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of
Family Medicine

-
European Edition

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of
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World Organization of Family Doctors - Europe (WONCA Europe)

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



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Prologue

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

That’s how we started the prologue of the World Book in 2015.

Now, 5 years later, in dramatic circumstances that are almost equal to a World War, we present you a new edition of the World Book of Family Medicine, the 2020 European Edition.

Let’s hope that this goes viral too!

Since WONCA is all about collaboration and inspiration, the main focus of this edition lies on working together, with our partners, the networks. But also talented individuals.

They wrote 25 contributions, 1000 words (more or less), 5 Take Home Messages (more or less) and 8 references.

Most of the contributors stayed within those limits, but every rule has an exception – as we as family doctors are well aware of.

These dramatic times asked for an Addendum, a focus on a looming problem and the way out. Colleague Radost Assenova made a strong contribution on burn-out and how to prevent it.
Stay safe!

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.

Berlin, December 2020

Panta rhei! Everything flows!

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1 – Infodemic, Health Literacy, Water, and the 25th Birthday of WONCA Europe

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There is an "infodemic" associated with the pandemic, short for "information epidemic", a phenomenon that portrays the rapid spread and amplification of vast amounts of valid and invalid information on the internet or through other communication technologies. The term has not been used much in the scientific literature before 2020.

Since the beginning of the pandemic, both the production and consumption of information have increased rapidly and significantly. The WHO stressed that infodemic is a serious threat to public health (PH), public action, social cohesion, and the political landscape as a whole. On the individual level, the infodemic creates confusion among recipients of information, specifically about the identification of reliable information. In the current pandemic, this constitutes a global scientific challenge.

Since the current infodemic is about health, information literacy must be focused on health - this is known as "Health Literacy" (HL). It is one of the most important degrees to which an individual can obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.

Now some include personal HL as well as organizational HL. Personal HL is the degree to which individuals can find, understand, and use information and services to inform health-related decisions and actions for themselves and others. Organizational HL is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. Those definitions emphasize people's ability to use health information rather than just understand it, and focus on the ability to make "well-informed" decisions rather than "appropriate" ones incorporating a PH perspective.

We have to acknowledge that organizations have a responsibility to address HL. So WONCA Europe and MOs also shall address that theme. In the 2019 WHO Regional Meeting, Dr. Tedros said "I leave you with 3 challenges for next year, 2020!

- 1-Determine the root causes,
- 2- Strengthen HL
- 3- Prioritize primary health services (PHC) "

Now with the current pandemic, we can easily see how important those three are. We should be ready for all mentioned above, but talking about HL, all of us can see that we were not, unfortunately. One can not put apart HL and PHC! Dr. Tedros reported that half of adults in 8 countries in Europe were not adequate in HL. In 2019 WHO Europe Meeting the Technical Expertise has seen HL as a social and a critical determinant of health. It was defined as a "Health Risk" also! Many political calls were made for HL. WHO has already started to use all other networks in Europe. WHO is prioritizing PHC and moving very fast on digital health which is both patient-centred and also contributing to the design of preventive measures for such risk factors in health. Digital Transformation started in many countries across Europe as long-term national strategies. Most users are young and there is a need to tailor the system according to the users. Communication between FD/GPs and patients also includes online consultation and e-health.

With the pandemics, e-health applications are increasingly used as additional tools to optimize patient-centred care. There are tremendous new developments and innovations in e-health and online consultation. EURIPA made a statement in WHO and EGPRN recently organized a research conference discussing many findings. Special attention must be given to teaching person-centred care in the FD/GP training programs, with a focus on education of FD/GP trainees in strengthening the role of the patient in PHC and how to involve patients in clinical decision making.

We have many positive developments, but still also many problems due to this pandemic, and its negative impact on PHC services, FD/GP education, and PH as a whole.

HL is something that governments shall focus on more, and we as FDs/GPs want our voices to be heard by them for the benefit of the public health of our populations. There are some barriers for sure. But we have a target, we will care for the Public Health of our countries, Europe, the World, and also we will care for our patients, so we need to learn to be like water. You may see the nature of water telling us a philosophy. For example, consider the water flowing from the mountain. Selects the path of least resistance to flow. In other words, if a rock comes out, it will not deal with it, it will not fight with the rock, it will continue to flow around. Inspired by this nature of water: "Don't mess with anyone who is dealing with you, if you do, you will stay in the same place. Walk around and continue on your way." Let's say that the water flowing from the mountain coincided with a road that could not walk around the rock. Does it accumulate and stop? No, if this is the case, water patiently begins to drill the rock drop by drop. Of course, it is not the force of the water that manages to drill the rock, it is the "continuity" of the drops, which they call "patience". We as FDs/GPs have those in our core competencies and training. Patience does not mean sitting without doing anything. The nature of water teaches that even the impossible can be achieved. Water always flows. That it is cleaned while it flows. I feel always flowing, always producing, and the WONCA Europe presidency was a very remote place for me in 2015 Istanbul Conference where we celebrated the 20th year with the first World Book. Now we are on the second one as a valuable monument from you all for the future. And many others will follow with the support of our MOs.

Dear members of WONCA Europe, now we stepped into maturity at the age of 25. Flow like water. Always renew yourself, every day. Don't let two days be the same. Leave yesterday, learn new things. For example, water is not afraid of change. But even though people say they like change, they mostly are very afraid of it. It tells how beautiful the water change is. Sometimes there is rain, sometimes there is snow, sometimes there is ice, sometimes there is steam. It takes the shape of any glass design when you put it in. It constantly adapts to its location, but its nature never changes. It adapts to everything, anywhere. Remember that those who adapt to nature always survived in the world. Because those who adapt are flexible. We as FDs/GPs are flexible enough to adapt ourselves within the frame of our discipline principles skills and competencies to run the PC in any health system, in any location, under any condition, including such a pandemic we are fighting in the frontline. Those who resist change are solid. Those who are flexible and those who adapt are alive. Water is clear, transparent. It is as it is. It is sharing, always nutritious, nourishes people, animals, nature. Wherever there is water, there are plants, there are animals, there are people, there is a beautiful life.

Because of this structure of water, some say "Be like water, my dear. *Panta rhei!*"

Happy birthday WONCA Europe !

Take Home Messages

- WONCA Europe and Member Organizations have a responsibility to address Health Literacy to prevent an infodemic.
- The power of "continuity" , which they call "patience" is the power FDs/GPs to overcome the hardest and it is in our core values, competencies and training.
- Those who are flexible stay alive. FDs/GPs are flexible enough to adapt within the frame of our discipline principles skills and competencies to run the PC in any health system, in any location, under any condition, including such a pandemic we are fighting in the frontline.
- Special attention must be given to teaching person-centred care in the FD/GP training programs, with a focus on strengthening the role of the patient in clinical decision making.



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2 – Teaching and Learning with Kasimir Malevich

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One hundred years ago there was a wizard, with a little devil as helper. One day, the little devil suggested that the wizard could become a great painter. With his magic wand he put shapes and colours on the canvas, moved a red spot here, a yellow circle there; but notwithstanding his work, the final result was horrible! A disgusting bulk of colours contrasting one against the others! The angry wizard hid the colours into a black square and inside it he found coloured circles, squares, rectangles, and started to put them together studying which could be the best combination. So, he produced beautiful pictures that made him one of the most famous painters in the world.

This was the introduction I gave this particular student: my four years old grandson, during our visit to the exhibition “Kazimir Malevich one hundred years after the black square”. So, the tale “Kazimir and the conquest of colours” was a teaching tool.

Another teaching tool was to find opposites: Kazimir painted the country, the workers and (one of the most remarkable among his works) the isolated red house without doors and windows. This included a return to the scheme of square. But he created also the Architekton “Jota”, an architectural model imagined for a future city. At the same time, we must consider the ways of the past and the new possible and future developments (in life as in medicine).

And also in medicine, we must go beyond appearances: in Malevich when we see “the black cross” we should understand that it is no more than the association or grouping of five black squares and four white squares. When we look at a patient and let him or her speak, are we able to see all these different aspects, all the components, all the different co morbidities and concurrent causes realizing the uniqueness of that patient?

When we teach our students, we push, encourage and motivate them by asking how they feel about themselves in the situations they have to face; and so it is the same with Matteo, observing Malevich’s works. I asked him:

“What colour do you feel today? “

“Did you ever feel yourself a black square?”

“What would make you feel like a red circle?”

When we teach our students, we can act to create role-plays, to form groups in

contrast each other, each other prepared to defend an idea or a position about what they are learning or seeing. So, for Matteo “to make square” as were Malevich’s squares, means joining forces to defend own ideas. We can create a square for defence, make a triangle or a wedge to go on the attack, or join forces making a circle.

“The head of farmer” is the key work for Matteo also. Here, he learnt the most from the philosophy of Malevich. His artistic and philosophical school of Suprematism proclaimed that the paintings were composed of flat, abstract areas of paint, serving up powerful and multi-layered symbols and mystical feelings of time and space. Matteo has seen the work and took a white sheet with only schematic contours of the face in where to put the colours. Here, he was able to enter colours as he wished. Then he cut the work done up and, combining different pieces like a puzzle, he was able to create new positions or new compositions with creativity.

Francesco and Matteo encourage you to “look under the surface”, to think about more than just what we see, to develop critical, independent thought, demonstrating that we can thoughtfully (teaching and learning) stimulate a young mind about unusual matters and at high level. A beginner’s mind in action.

At the end, Matteo went to the great hall, where the exhibition’s curators created for the first time the atmosphere of the opera “Victory on the Sun”: one of the most important works in Russian Cubofuturist Theatre. Then, he was in front of the theatrical figures drawn and designed by Malevich, and for the first time reproduced life-size in that great room. What was hypothetical, as seen in costumes drawn in pencil and seen in frames was now the reality: mannequins with the most fantastic costumes, each one different, as perhaps in medicine when the student sees for the first time real patients, each with their own large and different problems. Matteo was really involved all the time, even listening to the audio guide tape. He asked a lot of questions.

Later, at home, he explained to his father how the artist, at the beginning painted figures, to change later into triangles, circles and squares, and then to return to the figures. But many of these figures, at that time, were painted as empty heads without eyes, mouths and noses.

He asked me the reason for the empty faces. Would you have been able to answer him this question? Would you be ready to find a similar explanation in observation of your student?

Take Home Messages

1. Can very young people be introduced to, involved and interested in matters not usually considered suitable for them?
2. Do we believe such young people are not interested in or cannot be introduced to great matters? What, anyway, is “interest”?
3. How can we be sure there is none?
4. What signs of interest might we see in such persons, and how can we strive to both induce it and maintain it over time?
5. How to maintain memories to as to sustain interest for further discoveries?

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Bergamo - Mateo reflecting on Malevich's papers



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3 – EURACT Member Services Committee Chapter for WONCA World Book

EURACT MSC

Members: Adam Windak, Denise Velho, Dimitrios Karanasios, Esra Saatçi, Humbert de Freminville, Pavlo Kolesnyk, Renzo de Gabriele, Yolanda Ortega

About EURACT

EURACT - European Academy of Teachers in General Practice/Family Medicine (GP/FM) is a WONCA-Europe Network.

It roots back to 1974, with the creation of the Leeuwenhorst Group. It has grown to be the largest personal membership organization in Europe, with over 800 individuals and organizations in collaboration (OIC) members in 42 countries. These countries and their members are represented in the EURACT Council (one delegate per country) and these delegates in their turn elect the Executive Board of the Organization.

In every country of the WONCA-Europe region, GP teachers can apply for membership to their National Representative or directly to the website of EURACT. Country members elect their National Representative for EURACT Council every three years. Two Council Meetings (3 days) are organized every year (Spring and Autumn).

EURACT supports and promotes networking among GP Teachers and Academies, and organizes Teaching the Teachers courses, i.e. Leonardo Level 1, Level 2 and Level 3 Courses and Assessment Courses: all to be cascaded and run locally. Moreover, it organizes biannual EURACT Educational Conferences (Dublin 2016, Leuven 2018, Budapest 2021).

Finally, EURACT is also publicizing and developing common standards on teaching and furthermore on GP/FM Education.

EURACT Member Services Committee

The MSC - Member Services Committee - is one of the four EURACT Committees and aims to promote EURACT membership. Its responsibilities include:

- Improving the attractiveness of EURACT membership and communication with members;
- Advising on EURACT external visibility and marketing strategies;

- Advising the Executive Board about subjects pertaining to members, such as membership procedures, and provide documents/digital forms for simple members and OICs;
- Providing check-lists and documents for the organizers of courses, conferences and council meetings;
- Providing criteria for selecting bursaries for EURACT sponsorship;
- Conducting the selection process of candidates for sponsored places in EURACT courses and conferences.

EURACT courses

EURACT organizes several courses as Teaching the Teachers Courses (Leonardo Level 1, 2 and 3 and Assessment courses) and Bled Course.

EURACT developed a new high-quality conceptual framework in Europe, based on an expertise model for GP/FM teachers. The aim was to facilitate progression from novice to expert teacher by targeted courses and the expectations are to guide the development of GP/FM educators, set the basic standards for training the trainers at different levels and provide a sustainable background for the harmonization of GP/FM training throughout Europe.

“Leonardo Course - Level 1” aims at entrants (novice GPs) to practice-based teaching (with no prior teaching skills).

The main educational objectives are:

- To improve the level of one-to-one teaching in European countries;
- To ensure dissemination of knowledge and skills by course participants in their own countries;
- To stimulate development of GP/FM teaching in participating countries.

While the main topics include:

- Being a good trainer;
- Basic Education and Assessment Theory;
- Teaching methods and giving feedback;
- Learning styles and personal learning plans;
- Teaching through role playing;
- Preparing the practice and designing the program.

“Leonardo Course - Level 2” aims at competent teachers and those involved in department-based teaching as well as individual trainers.

The main educational objective is:

- To train educators from competent to proficient.

The main topics include:

- Small Groups Leadership and Facilitation;

- Managing Problem Trainees;
- Teaching from the Consultation;
- Curriculum to Program.

“Leonardo Course - Level 3” aims at proficient educators (lecturers, training program organizers, experienced trainers)

The course’s expectations are:

- To develop their own educational expertise;
- To provide teach the teacher skills for future GP/FM teachers;
- To maintain a European teaching skills program;
- To ensure that it is cascaded beyond the original partner organizations to other European countries.

There are some preconditions for the participants:

- Support of an Academic institution / GP Association;
- Have an identified educational supervisor.

The structure of the course is in the same way as a Masters’ module: the majority of the time is spent in self-directed study and there are three days of course work, divided in two parts, separated by several months.

“The Assessment Course for Trainers in Family Medicine” is aimed at experienced teachers.

Its objectives are:

- To understand different purposes of assessment, theoretical frameworks for assessment and the terminology used;
- To understand the assessment methodology most suited for GP/FM;
- To develop skills in using the appropriate assessment tools;
- To practice their skills in assessment and feedback in a secure learning environment;
- To understand the relation of assessment with teaching and learning, and on themselves as teachers;
- To be able to apply their knowledge and skills in their own context as teachers (time, level of students, place, country).

Finally, there is another course held annually in Slovenia, “Janko Kersnik Bled Course”. It has been held under the patronage of EURACT for 18 years, and it provides teaching for established teachers. The product of the course is a “ready to apply” educational module for family medicine students of various educational levels.

In the future, EURACT intends to develop new courses, relevant in Family Medicine Education. Below, you can find some feedback messages about EURACT Courses:



“EURACT offers a framework for the establishment and development of international learning and development cultures and structures in GP/FM. The EURACT Assessment course for trainers in Family Medicine is strongly recommended for those interested. International networking is an advantage to be considered and a challenge to be accepted.”

"The EURACT Level 1 course was a useful course that gave us a different perspective on learning and teaching methods, showing us that what we know is as little as a grain of sand in the sea, and was completed without boring the participant with fun games, quality lessons and group work. I'm looking forward to the Level 2 course."



“I attended 27th International EURACT Janko Kersnik Bled Course in September 2018 in Bled/ Slovenia. I appreciate the organizers. It was a very good organization. The course was very useful for me. The theme of the course was "guidelines and mindlines". There were very different and useful discussions about this. Also, Bled is very nice place and I advise all my colleagues to visit this wonderful place. There were not only academic topics but also a lot of social activities as well. I spent 5 unforgettable days of my life there. Thank you so much for everything. Thanks so much to Dr. Mateja and Dr. Vesna and other speakers and family physicians coming from different countries of Europe.”

“I attended the Leonardo Level 1 course in Edirne in March 2020. I have learnt various ways of learning and teaching. Thanks for the course, I improved myself.”

“I have attended Euract Level 1 Course. I was amazed by the instructors' teaching style. I was never bored and I realized that I still have a lot to learn in Family Medicine.”

“I have had three courses till now: Leonardo Level 1 in Adana, Turkey; Leonardo Level 2 in Jerusalem, Israel; and Euract Assessment course in Lisbon, Portugal. All courses were so educational and complementary with each other and we can also exchange useful information about primary health care with international participants. It is crucial that these courses continue for a strong primary health care. I appreciate all teachers and EURACT for the inspiring courses.”

Take home messages

1. The Leonardo Courses are a masterpiece of EURACT CME/CPD program.
2. The courses helped hundreds of family physicians to gain new knowledge, skills and attitudes related to being a good trainer.
3. They also have a significant contribution in the “identity of being a EURACT member”.
4. Other courses helped family physicians to improve both as family physicians and trainers.
5. New methods of teaching will have to be developed due to global changes not only technologically but epidemiologically, sociologically and due to changes in the conceptualization and paradigm of the discipline of Family Medicine.

If you are involved in teaching General Practice/Family Medicine consider joining EURACT and become part of a European network of teachers. We are continuously developing documents and publishing papers to achieve the highest standards in education.

Visit our website at:

www.euract.eu

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4 – Alignment of Undergraduate General Practice/Family Medicine Education in Europe: Standards for High Quality Education

EURACT BME Committee

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Background

How does one describe General Practice/Family Medicine (GP/FM) undergraduate education in European universities? Until now, there has been no minimum standards for learning goals, educators or delivery of education. The WONCA Europe statement of 2017 called for action towards a sustainable health workforce (WONCA 2017), so that the future needs for adequate numbers of skilled General Practitioners (GPs) and other health care workers would be met. Since then, the Basic Medical Education (BME) Committee of EURACT (European Academy of Teachers in General Practice/Family Medicine) has worked to draw up education requirements for the undergraduate GP/FM curriculum that should be achieved in the next few years. In addition to recent publications on medical education, the Committee utilized previous research carried out by EURACT, and definitions and statements published by WONCA and EURACT (EURACT 2014).

Why Are Standards for Education Needed?

As is widely known, the free mobility of the labour force within the EU (2011) allows young doctors to practice medicine across the EU. These young doctors often work in primary care. To ensure patient safety, we need a minimum level of quality and acquired competencies for graduating medical students.

However, dedicated educators in different European universities develop GP/FM curricula in different ways. The status of GP/FM varies greatly. First, GP/FM might not even have been recognized as a specialty with its own characteristics. Secondly, a representative of another specialty might lead the department of GP/FM education. Third, insufficient resources of skilled practising GPs might limit adequate clinical exposure in GP/FM settings, and fourth, most of the education might be provided through lectures, limiting the critically important practical learning and peer reflection to a minimum. These challenges have been overcome, but not everywhere. For the countries or faculties where these minimum standards are still only a dream, widely accepted minimum requirements would be useful in decision-making, and essential

to educate competent physicians for GP/FM. (Başak et al. 2009, Tandeter et al. 2011, WONCA 2017)

From Idea to Reality

Plenty of data gathering is needed to make a viable international document. We discussed definitions of GP/FM education multiple times to achieve consensus in the BME committee, and reviewed the existing literature on GP/FM education. A pilot survey of 15 medical faculties in 15 European countries during early 2018 unveiled the current state of the provision of undergraduate GP/FM education. It is obvious that there is huge variety in the GP/FM education within Europe. While some medical faculties offer GP/FM education from the first semester onwards, in other medical faculties the students might be exposed to GP/FM only during their final year of study. The number of days in GP practices within our 15 examples ranged between 2-60 days. (unpublished data)

Workshops both in the WONCA Europe conference in Krakow and in the 2nd EURACT educational conference in Leuven during 2018 offered platforms to extract knowledge, data, and reasoned views from the participants. One more workshop during the EURACT Council autumn meeting in Sofia during 2019 allowed the BME Committee to put the missing pieces in place, and this was followed by comments from EURACT Council experts, including Nele Michels, the new president of EURACT. We still need the approval from the EURACT Executive Board and Council meeting before these standards can be launched during the WONCA Europe conference in Berlin planned for December 2020.

Finally, when comparing the new standards to the previous EURACT BME Committee statement on undergraduate teaching in FM issued in 2014 (EURACT 2014), we drew almost identical conclusions. However, there are two new items. First, an emphasis on increasing early clinical exposure in GP settings during the first semesters is essential to foster students' professional identity, and to learn the basics of most branches in the WONCA tree (Littlewood et al. 2005, WONCA Europe 2011, Turkeshi et al. 2015). Secondly, the necessity of trained trainers or teachers is a justified standard in the 2020s. The table below describes the key messages of the new requirement within the document. Many obvious suggestions for the minimum standards changed during the process: to adapt these for all, we had to abandon some of the more ambitious plans.

Table. The key content of minimum requirements in undergraduate GP/FM education in Europe (to be published in 2020/EURACT).

| Key principles |
|--|
| <ul style="list-style-type: none"> • Many essential learning goals for every medical student can be learnt efficiently in GP/FM |
| <ul style="list-style-type: none"> • Teaching should be based on symptoms, not only on diseases |
| <ul style="list-style-type: none"> • Students should be taught on a one-to-one basis by experienced GPs, alongside other forms of education |
| <ul style="list-style-type: none"> • Teaching should include the outpatient setting |
| <ul style="list-style-type: none"> • Early clinical exposure to GP/FM should be implemented if at all possible |
| <ul style="list-style-type: none"> • The optimal duration of the GP/FM curriculum should be three months, and at least four weeks |
| <ul style="list-style-type: none"> • Every medical faculty should have a department or unit of GP/FM with a specialist in GP/FM as chair |

What's Next?

Education requirements are only useful if they are widely known and accepted. We hope that WONCA Europe will also accept these European requirements for GP/FM undergraduate education. However, it is even more important that

these recommendations will be available to those medical faculties and countries that need them most. All colleagues who are working hard to improve the education status of GP/FM in their own countries can use the requirements by EURACT to justify their demands to any leaders of the faculty, university or ministry. In addition, EURACT members are willing to write statements tailored to particular countries if this would be helpful. Alignment of undergraduate GP/FM education in Europe is possible. Meanwhile, let undergraduate GP/FM educators deliver the statements and documents to do it. While each university has its own pace, educators can speed it up if they work together.

Take Home Messages

1. Minimum standards were developed and launched in 2020 to promote undergraduate education in many European faculties
2. Diversity in exposing medical students to GP/FM in European universities may be a threat to patient safety: alignment is essential
3. Developing education requirements is a long process
4. Ask EURACT for support if you are working to meet the requirements!

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5 – Policy Statement on Continuing Medical Education for Family Doctors/ General Practitioners in Europe

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Introduction

The European Academy of Teachers in General Practice and Family Medicine is the education network of WONCA Europe. This article summarises the main ideas in the EURACT policy statement on Continuing Medical Education (CME) for General Practitioners/Family Doctors (GPs/FDs) in Europe.

Definition of CME

CME is defined as ‘any activity which serves to maintain, develop or increase the knowledge skills and the professional performance and relationships that a physician uses to provide services to patients, the public or the profession’ [1].

Impact of CME

There is good evidence that CME has an impact on physician performance and patient health outcomes [2]. There is agreement that this impact is apparently greater on physician performance than on patient health outcomes[2] .

How Adults Learn

An understanding of the theories about how adults learn is important when considering how to plan CME activities. Adults want to learn, they are self-directed, and they need learning to be relevant and applicable in their setting; when these conditions are met they are highly motivated [3].

Effective Interventions

Given the recognition that CME is effective, the next question is how to deliver CME interventions that support doctors to change their practice and improve outcomes for patients. Learning is dynamic and occurs on a daily basis as the GP/FD encounters difficult problems. Needs assessment has a role and several approaches to this are

required. Doctors use self-awareness to identify their learning needs. If this is done well there is some evidence that practice is more likely to change [4]. The best methods for self-assessment are those that support deliberate reflective practice such as logging daily issues where uncertainty occurs, feedback from colleagues and patients, observed practice with feedback, and reading. CME providers should in addition use objective assessments of learning needs such as peer review in quality groups, expert opinion, literature review, physician performance data and standardized assessments [1].

Embedding quality improvement approaches within CME activities is an interesting development. A method which incorporates these principles is the Quality Circle where small groups of health professionals meet regularly to reflect on and improve practice

Needs Assessment & Learning Methods

The identification of needs, together with an assessment of what is to be learnt and why, will lead to clarity about the objectives and the development of a learning plan. These should be clear, concise and ideally measurable.

The identification of objectives can enable educators to provide more effective learning opportunities. It is clear that no single modality of learning works under all circumstances. Effectiveness increases when a variety of methods are used allowing for interaction, multiple exposures, and longer programmes rather than shorter and that focus on outcomes considered important by physicians [2]. The opportunity for interaction is essential. This can be done both face to face and electronically. The traditional lecture and the dissemination of printed material are the least effective methods of CME. Lectures, if short, can have an important role in setting the scene and providing knowledge updates, prior to discussion in small groups of e.g. case studies.

The Role of Information Technology

Widespread access to Information Technology enables the development of new mechanisms of learning through on-line courses that can be of particular relevance to the GP/FD. Online courses need to follow the same principles as face-to-face CME. They need to be easy to use, involve practical exercises, repetition and feedback. Online communities of learners can be formed that further facilitate interaction and these networks are of particular relevance to doctors who work in isolation.

Evaluation of CME Activities or Programmes

It is important that providers of CME evaluate the learning activities that they develop. The Kirkpatrick model for training evaluation has been widely used. This describes the four levels at which evaluation can occur: participant satisfaction, knowledge and attitude change, improvement in physician clinical outcomes and improvement in patient outcomes.

Learning in the Workplace

Workplace based learning fits well with what is known about how adults learn. It is efficient and effective, enabling clinicians to gain knowledge in the setting where this knowledge can be applied. It is of particular relevance in primary care as GPs/FDs work in units which are dispersed within the community. Doctors often practice in teams and the work place can be productive for inter-professional learning.

The Role of Health Care Organisations and Employers

Employers and Health Care organisations need to understand the important role that CME plays in developing the quality of care and maintaining motivated and engaged professionals. They need to enable GPs/FDs to participate in

CME during their working week. Professional bodies and regulators need to recognise that the accreditation of hours of learning is not a surrogate for improved competence. Doctors need to be allowed flexibility in the type of learning that is recognised and this should include learning that can be demonstrated to change practice. There also needs to be an awareness of the effect that industry sponsored activities may have on influencing doctors' behaviour.

Some countries will require accreditation of CME programme; for this, the WONCA World Education Working Party has produced a set of standards which are designed for this purpose [6].

Conclusion

In conclusion, all CME providers need to recognise that GPs/FDs will respond best to programmes which are relevant to their practice and clearly address their needs. Delivery should involve a combination of knowledge updates and interactive learning. CME should lead to quality improvement and better patient outcomes.

This document outlines the principles for the provision of effective CME for GPs/FDs that are based on the current state of the evidence base.

Take Home Messages

CME should:

1. Be based on learning needs relevant to current practice and include the perspectives of what patients want and need from their healthcare.
2. Use methods which involve FD/GPs actively, encourage reflection and support changes in practice.
3. Be evaluated, adapted to changing needs and be free of conflicts of interest
4. Encourage social contact with peers through communities of practice.
5. Acknowledge the need to support physicians' well-being.

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6 – Educational Training Requirements for General Practice/Family Medicine Specialty Training: Recommendations for Trainees, Trainers and Training Institutions

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Background

The general practitioner or family doctor (FD) (1) plays a key role in primary health care and it is clear that General Practice/Family Medicine (GP) (2) is an important discipline among the other medical disciplines. The European definition of GP, issued by WONCA, states that 'GP is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical specialty orientated to primary care' (1).

European legislation (Directive 93/16/EEC and Directive 2005/36/CE) has contributed to the recognition and acceptance of GP as a medical specialty in many European countries but, unfortunately, not in all. There are countries where participation in specific GP specialist training before being accredited as a GP is not required. Furthermore, in other countries where GP specialist training is required and implemented, besides common features also great diversity and different levels are noticed. The time is ready to register GP on a European level as a medical specialty among the other recognised specialties and set clear minimum and common standards for GP specialty training schemes (2).

Therefore, the EURACT Specialty Training (ST) Committee, developed in 2018 'Educational Requirements for GP Specialty Training' (3). [The guideline describes requirements for trainees, for trainers and for training institutions. The trainees' requirements were structured around 6 themes: learning outcomes, teaching methodologies, assessment, duration of specialty training, training context and location, and selection of trainees.](#)

EURACTs guidelines mirror the WONCA-Definition of General Practice/Family Medicine - demonstrated through the WONCA-Tree, created by the Swiss College (4,4a - <http://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/regionDocs/European%20Definition%20of%20general%20practice%203rd%20ed%202011.pdf>).

Requirements for Trainees

The EURACT Educational Agenda provides a framework for trainees to acquire the core competences of GP (4). Learning objectives are defined for each competence,

covering knowledge, skills and attitude, next to possible educational methods to achieve the objectives. Teachers and training institutions can find inspiration in this framework. Nevertheless, some general principles should be taken in account; the training should be outcome-based, learner-centred, and mainly take place at the workplace itself (workplace-based learning). The learning environment should be safe and should support the trainees' development; important elements are constructive feedback and frequent interaction with trainers. Self-directed learning and reflective practice are key elements of GP specialty training. The 'doctor/trainee as a person' should be explicitly emphasized.

'The goal of assessment is to ensure the development of a confident doctor who is competent, takes responsibility for care of the patient and functions as a safe and professional FD' (5). Furthermore, the doctor should follow the principles of medical ethics. Assessment, either formative or summative, should be reliable, valid and programmatic; it should be embedded in the whole program of learning and should support the trainees' learning process and development. The training program should be planned in advance with a mix of assessment tools that should be used at different times and at different settings by various assessors. Trainees can use feedback and scores to develop and to grow towards being a professional FD. Trainees should be mainly observed and assessed in the workplace with respect to different aspects of practice (6).

The EURACT Educational Agenda and Performance Agenda generated a toolbox with per core competence examples of related assessment methods (4, 7). Training developers can choose tools adjusted to the objectives, settings and organization of their specialty training program.

European legislation determined minimum requirements with regard to duration and setting of the training: 1) a full-time course lasting at least three years, and 2) on the one hand, at least six months in an approved hospital or clinic and, on the other hand, at least six months in an approved general medical practice or in an approved centre where doctors provide primary care. Training must be more practical than theoretical and must be centred in a GP practice (at least 50% of the training), since it is the only place where the core competences of GP can be learnt. However, hospital-based training can be of value for GP trainees if the content of the clinical work is directed on the future GP work.

In addition to the workplace learning (on-the-job), some external curriculum-based training (off-the-job) can occur. Group learning, reflection, peer learning, seminars and workshops, visiting conferences, and learning specific skills can be a valuable addition to the trainees' learning plan.

Selection procedures play a crucial role in obtaining access to GP specialty training. These procedures should be credible, fair, and publicly defensible. The central aim should be to select the most suitable candidates. This is not as straightforward as it seems. Best selection practice involves a job analysis that identifies the required competences, the design of reliable assessment methods to measure them, and an on-going review of predictive validity against future performance.

Requirements for Trainers

It is essential that trainers, both in GP practice and in hospital, are officially accredited as teachers and regularly participate in teach-the-teacher courses. Guidelines for appropriate practices and educational settings concern infrastructure, governance, and educational facilities. Practices should provide a workplace with patients and appropriate working hours, involving the whole health care team, and maintaining an educational environment with protected teaching and study time.

Requirements for Training Institutions

A 'competent authority' should organise the GP specialist training. Although there are examples of good speciality training outside the realm of the universities, training institutions are preferably embedded in, or connected to universities or other academic institutions. A close relation with GP education in basic medical education is recommended.

In conclusion, the guideline can serve as a guidance and inspiration for all countries to implement GP specialist training and bring it to the highest standards, warranting registration of GP as a medical speciality. Currently, it also forms a base of international teach-the-teacher programs like the Leonardo Teachers Courses (EURACT).

However, theories and insights on (medical) education changes and also GP training should stay up to date with new knowledge, frameworks, and approaches. The CanMEDS framework, working with EPAs (Entrustable Professional Activities), inter-professional learning, peer-teaching and -learning, trainees' research, involvement in society, etc. are topics that could be investigated and implemented. Opinions of trainees and trainers should be also involved.

Furthermore, some issues are under discussion; firstly, the minimal length of GP speciality training. On the one hand it is known that developing mastery in GP takes time, taking into account all the clinical and generic knowledge and skills, the uncertainties and complexities of the workplace, and the practice management that is needed nowadays. On the other hand, by a more trainee- and individual-centred approach a focus on acquiring the needed competences could be the objective.

Secondly, little is known about the added value of GP speciality training in hospital posts; more research should be initiated. The same is true for the selection procedures of trainees: aims, methods and cost-effectiveness should be further investigated.

At last, one should realize that the quality of training programs relies on the (quality of) trainers and training practices. Being a trained teacher alongside extensive clinical work is a challenge; trainers should be allocated sufficient time and resources to give and to receive training. This should be resolved on the macro-level by faculty members and policy makers.

Despite these gaps, debate issues and new insights the guideline is already of use. It is produced in the specific context of Europe but its general principles are relevant to GP training in all countries. After all, the patients in GP across the world deserve highly trained specialists in GP.

Take Home Messages

1. EURACT's guideline 'Educational Requirements for GP/FM Specialty Training' supports implementation of GP specialist training and brings it to the highest standards
2. This warrants registration of GP as a medical speciality in countries where it is not registered as a speciality yet
3. Training must be more practical than theoretical and must be in a GP practice (for at least 50%)
4. Specific GP competences should be taught and evaluated in safe and supportive learning environments where educational principles like outcome-based, learner-centred, and workplace-based are essential, next to seeing the 'doctor/trainee as a person'
5. Trainers, both in GP practice and in hospital, should be officially accredited as teachers and regularly participate in teach-the-teacher courses

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7 – Tackling Chronic Respiratory Diseases in Primary Care: the Role of IPCRG

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Primary care (PC) has a unique role in managing non communicable diseases (NCDs). It's the only specialty able to assess patients in a holistic way, offer continuity of care over time and generations and also to coordinate care. Amongst the NCDs, respiratory diseases (NCRDs) impose a major challenge for PC, mainly due to the high prevalence of asthma, allergic rhinitis, chronic obstructive pulmonary disease (COPD), obstructive sleep apnoea and lung cancer, as well as of the core established risk factors that determine poor respiratory health. (1,2)

Prevention

Since cure is not currently a realistic goal in these NCRDs, appropriate management is essential to enable patients to control their disease well and enhance their quality of life. (1,2) However it is a complex problem. Prolonged exposure to smoke, including tobacco smoke, smoke from biomass-burning or kerosene stoves is a core risk factor for respiratory diseases. Other factors that may trigger airway irritation and inflammation are dust and outdoor air pollution, aerosol sprays and strong odours.(2) Smoking is an addiction that often begins in childhood, influenced by household smoking, and can be difficult to manage as it is a relapsing condition often requiring a combination of pharmacotherapy, that is rarely reimbursed and advanced counselling, that is not widely available. (3) However, it is eminently treatable using a holistic, bio-psycho-social approach and is therefore a high priority for PC. IPCRG has proposed a hierarchy of interventions depending on time and available resources. In its position statement endorsed by WONCA Europe it advocates for an equitable approach to behavioural and drug interventions and improved access to affordable pharmacotherapy. (3) It remains shocking that less than 20 countries in the latest survey have nicotine replacement therapy on their national formulary, despite being on the WHO List of Essential Medicines. (4)

Primary Care and Public Health: a Need for Collaboration

Even if PC succeeds in controlling tobacco dependence, air pollution, particularly occupational exposures, are hard to control by primary care services alone. They need

strong collaboration with public health authorities and organizations that can assist in improving socio-economic levels and working conditions. The IPCRG therefore supports the definition of primary care as not only the provision of high quality services delivered by a multidisciplinary team, but also public health approaches and individual empowerment [<https://www.who.int/docs/default-source/primary-health/vision.pdf>]

WHO has already set a strategic goal to control lung cancer, COPD and asthma, enhance early diagnosis and high quality management as well as improve quality of life and minimise premature deaths. (2) Primary care is essential in achieving this, and ensuring equality. The challenge is ensuring care is also of good quality. This is reinforced in the recent Alma Ata declaration, which also sets the holistic management of multimorbidity as a high priority. This necessarily includes NCRD management. [<https://www.who.int/docs/default-source/primary-health/vision.pdf>]

PC Challenges in Clinical Practice, Research and Education: the IPCRG Vision

Yet PC faces several challenges including lack of good quality evidence about managing multimorbidity, lack of collaborative action to control core risk factors, the challenges of balancing resources and demands of the community in a resource-constrained world, and offering and demonstrating comprehensive, long-term, people-centred quality care.

Whilst international and national guidelines exist to guide primary care to deliver good quality respiratory care, there is little evidence about optimal implementation strategies. Therefore we need research and education. Using a Delphi approach, IPCRG identified the research needed to improve primary respiratory care. (5) The findings outlined what was important to primary care. (5) The main challenges were diagnosis and simple but robust assessment tools to facilitate primary care management from the identification of the risk factors to the delivery of compassionate palliative care in different settings. (5) Ten years later (unpublished data) IPCRG has completed a new Delphi prioritization exercise and not surprisingly, the main challenges are still prevention and diagnosis.

IPCRG's track record in PC research and implementation science can be found at <https://www.ipcr.org/>

Examples include:

- The IPCRG social movement Asthma Right Care has adopted evidence from social movements for health, leading large scale change (NHS 2017) and right care to disrupt thinking and shift over-reliance on symptom relief and underuse of anti-inflammatory treatment (inhaled corticosteroids) for asthma. This persistent global problem leads to avoidable mortality, morbidity and waste.
- FRESH AIR funded by the EU Horizon 2020 programme produced evidence of the burden of NCRD in LMICs and how to implement effective low cost interventions. www.ipcr.org/freshair
- The UK National Institute for Health Research (NIHR) funds 3 programmes that work with IPCRG and its members in LMICs:
 - Global RECHARGE aims to develop effective context- and culturally- appropriate pulmonary rehabilitation programmes.
 - RESPIRE aims to reduce the impact and number of deaths caused by respiratory diseases in South Asia. IPCRG co-leads stakeholder engagement, the production of a MOOC for frontline workers, research and leadership schools.
 - Breathe Well is testing effective interventions such as pulmonary rehabilitation, smoking cessation and case-finding.
- IPCRG also coordinates the Global Health Respiratory Network, a collaboration of ten UK universities with respiratory health research programmes to improve the respiratory health of the world's poorest through

research collaborations. <https://www.ipcrg.org/projects/research/global-health-respiratory-network>

- UNLOCK (Uncovering and Noting Long-term Outcomes in COPD and asthma to enhance Knowledge), is an international collaboration set up by the IPCRG between primary care researchers to coordinate and share datasets of relevant diagnostic and follow-up variables for COPD and asthma management in primary care. <https://www.ipcrg.org/unlock>

Some of the challenges are not about research, but building confidence and competence in the global primary care workforce to deliver existing effective interventions in their setting. IPCRG's interest in closing the gap between knowledge and practice resulted in a comprehensive strategy recommending a blended learning approach sensitive to local circumstances and increasingly, the use of technology.⁶ Four target audiences (clinicians, academic workforce, clinical experts and potential leaders), and four approaches (teaching clinical practice, developing teaching capacity in primary care, stimulating discussion about effective educational methods and evaluation and promoting leadership) were identified.⁽⁷⁾ For the last six years IPCRG has pursued this strategy including the delivery and evaluation of Teach the Teacher programmes in children with asthma and treating tobacco dependence; e-learning in treating tobacco dependence and difficult to manage asthma. <https://www.ipcrg.org/projects/education>

IPCRG Collaborations

The IPCRG is the Respiratory Special Interest Group (SIG) for WONCA Europe and an Organisation in Collaborative Relations with WONCA global. <https://www.ipcrg.org/our-network/ipcrg-and-wonca>

It has recently signed a Memorandum of Understanding with the European Respiratory Society with a focus on activities improving the diagnosis of respiratory problems in primary care and good quality referral to and from secondary care. It has a peer reviewed open access journal, npj Primary Care Respiratory Medicine, published by Springer Nature, and co-owned by the publisher and our UK group, PCRS-UK.

IPCRG's Mission

IPCRG's mission is to work locally and collaborate globally in primary care to achieve its vision of a world breathing and feeling well through universal access to right care. Its three main objectives are:

- Create value for our country members (organisations and individual clinicians) by improving their confidence and competence in respiratory health and generating income that can be used to invest in programmes for which fundraising is difficult.
- Create value for society by raising awareness of respiratory health amongst citizens and policy-makers and influencing the availability of good quality respiratory care.
- Create value for our funders by increasing the accuracy of diagnosis, reducing the variation in care and improving respiratory outcomes.

All resources are open source and many are in multiple languages. These include practical desktop helpers written by primary care for primary care and policy position papers. <https://www.ipcrg.org/resources/search-resources>

IPCRG also reacted quickly to COVID-19 with a set of open source resources including a set of recorded webinars and slides on COVID-19 and primary respiratory care. (4) <https://www.ipcrg.org/news/covid-19-open-source-sources-of-information>

Take Home Messages

1. We must advocate for respiratory care to be included within universal health coverage given the burden of NCRD and PC's potential to have a substantial impact on reducing its impact and prevalence. PC efforts include not only management of the main NCRDs, COPD and asthma, but also in primordial, primary, secondary and tertiary prevention.
2. Further research evidence is needed to underpin the PC approach to NCRD management and control. The experience of COVID-19 demonstrates the need to understand how to assess, manage and palliate breathlessness better in primary care.
3. To fulfil IPCRG's vision requires a multidisciplinary response from policymakers, funders, PC professionals and researchers to prioritize research questions and implement the available tools in daily clinical practice.

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8 – Breathing and Feeling Well Through Universal Access to Right Care

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Janwillem Kocks, President,
IPCRG

The charity, International Primary Care Respiratory Group (IPCRG) is the respiratory Special Interest Group (SIG) of WONCA Europe and an organisation in Collaborative Relations with WONCA World <https://www.ipcr.org/our-network/ipcr-and-wonca>. Established twenty years ago, it is an organisation of organisations, now comprising 34 national primary care respiratory organisations and also a global community of practice reaching over 150,000 primary care clinicians. <https://www.ipcr.org>

Our mission is *working locally in primary care and collaborating globally to improve respiratory health*. We believe that primary care is the right place to prevent, diagnose and treat most non-communicable respiratory disease. Our scope is research and education. (1) This includes improving the diagnosis and supported self-management of symptoms such as cough, wheeze and breathlessness and common co-morbidities such as anxiety, depression and heart disease; treating tobacco dependence and encouraging physical activity.

The last year, 2019-20, saw an acceleration in IPCRG's role and influence internationally. We continued to build programmes to achieve our vision of a global *population breathing and feeling well through universal access to right care*.

Universal access aligns with the United Nations Sustainable Development Goal of universal health coverage, and our call for respiratory care and access to medicines to be part of this; "right care" aligns with the World Health Organization's ambition that people have access to good quality care and with the Lancet definition of right care: addressing misuse, underuse and overuse to achieve the right care for health and well-being in the context of financial constraints and multiple health challenges.

Our Four Strategic Goals:

1. Create value for our country members (organisations and individual clinicians) by improving their confidence and competence, promoting good clinical primary care respiratory practice.

Examples include our peer-reviewed guidance for primary care, endorsed by WONCA Europe, on treating tobacco dependence, (2) highly practical desktop helpers often in a range of European languages www.ipcr.org/desktophelpers, Teach the Teacher programmes to build peer: peer teaching competence in primary care (3) in

line with our education strategy (4), our conference programme to provide a platform for peer review of primary care respiratory research and our open access peer-reviewed journal npj Primary Care Respiratory Medicine in the top quartile of primary care journals.

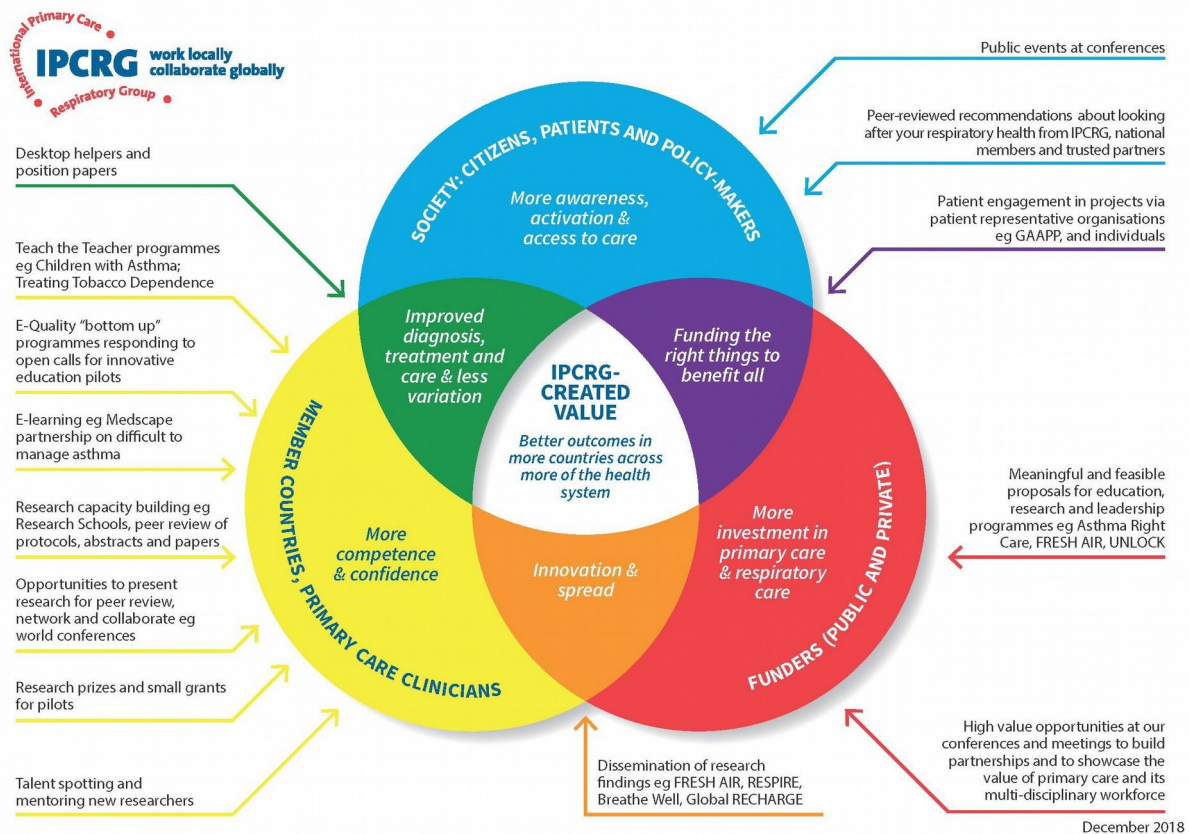
2. Create value for society by raising awareness of respiratory health amongst citizens and policy-makers and influencing the availability of good quality respiratory care in their community.

Examples include work as part of our FRESH AIR programme in [Crete](#). (5)

3. Create value for our funders by increasing the accuracy of diagnosis, reducing the variation in care and improving outcomes.

Examples include our UNLOCK programme. (6)

4. Run an efficient organisation with effective cost control and create additional value from income-generation programmes to allow the organisation to invest in infrastructure and projects for which fundraising is more challenging.



2019-20 Highlights

- Delivering a symposium and workshops at WONCA Europe
- IPCRG 6th Scientific Meeting in Bucharest, hosted by our Romanian team RespiRO, including our first Research School for novice clinical researchers on qualitative research; a research prize and mentoring for the Romanian team exploring e-cigarette use in adolescents;
- Growth of our social movement for [Asthma Right Care](#) reaching new parts of the health system by

engaging community pharmacists from over 20 countries, more people in more countries, including Greece and the Netherlands and now aligned closely with the new international GINA guideline 2019, to reduce reliance on symptom relief and increase use of anti-inflammatory treatment

- A new 4-nation Teach the Teacher programme to build teaching capacity to [improve care for children with asthma including the development of a primary care curriculum](#) that is being adapted locally and has been accepted with enthusiasm in Spain
- Production of a major e-learning programme for primary care with [Medscape](#) on the recognition, diagnosis, management and referral of difficult to manage asthma
- Appointment as the coordinator of the [Global Health Respiratory Network](#), improving respiratory health of the world's poorest through research collaborations, and [shining a light on the inequity in research funding](#)
- Continued expansion of the research output from [FRESH AIR](#) funded by a research grant from European Union's Horizon 2020 research and innovation programme
- Progress in 11 of our LMIC member countries that we introduced to UK universities, funded by the UK National Institute for Health Research, to set them on a pathway to build primary care research capacity so that they can inform national respiratory policy using locally-generated reliable findings: [RESPIRE](#), [Global RECHARGE](#) and [Breathe Well](#)
- IPCRG re-elected as the primary care representative to [WHO-GARD](#) at its meeting in Beijing
- Abstract call for our 10th World Conference received over 80 high quality abstracts; many shared during our successful [COVID-19 and respiratory health webinar series](#) replacing the May 2020 meeting
- First open call for session proposals to our 10th World Conference generated 51 proposals showing great international engagement and commitment
- New country members including Finland, as well as Uganda and Malaysia
- Release of [two new desktop helpers](#) and case studies on COPD including the management of co-morbidities
- An [e-learning programme on helping people quit tobacco](#)
- The launch of a new IPCRG website

2020-21 plans include:

- Further growth in the Asthma Right Care social movement to French-speaking countries, as well as expanding our Spanish and Portuguese groups' learning to Latin America;
- Our [World Conference in Dublin in May 2021](#) and our 1st IPCRG China Conference in Beijing in October 2021
- Expansion of our membership
- Delivery of a Massive Open Online Course (MOOC), on Primary Respiratory Healthcare in Resource-constrained Settings, online qualitative research school and online leadership school in partnership with University of Edinburgh RESPIRE programme.

Best abstracts

- [Using fractional exhaled nitric oxide to guide step down treatment decisions in asthma patients: A systematic review and individual patient data meta-analysis Kay Wang, UK. Porto 2018](#)
- [Can the utilization of a practice formulary improve antibiotic prescribing habits in Primary Care? Helena Hobbs, UK. Bucharest 2019.](#)
- [Assessing treatment fidelity of lay health worker support to increase uptake and completion of pulmonary rehabilitation in COPD. Viktoria McMillan, UK. Bucharest 2019](#)
- [Can singing improve health and wellbeing in COPD? SingStrong: A pilot study. Roisin Cahalan, Ireland \(webinar 2020 due to postponement of Dublin 2020](#)

Take Home Messages

1. Primary care is the right place to diagnose and treat common respiratory NCDs and CDs including asthma and COPD
2. IPCRG offers you practical guidance
3. If you want personal and professional development through respiratory research, quality improvement CME, we can help you
4. Our conferences and face-to-face teaching offer great networking opportunities in research and education

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9 – International Web-based Course on Research in Primary Health Care

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Background

Primary care research is a necessary prerequisite if we are to enhance the role of family physicians in health care systems and in the academic world, facilitate the optimal functioning of those systems, and to improve the health of populations.

Research gives the vision for the future development and prosperity of Family Medicine but resources as solid knowledge, skills and attitude towards research are much needed (1). The “**European General Practice Research Agenda**” has defined that primary care research must focus on context-relevant studies within realistic primary health care settings (2). Research courses could be a successful tool in networking between participants and encouraging primary care research (3). In order to overcome the isolation and lack of critical mass in general practice research, it is necessary to improve research training, build professional networks, facilitate mentoring, and improve the way we market general practice research to the wider community (4, 5)

EGPRN is widely recognized as an organization with focus on supporting young doctors to develop research skills and start their academic development. Its aim is to provide a suitable environment in which to discuss and develop research in primary care; to foster and co-ordinate multinational studies, to exchange experiences, and to develop a validated scientific basis for general practice.

How Did it All Start?

A one-day workshop on Research in Primary Health Care was organised by a joint collaboration between the European General Practice Research Network (EGPRN) and the Vasco da Gama Movement (VDGM) during the VDGM Preconference (Istanbul, 21st October 2015). Our main aim was to provide young family doctors with the knowledge, skills and attitudes necessary for performing clinical research in a Primary Care setting.

There were 30 participants from several European countries (including Italy, Portugal, Ireland, United Kingdom, Belgium, Finland, Estonia, France and Germany) with an

average age of 30 years. Fifty-three percent were General Practice / Family Medicine (GP/FM) residents and the remaining young family doctors.

After the first workshop, a short survey was performed, in order to understand the needs and perspectives of young GPs towards research and therefore adjust future initiatives. All participants considered that research training was relevant for their personal development, clinical decision making, and critical appraisal of the literature and for personal curricula improvement.

Reasons for an Online Course

EGPRN has a long tradition of residential courses (6). Since 1984, there have been EGPRN residential research courses in England, Denmark, Italy, Spain, Ireland, Portugal, Sweden, Malta, France, and Poland.

The problems encountered with these residential courses were too much stuff to absorb in a short period of time; expensive for participants; organizational problems: difficulties to gather all the teaching staff at the same time.

With the advent of new technologies, teaching research via online courses becomes more feasible, cheaper and suitable to the young audience. All these considerations have prompted us to start developing an International Web-based Course on Research in Primary Health Care. The online course was launched at the WONCA Europe Conference in Prague in 2017.

Description of EGPRN Web-Based Course

The specific objectives of the course are:

1. To help participants to formulate ideas that can be tested in a scientific manner.
2. To give participants a basic understanding of epidemiological methods and biostatistics.
3. To give practical experience of development of study protocols and applications for research funding.
4. To give practical experience of use of computers for database analysis, use of spreadsheets and statistical analysis.

To this end, the course contains 25 modules of teaching and a practical final step in which the participants are requested to present their own research project. Each web-based module consists of a 15-25 minutes didactic lecture, links to complementary materials in video, and a short post module examination. Lecturers in the course are experienced researchers from EGPRN.

The course is free of charge to EGPRN members and available upon the payment of a small fee for non-members. There are three different options to present the final project: in an EGPRN conference; at a WONCA conference; or in participants' own countries via local arrangements with the course leaders.

A Certificate of participation and graduation is given by the EGPRN to participants that complete all web-based modules and participate in the final practical half a day workshop, as a final step of the course.

Discussion

So far 29 participants from 11 Countries have successfully completed the 25 modules and participated in the final practical half a day workshop as a final step of the course. (Figure 1)

This course was designed to improve access to research training, which is a core competence in Family Medicine. The development of customised courses oriented to the actual needs and expectations of the participants and the power of new technologies can greatly improve research skills in the upcoming generations of Family Doctors. In EGPRN, we are conscious of the importance of qualitative research to understand real-world, complex issues, including how practitioners think and how our patients experience care (7). Therefore, in our Web-based course we have 3 modules dedicated to qualitative research which represent a good introduction to participants willing to pursue more advanced

Qualitative Research courses in the future. We know that while senior family physicians consider research to be a reserved field for academic departments, young rural doctors are willing to be involved in research - but are also those who face the most difficult obstacles in this field (8). A web-based course may contribute to make research training more available to those.”

Conclusions

Extending research capacity in GP/FM, followed by the development of evidence-based practice, can alleviate the lack of research output within the discipline of GP/FM in countries with lack or shortage of academic primary care departments.

The development of customised courses oriented to the actual needs and expectations of the participants using new technologies can greatly improve research skills in the upcoming generations of Family Doctors.

With this web-based course EGPRN hopes to address the “research skill divide” between academic and non-academic primary care and this is a milestone for EGPRN.

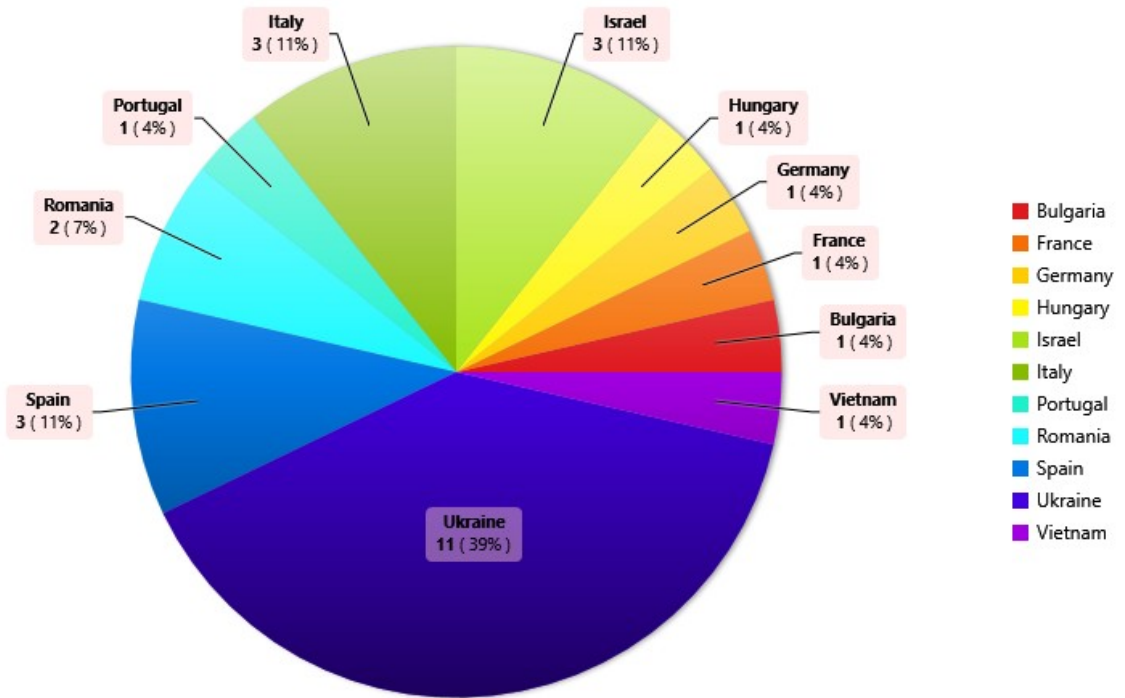
Take Home Messages

1. Research in primary care is essential as it gives the vision for the future development and prosperity of Family Medicine/General Practice.
2. EGPRN has a long tradition in residential research courses, but these have some limitations: expensive for participants and too demanding in what concerns the organizational process.
3. New technologies offer excellent opportunities for online courses.
4. With this web-based course EGPRN hopes to address the “research skill divide” between academic and non-academic primary care physicians.
5. Preliminary outcomes of the EGPRN Web-Based Research course are promising.

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Fig 1





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10 – How to Translate Tools, Scales and Indexes in a Reliable Way Using the Tool Assessment for Therapeutic Alliance (TATA) EGPRN’s Study as an Example

Le Reste JY, Nabbe P, Lazic D,
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R, Le Floch B, Le Goff D, Frese T,
Collins C, Cobek Unalan P, Neves
AL, Van Merode T, Vinker S,
Petek D.

Why should I take part?

Translating Tools, scales and indexes for pan European Family Practice is a basic task to enhance practice, teaching and research capacities within Europe.

Objective

The enhancement of quality of care is a constant objective in medicine. Technical knowledge is necessary but not sufficient to ensure that quality. Human factors and communication challenge are also in the balance (1-3). For communication challenge an initial education appears useful. Nevertheless, in most countries over Europe this initial education is informal and is undertaken using practice as the playground. No academic basic education is delivered to the student. In addition, there is no cultural background to assess the success for student and for physician in this specific exercise of communication. And this is despite the fact that it is essential in routine medicine (4). Communication is a huge domain where all aspects are not possible to evaluate. Inside communication therapeutic alliance seems to be an efficient theme useable in medical education and in practice (3) to enhance adherence to treatment and self-expertise of chronic disease. It goes far from the old paternalistic behaviour and pushes the patient as the key factor in the decision process (5). From this fact was born the TATA group within the EGPRN. In the absence of a gold standard measuring therapeutic alliance this group aimed to find the most validated tool to measure therapeutic alliance. As therapeutic alliance is still missing a consensual definition, theories are overlapping themselves and their authors designed corresponding tools (6). It was possible to establish a consensus around the idea of collaboration between patients and physician with the intention to define common goals inside a therapy. Recently researchers found that an efficient TA enhances chronic illnesses since it enhances adherence (diabetes mellitus, hypertension, obesity, cancer, polyarthritis, psychiatric disorders... (3,7,8) and therapeutic performances (3,7). TA should be a matter of concern especially if we consider European ageing population and the

growing prevalence of multimorbidity. Not only TA may improve health outcomes and health status but it could be cost effective too.”. Many tools have been designed over the past 50 years. The group first target was to find out the best evaluating tool for TA. To do so a systematic literature review, according to PRISMA guidelines, was undertaken and was achieved. Preliminary results showed at least 6 interesting tools with some validity data. The research team has achieved that systematic review according to the PRISMA guidelines. Then a Rand Ucla Method took place to find the best possible tool for GP. A forward backward translation of that tool in all the teams’ languages followed. The translated tools had then to be validated in all countries to ensure their validity data.

The workshop aims to encourage family physicians (FP) to conduct research and to provide them with the basic tools to translate relevant tools for Family Practice at a multinational level.

Methods

This interactive workshop will be suitable to understand and have the basic knowledge to undertake:

Systematic reviews according to PRISMA guidelines using a multilingual team

Consensus methods including Delphi and Rand UCLA for translations

Workshop map: 4 small presentations:

Systematic review methodology: how to integrate an international team work (working by pairs) the pilot group role

Consensus Delphi and rand UCLA pitfalls

Forward backward translations with a Delphi consensus procedure included

Publication plan.

For each question 20 minutes leave to play 5 minutes teamwork 5 minutes presentation of team work and 10 minutes of expertise to answer the teamwork leading to 1h30 (90 minutes) in total.

Results

By the end of the workshop participants will be aware of the basic tools they need to achieve the translation of the best available tools, scales or indexes.

Conclusion

This workshop will enhance the research capacities of all participants to conduct or follow a multinational research about translation and cross validation of tools, scales and indexes for primary care.

Take Home Messages

1. Therapeutic alliance is a new concept in the wider context of a doctor - patient relationship.
2. An increasing amount of evidence implies that the quality of the therapeutic alliance between the doctor and patient substantially affects treatment outcomes.
3. A tool to measure it needs to be verified in semantic and cultural equivalence before the validity analysis.

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11 – Can Social Prescribing Benefit Health and Well-being in the Community?

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EURIPA Workshop at WONCA 2018 Krakow, Poland **Introduction**

Social prescribing in the community involves health professionals referring patients to non-clinical forms of intervention, with the intention of enhancing the patient's health and well-being (Polley et al 2017). Social prescribing is based on the belief that not all patients' needs require treatment with drugs or other medical interventions but there is recognition that a patient would benefit if their social, emotional and practical needs were met by linking people to volunteers, activities, voluntary and community groups and public services. The purpose of social prescribing (SP) is to improve an individual's well-being and support people to take greater control of their lives by addressing the bio-psychosocial and environmental issues that impact on their lives (Moffatt et al, 2018). The concept of social prescribing has the potential to benefit not only individuals, but also communities, by people getting to know and support each other. The Royal College of General Practitioners found that social prescribing was amongst the most effective means of reducing GP workload freeing up their time to deliver clinical care (RCGP 2018). Evidence shows an average drop in demand by 28% (Polley et al 2017).

Objectives

It was envisaged that the workshop would help to provide an insight into social prescribing and to identify the potential for social prescribing in communities which may differ due to locality and cultural differences.

Method

In 2018, short presentations were made by EURIPA members at a workshop during the 23rd WONCA Europe conference in Krakow, providing examples of how social prescribing has been developed in different countries and demonstrating the impact on the health and well-being of patients within their communities.

Results

Discussion within groups covered a broad range of issues including the important challenge of how to raise awareness of SP. It was agreed that it is important that people understand what SP is, how you could participate in SP including self-referral, to know what facilities and activities are happening.

For practitioners thinking about social prescribing, they will need to consider how to identify people who will benefit from SP. The person being referred to a community activity may lack confidence to attend, and most importantly community activities need to be inclusive. Participants in the workshop agreed that there was a need for some form of quality assurance of the provision of social prescribing services in the community, including the reassurance that the right individuals were providing the services to ensure safety. The financial support for voluntary sector providers was important to enable the sustainability of the provision of services. Some other suggestions were to go into schools to discuss activities that would benefit health and well-being within the community. Creating links on the GP practice website to exhibit activities within the community. It was considered important to have a GP champion so it can be locally driven.

The Discussion

It was decided to follow up the workshop in Krakow with a workshop at the EURIPA 8th Rural Health Forum later in the year in Israel in 2018 to focus more on the needs of rural communities.

It was realised that in many rural communities that GPs have actually been doing SP for a long time and have built up an ongoing process in their communities. However, SP does not happen everywhere (not in all countries and varies within countries). For instance, in France Exercise on Prescription is free; Exercise on Prescription was also available in Denmark but when the funding stopped so did the project. In one location in Denmark, GPs were offered a large municipal building so other healthcare could be provided locally such as physiotherapy but also facilities to run a café run by people with mental health problems working part-time and get support. Within the building, large rooms for local groups to rent at nominal sum and participants have set up a Facebook group.

However, in some countries such as in Austria, the GP cannot prescribe to sports clubs and other activities as it is considered outside public health. As in Poland there appears to be a strict separation between health/medical and social care with no exchange of information. Even so there are activities in the communities, but they are not linked and are isolated from each other. In Romania there is the definition that referral to support services must be social. It is known that one hospital refers people to groups who have chronic conditions, social issues or are vulnerable.

In Norway there are quite a lot of referrals to groups within communities, however not the same range is offered everywhere as it depends on the population and how they relate to the local culture. In the Czech Republic it is part of everyday practice to tell patients to go, for example, to clubs for young mums. The system is not co-ordinated and varies according to locality so it was felt that there was a need for a more formalised approach. In Israel physicians are referring informally as there is a need to stop people keep returning to a clinic when they do not need medical care or treatment. It is beneficial to encourage patients to go to clubs and join in activities. This also creates opportunities for volunteering as it is known that frequently people develop from attending a club to becoming a volunteer.

Unfortunately, these clubs are not all subsidised or co-ordinated. In Spain they have created a centralised programme and are introducing the programme to communities. As Spanish GPs have to address many medical prescriptions there is no time to make the referrals themselves they give this role to a co-ordinator.

Following on from these workshops EURIPA took part in a European Webinar co-organised with the Polish Society of Lifestyle Medicine on Social prescribing. Speakers were from across Europe and there were over 150 participants

<https://medtube.net/lifestyle-medicine/medical-videos/26670-webinar-social-prescribing-remedy-to-chronic-health-problems>.

Conclusions and Future Prospects

It was realised following these discussions that there was a need for a project to understand more about what is happening in other countries across Europe and the barriers to further development and implementation of SP in rural areas. This will be taken forward but the planning has been overtaken by the Covid-19 pandemic. Understanding the impact the pandemic has had on SP also needs to be understood as there are consequences to people's health and well-being but potentially a lack of Social Prescribing activities to provide a response.

Take Home Messages

1. Social prescribing has the potential to create stronger links across sectors: health, social, charities, voluntary groups, housing for the benefit of the community
2. There is the potential to create a shift for the responsibility from doctors and the primary care team to the individual's themselves taking responsibility for their own health
3. There is a need for a co-ordinated approach so that everybody understands what social prescribing is and formalise processes of referral
4. There is a need for research to understand the benefits and drawbacks within health systems and cultures
5. Social prescribing has the potential for improving the health within a community and developing community initiatives

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12 – EURIPA Workshop: Chronic Care Model – Are There Differences Between Rural and Urban Areas in Europe?

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Introduction

Chronic care and multi-morbidity are the main challenges in rural areas facing various problems such as a rapidly ageing population, a potentially declining workforce taking care of these people and a long distance from centres of excellence. Following the first workshop in Denmark in 2016, EURIPA has continued this work (WONCA Europe, Prague 2017). This work could be useful for urban areas as well, as they also share many of the same problems such as the ageing population. There are implications for family medicine on to how it manages these vulnerable patients and this increasing workload. Hopefully, future work on this topic would involve all the WE networks.

The management and prevention of chronic conditions is a challenge for primary care providers across Europe, and particularly in rural areas where people are less likely to be able, or willing, to access appropriate healthcare. Research is needed to develop equitable chronic care models that focus on stakeholder needs, including those of individual patients, caregivers and primary care professionals, taking care of particular healthcare system and local dietary habits. Ensuring a high quality of life (QoL) for healthy and chronically ill citizens is a major goal of both governments and local communities. Those goals are underlined in the Alma Ata and Astana declarations. This goal can be achieved by means of a well-organised health care system, especially primary care that meets not only clinical requirements but, more importantly, patients' social needs and the needs associated with their living and working environments. (1-3)

Chronic diseases and their related disabilities determine the level of well-being of people worldwide. Results of the Global Burden of Disease Study, 2013 show that people are living longer, but with multimorbidity and increased disability. However, the literature lacks reports on the differences in the management of chronic diseases between rural and urban areas, as well as on the differences in disease prevalence and mortality in rural and urban Europe. Moreover, a comparison of the existing results does not allow unambiguous conclusions to be drawn regarding the influence of the living place on the QoL of patients with chronic diseases. It is therefore necessary to conduct further research on this group of patients. (4-6)

Objectives

To explore the possibility of collecting data from different studies on urban–rural differences across Europe and to establish an EU project to investigate this issue. The workshop investigated the interest in, and the receptiveness to a potential project on the application of a Chronic Care Model by EURIPA (European Rural and Isolated Practitioners Association) in rural areas across Europe.

Method

Existing data and conclusions from finished projects were presented and a SWOT analysis was carried out on the proposed EU project on chronic disease management in European rural areas. This was followed by small-group discussions on the possible approaches and domains of the project. Data were collected using an online survey. Responses from 227 General Practitioners (GPs) across nine European countries were analysed. A mixed-method survey design was used which included respondents performing a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis to evaluate the feasibility of adopting a chronic care model in their healthcare settings across Europe.

Results

Our workshop allowed for the identification of problematic domains in an EU project on chronic disease management in European rural areas. The workshop provided useful insights into perceived priorities. The expertise of healthcare professionals and the strength of the relationships and communications within and between professionals, caregivers and patients were found to be positive components of the system. However, ensuring adequate staffing levels and staff competency were described as issues that would need to be addressed promptly. Other challenges included enabling patients to participate in decision making by ensuring adequate health literacy.

Discussion

We are confident that our study will be useful for European, countries and local health policy makers to implement chronic care models that consider the peculiarities and priorities of rural care, characteristics that have been neglected far too often over the last decades. Ensuring adequate staffing levels and staff competencies are issues that would need to be addressed during implementation of a CCM in rural settings. Other challenges include enabling patients to participate in decision making by ensuring adequate health literacy. The provision of healthcare is often limited by resource allocation and the ability to cover 'out of pocket' payments (7-8). In some countries it is not possible for a GP to prescribe some drugs (statins, ARB inhibitors, some painkiller) without referring patient to the secondary care level. The rural population has greater healthcare needs but often does not have the opportunity to access services. Consequently, when we are developing health literacy and healthy living within our rural communities, in parallel we need to develop new ways of engaging and using facilities. Thereby the onus for health will lay more with individuals supported by knowledge and resources from and within communities. (1-3)

Conclusions

The workshop inspired participants faced with the challenge of chronic care management to tackle the differences between rural and urban areas. We concluded that a chronic care model could certainly have benefits for healthcare but that there are a range of socio-demographic and equality issues that will need to be addressed before its widespread use.

Take Home Messages

1. Healthcare policy makers will need to think holistically about systems to ensure sustainability and efficacy. Health care policy makers together with all levels of health workers have to think holistically about systems to ensure sustainability and efficacy with respect to Alma Ata and Astana declarations
2. Educating patients and caregivers, and improving their health literacy would be critical to the success of a CCM in rural communities
3. Major assets of the current health systems include the expertise, training and effectiveness of healthcare staff to improve control of non-communicable chronic diseases

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13 – Guidelines and Mindlines in Family Medicine

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Modern medicine is doing great harm. Doctors are failing in our duty to protect well-being. These are all unstoppable forces; protesting, it seems, is just howling in the wind. For me, medicine is about what we don't do, rather than what we do do. It's not about knowledge but experience, caring, and accepting uncertain (Des Spence).

Family doctors make diagnoses and manage problems in unique ways, however we rarely discuss openly how we think. Gabbay and Lemay have described 'mindlines' as the internal processes doctors use to reach their decisions. In this course, we will discuss the ways that family doctors make diagnoses and choose treatments based on the best evidence from clinical guidelines, combined with internal, personal knowledge in the form of mindlines. We will show how this process can be shared with colleagues, students, and patients to improve medical education and medical care.

Guidelines are a welcome help in working with patients as they offer professional, evidence-based and equal treatment for all patients, but too often reveal shortcomings in the multimorbid, in elderly, representing the majority of our visits, and especially in patients with less serious illnesses. At that time, the equipment can only be based on physicians' healthy wisdom, experience, ingenuity and the needs of the patient to avoid overdiagnosis and overtreatment.

How would you define guidelines? It is a piece of information on how something should be done (Cambridge). And how would you define mindlines? They are collectively reinforced internal tacit guidelines (Gabbay). Guidelines have many advantages: they are derived from evidence based practice, lack the reliance on memory, represent the standard of care, are measurable and offer the same quality of care for all patients. They have some disadvantages, too: are based on randomised control trials, RCTs, conducted on a selected population under controlled conditions, usually outside primary care, so we can not use them in specific situation, with particular patient, who is not "fitting" in any of the guidelines, they promote cookbook thinking, because they lack of creativity, if we do not follow them, we might risk legal liability for non-compliance. We can spot several conflicts of interest of their authors, resulting also in conflicting guidelines, disregarding patient's preferences and views, they focus on cost rather than on care..... Since we have nowadays new and new guidelines 'moving the goalposts', there is no surprise that the result is obvious: overdiagnosis!

Human decision making is very interesting process. How do humans make decisions show the 40 years old psychological research by Daniel Kahneman, which is still underused in medicine. Humans have dual process of thinking: system 1, which is fast, automatic, frequent, emotional, stereotypic and unconscious, and system 2, which is slow, effortful, not frequent but logical, calculating and conscious.

Gabbay and Le May invented the name mindlines and wrote: "Clinicians rarely accessed, appraised, and used explicit evidence directly from research or other formal sources; rare exceptions were where they might consult such sources after dealing with a case that had particularly challenged them. Instead, they relied on what we have called "mindlines," collectively reinforced, internalised tacit guidelines, which were informed by brief reading, but mainly by their interactions with each other and with opinion leaders, patients, and pharmaceutical representatives and by other sources of largely tacit knowledge that built on their early training and their own and their colleagues' experience."

So - how can we do better? What do we need from information sources? What are guidelines for? Who are guidelines for?

Information in the digital age should be relevant, valid, accessed quickly, with minimal effort, information tools are likely to be electronic, portable, fast, easy to use, connected to both a large valid database of medical knowledge and to the patient record, so they become a servant of patients as well as doctors.

What matters to the patients? They are preoccupied by their own morbidity, obsessed with prevention of all diseases (can we really prevent everything?), their quality of life, physical, mental and social functioning and independence, death- how and when, symptom relief with as little adverse outcomes as possible etc. Therefore they need: patient centred care, bio-psycho-social approach, patients' centred values and priorities, good doctor patient relationship, which enables shared decision making and coordination of interdisciplinary care, doctor's clinical expertise and individualised treatment goals. All these characteristics form our mindlines!

Take Home Message

1. Family doctors often follow the guidelines when dealing with patients and treating a particular health problem.
2. The aim of the guidelines is that all patients, irrespective of the place of treatment and regardless of their personal characteristics, have equal and comparable quality treatment. They offer optimum treatment for an individual health problem, which is supported by a systematic review of evidence, most of which are based on randomized controlled trials.
3. Most guidelines are based on the results of surveys conducted on a selected population under controlled conditions, usually outside primary care.
4. Can the family medicine practitioner use such guidelines in a specific situation, with a particular patient? Unfortunately, often not, because our patient or a healthy individual is not "fitting" in any of the guidelines. At that time, the family doctor must rely solely on his clinical knowledge and experience, on the knowledge of his defined patients, their families, the working and the social environment. This way of thinking is called "mindlines", common sense, knowledge and experience from practice.

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14 – Overdiagnosis and Quaternary Prevention - Policy and Practice in European Countries

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Background

Overdiagnosis, overtreatment and overuse are becoming the fundamental challenge to modern health care, possibly the biggest problem posed by modern medicine. Health anxiety is widespread and increasing while methods of investigation and treatment within specialist care and some parts of primary care are increasingly available. The expansion of medical interventions sometimes does not promote health, but cause harm. Therefore, WONCA Europe wants to strengthen and support the ability of family doctors to exercise professional judgment within their clinical practice, realising that many family doctors work in regions with poor access to appropriate investigations and interventions. WONCA Europe Council agreed to put overdiagnosis, overuse and overtreatment on its agenda, targeting its members, other medical professionals, health authorities, media and general population in order to stimulate public awareness of this problem, aiming at better use of healthcare resources and safe healthcare.

Aim

To get an overview of the policies and practices regarding overdiagnosis and related medical excess in European countries, and to analyse what actions are feasible and effective. Secondly to analyse facilitating factors, barriers and possible actions taken on this matter such as avoidance of mitigation of harm from excessive or unnecessary health interventions.

WONCA Europe states on its website that the general practitioner makes efficient use of health care resources, but too much medicine, overdiagnosis and overtreatment have become a challenge to modern health care. Examples include bacteria resistance from antibiotic overuse, over irradiation from excessive X-rays (over-investigation) and complications from unnecessary procedures (overtreatment). Furthermore, doctors are more likely to be sanctioned for non-intervention than for inappropriate or excessive intervention.

However, it is generally well acknowledged that many family doctors work in regions with low access to appropriate investigations, or long waiting times for procedures

which may result in missed or delayed diagnoses. Although related, delayed diagnosis and overdiagnosis can and should be analysed separately.

Wonca Europe Council recently agreed to put overdiagnosis and over-medicalization on its agenda, targeting its members, other medical professionals, health authorities, media and general population in order to stimulate public awareness of this problem, aiming at better use of healthcare resources and safe healthcare.

Methods and Learning Issues

Presentations on an evaluation of overdiagnosis and overtreatment in different European countries, followed by critical case reports from selected European countries. Participants are invited to reflect on their own situation and challenged to indicate which actions can or cannot be taken.

Take Home Messages

1. Demand balanced evidence informed and non emotional information material (e.g. invitation brochures) from providers and authorities in relation to cancer screening, health checks, etc.
2. Take initiatives to discuss potentials for overdiagnosis in settings where you have influence; in relation to colleagues, GP/FP representative organisations, lay people and health authorities.
3. Demand that authorities and funders put overdiagnosis on the public agenda and support research and dissemination of information on overdiagnosis, initiate and take part in research and professional development related to the problem of overdiagnosis.
4. Share your findings and experience in relevant fora, e.g. the WONCA networks, WONCA Special Interest Groups (SIGs), and congresses.

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15 – Tyranny of Health

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Health is an important value in our society and medicine has an important role to play in preserving and restoring health. However, there are trends in society, like healthism, that place disproportionate emphasis on health using both lifestyle changes, such as diet and exercise, and the resources of medicine, such as medication and surgery, in order to express this.

To perform as a professional family/general physician, you should know how to define health and disease, know the health hazards posed by modern medicine, know how to calm the patient, be aware of professionalism and true values and appreciate the ethical attitude towards maintaining and promoting health and treatment. The aim of this workshop is to discuss benefits and harms of the new paradigm of »perfect health« for everybody as a must. We will attempt to define a balanced view of health and disease in order to help doctors cope with the unbalanced demand for health at all costs in their practices.

What is GP/FP's mission? To treat- sometimes, to facilitate- often and to comfort- always. And what is health? Is it just absence of disease or perfect physical, mental and social health or just normal functioning according to age or maybe integrity, normal functions, coping with stress? But what is a disease? Is it a structural organ anomaly, a functional disorder, a deviation from normal, maybe God's punishment, fate or the consequence of our vices?

Tyranny of medicalisation- is it present everywhere? It means that we turn simple, everyday problems into diseases that have to be treated by professionals (e.g. dry eye, sleep disorders, bad mood, baldness, sadness....). Weingarten in 2006 wrote: "Being a woman is an incurable disease that requires lifelong pharmacological help: before pregnancy - folic acid, in pregnancy – iron, when growing up - HPV vaccination, in fertile period – contraception and in menopause- hormone replacement, in postmenopause - treatment of osteoporosis... So- do we nowadays need to talk about quaternary prevention? By all means, since there is evidence of damage, due to medical intervention. Let's have a look at the field of primary prevention! Some preventive interventions have significant health benefits (e.g. polio immunization), however, we also know of some interventions that have caused significant damage (influenza immunization campaign during the recent influenza pandemic, which has caused significant damage to hundreds of children now suffering from vaccine-

induced narcolepsy). What about the secondary prevention? Preventive examinations, like managerial screenings do not reduce neither morbidity nor mortality nor the overall risk of cardiovascular disease and cancers, but only increase the number of new “diagnoses”, incidentalomas, false positive results and consequent unnecessary treatment, so they can significantly impair the quality of life of healthy people. Cases of harm in tertiary prevention also exist: use of antiarrhythmics in myocardial infarction, which reduce arrhythmia but increase mortality, hormone postmenopausal replacement therapy reduce the incidence of CVD but greatly increase the incidence of breast cancer, stroke and thromboembolic events; even the intensified glycaemic control lowers glycosylated haemoglobin but does not reduce mortality...

This is why we have nowadays to talk about quaternary prevention! Marc Jamouille, Belgian GP, already in 1986 used the term “Quaternary prevention” for “patients” with MUPs, to identify patients at risk of excessive treatment, to protect patients from invasive measures, to counsel only treatment that is ethically acceptable and improves the health status of patients at risk of serious complications of the underlying disease. Since the problem is broader than patients, who feel sick, but their doctor can not find a disease, an EUROPREV working group on quaternary prevention (Carlos Martins, Maciek Godycki-Cwirko, Bruno Heleno & John Brodersen) proposed a new definition of quaternary prevention and published their idea as Quaternary prevention: reviewing the concept in European Journal of General Practice, 2018 (24: 1): 106-111. It goes: "Quaternary prevention are all activities to protect the individual (person / patient) from medical interventions, that would cause more harm than good."

At the end of our workshop the participants will be able to identify and define the types of healthism encountered in the practice in family medicine, the role of quaternary prevention in practising family medicine, list the harms of healthism and strategies used to cope with healthism, perform a “do not harm” approach and value the need for a balanced view of health and disease. We expect that the audience will start appreciating the quaternary prevention approach in practising family medicine, considering also patient's agenda and try to perform only the tasks that do more benefit than harm, their professionalism should base on knowledge, healthy wisdom, experience, ingenuity and the needs of the patient.

“Prevention and health promotion used to be a good idea, but unfortunately it was spoiled by the rise of the consumer mentality. The goal of preventive measures is no longer just to help individuals at risk due to their lifestyle, and thus to have a positive impact on the health and illness of the population. Instead, an industry that sells healthy products, nutritional supplements, and absolute health aids (what is that supposed to be?) Has achieved that health is no longer private and individual, but a moral duty, a new religion where the state seeks to intervene into the way of life, also against the wishes and interests of citizens. We are experiencing a real obsession with "health for all", maximum prolongation of life regardless of its quality, super health (healthism) and super healthy lifestyle (lifestyle) and the compulsion to all achieve these "ideals" (Petr Skrabanek, The death of human medicine and the rise of coercive healthism, 1994).

Take Home Messages

1. 1 GPs/FP should start appreciating the quaternary preventive approach in practicing family medicine, to consider also patient's agenda and to perform only the tasks that do more benefit than harm.
2. 2 Professionalism is based on physicians' knowledge, healthy wisdom, experience, ingenuity and the needs of the patient.
3. 3 Keep quaternary prevention in mind all the time!
4. 4 Never forget the ethical principle of patients' autonomy!
5. 5 Always consider the patient's side of the problem!

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16 – Teaching Quality and Safety in Postgraduate Education

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Introduction

There is a growing imperative to include quality improvement (QI) and patient safety (PS) themes in medical education in the recent years. Physicians and other healthcare professionals are expected to acquire QI and PS competencies needed in their daily clinical work in the health care system that would result in improved health outcomes and safe patient care.

A Competency Framework for Quality Improvement in Family Medicine was developed in 2012 with the aim to guide the development of postgraduate curricula for quality and safety in family medicine. It consists of a list of 35 competencies organized into the following domains: Patient Care & Safety, Effectiveness & Efficiency, Equity & Ethical Practice, Methods & Tools, Leadership & Management, and Continuing Professional Education. In 2014, EQuIP in collaboration with EURACT decided to develop an educational agenda for quality and safety in general practice/family medicine based on the Competency Framework for Quality Improvement in Family Medicine. The agenda represents an educational framework for teaching the core competencies of quality and safety in family medicine at the speciality training level, designed to serve as a basis for curriculum developers to set the learning aims and methods and the assessment aims and methods. The European Teaching Agenda on Quality and Safety in Family Medicine was approved and endorsed by EQuIP in 2018, followed by EURACT and WONCA Europe in 2019.

Educational Aims and Learning Outcomes of Quality and Safety Improvement Education

QI and PS require health care professionals to be clear about outcomes, know what changes would lead to improvements and know how to evaluate their efforts. In addition, a quality improvement approach requires workers to translate into practice evidence from their own efforts at improvement and those of others, including increased efficiency of service delivery as well as improved safety for patients.

According to the European Teaching Agenda on Quality and Safety in Family Medicine, at the end of the training in QI and PS, the trainee should be able to:

- define QI
- describe the basic principles of QI
- describe the methods and tools used in QI
- know the principles in ethics and legislation on QI
- identify the national organisations and programmes on QI
- identify and list the sources of information on QI
- approach doctors' health topic

Tools and Methods of Quality and Safety Improvement Education

Adult learning techniques have been identified as crucial in delivering curricula in QI and PS, demonstrating improvement in learner's knowledge and confidence to perform QI. Key characteristics of successful QI curricula include interface of educational and clinical systems, careful selection of QI assignments for the trainees/learners and appropriately trained faculty members.

Formal curricula in QI and PS usually include three main types of educational designs:

1. primarily didactic (lectures occasionally combined with small group sessions);
2. mixed didactic and experiential learning (lectures accompanied by a QI project / audit);
3. web-based curricula

The chosen format will depend on the learning impact a programme expects to achieve. Curricula based primarily on lectures and web-based modules are appropriate if the expected goal is providing basic knowledge in QI and PS, while behavioural change requires experiential learning. Most of the current curricula combine didactic and experiential learning, which is regarded as the optimal format, following the principles of adult learning.

Assessment Tools and Methods of Quality and Safety Improvement Education

Assessment is acknowledged to be essential to the educational process, both in terms of providing feedback and informing students about their performance (formative assessment) as well as decision-making for certification purposes (summative assessment). It is generally accepted that a variety of carefully selected instruments is needed in order to obtain a complete picture of a learner's competence and performance. In designing assessment, it is recommended to refer to Miller's pyramid for categorizing levels of assessment: knowledge (knows), competence (knows how), performance (shows how) and action (does). Knowledge of QI and PS concepts can easily be tested, but testing skills and assessing QI and PS performance represents a more complex and demanding process.

According to the existing literature, the optimal format for assessing the competence of residents in performing QI and PS activities is yet unclear. Currently there are several tools used for assessing QI and PS knowledge and skills, as well as QI projects:

- *Quality Improvement Knowledge Application Tool (QIKAT)*
- *Systems Quality Improvement Training and Assessment Tool (SQI TAT)*
- *Mayo Evaluation of Reflection on Improvement Tool (MERIT)*
- *Quality Improvement Project Assessment Tool (QIPAT)*
- *Multi Domain Assessment of Quality Improvement Projects (MAQIP)*

Due to expected effect of QI and PS education on the process of health care delivery, changes in clinical processes and patient outcomes may be used as measures in the assessment of QI and PS education. However, since QI projects often fail to demonstrate improvement in clinical outcomes and methodologically it is difficult to attribute changes in clinical outcomes to educational process, a more feasible aim represents assessing impact on behaviour change and clinical processes.

Take Home Messages

1. The European Teaching Agenda on Quality and Safety in Family Medicine represents an educational framework for teaching the core competencies of quality and safety in family medicine at the speciality training level
2. Adult learning techniques have been identified as key factors for success in delivering curricula in QI and PS, combining didactic and experiential learning as the optimal format
3. In the evaluation of QI and PS competencies, both in-training (formative) assessment and end-of-training (summative) assessment are needed
4. Assessing impact on behaviour change and changes in clinical processes may be more often used as measures in the assessment of QI and PS education in the future

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17 – Quality Indicators: From Useless to Useful

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Background

Many general practitioners (GPs) are understandably sceptical about the use of quality indicators. Easy access to data from electronic patient records (EMR) have made it increasingly common to construct and use simple indicators as measures for judging quality in primary care. In many countries indicators are also in used in pay-for-performance (P4P) systems. However, as described in the Position Paper “Measuring Quality in Primary Health Care” (1), GPs throughout Europe oppose P4P systems for several reasons. P4P can cause negative effects such as reductions in person-centred care and continuity of care. Decreased quality of care for diseases that not are included in the P4P system has been shown. A Cochrane review concluded that P4P is not associated with better outcomes for patients. P4P has been associated with increased use of tests or treatments but this appears to be due to better documentation rather than better patient care (2). Indicators on patient satisfaction have been used in P4P schemes, although patient satisfaction has a complex relationship with outcomes. Higher patient satisfaction is associated with higher levels of medical interventions, higher overall health care costs and prescription drug costs, and it has been shown to be related to increased iatrogenic harm and increased mortality (3).

Current quality indicators do not reflect the complex clinical content of primary care. Indicators are often based on single diseases and the assumption that there is a treatment alternative or an outcome that is always the “right one”. In reality, multimorbidity, patients’ personal preferences, lifestyle behaviours and socio-economic conditions affect the outcome of consultations and often make it impossible to follow guidelines for individual diseases. Thus, the doctor's most important task is to, together with the patient, plan care and treatment based on the individual patient's needs (4). In fact, many of the most important things a GP does are not measurable. In first-line care, where patients’ symptoms sit on the borderline between healthy and ill, factors such as patient-centred care, communication, and the patient-doctor relationship are central. Aspects that affect the quality of the relationship, such as knowledge of each other, trust, loyalty and appreciation are crucial (5), but difficult to capture in indicators.

If GPs feel that the complex reality, where they have their own internal motivation to

do a good job, is squeezed into a situation where focus is on individual metrics and money is the driving forces, the risk is not only lower health care quality, but clinician burnout (6).

However, quality indicators can be helpful, keeping in mind that they are no more than **indicators on quality**, not measures of quality (1). The indicators should cover different aspects of quality. Quality improvement is necessary in primary care and quality indicators are useful for initiating, stimulating, and supporting quality improvements in a GP practice. To know what to improve it is necessary to systematically monitor the quality of one's own work, the team's work, as well as the work environment. Comparisons with other primary care settings (benchmarking) can be inspiring, e.g. by using regional or national quality indicators. Peer group education using benchmark data is a strong educational tool that enables a discussion about outcomes between professionals in their own context. These comparisons can form the basis for a deeper analysis of reasons for differences in working methods and resource use which in turn can help and inspire improved structures, such as patient safety initiatives, and cooperation with others e.g. by using the Plan-Do-Study-Act model (7). The possibility to identify and act on individual patients' care gaps is also useful. Furthermore, working together in a workplace to improve quality brings joy to work (8).

Method

The workshop consisted of mixed short presentations and group work on 1) What quality indicators are, 2) Examples of use of indicators from several countries, 3) Possible better use of quality indicators.

Results

Examples of indicators constructed by insurance companies or national health authorities, and in some countries used for P4P, were given from Czech Republic, Slovak Republic, Ireland, France, Israel and the UK. These indicators were described by participants as uninspiring, using unreliable data, not measuring real quality and giving a feeling of "big brother watching". Using patients' opinions for P4P or using measures that depend on factors beyond the control of GP practice, such as patients' socio-economic situation, were also described in negative terms. Also, the conflict of heavy workloads leaving no time to consider what really needed to be measured and improved was discussed.

Some examples of indicators constructed by professionals for quality improvement in GP practices, were presented from Sweden, Canada and Finland. These were perceived as "measures that are important to me and drive our activity". The possibility of using data directly from EMRs was considered important. The need for practices to be able choose what they wanted to improve and to discuss measurements within the practice team was also emphasised.

Conclusion

Quality indicators can be either top-down (constructed by health care authorities) or bottom-up (constructed by frontline clinicians). They can be used either externally (e.g. for judgement, ranking or P4P) or internally (for quality improvement). Top-down indicators for external use were perceived as demotivating by many participants, especially when they were used for P4P. On the contrary bottom-up quality indicators for internal use were described as improving intrinsic motivation to do a good job. This makes them important for quality in health care.

Take Home Messages

1. Quality indicators are indicators, NOT measures of quality. As such, bottom-up quality indicators for internal use, are useful for quality improvement in health care.
2. Using indicators to compare results with other practices is a way to get inspired. Analysing reasons for differences can help quality improvement.
3. Working together in a team on quality improvement, with freedom to choose relevant topics, and with time to do it, helps bring joy to work.

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18 – Violence Against Female Doctors, Its Influence on Professional Mental Health and Prevention

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According to the WHO and the International Labour Organization the health-care professionals are at the highest risk of violence in their workplace among all professionals, they are 4 times more likely to be injured particularly because a doctor often deals with person in a stressful and emotionally taxing situation [1, 2].

Earliest studies of violence against doctors from the USA date back to the 1980s where 57% of emergency care workers had been threatened with a weapon. In Asia, violence against medical professionals has been reported from Israel, Pakistan, Bangladesh, and prevalence rates have been higher in comparison to Western countries. It was shown that 85% of doctors had experienced violence in their workplace in China, and up to 75% of doctors in India. A national survey in Australia revealed that 58% of general practitioners (GPs) (more with lesser years of experience) had experienced verbal abuse and 18% experienced property damage. In Europe GPs also reported some kind of violence: 78% - in the UK, 75.8% in Bulgaria, 60% in Portugal, 82.8% in Turkey. Verbal and sexual violence were seen more frequently among women, whereas physical and economic violence were more frequent with men [2-6].

Nowadays almost every doctor is worried about violence at the workplace, and very few are trained to deal with it.

Existing literature agrees that the violence is a ‘background’ concern for both female and male GPs, although women are more likely to express concern and report experiences of being afraid. Female GPs feel lesser safe than male physicians, both at work setup and during on-calls duties. Increased entry of women has rendered violence and its management more visible within general practice. The significant gender difference for aggression faced by the physicians was sexual harassment, which was faced more by the females than males [6, 7].

Risk Factors

The known **risk factors of violence against doctors** can be divided into 4 groups according to GPs’ assessment [8]:

- 1) Physical environment of the consultation - home visits, after-hours, practice organization (solo practice), practice location (in geographic areas of low socio-economic status), physical aspects of the practice (architecture), isolation;
- 2) Individual characteristics of the patient - general appearance ('rough' looking), sex, physical size, illicit drug use, age (younger patients being involved in illicit drug use), psychiatric illness, predictability, presence of companions;
- 3) Individual characteristics of the general practitioner - vulnerability of the doctor (mainly for female GPs), perspective of the GP (more cautious in their risk assessment with advancing age and greater experience);
- 4) The doctor–patient relationship.

The Top Perceived Causes for Violence

are reported to be long waiting periods, delay in medical attention, dissatisfaction with the treatment and denial of admission, among other factors [2]. Sometimes, the patients falsely accuse the doctor of harming them, which leads to aggression by the patients and their attendants [7].

According to GPs' perceptions the causes of occupational violence can be divided [9]:

- 1) Underlying causes.

Individual patient causes (psychiatric disease, use of illicit drugs, sexual motivations, physical illness, patient personality)

Societal causes (poverty and social dislocation, population density, respect for authority, "bowling for columbine" effect and the culture of fear)

- 2) Proximate causes (frustration accessing care, waiting times, denial of access to care or medical services, failure to discourage or circumvent violence (on the part of the doctor or practice, "naïve" practice culture, deficient interpersonal skills)

- 3) General practitioner vulnerability - provision of information to third parties, legal matters, licensing authorities, duty to service all patients

The Manifestations of Violence by Patient

usually comprise telephonic threats, intimidation, verbal abuse, physical assault, murder, vandalism, and arson. Unfortunately professionals report only serious and major injuries in contrast to minor ones while verbal violence is considered the most common.

Consequences

The violence leads to psychological issues such as depression, insomnia, post-traumatic stress, fear, anxiety, leading to absenteeism, being irritable, helpless and has resulted in worsening the patient-doctor relationship, professional burnout and not good clinical practice. Some doctors might abandon their workplaces, have an impact in their professional career and reputation or even injure themselves [2, 7]. The negative consequences of violence have a heavy global impact on the cost, efficiency and efficacy of the health system, affecting the delivery of health care services or their availability.

Prevention of Occupational Violence

It is important to be vigilant and look for early warning signs of violence by using the STAMP approach [2]:

Staring used to threaten is an early indicator of potential violence.

Tone and volume of voice have been associated with violent episodes (raised voices and yelling),

Anxiety in many people reaches dangerous levels, sometimes does escalate to violence (1)

Mumbling is a cue for violence as it suggests mounting frustration

Pacing by relatives has been observed in instances that resulted in violence and is seen as an indication of mounting agitation.

Management

The limited articles showed the experience of GPs with description of a diverse range of strategies for dealing with violence in their clinical practice. Despite the heterogeneous and often ad hoc nature of these measures, they could be seen as a schema of primary, secondary and tertiary strategies [8].

GPs' Strategies for Dealing with Violence in Clinical Practice [8].

Primary Strategies - measures designed to avoid the occurrence of conflict, aggression and violence. These strategies are identified here as consisting primarily of either a restriction of practice or discouragement of violence.

1. Restriction of Practice GPs confined their clinical practice to situations or patients with which they felt safest (but it leads to inequity of care)

- Population Level Measures

- Geographic (to eschew home visits especially in certain lower socio-economic areas)

- Temporal severely limited their after-hours work

- Demographic to avoid certain categories of patients (drug-seeking patients)

- Individual Level measures - 'vetting' individual patients for potential dangerousness and 'blacklisting'

2. Discouraging violence (avoiding practitioner isolation, companions & destination documentation, health professional support, police support)

Secondary Strategies - strategies to prevent aggression or lesser levels of violence escalating into more serious, physical violence. These strategies were further delineated into the categories of (1) personal; and (2) environmental measures.

1. Personal Measures - prompt consultation with agitated patients, interpersonal skills and negotiation techniques, acceding to patient demands, physical retreat

2. Environmental Measures - Physical Boundaries, Escape Routes

Tertiary Strategies are measures to deal with established violence - idiosyncratic measures (self-defence, alarm systems, "unorthodox" measures)

Take Home Messages

- 1) Training on effective communication needs to be imparted to medical professional which should include assertiveness training, refusal skills, anger management, and stress management. Psychiatrists and psychologists should be actively involved in such workshops for the benefit of medical professionals.
- 2) Good communication skills, appropriate body language and demeanor are regarded as important aspects of professional competence, required for both effective medical care for individual patients and an orderly and efficient work flow. GPs are expected to maintain a professional demeanor of emotional neutrality towards all their patients.
- 3) Violence against GPs warrants more attention. The social, economic, organizational and cultural aspects involved in this problem require an integral approach with extreme coordination between public organizations, medical colleagues and health care systems, towards a zero tolerance response.
- 4) The relentless attack on GPs need of continuous professional, administrative and legal support from the government along with systematic, coordinated implementations independent from daily political concerns.

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19 – Women and Leadership - WONCA Working Party on Women & Family Medicine

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More women are practising family medicine than ever before: the proportion of women has tripled to 45.5% in the past four decades in many countries, but women have yet to achieve equity of career conditions and opportunity. With the increased proportion of women in family medicine, we have seen numerous benefits to the profession, patient care and medical education. Working under similar conditions female family physicians often employ more patient-centred communication, spend more time with patients, and address a greater number of issues per visit than their male colleagues do. They spend more time on preventive and psychosocial aspects of patient care, and display higher levels of empathy, which are factors associated with higher patient adherence and greater patient satisfaction [1].

However, women are under-represented in senior leadership positions in private and public sectors, both in clinical practice and academic organisations: this is despite long-term recognition of the issue, and various initiatives aimed at encouraging and supporting women into leadership.

The impacts of gender-based challenges in women's professional and academic careers are linked with disproportionate rates of burnout, and can have negative effects on their career trajectories. Female family physicians just starting their practices might be especially susceptible to these challenges, with female sex, younger age, and early career status being independent risk factors for burnout [1, 2].

The WONCA Working Party for Women and Family Medicine (WWPWFM) was organized in 2001 with the following objectives: to identify the key issues for women doctors; to review WONCA policies and procedures for equity and transparency; to provide opportunities to network at meetings and through the group's list serve and website; and to promote women doctors' participation in WONCA initiatives [3, 4].

WWPWFM objectives are to enhance leadership skills among women family doctors, improve women's health at primary care, strengthen collaboration with other WONCA working parties, young doctors group and special interested groups (SIG).

Some of the main WWPWFM achievements are development and implementation of organizational equity strategies (see the 10 steps to gender equity, 2006), which were adopted by the WONCA World Council (in 2007). Important by-laws changes, and the

establishment of the WONCA Organisational Equity Committee, were consequences of this approach and were adopted by the WONCA World Council, in Cancun in 2010. The Gender Equity Standard (GES) documents and the “LEAD” STATEMENT were adopted as reference documents of WWPWFM in 2009 [3, 4].

While women doctors in increasing number in Europe prefer family medicine, whether equal opportunities are provided to women for clinical practice, research and leadership or not is still being discussed [5]. Women Leadership Pathways in Academic Family Medicine were analysed in 2016. The Council of Academic Family Medicine (CAFM) established a Leadership Development Task Force to specifically address the lack of diversity in academic family medicine leadership, particularly for women and underrepresented minorities (black/African American, Hispanic/Latino, American Indian/Alaskan Native). The task force identified four key domains within academic family medicine: clinician, researcher, undergraduate medical educator (UME), and graduate medical educator (GME). A critical outcome of the work of the task force was the acknowledgement that there are ample opportunities available for leadership development both within family medicine organizations and outside. However, a gap exists between program availability and the individuals who would benefit from them. Lack of a consistent platform promoting these programmes, in addition to the requirement for an external nomination (rather than self-nomination), may limit access to the most competitive programs [6].

As for leadership in practical health care there are several preparation and support programmes to develop leadership skills among healthcare professionals but only few address to integrated primary care. Leadership support aimed at developing skills for integrated-care implementation is insufficient and has to be developed of higher-quality knowledge about leadership focused on the implementation of the integrated primary care practice [7].

The WWPWFM “LEAD” STATEMENT [4, 8] endeavour to learn from the current leaders and maximise opportunities to be mentored, striving to become leaders and mentors ourselves so that may ensure the ongoing success of this Working Party, Wonca and family medicine as a whole world-wide. With support for each other it aim to reach a critical mass as role models so as to normalise women leaders in family medicine. WWPWFM affirms the value of the different choices available to women in family medicine including research, clinical and academic work, supports the role of emerging technologies in these areas with the aim to improve access globally to improve knowledge transfer and exchange. The Working Party works to foster collegiality among women, in the context of the workplace and the community, building support networks and leadership development opportunities for women family physicians and becoming role models for collaborative practice, strives for equity in the availability of flexible working arrangements for women in family medicine, overcoming barriers to achieve satisfying personal and professional lives. The tasks of WWPWFM for future are to enhance the leadership skills of women by new developed programs.

Take Home Messages

1. Wonca Working Party for Women and Family Medicine (WWPWFM) is a network which enhance leadership skills among women family doctors, improve women’s health at primary care, strengthen collaboration with other WONCA working parties
2. Female family physicians need more engagement in partnerships, funding and leadership positions in private and public sector, in clinical practice and academic organisations as this has approved benefits
3. The development of effective training programmes and mentorship in leadership skills for female family physicians will help women to develop their careers

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20 – What Do You Know About the Particularities of Your Immigrant Patients?

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Culture is a regulation system of interactions between people of a community which facilitates the lecture and the representation of the world in a coherent way.(1). It's a language (1) related to a place (2). We belong to this origin.

But, concretely, why does a person decide to leave? There must be something missing in his life conditions, and there must be some expectation to find it elsewhere.

What Does the Decision to Leave Mean?

It's never an easy one. There's necessarily a context of suffering, maybe despair, violence, oppression, precarity, poorness, illness. And there's the growing determination to get a way out: expectations, illusions, investment with major risks, but still more than these worst conditions... What else it may be, there's always a strong motivation driving behind!

No matter the reasons for migrants to leave their homeland, they will always have their culture as companion. With his impermeable presence and persistence. How to cultivate this culture? We are all concerned.

Each individual choice is a transgression (1) and a separation from the language to its place. Exile is out of place (2). Attached to his origin by his mother tongue, the migrant will be accompanied, not only by his childhood family memories, but also by the transgenerational traces of his family history. The mother's language is above all a location from where one will inevitably be chased away (3). Moving through life, a progressive gap will be constituted between the place and the subject: where he remains and where he exists (2).

While searching for what's missing in his life conditions, the migrant brings his own contribution to the chosen place.

We may ask differently (Devreux): "What brings the other culture to us what we have scotomized in ours?" (2).

Migration is a Course (1).

Along the way, along a whole life story, of suffering, of missing, of hope, expectations, illusions and deceptions. It's a story and should also be a report.

Listen to them! They have a story to tell. A narration is addressed to an audience. Maybe it's the source of a myth. But this way we may hear ourselves through the other's fantasies.

"Each person is a course of ideas which cannot be broken" (Montesquieu) (4).

The Attempt of an Overview.

Let's simply take some time to reproduce the journey of the migrant. There's a time for departure, followed by the course trajectory, and there is an issue: several times it's fatal, commonly they expect an arrival, certainly not easy.

We consider 4 phases :

1. reception: the discovery of another landscape, another culture
2. vulnerability: the exposure, the dangers,...
3. adaptation: resilience and search for solutions
4. expectations: anticipation and projects, circumspection...

These 4 phases may be followed by return, as there is no issue or no possibility to stay.

Try it again If you have the means...

Or you can stay!

The best issue doubtlessly is integration, allowing to be followed by installation. Where integration is compromised, often demands are with hope of later, or necessity of immediate return.

New attempt of departure? If you have the determination...and the means. Beginning a second circle...(5)

We need to offer to our migrated patients the optimal conditions for them to be able to report what happened to them. We are often confronted to awful or horrible life experiences, particularly undergoing violence, generating severe illnesses, or violent behaviours by themselves.

We have to support with reflective listening and with empathy. Let's take our mirror to the other's culture and discover what reflects from theirs to us.

In conclusion, we need to try to sharpen our insights and our medical understanding of the migrant patient's problems and the psychotherapeutic means that might be used to alleviate suffering. We listen to his narration and we try to reconstitute, together with him, a life story and the connected event story which make sense conjointly.

Take Home Messages

1. Migration is the journey from missing life conditions to expectations to find them elsewhere.
2. Listen to the narration of the migration course
3. Consider the 4 phases of migration (reception, vulnerability, adaptations, expectations)
4. Use reflective listening and empathy
5. Sharpen your insights.

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21 – How to Preserve the Human Side of Medicine?

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I would like to introduce you to the Levenstein Model (1).

A patient's complaint is produced among two interventionists: the GP and the patient himself. This stimulates the GP's hypotheticodeductive approach and generates questions. The GP tries to find answers to the problem. He collects and assembles multiple data in order to get a diagnose and to propose a treatment.

On the other side, the patient has his own expectations and fears. He wants to understand what occurred to him. He searches for sense, he worries about origin, about the reasons of occurring changes and environmental influences.

The GP needs to transpose his response to the presumed problem for the patients needs of understanding. This is a difficult challenge, but it's the aim of patient centred approach.

This means we have to recognize the experiential knowledge of the patient and the people next to him, their capacity to develop care competences, their psychological, social, cultural and spiritual dimensions (7)

Our task will be facilitated, if we consider that he tries to express his suffering. Is it a verbal complaint or is it a symptom? The consolidation of the context may generate concepts.

We consider suffering as the required condition for the Primary Care Psychotherapy, according to the ethical approach. That means we have to try to join Ethics in General Practice with GP's competencies in Primary Care Psychotherapy.

Focusing on suffering, we listen; the patient begins narration, telling about what happened in a certain context, reporting the event story. There's a context of environmental constraints, of predetermined expectations. Something occurred, not to be seen beforehand, and this happening affected the patient and his defences. And, further on, by the way, at some relevant moments, he will relate to some periods of life story. He might refer to his family, to his school days, to further job experiences... While we are practising reflective listening, referring to aspect (2), to silence, to reformulation and quotation, asking open questions. So he develops his own subjectivity: this is the expression of the patients perspective, generating the GP's empathy.

Such complaints in their relevant context reveal both major difficult specificities of

the GP's practice: uncertainty and complexity. This brings us to the concept of the GP's flexibility.

Flexibility is the GP's capacity to act in a relevant way adapting to uncertainty and to complex clinical situation, considering biomedical evolution and changes of the society, in respect of ethics and cultures (3).

Flexibility refers to active adaptability (4). It is not a passive attitude, it is not softness. In metallurgy, flexibility is the property of a metal to be brought in a certain position and to stay this way until the next modifications.

So, flexibility facilitates to adapt to circumstances, to maintain or to change again, taking care of evolution.

In order to dispose of this capacity of adaptation, we must try to be able to judge about a determined situation, the resulting consequences and their acceptability (5).

Finally, we have to judge with responsibility and flexibility, requesting active adaptability and even "flexible strength" (6).

Of course, to be able to do so, our practice requires intervision. We can't any more train, work, accompany, take decisions... alone. We must refer to networks, to multidisciplinary competitions.

In conclusion, when the patient reveals his suffering, he hopes for change. This allows him to evolve. Professionals are the experts of the illness, patients are the experts of living with them (7).

Ethics are based first on an intention which is goodwill, leading to a behaviour what tries to give good treatment, and finally achieving, through flexibility with responsibility, to an attitude which is benefaction.

Take Home Messages

1. Facilitate the patients means to notice his suffering
2. Connect the event story to the life story
3. Use the GP's capacity of flexibility to overcome uncertainty and complexity.
4. Get intervision.
5. Consider the patient as an expert of living with his illness

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21 – “THE UNIVERSE OF DRUGS” ESCAPE ROOM.

Game-based Learning Session on the Approach to Recreational Drug Intoxications in the Outpatient Setting and Emergency Department

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Introduction

Since 1960-s drug abuse and its consequences started to form a significant public health issue. Nowadays, the non-medical use and abuse of prescription and illicit drugs is a serious public health problem, responsible for (WHO) 2.4 million life-years lost due to disability and mortality in 2004". An increasing number of cases of life-threatening drug intoxication by so-called recreational "club rugs" have shaken the planet in the last 10-15 years and the use of psychoactive chemical - submission substances have recently acquired a new dimension owing to atrocity of sexual crimes associated with Drug Facilitated Sexual Assault.

Although emergency medicine is a separate specialty in many countries, in most European health systems family doctors perform on-call in out-of-hours services and some work in the in-hospital and out-of-hospital emergency services, and knowledge of emergency and toxicology bases is part of the curricular program of a family doctor all over the planet.

Aim

We believe it is imperative for physicians to know the alarming signs and symptoms of Drug Overdose (DoD) to improve it's early recognition, to prevent a consecutive severe neurotoxic damage and to increase the possibility of patient's survival by providing an early and correct treatment.

The Innovative Design of a New Modality of the Workshop

In Bratislava WONCA Europe 2019 we have presented the first edition of a Skill-building workshop with a unique opportunity to exercise clinical-diagnostic thinking in

the actual scenarios of overdoses by recreational drugs currently more popular and problematic in the European territory. The project took advantage of the exclusive knowledge and unique experience acquired in the emergency services of the 2 main Ibiza's and Madrid's hospitals and the "SAMU 061" service of the advanced life support of the Balearic Islands and Formentera.

We also had the privilege of having a psychiatrist in our team, specialist in addictions, to help to deepen the knowledge of addiction / alcohol impact on short- and long-term mental health of the group of patients, objective of our workshop.

How to Play with Serious Things. Proposal of the Material to Present and Detailed Methodology

The workshop started with the shocking ice-breaking video of the dangerous effects of recreational drugs popular in Europe, followed by introduction of the group psychiatrist giving brushstrokes about the importance of approaching addiction or sporadic and compulsive consumption of these substances for the patient's short and long term mental health, though initially used for seemingly innocent and recreational purposes.

After the first staging, the two main classification theories of "designer drugs" have been presented, to help to understand the pathophysiological mechanisms of their action and facilitate diagnosis and treatment in real situations.

If you decide to reproduce our workshop, we advise the listeners to be presented the list of illicit drugs currently used for recreational purposes, after what the warning signs, essential to distinguish in an intoxicated patient, are to be discussed, and the algorithms of the immediate diagnostic orientation must be defined.

Finally, with the videos or descriptions of real cases, the joint work of diagnostic evaluation and main lines of the therapeutic approach will have to be carried out.

Aim to face challenges of:

- diagnostic evaluation of the patient,
- decision making,
- organization of the human team (nursing, witnesses, security agents, police, firemen, technicians)
- election of means of approach
- the pharmacological and non-pharmacological treatment of the patient.

Learn Playing

In an entertaining and time-dependent context of a Medical Escape Room we have created the scientific space with an opportunity to exercise clinical and diagnostic thinking in the Drug Overdose by recreational drugs scenarios, currently more popular and problematic in Europe.

Participants could leave the scientific maze of Escape Room only after solving dilemmas of rapid warning-sign's recognition essential to distinguish in intoxicated patient. Analysing algorithms of immediate diagnostic orientation based on their physiopathological mechanisms and deciding pharmacological and non-pharmacological treatment of the patient were all taught through game, action, and adrenaline pumping!

Conclusions

- Drug addiction is actually a very old phenomenon, but in the last 10 years we have been through many and fast changes linked to the use of the internet and the marketing of 'new drugs', which have begun to transform profoundly the «traditional» usage patterns.
- It is necessary for the Family Physicians to be able to help our patients, to be acknowledged in the new types of drugs, the characteristic of each one of them (as a group of drug), the symptoms and the possible antidote.
- The growing use and types of synthetic drugs makes necessary to understand how to organise first clinical approach to intoxicated patients without knowing the precise chemical substance but the main classification and effects of the different drugs.
- The care of an intoxicated patient requires the methodological evaluation of the signs and symptoms that it presents, which allows the physician to make a diagnostic and syndromic approach and to categorize the severity of the situation.
- Supportive measures should supersede all other considerations in the management of the poisoned patient. The ABC's always come first independently of the type of drug or the quantity of consumption. The vital signs are the most important clues to the diagnosis of poisoning and should be measured often and accurately VS Treating the clinical picture with a correct management of the patient is the key to its progressive and rapid evolution. In the evaluation, the steps of the ABCD should always be followed, in order to carry out measures aimed at preventing the absorption of the toxicant, to favour its elimination and the use of antidotes according to the case.
- Until the date, the main way to reduce the non-medical drugs use and dependence was the prohibition and inspection of its use. But, the WHO encouraged recently to develop health (Harm Reduction)programs to ensure the continuous care of drug addicts (from primary prevention and risk reduction to the management of drug use disorders, rehabilitation, care and mitigation of harm) over the law enforcement strategies. That will require from the GP's an extensive knowledge of the drugs and effects not only to warn promptly about them but to go along with the patient to its recovery.

Take Home Messages

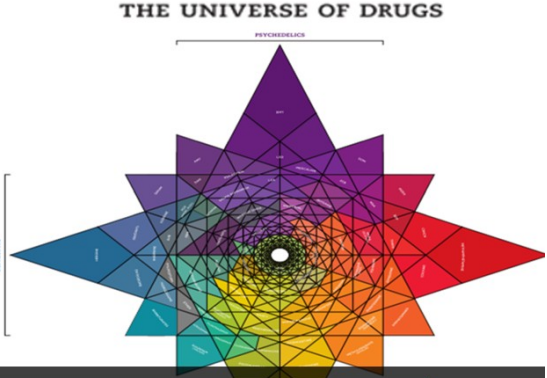
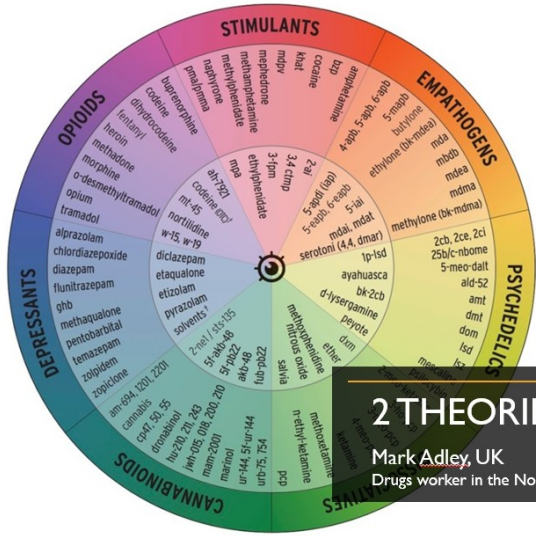
1. Serious gaming and gamification education have the potential to provide a quality, cost-effective, novel approach that is flexible, portable, and enjoyable and allow interaction between students, teachers, and peers.
2. Drug addiction it is a public health problem that continues to grow and adapts to new circumstances and social problems.
3. As family doctors, it is our duty to be up to date on the profile of consumers and on new trends to provide a comprehensive and holistic response to our patients.
4. In addition, in order to help our patients in times of acute intoxication, we must know the most commonly used substances and what their antidotes are, as well as correctly handle basic and advanced life support skills.
5. In order to tackle the problem, it is extremely important to create multidisciplinary care teams in which the family doctor participates introducing the attributes of accessibility, longitudinally, coordination and comprehensiveness; for example, Harm Reduction programs.

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THE DRUGS WHEEL

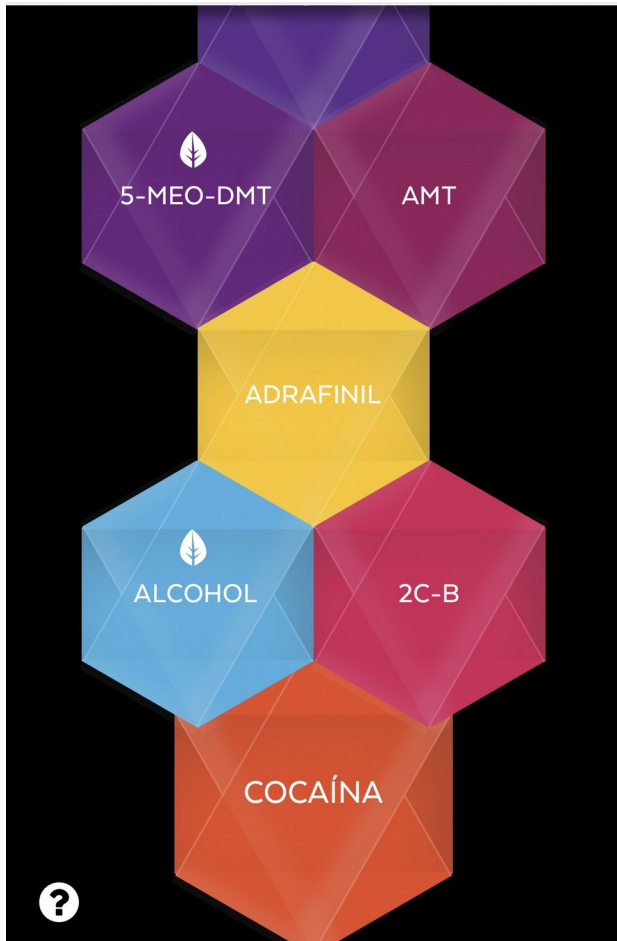


2 THEORIES OF THE UNIVERSE
 Mark Adley, UK
 Drugs worker in the North East of England
 Brun González, Mexico
 Espolea-harm-reduction advocacy group

Illegal stimulants **Hallucinogens** **CNS depressants**

Recreational drugs – most frequent causes of overdose medical care

The graphic features three columns, each with a distinct image and a label in a red button. Below the columns, three black and white photographs show individuals in extreme states of distress, likely representing the medical consequences of recreational drug use. The first image shows a person with wide eyes and a distorted facial expression. The second image shows a person's face with multiple eyes, a common visual hallucination. The third image shows a person slumped over, possibly unconscious from overdose.



RULES

1. You are participating in a SCAPE ROOM WORKSHOP, once you are inside, you'll have to work in groups in order to solve the challenges step by step, so you can get out of the room.
2. First, go to your group (color of the sticker)
3. Who has the bigger sticker is the leader
4. Follow the coordinators rules, and advices.
5. The leader has to log in KAHOOT.IT
 - a. The group has to answer the question, but only the leader can upload the answer!
6. The group with higher marks will receive a kit first.

PASSPORT (INSTRUCTIONS)

First stamp

First, pick the paper with the WORD SEARCH, and find all the words written in the paper.

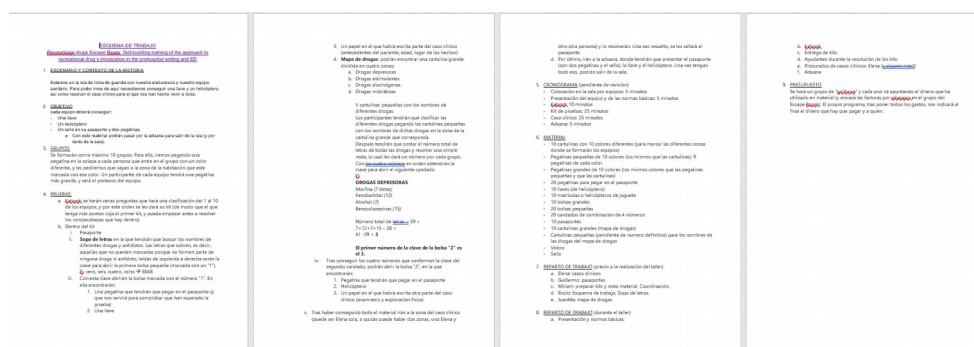
1. With the remaining letter then, you'll find 3 numbers in letters, which is a CODE to open the lock
 - Open the lock, then open the bag
 - Take the sticker and put it in this page
 - Take the small paper roll, and the key (save it for later)
2. Pick up the large coloured paper and open it.
 - You have a drug's map in front of you.
 - Pick the deck of cards and place each card in the right place
 - When you think everything is at its right place, GO TO THE CHECKPOINT (FIRST GROUP TO COME IN FIRST SERVE BASES, IT'S A GAME, SO FIGHT FOR IT !!)
 - You will receive more items /and a NAME / and this page will be stamped.

Second stamp

- ✓ You'll have to answer a few questions printed in the case cards, always taking account of the team.
- ✓ If everyone agrees with the answer, then you can go to the 2nd CHECKPOINT
- ✓ If you gave the right answers, you'll receive the 2nd stamp.

FINAL STAMP

1. Go to FRONTIER CHECKPOINT and bring the PASSPORT completed, and the KEY + NAME . IF everything is correct, everyone in your group are safe and can leave the ROOM... CONGRATS!!







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23 - ASPIRE Global Leadership Workshop: Leadership in Training Curriculum

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The World Organization of Family Doctors (WONCA) remarked that “leadership training has a direct impact on the ability of physicians to make continual system improvements.” [1] Leadership skills are an important skill set for young doctors as they progress in their careers, improving both their personal and professional competences. Within this goal in mind, the ASPIRE Global Leaders Program was established in 2015 as a special interest group of the WONCA Young Doctor Movements. The program aimed at increasing leadership abilities, international collaboration and engagement of Young Doctors in the WONCA events by organising workshops and mentor/mentee matching meetings.

Today, more and more evidence shows the positive impact of leadership and management skills. Effective self-leadership affects physician’s well-being, improves satisfaction and leads to less burn-out. Additionally, leadership quality has an impact on patients, organization outcomes and finances. Amongst several definitions of leadership, one of them is “a process of social influence, which maximizes the efforts of others, towards the achievement of a goal.” [2] There has been a progressive distancing between Leader and Manager, focusing on the benefits of a positive leadership on the team work and health determinants. We do not need to be the manager or the coordinator of a Unit / Department to perform several tasks where leadership skills would improve and facilitate the outcomes, even though we do not always realize that we are in fact the leaders in the situation.

Even though leadership is seen as a core competence for doctors, the skills are rarely taught and reviewed during the course of the medical training, both in pre graduate as well as in postgraduate settings. This should be considered as an important omission to address as the integration of leadership skills in residency training has the potential to improve the quality of healthcare delivery. [3]

Some family medicine programs in different countries provide leadership training with different modalities: formal teaching or courses, workshops, or mentoring relationships. However, by the time our workshop took place, there was no recommendation regarding Leadership, even though some of Family Doctors competencies mentioned in the WONCA Tree would largely benefit from it. EURACT - the WONCA Europe network of European Academy of Teachers in General Practice /

Family Medicine - published recommendations for the Residency Programs and the skills and competences that should be taught and trained meanwhile.

Hence, the ASPIRE Global Leaders Program submitted a workshop to the 23rd WONCA Europe Conference in collaboration with the Vasco da Gama Movement and EURACT. The aim of the workshop was to discuss the existing leadership training for young doctors as part of the Family Medicine curriculum and reflect on the barriers and future solutions.

During the workshop residents, young doctors and tutors gave examples of existing elective leadership training for the young family doctors in the current Primary Care settings. All the participants agreed on the necessity of a training as part of the Residency Programs. The format, the duration and the specific contents were not so consensual.

The outcomes of the workshop showed that a longitudinal curriculum that starts in Undergraduate training with an understanding of the core leadership competencies is needed. This should be followed by preparing for practice in Specialty training, focused on specific leadership skills development, and with Continuing Medical Education, for further development and attention on the opportunity for those wishing to lead in a bigger scale.

We conclude that there is the need for further study and discussion within different stakeholders in order to identify the need for specific leadership skills. As for the next phases, in collaboration with EURACT, teaching materials and self-assessment tools can be developed to assess leadership styles, strengths and weaknesses. We urge WONCA Europe as well as WONCA World to take an action to prioritise, implement and uniformize Leadership Training within and across the countries.

Take Home Messages

1. Despite some existing initiatives, there is a consensus regarding the need and urgency of including Leadership training as part of the Family Medicine Residency Programs.
2. Further discussion is required to identify the high priority skills and competences for Family Doctors as well as available resources.
3. Collaboration of different networks such as ASPIRE Global Leaders Program, EURACT, other WONCA networks and interested stakeholders is needed to develop and promote leadership training for young doctors.

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24 – The Legacy of Intimate Partner Violence in Heterosexual and Gay (LGBTQ) Communities. New Challenges for the Family Doctor.

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Duncan, Kirsty, Australia
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Monteiro, Nina, Portugal
Nobre, Maria João, Portugal
Pas, Leo, Belgium
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Rigon, Sara, Italy
Thomas, Claire-Marie, UK

The “classic” gender violence of the heterosexual couples has left a painful legacy to the LGBT community. Recent researches show that rates of Intimate Partner Violence (IPV) in Lesbian, Gay, Bisexual, and Transgender, and queer (LGBTQ) community are similar to or higher than the rates found for heterosexual women.

Though hardly worked, it seems to be that existing approach programs turn out to be incomplete and insufficient to address this problem in heterosexual women, being practically unknown in sexual minorities. The greater part of health professionals seems to have a vague and unclear knowledge of many basic LGBTQ+ concepts and specific health needs (social isolation, substance abuse, eating disorders, intimate partner violence, cancer prevention, etc...)

The reality is that most of nowadays family physicians are not conscious nor trained to identify nor manage the differences in professional help need between sexual minorities and heterosexual patients.

The main objective of this work is to raise awareness for the characteristics and specific needs for the LGBTQ related to partner violence, contrasting them with those of the heterosexual couples and so to work specifically on communication skills. We want the participants, on one hand, exercise how to approach the aspects of sexual orientation and on the other, how to handle with family violence in homo and heterosexual couples.

"Know and Win" Quiz

We offer you to check your knowledge/understanding of the differences between the Gender Based Violence and Intimate Partner Violence in LGBTQ couples, analysing the myths and popular misconceptions that we will comment on next. To do it correctly the essential thing is to keep in mind peculiarities and specific needs of both types of the intimate partner violence victims and its definition.

Intimate partner violence (IPV) is a pattern of behaviours utilized by one partner (the abuser or batterer) **to exert and maintain control over another person** (the survivor or victim) where there exists an intimate and/or dependent relationship. This control may be physical, emotional, sexual or financial.

Myth N1: Domestic violence is specifically related to heterosexual relationships

- This initial statement is absolutely false. One anonymous survivor wrote: “Domestic violence is often oversimplified as relating to male and female relations derived from sexism, but not acknowledging the larger framework of oppression, exercise of control and power...”

Myth N2: “LBT women report domestic violence more frequently than GBT men”

- Statistics say that the ratio of percentages of complaints made by women of heterosexual couples and men and women of LGBT couples is practically identical. However, in this calculation there are a series of powerful biases such as country, religion, social behavioral standards.

Myth N3: The abuser usually meets typical characteristics: Butch; Race / Class; Body Size.

- Domestic violence has a high prevalence regardless, income, education, culture, gender and sexuality.

The main concepts of the similarity and differences of the two types of intimate partner violence are summarized here.

Signs That the LGBT Intimate Partner Violence (IPV) Have in Common with Heterosexual Intimate Partner Violence.

- No one deserves to be abused.
- Abuse can be very diverse and often is emotional, psychological (verbal, emotional, stalking...), financial, sexual or physical
- As we’ve already mentioned, the incidence rate in victims of female same sex battering is approximately the same as the incidence rate in victims of female heterosexual victims
- The victim may be actual or former partner
- The more dominant partner may use its power to coerce or humiliate the partner: abuse often is used to maintain control and power; intimidation can be used to gain that power.

Now, let’s analyse what is different/specific to LGBT intimate partner violence (IPV).

- Additional difficulty to disclose and find appropriate support due to social prejudices
- Deep-rooted stereotype as homophobic (care providers as well as police ...)
- Lack of shelters, structures and charities geared to helping to IPV victims
- LGBT people historically have been offered “help” to become “normal”, so they may automatically be suspicious of “help” from any institutional representative.
- Utilizing services such as legal system is like “coming out”
- Hard to find LGBT sympathetic friends, since community may not be eager to “air dirty laundry” and the abuser's incrimination can lead to marginalization of an already oppressed community member.
- Some LGBT survivors know few or no other LGBT folks and leaving the abuser could mean isolation from LGBT community.
- Sense of shame: LGBT community may be small and everyone the survivor knows, may promptly learn of the abuse.

- Abuser can use children to manipulate and blackmail, because if survivor leaves, he/she has no parental rights to kids
- Among transgender people the risk of suicide attempt goes up to 40%, along with other mental health conditions (depression, anxiety, isolation, shame).
- As family physicians we must be prepared to be in contact with psychologists, psychiatrists and to refer patients to specialized clinics if this possibility exist.

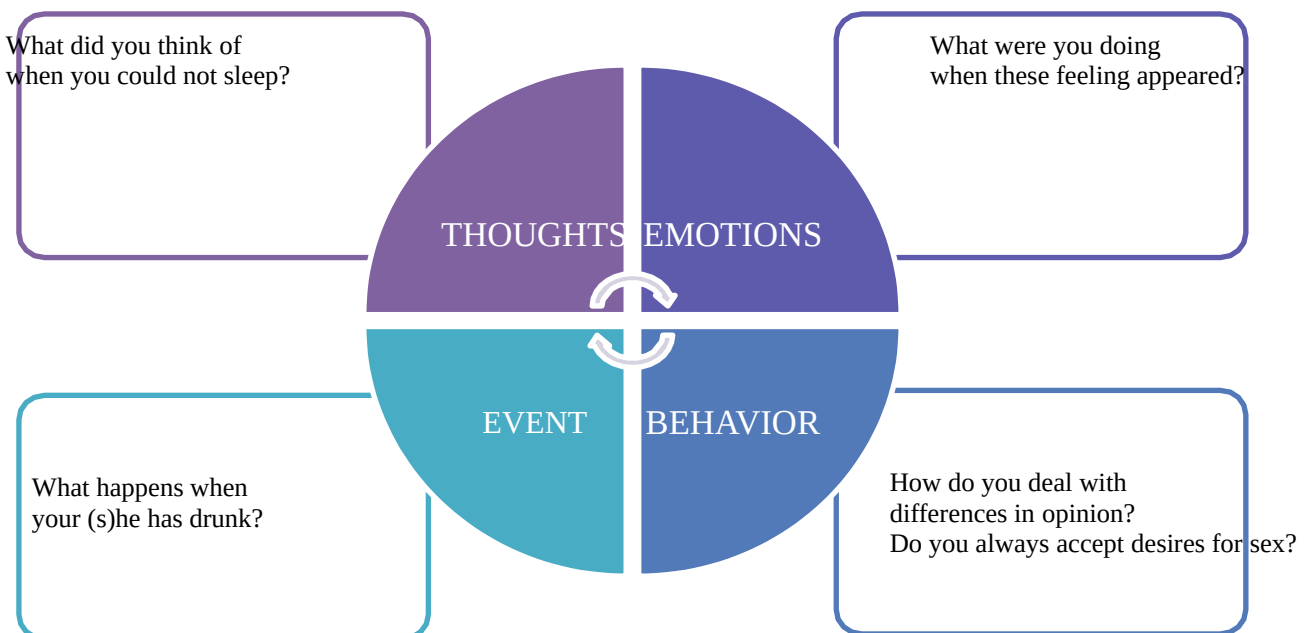
Forms of Abuse Specific to LGBT People

- Outing or threatening ‘to out’ the victim to family, friends, employer, police, community, or using in child custody disputes.
- Justifying abuse with the notion that partner is not “really” LGBT.
- Denying victim access to LGBT-community events
- Telling the partner that abusive behavior is a normal part of LGBT relationships or that it can’t be considered Domestic Violence because it is occurring between LGBT individuals.
- Portraying the violence as mutual or even consensual.
- “Safety” for LGBT victims is more than a shelter, protection orders or safety plans
- The rate of the necessity of feeling safe results to be lower than the one to be oneself, to feel unafraid of homophobic, heterosexist responses and attitudes of service providers

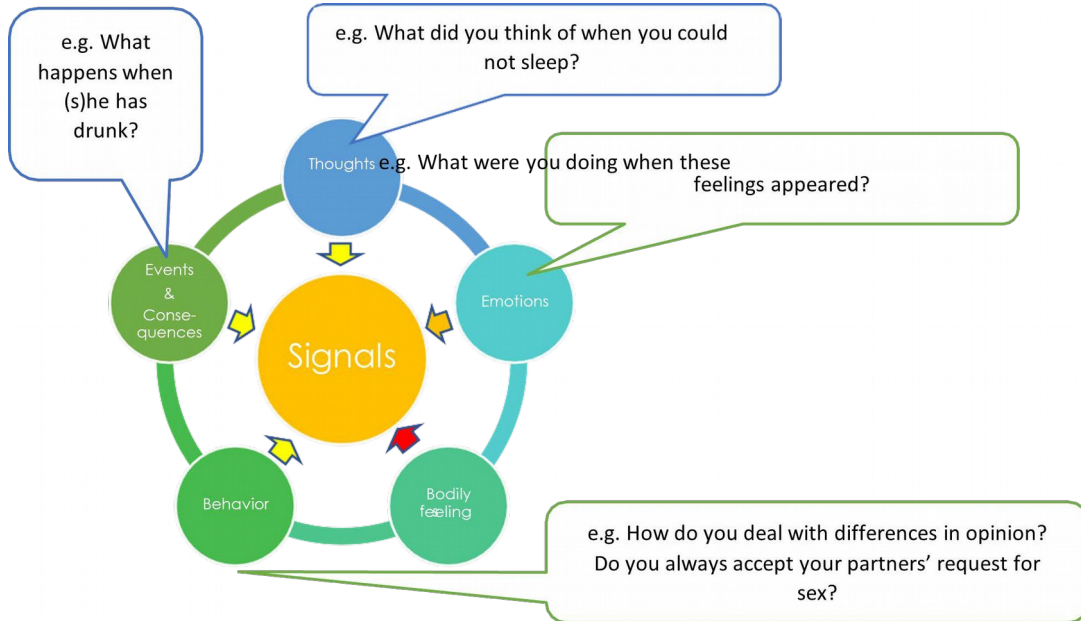
Hence, we offer several simple concepts of the possibility of psycho-behavioral intervention at the primary care consultation level.

A cognitive disclosure & Exploration of Indicated domains allow to react more effectively to presentations and consequences of hidden violence

Start Asking at any complaint



When violence has been disclosed, GPs should help to phrase concerns and context, inviting to reflect about possible solutions for change. The best attitude is to leave the ‘problem exploration’ approach to an exploration of patient ideas, concerns and expectations using ‘patient empathy’ and basic counseling techniques, open ended questions, summarizing and reflecting about ideas, feelings, emotions and reactions. Using techniques of motivational interviewing can be helpful in increasing the readiness for change in those who contemplate leaving abuse relationships, moving from the contemplation phase to preparation or action phase. Finally, a stepped care & multi-sector communication principle are suggested to orient patients to specialized services if they are available.



Methods

Ideas Concerns Expectations of CLIENT SYSTEM
 Leave ‘problem exploration’ FOR ‘patient empathy’
 Move from balance TO to CHANGE TALK

Skills for health care teams

Open-ended questions
 Affirmations
 Reflections
 Summarizing

Motivational Interviewing: Change talk

| DARN | CAT |
|------------------------------------|--|
| Desire: “I want/would like/wish to | Commitment: “I am going/intend to /Will” |
| Ability: “I could/can” | Activation: “I am ready /preparde to” |
| Reasons: “I want this because” | Taking steps: “I did/I strated to” |
| Need: “I ought/have/need to” | |

Rollnick, S, Miller, W.R., Butler, C.C. & Aloja, M.S. “Motivational Interviewing in health care: helping patients change behaviour”, (2008), p.33. <http://gbv-response.eu>

Client centred care and management in practice

| Care providers should | Person centered | | Practice centered |
|-----------------------|-----------------|--------------|-------------------|
| 1. Ask | 1. Empathy | Idea? | 1. Audit |
| 2. Asses | 2. Engage | Concern? | 2. Engage |
| 3. Advice & Agree | 3. Express | Expectation? | 3. Share |
| 4. Assist | 4. Enhance | Impact | 4. Rearrange |
| 5. Arrange | 5. Empower | Autonomy | 5. Manage |

Stepped Care & Multi-sector Communication Principles

| | |
|---------------------------------------|------------------------|
| 1. Describe signals | Ask |
| 2. Concert with carers in own setting | Discuss |
| 3. Consult advisory- or reportcenter | Consult |
| 4. Discuss ICE IA with client | Agree/advice |
| 5. Weigh risk violence | Assess |
| 6. Decide how to assist | Assist: needs & safety |
| 7. Securing safety | Report |
| 8. And/or report | Assure future & Safety |
| 9. Active Follow-up | |
| 10. Arrange protection | |

Adapted from the 'Dutch reporting code'

14 Maximum Attention and Focus Points

- Domestic violence equally occurs among LGBTQ as in hetero-sexual (ex-)partners
- Domestic violence is not conditioned by, nor related to income, education, culture, gender and sexuality.
- Accept LGBTQ as individual, avoid silence, speak about the relationship.
- Accept and respect the person's gender identity (pronoun) Do not react negatively to patient's appearance or self-presentation
- Abused patients often don't perceive themselves as victims, blaming themselves for the problems with their partners (even more in homosexual couples for their being different), so they are not likely to ask for help
- Don't make assumptions, don't disregard the authenticity of the patient's feelings and experience
- Abused patients often don't perceive themselves as victims, blaming themselves for the problems with their partners (even more in homosexual couples for their being different), so they are not likely to ask for help
- Don't make assumptions, don't disregard the authenticity of the patient's feelings and experience
- Among LGBT people the risk of suicide attempt goes up to 40%, along with other mental health conditions

(depression, anxiety, isolation, shame).

- Collaborate with psychologists, psychiatrists and refer pts to specialized clinics if this possibility exist.
- Local support groups are immensely helpful.
- Family doctors are often the first and only health professionals with whom abused persons come into the contact, therefore, it is of great importance for GPs to be aware and alert, as they are essential for the identification and prevention of Domestic Violence.
- DISCUSSION OF SEXUAL RELATIONSHIPS IS A TASK OF FM/GP AND HELPS TO OPEN THE DIALOGUE BETTER
- Don't be afraid to speak to your patients about sex and family violence: ask about their ideas, concerns, context, impact, and expectations

Take Home Messages

Old challenges for the family doctor: care for all!

1. Silence helps homophobia.
2. Stand up. Speak out.

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25 – Been There, Done That.

Attending European GP/FP Conferences in the Last 25 Years

Carl Steylaerts, MD, Belgium,
Erika Baum, MD, Germany

Carl graduated in 1987, and started attending European conferences in 1990. Erika graduated in 1977 and started international conferences of GPs in 1987. Back then, they were organised in Klagenfurt by SIMG, the Societas Internationalis Medicinae Generalis. German and English were the conference languages. We remember vividly how a Swiss GP came and told us about his 25 years of research in his own practice, leading to the conclusion that lead in the exhausts of cars led to headaches, hence the increasing sale of aspirin tablets over the counter of his pharmacy ...

Wow! A GP can start research from a simple observation and then continue into multidisciplinary research ...!

Since then, a lot of things have changed.

In 1994, SIMG and WONCA decided to merge into WONCA Europe, with an inauguration in Strasbourg, France in 1995.

Only one official language during the conference, English.

Over the course of the last 25 years, we have heard a lot of variants of the English language ... Italian English, Polish English, Finnish English but every year, the speakers became better and better.

The quality of the abstracts became better as well. A more methodical scientific language came in vogue.

Workshops on how to do proper research led to improved contributions.

More and more universities organised a GP department and that contributed also to the increase in quality of the abstracts, contributions and articles.

WONCA Europe decided that a European Journal was a necessity, and so we got EJGP, the European Journal of General Practice. Proud to have it!

First, the journal was published by a company, then another one ... and now, we have entered the era of authors paying for being published with free access to read and download for everybody, online. Markets changed, rules changed, financial streams changed. WONCA Europe adapted, perhaps according to Darwin's law: survival of the fittest.

From about 300 attendees in the 90ies, the numbers rose gradually to about 2000-3000, then slightly dropped. The price for attending rose also, from a mere 125 EUR in 1990 to the prices that we know today, 500-600 EUR, but exhibitions by pharmaceutical industry declined or did not take place in some conferences. Here also, markets changed, rules changed, financial streams changed ... and we adapted accordingly.

SIMG had a junior doctor committee, but in the first years of WONCA Europe, they had no such a thing.

Then VdGM was re-invented, with a steep rise in junior attendees.

Actually, VdGM is one of the most enthusiastic groups within WONCA-Europe! The future is bright!

Some countries make scientific work a daily practice, other countries leave it to hobbyism of a small group and of course, academics.

Hence, still a great variety in the quality and subjects of the abstracts.

It is clear that we need a comprehensive strategy for equal chances in all parts of Europe.

And then came ...

2020

This year, the re-invention of the virtual conference is realised. Yes, re-invented, because a small group of young Portuguese colleagues already experimented with that medium in the early 2000s. Travelling was and is expensive, junior colleagues that were not involved in academic work had not the money to attend ... so this virtual medium was created. But after about 2 years, they ran out of money and had different horizons to follow.

Man is a social animal. MOOCs (Massive Open Online Courses) are a different art form. Speaking to an audience that sits quietly in the room (sometimes more absorbed by their papers, cell phone or colleagues) is different when speaking online to someone at home, not very able to interact.

First, we needed to learn how make a contribution, then how to make a powerpoint, then how to speak in public ... and now, we need to learn how to speak in a virtual world. Conferences will become smaller, with less travelling and CO2 production.

Instead of one conference, several MOOCs will come into existence.

Fees will drop, so more attendees will show up.

Some will like it - others not. Most came to a conference also for personal exchange, sitting together during breaks or outside the congress venue and also enjoy the tourist experience. Because travelling is learning. About culture, science, human interaction, values ...

In short, to grow and keep growing!

In a sense, from Klagenfurt to the travelling circus of WONCA Europe, from German and English and different variants of English to quite good use of English, this next step was prepared (in Portugal) but it took a crisis like this to make the jump. What will the future bring? We propose a mixture of both as soon as possible: Virtual meetings but also conferences in presence. Perhaps in sequence one year to another or virtual with added social events. Most of us are looking forward to meet again, physically.

Because without the social interaction with peers in a sofa about an impromptu subject, family matters, chit chat among friends ... it will become a dull experience.

GP/FM Science is not created in a laboratory, but in real life. It is a science in its own right.

Different, but adaptive, creative ... and exciting.

Attending WONCA (Europe) Conferences once a year, trying to make a contribution from very different angles from the daily practice of a GP and from the academic angles was always a source of inspiration, meeting friends and new ideas

...

This Berlin Conference and those to follow will help us to find good solutions for the future - you are invited to accompany this process as actively as possible.

We look forward to meet you – again! And again!

Take Home Messages

1. To attend is to meet – friends, science, ideas
2. The future is bright
3. A comprehensive European strategy to attend is welcome
4. The future format of conferences will be different, but we'll adapt





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Addendum – The Way Forward From Burnout to Professional Satisfaction in General Practice/Family Medicine in the COVID-19 Pandemic

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The Family Doctor/General Practitioner (FD/GP) burnout is well-documented in literature and is marked by a feeling of a lack of energy, detachment, and disillusionment. All this can lead to irritability, poor decisions, and negative impacts on interpersonal relationships. Unmanaged conditions can also provoke mental health issues such as depression and substance use disorder which might affect the GP/FD.

Psychological threats might be typical of FDs. Care ethics specifies that in order to avoid burnout, we need to foster an environment raising the professional pleasure, understanding our own boundaries and limits. Burnout threat is always there in GP but more likely to happen in this COVID19 pandemic. Reviews demonstrate associations between burnout and different situational factors (External factors) as well as individual characteristics of the FDs (Internal factors). The SARS-COV-2 infection has hit almost all countries in an unprecedented manner. In just a few days, the external factors and entire societies changed drastically. Many eyes are focused on FDs who are “first in last out” standing on the front line of the fight. Many FDs paid the highest sacrifice with their own lives in the fight against the global pandemic.

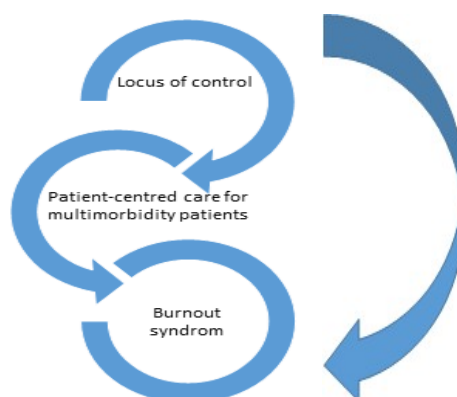
Several articles have been published on various clinical aspects of COVID-19. There is a lack of original data especially from GP settings on the balance in Burnout and GP professional pleasure. This contrasts with the key role of GP/FDs and the needed resources at the frontline of contact with possibly COVID-19 positive persons. In fear of spreading the virus, services for chronic multimorbidity patients have become difficult to manage as outpatient clinics have also been blocked or turned to telemedicine. There have been different steps in the approach used by the guidelines for family medicine: first, patient examination by family doctors has been disapproved. Family doctors are supposed to use phone interviews to assess their patients. Potential threat is the underservice of patients with multimorbidity and lack of GP/FD workforce. While most attention has been given to potential COVID-19 patients, other patients, especially those with multimorbidity, requiring care are still at risk of being left behind, seriously questioning the equity and safety of care. In this background article, our task is to discuss if a shift from burnout to professional satisfaction and pleasure may be possible for GPs/FDs.

The increasing prevalence of multimorbidity in Europe represents a major challenge to FDs because of the comprehensive needs of the demanding patients, the intensity of interventions, and the overload in primary health care settings which is a potential external risk factor for burnout. On the other hand, the adoption of “patient-centred approach”, which is one of the competencies of FDs, is also considered to be a key to providing good quality care for multimorbidity patients.

Besides a theory called “locus of control” explains human behaviour. It is generally accepted to be the degree to which people believe that they, as opposed to external forces (beyond their influence), have control over the outcome of events in their lives.

Much research has shown a relationship between locus of control and work-related outcomes. For example, a relation with work performance, work-place communication, work-related attitude, positive task experiences, work-place motivation etc. Internal locus of control has a positive relationship with job performance bringing satisfaction and pleasure. Researches also suggest that people who score higher on External locus of control tend to experience more negative emotions and difficulties. This is not to say, however, that an internal locus of control is always “good” and, vice versa, an external locus of control is always “bad.” Locus of Control considers the tendency of people to believe that control resides internally within themselves, or externally, with others or the situation.

However, little was known if a relation presents in between burnout among FDs and some of the specific factors as their locus of control and the people-centredness, person-oriented care.



The instrument incorporates three validated scales including Maslach Burnout Inventory, (MBI-HSS), the Shared Decision-Making Questionnaire (SDM-Q-Doc) for measuring person-centred care and Roter’s locus of control questionnaire. The SDM-Q-Doc is related to the specific consultation which makes it possible to focus on a multimorbidity patient.

We have already applied those tools to 319 FDs in Bulgaria and at the moment we are applying the same instrument to FDs in Turkey during the pandemic. I will share the preliminary findings with you only from Bulgaria. I have summarized the findings to the following groups:

I. Person-oriented (People-Centred) GPs/FDs with an “internal locus of control” have “lower levels of burnout syndrome”.

II. There is an association between an established psychological construct “locus of control” and identified difficulties in managing multimorbidity patients.

III. GPs/FDs with an “external locus of control” have a statistically significantly higher difficulties as below:

1. Poor collaboration with social services

2. Difficulty in assessing polypharmacy
3. Difficulty in reporting of adverse drug events
4. Poor communication with patients and relatives / caregivers
5. Challenges in shared decision-making
6. Poor patient cooperation
7. Lack of human resources in care

IV. FDs with “internal locus of control” tend to experience more satisfaction in GP/FM profession and have higher levels of shared decision-making performance.

Conclusion

The pandemic can serve as an opportunity to scale-up GP/FD care, mainly in empowering people for self-care, thus achieving higher quality of care, reducing workload on the GP/FD, relieving professional burnout by people-centred, person-oriented care. Young FDs with an internal locus of control are healthier, happier and more satisfied with their profession than those with an external locus of control. This difficult period we are leaving in has also highlighted the importance of FD/GP well-being. It is essential to continue the discussion on the internal locus of control and people-centred, person-oriented care, safe resources and models of care after the pandemic. FDs across Europe have to adapt themselves to the new circumstances created by COVID-19 when it ends. FDs with an “internal locus of control” should continue to deliver good quality, people-centred care, and maintain preventive self-care safely not only in the specific pandemic environment but even when it is over.

Take Home Messages

1. The more “patient centred care” the less “burnout” of the FD, the “better care” both for multimorbid patients and also for FDs’ “professional satisfaction” even in the COVID19 pandemic
2. The more “external locus of control” the less “professional pleasure” and the more “difficulty” in GP/FD profession in any condition.
3. While choosing medical specialization, it may help those young FDs to know that with an “internal locus of control” they are healthier, happier and more satisfied with their professional lives in GP/FM than those with an “external locus of control”.
4. The good news is that although it is said that it comes from childhood, there are evidences that FDs/GPs can change “locus of control”, regardless of how entrenched they are, by focusing on what he/she can control, turning criticisms into growth and seeking support in such emergencies as in current pandemic.

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25 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, 8 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)



Anna Stavdal (2016-2019)



Mehmet Ungan (2019-2020)

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!

Carl Steylaerts, MD, Belgium

Hon Treasurer 2010-2016

