



*EGPRN is a network organisation within
WONCA Region Europe - ESGP/FM*

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1st joint meeting of
The European General Practice Research Network
and
The European Rural and Isolated Practitioners Association

Attard – Malta
17th – 20th October, 2013

SCIENTIFIC and SOCIAL PROGRAMME

***THEME: “Research into Different Contexts in General Practice/Family
Medicine: rural vs. urban perspectives”***

Pre-Conference Workshops
Theme Papers
Freestanding Papers
One slide/Five minutes Presentations
Posters

Place

Hotel Corinthia Palace 5*
De Paule Avenue; San Anton BZN9023 – Malta
Tel: +356 21 440301; Fax: +356 21 465713
E-mail: reservations.malta@corinthia.com

This EGPRN-Euripa Meeting has been made possible thanks to the support of the following sponsor:



MIPC
Mediterranean Institute of Primary Care

77th EGPRN Workshop / 4th EURIPA Rural Health Invitational Forum
EGPRN – EURIPA joint meeting

The meetings of the European General Practice Research Network (EGPRN) have earned accreditation as official postgraduate medical education activities by the Norwegian, Belgian, Slovenian, Irish and Dutch College of General Practitioners.

Those participants who need an attendance certificate can contact Mrs. Hanny Prick, EGPRN Executive Manager, at the meeting in Attard.

“Research into Different Contexts in General Practice/Family Medicine: rural vs. urban perspectives”.

Dear EGPRN and EURIPA members!

Welcome to the conference in Attard-Malta in October 2013, from the 17th to the 20th.

The Executive Boards of EGPRN and EURIPA are proud to present a joint meeting to be held between the two organisations. The project has developed follows discussions held at the Wonca meetings in Warsaw and Vienna, where members of both Executive Boards agreed to have one of the first such inter-network meetings within Wonca Europe.

The name of EGPRW was changed to EGPRN many years ago to emphasise the importance of networking in research in family medicine. EURIPA has recently set up a research stream focussing on the field of rural and remote health and health care. This joint meeting on research in family medicine with the special topic of “*context*” and how it affects health care in family medicine is a unique opportunity for collaboration between two network organisations within Wonca Europe.

This is indeed a network meeting of networks!

We have prepared a joint conference with a special venue, the small Mediterranean island of Malta, which has been at the crossroads of trade and inter-cultural exchange since more than 6000 years. The venue is a classic five star hotel in the centre of Malta, next to the Presidential Palace and Gardens in Attard. The Hotel affords good meeting facilities, excellent fine and casual restaurants, and first class service. All this for prices which you would not expect, with a unique price to quality ratio which has been a feature of all EGPRN conferences and courses organised in Malta before (five from 1996 to 2004). The conference fee is very affordable, and with contained costs, coming to Malta with its strong international connections should be painless and easy.

The scientific programme is very exciting, with input for the first time from two organisations, offering a unique blend of research and expertise. Key note speakers with links to both organisations shall give the meeting an appetising opening, and the meeting is expected to be well attended, with participants from both networks. For the first time we shall have both a parallel and a joint meeting, with one day of parallel EGPRN and EURIPA conferences, and one joint conference day. Even the business meetings and social events of the two groups will be parallel and joint as appropriate. A new approach to working together!

Best wishes, and looking forwards to welcoming you in Malta!

Jean Karl Soler (Chair organising committee), Ferdinando Petrazzuoli (EGPRN)

Christos Lionis (Chair scientific committee), Jose Lòpez Albuin, Oleg Kravtchenko, Tanja Pekez-Pavlisko, Jean-Pierre Jaquet, John Wynn Jones, (EURIPA)

REGISTRATION

► Thursday 17 October 2013

REGISTRATION FOR PARTICIPANTS OF PRE-CONFERENCE WORKSHOPS ONLY

Location: Corinthia Palace Hotel

De Paule Avenue; San Anton BZN9023 – Malta

On arrival, every participant, who has not paid by electronic bank transfer, pays €25,= (or €50,= if a non-member) per person for each pre-conference workshop

► Friday 18 October 2013

REGISTRATION FOR ALL PARTICIPANTS

Time: 08.15 – 09.00 h.

Location: Corinthia Palace Hotel

On arrival, every participant, who has not paid by electronic bank transfer, pays €150,= (or €300,= if a non-member) per person.

FOR ALL EGPRN PARTICIPANTS

Social night on Saturday 19th October 2013

Gala Night! Dinner, speeches and dancing party.

At: Corinthia Palace Hotel, in the main restaurant.

Entrance Fee: €40,= per person.

Please address to EGPRN Registration Desk if you have not registered online.

Unfortunately, we have NO facility for electronic payments (credit card, Maestro) on the spot. We only accept EUROS.

We do NOT prefer pay cheques, given the extra costs. If you have no other option we will charge €25 extra.

SCIENTIFIC PROGRAMME & TIMETABLE

*77th EGPRN Workshop and 4th EURIPA Rural Health Invitational Forum
Attard, Malta, 17th to 20th October 2013.*

Theme:

*Research into different contexts in General Practice/Family Medicine:
rural vs. urban perspectives*

Conference Venue:

Corinthia Palace Hotel and Spa *****

De Paule Avenue, San Anton BZN9023- Malta

Tel: +356 21 440301 - Fax: +356 21 465713

E-mail: reservations.malta@corinthia.com

TUESDAY 15th OCTOBER, 2013

Location : Corinthia Palace Hotel, Attard-Malta

15.00 -20.00: “The FPDM-Study”

In: Corinthia Palace Hotel, Business Centre: President room

WEDNESDAY 16th OCTOBER, 2013

Location : Corinthia Palace Hotel, Attard-Malta

09.00 -18.00: “WomanPower”

In: Corinthia Palace Hotel, Business Centre: President room

THURSDAY 17th OCTOBER, 2013

Location : Corinthia Palace Hotel, Attard, Malta

1. Business meetings

- 09.00 – 09.30 :** **Joint meeting Executive Boards EGPRN and EURIPA**
In: Business Centre, President room, Corinthia Palace Hotel
- 09.30 – 10.00 :** Welcome and Coffee for **Executive Board EGPRN and EURIPA**
In: Business Centre, Corinthia Palace Hotel
- 10.00 - 12.30 :** ***Executive Board Meeting*** (only for the **Executive Boards of the EGPRN/EURIPA**) at the Corinthia Palace Hotel, Business Centre. (EGPRN in Business Centre, President room; Euripa in Business Centre, Ambassador room)
Euripa members join AGM at 11.30 am.
- 11.30 – 12.30:** **EURIPA Annual General Meeting** (only for EURIPA members)
In: Corinthia Palace Hotel, Antoinette room-1st floor
- 12.30 – 13.30 :** **Lunch**
- 13.30 – 16.45 :** ***Council Meeting with the National Representatives*** (only for **EGPRN-Council and EURIPA Council**)
In: Corinthia Palace Hotel, Chameleon Hall
- 15.00-15.15:** **Coffeebreak Council**
- 16.45 - 17.45 :** **Meeting of the EGPRN Working Groups** (last part of the Council meeting)
- **Research Strategy Committee** - in: **Chameleon Hall**
- **Educational Committee** - in: **Chameleon Hall**
- **Communication and PR Committee** - in: **Chameleon Hall**
P.s. Working groups may use the Ambassador room or President room of the Business Centre as well if they like.

2. Pre-conference workshops

- 09.00 – 12.00 :** Pre-conference Workshops for participants (registration necessary).
- **Workshop 1: on developing a research project for EU funding** (Leaders: Diana Spiteri from the Malta Council for Science and Technology). Including a showcase of the TRANSFoRm project by Prof. Brendan Delaney
In: Corinthia Palace Hotel, Chameleon Hall
 - **Workshop 2: Joint European Journal of General Practice/Scandinavian Journal of Primary Care: “Writing for publication”** (Leaders: Jelle Stoffers and Hans Thulesius)
In: Corinthia Palace Hotel, San Anton Room
- 13.30 – 16.30 :** Pre-conference Workshops for participants (registration necessary).

- **Workshop 3 on Research Methodology in the Rural Setting**
(Joint EURIPA/EGPRN, Leader: Christos Lionis)
In: Corinthia Palace Hotel, Antoinette Room
 - Hypothesis generation, research questions, methodology, barriers to research
- **Workshop 4 on Rural Proofing**
(EURIPA, Leader: Jane Randall-Smith)
In: Corinthia Palace Hotel, San Anton Room

3. Research project workshops (by invitation)

09.00 – 18.00 : “The FPDM-Study”

In: Corinthia Palace Hotel, Syndicate Room 1032
(Coffee 9.30-10.00) + (lunch 12.30-13.30) in Business Centre.

Social programme

19.30 – : **Welcome reception for all participants of this meeting** who are present in Malta at this time.

In: Corinthia Palace Hotel, room Chameleon hall.

Joint programme EGPRN-Euripa.

FRIDAY 18th OCTOBER, 2013

Location : Corinthia Palace Hotel, Attard, Malta

two parallel conferences EGPRN/EURIPA

Session includes two coffee breaks and one light lunch, in each parallel conference

- 08.30 - 09.00 :** **Registration at EGPRN/EURIPA registration desk**
(registration fee includes two coffee breaks and light lunch per day, and social events except Gala Dinner)
- 09.00 – 09.20:** **Welcome** by Chairpersons of Organising and Scientific committees.
Opening by Chairpersons of EGPRN and EURIPA
In: Chameleon Hall, plenary session
- 09.20 – 10.00 :** **1st Key Note Lecture – Prof. Richard Roberts**
Theme: “Rethink globally, react locally. How rural PHC research will change the world”.
In: Chameleon Hall, plenary session
- 10.00 – 11.00 :** **2 EGPRN/EURIPA Theme Papers – Plenary session 1**
In: Chameleon Hall
- 1. Ailís ní Riain (Ireland)**
Evaluation of the acceptability and effectiveness of telemedicine in chronic conditions in a rural general practice in Ireland.
 - 2. Sebastian Huter (Austria)**
Why would you go to a GP? A cross-sectional analysis about patient views of the role of GPs in the Austrian health care system and their differences by degree of urbanization.
- 11.00 – 11.30 :** **Coffee break in Caprice Bar**
- 11.30 – 18.25 :** **EURIPA meeting**
In: San Anton room
Workshops with main speakers, short papers and discussion
- 11.30-13.00: Workshop 1: Rural Medical Education: a focus on content and methods.**
Leaders: Jose Lopez-Abuin & Ioan Bocsan
Speakers:
- Prof. Ioan Stelian Bocsan: Cost-efficiency analysis and decision in preventive versus curative rural healthcare
 - Raquel Gomez-Bravo: the Spanish mandatory rural medical experience
 - Ivar Johaness Aaraas: the Tromso rural medical education experience
 - Ia Verulashvili: educating rural physicians how to deal with domestic violence

13.00 – 14.00: Light lunch

14.00-15.30: Workshop 2: Patient Safety: a focus on methods in assessing and reporting.

Leader: John Wynn-Jones

EURIPA has developed its own Patient Safety (based on MaPSaF) and Patient Involvement tools and is developing an educational initiative.

Two authors (Dr. John Wynn-Jones and Tanja Pekez-Pavlisko) will introduce the tools as well as running a shortened version of one of their practice educational workshops

15.30 – 15.45: Coffee break

15.45-17.05: Workshop 3: Out of Hours in the Rural Health Care Setting: a focus on research methods.

Leader: Oleg Kravtchenko

Speakers:

- Dr. Katarzyna Nessler, OOH/EC in Rural European Locations - Methodology of the Study;
- Dr. Linda Huibers, OOH in Europe - Goals and Pitfalls;
- Dr. Raymond Dokmo/Dr. Oleg V. Kravtchenko, OOH/EC - The Norwegian Experience.

17.05-18.25: Workshop 4: Reporting Rural Health Care Research: a focus on content and research methods.

Leader: Christos Lionis

- Health Care Research Priorities in rural settings.
- Overpassing barriers in implementing family practice research in rural settings.
- Qualitative versus Quantitative family practice research in rural settings.
- Exploring funding and intersectoral collaboration in rural family practice research.

11.30-18.25: EURIPA Poster walk

11.30 – 18.25 : **EGPRN meeting**
 In: Chameleon Hall

11.30 – 13.00: **3 EGPRN Free-standing Papers – Plenary session 2**
 In: Chameleon Hall

3. Paul Wallace (United Kingdom)

Can the internet be used by GPs to deliver brief advice for risky drinkers? Randomised controlled non-inferiority trial of primary care based facilitated access to an alcohol reduction website.

4. Patrice Nabbe (France)

Depression: the search for a diagnostic tool in Primary Care which will enable collaborative, interdisciplinary, Europe-wide research within General Practice.

5. Marie Barais (France)

“I can’t find anything wrong: it must be a pulmonary embolism”: suspecting pulmonary

embolism in primary care, a qualitative study.

13.00 – 14.00 : **Light lunch in Villa Corinthia**

P.S.!! Last moment to buy a ticket for the Saturday Social Event !!!

14.00 – 15.30 : **3 EGPRN Free-standing Papers – Parallel session A**
In: Chameleon Hall

6. Shlomo Vinker (Israel)

A new concept: annual accumulated duration of time (AADT) of primary care visits - is there an association with the quality of diabetes care.

7. Liliana Laranjo (Portugal)

Facilitators, barriers and needs in the self-management of type 2 diabetes – a qualitative study with Portuguese patients.

8. Liina Pilv (Estonia)

The transcultural validation of the Diabetes Obstacles Questionnaire.

14.00 – 15.30 : **3 EGPRN Free-standing Papers – Parallel session B**
In: Antoinette Room

9. Philip Wilson (Scotland-U.K.)

Use of technology in collection and communication of pre-hospital data by rural First Responders.

10. Gerda Längst (Germany)

Improving medication information in general practice - A qualitative study in the context of type 2 diabetes care.

11. Ana Clavería (Spain)

How many diabetic patients have I in my practice? An alert in the electronic health record helps patient registries improvement in primary care.

15.30 – 16.00 : **Coffee break in Caprice Bar**

16.00 – 17.00 : **5 EGPRN One-Slide/Five Minutes presentations – Parallel session C**
In: Chameleon Hall

12. Miguel Muñoz (Spain)

PRImary CARE HEart Failure European STUDY (PRICARHEF European Study).

13. Tuomas Koskela (Finland)

Interventions and models to amend shortage of general practitioners in rural and remote areas in Europe, IMAGinE Rural – a Finnish contribution.

14. Ferdinando Petrazzuoli (Italy)

Dementia management in primary care in Italy, Malta, Finland and Sweden.

15. Clarisse Dibao-Dina (France)

Interventions to withdraw benzodiazepine overuse in primary care.

16. Jean Karl Soler (Malta)

An international collaborative study within EGPRN using International Classification of Primary Care (ICPC) data from routine family practice.

16.00 – 17.00 : **2 EGPRN Free-standing Papers – Parallel session D**
In: Antoinette Room

17. Andre Nguyen van Nhieu (France)

Pubmed vs. Full-Text Query Performance in Systematic Reviews: Application to Non-inferiority Clinical Trials

18. Jarmila Mahlmeister (Germany)

“Nephron” - A New Educational Program for Hypertensive Renal Patients in general practice – Methodology.

17.00 – 17.30 : **Summing up of the day** by *Prof. Richard Roberts* (plenary session with input from both organisations)

18.00 – 20.00 : **Research project workshops (Weltermann e.a.)**

In: Corinthia Palace Hotel – Business centre

- *EGPRN working group on ‘Self-Medication and Home remedies’*

18.30 – 20.00 : **Practice Visits** (different general practices in Malta)

SATURDAY 19th OCTOBER, 2013

Location : Corinthia Palace Hotel, Attard, Malta

EGPRN and EURIPA joint conference

Session includes two coffee breaks and one light lunch

09.00 – 09.45 : **2nd Key Note Lecture – Dr. John Wynn-Jones**
Theme: *“Making the case for change in rural Europe through research: Filling in the gaps”*.
In: Chameleon Hall, plenary session

09.45 – 10.45 : **2 EGPRN/EURIPA Theme Papers – Plenary session 3**
In: Chameleon Hall

19. Glorianne Bezzina (Malta)
Urban-Rural Differences in Primary Health Care Service Provision in Malta.

20. Christos Lionis (Greece)
Practice-Based Research Network in Primary Care: a lacking story and learning points from an empirical model on Crete.

10.45 – 11.15: **Coffee break in Caprice Bar**

11.15 – 13.15: **4 EGPRN/EURIPA Theme Papers – Parallel session E**
In: Chameleon Hall

21. Anne-Lise Bolot (France)
Late declaration of pregnancy in France: an eco-epidemiological study of individual and environmental determinants.

22. Galo Sánchez (Ecuador)
Obstetrical skill in mandatory rural year in Ecuador, South America. A qualitative analysis.

23. Andrej Kravos (Slovenia)
Patient evaluation of family doctors and nurse practitioners: differences between urban and rural settings.

24. Michal Shani (Israel)
Can ACEI and ARBs prevent dialysis among diabetic patients?

11.15 – 13.15 : **4 EGPRN/EURIPA Free-standing Papers *Special Methodology Workshop* – Parallel session F**
In: Antoinette Room

25. Brendan Delaney (Ireland)
Data Mining of Electronic Sources of Primary Care Data in TRANSFoRm.

- 26. Nicola Buono (Italy)**
How to register FDs' workload in managing Influenza like Illness and Acute Respiratory Infections during 2012-2013 winter season?
- 27. Anne-Marie Scerri (Malta)**
Pharmacoepidemiology of Epilepsy - A Maltese Picture (Research in Progress)
- 28. Jean-Michel Perrot (France)**
What are the mainspring and brakes to realize a health care primary care centre in town or in the countryside in France?

13.15 – 14.15 : Light lunch in Villa Corinthia

14.15 – 14.30 : Chairperson's report EGPRN; In: Chameleon Hall
Chairperson's report EURIPA; In: Antoinette Room

14.30 – 15.45 : 4 parallel Poster sessions.

14.30 – 15.45 : Parallel group 1: Posters "*Rural and urban context*"

- 29. Andrzej Zielinski (Sweden)**
Distance to hospital and socioeconomic status influence secondary health care use.
- 30. Aune Rehema (Estonia)**
Prevalence of asthma, dermatitis and diabetes – does urbanization make it always worse?
- 31. Paloma Rodriguez Turégano (Spain)**
Comparison of the level of satisfaction between rural and urban emergency care services in Madrid.
- 32. Thomas Frese (Germany)**
Students' evaluation of practical training in rural versus urban GP offices.
- 33. Raquel Gomez Bravo (Spain)**
Influence of Breastfeeding in Postpartum Depression. Differences by residence (Urban / Rural).

14.30 – 15.45 : Parallel group 2: Posters "*Acute primary care / Technology*"

- 34. Birgitta Weltermann (Germany)**
Which measures do primary care physicians consider as typical self-medication and home remedies for common colds?
- 35. José-Philippe Moreno (France)**
Measuring C-reactive protein in general practice.

- 36. Claire Collins (Ireland)**
The Challenges of Diagnosing Community Acquired Pneumonia in General Practice.
- 37. Clara Guede (Spain)**
Abdominal aortic aneurysm screening by ultrasonography in primary care.
- 38. Charilaos (Harris) Lygidakis (Italy)**
An Online Tool for a Diabetics Association as the Means for Patient-led Research.

14.30 – 15.45 : Parallel group 3: Posters “Chronic diseases”

- 39. Roser Masa Font (Spain)**
Prevalence of cardiovascular risk factors and quality of life in patients with severe mental disorders.
- 40. Bernadette Burger (Germany)**
Barriers to the implementation of the asthma guidelines from the patients’ perspective.
- 41. Sinead Beirne (Ireland)**
Systematic Review: The effectiveness of educational interventions for primary care health professionals designed to improve self-management in patients with chronic conditions.
- 42. Jean Yves Le Reste (France)**
EGPRN’s Multimorbidity definition translation and homogeneity into 8 European languages.

14.30 – 15.45 : Parallel group 4: Posters “The discipline of Family medicine”

- 43. Liga Kozlovska (Latvia)**
Bias against Family Medicine lead to cognitive distortions in future and current family physicians.
- 44. Ida Liseckiene (Lithuania)**
Is the collaboration of family physicians, community nurses and social workers just a Lithuanian „Dream Team“?
- 45. Belisa Tarazona Chocano (Spain)**
The VdGM Hippokrates Exchange Programme.
- 46. Aysegul Yildirim-Kaptanoglu (Turkey)**
Organizational Variables on Family Physicians’ and Nurses’ Job Performance in Turkey.
- 47. Juliette Chambe (France)**
Prevalence of insomnia in general practitioners, and its influence on the care of insomniac patients.
- 48. Ioanna Tsiligianni (Greece)**
Home calls and visits could be a value source of information for evaluating health care

needs and living conditions? An analysis of a the home visits performed in a rural area of Crete, Greece

15.45 – 16.00 : **Coffee break in Caprice Bar**

16.00 – 17.00 : **2 EGPRN/EURIPA Theme Papers – Parallel session G**
In: Chameleon Hall

49. Julie Gilles de la Londe (France)

What difficulties might have Male-To-Female Transgendered Persons practicing sports?

50. Erika Zelko (Slovenia)

Development and Application of an Intervention Program in the rural settings Roma Community.

16.00 – 17.00 : **2 EGPRN/EURIPA Theme Papers – Parallel session H**
In: Antoinette Room

51. Francesco Chiumeo (Italy)

Allena Vita Coach: stratification (clustering), observation, stimulation (fosterage, persuasiveness, support).

52. Olimpia-Maria Varva (Romania)

Sustainability of Urban and Rural Systems.

17.00 - 17.50 : ► **Summing up of the day** by *Dr. John Wynn-Jones* (plenary session with input from both organisations)

► **EGPRN BARCELONA !! 8-11 May 2014**

Introduction to the next EGPRN meeting in Barcelona by the national representative and member of local host committee.

► **EGPRN poster prize and EURIPA Claudio Carosino prize.**

► **Closing** of the scientific part by the EGPRN and EURIPA Chairs.

20.30 : **Social Event !!**

Conference Dinner and Afterdinner Party.

Venue dinner: **Corinthia Palace Hotel, in Villa Corinthia**

After dinner Party in Chameleon Suite with cash bar + sandwiches

SUNDAY 20TH OCTOBER, 2013

Location : Corinthia Palace Hotel, Business Centre

- 09.00 – 10.30 :** **Joint EGPRN and EURIPA Executive Board meeting** to plan future collaboration and joint activities. **In: President Room**
- 10.30 – 11.00 :** **Coffee**
- 11.00 – 12.30 :** **2nd Meetings of the EGPRN/EURIPA Executive Boards**
In: EGPRN Business Centre, Ambassador Room
In: Euripa Business Centre, President Room
- 12.30 – 14.00 :** **Light lunch**
- 14.00 :** **Optional tour of Malta**

SOCIAL PROGRAMME

- * **Thursday 17th October:**
19.30 h.: Welcome Reception and one Key Note Lecture

- * **Friday 18th October:**
18.30-20.00 h.: Practice Visits (to local health centres/clinics)

- * **Saturday 19th October:**
20.00 h.: Gala Night.
Dinner and dancing in Villa Corinthia of Corinthia Hotel.
Euro 40.00 per person

- * **Sunday 20th October**
14.00 h.: Guided tour for those present

FRIDAY 18th OCTOBER, 2013:

Location : Corinthia Palace Hotel

09.20 - 10.00: 1st Keynote Speaker: *Prof. Richard Roberts, U.S.A.*

Theme: “Rethink globally, react locally. How rural PHC research will change the world”.

Most care in most health systems occurs in the primary care setting. About half of the world’s people reside in rural communities. Yet, nearly all medical research takes place in urban-based academic health centers, which provide care to less than 1% of the population. This mismatch has consequences for the health of the general public. It causes some to conclude that the wrong researchers are asking the wrong questions on the wrong patients in the wrong settings.

An analysis by Ionnaides confirms the limits of clinical science. He looked for the most influential studies and found 49 clinical intervention trials cited more than 1000 times over a 14 year period. Only 44% of these landmark trials had their findings confirmed by subsequent studies. In other words, the probability that a highly cited study produced results that were accurate and enduring was less than that of a coin flip. The reasons for the inadequacy of the science are numerous and complex. Three debatable assumptions stand out.

First is that those who focus exclusively on a particular condition, such as diabetes or heart disease, are best able to conduct the most useful research on that condition. Yet, family doctors collectively care for more people with diabetes than diabetologists, more heart disease than cardiologists, and so on. Thus, the questions posed and conclusions made by those with narrow expertise in a specific disease may be minimally relevant to the needs of those providing most of the care for that disease. This becomes even more apparent when considering the many manifestations of the disease in the general population and their associated interventions, from prevention to early detection to diagnosis to treatment to palliation. Finally, the growing number of those with multiple morbidities magnifies the limits of a narrow single disease perspective.

Second is that the best study design is a 12-week randomized, double blind, crossover trial. Such a design may suffice for a drug trial. Yet, it is inadequate or inappropriate for many health conditions and interventions. Exclusion criteria and brief study duration improve the precision and feasibility of research, but often result in findings of limited value for a very small population. Efforts to leverage the findings of limited studies through meta-analysis or systematic review often fall short.

Third is that human biology and the health effects of interventions are essentially the same, regardless of person. Yet, health status and outcomes vary greatly and depend on many factors including gender, race, age, geography, genetics, other morbidities, adherence to therapy, economic status, and other social determinants.

The limitations would be less worrisome if medical research were only an academic exercise. Yet, research findings become clinical practice guidelines, which drive performance measures that benefit or harm patients and professionals. Medical research must move out of the academic center and beyond randomized controlled trials. Uniquely positioned to bridge these knowledge gaps are rural communities and rural primary care clinicians. The relative isolation of rural communities offers a setting with fewer contaminants that influence research results, such as multiple sources of care. Resource limitations in rural settings compel prioritization and ingenuity in clinical problem solving. Rural clinicians have a holistic view and comprehensive knowledge of the patient, an awareness of the local community, and an ability to track outcomes over a lifetime, which make them ideal researchers to ask and answer important clinical questions. To

realize their potential, rural clinician-investigators will need new methods, new tools, and new resources.

The new methods of complexity science will address the multiple and confounding variables that traditional researchers avoid. Quality improvement initiatives and practice variation analyses will generate billions of data points, overpowering even the largest traditional clinical trials. New tools such as electronic health records, practice-based research networks, and standardized nomenclature (e.g., ICPC), will enable rural researchers to collect and interpret their data. New resources in the rural setting, such as methodologists and study coordinators, will help rural clinician-investigators to identify and answer the research questions that will most improve care for most people.

**Prof. Richard Roberts,
U.S.A.**

SATURDAY 19th OCTOBER, 2013:

Location : Corinthia Palace Hotel

**09.00 – 09.45: 2nd Keynote Speaker: Dr. John Wynn-Jones, United Kingdom.
Theme: “Making the case for change in rural Europe through research:
Filling in the gaps”.**

The author has been a rural GP for 34 years. His drive to promote rural practice and change attitudes was born out of frustration while dealing with government, professional bodies and academic institutions. The presentation will highlight the achievements that have made in establishing rural research over the last 20 years in the UK and Europe but at the same time emphasise that much more needs to be done. He was instrumental in establishing the UK Institute of Rural Health, the RCGP Rural Forum and the founding of EURIPA (which he chaired for 15 years). He was also a founder member of the Wonca Working Party on Rural Practice and now chairs this successful and dynamic working group.

Continental Europe consists of 49 sovereign states with 28 belonging to the European Union. Europe is a continent with diverse cultures, races and traditions which can make it difficult to reach a consensus and develop a uniform approach when initiating change. The EU in itself has 23 official languages, a population of nearly 500 million (16% of the worlds population) and landmass of 4.2 million square kilometres (<http://europa.eu/about-eu/facts-figures/>)

Data from the UN Department of Economic and Social Affairs

(http://esa.un.org/unpd/wup/unup/index_panel1.html) indicates that 27.4% of the population live in rural areas with significantly higher proportions of rural inhabitants in Eastern and Southern Europe. In contrast the same organisation states that only 10% of the Australian population are deemed to be

rural (USA 17% & Canada 19.5%) EURIPA (European Rural and Isolated Practitioners Association) represents rural doctors across Europe. Its strategic direction follows 4 main themes: Research, Education, Quality and Policy Engagement.

The 2010 WHO Europe Document “Rural poverty and health systems in the WHO European Region (http://www.euro.who.int/_data/assets/pdf_file/0019/130726/e94659.pdf) emphasises the importance of promoting rural health research in Europe. It states that the “health system, which is a determinant of health, is often not sufficiently equipped in rural areas to respond to the needs of the population, consequently contributing to rural–urban health inequities.” “The rural dimension is often neglected in analyses of health status and health system performance. Data on differences between rural and urban areas on these topics are typically scarce, lacking a comprehensive view of all health system functions, public health governance, and a full spectrum of health issues. In the health sector and beyond, limited data and analysis of the situation of rural populations, and in particular of the rural poor, contribute to their invisibility and neglect in policy processes in many countries”

On reflection, much has been achieved in the last 20 years. Rural problems and rural issues are now openly debated and comparisons between rural and urban populations are sought by statisticians and epidemiologists. Rural professional bodies and academic centres are gradually appearing across Europe and the European Journal of Rural and Remote Health has provided an opportunity for institutions and individuals to publish rural based research. We are beginning to see the academicisation of rural practice and the development of rural practice as a specific sub-theme in family medicine. However as the WHO document states much still needs to be done. Politicians and managers respond only to what they see as hard data and this is notoriously

difficult to find if we are to effect change in our communities. Europe still falls well below comparable rural communities in the research that it conducts.

Rural research can be divided into that carried out by government bodies, universities & large organisations and smaller scale, more often qualitative research conducted by the individual doctors or small groups working in their own environment. Both are essential to the future health of rural communities and rural practice.

The Keynote will go on to answer the following questions:

- Why do we need rural research
- Why is this research not happening
- What does research mean to the ordinary busy general practitioner
- How can we promote rural research on both a micro and macro scale
- What educational interventions can we develop
- What is the role of EGPRN and EURIPA
- What are the priorities for rural research in the future

Ensuring that research becomes an established norm in European rural practice will take time, resources and effort but it has to be done. Most importantly, we have to change the culture of rural general practice, we need to restore the natural curiosity and inquisitiveness of family doctors to ask questions and pursue that question until they find an answer.

The address will give examples of successful innovations from other parts of the world and highlight “GP heroes and case studies” where successful questions have been asked and as a result beneficial changes have been made to the care provided for their patients.

**Dr. John Wynn-Jones,
United Kingdom.**

Evaluation of the acceptability and effectiveness of telemedicine in chronic conditions in a rural general practice in Ireland

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Background: Telehealth initiatives can have significant benefits, especially for those with chronic illness. The potential role of telemedicine in addressing the challenges within Irish general practice needs fuller exploration and this evaluation contributes to that. Thirty patients with chronic conditions were monitored using the Intel Health Guide for fifteen months in a single rural general practice.

Research question: The evaluation examines the suitability, effectiveness and acceptability of telemonitoring to Irish patients and general practice staff and assesses the feasibility of implementing this approach across Irish general practice.

Method: Patients and primary care staff were interviewed. Patients also completed a satisfaction survey. Clinical data and information on health care utilisation were extracted from the medical records. PASW statistics package was used for data analysis. Interviews were taped, transcribed and analysed using a thematic content analysis framework.

Results: Patients were positive about ease of use of the technology. It provided a greater understanding of their condition and a greater sense of control. Practice staff identified shared understanding and patient empowerment as important. Patients made fewer visits to the Medical Centre during telemonitoring: total number of visits fell by 22%; number of visits to the GP fell by 19%; the number of visits to the practice nurse fell by 26%. Clinical parameters analysis revealed a mixed picture. The trends were for no worsening of clinical parameters.

Conclusions: This telemedicine project in a single rural general practice establishes telemonitoring as suitable, effective and acceptable to Irish patients and clinical staff. Patients have better understanding of their conditions. For healthcare staff, there are significant efficiencies in monitoring large numbers of patients with chronic illnesses. The roll out of this technology will require some changes in attitudes by healthcare providers and patients, but the evolution of technology will continue to make the process easier.

Why would you go to a GP? A cross-sectional analysis about patient views of the role of GPs in the Austrian health care system and their differences by degree of urbanization.

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Background: Since in Austria a gatekeeping system does not exist the inhabitants have easy access to all levels of care, which is reflected in a high utilization of both primary and secondary level of care.

Research question: It was the aim of this analysis to describe how patients see the role of GPs in Austria by assessing the conditions for which they would consult them. Additionally, it was assessed how this differs between rural and urban areas and whether or not it has an influence on self-reported first-contact behaviour.

Method: We used the nationwide patients' data-sample (N=1,791) from the European QUALICOPC study, which took place between October 2011 and May 2012. Statistical analyses included descriptive statistics and tests as well as correlations.

Results: Most participants assumed that people consult a GP for "abdominal pain" (83.7%), "routine and preventive check-ups" (83.5%), "blood in the stool" (80.4%) and "child with cough" (77.9%). The lowest rates of positive answers were found in "sexual problems" (30.8%), "domestic violence" (28.4%) and "relationship problems" (16.6%). In 8 out of 14 items a significant difference associated with the degree of urbanization could be found. Patient views and self-reported first-contact behaviour showed a small but significant positive correlation ($r= 0.105$, $p<0.001$).

Conclusions:

Patients of GPs in Austria suppose that most people would consult GPs for common somatic disorders but tend to avoid GPs related to psychosocial conditions. These findings highlight the importance for GPs of addressing psychosocial problems during the consultation because patients do not seem to bring it up by themselves. Moreover, the full range of the GP profile according to patients has to be strengthened to help in leading patients back to the GP, especially in urban areas, where the rate of direct consultation with specialists is very high.

**PRESENTATION 3: Friday 18th October, 2013
11.30–12.00 h.**

**FREESTANDING PAPER
Ongoing study with preliminary results**

Can the internet be used by GPs to deliver brief advice for risky drinkers? Randomised controlled non-inferiority trial of primary care based facilitated access to an alcohol reduction website.

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Background: There is a strong body of evidence demonstrating effectiveness of brief interventions by primary care professionals for risky drinkers but implementation levels remain low. Facilitated access to an alcohol reduction website constitutes an innovative approach to brief intervention, offering a time-saving alternative to face to face intervention, but it is not known whether it is as effective.

Research question: Is GP signposting of risky drinkers to an alcohol reduction website equivalent to face to face intervention?

Method: Randomised controlled non-inferiority trial for risky drinkers comparing facilitated access to a dedicated website with face to face brief intervention conducted in primary care settings in the Region of Friuli Venezia-Giulia, Italy. Adult patients are given a leaflet inviting them to log on to a website to complete the AUDIT-C alcohol screening questionnaire. Screen positives are requested to complete an online trial module including consent, baseline assessment and randomisation to either standard intervention by the practitioner or facilitated access to an alcohol reduction website. Follow up assessment of risky drinking is undertaken online at 1 month, 3 months and 1 year using the full AUDIT questionnaire. Proportions of risky drinkers in each group will be calculated and non-inferiority assessed against a specified margin of 10%. The trial is being undertaken as an initial pilot and a subsequent main trial.

Results: 12 practices have participated in the pilot, and more than 1300 leaflets have been distributed. 89 patients have been recruited to the trial with a one month follow-up rate of 79%. Data will be presented on engagement with the website and 1 month outcomes.

Conclusions: The findings of the pilot study suggest that the trial design is feasible. Modifications will be made to optimize performance in the main trial which will commence in January 2014.

Points for discussion:

1. Is the non-inferiority trial design the best way to address this issue?
2. Are GP internet studies of this kind being developed in other countries in relation to alcohol or other aspects of lifestyle?

Depression: the search for a diagnostic tool in Primary Care which will enable collaborative, interdisciplinary, Europe-wide research within General Practice.

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Background: Under the auspices of EGPRN, a collaborative European study in order to prevent depression in adult multimorbid patients in primary care was conducted. A single validated diagnostic tool (effective, reliable and ergonomic) was necessary in order to include patients by European GP investigators.

Research question: For collaborative research in Europe, what diagnostic tool for depression validated against the DSM-IV in primary care for adult patients, could be selected according to the best combination of three criteria: efficiency, reliability and ergonomics?

Method: A systematic literature review followed by a consensus procedure in two Delphi rounds with a roundtable of expert panel inserted (i.e. a RAND Appropriateness Method). The expert group inclusion criteria: they had to be European researchers, GPs and from different countries. The systematic literature review extracted validated tools against DSM-IV as standard diagnostic tool. The effectiveness criterion used was the Youden index. The criterion of reliability was Cronbach's alpha. Ergonomics data were extracted from the literature (structure, method of collection, duration...).

Results: The literature review collated 7 validated diagnostic tools against DSM-IV. With the first round Delphi, two instruments were considered sufficiently effective and reliable to be used: the Hospital Anxiety and Depression Scale (HADS) and the Hopkins Symptoms Checklist-25 (HSCL-25). Ergonomics was tested roundtable. With the second round, Delphi experts have selected the HSCL-25 for the following criteria: effective tool, reliable, with a satisfactory ergonomics combined.

Conclusions: A European multicultural consensus on a single diagnostic tool for depression in adult patients, which is effective, reliable and ergonomic in general practice has been obtained for the HSCL-25. This tool will provide an opportunity to select homogeneous populations across Europe to undertake collaborative studies.

“I can’ find anything wrong: it must be a pulmonary embolism”: suspecting pulmonary embolism in primary care, a qualitative study.

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Background: The Wells rule is a tool to support physicians in their decisions regarding Pulmonary Embolism (PE). The rule includes a subjective element: 3 points are allocated to the physician’s assessment of whether PE is more likely than an alternative diagnosis. The diagnostic process leading to the suspicion of PE is not well described in primary care.

Research question: How do family physicians (FPs) come to suspect pulmonary embolism?

Method: Semi-structured qualitative interviews with 28 FPs. The regional hospital supplied data of all cases of pulmonary embolism from June to November 2011. We identified the patient’s FP as the physician who had sent the patient to the emergency unit. The first consecutive 14 FPs who agreed to participate made up the first group. A second group was chosen using purposeful sampling. The topic guide focused on the circumstances leading to the suspicion of PE. A thematic analysis was performed by three researchers, using the technique of constant comparison, originating from grounded theory.

Results: The suspicion of pulmonary embolism arose out of four considerations: the absence of indicative clinical signs for other diagnoses than PE, a sudden change in the condition of the patient, a gut feeling that something was seriously wrong and an earlier failure to diagnose PE. The FPs interviewed did not use rules in their diagnostic process.

Conclusions: This study illustrated the role of gut feelings in the specific context of suspected pulmonary embolism in primary care. The results indicated an assumption that FPs tended to use clinical feeling rather than clinical rules when PE was suspected. The diagnostic accuracy of this aspect of gut feelings has to be evaluated before being recommended or taught.

Points for discussion:

Do you have specific experiences regarding suspecting PE?

A new concept: annual accumulated duration of time (AADT) of primary care visits - is there an association with the quality of diabetes care.

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Background: Guidelines are usually dealing with the content and frequency of visits but not with the duration of visits. Primary care physicians (PCPs) visits have become shorter. We established a unique central database with documentation of number of visits as well as duration of each visit.

Research question: To evaluate the association between annual accumulated duration of time (AADT) of PCP visits and the quality of diabetes care.

Method: An observational study of adult diabetes patients enrolled in one district of Clalit Health Services (CHS) in Israel during 2010. The number of visits and the AADT of visits of each individual patient to a PCP were retrieved. Quality assessment included follow-up (annual HbA1c, microalbumine, LDL-c, BP and fundus examinations), and outcome measures (HbA1c<7mg%, BP<130/80 mmHg, and LDL-c<100 mg/dl). Multivariable regression model was employed to evaluate the association between AADT and quality of care, controlling for the number of visits and other clinical and socio-demographic variables.

Results: The study included 40,116 diabetic patients, 50.2% males; age 64.7+/-12.8 years. Average duration of diabetes 6.3 years. Median number of visits was 15 and median AADT was 90 minutes. The final regression model included: annual number of visits, diabetes duration, insulin treatment, age, gender, socio-economic status and chronic diseases burden. There was a linear positive correlation between AADT of visits and the performance of all follow-up measures. For example in comparison between patients with AADT of 16-30 minutes and AADT>120 minutes the latter had an OR=1.76, OR=2.41, OR=1.65 and OR=1.65 in performance of fundus examination, HbA1c, microalbumin, and BP measurement, respectively. There was no association with the outcome measures.

Conclusions: AADT of visits was positively associated with diabetes follow-up but had no effect on diabetes control. AADT should be added to guidelines and for future cost-effectiveness analyses of diabetes care by PCP.

Points for discussion:

1. Does the duration of the visit really matter?
2. What should be the ideal length of a visit and is it cultural or health care system dependent?
3. Are there other outcomes that would be different when counting duration rather than number of visits?

**PRESENTATION 7: Friday 18th October, 2013
14.30–15.00 h.**

**FREESTANDING PAPER
Ongoing study with preliminary results**

Facilitators, barriers and needs in the self-management of type 2 diabetes - a qualitative study with Portuguese patients.

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Background: Diabetes Mellitus (DM) is a challenging health problem worldwide. Its rapidly increasing prevalence and debilitating complications are largely responsible for the increasing costs in healthcare.

Patients have a central role in managing the disease, as they are ultimately responsible for making the appropriate lifestyle changes and for adhering to medication. There is a lack of understanding relating to the needs and barriers that these patients feel concerning the self-management of their disease on a daily basis. Failing to address these issues can obviously compromise the long-term management of the disease, and lead to its negative progression.

Research question: What are the facilitators, barriers and needs in the self-management of type 2 diabetes (perceived by patients)?

Method: Fifteen patients with type 2 diabetes were recruited at a Diabetes Association in Lisbon, using a purposive sampling technique. Qualitative data were obtained using focus groups and demographic information was collected by a pre-session survey. The sessions lasted a mean of 60 minutes and were video-recorded with the patients' consent. Each session had a moderator and an observer, and followed a pre-tested questioning route.

Focus group data were transcribed and analysed using NVivo 10. The data were analysed by two independent researchers, following the constant-comparative method.

Results: Research in progress - we will have results to present at the conference.

Conclusions: Qualitative research is an important means to arrive at a better understanding of patients' perceptions regarding self-management. Considering the prevalence, chronicity, debilitating complications and costs associated with type 2 diabetes, there should be a greater focus on helping patients deal with their disease on a daily basis.

Points for discussion:

1. What can we do to address the issues identified?
2. To what degree are these issues context-specific?
3. How can qualitative research support doctors working in different contexts, so that they are able to better treat their patients?

The transcultural validation of the Diabetes Obstacles Questionnaire.

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Background: Patients with type 2 diabetes (T2DM) reveal different obstacles in living with the disease. The EGPRN EUROBSTACLE study was initiated in 2000 and led to the development a questionnaire to assess these obstacles using qualitative research methodology. The Diabetes Obstacle Questionnaire (DOQ) was the first tool to assess it. The questionnaire was validated in the UK and in Belgium.

Research question: To reduce the number of items and to find the best factorial structure across the studied countries, a transcultural validation of the DOQ.

Method: The DOQ carried out in Belgium, France, Estonia, Serbia, Slovenia, and Turkey. The study design was similar in all countries: five consecutive diabetes patients enrolled by GPs. Participants responded the DOQ and GP included clinical data from their medical records. Data of all 860 participants were included into analysis.

Exploratory Factor Analyses (EFA) was used to reduce the number of questions and to identify a new factor-scales and Confirmatory Factor Analysis (CFA) to reach the model with the best goodness-of-fit indices for the whole dataset and for each included sample.

Results: SV-DOQ of 39-items resulted for the whole dataset in 9 factors explaining 56.2% of items' variance. The Kaiser-Meyer-Olkin-measure was 0.92, Bartlett's test was significant ($P=0.000$), goodness-of-fit indices: RMSEA was 0.056 and CFI was 0.97. RMSEA- indices ranged in different countries from 0.066 to 0.083.

Conclusions: The Short Version of Diabetes Obstacles Questionnaire (SV-DOQ) contains the same factorial structure across the studied countries' samples, indicating that participants from different countries conceptualize the constructs in the same way. The DOQ-Version 2013 is ready for implementation into general practice in Europe as a valuable instrument to assess the obstacles people living with type 2 diabetes encounter in adhering to their treatment regimens.

Points for discussion:

Differences and similarities between countries.

**PRESENTATION 9: Friday 18th October, 2013
14.00–14.30 h.**

**FREESTANDING PAPER
Ongoing study with preliminary results**

Use of technology in collection and communication of pre-hospital data by rural First Responders

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Background: In many remote and rural areas of Scotland and elsewhere, volunteers provide immediate medical care when professional help will be delayed. Community First Responders (CFRs) are trained volunteers equipped with oropharyngeal airways, oxygen and an automated defibrillator. They are called when an ambulance is requested to attend a remote medical emergency, and they usually arrive within a few minutes. They are requested to generate handover report to give to the trained clinicians arriving at the scene, but these reports are generally uninformative and/or are created too late to be useful.

Research questions: Can technology be used to improve clinical management by CFRs? Can automatically generated handover reports improve communication between CFRs and clinicians?
Method: Prototype development, testing and evaluation.

Results: This is a project in progress. We have developed a working prototype involving an Android tablet PC linked via Bluetooth to a pulse oximeter and a respiratory rate monitor. A user interface allows the CFR to observe the patient's vital signs and allows input of observational data and a record of actions taken. A Natural Language Generation algorithm integrates the physiological data with the recording by the CR to generate a handover report. The system seems to be robust in terms of signal stability and a small scale evaluation by ambulance clinicians suggests that the handover reports are informative.

Conclusions: Digital technology may be useful in assisting trained volunteers to deliver immediate care and in generating good quality handover reports in emergency situations.

Points for discussion:

1. Can technology improve the performance of volunteers in medical emergencies?
2. Are structured handover reports useful in medical emergencies?

**PRESENTATION 10: Friday 18th October, 2013
14.30–15.00 h.**

**FREESTANDING PAPER
Ongoing study with preliminary results**

Improving medication information in general practice - A qualitative study in the context of type 2 diabetes care.

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Background: Research suggests that patients with type 2 diabetes mellitus (T2DM) have unmet information needs and often lack knowledge regarding their medication. This leads to poor medication adherence and non-achievement of treatment goals. General practices play a pivotal role in improving medication-related communication and information. Empowering patients to become active participants in their own treatment through adequate medication information is critical to the safety and quality of their care. However, there is insufficient understanding of how to best meet T2DM patients' needs.

Research questions: What are T2DM patients' information and communication needs regarding their medication, and how can these needs best be met to improve patients' self-management? Which opportunities and barriers to effective medication-related communication in general practice are identified by healthcare professionals?

Method: This qualitative study is part of the BMBF "Health Region/INFOPAT" project aiming to develop tailored information technologies to improve the care of chronically ill patients. Seven focus groups were conducted as a first step in the intervention development process, including 4 groups with medicated T2DM patients (n=23) and 3 groups with both general practitioners (n=7) and healthcare assistants (n=10). A semi-structured interview guide was used. Participants were recruited from urban and rural districts of the Rhine-Neckar Region in Germany. Focus group discussions were audio- and video recorded, transcribed verbatim and subjected to content analysis.

Results: Content analysis of experiences and perceived needs for support regarding medication information are currently being analysed. Preliminary results present implications both for what information is deemed to be essential, and for improving the practices of primary healthcare services to empower the patients to participate in the control of their medication.

Conclusions: Final results will be presented to inform the future development of a new intervention to improve medication information to T2DM patients in general practice.

Points for discussion:

1. Tailoring of medication information (amount and complexity) to the information needs of patients - what are the implications for general practice?
2. What should be the formats and sources of this medication information?

PRESENTATION 11: Friday 18th October, 2013
15.00–15.30 h.

FREESTANDING PAPER
Ongoing study with preliminary results

How many diabetic patients have I in my practice? An alert in the electronic health record helps patient registries improvement in primary care.

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Background: Variability in diabetes mellitus (DM) registered prevalence and control, were shown previously in two primary health care districts (PHC). An electronic health record (EHR) alert which informs physicians of abnormal laboratory results will improve the DM registry and follow-up.

Research question: Will the implementation of automatically generated alerts from different hospital laboratory databases and transferred to the EHR improve DM detection?

Methods: A community-based, randomised, multi-centre, controlled trial. Physicians (613) from two PHC districts (1,065,607 inhabitants) were randomised into two groups: G1 (intervention)/G2 (control). Randomisation unit was health center (126). All belong to the public health system of Galicia (Spain). Intervention: detecting abnormal fasting glucose (≥ 126 mg/dl) and glycosylated haemoglobin ($\geq 6.5\%$) in hospital laboratory databases, identifying patients concerned and comparing them with those recorded electronically as DM or not. G1 physicians are informed via an electronic alert. They will check the EHR and act by clinical guideline. Six months later, same type of alert will be provided to G2 physicians, to avoid inequalities among both groups.

Outcome: Prevalence of DM recorded per physician. This will be adjusted to take into account physician and centre-based factors (urban/rural, training units, hospital, municipalities).

Analysis: Descriptive, Kolmogorov-Smirnov test and parametric tests.

Results: The two groups did not differ in the independent and outcome variables at baseline.

Outcome variables follow a normal distribution. Bivariate analysis was carried out with outcome variables. DM prevalence increased higher in G1 significantly (difference=0.6179 (0.1112-1.2246), $p=0.046$). There were differences between rural/coast/urban centers, but not by other independent variables, by ANOVA analysis. N^o DM patients identified were 842/509 in G1/G2; and 183/80 subtracted due to duplicity (Vigo preliminary results).

Conclusion: The electronic alert improves DM registry quantitatively. It may drives to a better care for those DM identified and for untangling those who are not.

Discussion:

1. Do we want to get data or information from the EHR?
2. Do we want to comply with the Data Protection Act or with clinical practice guidelines?
3. Do we want to make decisions in our practice or take community decision?

**PRESENTATION 12: Friday 18th October, 2013
16.00–16.10 h**

**ONE SLIDE/FIVE MINUTES
Study proposal / idea**

PRImary CARE HEart Failure European STUDY (PRICARHEF European Study).

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Background: Heart failure (HF) is the final stage of most heart diseases, affecting more than 10% of population aged 65 years or more. Early mortality remains close to 25%. In a high percentage of patients decompensation from HF can be prevented and treated in Primary Care, avoiding hospital admissions and death.

Research question: To determine the predictors of hospital admission and death as a result of HF decompensation.

To create a predictive model that identifies patients at increased risk of hospitalization and short-term mortality.

To analyze if these characteristics vary between different European countries.

Method: Cohort prospective multinational study. General Practitioners from Spain, Portugal, France and Turkey have agreed to participate. We will include all patients consecutively attended in primary care as a consequence of a decompensation of HF.

The estimated sample size is 310.

Descriptive, bivariate, multivariate and survival analysis will be performed.

The outcome variables will be: Number of hospital admissions for any cause and mortality.

Sociodemographic, clinical, and laboratory variables will be also collected.

Four visits are intended: one the day of the decompensation, the second during the next 48h, the third visit in the first week and the last, one month later.

Results: IT IS A PROJECT PROPOSAL

Conclusions: This study could allow general practitioners to properly stratify the risk of hospitalization and death of patients attended by a decompensation of HF and optimize their management.

More countries are kindly invited to participate in the study

Points for discussion:

Is it possible to create a predictive model to properly stratify the risk of hospitalizations and early mortality in patients with Heart failure attended in primary Care?

There is a variability in the causes and the prognosis of decompensation from Heart

**PRESENTATION 13: Friday 18th October, 2013
16.10–16.20 h**

**ONE SLIDE/FIVE MINUTES
Study proposal/idea**

Interventions and models to amend shortage of general practitioners in rural and remote areas in Europe, IMAGinE Rural : A Finnish contribution.

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Background: In Finland, like in many other European countries, there is a shortage of rural doctors threatening access to and quality of health care for rural populations. A recent WHO report points out that though interventions to recruit and retain rural doctors have been implemented, there is a remarkable shortage of evaluation and evidence for any model. In the Kusadasi EGPRN meeting, Eva Hummer-Pradier introduced a collaborative study proposal IMAGinE Rural to evaluate the body of evidence on this topic. This study is a Finnish contribution to that.

Research question: To provide a Finnish inventory of interventions and organizational models intended to recruit and retain rural doctors and/or to delegate care to non-physician providers in order to maintain good care in a situation of dearth.

Method: Explorative, descriptive mixed method study combining quantitative surveys and focus group interviews. Current situation of rural health services and interventions to recruit rural doctors in Finland will be researched by survey focused on rural chief physicians. In addition, a survey focused on rural GPs will be carried out together with Finnish Medical Association. Rural GPs, local and national authorities will be recruited for focus group interviews to find out their concepts and experiences on rural health care and initiatives to amend a shortage of doctors in rural areas. Existing database regarding this topic will be also utilized.

Results: Results of the Finnish contribution to IMAGinERural will be published in a separate publication and the Finnish data will be shared with the collaborative IMAGinE Rural project as a Finnish contribution to that.

Conclusions: none yet

Points for discussion:

1. Relevant study methods to identify relevant study material
2. Participation of the other countries?
3. EGPRN as inspiration for collaborative international studies

**PRESENTATION 14: Friday 18th October, 2013
16.20–16.30 h.**

**ONE SLIDE/FIVE MINUTES
Study proposal/idea**

Dementia management in primary care in Italy, Malta, Finland and Sweden.

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Background: The growing burden of dementia has been extensively shown in the literature and the GP is often the first health professional that patients or their families consult about memory loss. Despite their focus on general practice as the cornerstone of the health care system, European countries differ considerably in the major characteristics of primary care. We therefore wanted to find out more about the management of dementia in primary care in Italy and Malta in Southern Europe and Sweden and Finland in Northern Europe.

Research question: How is dementia managed in primary care in Italy, Malta, Finland and Sweden?

Methods: The setting of our proposed descriptive study is primary care practices in Italy, Malta, Finland and Sweden. Among other issues we want to explore who is responsible for establishing the diagnosis of dementia and initiating drug treatment of dementia. Which specific test for cognitive dysfunction, instrumental investigations and blood tests are used? Data will be collected by collecting narratives of dementia patient cases, interviews with GPs, individually and focus groups, and surveys. In addition, systems mapping of dementia management in health care in the participating countries will be performed.

Conclusion: This study aims at describing dementia management in primary care in Italy, Malta, Finland and Sweden.

Points for discussion:

1. Pitfalls of the dementia diagnostic process in primary care
2. Relevant study methods for this study
3. Participation of other countries in this study

**PRESENTATION 15: Friday 18th October, 2013
16.30-16.40 h.**

**ONE SLIDE/FIVE MINUTES
Study proposal/idea**

Interventions to withdraw benzodiazepine overuse in primary care.

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Background: Primary care practitioners are the main prescribers of benzodiazepines. In France, 14.3% of patients over 60 years old take benzodiazepines regularly, although we know that the adverse effects of these drugs have been extensively documented and their effectiveness questioned. The actual recommendations in France are to explain modalities of withdrawal of benzodiazepines at each prescription (the first and the following) and to favour non pharmaceutical interventions, which are rarely accessible in rural areas.

Research question: What is the gap between the recommendations and the French general practitioners' practice concerning information given to patients and non pharmaceutical interventions proposed for benzodiazepine withdrawal?

Proposed method: The population selected will be patients over 60 years old with a prescription of at least one benzodiazepine for more than 1 month.

Data will be gathered from patients by trainees during 3 months in the Central region of France.

Collected data will include the medical history, treatments and psychosocial environment (rural or urban location, work, marital status, economical situation...) of the patients. The reason for the first benzodiazepine prescription will also be reported. Information that patients received from their general practitioner about benzodiazepine withdrawal and what helps will be investigated.

Points for discussion:

1. Which other characteristics need to be collected?
2. How to manage memory bias(time limit from the first prescription to determine)? Interest to collect the practitioner's opinion?

An international collaborative study within EGPRN using International Classification of Primary Care (ICPC) data from routine family practice.

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Background: This is a proposal for an international collaborative study within EGPRN using ICPC data from routine family practice structured using Episodes of Care (EoC) to study the contribution of patients' reasons for encounter (RfE) to the final diagnoses of common problems. This work is a progression of the TRANSFoRM project.

Research question:

1. To improve and extend data capture of all elements of the doctor-patient encounter in primary care through new optimised electronic medical record systems
2. To involve researchers in many European countries so as to make available datasets of larger size and scope than previously available
3. To extend the analysis of diagnostic associations with these new datasets
4. To perform new statistical analyses of the diagnostic process which would allow:
 - a. The calculation of the effect of multiple predictors for a diagnosis, correcting for the effect of conditional dependence
 - b. The calculation of the associations between RfEs themselves, independent of the diagnostic label by the doctor, studying the natural presentation and meaning of symptoms as they present in primary care
 - c. The analysis of the effect of time on a diagnostic association, during the development of an EoC.

Method: Databases are to be collected directly from the electronic patient records of participating family practices in different European countries. Participating FDs shall record details of all their patient contacts in an EoC structure using ICPC, including RfEs presented by the patient and diagnostic labels of EoCs. The relationships between RfEs and episode titles are to be studied with Bayesian methods and Latent Class Analysis.

Results: N/A

Conclusions: The outcomes of this research are likely to help us understand the diagnostic process in family medicine and to have direct applicability in developing diagnostic decision support systems for family practice.

Points for discussion:

1. Discussion of the utility of such empirical data on the international core of family practice in European populations
2. Discussion of the utility of analysis of diagnostic data from different populations

PRESENTATION 17: Friday 18th October, 2013 FREESTANDING PAPER
16.00-16.30 h. Ongoing study with preliminary results

Pubmed vs. Full-Text Query Performance in Systematic Reviews : Application to Non-inferiority Clinical Trials.

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Background: Systematic reviews usually rely on abstracts selected in Pubmed by means of a combination of keywords. Topics like non-inferiority trials are often missing from the title, abstract or even indexation.

Research question: Comparison of the performance of 2 query strategies to identify non-inferiority trials with mortality as a primary outcome in infectious diseases and oncology: Pubmed or Full-text using the search engine of each journal.

Method: Inclusion criteria: 1) generalist journals and specialist journals publishing non-inferiority trials in infectious diseases and in oncology; 2) original articles published in 2001-2012. Search terms in Pubmed and in the FULL-TEXT strategy were the same and also in each journal adding the option "original article". A non-inferiority trial with mortality as primary outcome was considered a "true positive".

Results: 296/502 trials included (59%) are non-inferiority trials and 166 (33%) include mortality as a primary outcome. In the Pubmed query strategy, 95/292 (32%) non-inferiority trials were identified and 85/166 (51%) "true positive" were found with the FULL-TEXT strategy. Pubmed strategy doesn't add any non-inferiority trials compared with the FULL-TEXT strategy. If 24 articles are included wrongly by the 2 strategies (14 trials with mortality as a secondary outcome; 10 without any trial presented) and 8 articles only by PUBMED strategy (no trial presented), the FULL-TEXT strategy led to 328 additional false positive (111 trials with mortality as secondary outcome; 19 trials without mortality outcome; 198 without trial presented).

Conclusions: FULL-TEXT strategy for systematic reviews could be an accurate alternative compared to the Pubmed strategy, knowing that most false positive are identified once the title. The main limits are the repetition of the research in each journal and the ergonomics of the search engine leading to a performance specific to each journal.

Points for discussion:

Best method to find information in the literature in primary care.

**PRESENTATION 18: Friday 18th October, 2013
16.30-17.00 h.**

**FREESTANDING PAPER
Research in Progress, without results**

**"Nephron" - A New Educational Program for Hypertensive Renal Patients in general practice –
Methodology.**

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Background: Patients with renal insufficiency have a lot of physical and mental stress, as well as professional limitations. Risk-factors, particular hypertension, but also adipositas, diabetes etc. accelerates the loss of renal function and with it the beginning of dialysis. Prospective data about the influence of a specific educational program in general practice on the progress of these parameters are not available yet in the German literature. Therefore, we developed a new multidisciplinary educational program for hypertensive renal patients.

Research question: Goal of the study is to evaluate the evolution of the renal function, disease-related knowledge, weight, blood pressure and quality of life of the program.

Method: A controlled prospective study in general practice in Unterfranken (Bavaria). The study-endpoints are: creatinine, GFR, blood pressure, quality of life, disease-related knowledge, beginning of dialysis, mortality. The project will take about 3 years. In the first six months, the study was constituted, the educational program was developed and the educating-team were trained as per curriculum the patients will then be recruited, trained and the data of the control-group will be analyzed. One year after training the last participants, the questionnaires will be analyzed and publications written.

Goal: Presentation of the concept and initial data of a new educational program for non-dialysis hypertensive- renal patients in general practice.

Urban-Rural Differences in Primary Health Care Service Provision in Malta.

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Background: Social homogeneity and an almost indiscernible urban-rural difference are generally assumed to be strong factors that reduce any tendency for health inequities in a small island community. Due to demographic changes and rising expectations, analysis of primary care service provision in urban and rural areas is crucial.

Research question: Are there any differences in primary care patients' self-perceived health, out-of-hours care and financial access in urban and rural areas?

Method: The dataset of the Maltese arm of the QUALICOPC Project was analysed for this purpose. A descriptive, cross-sectional study was designed. 70 practicing GPs were selected randomly from the Malta Medical Council Family Medicine register after systematically removing the inactive doctors. 10 patients presenting in each primary care clinic completed a self-administered questionnaire. Trained fieldworkers provided assistance when necessary. Differences between rural and urban areas were analysed using statistical tests such as chi-squared test. Direct logistic regression was used to estimate the influences on service provision in urban and rural areas.

Results: The logistic regression model predicting difficulty in accessing out-of-hours care contained six independent variables (sex, age, education, income, rural-urban, private-public). The full model containing all predictors was statistically significant, $\chi^2(8, N = 457) = 19.51, p = .012$. Only 2 of the independent variables made a unique statistically significant contribution to the model (private-public sector and rural-urban area). The strongest predictor of reporting difficulty in accessing out-of-hours care was rural-urban area, recording an odds ratio of 1.84. This indicated that respondents who lived in rural areas had 1.84 times more difficulty accessing out-of-hours care. There were no significant differences between patients' self-perceived health and financial access to primary care services in urban and rural areas.

Conclusions: Such findings provide information for policy makers to improve resource allocation and equity within urban and rural settings.

Points for discussion:

1. Improving the delivery of primary care through better accessibility
2. Primary care as a health equity producing policy

Practice-Based Research Network in Primary Care: a lacking story and learning points from an empirical model on Crete.

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Background: Practice Based Research Networks (PBRNs) are valuable entities which are established in countries such as the UK and the US. However, in certain European countries, including Greece, such networks are established with great difficulty.

Research question: Is it possible to establish PBRNs in countries with limited resources where academic General Medicine is underdeveloped? How can PBRNs be organized and what type of feasible methodologies and inexpensive organizational efforts should be developed and elaborated on?

Method: In Greece, the Cretan Practice-Based Research Network (CPBRN) was established in July 2006 in collaboration with the Clinic of Social and Family Medicine, University of Crete. Rural and academic experiences of the CPBRN have been utilized to address the above questions. To that purpose a "Stepwise Model", tested in Crete (Lionis et al. 2009) has been applied as an ongoing theoretical and empirical framework to guide the CPBRN. This network was built on three stages: (1) the selection of the participating qualified GP's (2) the development and identification of research capacity, and (3) the development of clinical databases for morbidity monitoring.

Results: Until now 20 GPs have joined the CPBRN and among them 14 serve rural areas. Three clinical databases for monitoring and reporting herpes zoster (HZ), anaemia, community acquired pneumonia (CAP) and dementia have been developed. Morbidity from HZ and anaemia has already reported in journals (Lionis et al. 2011, Lionis et al. 2012) and that of CAP in international conferences, while the clinical databases for the monitoring of vaccination coverage are in preparation. The major noted barrier was found to be time restriction of the participating GPs (Tsiligianni et al. 2013).

Conclusions: The development of a PBRN is feasible in a country with limited resources especially in rural areas where morbidity recording and reporting is frequently lacking.

Points for discussion:

Its discussion within the wide EGPRN-EURIPA audience could lead to a broad discussion of a European frame where the development of PBRN could be facilitated making research in primary care and general practice more relevant and beneficial for both physici

Late declaration of pregnancy in France: an eco-epidemiological study of individual and environmental determinants.

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Background: In France, each pregnant woman must send a declaration of pregnancy to the social services. This certificate is established during the first official examination by a gynecologist, a general practitioner or a midwife before the end of the fourteenth week of pregnancy. For woman declaring after 14 weeks pregnant, the risk is the loss of allowed benefits, but it is also a marker that the follow up of pregnancy is delayed. The individual factors of late declaration are well identified, but the environmental factors are less known.

Research question: What are the individual and environmental determinants of late declaration of pregnancy in France?

Method: The data collection was done prospectively from August 2011 to July 2012 at the departmental center for maternal and child protection, where all declarations transit for the department of Doubs. The spatial level of the canton was used to define the socio-economic and environmental determinants. In order to simultaneously consider the collective and individual levels of the data, the statistical analysis was conducted using a multilevel hierarchical model.

Results: Among the 6182 observed declarations, 7.2% are late declarations. Both individual and environmental characteristics were associated with late declaration. At the individual level, the age (less than 18 years), the absence of declared father, the socio-economic data reflecting precariousness and the type of access to care (especially general practitioners and hospital caregivers versus liberal gynaecologist) were significantly associated with late declaration. At the environmental level, deprivation, low density of population by canton and care supply were associated with late declaration.

Conclusions: These results highlight the major effect of low socio-economic status of pregnant women on late declaration. However, the results also illustrate a complex relation between the late declaration and the spatial context of the patient, particularly for the socio-economic collective context.

Points for discussion:

1. Interest of the multilevel analysis
2. The socio-economic environment of patients: a real impact on access to care?

Obstetrical skill in mandatory rural year in Ecuador, South America. A qualitative analysis.

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Background: Since 1970, Ecuador establishes a compulsory rural health service as a requisite to obtain the license to work in the country. These graduates are called "médicos rurales". The professional and personal experience is appreciated, but the aim of the program to serve the vulnerable rural population is not totally accomplished.

Medical education is hospital based with little contact with rural areas. Rural practitioners provide more obstetrical care and perform more procedures than their urban counterparts. There is little information on training and needs of rural doctors to acquire obstetrical skills.

Research question: What skills do rural doctors in south eastern Ecuador need? (Focus on obstetrics)

Method: Qualitative research (focus groups FG) was performed with rural doctors from marginal urban areas and rural areas. FG questions: How do you feel about obstetric skills training at the University? Did you perform any obstetrical skill needed in rural places? If you cannot do a certain skill through ignorance or lack of practice, how do you resolve it?

Focus groups were audiotaped. Analysis was based on grounded theory obtaining a theoretical construct after saturation.

Results: Results show the problems faced in rural practices: Insufficient knowledge and practice in undergraduate education, incomplete observation methodology to learn a skill, not meeting the education requirements and curriculum, the internship year as assistance work, disorganization during clerkships, insufficient communication and community work, differences in teaching methodology.

Conclusions: Not all required skills are practiced during clerkships, lack of standard for teaching practices - teaching doctors, lack of definition of the profile of recent graduate medical doctor between academic institutes and the government. The recommendation is to find a profile and changes to the curriculum to include rural practices and improve the skills lab.

Points for discussion:

The compulsory rural health service accomplishes their commitment in other countries?

How to meet the real skills need in rural practice into the curriculum?

Patient evaluation of family doctors and nurse practitioners: differences between urban and rural settings.

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Background: The roles of nurse practitioner (NP) in family practice settings are health promotion and routine follow-up of patients with chronic diseases. In Slovenia a pilot project "referenčna ambulanta" started in April 2011. NPs with additional education were included in family medicine (FM) teams. NP tasks in such teams cover some preventive activities and routine management of patients with stable chronic diseases.

Research question: The aim of this study was to compare family doctors (FDs) and NPs within urban setting and rural settings from the patient's view.

Method: A cross-sectional design was used. This study was performed in family medicine practices in Slovenia which started with the project in 2011. Patients evaluated FD and NP from February to May 2012. Patient evaluation of FD were assessed using EUROPEP questionnaire (23 questions) and patient evaluation of nurse practitioners was assessed using a Nurse Practitioner Evaluation Scale (NPES, 16 questions). We analysed differences between urban and rural family medicine teams.

Results: In 2011 107 FM teams started with the project. We collected data from 70 FM teams (65 % response rate). Patients evaluate FDs in rural settings better regarding 9 items (questions 7, 12, 15, 16, 17, 19, 20, 21, 23) and worse regarding 3 items (questions 4, 10, 22). Total EUROPEP score difference was statistically important (Rural FDs mean score: 86.7 + 11.9 vs. Urban FD mean score: 85.7 + 11.5; p=0.037). Patients evaluate NPs in rural settings better regarding 9 items (questions 3, 7, 8, 9, 11, 12, 13, 15, 16). Total NPES score difference was statistical important (Rural NPs mean score: 89.8 + 11.4 vs. Urban NPs mean score: 87.9 + 11.6 ; p<0.001).

Conclusions: Patients evaluated FDs and NPs as better in urban settings. The difference was higher for NPs.

Points for discussion:

1. Relevance of the results for practice
2. Use of new tool for patient evaluation: Nurse Practitioner Evaluation Scale – NPES

Can ACEI and ARBs prevent dialysis among diabetic patients?

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Background: ACE-I and ARBs are effective in treating diabetic nephropathy and reversing microalbuminuria in diabetic patients. However it is unclear whether ACEI and ARBs can prevent end stage renal disease (ESRD).

Research question: Can ACEI and ARBs prevent end stage renal disease among diabetic patients?

Method: Diabetic patients aged 40-70 years who were diagnosed as diabetics before 2002 and bought ACEI and/or ARBs for at least 4 months during the years 2002-2011 were included. Patients with diagnosis of ESRD before 2002 were excluded from study. End points were ESRD or death from any reason. Compliance was calculated for each patient according to actual prescription purchasing and number of treatment years with ACEI/ARB as number of treatment months per year. Cox regression was used to calculate hazard ratio (HR). Adjustments were made for age, gender, HbA1c, systolic BP and eGFR at start, hypertension, PVD smoking and insulin use.

Results: 9,895 patients were included in the study. Mean age was 59.6±7.4 years. 5,066 (51.2%) were men. Mean BMI was 30.4±5.7. Mean systolic BP was 141.1±20.2 mmHg, mean HbA1c was 8.6±2.1 and mean eGFR was 68.2±16.9 at start. Hypertension was diagnosed in 59.7%, IHD in 21.8%, CVA in 6.5%, and PVD in 3.9% of the patients. 39.6% were smokers. Unadjusted HR was 0.41 (P<0.001) for 11 months treatment per year and 0.17 (P<0.001) for 12 months treatment per year. Adjusted HR was 0.61 (p=0.009) for 9 months treatment per year, 0.62 (p=0.005) for 10 months treatment per year, 0.35 (p<0.001) for 11 months treatment per year, and 0.12 (p<0.001) for 12 months treatment per year, Compared to prescription purchasing of 6 months or less per year

Conclusions: In this retrospective cohort ACEI and ARBs treatment was associated with reduced rates of ESRD in diabetic patients. Better medication adherence was associated with better outcomes.

Points for discussion:

The protective effect of ACEI/ ARBs from ESRD is highly related to medication adherence.

PRESENTATION 25: Saturday 19th October, 2013

11.15-11.45 h.

SPECIAL METHODOLOGY WORKSHOP
Ongoing study with preliminary results

Data Mining of Electronic Sources of Primary Care Data in TRANSFORM.

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Background: The EU funded TRANSFoRm project is developing a decision support tool to assist primary care practitioners during consultations. This tool formulates and quantifies the likelihood of differential diagnoses based on a presenting patient reason for encounter (RfE). Electronic sources of primary care data are rich sources of clinical evidence. Using data mining techniques it is possible to generate clinically meaningful empirical evidence that provides a knowledgebase for decision support.

Research objectives:

1. Generate empirical evidence to support diagnosis of three patient safety use cases of chest pain, abdominal pain or dyspnoea.
2. Analyse relationships between RfE, diagnostic cues, demographics and recorded diagnosis as found in coded patient records.
3. Provide data mining tools that allow clinical review, quantifying and filtering of evidence based on the strength of derived associations.

Method: ICPC coded data from the TRANSITION project has been data mined to identify association rules between the patient RfE, diagnostic cues, demographics and the final recorded diagnosis. Quality measures have been calculated that measure the strength of the association for each association rule. A data mining tool allows filtering of rules based on RfEs, diagnostic condition, demographics and quality measures to identify statistically significant associations. Rules can be interactively commented, rated and selected for each population. The empirical evidence for selected diagnoses was compared to evidence based literature sources to establish agreement between empirical and literature sources.

Results: An empirical analysis of relationships between patients' RfEs and doctors' diagnosis within EoCs of common health problems as coded using ICPC.

Conclusions: Agreement between empirical evidence and literature evidence was strongest for more common cases in primary care. We conclude that whilst it is possible to derive clinically meaningful empirical evidence from data mining, there is a need to collect larger volumes of electronic data for successful analysis of less common conditions.

Points for discussion:

1. Discussion of the utility of such empirical data on the international core of family practice in European populations
2. Discussion of the utility of analysis of diagnostic data from different populations

PRESENTATION 26: Saturday 19th October, 2013

11.45-12.15 h.

SPECIAL METHODOLOGY WORKSHOP

How to register FDs' workload in managing Influenza like Illness and Acute Respiratory Infections during 2012-2013 winter season?

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Background: Influenza like Illness (ILI) and Acute Respiratory Infections (ARI) continue to be a considerable health problem in Europe. Diagnoses are based on clinical signs and symptoms which are very well known by Family Doctors (FDs). During the winter there is an increased workload for FDs due to the diffusion of influenza virus and respiratory tract diseases.

Research question: Are family doctors able to evaluate the workload in managing ILI and ARI syndromes during the winter season 2012-13 by recording their patient contacts in an episode of care (EoC) structure?

Method: Over a period of four months 8 FDs registered the number and type of encounters, patient's reason for encounters, procedures adopted, ILI and ARI diagnoses, drugs prescriptions and referrals to other health care providers. FDs recorded details of their patients using electronic patients records based on the International Classification of Primary Care (ICPC) Italian version, collecting data on all elements of the doctor-patient encounter for those diseases.

Results: Patients with suggestive symptoms for ILI and ARI were 1536 (average age 48.1 ± 18.7). ILI and ARI incidence was respectively 44.8% and 55.2%. The number of patient-doctor encounters was 1718. RfEs and EoCs were respectively 3800 and 1536. The total number of interventions (ICPC components 2-6) was 2929. Of them 45.3% were diagnostic and preventive procedures, 44.0% medications, 0.2% results, 9.6% administrative procedures and 0.7% referrals and other reasons for encounters.

Conclusions: ICPC allows FDs to analyze their workload in managing ILI and ARI syndromes in terms of patients' reason for encounters, procedures adopted and diagnosis made by them, drugs prescriptions, home and phone consultations, referral to the specialists. Recording the EoC provides FDs with lots of useful information which are essential to develop an appropriate, timely and incisive health planning in order to address all health care patients' requests for those diseases.

Points for discussion:

1. Which similarities and differences are there in collecting those data in your Countries?
2. Are there any other classifications in Primary Care able to best analyze FDs' daily work?

PRESENTATION 27: Saturday 19th October, 2013
12.15-12.45 h.

SPECIAL METHODOLOGY WORKSHOP
Research in Progress, without results

Pharmacoepidemiology of Epilepsy - A Maltese Picture.

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Background: Pharmacoepidemiological studies are used to assess events that occur during antiepileptic drug treatment, using drug administration as a key variable, in various populations/healthcare settings. Such studies are important in monitoring prescribing patterns, drug adherence, safety and efficacy, to encourage reflective practice, with a view to optimizing patient care.

Aim: To review the clinical data of a random sample of 400 persons with epilepsy and create a pharmacoepidemiological picture of anti-epileptic drug use in Malta.

Method: A literature review was conducted using a variety of medical databases linked to journals. The project was discussed with a statistician who determined that a sample size of 400 patients would be required to measure a statistically significant difference during statistical testing. The research proposal was accepted by the University of Malta Research Ethics Committee. Letters of consent will be sent, offering study subjects the opportunity to opt-out if they wish to. Limitations of the study were identified and adjustments made, where possible, to the methodology and data collection process. The next steps to be taken are to pilot the study, collect the data from clinical records and enter it in a spreadsheet with regular duplication of inputs to minimize data entry errors.

Results: These will consist of means; percentages - age/gender/patient groups, presence of specific triggers, number of patients on monotherapy/poly-drug therapy, folate prophylaxis in female patients; frequency tables - age groups, seizure types, demographics, issues in pregnancy; number/duration of hospital admissions; significance testing.

Conclusions: This study is being conducted in order to foster accurate documentation, to foster a culture of adverse event reporting/monitoring, as well as centralized reporting; to enable calculation of costs; to empower clinicians, health managers/administrators, politicians to establish well informed policies; to evaluate drug effectiveness (fit-free interval measurements) and to foster a culture of reflective practice.

Points for discussion:

1. Adverse event monitoring and reporting in post-marketing drug surveillance002E
2. The need for centralization of patient data in electronic form so that GPs can access hospital data and vice-versa.
3. Empowering the patient and minimizing barriers to acces.

PRESENTATION 28: Saturday 19th October 2013

12.45-13.15 h.

SPECIAL METHODOLOGY WORKSHOP

What are the mainspring and constraints to realize a health care primary care center in town or in the countryside in France?

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Background: The disaffection for the primary care and the reduction in the medical demography engender medical deserts in France. In this context, the president of the republic took the bet to develop Multi-professional Health centers to revivify the countryside. Every MSP is unique. There is no applicable standard model.

Research question: What are the mainspring and brakes met by the project leaders?

Method: We used a qualitative study using face to face semi structured interviews. We met the leaders, the political representatives who carried projects which succeeded or which failed. All those who agreed to meet us!

Results: The main observed engines are the existence of a pre-existent human team sharing a history and common values. This team is guided in its progress by a leader, benefits from an effective support (accompagnement) and is supported by the local elected representatives. The main observed constraints are the absence of motivation of the healthcare professionals and the lack of attraction of general practice for young generations.

Discussion: The links and the common history between professionals are fundamental elements to the commitment to the grouping or the collaboration of the health care professionals in a multi-professional medical center. The purpose is to make more attractive the MG for the younger generations, value the medical time, the acts of prevention and coordination.

Favour the creation of links between the professionals supportive of the idea of a multi-professional health care center, by proposing expanding (carrier) themes as the in-service training, the welcome (reception) of the students, and research in primary care. The exercise in the countryside was not considered as a slowing down factor.

Conclusion: We were surprised to discover the power of the human factor; the project's success is essentially bound to the human dynamics of the local healthcare professionals.

Points for discussion:

Multi-Professional Health primary care centre are they the new French deal to revivify the primary care exercise?

Distance to hospital and socioeconomic status influence secondary health care use.

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Background: Most of patients' problems can be solved in primary health care (PHC) however there are some cases which need secondary health care (SHC). Increased SHC use can also be a sign of insufficient PHC and expose patients to unnecessary diagnostics, increasing health care costs.

Distance between patient's residence and hospital, socioeconomic status (SES) or co-morbidity are some interesting factors which can be important to identify in order to provide better access to PHC.

Research question: How geographical distance to hospital and socioeconomic status influence use of SHC when taking co-morbidity into account.

Method: The population in this register-based cross-sectional study were all adult people living in Östergötland County with about 400 000 inhabitants. The data used in the study were obtained from the Care Data Warehouse in Östergötland. Co-morbidity level was assigned using the Adjusted Clinical Groups (ACG) Case-Mix System. Statistical analysis was performed to analyse odds of SHC use in the population and rates of SHC use by patients.

Results: Association between SES and use of SHC was both positive and negative. The risk of incurring SHC costs was 12% higher for individuals with only primary school education. Individuals in the highest income quartile had 9% lower risk of hospitalization. The risk of using SHC services for the population was not associated with distance to hospital.

Patients with higher SES and patients living over 40 km from hospital had lower use of SHC services.

Conclusions: We found that despite same co-morbidity level the other factors such as distance to hospital and socioeconomic status influence SHC use. Our results suggest the importance of understanding patients' use of SHC due to other factors than co-morbidity which could result in more adequate planning of PHC services in order to prevent potentially redundant use of SHC .

Points for discussion:

1. What other important factors can influence potentially redundant use of SHC.
2. What kind of intervention is possible to decrease it?

Prevalence of asthma, dermatitis and diabetes : Does urbanization make it always worse?

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Background: Most articles presenting the statistics about the prevalence of allergic diseases like asthma and dermatitis or lifestyle-diseases like diabetes have found that living in the countryside is protective against getting them.

Research question: Is there any difference in the prevalence of diabetes, asthma and diabetes in rural and urban population in Estonia?

Methods: Comparing the prevalence of selected diseases in two settings having the same territory size but a 200 inhabitant count difference. For the study we did not collect any extra data: family doctors just did their everyday work with their patients. All cases were registered in the same computer program that also provided the numbers of all persons in age groups in practice registers. As the primary care in Estonia is organized by family doctors' patient lists it is highly unlikely that a person in a doctors list, gets a diagnosis and it is not coded in the doctor's database. 12-month prevalence was calculated and the prevalence in different settings compared in MS excel tables.

Results: The prevalence of asthma in urban and rural regions was 2.58%/2.09% in men and 1.97%/2.21% in women respectively; the prevalence of diabetes was 2.78%/2.83% in men and 3.33%/4.41% in women respectively and the prevalence of dermatitis was 3.41%/6.03% in men and 3.54%/6.76% in women respectively. The only age groups where the prevalence of dermatitis was higher in urban than rural regions were 0-4 years and 15-19 years. The odds ratio (OR) for getting the diagnosis of dermatitis was 0.6 (CI 0.49-0.71) for urban men and 0.5 (CI 0.46-0.64) for urban women when compared to rural men and women respectively.

Conclusions: The prevalence of asthma and diabetes in rural and urban settings did not differ, but surprisingly dermatitis was twice as common in the rural region compared to the urban region.

Points for discussion:

Do we need to gather data of disease prevalence for rural versus urban population regularly?

The European Green Capital Award, initiated by 15 countries in 2006 in Tallinn, the capital of Estonia, has inspired the city planners to improve environment

**PRESENTATION 31: Saturday 19th October 2013
14.30-15.45 h.**

**POSTER
Research in Progress, without Results**

Comparison of the level of satisfaction between emergency care duties in rural practices vs urban in Madrid/Spain.

Belisa Tarazona Chocano, Paloma Rodriguez Turégano, Raquel Gómez Bravo, Miguel Angel María Tablado, Edgar Linares, María Cuesta de Don Pablo, Cristina Ordoñez Betanzos, Nacho Sevilla, Concha Díaz Laso, María Patrocinio Verde González.

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Main objective: To compare the grade of satisfaction among primary care staff of rural practices vs urban practices in Madrid.

Methods: Observational study of an online- satisfaction questionnaire delivery across primary care staff of rural practices and urban practices in Madrid to compare the level of satisfaction related to the working conditions, time per consultation, the volume of the consultation and related conditions.

Results: This is an ongoing project but there is evidence enough to expect higher satisfaction in the rural primary care staff than in the urban settings. The results of this study will be present at the Euripa-EGPRN meeting.

Conclusions: It is crucial to include the rotation in rural practices during the curricula and to underline the effort of the health professionals in the difficult duty of teaching. This strategy would help to recognize the labour of the tutors and the rest of the primary care staff and allow GP's to be trained in a bigger and more global vision of their specialty and the rural world would be much more appreciated for training.

Students' evaluation of practical training in rural versus urban GP offices.

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Background: Given the threatening shortage of general practitioners (GPs), a mandatory community-based practical training was implemented in German medical education.

Research question: We examined potential differences in medical students' evaluation of the practical training depending on whether it was performed in a rural or an urban setting.

Method: We analysed the evaluations of all students completing their practical training at Leipzig Medical School between 2004 and 2012. Beside socio-demographic information, the questionnaire contained items addressing the students' perceptions regarding the acquisition of different skills and competencies, the quality of teaching, and their overall satisfaction (6- or 10-point Likert items). The data of all 233 students completing the training in one of 44 rural GP offices (< 50,000 p.) were compared to a stratified random sample of 233 students completing it in one of 73 urban GP offices ($\geq 50,000$ p.).

Results: The response rate was 94.9% (2,599/2,739). The rural group evaluated the practical training statistically significantly better regarding 32 of 37 items addressing their learning gain and the quality of teaching. Students from the rural group felt better introduced into the importance of general practice, preventive tasks, treating chronically or terminally ill patients, and making home visits than students from the urban group. The overall quality of the practical training was rated higher by the rural group (2.5 ± 2.0 vs. 3.2 ± 2.2 ; $p < 0.001$; 10pt Likert item).

Conclusions: Despite all students being highly satisfied, the students who completed the practical training in a rural setting evaluated it better. This might be due to several specific characteristics associated with rural practice and a possibly higher motivation of the rural GPs. The relevance of the findings with regard to the quality of teaching, the recruitment of future (rural) GPs, and the recruitment of medical school associated GPs teaching undergraduates were discussed.

Influence of Breastfeeding in Postpartum Depression. Differences by residence (Urban / Rural).

Miguel Angel María Tablado, Pilar Medina Adán, Leticia del Valle Falcón, Antonia María Carmona Gallardo, Beatriz Aviles Gamez, Raquel Gómez Bravo

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Objective: Nonpsychotic Postpartum depression (NPD) is underdiagnosed. Its prevalence is 11%. The impact on mother and baby are clear. It is believed that breastfeeding (BF) may play a protective role.

To analyse the effect of BF in NPD. NPD is defined as score ≥ 12 points in Edinburgh Postnatal Depression Scale (EPDS). EPDS administered at 6 weeks postpartum in women followed for subsequent pregnancy and puerperium in 5 GP practices.

Secondary objective: To describe the prevalence of NPD and BF in rural and urban areas.

Material and Methods: Design: A prospective, longitudinal, multicenter, cohort study with 3-month follow-up. Scope: 5 AP CS (2 rural, 3 urban).

Subjects: Women attending midwife consulting in primary care. N = 83 (20 rural, 63 urban).

Consecutive randomized. Variable: Dependent: NPD: EPDS score ≥ 12 . Independent: BD defined exclusive breastfeeding or mixed feeding, age, number of children, type of delivery.

Results: 83 women, mean age 30.59 years. First child 10.8%, 60.2% second, 22.9% third, 1.2% fourth. 4.8% twin. Type of delivery: 48% vaginal delivery, 15% instrumental, 19% caesarean section. BF 72.3%. EPDS plus 3.3%. No BF and EPDS LM positive, 26.1%. BF and 8.3% positive EPDS. RR = 3.13% (95% CI, 1.058 to 9.265).

EDPS positive and BF similar in urban and rural areas. No statistical difference.

Conclusion: BF acts as a protective factor against the NPD defined with a EPDS ≥ 12 points. The sample was taken in rural and urban areas (not enough to determine differences between them). Most were second pregnancies and normal deliveries. Postpartum depression prevalence is 13.3% similar to that in the literature. It requires a larger sample cohort to control spurious associations.

Which measures do primary care physicians consider as typical self-medication and home remedies used by their patients for common colds? A cross-sectional study among physicians from several European primary care sites.

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Background: Patients use various self-selected measures to relieve symptoms of common colds. In preparation for a patient survey, primary care physician researchers were asked for their assessment.

Research questions: Which measures do primary care physicians consider as typical self-medications and home remedies used by their patients for common colds?

Method: A questionnaire was e-mailed to 17 primary care researchers from 12 European countries. These physicians had signalled their interest to participate in the EGRPN working group patient survey about measures for common colds. The questionnaire consisted of one open question with ten sub-items: "To your knowledge, what are typical measures your patients use as self-medication or home remedies for common colds?" Physicians were asked to provide options which were grouped as follows: pharmacological substances, teas, special food items, special recipes, alcoholic drinks, other substances to swallow, substances for the nose, for the throat, for inhalation, for external use, and general supportive measures.

Results: The participation rate was 59% (10 of 17 physicians from 7 countries). A total of 254 items were grouped. The five most frequently named groups were: self-medication (91%), eating special food such as oranges, curcuma, chicken soup (91%), herbal teas (82%), measures externally on the body (82%), topical nasal substances (73%), and general supportive measures. The five most frequently named single items were: paracetamol (73%), inhalation with eucalyptus oil (73%), nose spray (73%), staying at home (73%), and vitamin C (64%). Interestingly, alcohol containing beverages were named by 5 physicians only (46%), while herbal teas and other natural products ranked higher.

Conclusion: Our survey among EGPRN physician researchers provides an interesting insight into self-medications reported to physicians by their patients. We are interested to see if the patients' survey will show similar results.

Points for discussion:

1. Physician knowledge of items used by patients for common colds
2. Categorization of the items named
3. Implications for the patient survey this fall

Measuring C-reactive protein in general practice. Feasibility study.

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Background: The Quick Read CRP® is a device for measuring C-reactive protein in ambulatory practice. Currently, this system is not used in France in general practice. This type of device could distinguish between viral and bacterial infections. It could be convenient in rural areas where the biology laboratories aren't present.

Research question: The aim of this study was to evaluate the feasibility of using an ambulatory device for measuring CRP. The primary endpoint was the ability to include patients by general practitioners. The secondary objectives were to identify the difficulties of use, usage patterns and changes in antibiotic prescribing and additional examinations.

Method: Eleven volunteer general practitioners participated during 3 months in the winter period. They filled in a questionnaire about the time required to measure C-reactive protein, usage patterns, pathology patients, the difficulties and changes in antibiotic prescribing and additional examinations.

Results: The average inclusion by general practitioners was 30 patients. The time required to measure C-reactive protein was in accordance with the manufacturer's data at around 3 minutes. Only 2.2% of the measures have failed. The main measurement problem was related to handling. The Quick Read CRP® was used in the majority of cases in respiratory tracts infections. The device has reduced by 41% antibiotic prescribing and 52% prescription laboratory tests.

Conclusions: The use of Quick Read CRP® or identical device seems possible in general practice. Measuring C-reactive protein in respiratory tracts infections appears to affect the practice of general practitioners. A randomized cluster protocol study is being drafted.

Points for discussion:

1. reduction antibiotic prescribing and prescription laboratory test
2. future study

The Challenges of Diagnosing Community Acquired Pneumonia in General Practice.

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Background: The majority of cases of community acquired pneumonia (CAP) are managed in the community, although the majority of published studies report on hospital in-patients. Optimum management relies on accurate diagnosis. British Thoracic Society (BTS) Guidelines (2009) provide diagnostic criteria that do not rely on CXR, as this may not be readily available in the community setting. The overall aim of this project was to collect data regarding CAP in Irish general practice.

Research question: This paper focuses on the specific challenges of identifying CAP cases in general practice, adhering strictly to the BTS diagnostic criteria.

Method: Following ethical approval, prospective data collection was undertaken over one year to document CAP symptoms and incidence as it presents to general practice in Ireland. Data analysis was carried out using the PASW statistical package.

Results: Interim results presented here are based on the clinical notes recorded at the initial consultation from 14 practices whose profile was generally representative of Irish general practice. 209 cases were returned, ranging from 4-50 per practice. Demographic data suggests a typical patient profile for CAP. Strictly applying the BTS definition resulted in a definitive diagnosis in 29 cases (14%) with a further 108 cases (52%) likely to be CAP. Inclusion of known CXR results increases definite cases to 29%.

Conclusions: Our findings concur with international evidence on the difficulties of accurate case definition of CAP in the community. This has implications for the application of appropriate clinical care guidelines.

Points for discussion:

Clinical and research implications in terms of the difficulty in making diagnosis according to the guideline case definition.

Abdominal aortic aneurysm screening by ultrasonography in primary care.

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Background: Abdominal aortic aneurysm (AAA) screening in risk groups may decrease the number of ruptures and mortality. Investment in Primary Care (PC) will improve health outcomes and reduce hospital admission complexity, thereby getting better system efficiency.

Research question: Is AAA screening by ultrasound (US) in PC effective? What is the AAA prevalence in Vigo PC district? Is there an association with cardiovascular risk factors? Are there some genetic or inflammation biomarkers suitable for diagnosis and/or prognosis?

Methods: Design: Prospective cohort study comprised male patients 65-74 years. Setting: Integrated Management Area Vigo, with 583124 habitants, 20 PC services, and 53 health centers. Participants: 21 family physicians (FP), belonging to 12 PC services of Vigo.

Intervention cohort: all men aged 65 to 74, attended by each of FP researchers (approx. 1,460).

Expected uptake: 75% (52 patients per FP). Participating patients will sign informed consent to participate in the study. Patients who refuse to enter or not to sign IC will be losses. Exclusion criteria: age and sex.

Control cohort: men of the same age belonging to the area of Vigo. Data will be extracted anonymously from the administrative databases of the Galician Health Service (SERGAS) and therefore require no IC.

Main outcome variable measured: all-cause mortality. As secondary endpoints: cardiovascular mortality, surgery for AAA (type of surgery, scheduled/emergency), and type of discharge from hospital. Independent variables: demographic, clinical and genetic and inflammation biomarkers. Epidemiological analysis of chronic diseases and risk factors will be performed by a multimorbidity group (with participation of junior researches).

Analysis: a) AAA screening effectiveness: comparison of survival between patients with AAA detected in PC versus control cohort. Multivariate Cox models for outcome variables. b) Multimorbidity:

Descriptive and factorial analysis. c) Biomarkers: Case-control study.

Results: study proposal no result yet.

Conclusions: discussion is welcome.

Points for discussion:

1. How would you develop the multimorbidity database of each patient?
2. What are the limitations of the study?
3. Will ecography be the stethoscope of the future in PC?

An Online Tool for a Diabetics Association as the Means for Patient-led Research.

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Background: Patient and Public Involvement is bound to cause a wave of transformations in healthcare. Patients with chronic diseases are often skilled at assessing health information, making their own decisions.

The Federation of Diabetics of Emilia Romagna (Italy) launched a study investigating the behaviours, needs and expectations of the diabetics that receive insulin and use blood glucose self-monitoring devices.

This project would also evaluate the feasibility of the online platform versus the paper questionnaire.

Research question: How did the patients respond to the online platform that was employed for this purpose.

Method: The project was launched in February 2013 in cooperation with the Regional Administration of Emilia Romagna.

For this project, the online platform "Lumos!" has been transformed into an open public survey tool.

For the evaluation of the implementation, data on the access and usage were retrieved and analyzed from the logs.

Results: 158 questionnaires were compiled in the first two months; 63.9% were filled in by adult patients and 36.1% by the caregivers of mainly non-adult patients. The average age of the adult patients was 45.39 years (sd=16.13). 53.2% of the sample stated their email address voluntarily, although the field was clearly marked as optional, and nearly half of them replied to open questions expressing critical aspects. The median of necessary time for the questionnaire completion was 12:28 minutes (IQR=07:08-19:27) and the median of the percentage of the filled-out items was 78% (IQR=69%-82%).

Gender didn't influence these two variables, however the age of the adult patients was weakly inversely correlated to both the time and completed items ($r=-0.25$ and $r=-0.21$).

Conclusions: Both patients and caregivers were interested in participating in the online survey. The mean age and the voluntarily disclosure of the identity may indicate how online tools will be employed in the future.

Points for discussion:

1. What methods can be implemented to receive enough data from patients participating in such projects?
2. How do demographics influence online questionnaires compared to the paper-and-pencil ones?

Prevalence of cardiovascular risk factors and quality of life in patients with severe mental disorders.

Masa-Font R, Fernández-San-Martín MI, Martín-López LM, Olona-Tabueña N, Díaz-Mújica B, Martín-Royo J, Sanchís-Catalán R, Oller-Canet S, González-Tejón S, Viñas-Cabrera L, Tajada-Vitales C, Ibarra-Jato M, Alba-Muñoz AM, Barroso-García A, San-Emeterio-Echevarría L, Salvador Barbarroja T
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Background: Patients with severe mental disorders (SMD) may have a higher prevalence of cardiovascular risk factors (CVR) and poorer perceived quality of life. Primary health care is the appropriate level to follow-up these physical health problems and to offer counseling to mental health staff.

Research question: The aim of this study is to describe the cardiovascular risk factors and the quality of life of SMD outpatients of mental health centers.

Method: Cross-sectional study in patients diagnosed with schizophrenia, schizoaffective disorder and bipolar disorder selected consecutively in five mental health centers in Barcelona. Clinical parameters of CVR have been measured: anthropometric (body mass index: BMI, circumference waist, blood pressure), analytical (cholesterol, triglycerides, glycemia) and dietary habits; co-morbidities and drug therapies. Quality of life is evaluated by the SF-36 questionnaire. CVR is quantified by regicor score and Framingham score. Variables are described by measures of central tendency and dispersion, and then relate to each other using bivariate statistical techniques.

Results: 212 patients have been included; 53.8% men, mean age 45.6 years (SD: 9.1). Prevalence of CRV factors: smoking, 61.6%, waist circumference, 84.4%, obesity 67.5%, hypercholesterolemia 15%, hypertriglyceridemia 41.1% and hypertension 27.8%. The CVR average is 2.7% and 10.9% according to Regicor and Framingham score respectively. The SF-36 dimensions with fewer score are: vitality, general health and mental health, significantly worse in women than in men.

Conclusions: SMD patients have a high prevalence of CVR factors, especially smoking and hypertriglyceridemia. The perceived quality of life is worse in most dimensions compared to general population.

Studies are needed to determine effectiveness of collaborative interventions between primary care and mental health professionals to improve metabolic control and quality of life in patients with SMD.

Points for discussion:

1. The primary care follow-up of these patients
2. Is there less control or derivation of these patients to primary care?
3. Is there little record, control and follow-up of cardiovascular risk factors in these patients?

Poor Asthma Therapy or Resistance from the Patients? Barriers to the implementation of the asthma guidelines from the patients' perspective.

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Background: Although there are guidelines for asthma therapy in Germany, many patients are sub-optimally treated and suffer from uncontrolled symptoms. There are many reasons for the inadequate implementation of the asthma guidelines (AG) on the sides of both the doctor and the patient. The patients' perspective will be presented here.

Research question: What are the barriers to the implementation of the AG on the patients' side?

Method: Theme centred guided focus group (FG) interviews were conducted using a qualitative exploratory design. The central questions had the following topics: 1) Expectations/ priorities with respect to asthma treatment 2) Concepts of disease self-management 3) Personal experience of asthma treatment 4) "Fear of cortisone" as a risk factor for non-compliance. Recruitment was consecutive via registered general practitioners in the Greater Hanover area. Interviews were recorded on video, transcribed and analysed for content using the Mapping Technique and the Mayring method. Five FG, each with 6-9 asthma patients between the ages of 20 and 77 were conducted, to reach theoretical saturation.

Results: Preliminary results show that asthma patients want their GP to view their illness holistically and that they value complementary therapies highly. Therapeutic goals are medication reduction and autonomy. Younger asthmatics are often in denial of their asthma, while older patients tend to concentrate more on their illness, its treatment and alternative options to medication. The negative image of cortisone incites patients to modify medication without informing their doctor. Communication between GP and specialist is also an important subject. Attitude to guideline-based long term therapy seems to vary with age.

More results will be available for presentation at the meeting.

Conclusions: There are barriers to the implementation of guideline-based asthma therapy that are unrelated to GPs. The means of successfully overcoming these barriers must be examined in further studies.

Points for discussion:

1. Are there similar experiences in other countries?

Systematic Review: The effectiveness of educational interventions for primary care health professionals designed to improve self-management in patients with chronic conditions.

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Background: In recent years, a development in chronic condition management is the involvement of patients in their own care to improve outcomes. However, the related literature focuses on patient education to improve knowledge of the illness, which does not by itself bring about patient engagement or patient empowerment for self-management of chronic conditions.

In order to create a structured approach to effective patient self-management of chronic conditions in primary care, it is necessary to specifically assess which educational interventions aimed at health professionals in primary care improve self-management by patients of their own chronic conditions.

Research question: The primary aim of this systematic review is to examine the effectiveness of professional educational interventions designed to improve self-management of chronic conditions. The secondary aim is to inform the development of an educational programme for primary healthcare professionals across Europe which will be effective in empowering patients to improve their self-management of their chronic conditions (non-communicable disease).

Method: A systematic review using the following: PubMed, ERIC, EMBASE, CINAHL, PsycINFO, Web searches, Hand searches and Bibliographies with specified inclusion and exclusion criteria and search terms.

This review is concerned with all chronic conditions as they occur generically in the primary care setting, rather than focusing on any specific chronic condition.

Results: At the time of writing, the search of all outlined databases has been conducted with 6,816 abstracts identified - the first stage of the review of these identified 75 possibly relevant articles, with the second stage reducing this to 43 full text articles to consider. The initial results of the full systematic review will be presented at the EGPRN October 2013 meeting.

Conclusions: This systematic review has potential to contribute to improving patient outcomes through assessing the existing evidence for educating primary care clinicians in this domain.

EGPRN's Multimorbidity definition translation and homogeneity into 8 European languages.

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Background: An EGPRN working group has published a comprehensive definition of multimorbidity. In order to be used for collaborative research through the EGPRN that definition had to be translated into different European languages. The results have to be homogeneous to ensure future collaborative research.

Research Question: What is the homogeneity of the translations of the EGPRN Multimorbidity definition in Bosnian, Bulgarian, Croatian, French, German, Greek, Italian and Polish?

Method: The national teams undertook the translation using a forward backward translation system with a Delphi consensus procedure. In every country a group of 30 native expert GPs, English speaking, still in practice and having teaching or research activities had to be constituted. After reaching consensus a backward translation had to be undertaken for each national group and a meta ethnographic analysis had to be undertaken in the EGPRN Spring 2013 meeting to ensure homogeneity of the translated definitions.

Results: All national groups achieved the translation process. The backward translation found some difficulties with the translations of frailty, somatic risk factors and burden of diseases in most countries. Final agreement between the international group and the native teams was achieved for all translations. The meta ethnographic analysis ensured homogeneity of the translations.

Conclusion: The multimorbidity definition is translated and homogeneous in Bosnian, Bulgarian, Croatian, French, German, Greek, Italian and Polish. It is usable for further research within the EGPRN. The translation protocol is available on demand for other languages.

Biased based judgements against the Family Medicine lead to cognitive distortions in future and current family physicians (FPs).

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Background: Publications involving overgeneralizing the role and meaning of FPs' work and specialty of Family Medicine, prioritizing the truth over FPs' views, and other biases, concerning primary health care, are common worldwide.

Research question: What is the influence of bias based judgements about the specialty and work of future and current family physicians on their health and thinking.

Methods: Analysis of 147 published studies about cognitive, stereotyping, heuristic and educational theories, and 40 publications about young and current FPs' burnout, on Medline and Cochrane Databases. Inquiry of 200 FP trainees and certified FPs (International Cognitive Distortions Scale, adapted for FPs) about cognitive distortions they might have, and cognitive biases turned towards FPs' specialty and work.

Results: 88 FPs and FPs trainees' reported data were analyzed with SPSS program. Significant, statistically positive correlation between the biased based judgements towards the specialty of Family Medicine and FPs' work and cognitive distortions FPs had, was found, which means the more biases are turned towards FPs' specialty and work, the more FPs have cognitive distortions themselves (Pearson correlation, $p=0.000$). Significant statistically positive correlation was found between biased judgements towards FPs' specialty and work and FPs' destructive ways of thinking (Spearman correlation, $p=0.000$). Standard normal distribution showed the data were representative to all the family physicians of Latvia.

Conclusions: Cognitive communication mistakes cause destructive ways of thinking among FPs. Bias based judgements against the specialty of Family Medicine and FPs' work lead to cognitive distortions in future and current FPs. This study is first of the kind and more comparative studies must be taken.

Points for discussion:

It is proven, cognitive distortions worsen the gait of various patients' illnesses, however, the up-to-date unhealthy, work environment and global family physicians' burnout show that family physicians themselves seem to be in the group of risk for mental

Is the collaboration of family physicians, community nurses and social workers just a Lithuanian “Dream Team”?

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Background: According to Lithuanian legislations PHC team includes Family Physicians (FP), community nurses and social workers. For the provision of Long Term Care (LTC) nurses and social workers are responsible.

Research question: To investigate the collaboration between social and PHC services in Kaunas region (covers urban/rural areas) and to compare it's adequacy to a valid legislation basis.

Method: Questionnaire survey, all 57 PHC centers were invited to participate (33 agreed). In total 164 FP and 180 nurses were questioned, whose distribution according to urbanization corresponded to region data. The Chi square was used to test statistical differences in urban and rural areas. This survey is a part of the Project “Intersectoral collaboration solving PHC problems in social risk families” funded by a grant (No. SIN-12015) from the Research Council of Lithuania.

Results: Majority of FP (95%) and nurses (93.3%) corresponded incorrectly about the structure of LTC teams and stated that FP should be involved in such a team. Nurses were included as team members by 87.2% FP and 90.9% nurses; social workers were selected by 35.8 % FP and 43.3% nurses. Nurses from rural areas (48.6%) mentioned social workers as a part of LTC team less frequently vs. urban (29%), $p=0.03$. The major responsibility for LTC provision was incorrectly shifted towards physicians (stated 37% FP, 25% nurses); or to both - FP and nurses -(stated 55.2% FP, 63.3% nurses). The nurses and social workers, who are both supposed to be the main LTC providers, were selected by 0.6 % FP and nurses. The most frequent need of social services were related to aged persons, disabled adults and social risk families. There were no differences according to urbanization regarding last two aspects.

Conclusions: PHC providers lack the knowledge about legislation regarding the collaboration with social services. The collaboration between sectors has a more theoretical rather a practical basis.

Points for discussion:

PHC and social services should be improved. The legislation basis for collaboration of PHC and social services exists, though the reality differs. What would be done in order to adopt legislation into practice?

**PRESENTATION 45: Saturday 19th October 2013
14.30-15.45 h.**

POSTER

The VdGM Hippokrates Exchange Programme.

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Objectives: The main objective is to present how the VdGM Hippokrates Exchange Programme impacts on GP trainees in Europe. Since 2008 the Vasco de Gama Movement offers an international observational 2 weeks period in a GP Practice of a European country and since 2010 also in rural practices. Moreover we will show the value of exchanges and its relevance to professional development of future General Practitioners.

Methods: This observational descriptive study compares Hippokrates Exchange enquires, planning and completed exchanges from 2010-2012. Variables: requested countries, exchanges organized, completed protocols and VdGM Hippokrates Exchanges Certificate of Completion issued.

Results: There is an increase participation in the Hippokrates Programme with a increase in number of requests as well as completed exchanges. The most popular destination is still the United Kingdom however also Northern Countries have always hosted many GP trainees. Moreover we have also been observing a growing interest for other rural practices and European countries such as Italy, France, Germany, Croatia and Israel.

Conclusion: The Hippokrates Exchange Programme provides an insight into the context of General Practice in the primary healthcare system of other European countries and inspires the participants to undertake an active part in the development of Family Medicine at all levels. The interest for such an exchange programme is growing rapidly among GP trainees which helps us recruit not only new participants but also hosts as well as new destinations such as Israel and Latvia.

Organizational Variables on Family Physicians' and Nurses' Job Performance in Turkey.

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Background: The purpose of this study was to describe the influence of organizational variables on family practice centre of nurses' and physicians' job performance as reported by nurses and physicians in two cities of Turkey in the Marmara Region. In this study, the assessment of the effects, which are perceived by the family physicians and nurses, of 10 organizational factors that affect the nurses' and physicians' job performance were investigated.

Research question: What are the factors that influence the job performance of family physicians and nurses in Turkey.

Method: The reported influence of 10 organizational variables on job performance was measured by a questionnaire developed by Yildirim-Kaptanoglu et al. Nurses and physicians were asked to evaluate the influence of 10 organizational variables on their job performance using a five-point Likert-type scale (1- Never effective, 5- Very effective). The study used descriptive study design. Physicians and nurses who were included in this study were selected by stratified random sampling methods from Istanbul and Kocaeli. Frequencies, t-test, ONE WAY ANOVA and factor analysis were used for data analysis.

Results: The study showed the relative importance of the 10 organizational variables that influence physicians and nurses' job performance. Nurses and physicians in this study reported that workload and technological support are the most influential organizational variables on their job performance. Factor analysis yielded a five-factor model that explained 61.83% of the total variance.

Conclusions: Organizational variables influence on the job performance of physicians and nurses in different magnitudes at family practice centres should be followed-up seriously by health managers.

Points for discussion:

1. How to Evaluate Family Practice Center Job performance?
2. The rol of Family Physicians and Family Nurses on job performance?
3. The importance of job performance in primary care health center

Prevalence of insomnia in general practitioners, and its influence on prescriptions in the practices for the care of insomniac patients.

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Background: The prevalence of chronic insomnia is estimated around 19% in the French population. General practitioners have a higher risk of anxiety-depression disorders and addictive behaviour, which are commonly associated with insomnia. A recent study showed an association between physician's insomnia and their over-prescription of hypnotic drugs.

Research question: What is the prevalence of chronic insomnia in a population of general practitioners? Does it influence their prescription of hypnotics for their patients?

Method: A self-administered questionnaire was sent to 464 randomized general practitioners in Alsace (France). The questionnaire included a demographic part, Pittsburgh sleep quality index (PSQI), an abbreviated version of the Dysfunctional beliefs about sleep scale in 10 items (DBAS), and questions about how they took care of themselves and their patients.

ICSD-2 criteria were used to determine the diagnosis of chronic insomnia. They were classed in 5 groups depending on the frequency of the symptoms (from <1/month to \geq 3/week with diurnal consequences).

For our final analyses that are underway, we used Bayesian inference.

Results: 245 GPs answered the questionnaire (53%). Prevalence of insomnia was 15.5% (IC 10.8; 20.1%), but lower in the under 40 years old. Insomnia was associated with longer sleep latency, poorer sleep efficiency, and shorter sleep (6h07). 40.5% of insomniac GPs take hypnotic-sedative drugs, but some non-insomniacs GPs also do (3 to 37%). They rarely refer to a specialist. Insomniac GPs prescribe less "natural products" ($p=0.046$), and tend to prescribe more hypnotics. All of them give sleep hygiene advice. In our study, GPs sleep less (6h40) than the general population (7h00).

Conclusions: GPs have a similar prevalence of insomnia but are more sleep deprived compared to the general population. Insomniac GPs take less care of their own sleep disorders and use more hypnotics drugs than their patients. GP's insomnia seems to influence their patient's care.

Home calls and visits could be a valuable source of information for evaluating health care needs and living conditions? An analysis of the home visits performed in a rural area of Crete, Greece.

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Background: Home visits have received little attention in the literature as a source of population health care needs especially in rural areas. In addition, GPs seems to abandon home visit as a place for delivering primary care services.

Research question: Could home visits due to episodes of care being used to provide information about hidden morbidity, conditions of living and state of the family?

Method: An observational study has been designed to explore hidden morbidity, and potentially dangerous conditions of living in a well defined rural area in Crete. All the home visits that they were performed during a 4 year period have been studied and information relevant to the living conditions and the state of the family, have been extracted by using a pretested form.

Results: 124 visits in houses for various reasons were performed during the study period (change of catheters, end of life care, acute episodes etc). In total 43 houses were visited as in most cases the call for home visits was repeated several times. Conditions of living were often inadequate: no in house toilet (23 families), carpets and stairs (30 families), switches a distance from their bed (32 families), no house had bars for helping the elderly get up from their bed. A significant percentage of persons had signs of depression (26 out of 43). Pressure ulcers, skin disorders and one skin cancer were observed in 12 patients without this being the consultation reason. Further the majority used stoves, fireplaces or brasiers for heating resulting in a potential threat. 16 houses used liquid gas for cooking.

Conclusions: Home visits in a rural area in Crete revealed significant morbidity and inadequate conditions of living. They could be considered as an additional source for assessing population health care needs, while it can also assist the clinical decision process.

What difficulties might Male-To-Female Transgendered Persons practicing sports?

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Background: Male-to-Female transgendered persons (MTFTP) are significantly more often HIV-infected than the general population. Cardiovascular disease is an emerging area of concern in the HIV population. It is a challenge to prevent coronary heart disease. However, practicing regular physical activity seems to be particularly difficult among MTFTP.

Research question: What are the difficulties that MTFTP might have to face, practicing sports in everyday life and what could be organized to overcome them?

Method: Qualitative study, semi-structured individual interviews of MTFTP, until saturation. Double-coded between November 2012 and June 2013 in Paris and Nice, France. Participants were directly recruited from GP consultations, endocrinology hospital department, associations and web-forums. Framework analysis.

Results: Three main kinds of findings: 1) One-self: The "chronic pain" of not feeling well in one's own body, often described as too fat because of hormone therapy, too skinny because of illness or medication, not feminine enough, altered by aging or consequences of mutilating esthetic surgeries. The fear of developing muscles associated with masculine shapes. The fear of getting sick, worsening a fragile medical condition, discovering new feelings that could be taken as new symptoms. The asthenia due to heavy treatments or poor living condition. 2) Others: the painful discriminating stare from others in everyday life places and especially in the changing rooms of swimming pools or gyms. The obsession that the disease might be visible by others. The identity issue of not being able to "pass", to "appear normal". 3) The impossibility of obtaining track meet licences. The non adapted-structures and the non-conscious sport coaches of the Trans-problematics.

Conclusion: The difficulties are various and need specific interventions such as improving troubled self-esteem, reassurance on medical condition, educating specific sport teachers, proposing adapted sports on protected sites, creating sports licences not recognising the civil gender.

Points for discussion:

1. Summary of the obstacles: expected/non expected before the study and found bias
2. What are the objective tools that may be organized to help MTFTP practicing sports?
3. How to create a sport certification for MTFTP ?

Development and Application of an Intervention Program in the rural settings Roma Community.

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Background: The Roma in rural settings of Prekmurje are an indigenous ethnic group whose public healthcare expectations and needs have been unknown until now.

Research question: To identify their needs and expectations regarding public healthcare measures, and evaluate the effects of the intervention program carried out was our research question.

Method: A prospective intervention study of cases and controls was carried out in the Roma community. Mixed methods were used. The first quantitative part was used to evaluate conditions in the Roma population by EuroQol and EUOPREV questionnaires, and the qualitative part was used to evaluate Roma views on health protection and promotion using a semi-structured questionnaire and interviews. The analysis of the first stage of the project formed the basis for designing an intervention program, which was carried out in eight Roma settlements. In the third stage, a quantitative research method was used to evaluate the success rate of the intervention.

Results: The majority of the interviewees pointed out that every individual is responsible for his or her own health, did not experience discrimination at health institutions and made suggestions for improving the health status of Roma. The measurements of changes after the intervention showed improvements in knowledge of the normal values of selected health indicators, with the highest percentage recorded in terms of normal body temperature (21.7%; an increase from 23.2% to 44.9%, $p < 0.001$). The smallest change was recorded in terms of knowing the normal values of overall cholesterol levels (3.9%; from 1.2% to 5.1%, $p = 0.002$). The program was less successful in changing views on a healthy lifestyle.

Conclusions: The intervention program in the Roma community led to changes in the knowledge of specific healthcare indicators, but it did not cause changes in views on a healthy lifestyle.

Points for discussion:

1. How long should be the intervention that we can expect change of the Lifestyle?
2. How effectively measure the change in Lifestyle after intervention?
3. Can a rural environment be an advantage to explore marginalized groups or opposite?

Allena Vita Coach: stratification (clustering), observation, stimulation (fosterage, persuasiveness, support).

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Background: The WHO has found that 80% of heart disease, stroke and diabetes, can be prevented by a combination of information/awareness and a coordinated system of incentives / disincentives. Electronic communications, such as telemonitoring, may become qualified by "health tutoring" and intensified care . These processes can increase the number of citizens to care at low cost especially in rural areas. The study will test a new care delivery model, able to include a large number of people with cardiovascular risk in primary and secondary prevention.

Research questions:

- Can AllenaVita reduce cardiovascular risk?
- Can AllenaVita improve lifestyle and treatment adherence?

Method: Twenty patients, between 40 and 60 years, with cardiovascular risk factors and categorized according to recent guidelines, will be studied, each with care plan monitoring and care randomized trial. A system will be developed, which consists of a modular web based EHR that will be shared by patients, nurse and general practitioner, easy to use even for people with low technological expertise or disabilities, but able to use, independently or assisted, smartphones, tablets, PCs. We also applied persuasive technology that uses persuasion and social influence to drive change of behaviour in people. Behaviour is the product of motivation, ability and triggers.

Objectives: AllenaVita will improve adherence to treatment with patient awareness, motivational strategies, self-monitoring and intensified care. The study will examine one group with traditional telemonitoring and the other one without. The nurse has the responsibility of patient parameters and lifestyle monitoring, as well as the patient lifestyle goals agreement.

Results: Work in progress

Conclusions: AllenaVita will try to result in care efficacy in rural areas similar to the city context and the general practitioners reduce CV risks in a multidisciplinary process where registered nurses have a central role in monitoring and improving adherence to treatment.

Points for discussion:

1. May electronic communications, such as telemonitoring, become qualified "health tutoring" and intensified care?
2. May this new model make patients more responsible?

Sustainability of Urban and Rural Systems.

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The meaning of the Data-OMV consists of the exploration the role of human service sectors: health care, education, mental health, child welfare, justice, in providing efficient actions for the wellbeing of people living in urban, suburban and rural areas.

It is a longitudinal population-based retrospective study for 11 years, on family medicine and psychopathology, starting from a research essay-OMV since 2002 about Determined Means of Youths into Contemporary Social Systems, correlating also, data of APHA, Research settlements: Romania, Tunis, Turkey, Belgium, UK, USA.

Question: What are the similarities and differences in environmental problems and solutions, including social, economic, cultural, biological determinants of health, found in urban, suburban and rural research areas?

Methods: Examining the habits, behaviours, health status, relationships, mental values of children and youths in the school, where those were initiated helping the people adapt to environmental and technological changes, to identifying and promoting sustainable solutions; Collaborations with experts in the analysis and planning of urban, rural and regional systems.

Results: Higher rates of primary care services use than has been reported previously, continuing to relieve a substantial need among the youth and elderly, both with a psychiatric misdiagnosis disorder or functional impairment; Educational opportunities for the rural young, whatever research setting, are significantly less than the urban poor; Occupational mobility is greater in the last 6 years, from the rural habitats, low-income settings to urban zones concentrating educational, industrialized developments.

Conclusions: Role of the education sector and the primary care research setting as an usual source of health care (USC) suggested that the school and the family medicine center may function as the factors of mental health system; Greening business practices, entrepreneurial works including health care activity, emphasizing value rather than disposability, it's the sense of cutting down the waste while improving the quality of life.

Points for discussion:

Defining rural and urban taxonomies, this working paper would evidence the education achievements, health care, from an integrated medicine wisdom, explaining the differences between urban and rural systems, their interactions, influences, sustainability.