of interest.

Take home messages

- Improvement starts with measuring (indicators).
- Motivates healthcare providers for measurable change and improvement.
- Shows strengths and weaknesses to providers.
- Initiates quality improvement activities where they are necessary and useful.
- Has a high and scientifically well proven impact on change of performance.

Original abstract

http://www.woncaeurope.org/content/ws-56-european-practice-assessment-epa-practice-assessment-and-quality-management-indicators

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78 – The Role of The Royal College of General Practitioners (UK) in Developing Research Capacity and Capability in Primary Care

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The Royal College of General Practitioners (RCGP) in the UK is the largest professional organisation of General Practitioners (GPs) in the world with over 50,000 members. The RCGP has an important role in facilitating research by its members, building primary care research capacity and capability and collaborating with the academic community, particularly on its key strategic and clinical priorities. The RCGP recognises that there are potential benefits of undertaking research in General Practice, not only for patients themselves but also for the individual members of primary health care teams, the academic community and the wider NHS.

The benefits to GPs themselves in participating in research projects include the acquisition of new knowledge and skills which can lead to more satisfaction in their professional lives and create opportunities for career progression. The majority of GPs, of course, wish to be primarily the users of the results of research. However, a substantial minority of GPs do wish to collaborate in the conduct of research, although it is only a small minority who wish or have the opportunity to initiate research in General Practice. The growing emphasis on translational research and getting evidence into clinical practice have also contributed to many development and opportunities for GP research.

Professional bodies such as the RCGP have become increasingly involved in recent years in supporting the training of GPs to do research. The importance of research is clearly stated in the RCGP curriculum which sets out what is required to practise as an independent General Practitioner in the UK NHS (http://www.rcgp.org.uk/gp-training-and-exams/gp-curriculum-overview.aspx). In addition, the RCGP, through its charitable funding body, the Scientific Foundation Board (SFB) (http://www.rcgp.org.uk/clinical-and-research/research-opportunities-and-awards/scientific-foundation-board-sfb.aspx) provides annual "pump-priming" funding opportunities of up to £20,000 for individual GPs to get started on research projects with support from the local university departments. The SFB has been established since 1976 and has been responsible for nurturing the early research careers of general practitioners and primary care scientists who have gone on to develop key roles in academia (including one of the authors of this article, NM).

The College, of course, does not work in a vacuum and there are many other schemes which support GP research. These include the National Institute for Health Research (NIHR) in the UK which provides In-Practice Academic Fellowships in the form of entry level funding for GPs who wish to experience a "taster" of the GP academic life before deciding whether or not to embark on an academic career.

The RCGP is also keen to offer support to practices. The attraction of general practice based research includes both the geographical and demographic diversity of GP practices. The RCGP offers a scheme that provides the quality assurance of practices taking part in research. For example, the College provides a set of quality standards for the accreditation of "Research

Ready" (RR) practices (http://www.rcgp.org.uk/clinical-and-research/research-opportunities-and-awards/research-ready-self-accreditation.aspx). The scheme was initially commissioned by the Department of Health and developed in conjunction with the NIHR Clinical Research Network (NIHR CRN). The RR programme comprises five core competencies that cover the essential knowledge needed to safely and effectively undertake research in primary care. More than 1,000 practices in the UK have already been successful in achieving RCGP accreditation to undertake research by measurement against core competencies of the scheme which includes providing evidence of good clinical practice in research.

General Practice, of course, is "where the patients are" and GP electronic patient records offer an unparalleled opportunity for high-quality epidemiological and clinical research. This is exemplified by RCGP Research and Surveillance Centre (http://www.rcgp.org.uk/clinical-and-research/research-and-surveillance-centre.aspx). The incidence data provided through consultation data from over 100 practices in England and Wales provides the early warning of changes in the incidence of common illnesses such as influenza like-illness and incidence rates for acute illnesses, as detailed in the RCGP's weekly Communicable and Respiratory Disease Report for England and Wales.

The RCGP also provides recognition to an individual or group of researchers who have undertaken and published an exceptional piece of research relating to general practice or primary care, through its Research Paper of the Year award, now in its 18th year. There is a formal presentation of the winning paper at the annual RCGP Conference and an award of £1,000 to the authors. The most recent award was presented at the 2014 RCGP annual conference to Dr Joe Gallagher on behalf of the authors of the winning paper (*).

Exceptional individuals involved in research are recognised by the RCGP through other awards. The RCGP Discovery prize for the most sustained contribution to GP research have included such luminaries as Julian Tudor-Hart of "Inverse Care Law" fame. More recently the Yvonne Carter award, in memory of Professor Yvonne Carter, is presented jointly by the RCGP and the Society for Academic Primary Care (SAPC) and aims to support the career developments of a promising new researcher in primary care, particularly by facilitating international research links. The most recent recipient is a primary care scientist, Dr Helen Atherton. In terms of potential new awards, an appeal has recently been launched by the RCGP to support primary care mental health researchers through the Helen Lester Appeal for Mental Health Research. Helen Lester was a GP champion of patients with mental health problems.

Finally the academic hub of the RCGP, the Clinical Innovation and Research Centre (CIRC, currently chaired by Dr Imran Rafi) provides a link with external organisations to develop joint collaborative working. An example of this is the submission of research topics by key RCGP clinical champions to the NIHR designed to lead onto 'fully developed' research funding opportunities. A further example is a recent RCGP-NIHR Multimorbidity workshop which brought together key academics in Multimorbidity research with representatives from key organisations such as the National Institute for Health and Care Excellence to reflect the importance of translatable research.

Take home messages

- General Practitioners organisations have important roles in facilitating research by their members, building primary care research capacity and capability, and working closely with the academic community.
- There are considerable benefits to GPs themselves in engaging in research.

Original abstract

http://www.woncaeurope.org/content/3505-role-royal-college-general-practitioners-developing-research-capacity-and-capability

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79 – From Familygram to Personalised Medical Care

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Familygram

As a profession, family medicine has a myriad of specific tools designed for assessing every single patient in the context of his/her family and its psycho-sociological and health circumstances. Even though many modern techniques have been introduced into clinical care, family physicians continue to use tools deeply rooted in simple family assessment techniques, considering them a unique privilege of the profession. Patient/family assessment is provided by the Family Apgar, Family profile and Family history. Through analysis, a family tree and family genogram can be established. Connection and assessment is made of all obtained data results in a familygram profile, which is recognised as an integral presentation of the entire family and its social and health record, including personal comments.

Family Apgar is designed to test five areas of family function (**A**daptability, **P**artnership, **G**rowth, **A**ffection, **R**esolve). Every question is scored as 2 (almost always), 1 (sometimes) and 0 (hardly ever). A total score of 7-10 presents a highly functional family and 0-3 a severely dysfunctional family.

Family profile comprises of different assessments. Family structure and family form show a large variety of different, nationally or regionally specific patterns, often strongly connected to different cultural backgrounds or family policy models. Some new types of families represent different environments that affect family members and their attitude to social and health-related behaviour.

Family history (FH) has become evident as the gateway to medical genetics (recognizing inherited disorders). Creating a FH involves several steps, the family medical history questionnaire often being the first step in this process. Patients may be encouraged to contact relatives to obtain or confirm information. The face-to-face interview is a critical part of eliciting family history, with the ultimate goal to obtain a pedigree that includes at least 3 generations (age or year of birth, age and cause of death, ethnic background of each grandparent, relevant health information -e.g., height and weight-, illnesses and age at diagnosis, information regarding prior genetic testing and information regarding pregnancies).

Family history plays an important role in identifying patients who may benefit from predictive genetic testing. A positive FH has been recognized as a risk factor for the development of cardiovascular diseases (CVD), diabetes (DM) and various cancers, moreover, it has been identified as an independent risk factor for the development of CVD and DM. It is known that family history of common chronic disease is associated with a 2- to 5-fold relative risk of developing the condition, and this increases with the number of affected relatives.

IT supporting systems (ITSS)

Several IT supporting systems (ITSS) have been developed to integrate all elements of familygram. Some of them are oriented to pedigree profiling and offer a standardized system for pedigree storage. Other pedigree oriented ITSS are particularly intended for epidemiologists in the sense that they allow customized automatic drawing of large numbers of pedigrees and remote and distributed consultation of pedigrees. Some other pedigree ITSS fully integrate risk analysis and support for industry standard databases and are designed for genetic counsellors and work with genetic marker data, enable haplotyping and allow exports to a range of linking analysis packages.

Family tree programmes enable construction of family trees, offering an ability to import data from other genealogy programmes. Attractive charts and reports in a variety of formats can be drawn and the photos, audio, and video files can be added to the tree.

Graphical genotyping package ITSS combines genetic map data and locus data to display graphical genotypes. Data can be viewed by individual or by linkage group, and sorted on markers. Statistics are calculated, and simultaneous filtering/selection on multiple linkage groups are made possible.

However, gathering, filtering and inputting data is always a doctor's task, while ITSS only manages inputted data. If the inputted data are more complete, the output and suggested course is more comprehensive.

Future challenge: a personalized medicine

In the future, medicine will become more and more focused on personalized approach to the patient. Personalized health care (PHC) is a strategic approach to medicine that is individualized, predictive, preventive, and is based on an individual's specific profile. People subject to increased risk because of their family history are among the most appropriate candidates for genetic profiling to find possible new biomarkers. Biomarkers can help in better understanding of the disease, prediction of its onset and development. Such genomic approach can help to evaluate co-morbidity of selected chronic diseases horizontally and connect them with family history. This shall help to reveal new horizons of genomics in chronic diseases.

Such processes should be supported by an IT centralised vendor-neutral clinical data repository with support for real-time transactional health data storage, query, retrieval and exchange. This is structured data set for the validation of the decision support model, efficiency calculations and bio-informatic studies.

Views on personalized medicine can vary according to standpoint: for patients, it offers access to life or better quality of life; researchers see potential in their own areas of specialization; for pharmaceutical industry it offers the hope of developing more effective medicines as understanding of specific diseases advances; a physician sees a new way of treating a patient; for society, it may be perceived as offering scope for an overall improvement in healthcare – or a new cost.

It will be possible for patients and professionals to discuss options only if a common language and conceptual understanding of genetic and protein signatures and pathophysiology of the disease are available for both – taking account of the individual patient's psychological make-up (educational level, mental state, and attitudes to risk). Additionally, ethical standards must be evaluated taking into account the specifics of PM and creating an infra-structure in which genetic information is available in a regulated context.

To conclude, familygram opens the pathway to PM which is entering medical care. However no one, not even ITSS, can replace the family physician and its fundamental role in assessing the health of each individual within the context of family, society and socio-economic aspects and to communicate with the patient on his/her personal level.

Take home messages

- Familygram is an important tool for assessing every patient in the content of his/her family.
- Family history enables detection of risk factors and presents a gateway to medical genetics.
- IT supporting systems (ITSS) have been developed to integrate all elements of familygram.
- Medicine is becoming focused on a personalized approach to patient in the near future.
- Nobody can replace the family physician and its fundamental role in assessing the health of each individual.

Original abstract

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80 – The Growth of the Guideline – Provision of Evidence-based Care with Unintended Consequences

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The rise of evidence-based medicine

In the 1980s David Sackett, a professor of medicine at McMaster University, Canada, published a series of articles on how to critically appraise medical research to inform safe and effective clinical practice (1). This work was extended by his colleague Gordon Guyatt in the 1990s, who coined the term evidence-based medicine - clinical practice based on what has been scientifically shown to work for patient management of different conditions (2). There followed a series of papers in JAMA on 'Users Guides to the Medical Literature' with a particular focus on interpreting the results of clinical studies, and on deciding how to apply these in patient care (3).

At the same time Scottish doctor Archibald Cochrane was advocating for the use of randomised controlled trials (RCTs) to improve the effectiveness and efficiency of medical practice. The Cochrane Centre was established in Oxford, England in 1992 under the leadership of a health services researcher, Iain Chalmers. The aim of the Centre was to review and assess the entire body of literature on all interventions. This led to the establishment of the international Cochrane Collaboration in 1993, producing up-to-date systematic reviews and meta-analyses of relevant RCTs of healthcare, and subsequently the Cochrane Library database (4).

Chalmers and Muir Gray, a public health physician, established the Centre for Evidence-Based Medicine in Oxford in 1995, with David Sackett as director. This facilitated the spread of evidence-based medicine to the United Kingdom, Europe and beyond (5). Clinical practice now could be based on examination of the current evidence rather than tradition or authority.

Practice by Guideline

By the turn of the century this evidence was being incorporated into clinical guidelines, directing decisions regarding diagnosis and management in specific areas of healthcare. Guidelines usually include consensus statements of what is considered to be best practice, and often algorithms to aid decision-making. There was a rapid proliferation of guidelines for a huge variety of conditions, produced regionally, nationally and internationally by professional bodies, healthcare organisations, governments and international collaborations to help standardise and improve the quality of care. Guidelines rapidly became commonplace.

However guidelines themselves could be variable in their scientific validity, reliability and usability. In 2002 an international group of researchers from 13 countries (the Appraisal of Guidelines, REsearch and Evaluation [AGREE] Collaboration) developed and validated a generic tool to appraise the quality of clinical guidelines (6). This led in turn to the establishment of the Guidelines International Network, with member organisations such as the UK National Institute for Health and Clinical Excellence (NICE) and the US National Guideline

Clearinghouse, applying the AGREE standardised methods to produce quality guidelines.

There has been an exponential increase in the publication of RCTs, of systematic reviews distilling the accumulating evidence, and guidelines to inform best practice. Increasingly general practitioners (GPs) are expected to use guidelines to direct their clinical decision-making. In 2004 the Quality and Outcomes Framework (QOF) was introduced in the UK as a pay-for-performance scheme, covering a wide range of clinical and organisational outcomes, with financial rewards for meeting determined targets for these QOF indicators.

As the stack of guideline books accumulated on the consultation room floor, increased effort went into the implementation of guidelines, now a research topic in its own right. Approaches include educational sessions, making summaries available on GPs' computer desktops, and algorithms electronically incorporated into clinical pathways.

Benefits and unintended consequences

There is no doubt that understanding and applying robust scientific evidence from well-conducted trials can improve patient care and health outcomes. For example, achieving quality targets may result in significant health gains among patients with cardiovascular disease .

However there is also the danger that guidelines can lead to cookbook medicine, with less of a holistic, biopsychosocial approach to patient care. Many guidelines synthesise hospital-based studies of homogeneous patient groups. This may lead to fragmentation and consequent poor coordination of care. Applying single disease guidelines to a patient with multi-morbidity may lead to polypharmacy and adverse medication interactions. Insufficient resources for all GPs to implement the evidence may increase health disparities. The QOF tick-box approach focuses on what is easy to measure, rather than the less tangible clinical elements such as the nature of the doctor-patient relationship. Population health objectives may conflict with a patient-centred approach to individual care. Consultations have a finite capacity, and the quality of care may reduce for conditions not included in the incentive framework.

Sackett himself warned that scientific evidence can inform but never replace clinical expertise 7. Clinical decisions must always involve our patients within the complex and uncertain reality of their lives. Decisions must take into account a large array of factors, including patient preferences, social, moral and legal issues and resource constraints. Best practice requires the synthesis of scientific knowledge, the context in which it is applied and phronesis - the accumulated wisdom of the practitioner 8. Empirical evidence contributes to management decisions made by doctors and their patients, but must not supplant the contextual knowledge that both contribute.

Take home messages

- Evidence-based medicine led to systematic reviews and meta-analyses of studies to assess the effectiveness and efficiency of medical interventions.
- Clinical guidelines use distilled evidence to direct clinical decision-making.
- Best practice is incentivised by achieving specified quality indicator targets.
- Unintended consequences include fragmentation of care, polypharmacy, health disparities, and neglect of conditions excluded from the quality framework.
- Best practice requires the synthesis of scientific knowledge, the context in which it is applied, and phronesis.

Original abstract

http://www.woncaeurope.org/content/what-are-general-practitioners-obstacles-implementing-guidelines

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81 – Developing Culturally Sensitive Services in Primary Care

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The capacity for migration has increased in the 21st century due to the expansion of international relations, opening of borders, and the development of democratization processes in modern society. The reasons for migration differ with every case and may include; international expansion or work abroad, family reunion, return to the native land, looking for better quality of life, education, economic reasons or simply, a more peaceful life. The process of migration results in a population that has a variety of religious and cultural characteristics that must be considered during the provision of medical care.

The importance of cultural sensitivity was initially emphasized in providing services to members of ethnic minority groups, especially given the language and cultural barriers faced by non-English-speaking immigrants and the ethnic and economic barriers (8). Patients may not understand a prescription or general health recommendations correctly which may lead to low adherence to treatment (3). Patients may be prevented from discussing their problems as a result of language barriers or religious prohibitions.

The family doctor should start with the principles of individual liberty, human ethics and deontology, respect for beliefs, feelings and rights of patients, be aware of the cultural religious characteristics of its population, know manners, rituals and norms of behaviour, and consider them when providing medical care (1-3, 7). For example, the various cultures and religions have different attitudes to abortion, vaccination, euthanasia, blood transfusion, organ transplantation, resuscitation, autopsy, artificial insemination, sterilization, etc. Euthanasia and abortion are rejected by most religions, including Catholicism, Judaism, Buddhism, Christianity and Islam. Abortion is prohibited in most religions, but Muslims believe that the soul of the foetus appears in the first week of the fourth month of pregnancy, so abortion is allowed within that time frame. Artificial insemination is not recognized in Buddhism, but allowed by the Orthodox. In Buddhism and Islam, organ transplants and blood transfusions are only allowed from a living donor of the same religion and with his consent. The Jewish faith is against autopsy and organ transplantation, unless permission was given by the patient and his family before death. Buddhism and Judaism also deny artificial continuation of life, when medical equipment and intensive therapy prevent natural death, however, the physician should make every effort to preserve and save human life according to the Hippocratic Oath.

In daily life, there are also many occasions when it is necessary to be aware of religious and cultural diversity in the provision of health services, such as religious restriction diet, fasting, hygiene, possibility of examination etc (7-8). For example, religious restriction of food (fasting, restriction of meat) may lead to deficiency disease and decreased immunity. Also, religious diet restriction can influence prescribing therapy. Thus, Islam forbids the use of any products derived from pork. In India the cow is sacred, so medications based on bovine serum (some vaccines, regenerating drugs etc.) cannot be used. In Judaism, only kosher products are allowed to be ingested, and accordingly,

all drugs employed should be kosher.

The family physician must also consider that the need to perform religious rites and duties can lead to physical torture and psychological disorders, including depression (4). Some religious rituals can contribute to the development of certain syndromes and diseases, and lead to the spread of infections. Ignorance of them causes difficulties in diagnosis, false diagnosis and ineffective treatment. For example, eating traditional dishes from certain kinds of raw or insufficiently processed meats or fish, offal or animal brain can lead to the development of prion, helminthic diseases and different infections. Such lifestyle habits are transmitted from generation to generation without suspicion that it may cause harm to health.

On the other hand, the violation of religious and cultural features can lead to extremely negative consequences not only to patient, but also to doctor, leading to criminal liability. For example, blood transfusion without consent of the patient or his relatives is a crime in some Muslims countries and African states. In Muslim countries, male doctors, especially non-Muslim, may examine women and deliver babies in the absence of her family.

Nevertheless, the family doctor should remain patient, observe human ethics, compassion and empathy, do no harm and try to find a way to provide the necessary medical care as outlined in the Hippocratic Oath (1-3, 7).

It is clear that the education of family doctors should pay attention to the development of religious and culturally sensitive care to avoid mistakes and problems such as misdiagnosis, misunderstanding, non-adherence, and recidivism (1-3). In 1996, the Society of Teachers of Family Medicine published curriculum guidelines for teaching culturally sensitive and culturally competent health care to family medicine residents and other health professions students. Cultural Sensitivity permits us to respond with respect and empathy to people of all nationalities, classes, ethnicities, religions, ethnic backgrounds and other groups in a manner that recognizes, affirms, and values their worth (4-7). As a result, it is necessary to form culture competence in the family doctor, which is measurable as an important quality indicator of care. Quality indicators must incorporate principles and measures of cultural competence focusing on the policies, procedures, and resources needed to provide linguistically appropriate and culturally relevant services at all points of client contact within a system (1-3, 8). Several existing quality improvement tools have the potential to incorporate dimensions of cultural competence and can be used to define and track outcomes of interest for populations at risk (3).

Take home messages

- The patient's religion, their cultural and personal features need to be taken into account in health care as much as possible. This will avoid confusion, medical errors, misdiagnosis, misunderstanding, non-adherence and recidivism.
- The family doctor should be aware of cultural religious characteristics of his population, know manners, rituals and norms of behaviour, and consider them when providing medical care, observing human ethics and compassionate empathy.
- Cultural competence training should focus on empathic listening and development of communication skills that work across cultures and have to be monitored with special tools.

Original abstract

http://www.woncaeurope.org/content/43-developing-culturally-sensitive-services-primary-care

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82 – The MRCGP International - Developing a Truly Contextual Assessment

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It is 13 years since the Royal College of General Practitioners (RCGP) of the UK presented the framework and process for accrediting local developed postgraduate assessments of Family Doctor/General Practitioner competence at the WONCA World Conference in Tampere, known as the MRCGP[INT] programme. This is a brief progress report including the perspectives of colleagues and an external programme evaluation.

The purpose for developing this programme followed a 1996 survey of international colleagues and academic departments who were communicating with the RCGP. They expressed a wish to develop an internationally recognised postgraduate assessment of competence and qualification for FM/GP at a national or regional level, tailored to local needs, educational systems and practice; it was important that such assessment be equivalent in status to those in hospital-based specialist disciplines. The development of MRCGP[INT] has been undertaken on the premise that it is inappropriate to export the UK MRCGP exam, which is the exit assessment of the RCGP training curriculum towards the Certificate of Completion of Training required to practice as a GP in the UK (RCGP, 2013).

The MRCGP[INT] programme recognises that there is a generic core to the FM specialty, but there are important differences between countries in patient's expectations of their doctor, communication styles, cultural and ethical issues, such as consent and confidentiality, epidemiology, training and the legislative and resource framework of health and social care.

The programme forms part of the RCGP strategy to improve the quality of education and delivery of FM/GP internationally (RCGP, 2011). The RCGP collaborates with local examination boards to develop an assessment of competence of their FM curricula, which is then accredited as being of equal academic rigour to the MRCGP UK examination. The assessment design is based upon current best practice principles but incorporates, sometimes transitionally, test methods appropriate for local educational needs (van der Vleuten & Schuwirth, 2005) (Wass, et al., 2001). Then there follows an ongoing quality assurance re-accreditation cycle, to monitor, refine and raise standards. Rather than being a generic international examination, each MRCGP[INT] assessment is set locally to reflect that context. The aim is to assist that country in strengthening both the role of family medicine and local postgraduate education institutions. Successful candidates become International members of the RCGP, but this is not a passport to work in the UK or any other country.

There are now seven accredited MRCGP[INT] assessments. The purpose differs between countries; for Oman, Brunei, Dubai, Kuwait, Egypt and Malta it conjointly accredits the end point assessment of vocational training. Additionally, in Brunei the examination may be taken by candidates who have either worked or trained in family medicine elsewhere; in Dubai where many family medicine doctors are graduates

from countries without postgraduate training schemes in family medicine, it offers an opportunity to demonstrate the quality of their work and further their career (Ahmed, et al., 2010). The South Asia MRCGP[INT] is a consortium representing India, Pakistan, Sri Lanka and Bangladesh; again, for FDs who have had no structured training opportunities, as well as expatriate South Asian doctors working in neighbouring countries who intend to return to work in the South Asia region (RCGP, 2014). It is intended that Kosovo and Cyprus will have similar accreditation and provide a focus for quality competence assessment in those regions.

The challenge of taking the assessment in regions where family medicine is undeveloped, where there is little provision of speciality training or continuing medical education, is also an opportunity. For many candidates the MRCGP[INT] examination has acted as a stimulus for learning where one did not exist before. Success often comes after a long period of self-directed preparation and RCGP International membership enables the College to help support these outstanding colleagues in their continuing professional development.

A commissioned external evaluation of the MRCGP[INT] (Capacity Development International, 2014) conducted in March 2014 interviewed internal and external stakeholders, particularly colleagues representing accredited sites; reporting on:

Relevance: positively affirming congruence to RCGP strategy, WHO policy and the WONCA WHO publication. The MRCGP[INT] model is aligned with current thinking in good development practice: meeting country needs, building institutional capacity and promoting local ownership.

Effectiveness: MRCGP[INT] is based on partnership working and local empowerment, with long term collaborative and QA commitment. Problems of recognition by national regulatory bodies are a potential risk. Joint working on test writing, examining and standard setting should be further encouraged between sites to improve calibration.

Impact: The evidence is clear for developing robust primary care health systems with strong FM (Starfield, 2011). MRCGP[INT] has demonstrated that it is possible to provide a contextualised exam to rigorous assessment standards that strengthens countries own assessment expertise, rather than exporting its UK exam. There is, however, a need to address the paucity of both quantitative and qualitative research that demonstrates the impact of the MRCGP[INT]. Advocacy to focus political will to influence national and global policy is key to increasing the potential uptake and impact of the MRCGP[INT] Programme, with increasing recognition for FM/GP as central to primary healthcare.

Efficiency: MRCGP[INT] site hosts were extremely positive about the quality of academic support received. However, accreditation fee increases are a concern to sites, although the programme provided value for money.

Sustainability: There is significant commitment to continue the MRCGP[INT] programme. The programme is mutually valued. The RCGP should continue to tailor CPD support more to the needs of International members. The RCGP must remain mindful that MRCGP[INT] cost effectiveness is designed for the long term, and the resources available to current and future sites.

Take home messages

- FM/GP curricula and their assessment are context specific, with perhaps two thirds recognisable globally.
- FD/GP assessments of competence require rigour to be credible with all stakeholders, but it is inappropriate to export FM/GP competency assessments to other contexts.
- Collaborative working to build institutional capacity and promote local ownership works well.
- Recognition by national regulatory bodies and political support is necessary for sustainability.
- Opportunities can be made for FDs who have no postgraduate training to demonstrate their quality.

Original abstract

http://www.woncaeurope.org/content/301-mrcgp-international-membership-royal-college-general-practitioners-international-new

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83 – Do we Practice what we Preach?

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Doctors and especially general practitioners play an important role in health education and devote huge efforts to improve their patients' nutritional habits. This study has been performed in order to assess doctors' nutritional habits and to find out whether they follow good advice or not. I am convinced that patients take our advice more favourably if they observe that we practice what we preach.

In 2000, one hundred general practitioners from Budapest (67 women and 33 men) were asked to fill out a questionnaire containing 16 questions with regard to their nutritional habits. As a consequence of their life style, the majority of their food consumption is at dinner, with very little food eaten throughout the day.
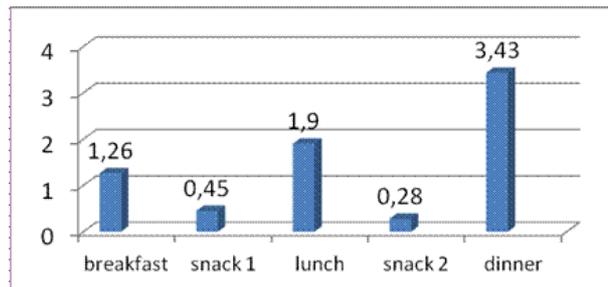
Diagram 1: The distribution of the daily nutriment intake (self estimate on a scale from 1 to 5)
Source: Author's diagram based on the 2000 questionnaires

According to the questionnaires, general practitioners in Budapest generally eat the minimal amount of food and liquid during daytime.
Consistently, their daily fluid consumption is only 1.2 litres per day in, as can be seen in diagram 2.
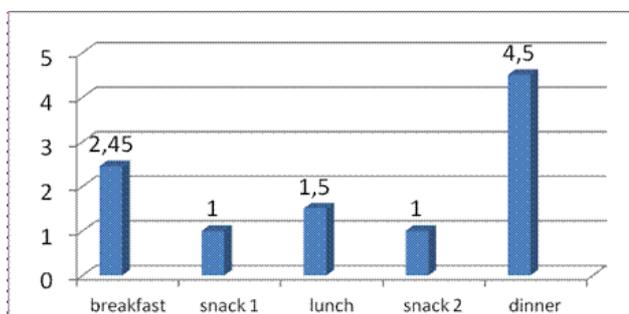
Diagram 2: Distribution of daily fluid consumption (dL)
Source: Author's diagram based on the 2000 questionnaires

While men generally eat hot dishes at least once a day every day, women only do so 4 times a week. More than one third of women do not have lunch at all. This ratio is only 13% in the case of men. 50% of men eat lunch in the comfort of their home but only 29% of women do the same. 26% of women eat a cold meal for lunch on the go, which is not as popular among men. 39% of the women questioned do not have any lunch at all on weekdays, while the percentage among men is only 11%. 81% of men questioned have three-course lunches weekends with their families. One quarter of physicians follow a special diet. 48% of the women who are on a diet want to lose weight; the percentage among men is 18%. The ratio of vegetarians was the same among the two genders. One fifth of the women and men were vegetarians. This is a relatively high number when compared to the general population.

Almost half of the respondents take some kind of vitamin product regularly. Furthermore, half of the doctors snack throughout day. According to the study, a general practitioner drinks an average of two cups of coffee daily. When it comes to selecting food, men are more likely than women to choose the tastiest foods. Women prefer ingredients which can be prepared easily. Cost appears to be a negligible factor in their food choice. For women the second most important factor is that the food they choose should be healthy. For men this is the second least important factor. General practitioners eat dairy products, fruits and vegetables almost every day, but they consume meat only 4 times a week. Doctors evaluated their own nutritional habit as medium level.

General practitioners play a distinguished role in health education even if they are not able to comply with these principles fully (probably because of their running life style and pressure of circumstances).

There are several new studies on the health condition of doctors. The biggest studies have been made in the USA (1) and in the UK (2). In Hungary in 2004, Drs Rubik and Kalabay (3) conducted a study among the doctors who graduated from Semmelweis University 25 years ago. The questionnaire contained demographic, somatic and morbidity data. The doctors participating in the study had to classify their own health status and lifestyle. They found that both BMI (Body Mass Index) and bodyweight had increased among both genders. The most remarkable bodyweight increase was detected among men working in primary health care (average 14.3 kg) and among women working in sedentary specialties. The men who work in primary health care had the highest BMI (average 27.4). Most of the smokers worked as surgeons and in primary health care (in this case, mostly women). Another, similar study compared 454 medical workers' health condition, lifestyle and health attitude in Szeged (Hungary) and Szabadka (Serbia) (4). Most of the nurses from both cities (roughly half of them) did not smoke (among the Serbian nurses there were more non-smokers). Nevertheless, the doctors in Szabadka smoked 20 cigarettes more a day than their counterparts in Szeged. 41.4 % of the doctors from Szeged did not drink alcohol, In Szabadka this ratio was a bit higher (44.7 %). There were some non-coffee drinkers in Szeged (19.2%) and Szabadka (21, 7%) as well. The most common amount consumed was 1-2 cups of coffee a day but there were many participants who drank 3-4 cups daily. Coffee addiction, meaning six cups a day or more was only observed among the Hungarian doctors (2.5%). It is alarming that most of the medical workers, including the Hungarians and Serbians, have at least one addiction!

In another study by the Medical University of Debrecen (Hungary) (5), 188 medical workers aged over 35 from 9 clinics were investigated. They had to rate their own health condition on a 1-5 scale. The average score was 3.99. 39% of the nurses were smokers and on average they smoked 13.2 cigarettes per day. 89% of the nurses attended screening examinations voluntarily on a regular basis.

Consequently, neither doctors nor medical workers pay enough attention to their own health (6). The rates of consuming non-essential nutrition, smoking and alcoholism among doctors and medical workers are not lower than the general population either in Hungary or throughout neighbouring countries. We should be taking better care of each other!

If we make a positive precedent, then our patients will take our advice more seriously (5).

Take home messages

- Our personal nutritional habits and the professional focus of doctors and medical staff are not balanced – we don't practice what we preach.
- We should pay more attention to our and also our colleagues' health!
- We should make some positive precedents if we want our patients to take our advice more seriously.

Original abstract

http://www.woncaeurope.org/content/465-do-we-practice-what-we-preach

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84 – Helping Family Physicians in Managing Families With a Difficult Child

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Prevention is one important task of family physicians. In the context of child and family difficulties, he is the closest professional in detecting primary signs of dysfunction. However, he needs to acquire abilities to recognize and manage parents' difficulties with their children. It may not be a frequent consultation complaint but when it does occur, the physician often does not have much idea on how to deal with the situation.

Opposition, temper, violence, school difficulties; what distinguishes a difficult child? How can one identify a family or a child at risk?

Aggressive or oppositional behaviour are not necessarily pathological. They might have different significance depending on the context, the environment or the age of the children. Symptoms displayed by the difficult child are variable: lies, stealing, aggressive or disrespectful behaviour which are not pathological if occasional. All children lie and it is between 6 and 8 years old that they can differentiate between real and false. After 8 years old, lies become intentional. Stealing is the most frequent conduct disorder but consistent with lying, it is not intentional prior to 8 years of age. Aggressiveness or temper may be the expression of unhappiness since infancy. Around 2 or 3 years old, a child may become opponent to affirm himself (Marcelli, 2009).

Dealing with a difficult child

First, we have to pay attention to the normal development and particularly to the period of the opposition phase (between 18 months and 2 years and a half). It is a period of self-affirmation but it is also a phase where the parents need to establish clear rules and boundaries. They must set limits for the child within a climate of love and respect. If this period has been difficult, the child may become an "enfant-roi" "child king" (French concept in sociology, Houssonloge, 2008).

Secondly, we need to evaluate the acute or chronic aspect of the difficulties. Usually, acute conduct disorders might be related to life events such as divorce or separation, disease of a parent or a grandparent, death or placement outside the family, boarding school,...

Chronic aspects of behavioural difficulties might be linked to the child's history. He might be unwanted, unloved or involved in couple problems. His parents could be mentally ill or violent. He could be neglected or abused.

He may be suffering from hyperkinesis (ADHD) or other psychopathological symptoms such as depression.

The management of the consultation

We need to pay attention to 4 aspects:

1. The child history: the conception (desire or not), the pregnancy (with eventual pre-term birth or hypoxaemia), childbirth and psycho-developmental aspects such as food, sleep, exercise, speech, school, toilet-trained…

2. The family history: history of the parents, history of the couple, brothers and sisters

3. Recent life events

4. Psychosocial aspects

We introduced workshops for family doctors, with the aim of increasing their understanding of "difficult children". Group sessions of 30 to 35 Belgian family doctors were organized. As in any workshop, the participants had to find their own answers. They were noted on a flip-chart, synthesized and, if needed, enriched with backup literature by the expert.

During these workshops, they had to first focus on normal child development and particular difficulties at different ages. Next, they had to propose, through case reports and videotapes, practitioner-specific solutions to help the child and his family.

Child difficulties often arise in families with relationship problems. Throughout 2 video sessions, FDs were trained to recognize normal child development and to assess acute or chronic difficulties.

The first videotaped situation concerns Mehdi, a young Moroccan boy. He is 2 1/2 years old. We see him at home during a meal with his brothers and sisters. He is the youngest of 5 children. He pushes his plate away. He can speak but is difficult to understand. He stamps his feet, ask for an orange and has a fit of temper. His sister tries to show him a book: he doesn't want this book; he wants another, precisely the one he may not have.
His mother says that it was not the same with the others; she doesn't understand, she brought him up the same way...

The second situation concerns Jérôme, 11 years old. He attends the consultation with his father. His mother is at the hospital for an operation. He remains silent. The practitioner tries to talk to him: nothing. We learn that the father had a hectic adolescence which he acknowledges in front of his son but he wishes a different one for him. We feel his pride when he recounts his adventures. Since their marriage, the parents have moved many times throughout the country and have practised several professions. The father no longer sees a first son he has from a previous marriage. We don't understand why. When he was very young, Jerome went to live with his grandmother for long periods during which his parents came to visit once a week.
The father doesn't understand: "Jerome has everything to be happy: a bicycle, a TV set in his bedroom... In spite of all that, he has fits of temper and sometimes pees on the carpet." At school he gets bad grades and the parents were told to consult a physician. "Nothing works any more. I hit him, I encourage him, it is just the same" says the father.
The boy has no activities, no hobbies with his father: he goes alone to holiday camps.

Participants have then to work in small groups. They share their experiences.

The questions are: "What difficulties does the child present?" – "How do you explain this behaviour?" – "What conclusions can you draw from this?" - "What would you suggest to the mother or to the father?" - "What would you say to him or her?"

In conclusion, FD's are in the front line and in the best position to detect such issues regarding the 'difficult child'. Providing them with the tools and skills to assist them in dealing with such situations can improve primary and secondary prevention of child and adolescent psychopathology.

Take home messages

- The FD is the closest professional in detecting primary signs of dysfunction in child development.

- He knows many details of family history and he has the confidence of the parents.
- He needs to acquire abilities to recognize and manage parents' difficulties with their children.
- He has a major role in primary and secondary prevention of child psychopathology.

Original abstract

http://www.woncaeurope.org/content/14-helping-family-physicians-managing-families-difficult-child

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85 – Family Systems Medicine: A New View of Training General Practitioners into Family Doctors

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Introduction

Human beings are social beings. They are bred and grow up in families, and nowadays even extended families.

We all know the words "he looks like his dad, she resembles her mother" and other little 'pearls of wisdom' that reflect the trans-, inter- and intragenerational influence.

So, it comes as no surprise that there is a huge influence on people with a disease or illness from their surrounding family members. When you have a patient in front of you, you actually have a whole family sitting there, and even threads to grandparents' sayings, doings and beliefs. You are confronted with a network that speaks from one mouth – even in the case of an influenza presentation.

Family systems medicine refers to the intersection between relationship dynamics and medical care.

Why a training in Family Systems Theory?

In order to provide the best care to patients, family physicians have to know the social and cultural context of their patients. Family Systems Medicine allows practitioners to think of the relationships of their patients, starting from families, to the community and other organisations or networks. Family Medicine focuses on the individual, in his context. At the basis of a Family Systems Medicine training is the understanding that there is more than biology alone.

It is argued here that to become a Family Doctor, a general practitioner should be trained in Family Systems Theory.

What constitutes good training?

A good model is in the Iceberg Model of Futuristic Thinking offered by Sohail Inayatullah.

He argues that we are confronted with litanies, offer advice and prescriptions, often to find out that it didn't work. "I want to lose weight, I want to quit smoking, I want my relationship to work, I want to sleep" are some of the litanies in a doctors' daily life.

Doctors should then look for the social causes, the world view of the patient and finally the metaphors that are embedded in his family. Inayatullah called it The Causal Layered Analysis.

So a good training is one where doctors learn to work with metaphors, give meaning to world views and social causes and act upon it.

Asking the "apocalyptic question" (what is the worst thing that can happen?), empowering (what would you do if I

gave you a magic wand, what would you wish for?), understanding the role of "the position in the family of origin" (first born, only child, sibling of a sick or handicapped brother/sister, etc), knowing not only the "genetic tree" but also the "relationship tree" with the subjective force of ties (single bond, double bond, triple bond, broken bond, distant bond, inexistent bond), knowing the important dead family members, seeing the elephant(s) in the room, being aware of and even knowing the secrets of the family (abuse, abortion(s), alcohol, drugs, jail time, etc) ... these are important topics in a training programme.

What is the result of good training?

It will come as no surprise that doctors trained this way often find that essential hypertension (or primary hypertension or idiopathic hypertension) is the form of hypertension that by definition, has no identifiable cause – unless you look at all the influencing strings of family, community, world view and metaphors.

Then treating hypertension (or other psychosomatic diseases) becomes a chess play in 3 dimensions – not only antihypertensive drugs, but a biopsychosocial approach is needed.

A Family Systems training also gives you the wisdom that family systems are homoeostatic systems – they contain the problem, also the solution, and strive for an equilibrium – panta rhei.

Intervision as a follow up of training

Continuous Professional Development (CPD) is essential for every family doctor.

Often, you get stuck in a "patient puzzle" - you see the pieces, but no way to get to an (elegant) solution. Then intervision or "inter-peer learning" is a good way to keep learning in the minefield that Family Systems Theory has opened.

Two know more than one, a group knows more than two … if it is a safe environment.

That group becomes a family by itself – as with any group of people that share a common interest.

A (2-year) training in Family Systems Theory is like learning to swim. You get your 50-metre diploma but under no circumstances can you swim an Olympic distance in an Olympic time – yet this is what you need to be able to do when you're a professional Family Doctor. Training is more than just reading a book, attending a few classes – it needs re-training, day by day, year by year. Sometimes a coach is needed and sometimes switching of coach and learning other methods is needed.

Conclusion

The litany of this essay is simple – learn, learn the family words and language, for goodness sake!

The social causes as to why this is not yet a reality in Family Medicine is layered in the World Views and Metaphors of our teachers.

"Medicine is a hugely biological matter, psychosocial topics are just a tiny bit of the reality and besides, they are the topics of some soft scientists, not aware of the importance of our profession".

There is an elephant in the room.

Take home messages

- In order to become a complete Family Doctor, you should be trained in Family Systems Theory.
- Taking biopsychosocial factors into account (as evidence-based as possible) leads to better therapy.
- Inter-peer learning is a strong teaching method.
- There is an elephant in the room.

Original Abstract

http://www.woncaeurope.org/content/54-family-systems-medicine-new-view-training-general-practitioners

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86 – Assessment of the Professional Attitudes of General Practitioners

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Purpose

For many years, professional attitudes have been a matter of concern (1). In recent years, the public perception of inappropriate attitudes and behaviours of some members of the profession highlighted the necessity either of a better assessment or a more detailed definition of professionalism. In this scenario different codes and declarations have emerged and with this, the rise of an increasing scrutiny inside and outside the medical profession. In this context, the issue of assessment of professional attitudes has been raised at WONCA meetings, at larger or minor conferences, world and regional level. Nevertheless, the approach to this issue is erratic and not systematic.

Definition of Professionalism

There is no universally agreed conceptual definition of medical professionalism. The shifting nature of the organizational and social milieu in which medicine takes place is perhaps the reason why there is no universal agreement (2). Nevertheless, as Hammer (3) stated about professionalism "You know it when you see it. You certainly know it when you see its antithesis. And you know it when you are expecting to see it, but do not". Today's definition of medical professionalism is evolving – from autonomy to accountability, from expert opinion to evidence-based medicine, from self-interest to teamwork and shared responsibility.

Attitudes, professionalism and assessment may be approached separately or in an integrated way that makes it even more complex. The assessment of professionalism must begin with a shared definition of the knowledge, skills, and attitudes to be assessed. To date, there is no WONCA shared definition of medical professionalism but revisiting several declarations, statements and papers we may list the following set of behaviours (4):

- Subordination of own interests to the interests of others;
- Adherence to high ethical and moral standards:
- Response to societal needs, and behaviours;
- Evidence of honesty and integrity, caring and compassion, altruism and empathy, respect for self, patients, peers, nurses, and other health care professionals;
- Accountability for themselves and colleagues;
- Recognition when there is a conflict of interest to themselves, their patients, their practice
- Demonstration of a continuing commitment to excellence;
- Ability to deal effectively with high levels of complexity and uncertainty;

- Critical reflection upon actions and decisions;
- Incorporates the concept of one's moral development and one's responsibility to the profession;
- Demonstrate sensitivity to multiple cultures;
- Maintain competence in the body of knowledge.

The Learning Environment

Attitudes are formed through various types of social learning. With the exception of childhood upbringing and personal cultural context, there is some evidence that the learning environment through adulthood, particularly at medical undergraduate and postgraduate study level, influences professional attitudes(5).

Therefore, we have to acknowledge the professional values of health organizations. Nowadays there is a conflict in learning practice environments between what is asked of the GP/FD regarding managed care policies (what we have TO DO) and the ethical guidelines issued (what we have TO BE). If we want to progress with the measurement of professionalism in medical practice we have to clarify the differences among these values in order to solve this dissociation. A dialogue needs to be established. It has to be clear that family doctors are called to advocate health care values rather than government or corporate values.

There must be an emphasis on the importance of professional behaviour in the institutions and everyone should be accountable, using the same measures.

As stated previously, learning of professional attitudes starts to develop early on, even prior to Medical School (public news about doctors, in particular about family doctors) but it is throughout medical school, during residency and later on in practice that professional values have to be viewed , tested, and assessed. For every level of this continuum it is critical to align the values of the profession with societal needs; to align teachers' undergraduate medical values with the values learned during residency or within the professional world of practice. Positive feedback is important but we should not escape negative feedback from peers either. The family practice community needs to be a structured learning environment where professionalism is acknowledged and rewarded and unprofessional behaviour results in negative consequences. Until now, some of these issues have not yet been addressed at WONCA meetings.

Assessment tools

An evaluation of professionalism must focus on the reasons for a behaviour, rather than just the behaviour itself. Professional behaviour assessment tools must take into consideration the contexts in which unprofessional behaviours occur, the conflicts that lead to lapses in behaviour, and the reasons the choices were made. Assessment cannot rely on a single tool or approach. Tools that exist include (6,7):

a) evaluations by faculty tutors or supervisors – rating forms are the most commonly used instrument and typically have one global "professionalism" item;

b) Scales to rate professionalism by nurses and patients but this has shown to be very time consuming and requires multiple responses per resident and student, which may make it impractical;

c) Peer evaluation – however, students, residents and professionals are very reluctant to provide negative feedback about fellows;

d) Self-evaluation – but most self-assessment focuses on assessment of knowledge and skills, rather than professional behaviours;

e) Standardized patients;

f) Simulations.

Take home messages

The culture of professional attitudes is as important as the expressed curriculum learning. If we want to progress in the development of assessment of professional attitudes we need:

- A consensus of what we are evaluating,
- To decide on the possibility of utilising the same tools with each admission process to assess professionalism during or at the end of each learning or practice process;
- To clarify the level of professionalism in each development stage;
- A mixed method to measure the professionalism culture should be defined and validated;
- To encourage reflective practice and self-reflection.

Original abstract

http://www.woncaeurope.org/content/64-assessment-professional-attitude-general-practitioners-gps

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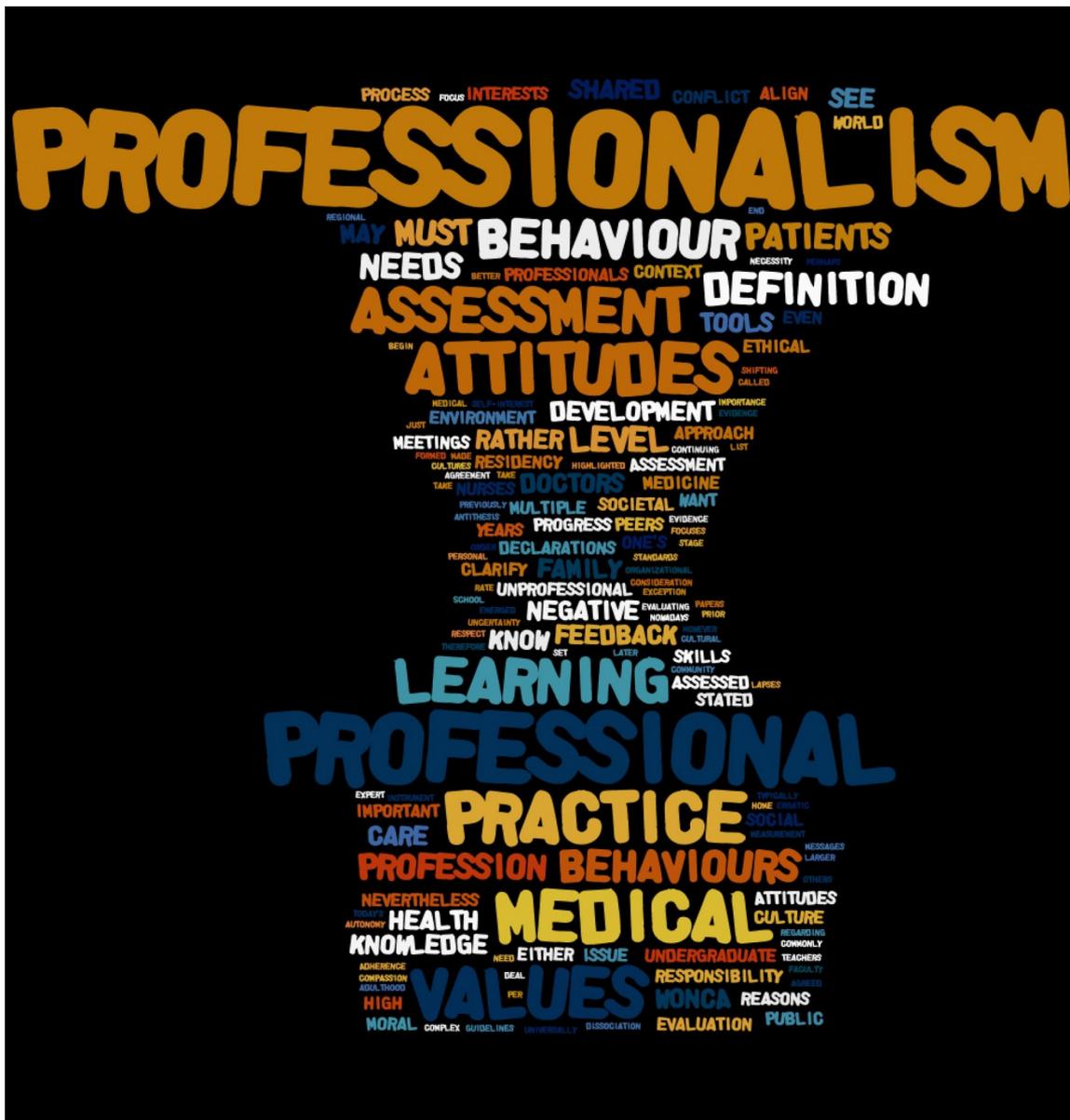
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87 – Family Medicine and Sustainability

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Sustainability and sustainable development is the process which fulfils the necessities of the present generation without depriving the future ones of the same chance to satisfy their needs. Even if Family Medicine wasn't involved in the movement since its rise, it appears evident that it is inevitably involved in the new aspect of contemporary culture. Sustainability is an important key lecture for Economy and Architecture, however, to date Family Medicine has been an inactive participant in this field, only recently becoming conscious of its role.

The resources which this generation is carrying into the future are not only material but, in particular, cultural, ethical and professional:

- Cultural, because our way of life attempts to impose efficiency in many different tasks and functions within a complex society and as a result creates many restrictions (specializations? Sub-specializations?). In this way we are losing the global perspective by focusing on the particular. In family medicine the essential problem is never particular and the whole is always essential. Family doctors have taken charge of the necessary process of simplification, with the main purpose of bringing back a global vision to the particular as well as the fragmented knowledge of specialized branches of medicine. This hidden, restless, personal engagement has witnessed the existence of an epistemological process which, though undervalued, is of extreme importance in health care and support. This remarkable process of synthesis and integration, silently carried out by family doctors, may become one of the greatest achievements of modern medicine as a whole.

- Ethical, because the greatest interest of Family Medicine is man within his own environment, primarily his family. Family Medicine is a guarantee of equity and is the principal author of the reduction of disparities in assistance, especially in areas where inequalities are greater. Human beings, whose nature has remained unchanged over the ages, still express needs and pains associated with their biological, psychological, social, emotional and rational sides; any distress always stems from any one of these aspects, although to different and variable extents. A suffering person usually looks for another human being who is willing and able to understand his/her uneasiness (disease) as a whole, someone who is able to find out its origins and offer a possible solution to satisfy these needs. This request for help is nearly always addressed to a doctor: a family doctor who is also advocate, intermediary and adviser.

- Professional, because Family Medicine derives its roots from scientific knowledge, technological application, laws and rules, traditions, deontology, ethics and agreement between men. Scientific and biological knowledge and application of new technologies constantly change the parameters of Family Medicine, which also develop in response to social pressures, although sometimes with resistance from family physicians themselves. A change in any part of this complex system of

relationships clearly affects the Discipline, which is under the influence of a multitude of conditioning influences, almost without realizing it, on a daily basis.

Within any single relationship between Family medicine and its satellite worlds, other sub-systems may come to light which, as a whole, contribute to the building of a universe of related cosmic worlds within an ever-moving and ever-changing galaxy. The Discipline must preserve its identity within this context whilst conserving its' main focus of the holistic approach to human beings. To preserve Family Medicine means to preserve respect, consideration, nobility and the freedom of every man. In this context, the areas in which the pathway to sustainable development guides Family Medicine are:
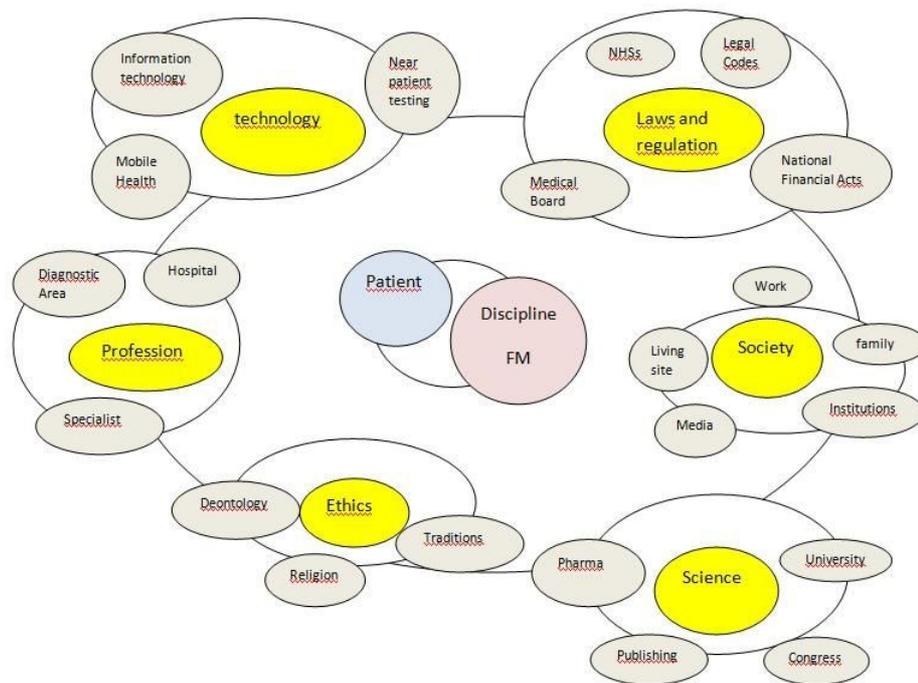
Figure: Cosmology of Family Medicine

Bioethics, evidence-based medicine, patient education, primary prevention, primary health care organization, robotics, recording of patient data, the teaching of family medicine, and Family Medicine itself.

The actions we need to take are:

- Strive for the highest quality of family doctors and provide continuing education to ensure the retention and learning of real clinical skills.
- Improve the study of humanities in the curriculum of future doctors.
- Improve research in Family Medicine.
- Always apply the criteria of quality, equity, cost-effectiveness and subsidiarity.
- Ensure free choice of management information systems.
- Decrease most of the bureaucratic burdens.
- Give citizens the opportunity to choose their preferred doctor regardless of geographical location and the number of patients per doctor.
- Allow doctors and nurses organizational freedom.
- Knowledge, research and discussion regarding sustainability and sustainable development in Family Medicine are still at "the gates of dawn".

Take home messages

- Survival of family medicine is essential for survival of equitable and effective health systems.
- Independence and autonomy of family physicians must be defended: only a free man can take care of another free man. Only high quality family doctors can ensure the survival of the discipline.
- Family medicine is the medicine of the person and guarantees the freedom of treatment for each individual.

Original abstract

http://www.woncaeurope.org/content/72-family-medicine-and-sustainability

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88 – How to Build an Ideal Healthcare Information System?

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An ideal healthcare information system (HIS) improves the quality of care and patient safety, and makes work easier and faster. Whilst achieving both of these goals, it also increases the cost-effectiveness of healthcare. The HIS should support the key tasks of the FD, particularly the provision of patient-centred and coordinated care, easy access and continuity.

Best available knowledge at fingertips

The first task of a HIS is to provide access to all medical knowledge and display it to both clinicians and patients in a format that is user-friendly. The knowledge must be searchable with any terms that the users come across in their daily practice and communication. The knowledge should be updated continuously and assessed for the quality of evidence with guideline recommendations transparently derived on the basis of the evidence. The recommendations should be graded for strength.

Personalized medicine and decision support

The total number of different data items (the sum of all diagnoses, tests, drugs, procedures…) is already about 100 000. This number will increase exponentially when whole-genome sequencing and analysis of gene expressions and proteins become routine. Computer systems are needed to integrate this data alongside available medical knowledge. Clinical decision support integrated with EHRs can already improve care and patient safety. It allows personalized medicine – the tailoring and application of guideline recommendations individually for each patient.

HIS supporting the specific tasks of the FD

The HIS facilitates communication between patients and their FD, as well as within the network of professionals that create virtual teams to provide patient-centred care. Patient empowerment is promoted through the sharing of medical knowledge, by supporting home measurements, and motivating and guiding self-care. Safe communication via personal health records, e-mail and video messages enables contact sometimes outside office hours, and simultaneously reduces long hours spent in the office and provides more flexible schedules for the FD. Continuity of care is improved.

The HIS supports the role of the family doctor as the coordinator of care. The FD has access to data recorded by other health professionals. Much of the data will be recorded by patients, either by themselves via intuitive user interfaces of personal health records (PHRs), or automatic monitoring devices. All professionals must have access to this data through consent of the patient. Correspondingly, data recorded by professionals into electronic health records (EHRs) must be available for patients via their PHRs or via a national EHR archive. Measures of functional ability and quality of life are used in the assessment of

patients and care planning.

The HIS protects the FD from information overflow and excessive workload by filtering important information, displaying summary data on one screen and prioritizing tasks. It gives primary responsibility to the patient as long as they are able to interpret the information. The HIS continuously monitors the data of all patients and simultaneously displays gaps in care to the FD. The HIS supports patient-centred care when a treatment plan is established by the patient, the FD, and multi-professional team. Care protocol templates are available for creating evidence-based plans, which are tailored to meet the goals and preferences of the patient. The HIS monitors that the goals set by the patient and FD together are met, and sends reminders to both the patient and the professional when necessary. Health inequalities will be reduced by targeting resources for people who have the most to gain from healthcare interventions.

A comprehensive decision support system is particularly helpful in the care of typical primary care patients with multimorbidity when discordant recommendations from single-disease guidelines need to be streamlined. The comprehensive medication review is a tool that analyses data from the EHR against decision support regulations and drug databases, checking evidence-based indications, laboratory monitoring alerts, warnings on reduced dosage in renal insufficiency, drug interactions and contraindications, potentially inappropriate drugs in the elderly, cumulative adverse effect risks of polypharmacy, maximum dosing and cross-allergies. The tool facilitates safe reduction in polypharmacy.

Practice and research united

An ideal healthcare information system (HIS) learns from every patient, every intervention and its outcome. Every data item in the electronic health record contributes to the body of medical knowledge as it is anonymously stored in a research database that contains the follow-up data of all patients. Associations can be detected, and hypotheses tested using such nationwide and international databases. Targeted, multi-centre randomized trials will be easy to perform by using software that automatically collects baseline and follow-up data from the EHR, and helps to record study-specific data on web-based electronic case record forms. The HIS also maintains a portfolio of the FDs experience in caring for different types of patients, and performing various interventions, and helps in identifying needs for continuous medical education.

Basic principles of HIS

To achieve these goals, certain basic principles need to be followed. The database where patient data are stored and the software applications displaying and processing the data must be separated and connected via open interfaces. This will allow the development of user-friendly software, including mobile apps, which are connected to the data. Competition in software development will improve usability. All data regarding each patient from both primary and secondary care must be accessible by means of the patient's permission ("one patient – one record"). Data confidentiality and safe communication between healthcare providers and their patients must be ensured. The coding of data must be nationally and internationally agreed to make automatic processing of the data possible, and allow high-quality software to be distributed across borders and languages. The key structured data set consists of a problem list, current medication list, results of measurements and laboratory tests, performed procedures, and functional assessment.

Responsibility of the whole population (for the FD, a list of patients and practice population) is enabled via patient data that can be aggregated, monitored, sorted and searched. Patient-centredness should be the guiding principle in software design, with virtual team building around patients, and patients themselves (not only professionals) as key users of medical software.

Take home messages

- Empowerment of patients is a strategic goal in building health information systems.
- Patient-centredness requires that one patient has one record – across primary and secondary health care.
- Coding of patient data allows processing by computer and enables clinical decision support, personalized medicine, and automation of many tasks.
- The primary care team can take care of the whole population via the information system and ensure that care can be offered equally to everyone who would benefit from health care interventions.

- Cross-sectional data from electronic health records of populations is used to create new knowledge.

Original abstract

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89 – Making Sense of Chronic Disease

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The number of people with chronic disease is increasing due to longer lifespan under better conditions and improved capacity for prevention and treatment of many life-threatening diseases. A chronic disease always induces changes in a person's life and might result in negative effects on quality of life and well-being. From a socio-economic point of view and from the doctor's perspective, there is a lot of knowledge about chronic diseases. But how do patients perceive life with a chronic disease? Patients do not always perceive themselves as ill when diagnosed (1). Patients have various ways of coping with a chronic disease. Can we as family doctors (FDs) contribute to a more successful coping process?

We performed a qualitative study based on analysis of audiotaped consultations initiated by two key questions. The patients had a variety of chronic diseases. Twenty women and seven men seeing their FD (the first author, their FD) in family practice were included. The key questions dealt with the feeling of mastering life with a chronic disease (2).

To have a feeling of control was important for our patients (3). Developing a personal explanatory illness model appeared necessary to gain control. Our patients created inner images of their illnesses by combining the perception of symptoms with the information provided by their doctor.

If the explanation from the doctor did not coincide with the perceived symptoms, it caused a lot of anxiety and distress. Emotions played an important part in the coping process (4).

Visualizing the disease could be helpful in improving understanding. A patient with chronic lower back pain was for example, shown a plastic spine and then said that she understood the anatomy and cause of the pain. Another patient saw the inside of her knee during arthroscopy and then fully understood her symptoms.

The future and issues related to treatment were of the utmost importance to our participants. We usually emphasize that the prognosis is important. Giving the condition a name was equally important, because how can the doctors treat a disease that they cannot even name? Naming the disease was also important for the participants when talking to friends and family about the disease.

For two of our patients the disease was an advantage in their new life. A younger father with a heart problem could be at home and take care of his son when he returned from school. An elderly woman with post-polio syndrome was glad that she could stay at home and read a lot of books, her favourite occupation. Her sons tried to persuade her to go for a daily walk.

The participants explained why it is important that the doctor listens to the patient. A young man with epilepsy wanted to tell the doctor his experiences about the associations between stress and attacks, but the doctor was more interested in the concentration of anti-epileptic drugs in the blood tests. The young man was

disappointed, and the doctor might thereby have missed some important information.

Cultural differences in illness perception were also observed. A young Turkish woman with pain in her joints and muscles did not understand that the word "rheumatism" as the term used by Turkish doctors did not have the same meaning in our country (5).

The key question design, triggering off the responses we have systematized in our project, is implemented in the context of clinical practice. It can be used as a clinical strategy for prompting a new dialogue, or - as in this study – as a research tool providing access to knowledge from patients on specific issues. The theoretical and methodological foundation of this design has previously been presented and discussed (6).

The key question procedure does give access to the full truth, but provides a partial and temporary insight into a specific domain – in this case about what could make a difference for patients with chronic diseases. We wanted to describe how patients experienced life with a chronic disease. Compared to a traditional interview study, the key question design holds a special potential for clinical validity, since the study context is similar to the situation where the findings are to be applied.

What this study adds to previous knowledge

As FDs we can explore patients' resources by focusing on what the disease means to the patient. According to Antonovsky, people hold different levels of General Resistance Resources (7). As doctors we can explore these. Our findings demonstrate how making sense of a chronic disease is a complex process, not just a matter of talent.

Kleinman and Aujoulat emphasized the therapeutic effect of illness narratives (8). To appreciate the patient's experience and be able to help, the doctor must witness a life story to validate its interpretation and to affirm its value for the patient.

Take-home messages

- Behind every patient with a chronic disease we find an unique person.
- To clarify the patients' explanatory illness model is important.

Original abstract

http://www.woncaeurope.org/content/bf103-making-sense-chronic-illness

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90 – A Practical Approach To Teaching Medical Students About Community Services

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This article is based on a presentation delivered by Dr Karen Flegg, Senior Lecturer from the Australian National University (ANU), at the WONCA Europe conference held in Basel, Switzerland, in 2009. The aims of the presentation were to describe an experiential method of medical students learning about community services; to outline the objectives of the programme; and to present an evaluation of students' views.

Background

The Australian National University (ANU) is located in Canberra, the capital city of Australia, with a population of approximately 360,000 people. In 2004, a new medical school was established at the ANU, delivering a four-year postgraduate medical degree. In the third year of their programme, students had a five month semester of integrated family practice and community paediatrics. Students spent four days per week in clinical attachments, mostly in private family practice clinics and community and hospital-based paediatrics. A minimum of six weeks of the five months of family practice was spent in rural towns.

Programme Objectives

The broad aim of the community placements programme was to teach medical students about the community services to which family doctors might refer their patients, or which the patients might be attending without the family doctor's referral. Specific objectives are outlined in Table 1.

Practical Application

The programme involved the students spending 13 half days in various community services and organisations. Five of the placements were scheduled by faculty staff and were mandatory, namely the Aged Care Assessment Team, a sexual health clinic, the after-hours medical service, a maternal and child health clinic, and a 'special education' school. The students also had to organise a visit to a rural community pharmacy.

For the other seven required placements, called 'selectives', the students chose and organised according to their own interests. The 'selectives' were required to include at least one geriatric or respite service, one primary care medical service, one paediatric service, two allied or community health services, one community organisation (NGO), and one other. Examples of 'selectives' are given in Table 2.

TABLE 1 – Specific objectives and rating on how effective placements were in meeting the objective

Specific Objective	Effectiveness rating 4 or 5 out of 5	
	n =	%
To experience the range of health services available in the community.	71 of 84	84.5
To understand the role of community services in primary health care and paediatric care.	66 of 84	78.6
To be able to select appropriate services for patients and work within a multidisciplinary team that optimises care.	67 of 84	79.7
To understand how to organise good quality referrals to community services by knowing what information the service needs.	56 of 84	66.7
To be able to explain the service to patients and or their families and develop a care plan incorporating other service providers.	70 of 83	83.3

TABLE 2: Example 'selective' placements

Primary care medical service	Youth health drop-in FD clinic refugee health service aboriginal health service
Paediatric services	"mother craft" nursing residential service for mothers and babies 'SIDs and kids' education evenings
Geriatric and respite services	Falls prevention clinic, aged care residence, dementia unit
Allied and community health services	Community nurse Allied health practitioners e.g. dieticians, podiatrists, chiropractors, naturopath, optometrist, dentists,
NGOs	guide dogs for the Blind National brain injury foundation Pegasus (horse) riding for the disabled
Other	funeral homes (undertakers) Alcoholics Anonymous meetings

Students were to aim for a variety of services, including in rural and urban areas, and then to spend about three hours at each service. They were asked to investigate how the service worked, who were the people providing the service, who the service was provided to, how the service was accessed by patients, and who funded the service. They were required to present a reflective writing task of 500 words on how the placements they had attended met the objectives of the programme.

Evaluation of the Programme

Three cohorts of students over a period of 18 months completed an evaluation on how effectively placements met the objectives. Table 1 shows the results.

Comments collected showed the usual variation of enthusiasm from medical students. Positive student comments included: "Important to learn what community offers", "Initially I thought it would be a waste of time but found it informative and moving"; "Was a great experience"; "Very effective for learning - wish I could do more". Negative comments included: "I was wasting time. I could have been learning real medical stuff"; "Difficult to organize".

One of the most challenging experiences repeatedly reported by students was attending Alcoholics Anonymous

meetings.

Discussion

It is generally acknowledged that giving medical students a broader insight into health services can have lasting effects and encourages a more holistic viewpoint (1).

Community service experiences are associated with improved academic performance, critical thinking, leadership, and conflict resolution, enhanced knowledge and acceptance of different ethnicities and cultures, greater understanding of the nation's social problems and increased commitment to future community service (2). Many medical schools in Australia over the past two decades, have included such a broader approach (3) and while a minority of students may see this programme as 'soft', the majority come to value some of the insights achieved. As a result of feedback from students and staff about the difficultly in arranging placements, changes have been made since 2009.

There are now only four compulsory placements (Aged Care Assessment Team, Sexual Health Clinic, Special Education school, Rural Pharmacy). It is suggested that students undertake at least six optional placements however there is neither a limit, nor a requirement to do any such 'selectives'. As a result of this change in policy there was considerable variability in the uptake of students completing 'selective' placements (see Table 3).

TABLE 3: Students Uptake of optional 'Selective' Community placements in 2013 – semesters 1 and 2 compared

Number of 'selective' program Placements per student	Semester 1 cohort	Semester 2 cohort
1 or less	6	23
2	6	7
3	5	4
4	3	3
5 or more	10	1
	Total 30 students	Total 38 students

The students are encouraged to choose their 'selective' placements in discussion with their clinical supervisor, and to use the community services available to patients of their placement family practice as a source of selection. It is now preferred for students to follow patients they have met in their family practice or paediatrics placement, into the community service they use.

The reflective writing task on community placement has been removed from the portfolio items, but the student can discuss their placement with their academic or clinical supervisor.

Conclusion

The recent change in programme has meant less work for the administrative staff in organising placements and generally the students are happy with the ability to schedule their own 'selective' community placements and especially with the flexibility in the choice.

As always, some students will do the absolute minimum required when there is any choice in the broadness of the education. It has also been noted that since 'selective' community placements became optional, the number undertaken decreases in semester two when the summative exams are approaching.

Faculty remain convinced that undertaking such placements provides a sound and valuable education and experience but has to be balanced against the manpower involved in organising these. Ideally broad-based education must be balanced against practicalities.

Take Home Messages

- Most students valued the chance to experience a variety of community health services and organisations.
- Students value the opportunity to follow the patient's journey from family practice to allied health.
- Reducing administrative load enhanced student responsibility and opened the door for self-motivation.
- Some students will always do the minimum possible at the expense of their own broad education.
- Comprehensive placement programmes present logistic difficulties for students and staff.

Original Abstract

http://www.woncaeurope.org/content/op-019-practical-approach-teaching-medical-students-about-community-services

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91 – New Technologies to Support Family Doctors

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Introduction

"One day in the future, you will be able to call anyone everywhere in just a few seconds by using a mobile device. Furthermore, this device also will be your computer ... and there's more: As a family doctor you will even be able to check your patient's blood pressure levels with the same device!?!".

Those days are not so far removed from today. Micro-CT-scanners, handheld ultrasonography, wearable microchips that monitor your vital parameters continuously, DNA sequencers in your toothbrush, hyperspectral imagers to detect melanomas in an early stage, the MRI scan (at 15dB) in your kitchen while you bake an egg, the gold nano-bullets in your bloodstream covered with antibodies to look for certain proteins, the thought control through a (Google) helmet for thought sharing, chips implanted in your eye to monitor your blood glucose and other haematologic parameters, you name it, it is or will be available over the coming years.

Personalised Medicine, Precision Medicine

We did a Pubmed search in November 2014 with "technology + primary care" as keywords and we accessed 8186 articles. All articles were written between 1969-2014. When we looked at the results in more detail, we observed that 3450 of them were written in the last 5 years; over forty percent of all the articles. This demonstrated to us the increasing importance of technology usage in primary care. There is a trend that people become more individualised in a global world, people want personal care, a personal doctor, and no mistakes. So they will welcome technology in the doctor-patient relationship.

Body Sensors, Microchips, Nanorobots in Blood, Wearable e-skins

Consider a tiny, wearable sensor that collects data and reports on the status of your body. It will measure vital signs continuously and alert the physician if there is something wrong.

With the help of a wireless transmitter, a microchip will circulate in your bloodstream and if it detects any local infection, it will detect the infection and treatment can be initiated. What if a nanorobot in your bloodstream could detect a problem before the disease manifests itself in your body?

Nanobots, called respirocytes, can keep tissue vital up to four hours even when it is de-oxygenated as in a heart attack or stroke. They can also repair the damaged area and keep away platelets from the damaged area.

Also, with the help of wearable e-skins, when medical assistance is needed, an alert from patients' e-skin will be transmitted to the medical centre and patients' data will be shared without any effort. No need to call an ambulance, no need to worry about location!

Multi-functional Radiology

It is obvious that radiology plays an important role in the diagnosis of diseases today. Consider doing an MRI scan at home in the future... Furthermore, there may not be a need to run diagnostic tests like MRI scan, CT scan, Doppler USG, etc. One multi functional machine will detect any kind of medical problem, symptom and biomarker. The machine will also be able to detect cancer from its outset.

Telemedicine, Holographic Data Input, 3D Printed Bio-materials and Drugs

In the future, the patients will monitor their vital signs and without the need to attend their health centre, they can inform their physicians.

On the physician side, patients' data will be accessible through means of holographic visuals. Screens and keyboards will be projected through all surfaces in clinics and patient data will be stored only in the cloud drives.

3D printers will be available for everyday use and when the physician offers a medication, the drugs and any patented molecule will be available to be printed at the patient's bedside. When the patient is injured, it will be possible to print a new tissue or simple organ by using 3D printers. Furthermore, with these printers, it will also be able to print humanoid robots. They can serve a sick child, educate an autistic child and can also serve as personal assistant to the elderly.

Augmented Reality

It is known that keeping patient's records in mind is a challenge for a physician! Augmented reality means living a life which is augmented by computer-generated input like audio, video, graphic or data such as FDS. A digital contact lens or Google Glass will be the best assistant to a physician. It will supply information regarding a patients' health status or will help to consult with colleagues from other professions.

Procreation and Contraception

Today, implantable systems can release hormones for up to 16 years as a method of birth control. In addition, another method is by using stents in the ovarian tubes that can be opened and closed simply through creating a magnetic field over the abdomen. You want a baby? Open! No baby? Close!

There will be a day when women get sick and tired of giving birth and request cloning; an extra-uterine device that will function as a womb and designed for home usage. Expecting parents can watch their baby grow. Live. On their bookshelf.

Conclusion

Once upon a time, having medical records and diagnostic images on the physician's computer were a great technological advance. Today, we are talking about nanotechnology, microchips under the skin and magical glasses. It is already known that with the Human Genome Project, it is possible to have personalized drugs according to genomic background. In 20 to 30 years, by altering the genomes of a person, it will be possible to be ageless and disease-free. Family doctors will then also be personal doctors, but with the help of all the technology, there will be more time for a congruent doctor-patient relationship.

Take Home Messages

- Today, at the beginning of the 21st century, lots of promising new technologies are emerging.
- Some of the future technologies include: body sensors, microchips, nanorobots in blood, wearable e-skins, multi-functional radiology, telemedicine, holographic data input, 3D printed bio-materials and drugs.In the future, we expect to print a new tissue or simple organ by using 3D printers and become ageless and disease-free.
- Family doctors will stay forever.

Original Abstract

http://www.woncaeurope.org/content/125-new-technologies-support-general-practitioners

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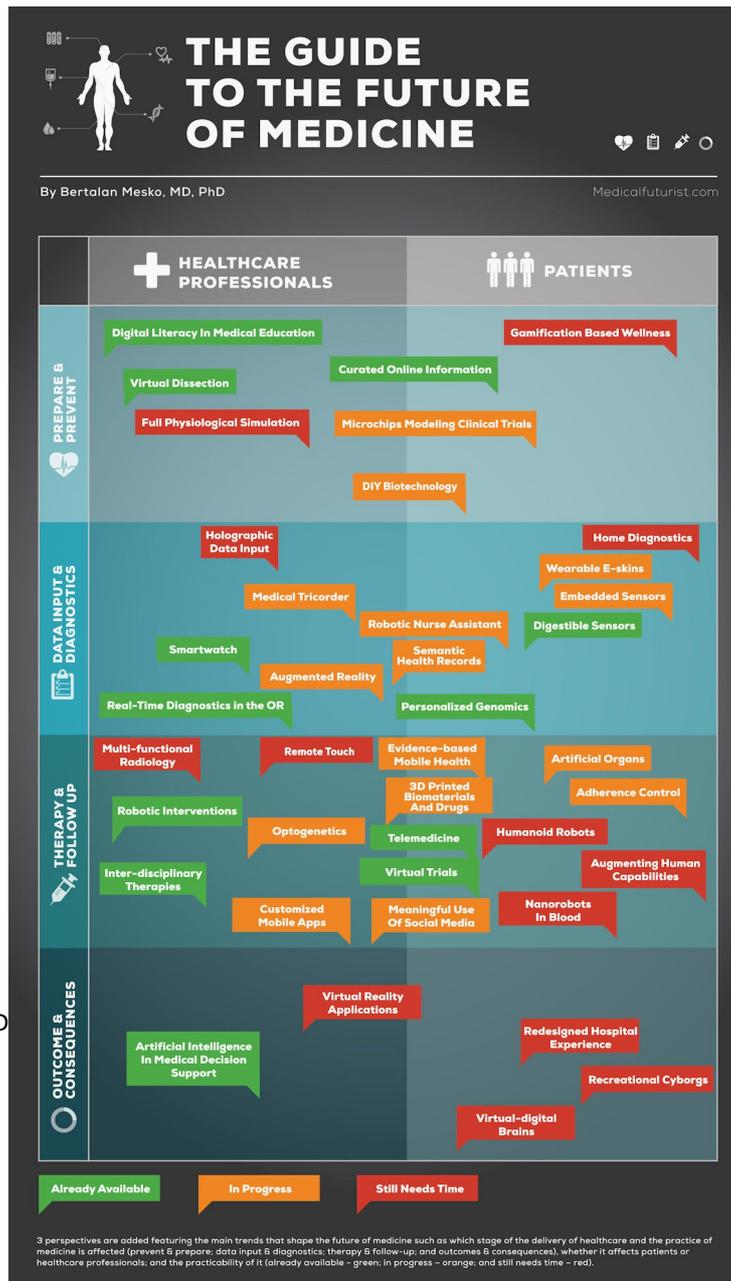
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92 – Patients' Rights and the Views of Family Doctors

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In democratic countries, the rights of patients have in general evolved in parallel with the recognition of the role of citizens in society, and have been favoured not only by the influence of health institutions and organizations, but also by the impetus of civil society and by scientific developments (1). However, in recent decades, the growing complexity of health systems, the development of science and health-related technology, the growing bureaucracy, team work and broader general access have led to medical practice becoming more risky, impersonal and dehumanized. All this means that patients' rights need restructuring and reviving as a key feature of the doctor-patient relationship. In addition, there is a growing need to establish new ways of ensuring patients' rights to protection in the face of new developments in information technology, genetics and the globalization of clinical research (2).

Under no circumstances can we claim excellence in assistance by simply applying maximum scientific rigour if, at the same time, we do not accept the norms, particularly those related with the protection of patients' rights. Nevertheless, despite its importance, there are few studies which consider professionals´ attitude in general, and those of family doctors in particular, towards patients' rights.

In 2007 we carried out a descriptive, cross-sectional study based on a postal questionnaire answered by 227 family physicians randomly selected from 72 Health Centres in the province of Murcia (south-eastern Spain)(3). The questionnaire included social and professional variables, and an evaluation of job satisfaction and of importance to patients' rights (both based on a Likert scale of 1-5; 5 being the highest level of satisfaction/importance).

The most valued right in the overall view of the doctors questioned was the right to suitable health care within a humane framework (4.86; 95%CI, 4.81-4.91), while the least valued right was the access to medical records (3.91; 95% CI, 3.76-4.05). These results contrast with those obtained 15 years ago, when the most valued rights were complete technical assistance and the freedom to decide on treatment, while the least valued was assistance in a humane framework. It seems that, over this period of time, professionals have chosen to prioritize the human quality of the doctor-patient relation over scientific-technical quality. Indeed this right has evolved from being the least appreciated to becoming the most valued one.

In contrast with the generally held opinion concerning the dehumanization of modern medicine, these results underline a growing tendency to recognize the real importance of personal values and of recovering the human aspect of health assistance.

The least valued right is patients´ access to their medical records, which seems to point to a certain lack of awareness on the part of professionals' concerning current Spanish law (Law 41/2002), which, as in most countries, establishes the patients´ right to access medical records and to obtain a copy of the same. As has been documented in other countries, it seems necessary for healthcare providers to be better informed of the patients' rights to access

information (4).

We found statistically significant differences in the assessment of patients' rights, which depended on various social and professional factors; for example, a direct association between doctors´ satisfaction and their views on patients' rights; and a significant correlation between the overall evaluation of rights and total satisfaction (P=.039). Older doctors attribute more importance to certain rights. Probably their longer work experience has shown that the greater the patient's involvement in deciding their treatment and the greater the understanding of the risks and benefits of the same, the more profitable the doctor-patient interaction is and the greater the likelihood of compliance with the treatment, resulting in an improved quality of any assistance (5).

Doctors working in an urban environment have a higher overall view of patients' rights, while those working in a rural environment tend to attribute more importance to the right to privacy. Family doctors are frequently the doctor not only of the patient in question, but also of their relatives, which on occasions can become a source of conflict, especially regarding the rights related to confidentiality. It seems that this a harder task to comply with in a rural environment.

On the other hand, the right to information, to choose doctors and the access to medical records are more valued in the urban environment, where the concept of autonomy is more widely accepted. Work overload is associated with some rights being less valued, and doctors with fewer patients on their lists give them more importance.

It is evident that quality health assistance requires the respect of people's autonomy, which implies having the time to listen, inform, obtain consent and record the symptoms in health history, which is difficult with the growing pressures of health services.

Physicians working in a centre accredited for teaching value patients´ rights more, especially those involving a better knowledge of law (choosing doctors, treatment acceptance, access to medical records, etc.).

The mean job satisfaction of family doctors was 2.79 (95% CI, 2.71-2.87). The importance of analysing professionals' degree of satisfaction lies in the fact that, among other factors, the quality of health services is directly related with the degree of satisfaction of those working in it. The overall degree of satisfaction of the family doctors in the present study was lower, consistent with other authors' findings. There is a direct and significant association between professional satisfaction and the value given to patients´ rights: family doctors who are more satisfied give more importance to patients´ rights (6).

While recent years have seen advances in doctors' recognition of patients' rights, there is insufficient evidence concerning the effectiveness of such advances, and further investigation is necessary in this respect. The first goal in ensuring that health policy revolves around the patient is to guarantee respect for patients´ rights (7, 8). This involves a sense of obligation and cooperation on the part of all health professionals. It is necessary to increase awareness of the importance of patients' rights and the responsibility that all carers share in respecting the same.

Take Home Messages

- Overall, family doctors attach a lot of importance to patients' rights.
- Physicians should be better informed of some patients' rights, e.g., patients´ rights to access medical records.
- Supplementary training to observe some patients' rights is necessary.
- Social and professional characteristics seem to have some influence on their attitudes of family doctors to patients' rights.
- The doctors with greatest professional satisfaction tend to attach greater importance to patients' rights.

Original Abstract

http://www.woncaeurope.org/content/bp6-patients%E2%80%99-rights-and-views-family-doctors

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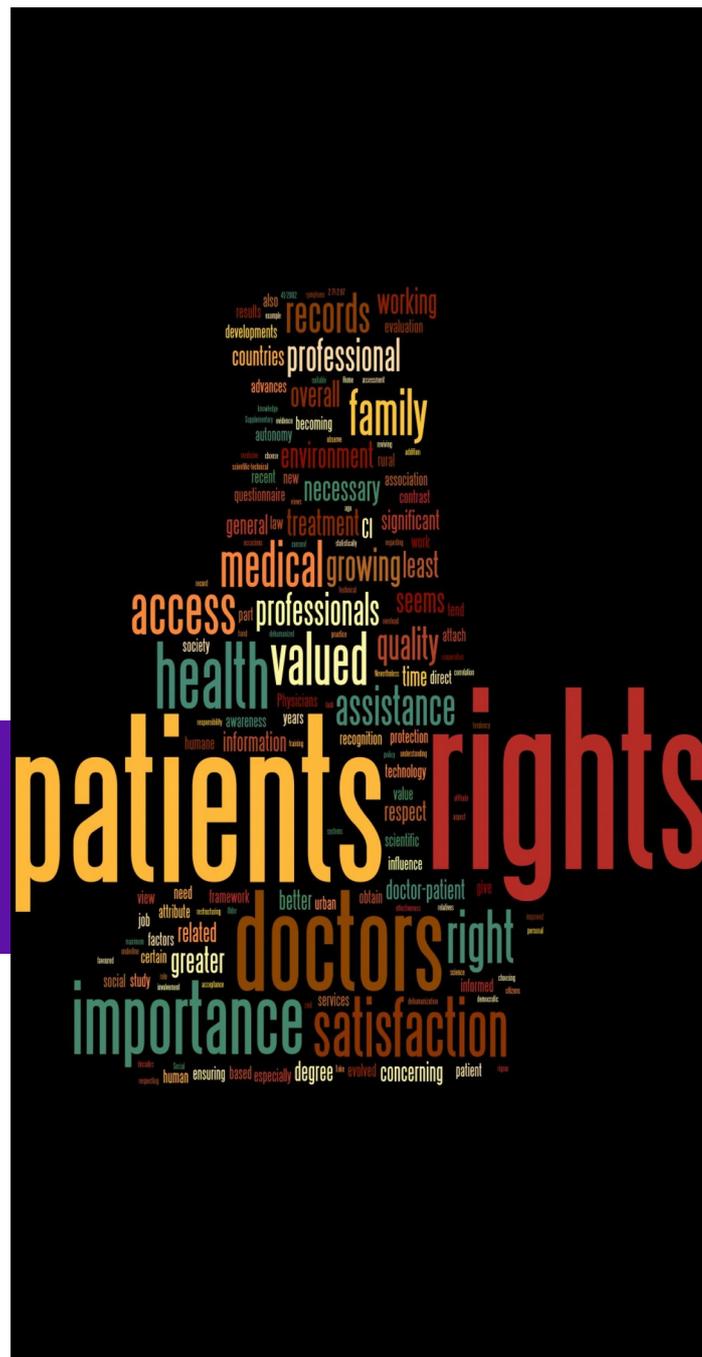
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93 – About Quaternary Prevention: First, Do No Harm.

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Towards patient-doctor relationship-based care

Clinical prevention, under the influence of public health, has been organised in a chronological manner since the middle of the 20th century. A paradigm shift from a chronological to a constructivist relationship-based preventive pattern of care (1) offers new insight into the practice of doctors, and brings to light the concept of quaternary prevention, a critical look at medical activities with an emphasis on the need not to harm. Quaternary prevention addresses the fundamental question of what constitutes too much or too little medicine. It is the fourth form of disease prevention, but also the fourth frame of action for family doctors.
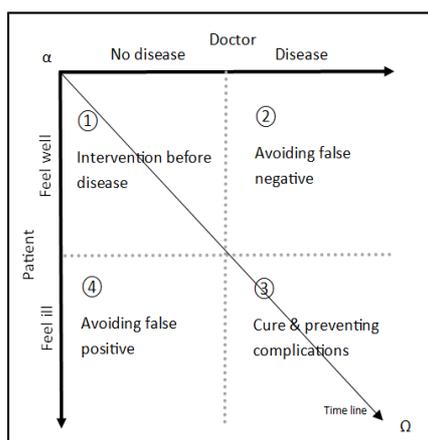
Figure 1. Four fields of the patient-doctor encounter based on relationships. The doctor looks for diseases. The patient could feel ill. Timeline is obliquely oriented from left to right, from alpha to omega, from birth to death. Anyone will become sick and die, doctors as well as patients (Jamoulle 1986).

The shift from time-based prevention towards a relationship-based organisation offers new perspectives into a physician's work. He or she observes him- or herself, and questions the ethical limits of their activities. In this sense, quaternary prevention is aimed more at the doctor than the patient. Moreover, the four definitions of prevention published in the WONCA Dictionary of Family Medicine (2) offer a structured way to discuss the activities of family doctors, including ethical considerations on the patient-doctor encounter. Quaternary prevention, also known as P4, is a new term for an old concept: first, do not harm. This concept enforces disciplines and attitudes such as evidence-based medicine, quality assurance, defensive medicine, avoiding abusive nosographic diagnoses and ethical issues including those linked to a heartsink patient.

Quaternary concept expanding worldwide

Disseminated by the colleagues of the WONCA International Classification Committee (WICC), the P4 concept is now widely recognized in Europe, Canada, South America and Asia. Astonishingly, quaternary prevention has lain dormant for two decades. With the expansion of Internet and social networks and facing the worldwide over-diagnosis movement, family doctors are now recently jostled with the idea. Endorsed by the Society of Brazilian Family and Community doctors (SBMFC), Quaternary prevention has been proposed as a core concept of the Brazilian health system (3) and has induced an international move in the whole of South America. Following the Quaternary Prevention Workshop during the WONCA Europe Basel Conference in 2010, the Swiss journal Primary Care published a paper on P4 in 6 languages (4). During the WONCA World Conference in Prague in 2013, a P4 seminar was organized with speakers from New Zealand, China, Iran, the UK and Belgium (5) and a poster was translated in French, Spanish, Portuguese, Vietnamese, Thai and Chinese (6) followed by a publication in the Hong Kong journal of family doctors. And during the recent P4 seminar in Lisbon WONCA conference in 2014, the tiny room was crowded with enthusiastic young doctors while the WONCA past president Richard Roberts was presenting the idea as seminal for the future of WONCA.
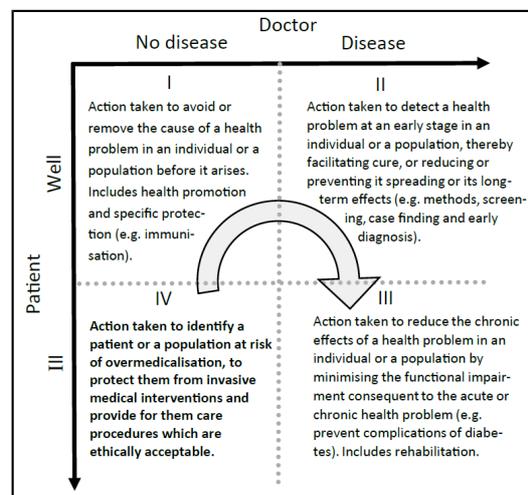
Figure 2. The patient-doctor relationship is at the origin of the four types of activities. The arrow shows that the P4 attitude is impacting all the activity (Jamoulle & Roland 1995)(Wonca dictionary 2003).

The enthusiasm generated around this topic shows that the P4 concept is used as a framework for a multifaceted repositioning of current questions and limitations of medical practice: disease invention, Attention Deficit Hyperactivity Disorder market extension, transformation of symptoms into disease, osteoporosis marketing, breast cancer epidemiology and screening, incidentaloma issues, flu & HPV immunisations, drug marketing in mental health, hypertension or dyslipidaemia, as well as empathy and communication or the value of the symptoms including when medically unexplained.

And this list is not exhaustive. Quaternary prevention involves the need for close monitoring by the doctor himself, a sort of permanent quality control on behalf of the consciousness of the harm they could, even unintentionally, do to their patients. Quaternary prevention is about understanding that medicine is based on a relationship, and that this relation must remain truly therapeutic by respecting the autonomy of patients and doctors. P4 attitude acts as a response to the family doctor facing over-medicalisation, as a resistance, a rallying cry against the lack of humanity of whole sectors of medicine and their institutional corruption(7).

A growing P4 network

The P4 network has now members in Brazil, Argentina, Uruguay, Bolivia, Ecuador, Peru, Canada, Iran, China, India, Thailand, Vietnam, Belgium, France, Germany, Italy, Spain and England expressing through websites, Facebook and Twitter. After the 2013 Curitiba Meeting in Brazil, members of the Brazilian P4 group have written the Curitiba Manifesto on quaternary prevention (8). For information about quaternary prevention-related events, links, bibliography and slides, have a look at the WONCA International Classification Committee website under the

Quaternary Prevention rubric (www.ph3c.org/P4).

Take home messages

- Prevention is not always better than cure.
- Prevention is a co-construction between patient and doctor.
- Ecology of health care requires a mastery of do's and don'ts.
- Medicine can be dangerous for your health.
- First do no harm.

Original abstract

http://www.woncaeurope.org/content/ws-057-about-quaternary-prevention

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94 – War – Terrorism – Ethical Challenges and Family Physician Education

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In spite of the fact that we are living in a modern, civilized world, every living creature- human beings, animals and plants-get a slice of natural or man-made disasters. Of course it is not possible to predict and shape the future but it seems that in most of the events as the main player in these disasters, man has had a chance to prevent them. The history of our world holds the clues as to what could have been prevented and what could not. Please take a history book from your country and have a look. Human beings like to break The Golden Rule stating that one should treat others as one would like others to treat oneself, defying all religions which decree "Do to no one what you yourself dislike" Koran (1).

Let's go to our specific profession "medicine" and more specifically "family medicine". Throughout the history of man, physicians have featured in these disasters, sometimes as medicine man, shaman or as doctor. This means that the conflicts encountered by physicians throughout humanity are not new. Since ancient times, depending on universal humanistic rules and the history of medicine - written or verbal - physicians have had ethical rules underpinning their lives in addition to their practice. Unfortunately, the wealth of experience does not mean great expertise and still "our daily routines confront us with situations that neither we nor Hippocrates could have anticipated" (2). The basis for medical ethics education was established. In general, the aims of this education are; awareness of values and ethical conflicts, knowledge of basic ethical principles, professional obligations and law and practical skills in clinical reasoning and decision making through the use of ethical principles (3,4). Although physicians know what to do in most situations, in most of the cases the dilemmas they face are complex and they are required to face them alone and manage according to their own standards within ethical boundaries (2). Specifically, ethical challenges are more frequent in family practice and more complex and this complexity stems from the nature of the work within primary care (3).

The Characteristics of Family Medicine Which May Create Ethical Dilemmas Are:

1. The emphasis on the patient as a psychosocial being, presenting in the context of culture, family, and community.
2. The existence of social and cultural diversity in the patient population.
3. The involvement in decision-making processes of multiple stakeholders, more than one of whom may be the physician's patient.
4. The interaction of the physician with vulnerable patient populations such as minors and the mentally disabled.
5. The physician's responsibility to manage the full spectrum of health conditions.
6. The responsibility to provide personal care to a patient over a prolonged period of time.

7. The inclusion of patients of all ages in the patient population.
8. The pressure of conflicting duties on the family physician due to health care system organization and change (3)

"Doctors are often among the first to witness evidence of torture, massacres or of other forms of cruel and degrading treatment" (5). Physicians accompany military forces during war to serve the army and they participate in military clashes which are contrary to our medical codes (2).

Unfortunately, there are findings that some physicians participated in human rights abuses including falsification of medical-legal reports of alleged torture, physical mutilation as a form of punishment and falsification of death certificates among those surveyed (6). Physicians are not only torn between humanity, personal feelings, national policies, and medical ethics during times of war and terrorism, but also in daily practice, even in safe places with no apparent acts of violence they encounter challenges (2,7).

It is claimed that modern life in times of peace as well as war and global terrorism, raises issues physicians have not encountered before (2). Uniquely, family physicians are often in the front line of organizational and social change and must be able to adapt to the increasing complexity of medical care options, expectations of patients and society, increasing cultural diversity of patients, and the health system organization (3).

Despite the strong evidence-based need for ethics education, recognized globally by professional organizations in family medicine, there were indications that ethics teaching was not being provided in residency programs (8).

It is well recognized that ethics teaching must:

- be integrated throughout medical training, building on the ethics education received in medical school and continuing into residency,
- aim to "custom-fit" the learner's needs at different stages of medical training, as new roles and responsibilities provide new ethical challenges, and
- address the particular ethical issues that occur in the resident's chosen specialty (8).

In conclusion; although we are living in a time of progress and civilization, numerous natural and man-made disasters are taking place all over the world. Vague opinions are put forth by the medical societies and ethical boards, but there is no clear statement concerning these issues (2).

Take Home Messages

- Before being a doctor, a physician is a human being, who should never forget The Golden Rule.
- "Medicine" as a profession rooted in ancient times, carries huge experience regarding humanity, but still faces challenges that are not predictable in every patient-physician encounter.
- Some physicians such as those working for the army are in conflict with the ethical codes of medicine but family physicians who are primarily confronting organizational and social changes face greater challenges.
- Family medicine carries a specific complexity regarding ethical issues because of the particular nature of primary care. Regardless of times of peace or war, modern life raises specific ethical issues that result in a need for a planned professional ethics education in family medicine.

Original Abstract

http://www.woncaeurope.org/content/p-215-war-terrorism-ethical-challenges-and-family-physician-education

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95 – Parents of a Newborn Child With Severe Disabilities: Coping, Resources and Needs. A Qualitative Study.

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Parents normally expect their newborn child to be healthy but a few percent of newborn infants will turn out to have some kind of disability or inherited disease even in countries with neonatal screening. Parents, who realise that their newborn child is disabled, experience severe physical and emotional stress. They have to adjust their present life, dreams and goals to a different and unforeseen reality. Some parents adapt well to this situation whereas others report long term distress and difficulties (1). These outcomes do not always correspond with the severity of the condition. A former paper from this study reported that the diagnostic process had a significant impact on parental reactions and adjustment to the diagnosis, especially in cases where it was not possible to state a certain diagnosis (2). We have also reported about the severe daily strain from taking care of the child, very little sleep at night, fear of losing the child concurrent with very stressful interactions with the social service system in particular (3). In this third part we moved on to examine how parents deal with their on-going challenges and how to support them (4).

The aim of this study was to explore how parents coped with the birth of a severely disabled child, how they maintained their energy levels and personal resources to continue coping and areas where they struggled. The role and support of the social service system and the health care system were examined in detail.

We used a qualitative design to explore parents' experiences during a two year period following the diagnosis of a child's disability. Children with expected severe multi disability were included (see table 1).

Parents were identified at the paediatric ward at The Danish State Hospital in Copenhagen and interviews were conducted in the home of the family by the first author. Interviews were repeated two years after the first interview. Mothers and fathers were interviewed independently. Parents were allowed to tell their story and experiences freely and we specifically explored sources of daily stress, how the parents evaluated their situation, sources of resources and the interaction with the health care system and the social service system.

Findings were analysed with a Grounded Theory approach and interpreted in a theoretical framework of Lazarus and Folkman's theories on coping (5) and Fredrickson's Broaden-and-build theory of positive emotions (6), as well as theories of positive illusions and benefit finding during severe adversity.

We found that parents continually created and sustained their personal resources through positive cognitive reappraisals of their circumstances, the consequences of those circumstances and their coping possibilities. A model was developed in order to illustrate the intimate relationships between coping and resources (fig.1).

Table 1: Characteristics of the interview families

Sex of child	Age at interview	Siblings	Diagnosis
Male	2 months	First child	Unknown
Male	4 months	First child	Unknown
Male	8 months	First child	Infantile spasms
Male	10 months	First child	Unknown
Female	1 month	First child	Lissencephali
Male	4 months	First child	Unknown
Male	27 months	Sister 5 years old	Wolf-Hirschhorn syndrome, diagnosed 18 months old
Female	1 month	Sister 30 months old	Down's syndrome

Figure 1
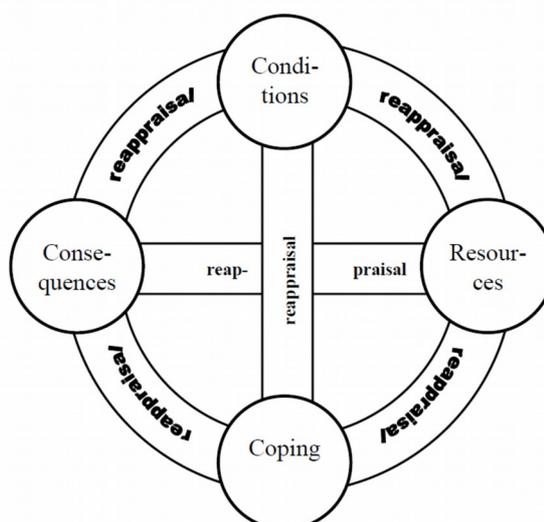
Several coping strategies were identified that supported parents' maintenance of resources including; emotional bonding, identifying supportive social relations, creating mental respite, meaning-making, benefit finding, evaluating existential beliefs, taking action, normalization.

Parents were taking action in order to relieve the disabilities by, for example, joining elaborate exercise programmes other than those recommended by the paediatricians. By taking responsibility, parents were stimulating their own resources, as cited by this mother:

I feel, after joining the training programme, those families (in the programme), it's another … it's a more optimistic view, that is easier for me to handle… because it is necessary, otherwise you don't survive this... and it's like we can do something, it is possible to make a difference.

The resource-creating process from this activity is illustrated in figure 2 below. Blue arrows indicate expected effect of exercise on the child; the green arrows illustrated the resource-creating effect on the parents.

We also found both personal and circumstantial causes of resource deterioration, often caused by the parents' interaction with the health care system and social service system.

When parents had to apply, document, argue and participate in numerous meetings etc. in order to receive necessary

help from the social service system this seriously deteriorated parental resources as stated by this mother:

It feels like a fight. And it often feels demeaning. If I apply for something, I only do it if I really think it's something that I need. I would <u>never</u> apply for something that could be just nice to have; it would be nice to have a television for him, but such things I would never apply for… and you have to push for answers, and take care not to seem irritating, because they (the social workers) have so much power.

Figure 2
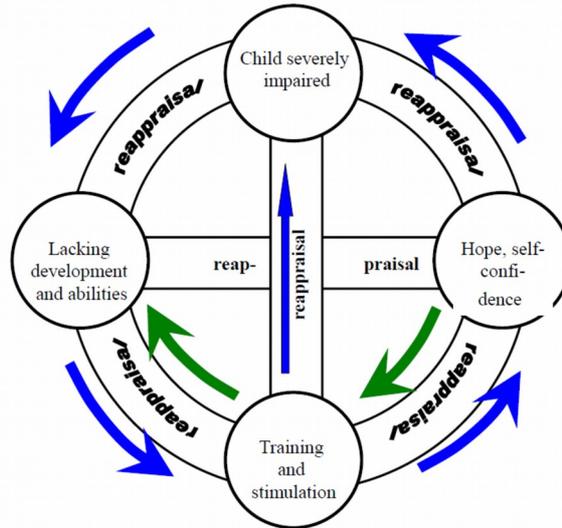
The effect on parental resources is again illustrated with green arrows, and the blue arrows illustrate the lacking effect regarding the strategy of obtaining help from the system. When experiencing bureaucracy, huge time expenses and uncertainty about their future due to the structure of the social service system, parents' resources deteriorated.

Figure 3
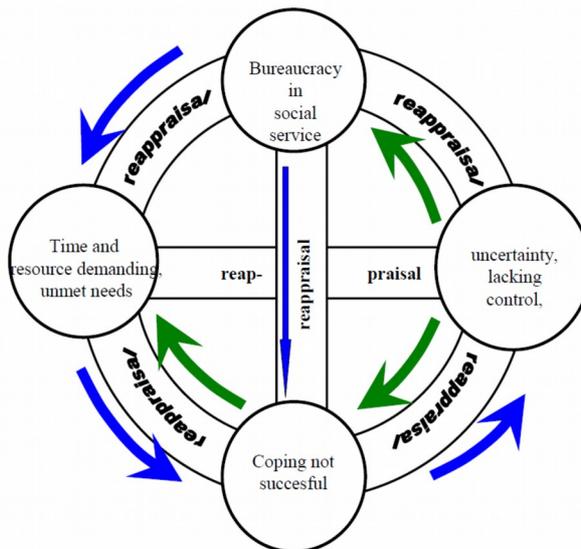
The strongest source for resource-creation was parents' appraisal of emotional bonds. Emotions for the child; love, responsibility and pride were essential. The communicative response from the child was vital in creating meaning, bonding and hope. These positive emotions infused parents with energy and purpose in their continuing care-giving. Furthermore, a strengthened marital relationship and the experiences of family and friends contributed to forming a close family network.

Meanings and consequences of this study

The theory of resource-creation is proposed as an addition to the current understanding of coping and the role of positive emotions. Coping and resources were found to be closely interrelated thus parental coping can be strengthened by identifying and support the parents' resources.

Parents with a disabled child are at risk of chronic sorrow and depression, as found in recent studies (1;7), so intervention is clearly needed. Other studies of coping in this parent population have found poor parental coping was related to feelings of threat to the family, poor health in the family and lower family satisfaction (1).

As coping *can* be improved through intervention (8), it *is* possible for health professionals to support parents' resource-creation in a number of ways, even in very severe cases of disability as other factors in and around the child and the family often play a significant role in parental well-being.

Take home messages

- Parents of a disabled child experience severe stress in all domains of life.
- They may be at risk of developing their own mental and physical health problems, but many parents seem to cope quite well.
- Parental resources are closely connected with their ability to maintain caring for the child and cope with daily life.
- Coping and resources may be supported or counteracted by the health care and social service system.
- Emotional bonding to the disabled child is a main source of resource to parents.

Original abstract

http://www.woncaeurope.org/content/bpop15-parents-newborn-child-severe-disabilities-coping-resources-and-needs-qualitative

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96 – Family Doctors' Career Towards Academic Level: Why and How

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Introduction

Over the last 40 years, there has been an accumulation of evidence on the importance of family medicine. There is more than enough evidence that the strength of a country's primary care system is associated with improved population health outcomes, that health systems with a strong primary care orientation tend to be more equitable and accessible and that primary care delivered by family physicians reduces costs and increases patient satisfaction with no adverse effects on patient outcomes.

But although the key contribution of primary care in producing good public health outcomes is now obvious, there has been less success in achieving the recognition of primary care as an academic discipline. Academic recognition is one of the key elements of equal status with other, well established disciplines, which also enables specific approaches to teaching and research. Because of this, family medicine societies throughout Europe have invested substantial resources in achieving this goal.

Within this arena, family medicine had to find its unique position (1), and at the same time lead the way for a better alliance between academia and the field of patient care. This required a simultaneous paradigm shift in the worlds of health policy and research and development, which may explain the time and effort required.

One of the key steps in this process was the writing of the European definition of family medicine (2). The development of theoretical models was a great intellectual challenge and helped in creating teaching and research agendas and curricula for family medicine worldwide (3-4). The work of experts in the theory of family practice successfully demonstrated how family medicine differs conceptually from other medical and health care disciplines and provided a much needed conceptual framework for teaching and research agendas.

Challenges and Problems

There is often a feeling that nothing much has changed for family practitioners outside the ivory tower of academia, and it is probably safe to conclude that in most countries family medicine has still not received the recognition that it deserves.

One of the big challenges in recognition of family medicine is the primary care paradox (6) which looks at the belief that although family physicians provide poorer quality care of specific diseases than specialists, primary care is nonetheless associated with better health, greater equity, lower costs, and better quality of care. Unravelling the paradox depends on understanding the added value of primary care.

It needs to be recognised that there are limitations as to what family medicine academics can achieve. The opinion of the clinician and academic bodies is no longer regarded as sacrosanct and a new dialogue is emerging between health care consumers and providers where academics are often excluded.

On the other hand, the benefit of this partnership is seen in the fact that countries which have achieved high standards in academic family medicine are characterized by equally high standards and esteem for family medicine. In these countries, professional organizations have understood that the benefit of academic bodies is often hard to measure directly, but is viewed with respect by policy-makers and the public.

Secondly, by joining the academic arena, family medicine is subject to the same criticisms as all the other academic disciplines about the detachment of academic medicine from reality and following agendas of its own that have nothing to do with the real problems. If family medicine academics do not maintain close links with their practising colleagues, this may become a real threat.

Key Success Factor

In the countries where family medicine has flourished academically, academic family medicine has managed to maintain and further develop good collaboration between practice and theory. Teaching practices and research networks are the natural environments for research and education in family medicine as much as laboratories and hospital departments are the environment for basic and clinical sciences and departments of family medicine are often a model for how collaboration between theory and practice can be achieved (5).

In order to maintain this link, a close cooperation between professional and academic organizations is necessary. This is not always easy, but is vital, and in particular in primary care and family medicine. This goes back to its central role in any healthcare system: to be effective, interventions should address the prevailing important health problems in the population under care. In other words, implementing and modifying innovations to meet local needs is an integral part of primary care development. This requires family practice with an academic connection in every community (7). This is the key factor of academic success in family medicine, where the discipline can fulfil its potential in contributing to the academic arena.

Conclusion

Regardless of obvious problems that still exist, the achievements in the academic development of family medicine in Europe have been remarkable. Family medicine has been successful in creating its theoretical background and in promoting itself as an academic discipline (8). Throughout Europe, many academic departments of family medicine have been established and it is now customary for every student at medical school to be taught about family medicine as part of the core curriculum. Specific training for family medicine is recognised as a standard for modern patient care and accepted as a rule in the EU, and is an aspiration for most of the countries that want to join it.

Family medicine is well placed to take over the responsibilities of a well established discipline. Theory has been useful in explaining why family medicine is unique, but new steps now need to be taken in order to prove its value to the public. They can be made only through partnership between the professional organizations and academic bodies. In order to maintain this link, a close cooperation between professional and academic organizations is necessary.

Take Home Messages

- Family medicine has achieved its goal of academic recognition in Europe.
- In order to do that, it has had to adapt.
- The need to maintain its specificities is now as important as it was decades ago.

Original Abstract

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97 - A European Observatory for Primary Care Development

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An observatory is a location used for observing terrestrial or celestial events. Also, it could be seen as a place where professionals, academics and citizens meet to consider new information about primary care/family medicine and share data that could lead to the development of policy and practice in this field. Public access to health information/data is greater than ever and in other fields there are examples of the involvement of citizens in helping to catalogue data (see The Galaxy Zoo)(1). In the health context, the Coulter Study in 2005 clearly demonstrated a desire from citizens to be involved in the development of primary care (2).

In this current 'age of data', GPs/Family Physicians have access to a large amount of information. However, this data is not analysed nor measured in a routine way. Typically, when used, it is for limited purposes and small projects.

At the same time, companies such as Google are exploring ways of gathering lifestyle data automatically and systematically from individuals for public and commercial use. Therefore it seems pertinent and timely for healthcare professionals, academics and citizens to give consideration to the establishment of processes and structures that would place these stakeholders in the forefront of this data revolution about lifestyle and primary care and the development of both policy and practice that could flow from such collaboration.

The concept of a European Observatory for Primary Care Development was developed some years ago(3). What should it look like? A good example was found in Ireland; the Heartwatch Programme (4).

You need one (or several) goals, you name the parameters needed to screen and collect information and perhaps additional parameters typically known to family physicians, e.g. the Family Apgar.

You then have to ensure privacy, involve the public in the collection and 'datamining' of the information, and report back to the individual patient as well as the general public.

A European Observatory might sit atop of a collection of National Observatories accessing data from local observatories, cities, counties, depending on geographical and demographical parameters. A purposive sample could be determined as a starting point and data collected. A local observatory can report back to the individual patient and other stakeholders using all media resources. A National Observatory can search for trends. When new policies are implemented, one can measure the impact or its absence.

Some trends only show up after 20 years, e.g. the effect of the onset of legalised abortion and the decline of crime and crime-related diseases (5) needed some time and shrewd researchers could see a difference between causality and a plausible relationship.

So, what benefits would a European (and why not later, a Global) Observatory provide?

Perhaps as a starting point one might investigate 'what already exists'. One example is to be found at:

http://www.who.int/influenza/surveillance_monitoring/updates/latest_update_GIP_surveillance/en/ .

But what should a European Observatory for Primary Care Development monitor and display?

Some possibilities might include medical education, e.g. medical schools offering a well-designed and internationally approved programme for a higher degree in Family Medicine; data on obesity, child mortality, teenage pregnancies and other parameters that reflect the impact of family medicine on a community.

Other starting points might include; the correlations that Barbara Starfield published (6) demonstrating one way forward to better quality and better health.

In terms of existing organisations, cognisance needs to be given to what role they might play and how the varying interests and foci of these organisations could facilitate the development of a European Observatory. Such organisations might include: European Observatory of Medical Demography UEMO, EQuiP, EFPC.

Next, the question of who, where and how the Observatory should be hosted? It is argued here that any host organisation would need sufficient drive and endeavour and a commitment to working with the politics and practicalities of the existing field. Also it would need the vision and resources to take the work forward. From the limited work done in 2005-6 my view was that a FD College with a desire to take a European perspective would be well-placed to lead the establishment of an Observatory with a possible link into WONCA Europe and WHO Europe. Perhaps at this time a better approach would be to consider how a consortium of Colleges might be able to develop sufficient mutual support and pooled resources to develop a vision of an Observatory and consider what first steps might be necessary to make the vision reality. Another consideration might be how other potentially interested parties (e.g. research bodies, local government, charities, etc.) might wish to contribute at an early stage. It is argued here that early stage involvement of 'other parties' in health and care development greatly assists sustainability. An example of this is the involvement of a city authority in the Heartwatch Programme in the UK. Here, local government worked together with primary care and the NHS to link-up sport and leisure services to the Heartwatch Programme.

Finally, one way forward would be for an interested party (a College?) to identify resources to initiate a scoping exercise that identifies interested organisations and the resource that they would be prepared to offer the development of a consortium. Also, it could help to establish common areas of health concern where systematic and coordinated data could be collected. This could be done from 2 perspectives: focus on where existing work has already been done at a national level; or, areas where little work has been done but there is an international recognition of the importance of particular health concerns. A good example of this second (and preferred) option is that of dementia. In a report in 2011(7), it was recommended that it is necessary to 'build more cooperative networks across Europe' in order to create 'greater coherence and synergy in research and understanding and opportunities for developing new comparative methodologies...and the harmonisation of data'.

It is hoped that this essay will provide the incentive for the latent idea of a Primary Care Observatory to be re-established on the European primary care agenda and challenge a critical mass of organisations to fund some further work to scope and develop plans for coordinated activity.

Take home messages:

- An Observatory would facilitate the coordination of data and shared learning;
- Its development needs a critical mass and a 'lead partner' to 'kick-start' the work.
- A scoping exercise would provide the development agenda.

Original abstract

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98 – New Era for Clinical Research in Primary Care

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Primary care is the cornerstone of the health services in many countries. Nevertheless, most of the knowledge that we base our practice on is derived from a secondary or tertiary care setting. The need for more research performed in primary care is urgent. It is essential to establish an infrastructure for independent research that is relevant to general practitioners (GPs), their patients and to the community. Such an infrastructure was set up years ago in the form of primary care research networks in the UK, Netherlands and the US (1-3), and there are new initiatives elsewhere, for instance in Ireland (4) and Norway (5).

Clinical trials in primary care have almost been synonymous with pharmaceutical trials. These trials have to go through an extensive process to ensure patient safety and scientific quality, and the pharmaceutical companies provide an infrastructure that secures that the involved practices will deliver what is demanded and adhere to protocol. The requirements that have to be met call for resources that most academic institutions cannot even dream of, and participation in such trials gives GPs the possibility to take part in research of high quality.

Participation in pharmaceutical trials offers many advantages, but there are also uncertainties and pitfalls, for both physicians and patients. One task of the GP in clinical practice is to balance pros and cons in a long line of different encounters every day, and sometimes to assist her patients in living with the necessary compromises and consequences. How to relate to the pharmaceutical industry is yet another area where these skills are needed as there are common, but also potentially conflicting, interests.

The industry itself is eager to point out the benefits for the physicians: Professional development and recognition, taking part in the evolution of medicine, and the opportunity for additional income (6). There should be no misunderstanding about the fact that there is a lot of money involved in recruiting patients for pharmaceutical trials. How much the GP should receive for his/her effort is always debatable, but the compensation should at least reflect the actual work involved. On the other hand the amount should not seduce GPs into taking part in bad science.

There are studies that will gain new knowledge or improve treatment options, but there is also a risk that some are just as much aimed at prolonging patent rights or strengthen market position. A thorough evaluation of proposed projects may be difficult, beyond the capacity of the average GP, and there should be a process for systematic assessment of protocols for studies aimed at primary care.

Participation in trials is often considered beneficial by patients that are included. Several studies have shown that other benefits than physical improvement is of importance to the patients. The combined perceived advantage of additional monitoring, the opportunity for assessment by a specialist and an altruistic motivation to help others is a consistent finding across several studies.

The assertion that patients will receive better follow up by participating in trials, with improved clinical outcomes from

study participation itself as an effect, is uncertain. The conclusion of summarized research on comparing the outcome of patients within or outside clinical trials is that there is no clear evidence of such an effect (7). There is a risk that the inclusion and exclusion criteria might bias the study population towards someone with a better prognosis, and other forms of bias can also influence the results. This has been most extensively studied in cancer research, but there is no reason that it should be different in primary care studies. A possible effect of this kind of bias is that the generalizability of the studies may be questionable, and assessing this is important to GPs who see a cross section of the general population.

The challenges introduced by current changes in demography cannot be met with yesterday's solutions. Technological development paves the way for innovations in primary care, and we already see the possibilities for data gathering and disease monitoring by the use of patients' home devices. This opens exciting possibilities for improved care and improved research, and family doctors should be at the forefront of this development and help secure that new ideas are introduced and properly tested.

We know that a large proportion of patients are willing to participate in clinical trials (8). We also know that GPs will benefit from taking part in studies, and participation in research should be considered an integrated part of primary care, not different from secondary care. This is not the case today. Therefore attitudes must change and sufficient resources, both time and money, must be allocated. This cannot just be the responsibility of the pharmaceutical industry and there must be an alternative based on existing health services and the academic institutions. Lessons from the UK and the Netherlands have taught us that establishing comprehensive public research networks is an efficient and cost-effective strategy to support high quality research in primary care.

Primary care research networks tie a number of general practices together under the common umbrella of a coordinating organisation based inside or outside the academic institutions. The infrastructure should be robust and sustainable, and the network must be able to deliver services essential to both researchers and participating GPs:

1. Recruit a sufficient number of GPs and practices capable of delivering patients to clinical trials.
2. Provide tools for extracting data from electronic patient records.
3. Assess practices and certify those ready for research.
4. Evaluate feasibility of proposed projects.
5. Estimate fair compensation for participating doctors, based on actual cost and time required.
6. Support inclusion of patients into clinical trials, and secure data from these patients.
7. Promote implementation of research based knowledge into clinical practice and health policy.

A primary care research network is the laboratory where we all need to bridge the current gap between clinical work and academic general practice in many countries. It will be the place where we can study research questions important to GPs, our patients and the community.

Take home messages

- Changes in demography call for innovations in both research and care.
- Practice based research in primary care is urgently needed.
- A permanent infrastructure is essential to secure that feasible projects are completed as planned.
- Primary care research networks are a well documented foundation for high quality research.

Original abstract

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99 – Family Therapy Skills for Medical Practitioners

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Introduction

Despite societal changes, the family remains the most basic unit in society. The general practitioner is, more than other health care providers, involved and associated with the family and develops a perceptive awareness of a family´s nature and style of living. One challenge in general practice is the need to pay attention to the stresses, social changes, and expectations of family members over time, as well as the effect that these and other family interactions have on the health of the individual patient (1). The concern is not only with psychological and psychosomatic disorders, but it is also emerging with chronic disease management in particular, which is becoming the major topic for general practice in our time. One example is the importance of the family's perception of disease and the treatment of diabetes (2).

A family-oriented approach is one of the basic attributes of general practice (3, 4). Family-oriented primary care involves thinking about the patient's problem in the context of the whole person and the person's significant others. These other persons, such as family members, can eventually be invited to help or be involved in the assessment or treatment processes. Although this can be considered a simplified model of family therapy in general practice, family therapy is in fact a much more complicated method, requiring specific competence, technique and allocated time, all of these conditions being barely achievable in daily routine practice.

Family therapy is one of the psychotherapeutic techniques used primarily in the treatment of psychosomatic disorders. It is proposed that – whenever possible – the whole family, not just the individual labelled as the bearer of the symptoms, enters into the treatment. A symptom is considered a stabilizing element in a dysfunctional family. The aim of treatment is to improve communication in the family and improve its functioning in order to stabilize the illness into healthier patterns without symptoms.

Family therapy uses a range of counselling and other techniques including: Structural therapy, Strategic therapy, Systemic/Milan therapy, Narrative therapy, Transgenerational therapy. Therapy usually takes place in multiple sessions spaced out over several months. Family therapy can be used in a variety of clinical settings, including general practice. There are few reports in the literature about the use of family therapy in general practice (5,6).

However, under current health care systems, it is not the task of a family doctor to engage in family therapy – unless they hold a particular interest and special training. Rather, it is the task of a family doctor to look for signals that make a contextual approach necessary, and then act upon it appropriately.

In order to find signals one has to undergo training in:

- non-verbal signals, especially the micro signals of contempt (7)
- designing a family tree
- designing a diagram of bonding and loyalty
- signals of abuse or other malfunctioning.

Moreover, communication, transaction and interaction analysis are essential skills. "Active listening" narrows the boundaries of interpretation and understanding, clarifying the picture;

"What do you mean by …?"

This helps us to get away from overmedicalisation, away from only using the medical microscope and learning to use the telescope that is required in such a setting. The concept "medically unexplained symptoms" is inappropriate here, since the symptoms can very well be explained but the doctor needs to be able to use the right "scope".

A doctor that stays in touch with himself and as humble as possible will go a long way.

Conclusion

Primary care or family doctors can learn additional skills to engage in untangling the puzzle a family presents. It is not a recipe that you learn from a cook-book, rather you learn it by observation, training, re-training and intervision.

Take home messages

- Pay attention to family interactions and consider them with regard to your patient.
- Explore the perception of chronic disease and its management in your patient's family.
- Family-oriented approach in general practice is not family therapy.
- GPs with special interest can become family therapy specialists after completing training and adjustment of practice organizations.

Original abstract

http://www.woncaeurope.org/content/14-w-family-therapy-skills-medical-practitioners

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100 – What We Do

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Family doctors and primary health care professionals are currently in vogue. International agencies, health ministries, and health systems proclaim the value of health services based on primary care. Thus, it is understandable that family doctors assume that their place in health care is secure. While that assumption is understandable, it is risky.

The Declaration of Alma-Ata (1) concluded in 1978 that primary care produced better outcomes, improved equity, and cost less than specialist-based systems. The 2008 World Health Report (2) confirmed that primary care remains essential in the 21st century. In the thirty years between those two documents, a number of studies demonstrated the key attributes that make primary care valuable (3).

This chapter will review the attributes and contrast them against the changing reality of Family Medicine, and the potential for family doctors to lose their hard earned status. I will focus on what I believe are the six most important attributes. To make them easier to remember, I will use alliteration and name the attributes with a word beginning with "C." At the end of the brief discussion for each attribute, a critical question is posed that can be used to assess the performance of a family doctor, primary care practice, or health system on that attribute.

What is there to "C" in family doctors and primary care?

Convenience – Historically, primary care has been where people first enter the health care system. Yet, there is a growing array of other settings where people now enter: emergency departments, urgent care, out of hours or home care services, hospitals, specialist practices. People also engage the system through telephone advice lines, websites or other electronic portals, and so on. Consequently, the number of first contact visits in primary care has diminished. Even within primary care, the number of first contacts with the family doctor has decreased relative to other members of the primary care staff. Health systems are under pressure to make it easier and more convenient to enter the system. Family doctors with reduced hours and limited availability are less easy and convenient for patients.
Critical question: How easy it is for patients to contact their family doctors?

Coordination – A vital role of primary care is to assure coordination of the many services a patient may require. In many systems, professionals other than family doctors provide these functions. Known as care managers or coordinators or navigators, the training of these professionals ranges from nursing to social work to on-the-job. There is also a wide variation in their ability to integrate and make coherent the often disparate care plans generated by various consultants or other specialists.
Critical question: How involved are the family doctors in coordinating and integrating their patients' care?

Context – A crucial element of knowing the patient is an awareness of her or his context. Understanding patients'

families, communities, work, religion, and other social determinants of health provides important insights into their health. Family doctors appear today to be less likely to live in their patients' community or remain in a single locale.
Critical question: How well do the family doctors know their patients' context?

Comprehensive – Better outcomes and lower costs result when family doctors provide most of the care needed by their patients (4). Fragmenting care across more professionals, even within the primary health care team, diminishes the skills of the family doctors (5). Decisions to delegate tasks or to limit clinical activities to narrow areas of interest shrink the scope of services provided by the family doctors.
Critical question: How comprehensive are the services that the family doctors provide?

Competence – Patients deserve and expect competence. Particular individuals, both within or outside the primary care team, may perform certain services more skilfully than the family doctor. Yet, the small marginal gain in a specific technical skill may be offset by too limited a perspective of or trust by the patient, with better overall outcomes when that specific service is provided by the family doctor. Moreover, family doctors with inadequate training, time, or motivation often fall victim to a self-fulfilling prophecy: "The less I do, the less I feel confident and skilled to do."
Critical question: How skilled are the family doctors to provide the services needed by their patients?

Continuity – One of the most important attributes of primary care is the continuity of the interpersonal relationship between the family doctor and the patient (6). Continuity permits greater knowledge of the patient by the physician and promotes greater trust in the physician by the patient (7). It is possible to extend, but not delegate, the continuity relationship to other members of the care team. In other words, the family doctor must have sufficient direct involvement with the patient for a trusted relationship to develop. Building on that relationship, other members of the care team can then be trusted to provide various services for, and develop their own relationships with, the patient.
Critical question: How strong is the relationship between patients and their family doctors?

Practices and family doctors that answer "VERY" to all six critical questions provide better primary care. Health care systems that have strong primary health care do better. Thus, the best health care systems are those that respond positively to a single essential question:
How well do the family doctors know, foster trust in, and provide services for their patients?

Conclusion

In essence, good family doctoring comes down to leveraging trusted relationships and providing comprehensive services, thereby achieving better outcomes (8). The risk today is that in our pursuit to measure well against disease-oriented metrics and to manage growing patient needs and demands, we will give in to the temptation to limit our availability to our patients and fragment their care across more disease-focused professionals. Our challenge is to develop new strategies and technologies to better know and better serve our patients. Family doctors are not valued because of what we think we do or say we do or used to do. We are valued because of what we do.

Take Home Messages

- Health care systems do better when they are built on strong primary care.
- Strong primary care depends on six key attributes: convenience, coordination, context, competence, comprehensiveness, and continuity.
- Recent trends suggest that family doctors, and their practices, may not be performing on the six attributes as well as before or as desired.
- Family doctors must develop improved strategies to better know, foster trust in, and provide more services to their patients, or their relevance will decline.

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Epilogue

So this is the end of this book, but it is also the beginning.

We hope that by reading this book you have discovered, or rediscovered, the richness of our professional discipline of family medicine, the breadth and variety of the issues which we address in our daily work as family doctors, the ability of family medicine to adapt with the challenges posed by the different health systems in each of our countries, and the great joy that comes from the privilege of being a family doctor.

The take home messages in each chapter underscore the core concepts of family medicine, that apply wherever in the world we work, and provide valuable advice from our global panel of experts that each of us can adapt to our everyday work.

We hope that, like us, you have been inspired by the contributions from our colleagues from around the world.

We thank all the contributing authors, and we thank the editorial team led by Mehmet Ungan and Carl Steylaerts, for this remarkable publication.

As we said, this is the end but also the beginning, and we look forward to this being just the first in a series of books providing important lessons from family medicine.

And we leave you with three final Take Home Messages:

- The contributions to this book have demonstrated how much each of us can learn from our family medicine colleagues;
- The contributions to this book have reinforced the special distinctiveness of our professional discipline of family medicine and the qualities that we need to nurture and cherish;
- We hope you will take the lessons you have gained from reading this book, and apply them to your own clinical practice, and that you will continue to provide excellent care to the people in your community who trust you as their family doctor to provide them with medical care and advice.

Acknowledgements

Writing this acknowledgement is like describing your first honeymoon night. Almost everybody knows how it goes, so it is futile to try it. Those who don't have had the experience, well, let's not spoil it for them.

We owe a lot to a lot of people, all over the world.

Those who want to compile and edit a book like this, will enter into the same unknown territory as we did. And will refer to friends and colleagues and secretaries all over the globe. We thank all of them.

The list would be endless, suffice it to be acknowledged that we didn't do this alone.

Just two persons cannot be dismissed.

Leo Bormans, the compiler and editor of the World Books on Happiness, Love and Hope, gave us a tremendous example on how to do this. And Janko Kersnik acted as a hidden power behind the scene. Thank you both.

The WONCA Europe Executive Board, presided by Job Metsemakers, decided that this book would be an excellent gift to all the general practitioners and family doctors all over the world. Free of charge. Let's thank them.

As mentioned in the Prologue, some of the authors weren't the original submitters of the abstracts that were chosen by the independent jury. They acted as stand-in or, if you like, body double. They did great.

Thanks!

The Authors of
The World Book of Family Medicine
European Edition 2015

20 Years of WONCA Europe – Some History

In 1959, the Societas Internationalis Medicinae Generalis was founded in Vienna as the first European GP organisation.

In 1972, WONCA was founded as the first global GP/FM society. In 1992, WONCA organised a first WONCA Europe congress in Barcelona, Spain.

In 1994, the "Group of 8" - being 4 members of WONCA and 4 members of SIMG decided in Estoril, Portugal to merge the 2 organisations into the European Society of General Practice / Family Medicine, and it was inaugurated in 1995 in Strasbourg, France, in the European Parliament.

Since then, 6 Presidents have led the organisation.

Frede Olesen (1995-98)   Chris van Weel (1998-2001)   Philip Evans (2001-04)

Igor Svab (2004-10)   Tony Mathie (2010-13)   Job Metsemakers (2013-16)

In 2001, some of the former Executive members gathered in Vienna. They called it Veteran's Day and a few pictures are on the website at http://www.woncaeurope.org/content/veterans-day-2000-part-1, http://www.woncaeurope.org/content/veterans-day-2000-part-2, http://www.woncaeurope.org/content/veterans-day-2000-part-3.

Nostalgia rules!

WONCA Europe's history is however by far and foremost … in the abstracts of the thousands of contributors that research, teach, develop and apply quality measures, contemplate about prevention and/or rural medicine … and think about the past, the present and the future. Not to mention the Special Interest Groups, working on the boundaries of our and other's specialty.

Wherever we go, someone took that path long before we did. The future reflects history.

Words awaken the spirit, examples inspire that same spirit. And that's what it is all about. WONCA spirit.

What is a World Book?

It is a series of 100 titles selected from 20 years of World and European WONCA Congresses, by concept small essays on the topic inviting to read more. It is in no way meant to be exhaustive text book material, but short and crisp texts to highlight why the title was selected in the first place.

Why a World Book?

When you have an Anniversary, WONCA Europe's 20th to be precise, it is time to reflect, to look out for more, and for exchanging gifts. Selecting the best 100 titles, asking the original or guest authors to make a crisp contribution is a way of honouring our past, but also a few good moves into the future. The future of the World, of Family Medicine, of WONCA. Hence the title ;))

Since the selection was biased by a European look, we decided to name it European Edition.

How did we do it?

Collecting the abstracts, making them digitally available, correcting for language, selecting a long list, asking a competent jury (Executive Members of the Board of WONCA Europe and WONCA World) to come to a short list of 100.

What is to be expected from a World Book?

Inspiration. Also a sense that when you present at WONCA, your work is not lost and there is a chance that – who knows when! - there will be more to follow. When? As soon as someone comes with the idea …

Volunteering

One can ask oneself: what's all this volunteering good for? (Perhaps you didn't know: all the authors did this for free, including the editors).

Let's use the Ant's Theme: an ant doesn't ask whether it is useful to live, she just carries out a task, like the rest of the tribe. And by doing so, the tribe survives and thrives.

Enjoy !