

Dublin meeting presentation abstracts

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PRESENTATION 1: Friday 13th October, 1995
9.30-10.00 h.

TITLE: The exploration group.

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The most genuine feature of primary health care is the first contact with the authentic complaint of the patient. The most frustrating feature of primary health care is it's difficulties to assemble a sufficient number of patients with the same disease to do statistical work on it. So primary health care is structually strong in inductive research and has difficulties in deductive research. Despite the fact that this is known since a long time, inductive research is rarely used in primary health care.

We developed the exploration group as a method to produce valid research hypotheses and tested it in several well-documented research projects.

The exploration group consists of a group of 10 to 15 peers that are confronted directly with the chosen research subject.

The group considers a first clinical case and decides what observations could be relevant (primary codes) and what discipline could help. A representative of that discipline is invited to guide the group. The representative brings his or her knowledge in the group in the format of words or short statements that also have to be observed (secondary codes).

The group passes the codes through a process of analytical induction: this is a process that eliminates codes that aren't felt as constantly true. From these surviving codes (key-codes) an hypothesis is formulated. This hypothesis is then compared with the ideas of the patients and with literature. At the end a deductive study proving the formulated hypothesis is designed.

Following this script hypotheses have been constructed on incest-victims, heroine-addicts and preventioncard users. These hypotheses proved to be usefull and unexpected.

Now two problems emerge. Firstly, a small research unit cannot do all deductive research that results from the inductive research programs. The normal flow of ideas : through the scientific journals is also blocked since the journals do not accepts results of purely inductive research. A good transfert of hypotheses from primary health care to deductive research (eventually in secondary health care) is needed. We argue that primary health care journals should reserve place for inductive research results.

So primary health care can voice the most genuine part of their scientific work.

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PRESENTATION 2: Friday 13th October, 1995
10.00-10.30 h.

TITLE: The role of the 'focus group' as an appropriate primary care research tool - A study of management decision making on the use of Primary Care Information.

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Introduction: There is increasing demand on general practices to produce information for management purposes. Many FHSA's and DHA's are supporting projects aimed at extending and improving the availability and reliability of general practice data. The use of information by management, however, remains unclear and management decisions, often appear both inconsistent and idiosyncratic. As part of the Wakefield and Pontefract Primary Care Health Information Project, the use of information by primary care teams, public health and the FHSA has been the subject of in depth study. This paper will

present the results of one aspect of our work, designed to explore the role of primary care information in management decision making; and will discuss the use of a 'focus group' as a suitable data collection tool.

Method: Senior primary care management teams were asked to present and discuss examples of recent management decisions at a video recorded 'focus group' meeting. Using health promotion banding data, key attributes of effective decision making are explored.

Results: The 'focus group' method has in this study proved to be an effective and efficient way of exploring issues with management teams and encouraging informants to critically appraise their decision making.

Data analysis has suggested management decisions are often based on inadequate, anecdotal information and that even when data from primary care are available, they are mistrusted and unused. Improving the quality of primary care information is insufficient to guarantee its appropriate use in management decision making.

As a qualitative data collection tool the 'focus group' has rarely been used in European research studies. It may be appropriate however, across a range of topic areas and different cultural settings.

It is hoped the presentation will stimulate debate around the advantages and disadvantages of 'focus groups' and provide a form for a cross cultural dialogue on this and similar methodologies.

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PRESENTATION 3: Friday 13th October, 1995
10.45-11.15 h.

TITLE: Retrospective review of medical records as a tool to assess compliance to guidelines - examples from management of hyperlipidaemia in general practice.

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Aims, methods and results: A randomized controlled trial (randomization by group) was conducted to evaluate the effects of non-commercial treatment information through group 'detailing' by pharmacists on the management of hypercholesterolaemic patients. 134 community health centres (CHC) with around 570 general practitioners were randomly allocated to an intervention and a control group. Information was conveyed by pharmacists during four group sessions based on national expert guidelines. 321 doctors participated in the information campaign. Effects on knowledge and attitudes were explored through questionnaires to all doctors and interviews with 20 doctors before and after the intervention. Clinical performance was studied through collection of prescriptions from the pharmacies and through a retrospective review of 2883 medical records. The review was performed by research assistants. Thirty-two patients (age: 30-65 years) with hypercholesterolaemia (>6.5 mmol/l) were randomly selected at each of the 112 consenting CHC's and were followed for up to 16 months after the intervention. Only 247 (14%) of 1728 hypercholesterolaemic patients with at least one other risk factor for ischaemic heart disease, were treated with a lipid-lowering drug. There was a significantly higher rate (44% vs. 24%; $p < .01$) of drug treatment for high-risk individuals in the intervention group. Diagnostic investigations and non-pharmacological treatment were also closer to the guidelines in the intervention group.

Hypothesis: Retrospective review of medical records can be regarded as a valid tool to assess compliance to guidelines in general practice.

Discussion points: What criteria should be met by the medical records to fulfill the hypothesis? Can situational factors have such influence on the doctor's performance that they can reduce the relevance of the documentation in the records? What is the validity of the documented data?

Relevance: Improvement of practice performance is the main objective in quality management. Assessment of data recorded in patient files yields one performance indicator and will probably be even more important in the future with an increasing rate of computerization. Harmonisation of methods is essential when comparing practice performance within a country or between different countries.

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PRESENTATION 4: Friday 13th October, 1995
11.15-11.45 h.

TITLE: Criteria-based reviews.

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Literature reviews are the basis for every empiric research. The huge amount of research papers available for review (e.g. emerging from an automated search) urges for a method for selecting and describing studies in a systematic way.

This study is focusing on the value of criteria for a methodologic assessment of diagnostic research in patients with abdominal complaints in general practice.

On the basis of the critical reading criteria by Sackett et al. nine methodological criteria were elaborated.

The criteria are:

Was the setting of the study relevant for general practice?

Was the disease clearly defined?

Was there a reasonable variety in severity of the diseases (spectrum) in the case group?

Was the source and selection of the patients be adequately described?

Was the reference ('gold') standard appropriate?

Were the interpretations of the reference standard and of the diagnostic test applied independently?

Was the inter- and intra-observer variability of the recorded symptoms measured?

Was the study is described clearly so that others can repeat it?

Were the data-analysis, statistics and presentation adequate?

These criteria were then applied to papers for six separate reviews and 69 studies were selected from on-line Medline search.

Two reviewers scored if studies met the criteria. Disagreements were discussed until consensus was reached.

All criteria appeared to discriminate separate studies. The assessments showed a lot of methodologic deficiencies including patient selection, lack of blind comparison to a gold standard, test population, definition of diagnoses, the lack of less severe outcome's. The quality of the studies reviewed is not obviously related to the results of the studies.

It is concluded that these methodologic criteria are helpful in omitting research papers and they therefore promote the accessibility of the best papers.

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PRESENTATION 5: Friday 13th October, 1995
11.45-12.15 h.

TITLE: Virtual outpatients a revolution in the referral process - a feasibility study.

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Research Hypothesis: Video conferencing is no better than conventional outpatient consultations.

Methods: Literature review

- Feasibility study to pilot the technology and evaluation
- Proposal for Randomised Controlled Trial

The presentation will focus on the feasibility phase with one slide listing the key features, it will be introduced along these lines:

What is the main idea/hypothesis to be discussed?

Will videoconferencing become a useful alternative to conventional outpatient referrals? Video-conferencing technology is now available off the shelf at prices already comparable with other high tech office hard ware. Prices will fall. There is an opportunity to evaluate its potential use, and influence its application in health care. It may provide a platform to redefine methods of providing specialist advice in a way that the telephone has failed to do. Outpatient referrals are a major area of activity, with 40 million consultations a year in the UK. A third of referrals are for reassurance and another third simply to access a specialist investigation or procedure. It is possible for these consultations to be held in the GPs surgery, with the specialist on screen.

What is the study methodology?

- Literature review: using personal contact with other key players, including in industry, electronic searches of general databases such as Medline, and specialist telemedicine

databases available over the Internet.

- Feasibility study: units are installed at two North London hospitals and six group practices, two of which are fundholders. The total fundholder at present does not primarily use either of the participating hospitals. Consultants in the following specialities have agreed to participate: psychiatry of old age, ENT, O&G, gastro-enterology, endocrinology, oncology, dermatology, medical physics and orthopaedics. Consultations will be trialed in three different modes: instant dial up, scheduled, and stored like mail. A health economist will advise on data collection for an evaluation of costs and benefits. Training needs and other operational requirements will be explored.
- Proposal for Randomised Controlled Trial.

What do I hope to get out of the presentation at EGPRW?

- Constructive criticism
- Individuals expressing interest with relevant knowledge and skills
- The prospect of a presentation concentrates the mind

How is this relevant to the gp at an international level?

- There are Institutes of Telemedicine in several countries such as N Ireland, Norway, France and several US states so there are opportunities for GPs to get involved academically in this field in several countries already.
- The project will explore whether new technology can improve communications between primary and secondary care which has relevance internationally
- International technical teleconferencing standards exist and the project would welcome links with other researchers in the field.

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PRESENTATION 6: Friday 13th October, 1995
13.30-14.00 h.

TITLE: The RAMBAM - Israeli Family Practice Research Network.

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The RAMBAM - Israeli Family Practice Research Network, founded in 1992. The Network is an organization of 80 family physicians from throughout Israel who work cooperatively on research projects of health policy and primary care interest. The Network established by-laws and acts according to them. Research projects must originate with members, who are involved in all stages of the research - from planning to write-up.

Governance is coordinated through a Steering Committee, composed of a chairman, a coordinator, the head of the Israeli Health Policy Center, a scientific consultant as well as four regional and three member representatives. The Network is supported by an Health Policy Center and the Israeli Association of Family Physicians.

The major development has been the completion of several research projects: "Law Back Pain in Family Medicine", "The prevalence of Sexual abuse among Family Practice Patients", Referrals by Family Physicians to Specialists and Patients opinion, Quality Control of Physician Practice. Other projects that are in various stages of piloting or execution include Headaches, Depression in Primary Care, Osteoarthritis of the knee, Women's Health Issues and Nurse-Physician Working Relationships. The law Back Pain Project looked at the epidemiology of LBP as well as patient models of pain in relation to variety of outcome variables.

230 cases were collected and the most remarkable finding has been the benign nature of LBP in terms of work loss and function. The sexual Abuse research examined the prevalence of previous sexual abuse among adult patients attending family medicine clinics from around the country. Outcome measures included mental status, functional status and depression. The results showed that one in three women and one in six men has been sexually abused. There also appears to be a relationship between a history of sexual abuse and current functional status and mental health. The referral project has collected data on 1200 referrals out of 12,000 encounters.

The Network members meet twice a year. During these national conferences they present the topics, discuss them in working groups and organize the group that will take part in the research project.

During the conference, the Network Members also participate in research workshops and lectures. The aim of the Network is both to do research and to train each member to be an active researcher.

Future activities include linkages with other national and international networks.

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PRESENTATION 7: Friday 13th October, 1995
14.00-14.30 h.

TITLE: Eurosentinel: development of an international sentinel network of general practitioners.

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The Eurosentinel project (1988-1991) was a European concerted action. The objectives were the following:

- To encourage and assist in the development of sentinel networks in as many member countries as possible.
- To start international recording of conditions in which there was a specific international interest.

The ultimate goal was to establish a very European network of sentinel practices.

Methods: Conditions for the international recording of health problems had to fit into the GP's daily practice, they should have a potential impact on public health and medical care, but the workload had to be in conformity with the ongoing activities of any participating network. The following conditions were recorded internationally: measles, mumps, HIV-antibody tests and influenza-like illness. Also a one-month descriptive study on laboratory tests was done.

Results: In the study on laboratory tests, the number of encounters per week was the most (negatively) associated with the rate of the blood test. The inter country differences were the strongest discriminating factor, possibly associated with organisational characteristics of the health care system. The information on the incidence of measles and mumps, was useful to evaluate the impact of vaccination policy. The registration on HIV-tests showed differences in the frequency of testing, as well as in the reason of testing. The collection on the consultation rates of influenza-like illness on a European level, can be used as an early indicator for an influenza epidemic.

Discussion: In the Eurosentinel project, important data on general practice were recorded. The heterogeneity of the networks is however considerable. Diagnostic guidelines were not the same in all networks. In the participating countries different denominators were used; a population denominator is to preferred. Even when using GP's as denominators, it

is necessary to make good definitions of a GP and a usual pattern of consultations. Another problem involved the different ways of expressing the results (per 100.000 inhabitants, per 100 encounters or per GP). The Eurosentinel project was an important support for the development of several sentinel practices and it encouraged international cooperation. The latter is still continued in the field of HIV-test prescriptions and influenza surveillance.

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PRESENTATION 8: Friday 13th October, 1995
14.30-15.00 h.

TITLE: Morbidity Registration in General Practice.

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In discussions on registra-tion of morbidity in general practice it is not infrequent-ly suggested that one uniform registration system should generally be adopted. However, this is contradiction with the principle that specific aims often need specific methods. There is no reason that this would not apply to registration of morbidi-ty.

Recording and registration of morbidity are can make important contributions to ;

- health care
- medical education
- postgraduate training and quality improvement
- policy making: for the profession; for the government; or for financers
- research: exploration/orientation; based on the system's database; or specific questions needing additional research based on a sample from the system.

Clearly, for and even within all these application fields specific requirements can be formulated which have consequences for the contents and the design of morbi-dity registration systems. For example, demographic representativeness and a complete contact registration may be is impor-tant for monitoring local or national primary care and for cost-of-illness evaluations, but not so much for a case control study rando-mised

trial based on a patient sample from a problem list oriented system. For the follow-up of a nation's health status it may be most efficient to carry out a series of cross-sectional surveys over time, while for the study of the course of chronic illness a continuous registration is needed. And to describe actual care, no diagnostic criteria or standardization of follow-up should be defined in advance, while on the other hand a morbidity based general practice sampling frame may need such criteria or standardization in order to warrant its validity.

In general, we can take the position that most important field of application and objectives for a system should be defined before its design and methods (framework, basic data set, software and hardware) are developed for this specific context.

In addition, important topics needing more attention in the near future are:

- development of the specific methodology needed to achieve effective and efficient harvesting of valid knowledge from morbidity registration systems, satisfactorily dealing with numerous potential biases;
- refinement- of analysis methods in order to deal better with with complex longitudinal databases;
- and last but not least: development of the potentials of the fascinating mutual rapprochement of computerized practice recording for individual care and registration on aggregate levels, using advancing technology.

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PRESENTATION 9: Friday 13th October, 1995
15.15-15.45 h.

TITLE: Study " PHARE "
Pharmaco-epidemiology in general practice.
Comparison between a group of g.ps. Chosen at random and a group of g.ps. Belonging to a research network.

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As often in an epidemiological study in general practice, the pharmaco-epidemiological study "PHARE" was faced with a problem of choice: either to select a group of G.P.S. chosen at random or to select a group of G.P.S. belonging to a research network . We decided to select both and the comparison of the two groups became one of the most important secondary objective of the study.

12 G.P.- coordinators were selected to manage 10 G.P.S of each group. They had to contact them regularly during the study and to assure that the double of prescriptions were sent, that the patient had sent back the questionnaire at the end of the treatment and that the G.P.S. answered the pharmacological document. On the whole, all the 120 G.P.S. of the network and 100 out of 120 of those chosen at random included patients.

The comparison was made on the characteristics of the G.P.S., on their patients included in this study, on their prescriptions as well as on their confirmed side effects. The two groups were also compared on the missing datas.

The network G.P.S. formed an homogeneous age group of an average 43 years old, they were often in group practice and were active in professional training. They conducted as many consultations, but less visits than those selected at ran-dom(1170 to 1554).

No difference was detected on the patient profiles.

The volume of prescriptions (3.25 vs 3.32 drugs per patient) differed slightly: the network G.P.S. prescribed less cardio-vascular drugs (22% vs 25% in volume) , a little less metabolic drugs (7.3% vs 8.7%) , a little more gastro-enterological drugs (9.4% vs 7%) and antalgics (10.2% vs 9%).

No difference was detected between the two groups as far as side effects were concerned, validated or not. The group of G.P.S. selected at random showed twice as much essential datas missing as the network group, 27.4% vs 11.4% for drugs responsible for validated side effects and 23.6% vs 10.6% for causality.

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PRESENTATION 10: Friday 13th October, 1995
15.45-16.15 h.

TITLE: A computer assisted method for consecutive patient identifica-tion for research in the out of hours service.

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Introduction: A Danish reform in the out of hours service with extensive use of computers has previously been described at an EGPRW meeting.

Aim: To describe a computer assisted method for consecutive patient identification, and to present results from a study concerning necessity and transfer of contacts in the deputizing service in Denmark in 1994.

Methods: Three research modules were connected to the GP's computer. The first module delimited the research cohort (eg, age range, sex). The second module included patients by random selection at the end of the record typing (eg, one out of five). The third module was a screen with defined inclusion criteria (eg, prescription of opiates). A computer screen with specific research questions appeared after the patients had been selected. These had to be answered before the GP could continue to the next patient. Answers and data about the patients were automatically downloaded. Supplementary, questionnaires to the included patients were mailed the following day. Address labels were made automatically by the computer.

Results: The third module was used in a project concerning patients in pain. The response rate was 74%. The first and second modules were used in a survey where necessity and the possibility of transferring of out of hours contacts to daytime were estimated by GP's and patients. Ninety-one percent of the GP's participated. Twenty-five percent of all contacts were assessed of a lower degree of necessity. According to the GP's, contacts concerning children and the older patient population were considered of highest necessity. Thirty percent of the contacts were patients with symptoms during daytime but without contact to a doctor during the previous 48 hours. Regarding these contacts 25% (GP's) respectively 45% (patients) could have been prevented.

Discussion: The high response rates show that it is possible to get GP's to participate in research if the questionnaire is a part of the normal computer routine and if the questionnaire is not too time-consuming. Some contacts to the out of hours service could have been prevented according to GP's and patients.

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PRESENTATION 11: Friday 13th October, 1995
16.15-16.45 h.

TITLE: The role of oak pollen in hay fever consultations in general practice and the factors influencing patients decisions to consult.

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A structured questionnaire survey of 364 patients from four South Birmingham general practices consulting with hay fever between 4-4-1994 and 5-8-1994 was undertaken to examine symptomatology with reference to available pollen data. Weekly consultation rates were compared with pollen counts from MAARA (Midlands Asthma and Allergy Research Association) at Derby. Consultations were divided into 2 periods: Early (day 1-60) and Late (day 61-124) and responses to the questionnaires were examined in the two periods. Data were also examined by age.

Of the 364 subjects 38% consulted in the Early period and 62% in the Late period (Fig.1). 20% of patients consulted and 41% developed symptoms prior to day 40 which was the start of the grass pollen season. 91% of patients who consulted in the Early period and 99% of those in the Late period had already experienced symptoms.

Most patients who consult with hay fever do so because they are experiencing symptoms and only a small proportion perceive their decision to consult as being influenced by information on hay fever in the media. This media effect was noticeable in the age group 0-14 years where 23% felt they had been influenced. Hence early consultations for hay fever are largely a true response to symptoms. The early new episodes of hay fever reported by the Weekly Returns Service (1989 to 1995) coincided with oak pollen (Fig.2).

This work utilises three data bases; (1) A questionnaire survey based in four practices, (2) Data from the Weekly Returns Service (RCGP Sentinel Network) which corroborates the timing of questionnaire responses from the practices and also provides information from other years, (3) Pollen data from MAARA. The analysis of these data bases combined

allows us to conclude that in England and Wales oak pollen causes significant hay fever symptoms prior to those attributable to grass pollen.

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PRESENTATION 12: Saturday 14th October, 1995

8.45-9.15 h.

TITLE: "What if the patient is right?"

A study of a doctor's and his patients' interpretations of symptoms as pre-sented during the consultation compared to the long-term outcome of the disease.

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This study was inspired by patients who, as it turned out, knew better than the doctor regarding the medical interpretation of their own symptoms.

Introduction: Physicians, having spent many years studying medical science and practising medicine, often feel that a doctor is the best judge of patients' symptoms and which procedures should be followed.

Nobody who sees a doctor is, however, without knowledge and experience. Patients have spent all their lives learning the way their own body functions and reacts. This knowledge, as a rule, is subconscious and stored in the body itself and has been named intuition and tacit knowledge. It is difficult to describe in words, and reveals itself mostly in non-verbal behaviour.

Eliciting patients' own views on the nature of their illness and which steps to take may therefore be a way of revealing the patient's unspoken knowledge, thereby helping the doctor to understand the patient's problem.

Objective: To study the doctor's and his patients' interpretations of symptoms as presented in the context of the consulting room and to compare these with one another, and with the long-term outcome of the illness.

Design: Consultations were videotaped. The patients were interviewed 3-6 months later and their medical records were summarized.

Setting: The author's general practice in a small town in northern Norway.

Subjects: All patients over 15 years of age consulting the author and presenting a new symptom, provided that the patient had given consent for videotaping.

Outcome measures: The doctor's diagnosis as noted at the end of the consultation and the patients' views as recorded on the videotape; compared to the doctor's diagnosis after a review of medical records and the patients' views given at a follow-up interview, both taking place 3-6 months later.

Results: Preliminary results will be presented orally at the EGPRW meeting in Dublin October 1995.

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PRESENTATION 13: Saturday 14th October, 1995
9.15-9.45 h.

TITLE: Patient opinions of direct referral to specialists and the role of the family physician.

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Introduction: There are ample studies cited in the literature that analyze the proportion of and reasons for referral to specialists, and the quality of communication between specialists and primary care physicians. But to date, no study has examined the central assumption on which decisions about maintaining or eliminating the "gatekeeper" role are based: patients' opinions about direct access to specialists, and about the desired role

of the family physician.

The goals of the study were to examine the current extent of direct referral to specialists, and patients' opinions about direct referral and about the role of the family physician as physician of first contact.

Methodology: The study was conducted among members of KHC in Jerusalem, a centrally-located urban area where there is competition among sick funds, and in the northern valley region, a peripheral, rural area where KHC has a very large market share. In each region, interviews were conducted with a random sample of patients visiting primary care facilities and specialists' facilities (ENT, dermatology, orthopedics, neurology and cardiology). Interviews were conducted randomly, during all hours of clinic operation. All patients visiting the clinic at the time of the interviews were interviewed. The interviews were conducted by trained research assistants using a detailed questionnaire that included demographic information and questions concerning the patients opinion of direct referral to a specialist, the role of the family physician and satisfaction with the family physician and specialist.

Results: 1.775 respondents were interviewed, providing an 82% response rate. Of the total sample, 57.7% preferred to turn directly to a specialist and 42.3% preferred to be referred through their primary care physician, whether he was a family physician, general practitioner or pediatrician. A multivariate analysis indicated that the preference for direct referral to a specialist was significantly correlated to young age ($P=0.0053$), high education ($P=0.0008$), dissatisfaction with the primary care physician ($P=0.0000$). Sixty two percent of those who preferred direct referral claimed that their reason was the saving in time and bureaucracy, while 19% claimed that the specialist was more of an expert in their eyes than the family physician. Sixty seven percent of those preferring to be referred to a specialist through their family physician stated that the family physician knew them and knew better to which specialist to turn, while 22% stated that they wanted to hear the opinions of their family physician, and were accustomed to turning to him. Sixty three percent of the respondents claimed that they preferred being able to turn first, and at any time, to their family physician with the majority of their problems. Preference of the primary care physician as the first contact for the majority of problems was significantly correlated (based on a multivariate analysis) with age over 44 ($P=0.000$), having an independent physician as the primary care physician ($P=0.02$), and satisfaction with the primary care physician ($P=0.000$).

Because satisfaction with the primary care physician was found to have a significant impact on patients' preferences, a linear regression analysis was conducted to analyze the correlates of satisfaction. It was found that satisfaction with the primary care physician was correlated with age over 44 ($P=0.04$), residence in the northern valley region ($P=0.0076$), and specialization in family medicine ($P=0.0001$).

Conclusion: The findings are relevant to policy-makers in Israel and in other European countries which are debating how to balance pressure to contain costs and maintain the family physician as gatekeeper, with patients' preference for direct access to specialists. In spite of competition, which can lead to the adoption of direct access - sometimes

presented as being advantageous and representing better service - analysis of patients' preferences shows that family physicians can be marketable as a first "address" for patients, especially if they are perceived as high quality physicians, and if further referrals can be made quickly and efficiently.

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PRESENTATION 14: Saturday 14th October, 1995
9.45-10.15 h.

TITLE: The breakdown of adaptability. Sexually abused women experiencing childbirth.

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Within the frame of a research project in the interface between science and the humanities, 30 female incest survivors between 16 and 70 years of age have participated in 90 to 180 minutes audiotaped face-to-face in-depth interviews about their experiences from meetings with physicians and health care workers in different settings. The interviews have, among other aspects, been analyzed with regard to the women's communications about pregnancies and deliveries.

Excerpts from the verbatim transcribed dialogues will be presented to allow insight into my analytic approach to the specific context of highly conflict-loaded situations linked to interactions with representatives of the health care system.

An embodiment of hidden sexual assault and an idiosyncratic adaptation to incompatible realities in the wake of social taboo violation seems to offer a certain kind of trap for sexually assaulted women when having become pregnant and giving birth. A delivery is in general a situation of unknown danger. Being dependent on other's help and being forced to expose one's body to strangers enhances vulnerability. Give them access and rely on their respect demands great confidence. Consequently, this may represent one of the most threatening situations for women with abuse experience in general, and sexual abuse in particular. The obvious conflict between their actual need for help and their

habitual strategies for avoidance may lead to an overload of impulses, resulting in a breakdown in clarity about time and space, where "there-and-then" becomes confused with "here-and-now". Such states of confusion rooted in untold sexual trauma are perceived as indicating mental illness, leading to what might be called mistaken psychiatric interventions.

A debate of the theoretical framework for psychiatric diagnoses might be appropriate in this connection.

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PRESENTATION 15: Saturday 14th October, 1995
11.00-11.30 h.

TITLE: Home visit Request Survey

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Hypothesis: A group of Family Physicians providing Primary Care from Paola Health Centre, are of the opinion that Home Visits are requested too frequently and for trivial complaints, and that a number of home visits requested could be dealt with more efficiently at the health centre. Thus a questionnaire was designed in order to test the following points:

1. To quantify the number of home visits dealt with at Paola Health Centre.
2. To determine which type of illnesses require home visits.
3. To determine the quality of requests for home visits.
4. To determine whether the home visits requested are necessary or whether they could be dealt with at the Health Center.
5. To determine whether vetting of home visits by a doctor improves efficiency.

Methodology: During a period of four weeks from the 12th June to the 9th July 1995, all the home visits requested at Paola Health Center will be dealt with as usual, but a questionnaire is to be filled up for every home visit attended.

Presentation at EGPRW: By means of this presentation, I wish to highlight some of the difficulties the Maltese Family Physician has in his everyday work, and to stimulate further international studies about home visits in family practice.

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PRESENTATION 16: Saturday 14th October, 1995
14.00-14.30 h.

TITLE: Ensuring anonymity in general practice surveys.

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Obtaining good response rates from randomly selected general practitioners in research surveys is difficult. General practitioners are increasingly targeted by researchers and they complain of survey fatigue. Yet poor response rates lead to poor quality research and the inability to generalise findings. One approach to increasing response rates, particularly in surveys involving sensitive topics, is to use anonymous questionnaires. However, such questionnaires suffer from the inability to differentiate between responders and non-responders. We wish to describe a method being used in Ireland in a national survey of stress and morale among general practitioners in the Republic of Ireland and in Northern Ireland. The method is designed to ensure complete anonymity yet allows the identification of responders and nonresponders

Anonymous questionnaires are being sent to a sample of 900 general practitioners selected at random from all general practitioners in the Republic of Ireland. Included with the anonymous questionnaire is a small numbered reply card. On the card is a statement indicating that doctor has returned a questionnaire. Doctors are requested to sign or stamp this card with their practice stamp and return it in a separate stamped addressed envelope provided. The covering letter which accompanies the questionnaire assures the doctor that there is no link between the reply card and the questionnaire. Knowing which doctors

have and have not returned reply cards will permit us to send a second and third reminder only to non-responders thus decreasing our survey costs. More importantly, the ability to identify reluctant re-sponders and nonresponders will allow us to assess the possibility of non-response bias. It is hoped that this method will improve our response rate thus allowing us to obtain meaningful and generalisable findings.

By presenting this work at the EGPRW we hope to inform our colleagues, gain experience from others who have worked in this area, and raise the issue of responsrates from general practitioners.

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PRESENTATION 17: Saturday 14th October, 1995
14.30-15.00 h.

TITLE: Qualitative research with an interpreter in general practice.

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People from ethnic minorities are not fluent in the main language of the country to where they have migrated, due to many factors such as ethnicity, education, class, gender, age and geographical location after migration. However, access to services, including health services, depends on the acquisition of this language. Communication is often only possible with the use of an interpreter. Whilst interpreters are used in increasing numbers for provision of services, their use in research is often barely acknowledged, if they are used at all. There has been little written about the use of interpreters in Primary Care Research. Such a way of working is not unproblematic, but can enrich both the process of the research and its outcome.

I will present results of working with an interpreter in a small qualitative research project, involving twenty women from South Asia (predominantly Muslim women from Pakistan), who were between the ages of forty and sixty. The research was looking at middle-aged

South Asian women's attitudes to and knowledge of the menopause and hormone replacement therapy. I worked with a local woman, trained as a nurse who spoke fluent English, Urdu and Punjabi, and who had been trained prior to the project in research techniques. Undertaking the interviewing was very much a collaborative, interactive process, and we found it impossible to work in a traditional way of interviewer/translator. Using an interpreter meant that language was no longer a problem for the women being interviewed. Because of this, we were able to explore more contextual factors that influenced some of the women's health behaviours, and found that cultural factors, access to information and issues of race and gender were often as important as language problems.

In a multi-cultural Europe, other GP's performing research finding ways of hearing the voices of people who do not speak the predominant language is a pressing need; there are many potential ways of finding out what ethnic minority groups have to say, and an interactive method of using an interpreter or advocate is one method that I think would yield great dividends. I hope to hear how other researchers have tackled similar situations.

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PRESENTATION 18: Saturday 14th October, 1995
15.00-15.30 h.

TITLE: Evaluation of the effectiveness of an intervention with alcohol problem drinkers in General Practice.
Emgam-eva study.

AUTHOR(S): Dominique Huas
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Introduction and aim: A controlled and prospective study will attempt to measure the effect of a simple intervention for problem drinkers by comparing patients in two groups,

the treatment group where physicians have had specific training in the intervention and the control group of the usual practice setting. The study goal is to demonstrate that G.P.s with specific training are able to intervene in a population of problem drinkers more effectively than those without training

Method: 100 G.P.s have been recruited in 5 french areas. Doctors are chosen at random for training. The patients included are male problem drinkers over 18 and less 65 years old.

Assessment of the efficacy must focus on the modification of the patient's behaviour with regard to their consumption of alcohol and their need of medical care. To assess the long-term effects of this intervention, a three year follow-up program has been planned.

Control group: the 50 G.Ps have only been learned to identified the problem drink-ers and to prescribe biological tests (GGT, MCV) The patient will be tested again every year.

Intervention group:

The training of the 50 doctors : during a two days training course, the main themes of alcoholology and the strategies for motivating problem drinkers were deal with.

The therapeutic project: the same selection process as that of the control group was used for selecting suitable patients. Then a short (10 mn) intervention is done with all the patients which centers on the importance of reducing the consumption of alcohol to less than 28 drinks per week.

Judgement criteria for assessment

Self declared consumption of alcohol

Biological tests : GGT, MCV

Morbidity

Mortality

Need of medical care

Conclusions: During the meeting in Dublin, I will be able to present the first results about the applicability of the protocol.

Reason for presenting at EGPRW: Although the study has started in May 1995, we need to receive your opinion about our protocol.

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PRESENTATION 19: Saturday 14th October, 1995
15.45-15.55 h.

TITLE: The self traction: comparative analysis of the treatment effects.

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Introduction: In October 1994 I introduced a new treatment method for painful conditions connected with cervical and lumbal spine areas. I called the method the self traction. The method was performed by 155 patients. After the treatment 82% (n:0,001) of patients stated that the pains had diminished.

Because the results of this research were satisfying I carried out a new research. Within this research I compared the self traction method and the classical extension treatment combined with some other methods of physical treatment.

Method: 50 patients with pains in the cervical and lumbal spine areas performed the self traction for 14 days. The other group of 50 patients was treated by the classical extension method. Also for 14 days, I measured the relevant clinical pa-rameters before and after the treatment, then I made statistics.

Results: If I compare the research results of those treated by the self traction and those treated by the classical extension method, the difference in statistics isn't really noticable. However, the patients treated by self traction claimed the method to be efficient. The method showed up to be equal to the other physical treatment of the painful conditions in the cervical and lumbal spine areas.

Discussion point: The research shows that the self traction treatment is a succesful method of curing the painful conditions in the cervical and the lumbal spine areas. If the following researchers of this method confirm the previous results, the self traction could be used as an additional method of treatment in general practice.

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PRESENTATION 20: Saturday 14th October, 1995
15.55-16.05 h.

TITLE: How can patients appreciate benefit and quality of medical procedures? The "Therapeutical Index" a kind of guideline structure for doctor and patient.

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Background: Not only in Germany patient act more or less passively like clients of a 'welfare state', rather than like sovereign consumers.

Current practice: When the patient hands in his or her health insurance chip card to the physician, automatically a legally valid, albeit implicit service contract is accepted between the two. In order to be able to execute his or her right to self-determination, the patient needs to be fully informed about the recommended procedures, i.e. about the therapeutic index (TI) as the relation between potential benefit and possible harm ensuing from treatment or non-treatment, resp. In theory, the patient should also know whether his or her primary physician - or a consulted specialist - has been obtaining regular post-graduate training in the subject of the actual consultation, and what the treatment rates, the success rates, and the failure rates achieved by the individual physician have been regarding the condition in question. Such information would, besides certain other necessary conditions of the physician-patient-relationship, allow a patient to realise his right to self-determination. Other conditions relate to the personal bond between physician and patient, to a trusting relationship, and to transparency of the reimbursement procedure.

Prospect: In addition to efforts to improve quality assurance on the part of the service providers, also patients must be encouraged to take an interest in the benefit and quality of medical services. Non-profit consumer service should increase their offers to help patients develop individual responsibility and initiative. Knowledge and understanding of prices, costs, and the principle limitation of health care resources could lead to more solidarity than can currently be observed.

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PRESENTATION 21: Saturday 14th October, 1995
16.05-16.15 h.

TITLE: Utility and problems in the spirometry.

AUTHOR(S): Mate García Xavier, Pañart Sánchez, Xavier
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Spirometry can be done in any Primary Health Care Center (PHCC), but in actuality problems are commonly observed in the accomplishment and the interpretation.

Objectives: Describe the main technical problems and the diagnostic utility of spirometry in primary care. Also to explain the relationship between spirometry and subjective symptomatology of patients.

Design: A descriptive, retrospective study from 1991 to 1994.

Setting: TERRASSA NORD 32.000 inhabitants covered by a PHCC.

Participants: All the spirometries done in this PHCC during the last four years.

Measures and interventions: Spirometries, without broncodilatador trial, made with a Vitalograph alpha spirometre following the SEPAR (Sociedad Española de Patología del Aparato Respiratorio) protocol (FVC, FEV1, FEV1/FVC, variation between curves, logarithmic graphic errors) done by four assistants without any specific preparation or any medical supervision. Before the spirometry a questionnaire was completed regarding respiratory symptoms (cough, expectoration, dyspnea). The results were coded and processed by SPSS v. 4.0 with the X2 test.

Main results: 629 spirometries were done (525 patients). The average age was 52,4 (SD 17,8) with a majority of men (62,4%). 45,8% of trials were incorrect because of: incorrect patient characterization (27,2%), >5% variation between curves (10,8%), logarithmic graphic errors (7,8%). Of all properly completed, 38,7% proved to be pathologic (13,5% obstructive, 25,2% mixed, without any restrictive).

The most frequent respiratory symptoms were: dyspnea (66,3%), and cough with expectoration (42,8%) which have demonstrated a significant relation with a pathologic spirometric pattern ($p=0.003$ and $p=0.033$ respectively).

Conclusions: The high percentage of erroneous spirometries, caused by a lack of preparation and medical supervision transforms a useful test into a misleading one. Conversely, a properly performed spirometry shows a close relationship between

symptomatology and pathologic results. The authors believe that spirometry should not be used if quality control can not be ensured.

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PRESENTATION 22: Saturday 14th October, 1995

16.15-16.25

TITLE: Women's complaints against their husbands in general practice.

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The health and disease are strongly connected to physical and social environment. The human relationships have strong influence in the outcome of illness. The knowledge of the family context and its function provide advantage on the GP/patients relationship. The decline of the extended family, women working outside the family and the changes in the family members roles changed behaviours and relationships within the family. Family problems often arise from lack or difficult communication (special feelings communication). In a patriarchal society often women don't express their feelings or express through psychosomatic complains.

A GP/Family Doctor has an important role on family care and preventing family distress. Women's complains against their husbands are frequently referred to their family doctor. The author studied the complains referred by the women who attended her consultation. Some of the most important complains were: communication problems, sexual problems and violence.

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PRESENTATION 23: Saturday 14th October, 1995
16.25-16.35 h.

TITLE: About Legevakthåndboken.

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Legevakthåndboken ("The Clinical Handbook for Out of Hours Medical Care") is a comprehensive, yet compact, reference handbook for doctors on call outside of surgery hours.

At the moment the book is the best-selling medical text (in Norwegian) in Norway. We see this as an indication that many colleagues perceive delivery of out of hours services like we did when we decided to write the book - as one of the most challenging aspects of modern primary health care.

In no other clinical context do general practitioners meet a less selected patient population. Time constraints may be considerable. Quick decisions are often required. The diagnostic process may have to build on clinical observations alone, and the doctor must in many cases initiate therapeutic procedures without the support of laboratory results or technical devices. In most instances there are no colleagues available for advice or discussion.

Providers of out of hours services are consequently required to have excellent clinical skills and a good general theoretical overview in order to do a good job. It is however impossible, even for the most experienced of physicians, to be fully up-to-date in all medical fields at all times.

We therefore felt a need for a handbook for doctors on call outside of surgery hours. The book would have to be sufficiently concise and compact to fit into the back pocket of a doctor's bag, yet comprehensive enough to answer most of the questions that may arise during a night on call. The result of this process was the creation of Legevakthåndboken.

Reviews have stated that, given its broad scope, Legevakthåndboken is a unique and comprehensive handbook for doctors providing out of hours services. The reader can quickly find central information about clinical pictures and problems, and the book describes symptoms, findings, investigations, differential diagnoses, complications and treatments for a broad range of conditions.

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PRESENTATION 24: Saturday 14th October, 1995
16.35-16.45 h.

TITLE: Anaphylaxis: rarely seen, but seldom forgotten.

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A telephone survey among a random sample of Flemish GP's was carried out end 1994. They were questioned about their experiences with IM/IV injections on the subject of anaphylaxis.

Out of a population of +/- 6000 Flemish GP's, we selected at random 466 GP's. 396 were true GP's, and 8% of them didn't respond.
All of them gave IM injections, 4/364 didn't give IV injections. 2/364 gave more dan 40 IM/wk, but one of them did it in relation with ozon-therapy.
82/364 (only with IM), 12/364 (only with IV), 3/364 (both IM+IV) encountered a life endangering reaction. 90 cases were reported to be anafylactic reactions. We suppose that there is an overreporting.
31/364 (on AB), 14 (on NSAID), 9 (on ACTH) were the most common products reported giving trouble.
5/97 people died.

Conclusion: Although anaphylaxis is are rare phenomenon, it is a disrupting experience for doctor and patient. Luckily, most survive.

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PRESENTATION 25: Saturday 14th October, 1995
16.45-17.15 h.

TITLE: Research in family practice: possibility or necessity?

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Independence of Family Medicine as a new discipline is debated in some countries, and in Hungary as well. In the same time the family physicians became more and more important participants in the health service. For the acceptability of the family physicians is basically needed to describe the essentials of Family Medicine and to collect special information about the work and tasks of basic health service. These information could be based on special research in family practice. The other aspect of the research done by family physicians is the connection between the research and teaching of Family Medicine.

In Hungary different research activities were realized from the independent self-motivated studies until the large research groups during the last two decades. Morbidity, mortality studies, cross-sectional investigations, drug utilization, quality assessment, or other very special family oriented one were made and published. The results were directly or indirectly influenced by the improvement of Family Medicine, the effectiveness of daily work and/or teaching and learning of the new discipline. The results of the previous studies and the special task in connection with research in Family Practice in the near future will be summarized. The national experiences have some debatable questions and possibilities of the international contacts and collaborations will be discussed.

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PRESENTATION 26: Saturday 14th October, 1995
17.15-17.45 h.

TITLE: An Evaluation of Laboratory Diagnostics Efficacy in Family Medicine.

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One of the necessary directions of scientific investigations in general practice and family medicine is learning of efficacy of diagnostic procedures. Along with the integral valuation of practitioners offered by Jan-Joost Rethans et al (1995), there are other methods which can discover some advantages and disadvantages in the diagnostical methodology of physicians and check the level of their knowledge in the different fields of clinical laboratory diagnostics.

We proposed to determinate the efficacy of laboratory test by the evaluation of the quantity of pathological results in percentage to the total number of analyses (A. Shleikin, Yu. Zubkova, 1995). The studying took place in the Family medicine department of Avalanche Medical Company during 1994-1995 years. According to our data efficacy of clinical blood tests (CBC) for practitioners makes 7.2-14%, of urine tests - 4.3-7.0%; mark here that average efficacy of blood and urine tests fluctuates for different practitioners from 7.1 to 10.3%. Efficacy of smears was found to be: gynecological - 11.5%, urological - 8.9%. Average efficacy of biochemical blood tests is 12%. Of the last are most efficient: cholesterol and bilirubin fractions, creatine kinase, LDH and their isoenzymes (76% to 21%). On the opposite, determination of urine acid, urea, phosphate, creatinine, calcium and triglycerides proved to be less efficient. Low is the efficacy of GOT examination, which is often appointed along with GPT as a screening liver test, though it is known that for that purpose GPT test is enough. Using GOT chiefly in myocardial infarction diagnostics and for valuation of acute hepatitis process might make this test more informative. The fulfilled work has discovered the most high efficiency practically of all types of tests for a physician who has wide experience in hospital work and the least efficiency for a physician who has not been improving his medical skills for rather a long time.

Conclusion: Using this method we can valuate both the general rate of efficacy of diagnostic procedures in a medical institution and the rate of some physicians. This information can help us to check the work of the practitioners and take some steps to improve their skills.

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PRESENTATION 27: Sunday 15th October, 1995
9.00-9.30 h.

TITLE: Frequent attenders to Accident and Emergency departments and their use of general practice services.

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Introduction: Anecdotal evidence suggests a large number of individuals attend Accident and Emergency (A/E) frequently, creating a heavy workload. A/E staff perjoratively label them as problem patients whose attendances are inappropriate. The implied question underlying much of this prejudice is: why can general practice (GP) not deal or cope with these patients. However, their use of GP services is not known.

Hypothesis: High users of A/E departments may also be high users of GP ser-vices?

Aims:

- (i) to identify and describe the characteristics of adult frequent attenders to A/E for a 12 month period
- (ii) to describe their use of GP services
- (iii) to explore their health seeking behaviour

Method:

1. A computerised database of A/E attendances was used to define and identify a group of frequent attenders and controls.
2. Questionnaires were sent to the groups seeking information on their health, their perceived use of A/E and general practice services and incorporating the Hospital Anxiety and Depression (HAD) scale.
3. Consent was sought to extract data from their GP records. This included number of consultations, content of the consultations and outcomes in terms of the number of prescriptions issued and number of referrals made.

Results:

The definition of a frequent attender was 5 or more attendances to A/E in the study period.

401 frequent attenders (0.95% of all A/E attenders) were identified and accounted for 6% of the workload. The response rate from the postal questionnaire was 48% and 30% agreed to a review of the GP records. Initial results suggest frequent attenders differ from controls in terms of higher scores on the HAD scale, greater perceived illhealth and greater use of GP services.

Discussion:

Frequent attenders are common to parts of all health systems and are increasingly becoming a focus of attention in order to understand, rationalise and improve their care. Frequent attenders to A/E are a difficult group to access as low response rates from postal questionnaires and accessing GP records are particular problems. Alternative methodological approaches need to be considered.

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PRESENTATION 28: Sunday 15th October, 1995
9.30-10.00 h.

TITLE: A study comparing the care, in terms of process, outcome and cost, provided to non-emergency A&E attenders by general practitioners, working integrally within the A&E department, and usual medical staff.

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Purpose: To determine if care provided by GP's to non-emergency patients in an A&E department differs significantly from care provided by usual A&E staff in terms of

process, outcome and cost.

Design: A randomised controlled trial.

Setting: A&E Department of St. James' Hospital, Dublin 8. Three local general practitioners were employed on a sessional basis to work in the department.

Patients: All new attenders, not referred by a GP, categorised by the triage system as not having "life threatening" or "urgent" conditions. This would usually mean that 64% of all attenders would be eligible for inclusion.

Main outcome measures: Number undergoing investigation, referral or prescription, type of disposal, Consultation Satisfaction Scores (RCGP validated instrument), one month health status and differences in marginal and total costs.

Results: 4,684 patients participated. For each triage category GP staff, in comparison to usual A&E staff, performed fewer investigations ($p < 0.005$), referred less ($p < 0.005$), prescribed more often ($p < 0.005$) and disposed of more patients to the community ($p < 0.005$). Analysis by presenting complaint, according to triage category, produced similar results.

435 patients (72% of those eligible) completed the Consultation Satisfaction Scores and 258 (69% of those eligible) provided health status information one month after consultation. There were no differences between patients managed by GP or usual staff regarding outcome measurements.

For all patients seen by the GP's during the study period, estimated marginal and total saving were Ir£ 1,976 and 89,777 respectively.

Conclusion: GP's manage non-emergency A&E attenders safely and using less resources.

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PRESENTATION 29: Sunday 15th October, 1995
10.00-10.30 h.

TITLE: Scapulo-humeral capsulitis and diabetes.

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Introduction: Scapulo-humeral Capsulitis (SHC) is a restriction in shoulder movement, usually painful, and 6-7 times more common in the diabetic population. There are few studies designed to evaluate the relationship between SHC, previous micro-vascular complications and glycemic control. The pathogenic mechanism of SHC is unknown however diabetes and microvascular disease are thought to be involved.

Objectives: To measure the prevalence of SHC in the diabetic population cared for at a Primary Health Care Center (PHCC) and compare this with that of a population of diabetics admitted to the hospital. Also, to assess the association between SHC, chronic complications, and glycemic control.

Subjects and methods: All diabetics (n = 408) followed by five Primary Care Units (PCU) of the PHCC. Diabetics admitted to or seen by the Endocrinology service of the reference hospital during the period from March to December, 1994 (n = 80). A prospective evaluation was made of various demographic variables, risk factors for SHC, length of time since diagnosis of diabetes, type of treatment, and the existence of other micro-vascular complications. A physical exam was done to detect SHC and glycemic control was assessed.

Results: The prevalence of SHC in the PHCC was 3.4 % (n = 14), while among hospitalized diabetics, 7 cases were detected (9% of the total). The presence of SHC in the hospital setting was related to the length of time since diagnosis (p = 0.005), infra-aortic macrovascular disease (p = 0.02), and to diabetic retinopathy (p = 0.07). In the PHCC no relationship was found with any of these variables. Glycemic control and lipid profile showed no relation with SHC in either study population.

Conclusions: SHC is a relatively frequent complication of diabetes which is poorly understood. The fact that no relationship was found between SHC and chronic diabetic complications in the PHCC population, as well as the lower prevalence of SHC in the PHCC compared to the hospital population, could be due to the lower number of chronic complications in the PHCC population. SHC is more prevalent in those diabetics with evidence of chronic diabetic complications.

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PRESENTATION 30: Sunday 15th October, 1995
10.30-11.00 h.

TITLE: Health care system reform in Albania.

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The final goal of the health care policy followed by the Ministry of Health is the further improvement of the health services. The whole health care system, including the preventive measures and the primary and hospital health care institutions, are trying to further develop the various health sectors.

The main aim of the reform is: The improvement of the health services in all the health institutions. A number of measures are taken for the full realisation of this reform:

1. Rehabilitation of all physical structures.

The inherited health institutions were almost completely destroyed and some of them are out of use for the moment. Around 80 percent of the buildings were out of use. Therefore, the carrying out of the health services by these institutions was almost impossible.

2. Medical equipment and apparatus.

Even the most simple medical apparatus were lacking in Albania. The existing equipment were used for around 25 years and could not function properly.

3. Personnel's training.

The specialisation and the qualification of the medical personnel with the present scientific theories is considered to be a priority in our work. The qualification of the directors of the health institutions to lead the reform was very necessary.

4. Compatible forms were to be found that would help the financing of the health system in Albania.

5. The privatisation of the health services was a primary need for the further development of the reform. This would increase the direct financing of the health services and would make the various health institutions compete with each other. Such a concurrence will improve the quality of the health services.

Taking into account the situation of the health services in Albania and the immediate needs that need to be faced, the Ministry of Health designed a platform for the general privatisation of the dental services, keeping the state responsible for the preventive and dental services for ages up to 18 years old. Also, the whole pharmaceutical network

service was privatised, aiming a more complete financing of the dental services and a more complete supplying with the necessary medicines. Evaluating health not just as a lack of disease, and taking into account the fact that the health issues are connected with many other factors apart of the health ser-vices, such as the living and labour conditions, the education, the social-economic conditions, and other biological factors, etc. The Ministry of Health is promoting the medical preventive measures to all state and private institutions, to associations and individuals and to the entire society.

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PRESENTATION 31: Sunday 15th October, 1995
11.20-11.50 h.

TITLE: Is Comprehensive geriatric Assessment (CGA) superior to minimal geriatric assesment (MGA-PC) in a general practice setting?

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Introduction: Comprehensive Geriatric Assessment (CGA) has been shown to be an effectice method to reduce mortality, disablement and excessive health care consumption both in geriatric hospitals and in the ambulatory setting. Based on the experience of our previous research a Minimal Geriatric Assessment for Primary Care (MGA-PC) using a one-page-geriatric-assessment-chart was developed and evaluated in a multicenter study.

Method: 20 general practices documented 1664 patients aged 75 or over for 4 weeks using the geriatric assessment chart. 400 patients stratified for disablement status were randomly assigned to an intervention group with additional CGA and to a control group. The intervention group was assessed including extensive medical history, review of medication, treatment and preventive measures, physical examination and functional tests, ADL and IADL-Status, Hamilton Depression Scale, Hierachic Dementia Scale,

socioeconomic status, housing conditions, heteroanamnesis if indicated, clasification of handicap (ICIDH) and psychiatric disorder (CAMDEX-rating). Examinations were performed by specifically trained junior doctors who wrote a two-page summary of each patient's status supervised by an experienced GP. Results were discussed with the GPs who- as a consequence - could initiate new activities. Within two years all patients were reassessed with CGA.

Results: To our surprise interim analysis of overall functinal status and mortality at follow-up shows no significant differences at the 0.05 level in mortality between intervention and control group (Table 1).

Conclusions: Our findings are preliminary because the full data analysis is not yet available. If a MGA-PC technique is used no additional reduction in disablement and mortality can be reached by CGA. Testing MGA-PC in the international setting is recommended and currently piloted in Spain (J Gervas), the Netherlands (Harm Marvik), England (Steve Illife).

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PRESENTATION 32: Sunday 15th October, 1995
11.50-12.20 h.

TITLE: What constitutes controlled hypertension: a population morbidity assessment of five sets of hypertension guidelines

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Background: Several countries have produced guidelines for the detection and management of hypertension. All differ in terms of the blood pressure level at which treatment is recommended and the quantity and type of cardiovascular risk factors that are assessed.

Aim: This study set out to assess how individual and population control differs when alternative sets of guidelines are followed: UK, WHO, USA, Canadian. The "gold standard" are guidelines from New Zealand which categorise each individuals absolute risk of a cardiovascular event in the following 10 years.

Method: A random sample of 895 Labelled hypertensive patients (known hypertensive patients currently on treatment) was selected from 20 Oxfordshire general practices. Computer-based morbidity data was collected for each individual and risk stratification according to New Zealand guidelines carried out.

Results: A wide variation in the proportion of patients with controlled hypertension occurs depending of which set of guidelines are followed: UK (46.6%), WHO (40%), USA (17.8%), Canada (84.6%) and New Zealand (59.6%). When absolute risk of a cardiovascular event is estimated a large proportion of patients who are deemed to be controlled have a substantial risk of a cardiovascular event, 60.3% according to WHO criteria and 31.5% according to Canadian criteria. Conversely, a large proportion of individuals deemed to have uncontrolled hypertension have a small absolute risk, 50.6% according to USA criteria and 73.4% according to WHO criteria. Age appears to be the strongest independent risk factor for poorly controlled hypertension: 18.3% of the 40-49 age group having uncontrolled hypertension compared to 59.2% of the 70-79 age group.

Conclusion: Calculation of absolute risk allows a more realistic index of likely benefit from anti-hypertensive treatment. Blood pressure measurement should be assessed in conjunction with other cardiovascular risk factors. Some sets of guidelines fail to make a correct estimate of absolute risk of cardiovascular disease in patients with established hypertension.

*This page was last updated on **June 7, 1998***
