

## Vaxjo meeting presentation abstracts

Go to Presentation Abstract number:

[1](#) | [2](#) | [3](#) | [4](#) | [5](#) | [6](#) | [7](#) | [8](#) | [9](#) | [10](#) | [11](#) | [12](#) | [13](#) | [14](#) | [15](#) | [16](#) | [17](#) | [18](#) | [19](#) | [20](#)

[21](#) | [22](#) | [23](#) | [24](#) | [25](#) | [26](#) | [27](#) | [28](#) | [29](#) | [30](#) | [31](#)

[Home Visits Study](#)

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PRESENTATION 1: Friday 10th May, 1996  
9.30 - 10.00 h.

TITLE: Fatigue in the first-year after childbirth

AUTHOR(S): Alm Lagro-Janssens  
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Aim: To gain insight in the frequency and type of health problems, especially fatigue, presented by women in the first year after childbirth.

Method: The study is a historic cohort analysis. Data were used from one of the four practices of the Continuous Morbidity Registration (CMR) of the Department of General Practice at the University of Nijmegen. In this registration every episode of illness is encoded according to the ICHPPC-2. In this study the CMR was used to select the study population. All women with a delivery in the period 1987-1993 were included in the study. The characteristics of the delivery were collected from a registrationform of the

partus, which is obligatory for midwives and obstetricians in The Netherlands to fill in. The health problems from mother and child in the postnatal period were collected from the patient record.

Results: The study population comprised 310 post-partum periods in 227 women. The median age at the moment of delivery was 31,7 years. In the first year after delivery 93% of the women consulted the general practitioner, mostly (75%) because of uro genital problems (including contraceptional advice). One out of four women consulted for symptoms of fatigue. Fatigue was caused in the majority (95%) by mental overstrain and very seldom by diseases such as depression, thyroid disorders or anaemia. Primiparae suffered significantly more from fatigue than "experienced" mothers and women with nervous complaints in their history also consulted more frequently with fatigue after childbirth. The presence of fatigue post-partum was not influenced by the age of the mother at the moment of delivery. Women who delivered at home had less problems of faigue.

Finally, women with symptoms of fatigue more frequently presented with other illnesses and they presented more health problems of their child as well.

Conclusion: Allmost all women consulted their general practitioners in the first year after delivery. Complaints of fatigue were raised especially by primiparae, by women who had not delivered at home and by women with nervous complaints in their history. The general practitioner is in an excellent position to notice these women and to give the support they need.

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[Back to the top](#)

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PRESENTATION 2: Friday 10th May, 1996  
10.00 - 10.30 h.

TITLE: The dynamic attitudes and the balancing of fear and control expressed by women in a qualitative study of womens's attitudes to hormone replacement therapy.

AUTHOR(S): Frances Griffiths.

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The rates of prescribing of hormone replacement therapy throughout Europe and the US vary widely. Therapy is now being recommended for some women for the prevention of osteoporosis and cardiovascular disease. This can be seen as part of the development of prevention strategies and surveillance medicine in primary care. There is a growing interest in the use of qualitative research methods in general practice which was explored at the EGPRW meeting in Dublin 1995.

The aim of the research was to find out women's views on the use of hormone replacement therapy. The researcher had already carried out a postal questionnaire survey of women's attitudes to hormone replacement therapy in Stockton-on-Tees, N.E. England. The current research builds on this work. However it uses qualitative methods to seek a depth of understanding of women's attitudes that survey cannot reveal.

Women willing to be approached for interview were identified in the postal questionnaire survey. This group was categorised using cluster analysis to give subgroups for selecting women for interview to ensure a range of attitudes and experience. Individual interviews were conducted with 17 women, and 22 women attended one of five focus groups. The researcher worked alone throughout. The method of analysis and the interaction between the method of analysis and the results will be described.

The results presented will focus on the issues of fear and control expressed by the women in discussing their health and hormone replacement therapy. The results will also illustrate the dynamic nature of women's attitudes and the experiences that influence women's attitudes. The presentation will explore the way the method of data collection and analysis may have affected the results.

The presenter hopes to attract further reflections and comments on the methodology and the results, and to gain experience in presenting the results of a qualitative study to a medical audience.

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[\*Back to the top\*](#)  
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PRESENTATION 3: Friday 10th May, 1996  
10.45 - 11.15 h.

TITLE: Why young women in Dublin, choose to attend family planning centres for their contraceptive needs.

AUTHOR(S): Mary Smith

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Background: Access to contraception is fundamental to preventing unwanted pregnancies. Understanding what motivates women in choosing contraceptive services, can inform the service providers, may help to improve the services on offer, and ultimately, the uptake of the service.

Aim: The main objective of this study was to assess the factors influencing women, in particular young women, who choose to visit family planning centres for contraception, rather than their general practitioner (GP).

Method: A self administered questionnaire was distributed to all consecutive attenders at a representative sample of clinical sessions of all three centres of the Irish Family Planning Association (IFPA) in Dublin, over a four week period, in 1995. 20% of all clinics were thus involved. 248 questionnaires were completed, representing a response rate of 55%. Of these, 194 women attended on the day for contraception. Their responses form the basis of the quantitative data. Twenty of these women were interviewed prior to completing the questionnaire. These interviews formed the basis of the qualitative data.

Results: (1) More than half the women do not know if their GP offers contraceptive services and have never asked. (2) More than half the women share their GP with other family members and this may mitigate against using their GP for contraceptive services. (3) The specialist nature of the IFPA was one of the strongest factors influencing choice, with over half the women indicating this. (4) The gender of the GP plays a role, but not in all circumstances. One third of the women wanted only a female doctor for contraception, but twice that number wanted only a female for a smear test. (5) The qualitative data showed a strong demand for more information on contraception and sexuality. The assumed anonymity and confidentiality of the IFPA, the sense of privacy and a non judgmental ethos were factors identified in the qualitative data as being highly valued by the women.

Conclusions: GPs who wish to improve the uptake of contraceptive services in their practice should inform their patients that the service is available, reassure women that consultation is welcomed and guarantee the strictest confidence, provide access to a female practitioner for gynaecological examination, and information that this is available, and provide verbal and written information on contraceptive options. There will remain however, for the foreseeable future, a section of women who are committed to specialist centres, and their choice must be respected as well as understood.

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[Back to the top](#)

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PRESENTATION 4: Friday 10th May, 1996  
11.15 - 11.45 h.

TITLE: Health problems of female patients in the centralised primary care centre for out of hours medical care

AUTHOR(S): Arto T. Vehviläinen  
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Introduction: Many European countries, including Finland, are introducing major changes in their organisations of out of hours services in primary care. During recent years in Finland there has been great interest in developing a personal doctor programme with defined lists of patients. We studied whether the list system has any influence on health problems of female patients during out of hours work in centrally organised primary care.

Material and methods: The study was carried out in 1990 before the list system and in 1993 during the list system ---in one health centre of 39 495 inhabitants (in 1993) in central Finland. During the study period, a questionnaire for each out of hours patient was filled in by receptionists in the study area. Name, age and gender, and information concerning the symptom or symptoms reported by patients to receptionists as reason for encounter were registered. In the study, 12 weeks of each year (one week each month) were subsequently randomly selected from the 52 weeks. Symptoms were coded with the International Classification of Primary Care (ICPC) and data were analyzed using SPSS/PC+ statistical program.

Results: In the study, 6114 out of hours consultations were made by female patients, 3609 (59%) in 1990 and 2505 (41%) in 1993 ( $p < 0.001$ ). The total annual twenty four hours out of hours consultation rate per 1000 female inhabitants decreased from 826 to 552 (33%)( $p < 0.001$ ). The highest decrease (53%; from 147 to 69 consultations per 1000

female inhabitants) by ICPC main codes was among females having musculoskeletal problems (L). Females having neck or back symptoms reduced out of hours consultations most significantly (62%; from 63 to 24 consultations per 1000 female inhabitants).

Discussion: We conclude, that improvement of continuity of care for female patients having musculoskeletal problems is partly a question of organization. This improvement is also economically justifiable.

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[Back to the top](#)

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PRESENTATION 5: Friday 10th May, 1996  
11.45 - 12.15 h.

TITLE: Health check ups in primary care - does structured counselling make a difference?

AUTHOR(S): Erika Baum,  
Norbert Donner-Banzhoff,  
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Objectives: To determine whether structured counselling by GPs and community general physicians is more effective than usual care. The study focuses on cardiovascular behavioural risk factors. Particular attention will be paid to the roles of gender, social class, and region (former East vs. West Germany) as potential effect modifiers.

Design: Randomized controlled trial.

Setting: 72 practices (GPs and general physicians) in the land of Hesse (former West Germany) and Thuringia (former East Germany).

Subjects: Patients with cardiovascular risk factors detected by check up in practice.

Intervention: Participating doctors are trained in counselling according to the "Stages of Change" model by Prochaska. Patients' readiness to modify their behaviour is assessed by a newly developed instrument. Counselling is then tailored to each patients' stage.

Outcomes: Smoking status, blood pressure, lipid levels, body mass index, quality of life, and stages of behavioural change one year after baseline.

Results: At the conference we will present results of the baseline survey. The descriptive analysis of 600 attenders for check up will deal with demographics, risk factors, readiness for change, and medical history.

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[Back to the top](#)

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PRESENTATION 6: Friday 10th May, 1996  
12.15 - 12.45 h.

TITLE: "Everyone's different": How South Asian women seek help for the menopause.

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Introduction: Anthropological research suggests that the experiences and meanings of the menopause vary between cultures. These are often dichotomised to a "Western", biological meaning where women experience troubling menopausal symptoms, or a natural, life event meaning, where women are relatively symptom free. It could be concluded that the meanings ascribed will influence how, and from whom, women will seek help for any problem. As any cultural stereotypes, these must be critically examined,

especially now that HRT is being advocated for more and more women.

**Method:** A qualitative research project was undertaken with peri-menopausal South Asian women living in the north east of England. 21 women aged 40 to 60 years were chosen as a random sample from two GP Practice lists. They were predominantly Muslim women from Pakistan, and were interviewed with an interpreter. The interviews were transcribed and content analysed.

**Results:** The stories of some of the women will be presented to illustrate the wide range of experiences and meanings of the menopause. None of the women knew a Punjabi word for the menopause, and all explained that there are cultural taboos about talking about menstruation and the menopause. Despite this, all the women who were peri- or post-menopausal had sought information from informal or formal sources. The women with a more medicalised view were more likely to seek help from their GP, but were no more likely to be prescribed HRT.

**Discussion:** Care must be taken when making cultural assumptions about any group. This study suggest that social, cultural and educational factors all influence experience of and health-seeking behaviours for the menopause, and these interact with the actions of individual GPs. As this is a small study, it would be of great interest to hear the experience of GPs from across Europe, to see whether they reflect this heterogeneous picture.

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[Back to the top](#)

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PRESENTATION 7: Friday 10th, 1996  
13.45 - 14.15 h.

**TITLE:** Involuntary childless women and women with children  
in General Practice - a case control design

**AUTHOR(S):** Monika Rupp,  
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Main idea/ hypothesis: There is some evidence that involuntary childlessness is a major life event which may result in an increased rate of diseases or psychosomatic complaints. This study set out to test the hypothesis that involuntary childless patients consult their GP more frequently, need more referrals and suffer more from unspecified health problems and/or psychosomatic complaints.

Methods: To date, the study has taken place in five practices. Together with the doctor and the practice nurse all patient charts were reviewed. Childless people with a certain or possible desire to have a child (study group) were compared with patients with children (control group, matched by age and sex). Some sociodemographic data, the frequency of consultations and referrals and reason for encounter (ICPC) within the last 24 months were documented. Since it was not possible to ensure the criterion "wish for a child" we tried to assess the validity of this statement through the doctor or the receptionist.

Results: We will report about the chart review of 110 patients. Childless women consulted their GP more frequently than women with children (1060 vs 850). No major differences in the groups of diagnoses could be detected with the exception of skin diseases (cases: 31%; controls: 20%). "Social problems" as reason for encounter, although rarely documented, was exclusively found in the study group. The number of referrals was considerably higher for the controls than the cases (55 vs 38).

Relevance for the GP and conclusions: The following questions are to be discussed:

- Is the (rather incomplete) documentation in general practice sufficient to make an expressive inquiry based on the patients charts?
- How convenient is the use of ICPC in such a study design, if it permits only a rough classification or a division in small numbers of patients?

The GP should be aware of infertile patients and their needs. However, these patients do not seem to suffer from diseases more often than other patients. A small subgroup of infertile patients may be exposed to social stress - perhaps in connection with their childlessness.

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[Back to the top](#)

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PRESENTATION 8: Friday 10th May, 1996  
14.15 - 14.45 h.

TITLE: Patterns of bleeding in women aged 45-54 years.

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In general practice gynaecological themes are common. Most women in western countries undergo several gynaecological examinations throughout their lifetime, some without relation to a disease. The rate of invasive diagnostic procedures increases rapidly in women approaching the menopause, i.e. endometrial biopsy, hysteroscopy etc. Many women undergo hysterectomy. Almost one fifth of Danish women have undergone hysterectomy by the age of 60. Most of these hysterectomies are due to "abnormal" bleeding and uterine fibroids, 14% are due to malignancy. Hysterectomy rates vary widely over small geographical areas within the country, but also between different countries. Danish hysterectomy rates are twice as high as Swedish rates, but in U.S.A. and Canada the rates are about five times higher than in Sweden.

You may ask yourself why the hysterectomy rate in general is that high, and why it varies that much within the country and between countries.

As the main indication of premenopausal hysterectomy is abnormal bleeding and fibroids, it is amazing that the normal variation in bleeding patterns in premenopausal women has never been investigated, and that the prevalence of fibroids is not known. The variation in length of the menstrual cycle has been demonstrated by Treloar, but normal variations in the amount of bleeding and days of bleeding in each cycle are not known. Could it be so, that so called abnormal bleeding in premenopause is rather normal? Even though the overall hysterectomy rates are declining, rates of alternative methods as endometrial ablation and myomectomies are rapidly growing. Are we treating pathology or normal physiology of the premenopause?

This paper will present a study including 2000 Danish women aged 45-54 years. They were asked to answer a mailed questionnaire. The response rate was 79,7%. Subsequently 1063 of the respondents were asked to record their bleedings during a year (1996) using a calendar diary. Women who had undergone hysterectomy, or who were taking HRT, contraceptive pills or hormone-releasing IUDs were excluded.

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[Back to the top](#)

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PRESENTATION 9: Friday 10th May, 1996  
14.45 - 15.15 h.

TITLE: Sexual abuse in a primary care district.

AUTHOR(S): Gunilla Risberg,  
Göran Westman,  
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Since the 1980's sexual abuse has been recognized as a common phenomenon. As this knowledge is likely to affect those of us working in the health care system since one can expect that sexual abuse has effects on women's health. I carried out an investigation on this subject.

Questionnaires were mailed to all women born in 1971, 1961, 1951, 1941 and 1931 in my primary care district, an urban area in the northern part of Sweden. Three questions were asked about their experiences of wife battering, sexual abuse as a grownup and sexual abuse as a child. The questions were to be answered by yes or no. Beneath each yes/no question space was left and the woman was asked to tell about the abuse in her own words if she wanted to. The fourth and last question dealt with effects on health. The abused woman was asked if she saw any connection between the abuse and the health problems.

175 women answered the questionnaire, 50 of them after a follow-up letter. 25 women wrote yes as an answer on one or more of the three questions concerning experience of sexual abuse. Many of them told their stories and gave examples of effects on health. More results and analysis will be presented.

What kind of knowledge can you get through an investigation like this? What are the limitations? These questions will be discussed in the presentation when introducing the investigation to follow - in-depth interviews with some of the women participating in this study.

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[Back to the top](#)

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PRESENTATION 10: Friday 10th May, 1996  
15.30 - 16.00 h.

TITLE: Women with vaginal discharge in general practice.  
How do they experience it? What is the effect of patient education?

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Data on the frequency of vaginal discharge, the views of women with vaginal discharge and their behaviour are scarce. The objectives of this study were the following:

- To register how women feel and think about vaginal discharge;
- To determine their need for more information about this topic;
- To measure the effectiveness of a patient leaflet and of oral information about vaginal discharge.

Methods: In 31 general practices , an anonymous questionnaire was issued to fifty consecutive women aged 15-70 who attended the consultation. Women were asked about the occurrence of troublesome discharge, their reaction to vaginal discharge, their knowledge about this topic and the need for more information. With these data, a patient leaflet was drafted. In a group of female students aged 17-22, the effect size of different health education methods (oral information, patient leaflet) was determined by means of a knowledge and attitude test, and then compared with a control group.

Results: A total of 828 women returned the questionnaire. Almost 33% of respondents had vaginal discharge at that moment, but 66% said they had vaginal discharge in the past. Many women regarded vaginal discharge as 'something normal', but 44% of the respondents indicated they would see a doctor about it. When asked about possible causes

and preventive measures, many women did not answer the question or claimed they did not know the answer.

The general knowledge of women about vaginal discharge was low ( mean number of 6.3 correct answers on 15 knowledge-items). After intervention, the knowledge increase was greater in women who got the leaflet (mean score of 9.7), in comparison with the control group. The effect was significantly higher for the group who got the oral information ( $p=0.02$ ) and for women who got a leaflet with oral information ( $p=0.002$ ), compared with those who got only a leaflet.

Discussion: Women do know less about vaginal discharge and need more information. The presentation of this paper can open the discussion about the need for this kind of intervention research and about the conclusions which can be drawn for practice management.

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[Back to the top](#)

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PRESENTATION 11: Friday 10th May, 1996  
16.00 - 16.30 h.

TITLE: "I'm under a doctor",  
Strategies to deserve medical attention among women with biomedically undefined musculoskeletal disorders.

AUTHOR(S): Eva Johansson,  
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Göran Westman.

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Problem: Musculoskeletal pain disorders form a growing and costly health problem in many industrial countries, foremost among women. This increase has challenged insurance companies, politicians, as well as health care professionals, to interesting discussions about etiology, diagnosis and treatment. For instance, bodily symptoms without a clear-cut physical pathology have been addressed as psycho-somatic, alarm

signs, or even malingering phenomena. Being family physicians ourselves, we have experienced the frustrating mismatch in encountering female patients with diffuse, medically undefined musculoskeletal disorders.

**Purpose:** To learn more about what female patients expect and experience when they consult a doctor, a qualitative interview study was conducted. Our aim was to throw light on how women's medical problems are related to daily life experiences and women's subordination in society.

**Method:** Twenty women, all patients at Mariehiems Vardcentral Umea, participated. They were sick-listed due to musculoskeletal disorders of undefined origin. Data were collected through repeated semi-structured interviews during two years, and were analyzed according to grounded theory.

**Findings:** In our talk we will go into the distrust female patients with undefined, yet disabling, musculoskeletal disorders experience in their encounters with physicians. The participants experienced being ignored, disregarded and rejected, and had developed new strategies to get medical attention and 'a credible diagnose'. They were somatising, claiming under cover, and pleading to capture the doctor's interest. In addition, they upheld self respect by mystifying and martyrizing themselves and their symptoms, and condemning the ignorant doctor as worthless. The patient's perspective of the doctor-patient relation is summarised as "I'm under a doctor". The concept includes the consultation context; the biomedical framework, the power asymmetry, and the gendered positions the patients and the doctors act in.

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[Back to the top](#)

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PRESENTATION 12: Saturday 11th May, 1996  
9.00 - 9.30 h.

**TITLE:** Do doctors act consistently when they meet the same patient twice? A study with standardized (simulated) patients visiting general practitioners during real surgery hours.

**AUTHOR(S):** Jan-Joost Rethans  
Lars Saebu  
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Introduction: Inter-doctor variation (that is the variation between doctors) has been intensively studied and has been one of the reasons for several national colleges to start producing guidelines or standards for good general practice. However, we do not know much about intra-doctor variation (that is the variation within doctors). This raises questions as: What actually is intra-doctor variation? Does intra-doctor variation exist in real practice and can one assess it on a valid and reliable way? We conducted a study with the aim to assess intra-doctor variation in real practice.

Methods: During normal surgery hours 24 general practitioners in Trondheim (Norway) were each visited by 2 standardized (simulated) patients, indistinguishable as such. The patients presented a standardized role of a 65 year old female patient with a history of angina pectoris. The patients were also trained to report, after the consultation, in a reliable way what actions the doctor had taken during the consultation. Each general practitioner was confronted twice with the same standardized patients, the visits being two months apart from each other. The actions taken during the consultations were compared for the first and second round of the patients and were correlated for the individual doctors.

Results: When compared with a "gold" guideline for treating patients with angina pectoris the doctors did very well. For the group of doctors there was no significant difference in the number of actions taken during the consultations between the first and the second visit of the standardized patient. However, for the general practitioner as individuals, the (pearson) correlation for the number of actions taken between the first and the second round was only 0.4.

Discussion: It seems that general practitioners as a group act consistently if they are confronted twice with the same patient. However, as individual they do not: there is substantial intra-doctor variation when doctors are confronted twice with the same patient. Aim of the presentation: We hope to focus attention on the method of standardized patients and to ask the participants of the EGPRW meeting their opinion about intra-doctor variation.

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[Back to the top](#)

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PRESENTATION 13: Saturday 11th May, 1996  
9.30 - 10.00 h.

TITLE: Methods for assessment of quality in general practice.

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Quality assurance can be described as a continuous process of planned activities, based on performance review and setting explicit targets for good clinical practice with the aim of improving the actual quality of patients care.

An important part of this definition is the statement 'based on performance review'. This requires that, for quality assurance activities, data about performances is collected. When practitioners or researchers wish to collect these data (or assess quality) they face several problems which have to be solved before the process of quality assurance can be successful.

Most important problems are: what sort of data have to be collected and by which method(s) do these data have to be collected? If one does not address these problems in the right way, there is a fair chance for at least a partial failure of the quality assurance project involved.

But how precisely does one decide what sort of data and which methods have to be used?

Based on the experience within the Centre for Quality of Care Research of the Department of General Practice in Maastricht (The Netherlands) and within the Department of General Practice in Trondheim, this presentation intends to give the audience a frame which will help him/her to take these decisions in a rational and logical way.

The frame is based on three essential questions, addressing issues such as direct and indirect methods and performance or competence data. The methods commonly used for data collection within quality assessment will be presented.

Aim of the presentation: We believe there is a need for a paper to help general practitioners in choosing the right quality assessment method and to provide them with an overview of methods which exist in quality assessment research. Currently we are in the process of writing this paper. We hope that the EGPRW audience will be prepared to discuss the content of the presentation and give the presenters feedback. There will be strong emphasis on discussion.



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[Back to the top](#)

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PRESENTATION 14: Saturday 11th May, 1996  
10.00 - 10.30 h.

TITLE: The importance of PHC research in the restructuring of changing health care systems.

AUTHOR(S): Miklós Fodor

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Background: The Hungarian Health Care Restructuring Program focuses on PHC, as the health status of the population is among the worst ones in Europe and is continuously worsening. Life expectancy at birth is 65 years in males and less than 73 years in women. Infant mortality in the last 30 years has reduced from 47,6/1.000 to 14,8/1.000 but even today is about twice as high as the European average. In the last 30 years the age adjusted mortality in the 30-39, 40-44, 45-49 and 50-54 age groups increased double in males and also rised in women. The number of disabled persons increased too: from every 1.000 active worker 1 became disabled yearly. The large number of hospital beds and emphasis on the role of specialists are characteristic of the health care system in Hungary. The health care reform starting 1992 focused on PHC. Strengthen the PHC the Ministry of Welfare established the National Institute of Family Medicine (NIFM) in 1992.

Methods: This Institution is the basic methodological and research Institute of PHC. The relevant goals of the National Institute Family Medicine in relation to the objectives of the centers we believe are as follows:

- To strengthen and promote the Primary Care Concept and Family Medicine as a speciality to the public, General Practitioners and to the rest of the medical profession.
- To research, promote and support patient education and preventative measures delivered through the primary care network.
- To provide decision support to the different stakeholders in health policy development, health services structure and reimbursement system development based on research (including collaborative international studies), health management science and model experiments in primary care.

Results: In the past 3 years the research concepts, methods, short and long term objectives have been elaborated. The following subjects are in the first line of our research work:

Health Information System  
Management Information System  
Quality improvement  
Outcomes measurement  
Cost effectiveness

Morbidity registration in PHC  
Health promotion disease prevention.

Conclusion: The NIFM has been chosen to be an institution which will support health policies that enhance the restructuring of Hungarian health care and place more emphasis on public health. For the short term a plan of work for relevant research topics has been developed after consultation of many parties and with involvement of other professional research bodies.

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[Back to the top](#)

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PRESENTATION : EGPRW HOME VISITS STUDY

Saturday 11th May, 1996  
11.15 - 11.45 h.

TITLE: Home visits in European General Practice.

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The project of the EGPRW Pilot Study of Home Visits in European General Practice is now fully developed, and the data collection period ought to be soon after the EGPRW

meeting in Växjö, Sweden.

Design: Transversal observational quantitative analytic study. Observational qualitative descriptive study.

Setting: European countries with EGPRW national representation.

Subjects: Home visits demands in a European sample of general practices.

Main outcome measures: Home visit rates. Reasons for home visit requests. Health problems prevalence in home visiting. Home visit outcomes.

Results expected: Knowledge of home visiting process, demand and supply in European countries. Identification of factors related to different home visiting patterns in Europe. Understanding of actual European situation of home visiting.

A comprehensive presentation will be made, in order to raise discussion about the project.

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[\*Back to the top\*](#)

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PRESENTATION 15: Saturday 11th May, 1996  
11.45 - 12.15 h.

TITLE: Type and value of questions asked upon the request for a home visit.

AUTHOR(S): Waltraud V. Fink  
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Background: In Austria most requests for a home visit are made by telephone. For various reasons the doctor would like to know which kind of complaint he will have to deal with.

Research question: Is it possible to improve the effectivity of communication by telephone by using a diagnostically oriented questionnaire?  
In order to find out which questions should be asked, experienced general practitioners

should be observed in their daily routine, as to the information, which is are relevant to them concerning a request for a home visit.

Method: In two GP's practices the questions that were asked whenever a request for a home visit was made, were taken down for 7 and 11 months respectively. In the one practice the doctor himself answered all the telephone calls. In the other practice the doctor's receptionist also accepted requests for home visits. Before the doctor visited the patient he/she wrote down the anticipated result of the consultation, which then was confirmed or corrected after the actual visit.

Results: On an average it came down to one or two questions on the telephone. Only 14% of the patients called the doctor themselves. There was almost no difference in questioning regardless of whether the patient was known from a previous consultation or not or whether the call was urgent or not. Most frequently the participating doctors and the receptionist asked for the duration of symptoms. Other questions will be listed according to their frequency. The GPs predominantly asked the same questions. In one half to two thirds of the cases the anticipated result of consultation corresponded to the actual situation.

Conclusion: It turned out that the main purpose of the information collected on the telephone is to judge the urgency of the situation. This is done by asking only a few questions. It is true that the information received leads to diagnostic speculations about the possible complaint: on his way to the patient the doctor can determine what he is going to ask or examine. But there is no point filling in a detailed questionnaire while talking on the telephone, because a proper diagnosis will only be possible when the doctor actually sees the patient.

Discussion: There are so many possibilities of results of consultation. We found that to "guess" them right is no criterion for satisfactory management of telephone calls requesting a home visit. It is only important to be aware of potentially dangerous disorders, which need urgent treatment, especially in cases with very common problems. Further investigations should concentrate on cases where with hindsight the doctor should have visited a patient more urgently.

Another problem, when a call is responded to only by "telephone advice": here R.N. Brauns "Diagnostic Protocols" could be used for the history taking. (In Austria "telephone advice" is officially not used).

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[Back to the top](#)  
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PRESENTATION 16: Saturday 11th May, 1996  
12.15 - 12.45 h.

TITLE: Continuity and Longitudinality in Primary Health Care - The EGPRW - Study in Germany.

AUTHOR(S): Martin Beyer  
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--Introduction: It has often been observed that the different structures of primary care in European countries influence the asset of the practice, the workload of the GP, the structure of morbidity care, and the doctor-patient-relationship. An international study was conducted by the European General Practice Research Workshop to observe the frequency and modalities of encounters with the GP, the health problems presented, and particularly the doctor's knowledge of that problem, the patient, and his family. A great part of the German contribution was performed at Hannover.

Method: 11 GPs documented every encounter in practice or elsewhere during one week by means of a questionnaire. Additionally all encounters that were managed by the practice staff were documented on a short form. The data will be compared with a second German sample (other centre, 8 GPs) and a short glance will be made to preliminary results from other European countries (cf. Pastor-Sanchez et al. at the Porto-meeting).

Results: 2547 contacts (in addition 1345 with staff only) were reported. The weekly contact rate is higher than in other European countries. The most frequent problems in encounter were hypertension (4.5%), acute allergies (3%), acute respiratory infection (different locations, sum = 5%), neck and back pain (different locations, sum = 5%) and diabetes (2.4%). In spite of the contact frequency the duration of encounter was not shorter than in many other countries. The rate of home visits was 8%, the referral rate 5%. Specific patterns of continuity and longitudinality can be shown for some frequent acute and some chronic conditions. Differences will be described between urban and countryside practices.

Discussion: The results give an important insight into German general practice (e.g. workload of doctors and practice staff). Structures of morbidity can be compared with (the few!) earlier studies in Germany (e.g. the EVaS-Study in the early 1980s). The impact of different factors: doctor-related, patient-related, case ('disease')-specific, and structural, are to be discussed.

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[Back to the top](#)

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PRESENTATION 17: Saturday 11th May, 1996  
14.15 - 14.45 h.

TITLE: General Practitioners' belief in prevention and expected patients' attitudes in five European countries.

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Disease prevention becomes an increasingly important part of the work of the general practitioner. In studies on preventive activities great variability among general practitioners within the countries has been found. The belief that preventive activities are successful in preventing cancer and the expected reactions by the patients might be an important factor that plays a role.

We used a standardised questionnaire that was pretested in Flanders. Later on it was sent to general practitioners in Flanders, Spain, Portugal, Slovenia and Ireland. Belief in preventive procedures was measured as were the expected reactions of the patients.

We have supposed that there should be a correlation between the GP's beliefs and their patients expectations. The aim of the variable belief was to measure the belief in medical procedures in cancer prevention.

The strength of the study lies in its international design. The countries selected represent a variety of different health care systems in Europe. There are countries where the general practitioners are salaried employees (Spain, Portugal), countries in transition from a socialist system (Slovenia), countries, where the GP competes in an open market with specialists (Belgium), and a country where a contract defines the role of GP (Ireland). It was tempting to examine the effect of the health care system on the beliefs and expectations of the general practitioners regarding prevention.

Indeed it was shown that the health care system characteristics play a major role in explaining the variability of the two scales. The three countries where the correlation is statistically significant, are Portugal and Slovenia with salaried systems and Ireland with a contract system. The findings point again to the importance of good health system policies which reflect not just the health workers' performance, but their beliefs and expectations as well. On the other hand, the expectations might be strongly linked to a health care tradition, which is extremely different in the countries represented in the study. This is an important message for Europe with its different health care systems merging into one, in the future.

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[Back to the top](#)

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PRESENTATION 18: Saturday 11th May, 1996  
14.45 - 15.15 h.

TITLE: Analysis of family planning (FP) in Lithuania.

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The aim of this study was to analyse how family planning in Lithuania is done what kind of contraception they are using and knowing; what effect has natural family planning method- symptothermal.

Method: A confidential and coded questionnaire with 20 sections was offered randomly to fertile age women in clinics and maternity consultation. 400 replies were received. Information was obtained on many aspects: age group, marital status, parity, previous contraception and present natural method employed, living place (city or country), development.

In Lithuania in 1991-1993j was developed NFP programme. Was organized course of FP teacher in Lithuania. The data were collected during courses of NFP teachers training programme.

Results: three and more FP know 200 women. NFP methods know 129 women. Most of them know only rythmo method. Don't know any one method 35 women. Only 649 (256) of all questionaired women were used contraception (FP). Most off them 120 were priority condoms and IUD like FP methods. Only few women used pills. About 69 women used NFP (rhythm, Billing's( and 63 coitus interruptus.

Among 175 symthothermal method (SM) users 49 (28%) tried to achieve pregnancy; 125 (71,4%) of them avoid it. Among all of the users 198 regarded themselves as Catolics. 11 of other reigion , 16 don't practise any religion. Development: 71 have degrees of high education, 63 proffessional, 41 secondary education. 156 were married, 19 unmarried or devorsed.

Conclusions:

1. More then half of women used NFP methods and coitus interruptus.
2. Populary FP methods were IUD, condoms snd NFP.
3. Most of SM users have a high or professional education, are Catolics and are married.

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[Back to the top](#)

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PRESENTATION 19: Saturday 11th May, 1996  
15.15 - 15.45 h.

TITLE: The structure of the gynaecological morbidity in a private medical firm of family medicine.

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The radical changes in the political, social and economic life of Russia have provoked reforms in the Public Health Care. One of the new trends is the creation of family medicine. The private firm of family medicine Avalanche founded in 1993 is an example of development of the private sector. After two years of steady work the conditions for studying patient morbidity statistics evere.



654 female patients from 600 families served by Avalanche were in need of gynaecologist. 82 of them (11,6%) were found to be healthy. We distinguished 5 age-groups according to the features of the reproductive system specific for each age-group. Most typical gynaecological diseases were inflammatory, functional and tumour pathology. Gynaecological pathology structure depends on the women age-groups. For the first group (0-12 years) inflammatory diseases of the lower genital tract are prevalent (75%).

In the second group (13-17) functional disturbances (33%) and unwanted pregnancies are most frequent.

The third group (18-44) was characterized by a wide spectrum of gynaecological pathology including the inflammatory diseases(36%), sexually transmitted diseases (STD) and the lack of contraception.

Prevailing reproductive tract infections were: Trichomoniasis 37%, Chlamydiasis 38%, Candidosis 22,5%, Gardnerell 22,5%, Mycoplasmosis 18%, Gonorrhoea 7%, Herpes 4,3%.

The fourth group (45-54) are the periclimacteric patients with an increase of functional disturbances including irregular menstruation, hyperplastic endometrial processes, climacteric syndrome and tumour processes connected with them (increasing of frequency of the functional disturbances is in proportion to tumours). Like elsewhere in Russia the patients of our firm often resort to an abortion as a means of fertility regulation and rarely use highly effective contraception means though all of the patients belong to a social group with a high income level.

#### Conclusion:

1. Gynaecological morbidity pattern for the patients of the private firm correspond to those in Russia as a whole.
2. the main problem of women of reproductive age are sexually transmitted diseases and family planning. It is very important to take this point into consideration while training family doctors as wide profile specialists for they are the first to meet family problems and have an opportunity to influence their patients.
3. Our experience shows the necessity of having two specialists: gynaecologist and urologist in the staff of a family medicine firm along with the general practitioners.
4. Combined permanent control over the patients of a family doctor and a proper specialist may cause positive changes in reproductive health indexes.

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[Back to the top](#)

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PRESENTATION 20: Saturday 11th May, 1996  
16.00 - 16.10 h.

TITLE: Breast cancer: patient follow-up in General Practice

AUTHOR(S): Milica Katic  
Vesna Pleši\_  
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Breast cancer is the most frequent cancer in women and in the Republic of Croatia it represents 20% of the total number of all cancers. In the Republic of Croatia a total number of 1400 women per year are registered as having breast cancer. The risk of local recurrence and a new cancer in the contralateral breast, and the risk of distant metastatic relapse is present during the rest of patient's life.

Usually, the breast cancer patients were diagnosed, treated and followed up by a specialist (surgeons, oncologist, etc.) At the same time these patients also should have been given continuous and comprehensive care by a general practitioner. The best health care would be achieved through common care provided by specialists and GP in the way that each physician identifies and operates his specific tasks.

In the Health Centre Novi Zagreb 48 GPs have a total of 46238 women registered on their lists. According to data of the Department of Statistics a total of 469 breast cancer patients were registered in 1993 and 1994. With the aim of investigating the breast cancer patients' follow-up in general practice, we collected data from medical records of 27 registered patients in three teaching practices. The follow-up data were recorded as follows: for 21 patients during the first year, for 15 during the second year, for 12 during the third year, for 8 during the fourth year and only for 6 during the fifth year. The clinical breast examination performed by general practitioner was recorded for 6 patients. During 1994 and 1995 6 patients died. Out of 21 living patients 8 patients survived more than 5 years. GPs knew more about their breast cancer patients than was recorded in medical records. Data collected from medical records were insufficient for assessing the breast cancer patients' follow-up in general practice. In further research we are going to collect more information from other sources, for instance, from patients, other parts of medical documentation and from GPs who provided continuous care for breast cancer patients.

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[Back to the top](#)

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PRESENTATION 21: Saturday 11th May, 1996  
16.10 - 16.20 h.

TITLE: Characteristics of the utilization in a primary health center.

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In order to find the utilization of our Primary Health Center (Sant LLàtzer in Terrassa) we have analyzed the data computed from the 1st of April 1994 to the 30th of March 1995 in on-demand, pre-programmed and emergency consultations.

Results:

- Global frequency (4.96) is comparable to that of other primary health centers.
- Women are seen more often than men, as are those over 60 years of age, features also described in other studies.
  
- Emergency consultations do not follow the same characteristics for gender and age as on-demand and sheduled visits:
- Frequency of Emergency visits is the same for all ages and gender.
- Proportionally, women consults less frequently than men in all age groups, and older people are less likely to frequent than young people.

In our Primary Health Center older patients are seen by their own family doctor more than young patients, and women more than men.

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[Back to the top](#)

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PRESENTATION 22: Saturday 11th May, 1996  
16.20 -16.30 h.

TITLE: Do women accept a sickness certification less easily than men?

AUTHOR(S): Meritxell Fiter  
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It is known that the acceptance of a sickness certification is influenced by factors such as the degree of responsibility at work, the educational level or the salary scale. Are there any differences between men and women regarding the acceptance of a sickness certification?

Objective and methods: To describe why men and women do not agree to a proposal of sickness certification six general practitioners of Andorra registered: - during a period of one month, - the reasons to refuse a proposal of sickness certification and studied the relationships with:

- the reasons for encounter and to propose the sickness certification;
- the social and economic level;
- the proportion of salary in relation to family income;
- the degree of responsibility at work;
- the number of dependent persons in the family and their age.

The relationship between these variables are studied in a multivariate analysis.

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[Back to the top](#)

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PRESENTATION 23: Saturday 11th May, 1996  
16.30 - 16.40 h.

TITLE: Have attitudes to breast feeding changed? What are the reasons given by women influencing a decision about breast feeding?

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This study looks at all pregnant women cared for by the same GP, in a GP setting, over the year 1995/96, with an enquiry into how they had chosen to feed their baby and why. The results were compared with the same study, done in 1967 by the same doctor-then a final year medical student.

In 1967 the enquiry of post partum patients in a hospital setting as to the chosen method of feeding their baby and the reason for that choice, looked specifically at attitudes to breast feeding. The present enquiry endeavoured to mirror this survey, matching patients where possible, with the intention of recording contemporary attitudes and outcomes. Patients were interviewed by the doctor at six weeks post partum when they attended the surgery for routine check up. Age, parity, method of feeding in previous pregnancies, their job and that of their partner were recorded, as well as the information regarding their decision about feeding their baby.

Little difference was recorded between the surveys of numbers breastfeeding. Set against a period of considerable social change 1967-1995, with regard to the changing economic and employment status of women, concepts of body image, sexuality, disintegration of family life, has any of this influenced attitudes to breast feeding?

This paper gives a descriptive analysis of recorded comment. If breast feeding is to be promoted as a healthy option it is important to recognise those factors which need to be addressed to instigate change.

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[Back to the top](#)

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PRESENTATION 24: Saturday 11th May, 1996  
16.40 - 16.50 h.

TITLE: Traumatized patients: The contribution of general practice.

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At the department of General Practice of the university of Limburg a study has been started aimed at the contribution of the general practitioner to the recognition and care of traumatized patients. The various types of traumata will be taken into consideration, namely disaster, violence and abuse.

Data will be collected on:

- traumatized patients in the open population compared to those known as such by the general practitioner: frequency of the various types of traumata
  - predictors for coping with traumatizing events
  - present quality of the care given by general practitioners to traumatized patients; problems encountered by patients, general practitioners and agencies working in this field.
- The results of this study will culminate in the construction of guidelines for improved care of traumatized patients by the general practitioner, as well as a plan for the implementation of these guidelines.

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[Back to the top](#)

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PRESENTATION 25: Sunday 12th May, 1996  
9.00 - 9.30 h.

TITLE: Gender differences in hepatitis C infection: The Cretan paradox and female predominance.

AUTHOR(S): Christos Lionis  
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Objective: The diagnosis of chronic liver diseases was frequently found among the GP' s records in a geographically defined primary health care area in rural Crete. A project was planned to study the prevalence of hepatitis A, B, and C markers in this particular area and to discuss the demographic and clinical features of infected persons. The aim of this paper is to study the gender differences and to discuss the potential explanatory factors at the local level.

Study population and methods: Serum samples were obtained from 257 subjects (163 females), aged 15 years and over, who visited the primary health care services of the Spili Health Centre between July 1993 and March 1994 and from 164 subjects selected from households in three neighbouring villages of the study area. Hepatitis C (anti-HCV) antibodies were tested with commercial enzyme-linked immunosorbent assay kits. A detailed past history was taken concecuing potential risk factors with a semi-structured questionnaire.

Results: Anti-HCV were found in 28 (10.9%) people tested in the first group. Although the difference between males (7/94) and females (21/163) was not statistically significant ( $P=0.086$ ), a definite trend was recorded. Five (3%) subjects from those randomly selected were found HCV seropositive, 2 of them (2.4%) were males and 3 (3.7%) were females.

Conclusions: HCV seropositivity has been strongly associated with male gender in a number of European epidemiological studies either being conducted on volunteer blood donors or on healthy (asymptomatic) individuals from the general population. In our study, females were the predominant gender in the HCV-infected individuals and this finding is in contrast with the existing references. Although a number of methodological considerations should be discussed, the main hypothesis, which has to be discussed, is that the higher prevalence of anti-HCV in healthy Cretian females could be explained by the high risk gynecological (medical and paramedical) interventions to which they had been exposed. An international epidemiological study focussing on hepatitis C should be carried out, particularly in Southern European Countries.

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[Back to the top](#)  
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PRESENTATION 26: Sunday 12th May, 1996  
9.30 - 10.00 h.

TITLE: Individual mammographic breast cancer screening in women aged between 50 and 69: clinical audit in 41 general practices in Ile-de-France.

AUTHOR(S): Hector Falcoff

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The objective of this study was to evaluate the practices of 41 voluntary general practitioners vis-à-vis the following agreed recommendation: "all women aged between 50 and 69 should undergo mammographic screening every three years by a radiologist with training. The breast x-ray should be outstanding and accurate and form part of a thorough checkup".

Each participant had to include consecutively the first 25 women taking medical advice, aged between 53 and 72 and registered with the practice for at least 3 years. A sample of 759 women was constituted between october 1992 and march 1993.

57,3% (435) of the women in this sample had had a mammography less than 3 years before (50,6% as a systematic screening, 6,3% for diagnostic purposes, 0,4% for an unknown reason). Among these 435 women, the initiative for ordering the last breast X-ray came from the GPs for 225 patients (51,7%); from a gynecologist in 43,2% and from other doctors in 5%.

A patient from the sample group had less likelihood of doing mammographic screening if: she was not undergoing hormone replacement therapy; was older than 62; had no complementary health insurance; was a shopkeeper or was employed in manual labor either on salary or as a craftsperson; had been registered with the practice before 1985; was foreign-born or had seen her GP more than nine times over the past year. In a multivariate analysis, use of hormone replacement therapy, age, lack of complementary health insurance, socioprofessional status and year of first contact with the GP remained as predictors of non-compliance with the screening guidelines.

324 patients did not have screening done. For 169 of them (52% of 324), this lack of screening appears to be in keeping with the practices of the doctors ("no advice for screening" or "misunderstanding GP/gynaecologist").

Despite a good general rate of screening (near the 60% mark that mass screening



programs seek to obtain) we note that nearly half of the unscreened cases were avoidable on the doctor's behalf.

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[Back to the top](#)

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PRESENTATION 27: Sunday 12th May, 1996

10.00 - 10.30 h.

TITLE: Family physicians' initiative to increase compliance with mammography - an innovative community project.

AUTHOR(S): Sophia Eilat-Tsanani

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Background: Breast cancer is the most common malignancy in the world and in Israel. In Israel, women aged 50-75 years are advised to undergo a mammographic screening examination biannually. The family physician, as the most suited professional, is required to refer the patient. However, the lack of a structured referral system is reflected in the low utilization rate for mammography. A similar situation has been reported from the United States, where women are also referred for mammography by family physicians. We present an innovative program in which family physicians in an urban clinic developed a model framework for referrals, coordinated with radiologists and surgeons, and aimed at increasing compliance among women referred for mammography.

Methods: The study was community-based in a population of 527 women aged 50-75 and was conducted outside of the routine reception hours. The family physician conducted the initial referral system, the analysis of results and referrals to surgeons (when indicated), in accordance with a study protocol.

Results: In 1993, the year prior to the study, women referred themselves for

mammography. Utilization of mammography for that year was 12%. During the study year the utilization rate was 79%. A correlation was observed between compliance and country of birth. Patients born in Europe or American had higher compliance rates than women born in Asia or Africa (88,5% vs. 71,55%). Married women were more compliant than unmarried women (81% vs. 65%). No correlation was found between compliance and age, family history of cancer in general, or breast cancer in particular. Six new cases of breast cancer were discovered, two grade 2 and four grade 1.

Conclusions: The initiative of family physicians increased the utilization of mammography among women under their care. The family physicians were able to carry out this initiative by allocating time outside of their routine reception hours. A relative large number of new malignancies was found, but this impression should be confirmed or negated by a large-scale study using the same methods.

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[Back to the top](#)

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PRESENTATION 28: Sunday 12th May, 1996  
10.30 - 11.00 h.

TITLE: The impact of marital relationship on the rehabilitation process in a group of women with musculoskeletal disorders. Report from a qualitative study.

AUTHOR(S): Katarina Hamberg  
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Introduction: A lot of visits at health centres in Sweden are made by women suffering from musculoskeletal pain (MSP). Despite proper investigation a substantial part of MSP remains biomedically undefined which causes frustration among physicians as well as female patients. The aim of our investigation was to reach a better understanding of the life situation of such female patients, and to elucidate the impact of family life on rehabilitation endeavours. The research was conducted in a gender perspective and a crucial analytical concept was the "marriage contract", i.e. the pattern of division of

duties and power structure within the marital relationship.

Method: Twenty women sick-listed due to undefined MSP participated. Data was gained by repeated thematic interviews conducted during two years. The interviews were audiotaped and transcribed. The analysis was made according to grounded theory. The researcher (KH or EJ) was also the participant's family physician. Medical records and notes made in the period of each encounter served as an additional source of information.

Findings: The domestic and parental workload was difficult to manage in the situation of pain. Nevertheless, the women hesitated to reduce their contribution at home or to let the husband/partner take over chores. We focused especially on conflicting situations where the rehabilitation measures disagreed with the terms in the "marriage contract". The participant's ways of coping with the "contract" in these delicate situations could be described in three types of strategies; accepting the terms, negotiating for new terms, and breaking the contract. The impact of the "marriage contract" and the type of strategies on the rehabilitation will be exemplified.

Discussion: Attention to conditions in family life is of utter importance in research on women's health in general practice. Analyzing obstacles in the rehabilitation process in the light of the "marriage contract" helped us grasp the meaning of seemingly contraproductive priorities made by women in the situation of pain. The "marriage contract" is probably of high relevance well beyond research on women with undefined pain.

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[Back to the top](#)

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PRESENTATION 29: Sunday 12th May, 1996  
11.15 - 11.45 h.

TITLE: Diagnostic and therapeutic procedure for patients with suspected osteoporosis.

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Osteoporosis is a common illness specially among women in the postclimateric age. The pain associated with osteoporosis is a common reason for contact in general practice and the patients expect efficient and specific treatment. However, the sensitivity and specificity of laboratory parameters or routine radiologic analyse the value of bone densitometry in the diagnosis of osteoporosis.

Between 1990 and 1996 all patients where osteoporosis was suspected based on standard criteria, were referred to CT densitometry or photonabsorption densitometry.

Within the 5 years studied 152 bone densitometric measurements were performed on 120 different female patients. Significant osteoporosis was found in 29% of patients, the majority of which occurred in the age group between 60 and 69. However, even in the age group between 40 and 49 10% of patients had significant osteoporosis.

These results indicate that bone densitometry is of high value to correctly diagnose osteoporosis. Around 30% of patients presenting with symptoms highly suspicious for osteoporosis in fact have decreased bone density. In these patients specific therapeutic interventions can be started and their efficiency evaluated by control densitometric measurements. Therefore bone densitometry is of high value in the diagnosis as well as in therapy of patients presenting with symptoms of osteoporosis.

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[Back to the top](#)

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PRESENTATION 30: Sunday 12th May, 1996  
11.45 - 12.15 h.

TITLE: A woman's question: who cries in general practice?

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To cry is a specific human activity. According to the literature, research on crying is limited to Genetics (cri-de-chat syndrome), Neurology (uncontrolled crying after stroke), Nursing (don't be afraid to cry), Pediatrics (excessive infant crying) and Psychiatry (don't cry but scream-"Weine nicht, abert schrei"). What about General Practice?

As general practitioners (GPs) we have direct experience of crying patients. But we know nothing about the frequency and about the characteristics of patients who cry. Our research questions were: how frequently do patients cry during the medical encounter? and what are the main characteristics of patients who cry?.

In 1995 we recorded all encounters in which a patient cries. The definition of crying is not about the noise but about the emotion and its physiological main consequence: tears. Our criterion was at least one tear.

Three GPs finished the registration (one, the first author, ALM, could not finish the study: he is in coma; we sign this abstract in his name). Doctor A, a male GP, attended 6,883 patients in 225 working days; 23 patients cried (21 women); the incidence rate was 3.3 per thousand; the main reason for crying was depression. Doctor B, a female GP, attended 6,204 patients in 220 working days; 60 patients cried (52 women); the incidence rate was 9.7 per thousand; the main reasons for crying were depression and anxiety. Doctor C, a male GP, attended 5,472 patients in 195 working days; 74 patients cry; the incidence rate was 13.5 per thousand; the main reasons to cry were depression and family problems.

We recorded the whole patient' history, her family situation and her relationship with the GP of every fifth crying patient in full. We will present quantitative and qualitative information: a picture of our profession, from reactions to cancer diagnosis to "my dog is ill".

Of course we think this is a topic to be explore by the EGPRW members in a (simple) international project.

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[Back to the top](#)  
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PRESENTATION 31: Sunday 12th May, 1996  
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TITLE: Home visting for the elderly: a comparison between german, dutch spanish and british practices

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Introduction: The home visit is a typical and - in many countries - specific intervention of general practitioners in Europe. As many elderly patients are at risk for activity restriction home visits of their doctor may be essential to provide continuity of care. In a study on geriatric assessment we examined the correlation between disablement and home visting in four European countries.

Method: During four weeks all patients aged 75 or over were documented by their doctors by means of a geriatric assessment chart. Doctors received oral and written guidelines how to assess their patients. Socioeconomic data, living status, reasons for encounter, chronic impairments, cognitive status (5-point-scale) and disablement (6-point-scale) were assessed. In addition, the availabilty of support from relatives, nurses and other professional helpers were noted. The number of total encounters and home visits by general practitioners during a three month period was documented.

Results: A total of 855 patients in Germany, 605 in The Netherlands, 402 patients in Spain, 62 in Great Britain (one practice only) were documented. Whereas the number of consultations in the practices varied widely and could not be predicted by the health status of the patients there was a significant relationship between frequency of home visits and disablement status ( in Table 1, the disablement scale is condensed into three categories).

Table 1: Mean number of home visits by disability by country

D			GB			E			NL		
Disability			Disability			Disability			Disability		
none	mild	severe	none	mild	severe	none	mild	severe	none	mild	severe
0.6	1.3	4.6	1.9	2.2	1.4	0.2	1.0	1.0	1.5	3.2	4.3
n=397	n=329	n=127	n=27	n=27	n=8	n=274	n=107	n=17	n=441	n=137	n=37

Age and disablement were significant predictors of home visits. A 2x2x2x3 analysis of variance (regression approach, factors: disablement, sex, age and country (Great Britain was not entered)) was performed. The main significant effects were country (2%) age (1%) and disablement (2%). Significant two-way interaction effects were due to a high rate of home visits in the old-old and severely disabled in Germany and The Netherlands compared to Spain.

Conclusions: Home visit rates by GPs are highly correlated to patients health status which may be not necessarily the case in all countries. The lower rates in Spain and in one British practice was due to the fact that other health care providers perform home

visits in the disabled elderly. The influence of different health care systems and cultures on home visit rates was as important as the patient's health status. Further studies should be undertaken in Europe to assess the outcomes of this specific intervention. In these studies an assessment of the severity of patients' disablement is of paramount importance.

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