

**Steadfast Flexibility – Supporting Good Practice\***Professor Chris van Weel<sup>1</sup>

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**Introduction**

Clinical practice is at a cross-road: it has to be able to 'deliver' – in a humane context of care for patients – the ever increasing potential of medical technology and innovation, but at the same time the socio-demographic and health status changes of communities and societies pose unfathomed challenges for health care [1]. Supply and needs of health care each in their own right drive medical practice but with little or no co-ordination between the two of them, resulting in overmedication alongside deficiencies in care. This puts strains on medical practice wherever doctors engage with patients. But the strain is nowhere felt stronger than in family practice where generalist medical care is provided for all patients and their families for all health problems in all stages of severity [2, 3]. Here, care is delivered with close contact to the local community where patients and families live, and here, medicine and society meet in an inevitable way.

This paper explores the position of family practice in relation to research and academic development – family medicine – that results from this. Scientific knowledge – Evidence-based Medicine (EBM) – is a leading principle for safe and effective medical care. Patients are entitled to 'the best' treatment and care for their health problem, irrespective of who they are, where they live, or their social, economical or religious background. Their central position in health care commits family practice and family practitioners (FP) to practice EBM. But EBM is more than the appropriate *application* of available knowledge and technology; it is essential that knowledge and technology continue to be developed in response to the

needs of individuals and communities and that we accurately define what is and what is not convincing in terms of 'evidence'. *This* is the essential contribution of family medicine – academic leadership, to *direct* science and research in an environment of increased commercial and market interests, and to *articulate* this.

**Background**

This was the background against which WONCA organized the 2003 Kingston conference 'Improving Health Globally and the Need for Primary Care Research' [4]. The conference recommendations form a basis for the global development of a family medicine research policy and a strengthening of research capacity. In particular, the conference recommended the development of a research infrastructure with university departments and research institutes, and their link with family practice: practice-based research networks (PBRN) [5, 6]. Mentoring and training of family medicine researchers, the development of a research mission and research forums (journals, conferences) were the other elements of these recommendations.

It is essential that research is not considered an aim in itself, but that it is seen as a tool – a critical tool – to make patient care more effective and efficient, safer, more personal, and more relevant for individual patients. In order to be able to do this, and to apply useful scientific knowledge, the research enterprise of primary care must be better tuned to the problems, challenges and questions FPs and their staff encounter in their daily practice. .

*Practice and practice-based research networking*

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Research and the questions it explores should originate from general practice [5, 6]. But in order to serve family practice, research has to be based on or grounded in its core values, the 'paradigms' of the discipline. Research in this context is broader than collecting data – it includes as well the insight and wisdom to put data into a context for interpretation. This is essential to enable FPs to approach the huge variation in health problems and individual patients they encounter in a consistent way. Without this FPs might easily become magical jacks of all trade.

Episodes of illness [7] and patients' careers [8, 9] start with a professional interpretation of the health problem presented to the FP. It is obvious that this requires the 'correct' diagnosis and the most likely diagnoses made in family practice are the health problems encountered in daily practice. *Table 1* lists the most prevalent acute and chronic conditions encountered in the Nijmegen academic family practices network [6, 10]. It should be kept in mind that other FPs working in different populations and practice settings may encounter other morbidity most frequently and all together, this is the clinical domain of family practice and the basis of its expertise. Further developing diagnostic tools and procedures for this epidemiological setting, including the application of tools available from other health care settings, is important to strengthen FPs' professional skills.

But 'the correct diagnosis' is only a small part of FPs' clinical competence. Paramount is the 'correct interpretation and application' of health problems, in the context of the patient's living environment, and this brings family medicine's core values to the equation. Quite often signs and symptoms patients suffer and present to the FP are a reflection of problems elsewhere in their environment – for example their family or work circumstances. Exploring these circumstances is a key component of family practice, and the importance of this exploration can be inferred from the dominant position of 'nervous-functional complaints' in the acute and chronic health problems listed in *table 1*.

A diagnosis can only be 'correct' when it is serving the needs of the patient – when the prospective outcome of treatment is likely to bring the patient more benefits than harm. This is why family medicine is required to repeatedly take a stance against spurious diagnoses and interventions, including the vested interests often hidden behind them. Developing methodology to explore and interpret health problems in individuals in a systematic and consistent way is a key component of family practice. This requires innovation, rather than the application of medical technology, and the

skill to be able to 'think outside the box'. Multidisciplinary collaboration with behavioural sciences is important.

#### **Expertise and clinical domain: research evidence**

To appreciate fully the vital importance of clinical research in family practice, requires acknowledgement of the fact *that* FPs possess a unique clinical expertise. This seems counterintuitive, particularly when family practice is presented as 'general practice' and contrasted to 'the specialist'. One of the charms of research is that facts can speak their own language and make their own point, and in this respect an old and almost forgotten study may help.

The study was done in 1982 in the Netherlands, by researchers who were interested in clinical decision making. They compared the clinical performance of FPs and internal medicine physicians in hypertension management [11] (*figure 1*). Both groups of doctors were presented with two cases: 'uncomplicated' hypertension and 'complicated' hypertension and their performances were scored on the basis of pre-defined criteria. FPs, when confronted with 'uncomplicated hypertension' demonstrated an effective performance and achieved their objective with relatively few diagnostic and therapeutic interventions. This changed, in the case of 'complicated' hypertension: FPs' performance took more time and became much more explorative, using more diagnostic and therapeutic interventions. This was in contrast to the performance of internal medicine physicians, who demonstrated a much more focused and efficient approach to 'complicated' hypertension.

Figure 1: Comparing fps and physicians-internal medicine [11]

	UNCOMPLICATED HYPERTENSION	COMPLICATED HYPERTENSION
FAMILY PHYSICIANS	Few interventions Limited time Purposeful	More interventions More time Exploring
PHYSICIANS	More interventions More time Exploring	Protocol driven Relative limited time Purposeful

This is fully in line with expectations, and often without much further ado it is concluded that internal medicine physicians are better equipped than FPs to treat health problems such as hypertension. This is why 'specialists' so often maintain a key position in continuous medical education and it is also the reasoning behind special interest on clinical programmes in which

FPs are exposed to the clinical world of the hospital setting to improve knowledge and skills. In this respect it may be interesting to further follow the study findings and look at performance of internal medicine physicians when they found themselves confronted with 'uncomplicated' hypertension: under these circumstances they took more time, adopted a more explorative approach and used more diagnostic and therapeutic interventions. What the study in fact demonstrated was the importance of the clinical domain for medical practice. FPs working in an environment of 'uncomplicated' hypertension set all hypertension against that norm and focuses their care accordingly. Identification of deviations from that norm invokes additional interventions. On the other hand, the physician's clinical domain is that of 'complicated' hypertension, and exceptions to that rule ('uncomplicated' hypertension) can only be dealt with at the expense of additional interventions.

What is true for 'uncomplicated' hypertension is also true for 'early signs/symptoms', signs/symptoms in the absence of an obvious somatic, physiological explanation and many other health problems that FPs have to deal with on a regular basis, and this is when professional experience is a valuable but poorly understood resource.

#### *The ecology of health care.*

The 'Ecology of Health Care' [12] analyses the place of care from a community perspective. In any community or population at any given time about 80 % of people experience at least one episode of poor health, and this is the recruitment ground for professional medical care. In fact about three quarters of them consider visiting a doctor. However, no more than one in ten are actually in contact with a primary care physician – most often an FP – and only a few per cent visit out-patient departments, home health care, emergency care or receive in-hospital care (figure 2). This reflects what is called 'the iceberg' of illness and disease: 90% of the individuals with a health problem are outside professional care, emphasizing the importance of self-care and lay care. The 'ecology of health care' quantifies the contributions of primary care and hospital care for society and for the course of this paper illustrates three paradigms of family medicine:

- a morbidity domain in its own right, different – in nature, presentation and prognosis – from the specialists' sector and it can only be studied in family practice (table 1) ('the correct diagnosis')
- a central role in legitimating professional health care, analyzing why patients seek care and navigating patients through the

health care system ('the correct application'). Table 1 exemplifies elegantly the diverse approach needed: the acute illnesses are to a large extent self-limiting with explanation and reassurance the most valuable interventions in an otherwise restrained approach. The chronic disorders, on the other hand, list all the major health problems of society and require pro-active, long-term care after early diagnosis

- a community perspective, directed at the most important needs of the community, relating health problems to social, societal and psychological determinants ('the correct interpretation').

Figure 2: The ecology of health care [12]

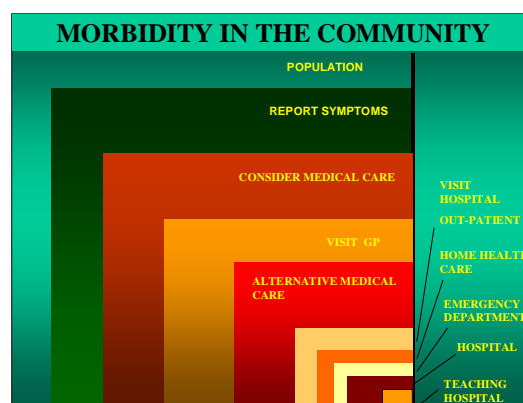


Figure 2 helps us to understand why high quality primary care is such a determining factor of the overall health status of communities. [13] It should, however, be a sobering thought for the discipline of family medicine that this effectiveness is to a large extent based on clinical *experience* of FPs which is based on rather than *evidence*: procedures of early diagnosis, predicting over-medication and medicalisation or strengthening self-care have thus far received scanty attention in clinical research. [14] A better understanding of FPs' clinical decision making might harvest vital evidence to further strengthen primary care expertise. PBRNs offer an excellent setting to explore diagnostic and prognostic research in depth and to take into account existing expertise, for example with 'usual care' as one of the study's modalities.

An intriguing example of the poorly fathomed 'value' of FPs expertise comes from the sad experience in promoting large scale use of hormone replacement therapy (HRT) for 'healthy' post menopausal women. This practice was triggered by a descriptive study in 1991 that reported cardio-protection of HRT. [15] After millions of women were put on HRT, however,

RCTs reported an elevated cardiovascular and breast cancer risk. A methodological analysis of how to explain these contradicting findings illustrates a number of points. It emphasizes the limitations of descriptive research, which depends on the actual treatment given to patients studied. *Selective* prescription of HRT to women at low cardiovascular risk is a most likely explanation of why the initial study [15] was, in hindsight, misleading. [16] This exemplifies how FPs' clinical experience, with their awareness of cardiovascular risk, was more than a decade ahead of the scientific knowledge of HRT risk. [17]

### Evidence, knowledge and understanding

The need of the discipline of family medicine is summarized by not just knowing what diagnostic and therapeutic interventions work, but by coming to an understanding as to why this is the case. Only then will it be possible to articulate the effectiveness of family practice as otherwise family practice will remain a 'black box'. The need of insight and wisdom on top of knowledge makes the case for qualitative research in addition to or combination with, quantitative methods.

Table 1 : Morbidity in family practice 1998-2003 [6, 10]

ACUTE	Incidence*	CHRONIC	Prevalence**
Respiratory tract infection	157	Chronic nervous complaints	143
Myalgia neck, shoulder, arm	126	Varicose veins	60
Functional complaints	117	Obesity	47
Minor trauma	100	Hypertension	42
Vaginitis (women only)	56	Deafness	33
Dermatitis	46	COPD	31
Tonsillitis	42	Hyperlipidemia	26
Low back pain	40	Asthma	23
Ear wax	40	Chr. Isch. Heart disease	22
Urinary tract infections	38	Psoriasis	15

\* incidence = number of new cases with diagnosis/1,000 patients during one registration year

\*\* prevalence = number of cases with diagnosis/1,000 patients during one registration year

This experience illustrates three other points of family medicine research, here only mentioned in passing: the need to study risks of medical interventions next to their benefits; the need to do so in a longitudinal design [10]; and the need to be aware of the importance of the external validity of research: the extent to which studies represent an important problem encountered in family practice and the degree to which the findings can be transferred – implemented – in regular family practice. PBRNs have the potential to deal with these aspects in a constructive way.

This is particularly true for the socio-medical context and the FP as a personal doctor. The paradigms of family medicine are founded on the view that diseases do not stand alone but take place in human beings living in a community and that this interacts with the lives of these individuals. But evidence of the practical implications is at best only weak and circumstantial. An interesting recent study of FPs' treatment of depression [18] may provide helpful data that the socio-medical context matters.

The study looked at the outcome of depression treatment by FPs in relation to their

performance. In a first analysis they addressed FPs' clinical competence – measured as their ability to apply depression guidelines – and found that FPs adhering to the prevailing guideline achieved, in comparison to FPs who did not, better outcomes for their patients. The second part of their analysis addressed the FP-patient interaction operationalised as 'empathy' (patient-centeredness). This resulted in four sets of outcome-determining factors, FPs who did or did not follow guidelines and did or did not relate well to their patients. The final analysis showed that FPs who demonstrated clinical competence in combination with an empathic relation with their patient achieved the best outcomes of their management of depression. In other words, it is the **combination** of clinical and inter-personal competence that determined effectiveness. There is a need to study this for a variety of health problems in a variety of health care settings.

### Conclusion

In conclusion, it is crucial for the future of family medicine to develop a culture of research and science that is directed to the field of family practice, involving practice, practitioners and their care of patients.

PBRNs are a recognized method to open the field for research and should be recognized by the research community as a vital part of research infrastructure. (Co-)ownership of research that is directed towards the clinical field relevant questions enhances the likelihood that research findings will be acknowledged and implemented and PBRNs offer a logical structure to share the study questions and findings with FPs and their staff. There are more and more signs that this approach will enable research in the unfathomed problems of clinical care and has the potential to change practice.

A second conclusion is that family medicine research should include a systematic exploration of the existing clinical expertise and reasoning of FPs and feed back its findings for FPs' professional development: the 'reflective' practitioner.

This results in research directed at the paradigms and core values of family medicine [Kingston]:

- The clinical field of family practice health problems;
- The aspects (inter)personal relations and behavior;
- The structure and community setting of health care.

The main scientific challenge is in the integration of findings from the variety of domains FPs cover. This calls for the use in a comprehensive way of different (qualitative and quantitative)

methodologies and requires a multidisciplinary study setting. It is essential to gain wisdom and insight in addition to mere facts and evidence. That will provide the rock-solid basis for FPs to provide solid, steadfast high quality care with the flexibility to tune it to individual patients' needs.

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## Practical Solutions ?

### Wonca Europe, its Networks and Organizations

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#### INTRODUCTION

Europe is characterised by diversity in all areas of society. One of the areas of diversity is the way health care is delivered, but some principles are universal. Family medicine has at least since Alma Ata been recognised as the key element of a good health care system. This importance is stressed by many declarations, policy papers and research articles.

Over the years, evidence of importance of family medicine has accumulated and there is more than enough evidence from research that show that the strength of a country's primary care system is associated with improved population health outcomes, that health systems with a strong primary care orientation tend to be more equitable and accessible and that using primary care physicians reduces costs and increases patient satisfaction with no adverse effects on patient outcomes. In the beginning of the 21st century, family medicine was well established in all health care systems in Europe. In most countries in the former Soviet block it has been accepted as the basis for their new health care systems.

The question remains whether family medicine has been able to meet these challenges put forward by policymakers and whether it was provided with sufficient resources to meet them.

#### WONCA

Helping in achieving a better position of the discipline in Europe is an important challenge for international organisations of family medicine, like Wonca Europe. The organisation was established in 1995 and represents the European region within Wonca world, the global organisation of family doctors.

It is an international organisation of colleges and networks organisations and represents the strongest region within Wonca world. Currently, Wonca Europe has 39 member colleges from... countries with a wide diversity of problems that need to be addressed. While some colleges are well established and well organised, the others still struggle in order to be properly recognised within the scientific and professional community.

The other constitutive body of Wonca Europe are its three network organisations. EQUIP, the European network for quality in general practice is concerned with the quality of care, delivered by general practice. EGPRN, the research network, is organising regular meetings of researchers in family medicine and is conducting courses on research training for general practitioners. EURACT, the educational network of Wonca Europe, is running courses for teachers in family medicine and has been very active in developing many policy papers, the most prominent are probably the European definition of general practice and the teaching agenda for general practice. Each of the network organisations meets twice a year. One representative of each of the networks is a member of the Wonca Europe executive committee.

Over the time, other networks have also been established. The most prominent are EUROPREV, which is the network organisation for prevention and health promotion, and EURIPA, the network of rural doctors. Both of them receive regular support for their activities through the organisation. Wonca Europe has recently been strengthened by the Vasco da Gama movement of young doctors. The movement was established during the Wonca Europe conference in Amsterdam in 2004 and has proven to be a very important component of Wonca Europe.

There are also groups with an interest in specific areas of medicine: there are special interest groups in respiratory diseases, in cardiovascular diseases, in occupational medicine. Their role to the organisation is very important, because they often serve as a source of expertise in specific clinical fields and in communication with organisations of clinical specialists on common projects.

The role of Wonca Europe is to work internationally by helping the exchange of knowledge, by networking with other organisations and to serve as advocates of the discipline internationally. The usual strategies include organising annual conferences, publishing a journal, producing statements and lobbying for policy changes at international level. These strategies have had some success in the past: the European Journal of General Practice has received a status of a journal, indexed in Medline, the European definition of general practice has been translated in most European languages and is often used in discussions with policymakers and lay people as a tool of explaining the importance of family medicine. The EURACT teaching agenda is a template that can be used for the development of curricula according to the new definition. The Wonca Europe meetings are increasing in attendance of delegates and are becoming a real meeting place of family medicine experts.

### **CHALLENGES FOR THE FUTURE**

Nevertheless, there are many challenges that need to be achieved. Europe has experienced a lot of changes in the last 30 years. We have proved to the public that family medicine has an important impact on health of populations. This important fact, supported by ample research evidence, means that we must take a proactive and not a defensive role. Family doctors are now increasingly being involved in the academic environment and are influencing the development of their health care systems through their professional organizations. As individuals they have been able to change in order to meet these new challenges.

Countries are constantly changing their health care systems, always claiming to be raising the importance of primary health care, but the practices are not always in line with their claims and the successes are variable. Some countries have shown great improvement in the development of the discipline over the last

two decades. In order for the organisation to become recognised as a true key player, a lot of work still needs to be done on its image, cooperation with the public and other professionals.

In the future, Wonca Europe is aiming at achieving its goal of increasing its membership so that every European country would be included in the organisation. Better cooperation with other professional organisations is necessary in areas of common interest.

Family medicine is able to take over the responsibilities of a well established discipline, which is characterized by partnership between the academy and practice. Theory has been useful in explaining why family medicine is unique, but future research should take into account the relevance of development projects in practice. New steps need to be taken, the steps that would prove our value to the public. They can be made only in partnership between the professional organizations and academic bodies.



## History ?

### Development of Family Medicine in Turkey

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The time period when one of the kilometer stones in Family Medicine (FM) in the world Francis Peabody emphasized in 1923 that “as a result of specialization in medical sciences patients standing abandoned and so there has to be a specialization branch to take charge of humans completely”, Republic of Turkey; after Turkish War of Independence, in health area; new structuring and fighting for contagious diseases and vertical (care specific) organization were started to application. In those dates physician count was 554 in our country for 12 million populations.

In 1947, when Dr. Behcet Uz was the Minister of Health (MoH), for health centers a new specialization education started with the name of “General Health Specialization” , but; this application ended in 1955. In these years there was improvement in FM in the world (FM/GP applications in England 1947, Canada FM College 1954)

In 1970s when discussions about primary care were in spotlight, “family physician” term also started to use. These years were following to formation of Millis and Willard Reports in USA (1966) and American Board of Family Practice (1969). In these years there were two kilometer stones for international improvement of FM (1974; Leeuwenhorst, 1978; Alma Ata).

In our country “Specialization in Family Medicine” took place in Physician Specialization Regulations by 05 July 1983 (Spain 1979, Italy and Norway 1985, Greece 1986) and first department set up in Gazi University. Specialization education started in 1985 in Ankara, Istanbul and Izmir MoH education hospitals.

Association of Family Medicine (AHUD) founded in 25 July 1990 (After that in 2 March 1998, with the decision of Council of Ministers that name changed as Turkish Association of Family Medicine “TAHUD”.)

Ministry of Health, Health Project General Coordination organized a group study in Ankara about “Family Physician Education to Improve Primary Care Health Services” in 1-2 September 1992.

First “Family Physician Trainer Course” in our country coordinated between 26 – 30 April 1993 in Ankara by Ministry of Health (with educational support of Royal College of General Practitioners) and 88 family physician specialists had trainer certificate.

According to YOK ( The Council of Higher Education of the Republic of Turkey) decree in 16 July 1993 (number: 12547); “it is suitable to set up family medicine departments in medical faculties”. Following to this decision in 17 September 1993, Family Medicine Department set up and resident training started in Trakya University/Edirne.

First National FM Congress organized in Istanbul through 25-26 November 1993. In 27 May 1994 as a first Assist Prof as a family medicine specialist appointed to staff (Osmangazi University/Eskisehir).

By MoH, Ankara in 1994, than Bursa and Izmir in 1996 “Family Medicine Application Centers” opened, but this application couldn't grow up and not reached to success. In following years similar applications announced to start in Bilecik but couldn't accomplish!

“Branch Directorship of Family Medicine” set up in MoH, Basic Health Services General Directorship in 26 October 1994 and further years changed as a department.

In this period, AHUD have initiated postgraduate educations for family medicine specialists and residents. (“*Immunization Course*” 10-11 April 1995 in Izmir was the first activity that certificated in this area.)

In April 1995; “Family Medicine Specialization Curriculum” published by MoH, Health Projects General Coordination preparation at the result of some studies with more than 200 applicants, previous years. Same year, FP symposiums realized in Trakya ve Cukurova Universities.

AHUD had role in WONCA Europe Regional Meeting in 7 September 1995 and improved international relationships.

Our 2 friends succeeded in FM Assoc Prof examination in 1996. Five of 23 family physician specialists who succeeded in Assoc. Prof. examination until 2007 appointed to Prof degree.

Turkish Board of Family Medicine (TAHYK/TBFM) lined up in 6 December 1998, studies in this topic accelerated especially in 2004; as a result of wide participated and long breath studies, “*Family Physician Specialization Education Core Curriculum*” and “*Assistant Report Card*” published.

Journal of Turkish Family Medicine; has been regularly published since 1997. It is registered in Turkish Medical Index. Besides; last years grasping of discipline importance in our country, growing staffs and with the increased experience published book and scientific journal count had an increase (PRN Aile Hekimligi Dergisi, Aile Hekimligi, Turkish Journal of Family Medicine and Primary Care-on line..).

Until today, 7 national FM congresses organized. After 2001, without congress coordination years, organized National FM Days count has reached to 4. Scientific activities of TAHUD substations in their regions going on with a progressively increasing manner, their number reached 8. Besides, existing 38 FM department's pre and post graduate period activities going on with growing manner.

As a first international activity EGPRW (EGPRN) Meeting organized in Ankara through

8-11 May 2003. Additionally “WONCA Europe 2008” will be organized by TAHUD in September 2008 in Istanbul.

TAHUD, affiliated to international corporations in its area and its representatives are actively taking part as executive members.

According to (9 December 2004, 25665) “Law in Family Medicine Pilot Application” and with its support (6 July 2005, 25867) “Ordinance in Family Medicine Pilot Application” laws, pilot application started in Duzce since 2005 and recently expanded to 10 cities and aimed to increase 22 cities in 2007.

In steps of regulations’ development and application, having discipline–system conflicts, transition period educations and pilot applications even major spotlight topics of FM specialists and country.

Today Family Medicine is beside a young discipline have dynamism that brings community needs, believe to express qualified service, educated staffs that working beside futures and experience; is one of assurance of healthy future of our country.

## Family Medicine in Europe

### Family Medicine in Lithuania

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Lithuania is one of the three Baltic States, which regained independence in 1990. Back in 1989 a Congress of Physicians of Lithuania took place in which the necessity to reform the health care system was discussed. To implement these reforms the National Health Care Conception was adopted in 1991 by the Parliament. The main goal of reform – to optimise health care resources and services for better health of population. The development and reformation of Primary Health Care was underlined as a key factor of a whole Health Care Reform. The main concept urges development of the primary health care services reorienting them from disease centered episodic activities to patient needs, continuity, comprehensiveness, health promotion and disease prevention.

For this purpose in 1992 departments of Family Medicine were established and family medicine residency program was created in Kaunas University of Medicine and Vilnius University. At that time first 30 resident students were admitted to the residency. According to the reform goals, all practicing physicians in primary health care level (district internists and paediatricians) should be replaced by family doctors (GPs) until 2010 year. With an average of 1600 population per one GP, Lithuania needs approx. 2100 GPs. That means, that approx. 1700 district doctors should be retrained into GPs and other 500 should be trained by regular residency. Therefore since 1997 retraining process of district doctors started in both universities and every year graduates approx. 250 of trainees. In the year of 2000, 1000<sup>th</sup> graduate received

Family Medicine diploma. Currently (at the beginning of 2007) there are almost 2200 trained or retrained family physicians.

During 2001-2002 years residency program was upgraded. The EU experts recognized the program as conforming to the EU requirements.

In 1996 the Lithuanian College of General Practitioners was established, which in 1999 became a full member of WONCA. Currently there are over 300 members of the College of GPs. Main goal of the College – promotion of continuous medical education and quality of care. Under guidance of the College or Department of Family Medicine of Kaunas University of Medicine national conferences for family doctors takes place 8 times per year and 200-300 participants take part in these conferences. Since 1999 y. 30 to 60 GPs – members of the College participates in WONCA events every year.

In 1997 a scientific journal for family physicians “Lithuanian General Practitioner” was issued. Today it is a monthly magazine printed in 1000 copies. This year the magazine celebrates its 10<sup>th</sup> birthday. Almost a half of all pages of the journal is devoted for publication of scientific articles, 30 percent of them family physicians are authors and co-authors. The journal is also available on the website <http://www.bpg.lt>. In 1997-1998 and 1999-2000 PHC reform process was reinforced by PHARE interventions: 40 trainers in family medicine were trained, two university departments of Family Medicine were equipped, and

establishment of 54 private GP clinics across Lithuania was supported.

**Family medicine today:**

Currently, more than 2200 family physicians have graduated and 100 more are studying in the residency. Primary health care services provided by family doctors gradually is increasing and currently covers approx. 75% of Lithuania population, of them 97 % rural population particularly. 200 public and 120 private GP clinics are in operation. Health care system financing principles are based on compulsory health insurance. PHC services are reimbursed by capitation fee of patient list, which average is about 25 Euro per capita per year.

Since 1998 existing partial gate – keeping role in 2002 was switched to complete gate-keeping. That means – all health problems (excluding critical emergency) must be seen and evaluated by GP. Since March 2003 some elements of “fee for service” are coming up: “fee for service” principle is used mostly for preventive/monitoring activities (early cancer detection, Pap smear, mammography, cardiovascular diseases risk evaluation, prostate cancer marker evaluation). It takes approx. 25-30 % of whole physician/nurse reimbursement part.

*Problems:*

1. Not all GPs graduates are practicing family medicine (almost 25 % of them after graduating of retraining returned to district doctor practice or do not practicing family medicine at all).
2. PHC services provided by GPs remains oriented to problem solving rather to problem prevention;
3. GPs does not operates in full professional competence (range);
4. There is lack of stimulation to perform quality and/or comprehensive services by GPs;
5. Family physicians and other PHC service providers are overloaded by paper work – to 60 % of daily working time GPs spend on paper works.
6. Insufficient income does not allow to provide “patient friendly” services (short consultation time, long waiting list, beaurocratic referral system, lack of preventive activities), and keeps physicians on “looking for additional earning” regime;
7. MOH regulations as “primary health care provision round o’clock despite holiday days” does not match with practical/financial potency of PHC settings;
8. Absence of e-health system negatively interacts on accessibility and continuity of care and in-time exchange of patient data between primary and consultant levels.

**Initiatives for Establishment of Rural Health in Hungary****Simek Ágnes<sup>1</sup>**

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**Abstract:**

There is a strong and well-managed primary health care in Hungary which fulfils quite well its gate-keeper function. But there is no rural health care. The disadvantages of the villagers are considered as a social problem.

Hungarian Academic Association of Rural Health (HAARH) set its main target in 2003 to form and elaborate rural health care in Hungary.

The association has finished different studies on health and social status of rural population, on the health services in rural areas, on the mental status of rural family physicians, on patient-compliance and on cost-effective medication.

The members of HAARH made efforts on implementing Rural Health as an element of Medical Universities' curriculum, to disseminate the knowledge of Rural Health among non medical partners, to make Rural Health accepted as an independent discipline and to be studied in health care universities.

The studies are finished, their results are published, and the ongoing new surveys are on alcoholism and on hypertension.

The Association has its special conference in every year on different topics in connection with rural and remote health. The summary of them are sent to the chief officers of Health Care in the Ministry, in the Public Health Institute and in the Professional Chamber.

HAARH reaches the honour to be accepted as a special group of Professional College of Family Medicine and takes part in the preparation of elaborating professional guide-lines for GP's and represents special interests in preparation of different laws. Rural health is taught in the Medical Universities, and members of HAARH pays active role in the forming of curricula. A functioning and fruitful cooperation is under construction with the Hungarian NGO-s and with the national and international Rural Health Associations.

**Introduction:**

There are relevant data of Hungarian Statistic Office: 8 % of Hungarian population is declared to live from agriculture, 60 % of Hungarian population is living in rural area, 42 % of urban population have „hobby garden” in rural area, Hungary is declared to be „industrial country”.

Rural family physicians have their experiences:

**There are less cultural, social, educational opportunities in the villages.**

Villagers are poorer, less educated, worse informed in comparison with citizens.

There is worse accessibility, opportunity to get proper indicated services for the villagers.

In 1991, an association called **FAKOOSZ** was established which a Trade Union is for Rural Family Physicians. This organization - beside the others defends of interests in education as well.

Its scientific activities have been:

- Functioning as mentor, lecturer in the **Universities**, leading special colleges on rural health, taking part on creating educational curricula of Family Medicine Department.
- Giving **presentations** on rural health problems and surveys on local, national and international conferences.
- **Cooperating** with organizations on Rural Health in Hungary and abroad.

**Aims:**

In 2003, **Hungarian Academic Association of Rural Health** was founded to broaden the scientific activity of FAKOOSz independently, focusing only on the Rural Medicine and education.

Its main targets were:

In the field of health care

- To define health status of rural population
  - Specificity of rural health care
  - The differences between health care in rural and urban areas
- To make steps for reaching equal services
- To guarantee equal chances
- To implement community health care in the field of education
- To continue scientific activity
- To take part in gradual, post gradual education, in CME
- To reach the acceptance of Rural Health as independent, complex science
- To continue cooperation with national and international organizations
- To synthesize different activities in Hungary in rural health

- Activities
- Motivation
- Education
- Active work
- Evaluation

It means different **audits** have to be delivered for health promotion for improving the service in rural area, for ensuring equal chances in the healing process of the villagers.

Introduction of quality **assurance** was considered one of the basic elements of providing the same services for the rural population. Individually, in small groups rural family physicians has been educated in this field and applied the knowledge in the everyday work.

In the education, managed by the Association new elements small group education, consensus-groups and the method of andragogy were adapted.

#### Method:

What could the rural family physicians do working isolated all over the country?

The work-plan below was set up:

- Relevant data collection
- To define which are the severest problems
- To set up priorities
- To define what we ought to do?
  - What we are able to do?
- How we can manage it?
  - Collaborators, supporters
  - Financial background
  - Methods
  - Manpower – participants
  - Tools

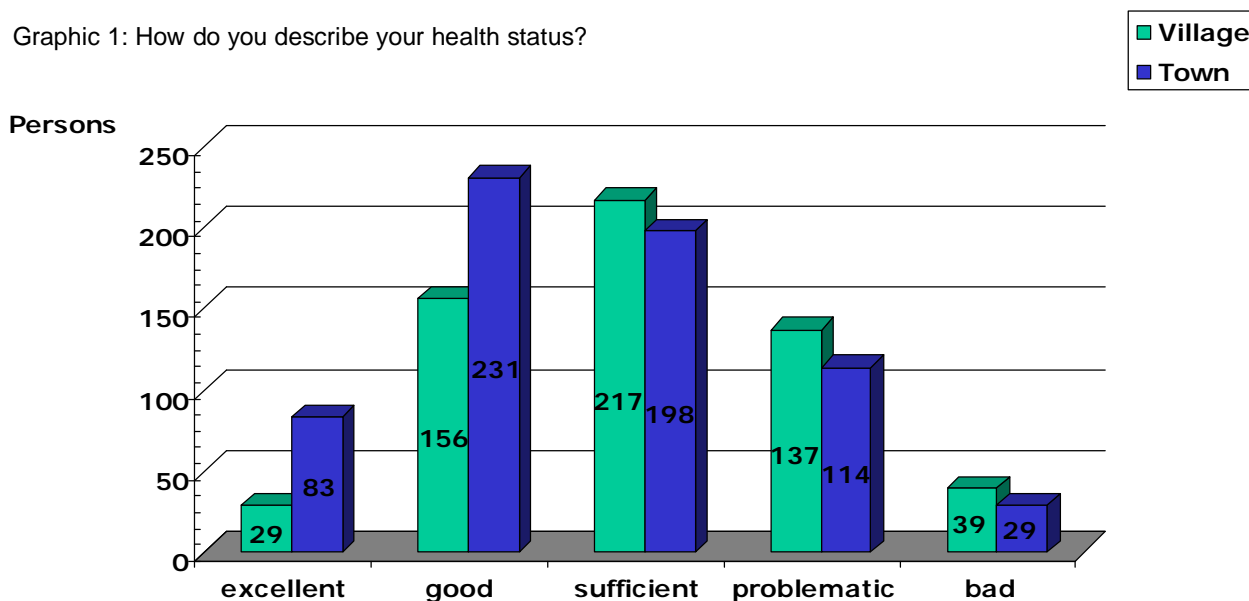
#### Results:

The first large assessment made for gaining relevant data was the "**Health status of rural population by the patients' estimation**".

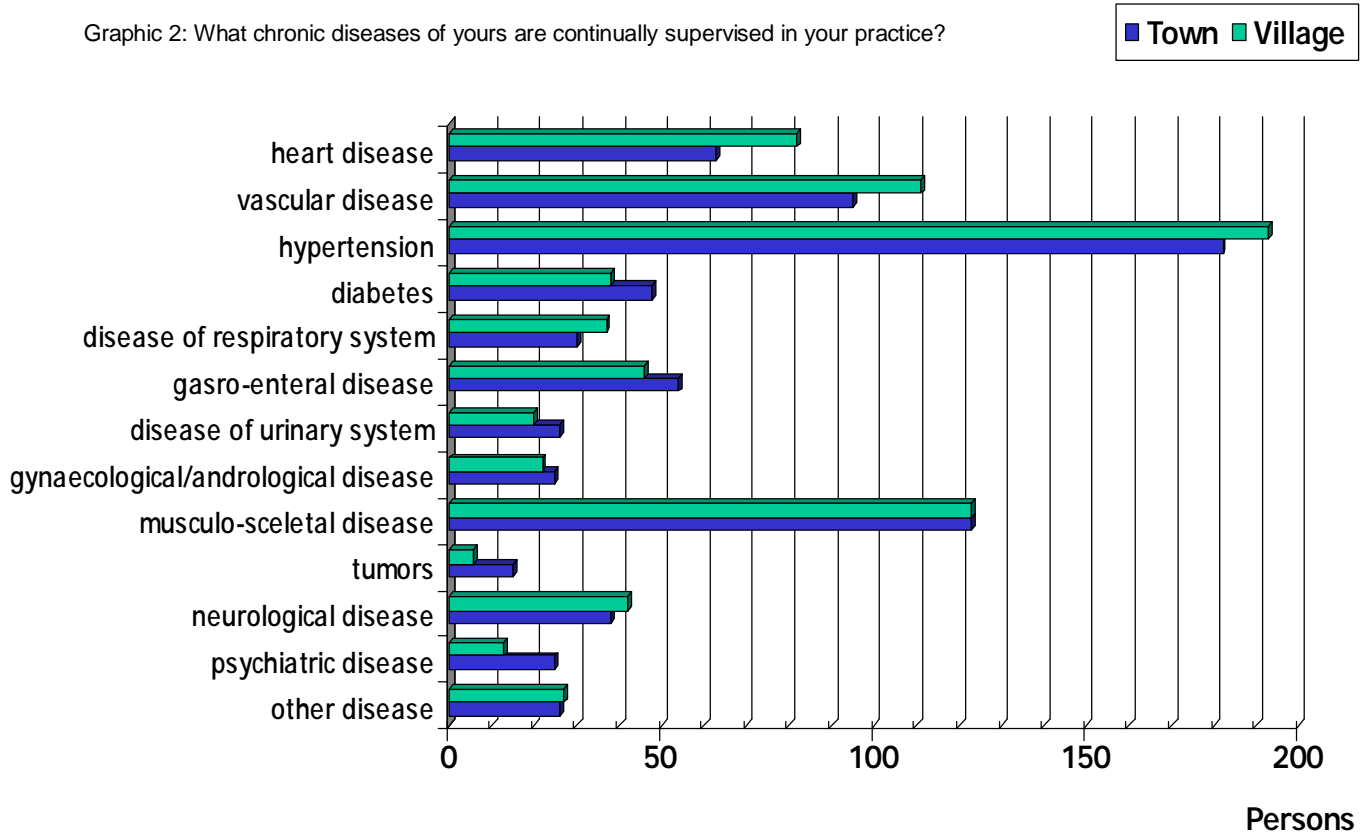
The tested patients had to describe their health status, their everyday complains, to give data about their social background, their education, the accessibility and the consumption of health care.

There are only some basic elements from the long and detailed survey.

Graphic 1: How do you describe your health status?



Graphic 2: What chronic diseases of yours are continually supervised in your practice?

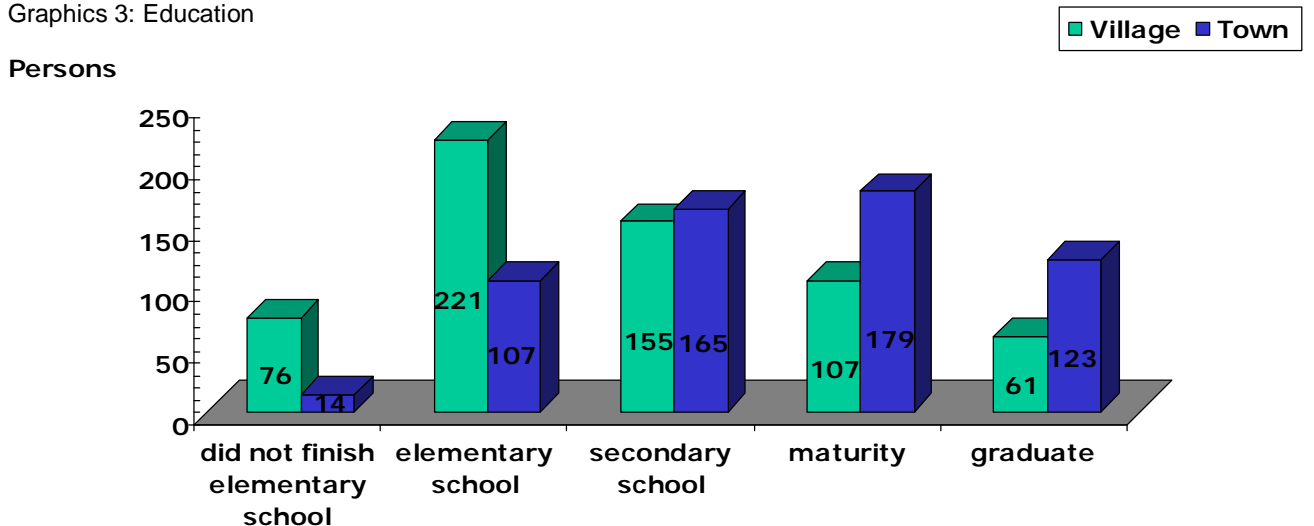


The rural population consider their health status worse than that of the citizens, and they are really under medical supervision due to more chronic diseases.

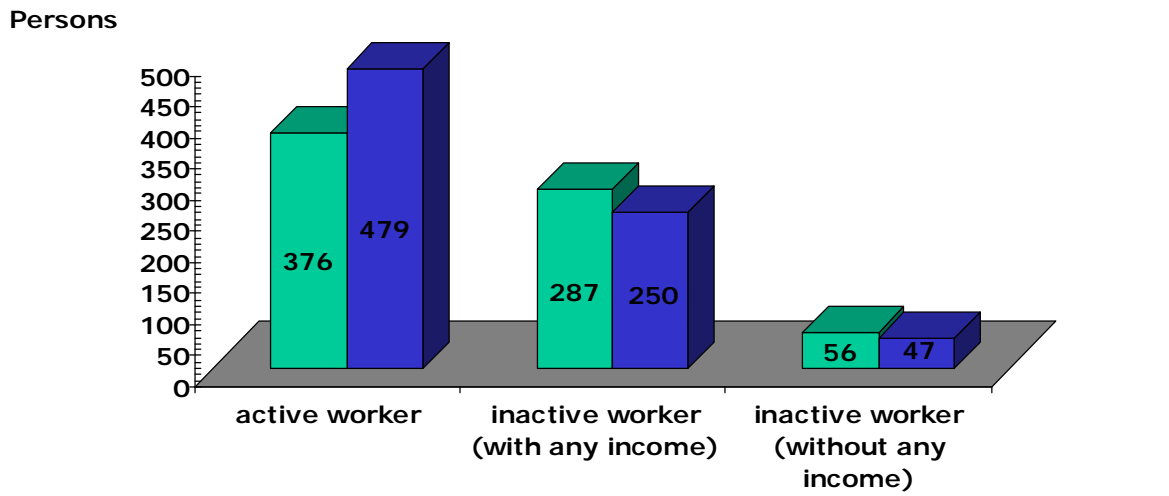
**Social background of rural population**

Also the daily experience that the social background of the villagers are worse than that in the urban area and the educational level of the rural population is lower than in the cities.

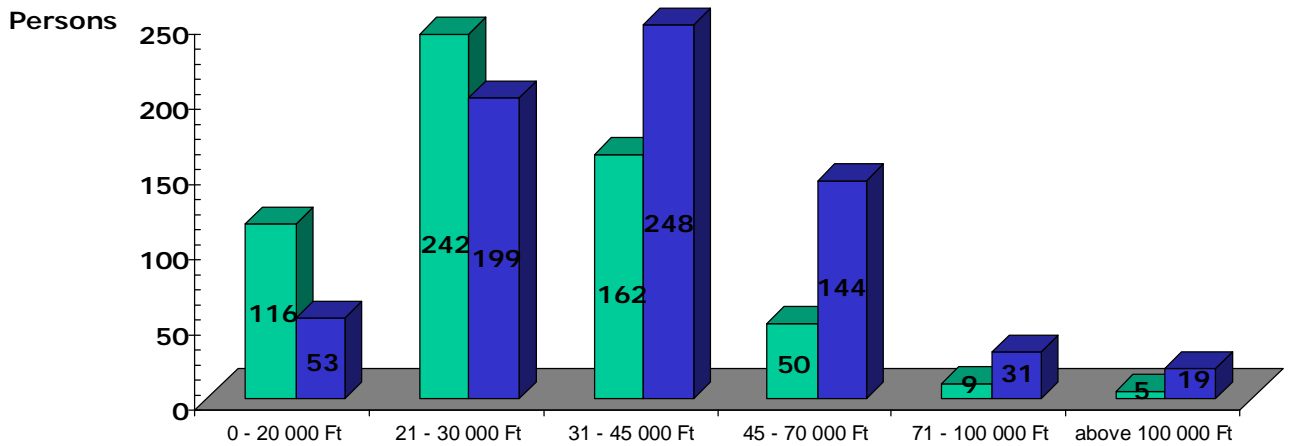
Graphics 3: Education



Graphics 4: Employment



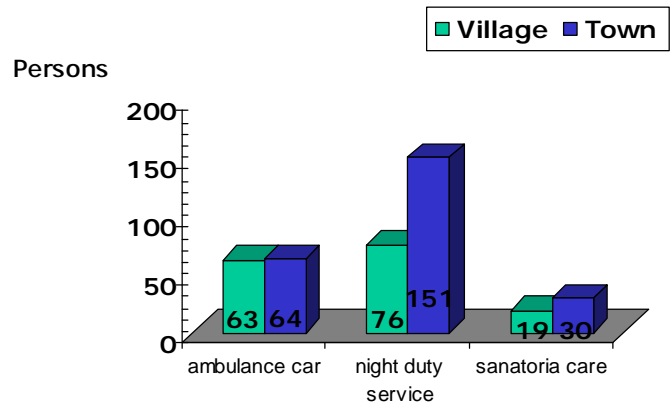
Graphics 5: Average income



Graphics 6: Did you apply for ... in 2000

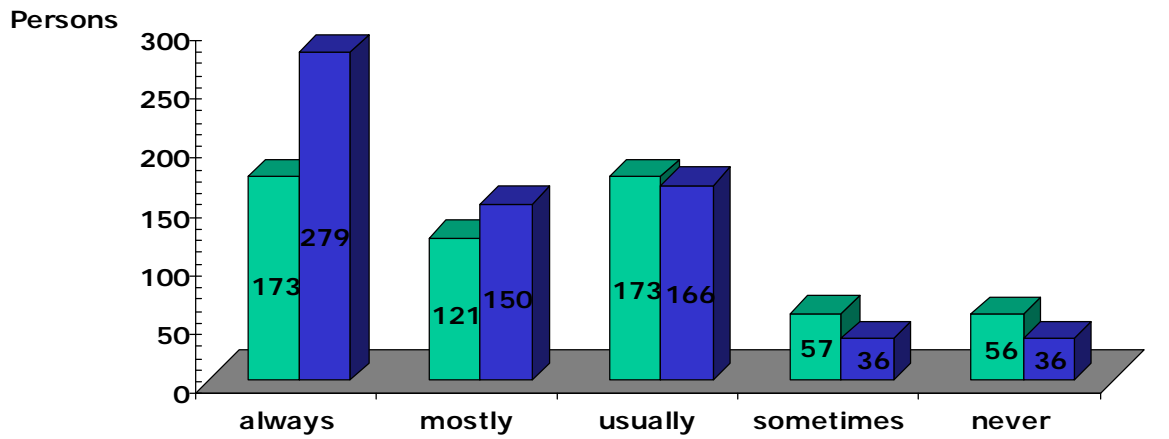
**Accessibility of health care for rural population**

The other crucial element of rural health service is accessibility. Only two flashes from the numerous disadvantages of the rural population which are the result of bad roads, old cars, bad telephone communication and poverty.





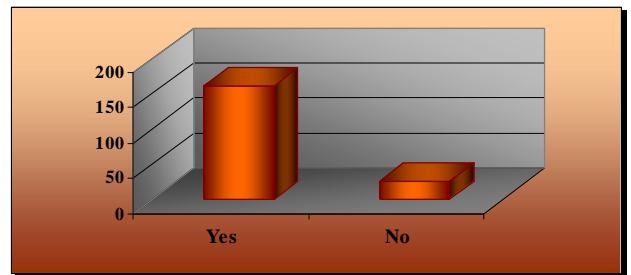
Graphics 7: Is the health care available for you after surgery hours?



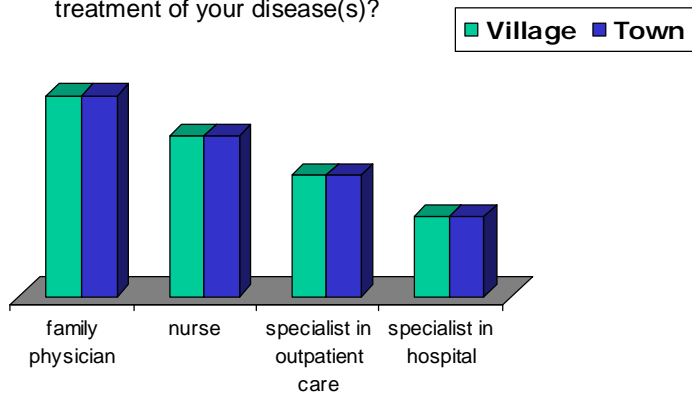
**Cooperation**

The evaluation showed out that the compliance and the intention for cooperation with the primary health care staff is the same in the villages and in the cities.

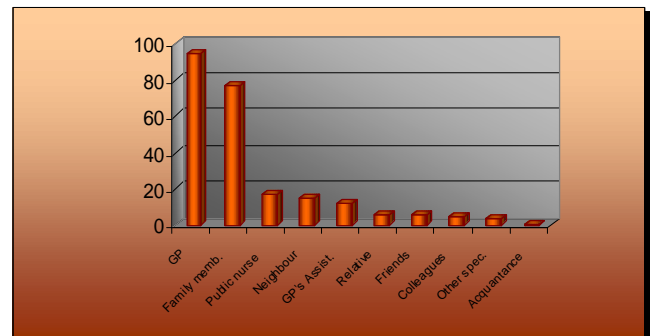
Graphics 9: Do you follow only the prescription of the GP?



Graphics 8: Who are the participants in the treatment of your disease(s)?



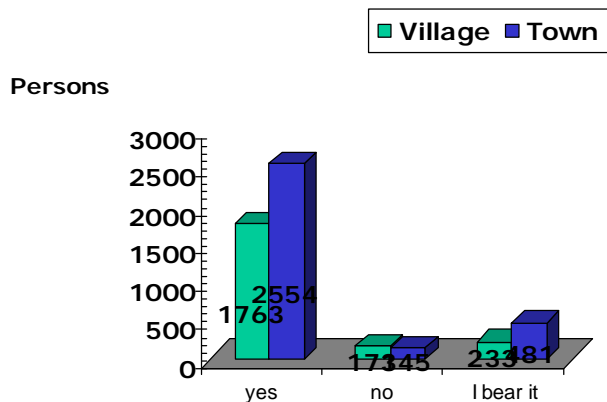
Graphics 10: Whom do you turn to if you have any health problem?



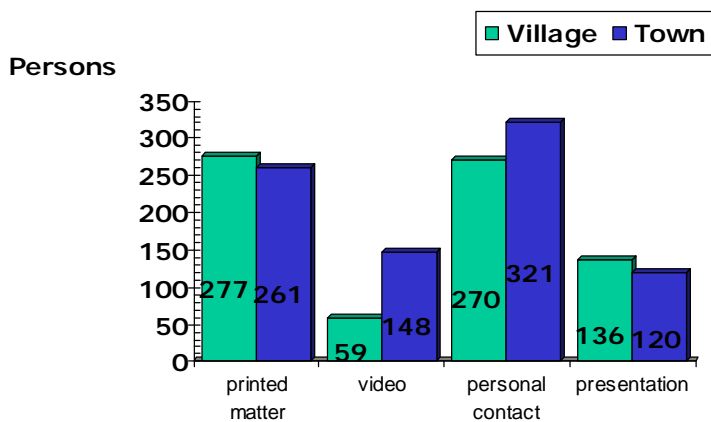
In an other survey the acceptance of the GP's treatment was detected.

In the previous study there were some questions on information.

Graphics 11: Is it important for you to call your attention to the most frequent illnesses of the population?



Graphics 12: What is the preferred form of the information for you?



After these two surveys the **priorities** were set up. The most important elements what must be improved in rural health care are:

- Accessibility
- Continual care
- Education

**Accessibility** depends on the condition of roads, on the telephone-net, on the location of out-patient care institutes and hospitals. The government implemented wide-spread and

basic reforms in health-care this year which aimed to solve these problems.

5 years ago a new service was introduced in primary health care: Controlled Patient care, which provides the easiest, simplest, more complete way of medical care for the sick persons. The system requires the correct recording of screening and preventive activity of the medical practice and continual reporting of the care of **chronic diseases**.

The third and actually investigated element is **Continual Patient Education**

Hungarian Academic Association of Rural Health elaborated last year an **educational program** for teaching the population the most important elements of health promotion.

**In nursery** we suggest to deal with the hygiene of the body, and the environment and make plenty of physical exercises in every time and every place.

**In elementary school** the pupils should have to get all knowledge about their body, about the physiological processes, about the healthy lifestyle and get some information on first aid. Beside that they should have been led on different excursions on the ground, on the waters, maybe in the air. They must learn the life-threatening situations and to be able to avoid them.

**In secondary school** beside the "official subjects" we consider a very important topic to deal with problem solving practices, to acquire ability of prevention of depression, to avoid abuses. Students could acquire the elements of home care, to recognise the most frequent symptoms of the most common diseases. They should continue to adopt the elements of healthy life-style: regular regimen, permanent moving exercises, and healthy diet.

Beside the above all of **adult population** should have to know the element of self-treatment, the signs in different illnesses when to turn to doctor is inevitable. They have to take active part in continual care and they should have information on different social services for sick persons.

For the population suffering from given diseases "**patients clubs**" must be organized for changing information and for continual education.

The result must be to reach the well educated patient, who considers his/her health as a value and who take part with high compliance in the common work.

We also have to endeavour to form for the cooperation between governmental and non

governmental organizations, to make the basis of community health care for providing equity and equality to the rural population.

In this task Primary Health Care and also the Hungarian Academic Association of Rural Health has great responsibility, which we undertake and try to fulfil for our patients' right.

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## EURACT Educational Agenda: The Way to Implementation

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The EURACT Educational Agenda is an official document, adopted in 2005 by the European teaching community, that translate the new definitions of the GP/FM profession into a list of competencies that should be achieved at the end of vocational training, and should be maintained during lifelong learning. It describes the competencies in 8 chapters, 25 competencies and 80 subcompetencies. It puts GP training and learning in the international trend of harmonizing the roles (like CANMEDS) or balancing against other specialties. But what can be done with this list? Practical implications will be discussed starting from different testimonies: translation exercises in Portugal and Italy, implementation efforts in Poland, framing of future education curriculum in UK, construction of an electronic check list system to guides progression and completeness of the learning process in Denmark and Belgium. The purpose is to give a clear view on the content of the agenda, the value and the usefulness of the competency framework for their personal and national purposes.

### Why an educational agenda?

It is designed to provide a framework to teach the core competencies for those involved in delivering general practice education and in developing programmes of teaching general practice. However not only can it be used by individual teachers and course organisers but also should be used to determine priorities in teaching and learning general practice and contribute to national policy development. Calling this an “agenda” is deliberate. By this it is meant that it is both a dynamic review of where we are now in family medicine teaching and learning in Europe and it marks where work has still to be done - the other element in “agenda”. It is hoped that it will lead

discussions, reflections and amendments, and will stimulate groups of experts to discuss some of the themes, and the production of further papers on the issues raised. After some years, this may lead to updated versions.

A background for recommendations to curriculum developers and researchers  
For the last 30 years family medicine has led the way in developing education methodology, educational processes and assessment. This has been in spite of working in education systems designed for the training of other disciplines and in institutions where family medicine is not practised. With the increasing pressure on the medical curriculum it is important that we address these issues. In a number of countries training programmes are being extended and the locus of training is changing towards general practice placements and away from hospital attachments although the situation is very variable.

### The central focus is general practice vocational (specialty) training

If the new definition of the discipline sets out the core competencies that have to be acquired to be called a trained GP/FP, then the educational agenda must support and underpin the content of the GP/FM specialty training in Europe. The six core competencies for the discipline are the starting point and this document uses these as the framework for its six agenda-chapters. They can be seen as the hallmark of a GP/FM educational program, and should be at its centre. In each of the chapters we identify the specific educational objectives, and from these derive appropriate learning and assessment methods, and the specific options for the setting and the timeframe within the curriculum.

From time- and discipline-based to competence-based learning

In this document we have decided to stay at a global conceptual level and have not outlined more detailed statements on such things as time and place. We want to promote a move from time- and discipline-based to competence- and outcome-based learning. We need to move away from the time- and institution-based thinking about the curriculum towards producing a relevant education programme both in and for general practice that is mainly competence driven.

Harmonization in Europe at the level of learning outcomes

With this educational agenda, we want to contribute to the harmonisation of the learning outcomes of the different educational programs all over Europe at this level. Perhaps it is sufficient to achieve an optimal “tuning up” of the national specialty training programs, by growing to more and more convergence and common understanding. EURACT hopes that this educational agenda, derived from the core competencies accepted by all European GP/FM academies during the WONCA Europe meeting in London 2002, completed with the learning options defined in this educational agenda and presented at the WONCA Europe meeting in Amsterdam 2004 can lead to an acceptable harmonization instrument for the content of the vocational training all over Europe.

#### Case Vignettes

Case Vignettes were created and will be more created to see EEA in the practical life of Family Medicine, to stimulate thinking, reflexion, teaching and learning so to consider that and how all six core competencies are in many real daily situations in our offices and to reflect how they are different and at the same time so similar and how they can help family doctors to afford and resolve the cases in their daily work for patients.

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## Sport Program in Older Adults

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The effects of aging become noticeable usually around the age of 30 years, after the maturity is reached at age 20 to 25 years. The age-related physical and physiological changes vary from one person to another and from one body system to another within the same person, and generally these changes cause decline of organ function.

One of the reason of these negative physiological and physical changes is physical inactivity. It is recommended being physically active living and doing exercise to delay aging effects, to prevent developing or worsening of chronic diseases, and to improve quality of life. Because of these properties, exercise can be accepted as a medicine. Exercise and medical prescriptions are quite similar. When prescribing exercise, its' action (aerobic, strength, flexibility), dose (function of intensity, and duration), therapeutic goal (frequency), and half-life (length of time for recovery from an exercise session) should be taken into consideration.

Aging is a period which is encountered diverse and multiple health problems and can be characterized by a decreased ability to adapt to and to recover from physiologic displacing stimuli. Therefore, before the planning of exercise, (a) subjective data (complaints, symptoms, recent experience related with exercise, demand, medicines used), and (b) objective data (information collected during physical examination and laboratory studies, e.g., aerobic, endurance, strength, flexibility, neuromuscular, and functional performance tests) are collected. Using information from the subjective and objective data-gathering steps, a list of specific problems is generated (c). Then overall management plan including exercise programming is formulated (d) and a schedule for follow-up reassessment is developed (e).

The main factor which is taken care when selecting and getting objective data is the safety, and the effect of the tests on the older adults. The older adults' exercise and test responses may be different even though they are the same age. Additionally, test response can be affected by individual's condition, loss of physical and physiological capacity, chronic disease, and sometimes it is very difficult which factor is responsible from this situation. Finally, latent or asymptomatic diseases can be triggered by the exercise tests. Therefore, medical control is necessary before the tests and exercise in older adults, submaximal tests are preferred, and usually medical supervision is required during the tests according to the medical recordings and the test results.

After discerning the older adult's problem (s), the following tests which are the most appropriate and the best characterized the exercise capacity can be selected: treadmill or cycling with modified Bruce, Naughton, Balke or Ware protocols to measure the *aerobic capacity*; 6-minute or 12 minute walk tests to measure *endurance*; dynamometer, isokinetic equipment, free weights and 1RM or 4-8RM to measure muscle strength; one-leg balance and tandem walk tests to measure neuromuscular condition, chair sit-and-reach, and back scratch tests by using tape measure or goniometer, and flexometer to measure flexibility, and functional performance tests such as chair stand, biceps curl, and up-and-go to measure ability doing physical activities of daily living.

The main purpose of the exercise in the older adults, is living healthy, and in good quality. The exercise program which will be formulated after getting subjective and objective data, and also listed the problems should include aerobic, strength, flexibility components, and the goals of the program should be to increase balance and coordination, improve

independency on the daily living activity. The program should also be bare, sustainable, and acceptable by the client. Additionally, socioeconomic position and facilities of the older adult, nutritional status, clothes and shoes weared, environment conditions such as temperature, humidity, altitude, and ground should be taken into consideration. It is very important the compliance of the older adult and to continue the exercise program regularly. Thus the gain provided by the exercise can be conserved and is not lost. Therefore, the exercise experience of the older adult and his demands and requests are asked and the client should be informed about the content of the program and the importance of continuity. Exercise training properties such as; type, intensity, frequency, and duration should be taken into consideration when giving the exercise prescription. Because there is decline in balance, cognition, organ function, muscle mass and strength, repairment process after injury, working capacity, proprioception, coordination, visual, and auditory function, and also most of the older adults have chronic diseases which affect exercise capacity.

Low intensity and short duration during initial phase of programming exercise should be necessary. Then, the intensity is increased according to the client's response. Adaptation period may be choosen as two or three weeks. Warm-up and cool-down periods should be as long as 10-15 minutes. Periodic evaluation and motivation of the older adult is important to compliance the program.

The muscles which will be strengthened are determined according to the muscle test results, and the most used muscles in the daily living activities are selected. Free weight, isokinetic equipment, and theraband may be used as a load. Initial intensity can be 13-14 Rating of Perceived Exertion (RPE) or 30-50% of 1RM or multiple RM (4-8 repetition), and is increased progressively. Progression is arranged through increasing repetition, number of sets, and/or intensity according to the client's response. Daily training session is 20-60 minute, and frequency is 2-3 days in a week. When the training intensity is low, the rest period between the sets may be in short duration (70% 1RM intensity, 2-3 minute), however if the training intensity is high, the rest period between the sets should be longer (90% 1RM intensity, 4-5 minute).

Physical activities such as walking, cycling, and swimming which use large muscle groups are suitable as aerobic activities, and may be 3-5 days/weekly. Daily training session begins with 5-15 minute, and may be increased to 60 minutes, the training intensity should be low or

moderate. There are several methods of determining the training heart rate, such as RPE, maximum heart rate, maximum heart rate reserve, and metabolic equivalent (METs) or  $VO_2$ . Initial training intensity may be low (10-11 of RPE, 35-54% of maximum heart rate, 20-39% of maximum heart rate reserve, 2-3.9 of MET) or moderate (12-13 of RPE, 55-69% of maximum heart rate, 40-59% of maximum heart rate reserve, 3.2-4.7 of MET) according the client's situation, and is progressed gradually. Intensity or daily training duration (preferable) is increased in every week or in every two week.

The soft tissues which will be stretched are determined according to the flexibility test results. Static stretching may be done after all strength and aerobic activities, as well as after completing four to five repetitions per muscle group of a particular exercise. Holding time is 10-30s and the frequency is 3-5 days/weekly. Low intensity and long-duration stretching is extremely important in creating elastic changes in the muscular system. It is suggested that a longer-duration stretch (60s holding time) may be beneficial to overcome the collagen deposition and muscle stiffness associated with aging. A stretch should never be performed in a ballistic or "bouncing" motion. Additionally, older adult engaging in stretching should attempt to minimize potential muscular strain by keeping the back as straight as possible because of possible osteoporosis.

Simulated daily living activities such as balance on one leg, ascending and descending stairs, tandem/semi-tandem walking, sitting and standing, walking up and down and the techniques to prevent falling, improve neuromuscular coordination and decrease the risk of dependency. These type of activities are performed in 8-10 repetitions or given 1-3 minute for each of activity and the frequency is 3-5 days/weekly.

Security and preventing injury have the primary requirement in the training program of older adults. Reaching training intensity is not necessary, especially in aerobic training, in the frail older adults. It is advisable not doing cervical circumduction movements, isometric and static strengthening exercises.

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**Systemic Family Medicine in the World:  
Adapted From an Address to the 2nd European Conference on Systemic Family Medicine,  
Antalya, Turkey 25-29th April 2007**

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Since the middle of the twentieth century, general practitioners (GPs) around the world have staked a claim to being specialists in 'family' medicine. In spite of this, most GPs have continued to practice in a way that is still focused on the physical problems of individuals, and not on the way that illness can have an impact on the whole family. A number of influential movements have placed an emphasis on the importance of psychology in general practice. These include the Balint movement and patient-centred medicine.<sup>i</sup> <sup>ii</sup> However, even these progressive movements within family medicine have tended to be centred on individual patients and not on the family or the other networks that affect individuals. GPs as a profession have been largely unaware of a field of psychological treatment that has developed over the last fifty years - one that places the family at the centre of its attention, and also works directly with families rather than individuals to bring about change. That field is systemic family therapy, a form of 'talking treatment' where people with psychological problems are always seen together with significant family members and even (on occasion) others who care for them including teachers or social workers.<sup>iii</sup>

Systemic family medicine (also known in the United States as family systems medicine) has arisen through a marriage of family medicine with family therapy.<sup>iv</sup> It has resulted from GPs and family therapists becoming interested in each others' ways of working, and of

understanding. It has developed through close professional relationships between some GPs and some family therapists. It has grown particularly through the presence of family therapists working alongside primary care, and through the training of GPs in family therapy skills and ideas. In some cases, this has led to GPs carrying out family therapy with their own patients, and within their own practices. More often, it has led to an entirely different way of practicing ordinary, everyday family medicine. Rather than 'doing therapy', systemic GPs have been practicing family medicine in a more therapeutic way. One way of describing this is that they have become systemic practitioners.

Systemic practitioners believe in the fundamental importance of the family, the team, the organisation, interactions, and contexts. We see these as central in the causation of many problems, in their continuation, and most importantly in finding ways of helping people. Systemic family medicine helps us to open up the lens, to look at the wider picture and to offer people the chance of better ways of understanding problems, talking about them, living with them, or changing them. It is about approaching all of our work in terms of interactions rather than simple linear explanations. We pay more attention to patterns of behaviour rather than apparent facts, conversations rather than diagnoses, and the evolution of new and more helpful narratives rather than simple 'solutions'.<sup>v</sup>

As systemic practitioners, we use different techniques from most of our colleagues. We prefer to work with more than one person: a couple or family rather than an individual, and perhaps by having a co-worker like a psychologist or family therapist in the consulting room with us. We seek to empower rather than treat. What this means is that we question patients and their families about their experiences, trying to stimulate their own thinking about what they can do to help each other - rather than just offering lots of answers, explanations and advice about everything. We find that this kind of approach is especially helpful in relationship and family difficulties, mental health problems, 'grey area' conditions like chronic fatigue, unexplained symptoms, frequent consulters and patients who cause conflict. However, they also help in a huge range of other situations. These include ordinary, everyday consultations where people want to talk about their symptoms and fears, and also in cases of chronic illness and disability, in dealing with distress and conflict in the team and workplace, and in helping different professions to work better together.

Systemic family medicine has developed in different ways around the world. It has been an active force since the 1980s in the United States, mainly through the influence of the journal 'Families, Systems and Health', and also through the work of the Collaborative Health Coalition - an organisation that encourages family physicians and psychologists to work alongside each other. However, most doctors in the US are probably still not aware of systemic approaches to family medicine, and continue to practice in quite technocratic ways. By contrast, the country where systemic family medicine has become most dominant is probably Finland, where family therapy itself is very well established. Largely through the work of Professor Pekka Larivaara and his colleagues, Finland is now moving towards a system where teams of family physicians and family therapists will jointly look after different areas of the country. Similar ideas are beginning to have an impact in other Nordic countries including Norway and Denmark, where family physicians are learning to use some systemic skills and ideas. In Britain we have had trainings for GPs in systemic family medicine for over a decade, mainly based at the Tavistock Clinic in London, but only a minority of GPs have attended such training. However, we are now using systemic ideas and skills in order to encourage GPs and their teams to give and receive regular clinical

supervision, and in this way systemic ideas are starting to spread more widely.

The situation in Turkey is an interesting one because family medicine itself is at a relatively early stage of development as a distinct speciality, and you have the opportunity to integrate systemic ideas from the very beginning. This may mean that family physicians in Turkey can emphasize the psychological side of illness, and the family dimension, as essential aspects of the speciality. Through collaboration with systemic family physicians elsewhere in Europe, it may also be possible to integrate this approach into undergraduate training medical training, and in the postgraduate training of all family doctors in Turkey.

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**General Practice and Medical Anthropology: Partners in the Study of the Doctor – Patient Relationship within the Mediterranean Setting**Christos Lionis<sup>1</sup>, Gabriella E. Aspraki<sup>2</sup><sup>1</sup>Associate Professor of Social and Family Medicine, <sup>2</sup>Research Associate, Clinic of Social and Family Medicine, Medical School, University of Crete**Abstract**

It is well documented that the doctor–patient relationship is one of the keys to successful patient treatment. The importance of this relationship appears to be more pronounced in General Practice due to the long term, personal relationship developed within the context of primary care. In the present paper we discuss a number of parameters, which are crucial to the doctor–patient relationship. A special emphasis is placed on the Southern European and Mediterranean settings.

**Keywords:** Doctor-patient, communication, Primary Care, Mediterranean

**Introduction**

The doctor–patient encounter has attracted growing interest in the current literature. It is now well documented and widely accepted that one of the keys to successful treatment of the patient is a good working relationship with the doctor.<sup>i-ii</sup> In General Practice/Family Medicine (GP/FM), furthermore, where the relationship between doctor and patient is more personal and long lasting, effective communication seems to be vital in establishing rapport with the patient and enhancing the doctor's effectiveness; however, further study is needed in this direction. Despite the above, doctor–patient issues have received little attention in certain Southern European countries, including Greece.<sup>iii-iv</sup> This can be partly explained by the absence of relevant training courses in Medical Schools.

In Greece, specifically, the Medical Faculty of the University of Crete is the only academic institute in the country, which offers an undergraduate course to medical students and teaches them communication skills (<http://vml.med.uoc.gr-doctor-patient>).

Furthermore, as a result of close collaboration with the Institute of Social Sciences, University of Leiden, the Netherlands, this Medical School experiences the important contribution of Medical Anthropology in teaching medical students the concept of illness and health behavior and implementing certain theoretical models into research in the utilization of health care services.<sup>v-vi</sup>

In the present paper, we draw on the above experience to discuss the doctor-patient relationship with the aim to highlight some of its most important determinants. According to Silverman et al (2005)<sup>1</sup>, the type of relationship established between a doctor and his/her patient seems to be a complex issue which involves a number of parameters, including: the type of partnership between doctor and patient, the type of skills acquired by the doctor, the type of patient, the type of setting where the medical encounter is performed and the medical interview. Teaching

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the doctor-patient relationship issues to medical students within the Mediterranean setting is a difficult task, since contemporary evidence is lacking. Thus, a clear objective of this paper is to examine each of the above parameters in more detail drawing specifically from our experience of the Southern European and Mediterranean settings.

### **Towards an effective communication between patient and doctor**

#### *Type or partnership*

The type of partnership between doctor and patient has undergone major changes through time.<sup>5-vii</sup> From a type of paternalistic relationship, which was exercised by the doctor towards the patient and the decisions were solely the responsibility of the former, we have moved towards relationships of mutuality and processes of joined decision making.<sup>viii-ix</sup> Patient rights have come to the centre of attention of institutions and bodies involved in health care, and various models of involvement of the patients in the management of their health have been implemented across the globe, such as the Patient and Public Involvement Forum in the U.K. (<http://www.cppi.org>).

Furthermore, as the principle of autonomy and involvement assumes central role in health care the role of family and caregivers in the therapeutic process is enhanced. The doctor not only needs to enter into a collaborative partnership with the individual patient, but also to take into account the familial and social background of the patient. In general practice and primary care, whose object is to a large degree the management and treatment of chronic conditions, the role of the family and caregivers is prominent. The discussion on the burden of the family in cases of chronicity provides further confirmation of the family's role.<sup>x</sup> In addition, the role of family and caregivers is particularly enhanced in cases of patients whose ability to communicate is limited. It follows from the above that the shared decision model of partnership often involves not only the patient as an individual, but a nexus of relationships (family and caregivers). The practice of family consultation may be more complicated as it involves multiple networks of relationships, and is therefore more time consuming, but it is rewarding in that it provides a holistic perspective. GP/FM in Europe is still focused on an individualistic type of partnership, although the new European definition of

GP/FM makes a strong reference to the concepts of family and community (<http://www.woncaeurope.org>).

In the Southern European setting the transition to an autonomous patient role has not been made and the paternalistic model still seems to hold strong.<sup>xi</sup> In rural Crete, despite the severe burden they experience, informal caregivers of patients with major mental disorders did not seek care from their primary care doctor.<sup>10</sup> More research is needed in order for the existing situation to be depicted, future tendencies to be deciphered and policies to be designed.

#### *Type of acquired doctor's skills (the doctor's side in the communication process)*

Communication with the patient is a demanding situation, which requires a range of skills from the doctor. In order for the encounter to be successful, the doctor must be empathetic towards the patient and alert to both verbal and non-verbal messages in the communication process. Communication skills, however, do not constitute a natural gift endowed the doctor, but are acquired through education<sup>1</sup> and, hence, communication is included in the curricula of numerous medical schools. Furthermore, the type of communication and the expectations held from their encounter, by both patient and doctor, are culture specific. As Harrison<sup>xii</sup> has shown, patients in the Emirates evaluate their communication with the doctor differently from patients elsewhere. In Greece, patients tend to express their gratitude to the doctor through the offer of homemade tidbits or products such as house wine.<sup>11</sup> It is therefore very important that the doctor is aware of the cultural characteristics of the patients. This needs an active effort on the part of the doctor to get familiar with the patients' culture. In rural Crete, the constitution of a list of disease names in local dialect facilitated both research and clinical practice.<sup>xiii</sup>

In all situations of communication with the patient Silverman et al., identify the skills required as follows: content skills, process skills and perceptual skills.<sup>1</sup> As the authors explain, the doctor must know both what to say, and how to say it to the patient. Equally important, the doctor must be alert to the feelings and thoughts generated by the situation both within himself and within the patient. Those feelings and thoughts must be taken into account and addressed by the doctor when consulting with the patient. The above form is indissoluble and equally

important aspects of the doctor-patient encounter.

Non verbal communication also seems to have an important role in the doctor-patient relationship, especially within the Mediterranean setting, as a consensus report in Reggio Emilia, Italy underlined.<sup>3</sup> Further research is needed to explore this important issue especially during the patient's first encounter with his/her general practitioner.

*Type of patient (the patient's side in the doctor – patient relationship)*

In a type of partnership where responsibility is shared between doctor and patient, the role of patient in the relationship is accentuated. The doctor should acquire and make best use of all information on the patient's background. Different cultural and social characteristics greatly determine the way in which the patient relates to the doctor, accepts treatment and complies or not with the doctor's instructions.

Suchman<sup>xiv</sup> introduced a model, which proposes five stages of illness and medical care: the symptom experience, the assumption of the sick role, the medical care contact, the dependent patient role and recovery/rehabilitation. By making general practitioners aware of the above five stages, medical anthropology provides a satisfactory explanatory theory of patient behavior and thus helps doctors better understand their patients' behavior. With such knowledge a course of action which might appear unreasonable to the doctor, such as non-compliance or seeking medical advice at a late stage when medical services are no longer capable of stopping the natural course of the disease, might make sense and be dealt with. Furthermore, knowledge of patient behavior can help eliminate feelings of anger or frustration in the doctor.

A last issue to be mentioned is that the patient comes to the doctor with specific beliefs and concerns on his/her condition, with feelings of hope, fear or despair and carrying particular expectations from the doctor. All the above often constitute a mute background to the doctor-patient relationship, which can prove either facilitating or hindering to the encounter. The doctor must be aware of the existence of hidden agendas in the encounter with the patient and aim towards bringing hidden worries, fear, doubts to the fore. It is only then that tensions generated by such feelings can be resolved and the relationship with the patient can be productive. This part of the

doctor-patient encounter is not only important for the establishment of a good and effective relationship, but provides a major contribution in the success of health promotion programs in primary care and especially in the ones which focus on behavior modification. GP/FMs should be aware of the principles of the Theory of Planned Behavior<sup>xv</sup> and be well trained in translating it into research and clinical practice. There is little experience from the translation of this theory into practice. Attempts have been undertaken at the Department of Social Medicine, School of Medicine, University of Crete to explore the possibility of the implementation of this theory into intervention programs which aimed at reducing the use of over-the-counter medicines.

*Type of setting*

The doctor's office and its capacity in both technologies and staff critically influence the doctor-patient encounter. Both the waiting area and the doctor's office must offer a calm and reassuring environment for the patient. It is important that the patient is welcomed by the appropriate personnel and informed on issues such as, processes that must be followed, waiting time, possible delay and reasons of delay. The office itself must be provided with all the appropriate technological and medical equipment, which will enable the doctor to provide the proper treatment. The appropriate setting in terms both of human and of technological capacities, can induce a feeling of trust in the patient, and can greatly reduce anxiety and uncertainty. Despite the discussion of the setting in modern industrialized societies and among certain European and Australian colleagues,<sup>xvi</sup> the issue is still not sufficiently resolved in Southern Europe, where a conventional arrangement of the doctor's office, reflecting the paternalistic type of relationship is still predominant. Advances in electronic technology make possible the communication between patient and doctor without face-to-face consultation. The introduction of telemedicine has an impact on the new skills and training programs needed for the improvement of doctor-patient communication in such a setting.<sup>xvii</sup>

*The medical interview*

The medical interview is the time *par excellence* where the communication between doctor and patient is performed and worked out. Taking the patient's history and performing a medical interview are among the skills acquired through the years of medical education. However, a problem which has

been identified is the rigid adherence of many doctors on what is meant to be a rough guide for the acquisition of a patient's medical history. The enhanced Calgary-Cambridge guide<sup>1</sup> addresses the shortcomings of a typified medical interview and provides clues towards an interview which will be flexible and allow the patient to provide richer information on his/her condition and background. The Calgary-Cambridge guide provides detailed and useful guidelines for every phase of the medical interview: initiating the session, gathering information, physical examination, explanation and planning and closing the session. The anticipated result is one where both the patient leaves the doctor's office reassured, with a clear plan to follow, and the doctor is in hold of all the useful information needed for a successful rapport with the patient and treatment plan. The translation of this model within the Mediterranean and southern European settings and discussion of its key elements remains to be studied.

### Conclusion

In conclusion, it is a fact that the patient-centered, or relationship-centered approach to the medical work, requires more time than the traditional paternalistic approach which seems to be preferred by many Southern European practitioners. However, the benefits from the former model are undoubtedly worth the time investment. The factors, which have an impact on the quality of the consultation are wide ranging. Establishing a good, working relationship with the patient is a complex issue, yet vital for the successful outcome. Further research is needed in order to determine and quantify, where possible, the different factors affecting consultation. A discussion of physician's skills with emphasis on verbal and non verbal communication, awareness of the patient's background, the symptom experience and sick role, remain to be explored within the Southern European and Mediterranean setting. Towards the above direction, a collaborative study among Southern European countries could usefully highlight particular key issues for an effective partnership between doctor and patient. Previous country-to-country collaborations should be led towards this goal.<sup>xviii</sup>

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**EURACT's DEFINITIONS OF GENERAL PRACTICE/FAMILY MEDICINE – Similarities to and differences from systemic family medicine?**Pekka Larivaara<sup>1</sup><sup>1</sup>Professor in Systemic Family Medicine, Department of Public Health Science and General Practice Oulu University, Finland**Abstract :**

In 2002 EURACT (European Academy of Teachers in General Practice) published a statement which defines the discipline of general practice/family medicine and describes its core competences. EURACT's definition includes eleven characteristics of the discipline, which are clustered into six core competences of the general practitioner/family doctor. The Euract Educational Agenda of General Practice/Family Medicine was published three years later and it wishes to contribute to the harmonization of the learning outcomes of different medical education training programmes all over Europe at this level. This article introduces these Euract's definitions and some main points of the educational agenda. It also looks for similarities and differences between the Euract's definitions and the basic premises of systemic family medicine.

**Introduction**

European general practice has a long history but not until in 1974 the first statement "The General Practitioner in Europe" was produced by Leeuwenhorst group (1). At that stage general practice/family medicine was in its infancy as a discipline, particularly with regard to its teaching and research base. Almost 30 years later the world has moved on and nowhere this change has been more apparent than in the provision of health care. General practice/family medicine is now well established in all health care systems in Europe and is recognised by health service providers as being of ever increasing importance.

Since the work of the Leeuwenhorst group several definitions of general practice/family medicine have been written and they are mainly focused on general practitioners' professional activities, not on the characteristics of the discipline.

Euract (European Academy of Teachers in General Practice) published the newest definitions of European general practice/family medicine in 2002 (2). This work came about as a result of revising previous definitions, as it had been felt that they had come updated and needed revising for the 21st century. By writing the new definitions Euract would like to produce a consensus document on definition and competencies. The statement was produced as an aid to individual teachers, students and practitioners. It defines both the discipline of general practice/family medicine and the professional tasks. The group of authorities in Europe felt that general practice must be identified as an academic discipline. It is not the sum of other specialities added together, but it is a specific discipline with its own education, research and practice.

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### **Discipline and specialty of general practice/family medicine defined by Euract**

Euract wants to make sure that there is a need to define both the discipline of general practice/family medicine and the role of the specialist family doctor. The former is required to define the academic foundation and the framework on which the discipline is built, and thus to inform the development of education, research, and quality improvement. The latter is needed to translate this academic definition into the reality of the specialist family doctor, working with patients in health care systems throughout Europe.

The characteristics of the discipline of general practice/family medicine are that it:

- Is normally the point of first medical contact with the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned.
  - Makes efficient use of health care resources by coordinating care, working with other professionals in the primary care setting and by managing the interface with other specialities, taking an advocacy role for the patient when needed.
  - Develops a person-centred approach, and oriented to the individual and his/her family, and their community.
  - Has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient.
  - Is responsible for the provision on longitudinal continuity of care as determined by the needs of the patient.
  - Has a specific decision making process determined by the prevalence and incidence of illness in the community.
  - Manages simultaneously both acute and chronic health problems of individual patients.
  - Manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.
  - Promotes health and well –being both by appropriate and effective intervention.
  - Has a specific responsibility for the health of the community.
- Deals with health problems in their physical, psychological, social, cultural and existential dimension.

General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of the comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patient. So, they integrate physical, psychological, social, cultural and existential factors. The specialist family doctors must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care.

### **Core competences of general practice/family medicine defined by Euract**

The definition of the discipline of general practice/family medicine and of the specialist family doctor must lead directly the core competences of the general practitioner/family doctor. The eleven characteristics of the discipline relate to eleven abilities that every specialist family doctor should master. Because of their interrelationship, Euract clusters them into six independent categories of core competences. The main aspects of each cluster are:

- Primary care management: the ability to manage primary contact with patients; to co-ordinate care with other professionals.
- Person-centred care: the ability to create well –functioning doctor-patient relationship.
- Specific problem solving skills: the ability to relate specific decision making processes to the prevalence and incidence of illness in the community; to make effective and efficient use of diagnostic and therapeutic interventions.
- Comprehensive approach: to manage simultaneously both acute and chronic problems in the individual, to promote health and well being.
- Community orientation: the ability to reconcile the health needs of individual patients and the health needs of the community in which they live in balance with available resources.
- Holistic approach: the ability to use a bio-psycho-social model taking into

account cultural and existential dimensions.

### **Euract Educational Agenda**

The educational agenda was published in 2005 (3). It is a large and ambitious statement which includes 48 pages. The agenda aims to offer an educational framework for teachers and learners. It gives a guide for basic medical education, but its central focus is in specialist training. In the agenda the authorities emphasize that general practice/family medicine is best learnt in practice and recommends early clinical exposure of medical learners already at the beginning of medical school. Learning process in general practice/family medicine is a lifelong issue. The family doctors have to accept the complexity of the real practice which is holistic in outlook, dealing with illness and disease in the context of the patient, their family and the whole community. In the agenda a biopsychosocial model is introduced (4). It means a paradigm shift in modern medicine and it dissolves the body-mind split. The clarification of the biopsychosocial model can be occurred in different kinds of learning contexts: reading articles, listening lectures, conversation in small groups, doing role plays, exploring the family doctor's own personality and having supervision. Constructivism is also introduced as an educational model that puts "the learning process of the student/trainee as the central point. Teaching and learning should be very much based on case studies, narratives, patient stories, and the global context that can be taught and learnt in the practice context.

The agenda focuses mainly on the concepts of the contacts of the physician with patients, comprehensiveness, coordinated care, cost-effectiveness and patient advocacy. The most effective teaching tool is often role modelling. According to the agenda the teachers have to understand that there is a parallelism between the doctor-patient relationship and the teacher-learner relationship. The teachers/tutors should act as facilitators, stimulating self-directed learning, critical thinking, and reflection to enhance personal and professional growth. Tutoring should be solution-focused rather than problem-focused, with elements of a system-based approach to at least include the person, the family and the community dimension. The education should emphasize the student/trainee as a person, developing personal strengths. The doctor's own values, attitudes, and feelings are important determinants on how he/she practices

medicine. So, education should aim at understanding and learning to use one's own attitudes, strengths and weaknesses, values and beliefs in a partnership relation with the individual patient and his or her family. This requires a reflective approach and to develop an insight and an awareness of self.

Instruments like genograms, family tree; eco-mapping are specific and good methods for teaching and clinical work. During specialist training the family doctor has first to have personal experience of being "in a patient role" in which the teacher draws a family tree of eco-map for him or her. After that experience the doctor could be an expert for using these tools in the practice. Video patient-case recording are also good tools for reflective teaching and learning.

In the agenda the authorities also emphasize that the family doctors have to understand the structure of the whole health care system and have to understand the interrelationship between health and social care. So, he or she has to have an ability to work as a member or as a leader in interprofessional teams. For adopting these skills the doctor has to learn basic theories of effective team work.

The practice should be as much as possible based on scientific evidence that is relevant for and in general practice. Combining and balancing the experience based and evidence based approaches in the development of practice guidelines provide an authority-based approach which completes the support from scientific community. The specialist training programme should have a constructivist curriculum with enough learner exposure. There is a need for tacit learning from books and written documents, but the real cases are not in the books.

### **Some basic premises of systemic family medicine**

Systemic family medicine is a new field of medicine and its theoretical basis is on family therapy approach and it was begun to teach general practitioners/family doctors first in the US and Canada and later in several places in Europe (5, 6, 7). In systemic family medicine a family is defined as any group of people related either biologically, emotionally or legally. The physician mobilizes the patient's natural support system to enhance health and well-being. The basic premises of systemic family medicine are:

- Family-oriented health care is based on a biopsychosocial systems approach.
- The primary focus of health care is the patient in the context of the family.
- The patient, family and clinician are partners in health care.
- The family-oriented clinician reflects on how he or she is part of the treatment system.

In systemic family medicine the family is seen the primary source of health beliefs and behaviours. Stress of the family developmental transitions may become manifest in physical, psychological or psychosocial symptoms. Sometimes these symptoms can serve an adaptive function within the family and may be maintained by family patterns. Families are a valuable resource and source of support for the management of illness. In systemic family medicine the practitioners try to “destroy” the illusion of the dyad (doctor-patient relationship) in medical care. The main focus is the patient

in the context of the family. So, instead of the traditional dyad approach systemic practitioners propose a “triangular perspective”. This triangle involves the clinician, patient and family working together in a medical-care partnership.

In systemic family medicine a genogram is an essential tool to recall about information about family. Family is seen as a system: human body is more than organ systems operating to one another. The systemic-oriented doctor is interested in family structure: hierarchy, boundaries of subsystems and family members' role selection. Many families have alliances and coalitions. The doctor is also interested in what kind of processes are going on in the family. Do the family members have enough individual autonomy? Triangulation is an important concept, too. E.g. a child is drawn to his/her parents' conflicts. The systemic-oriented practitioner is also interested in family's developmental stage and family life cycle and intergenerational coalitions.

**Table 1:** Differences seen in the practice of general practitioner and systemic practitioner

General practitioner	Systemic practitioner
<ul style="list-style-type: none"> <li>• Bases his/her work mainly on professional practices, not on any special theory</li> <li>• Asks often linear questions</li> <li>• Primary focus is the patient, person-centred care</li> <li>• Focus mainly on biomedical symptoms and diseases, is interested in diagnoses and seeks methods to treat (care for) the patient</li> <li>• Offers often prescriptions</li> <li>• Works mainly alone with one patient as an expert</li> <li>• Almost never works with a family therapist</li> <li>• Works mainly in his/her office</li> <li>• Uses seldom the genogram as a tool</li> <li>• Has mainly collected his/her theoretical speciality training hours from short 1-2 days seminar fragments which deal with common diseases and thinks that several years work in primary care setting makes you competent.</li> <li>• Gives often answers and advice to the patient's questions</li> <li>• Sees himself/herself in an interprofessional team as a leader and other professionals as assistants</li> <li>• With somatizing patients pays often first attention to the patient's somatic symptoms and if doesn't find any disease, starts to seek psychological reasons</li> </ul>	<ul style="list-style-type: none"> <li>• Theoretical basis is on systems theory and on family therapeutic theories</li> <li>• Asks often circular questions</li> <li>• Primary focus is the patient in the context of the family (therapeutic triangle)</li> <li>• Focus on several levels in the biopsychosocial model, is also interested in family characteristics, structure, process and life style</li> <li>• Offers often descriptions</li> <li>• Works often with a co-worker and several family members and tries to get shared expertise</li> <li>• Works in a difficult case situation with a family therapist</li> <li>• Does also home visits</li> <li>• Uses often the genogram as a very important tool</li> <li>• Has participated in a longer (e.g. 1-2 years) process like training programme in systemic family medicine and thinks that such a training change their working style completely</li> <li>• Uses often reflective working style, sometimes reflecting team</li> <li>• Includes in interprofessional team work families and bases his work on social constructionism (helps the team and family members to create new meanings and realities)</li> <li>• With somatizing patients explores from the beginning of their collaboration both somatic, psychological, family and other social issues</li> </ul>

### Similarities and differences between Euract's definitions and the principles of systemic family medicine

It seems to me that these both disciplines have become closer to each others in theory during the last two decades. As I see it they both:

- Emphasize a holistic approach: Caring for the whole person in the context of person's values, his family beliefs, the family system, and the
- 
- 
- culture and the socio-ecological situation in the larger community.
- Consider systems theory and the biopsychosocial model as the basis for general practitioners/family doctor's work.
- Introduce the idea that a human being is more than its parts.
- Respect the autonomy of their patients.
- Consider interprofessional teamwork as an effective tool in primary care setting.
- Consider doctors' own values, attitudes, and feelings important determinants on how practice medicine.
- Introduce the idea of the need of paradigm shift in modern medicine which dissolves the body-mind split.

However, in spite of these similarities in theory many differences can still be seen in practice. The differences are presented in table 1.

### Conclusion

In conclusion I would like to point out that during the last ten years the Euract's authorities have done very valuable and appreciated work in preparing the new definitions of general practice/family medicine and in writing the Educational Agenda. Now challenge has been given to the training

institutions and units in different countries all over Europe. In the University of Oulu in Finland the first 2-year training programme for specializing family doctors has been planned and it will start in the spring of 2008. The programme is mainly based on the Euract's definitions and Educational Agenda. It also includes some ideas from systemic family medicine. From now on we recommend that all would-be specialists in general practice/family medicine would go through this programme.

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## Family Orientated care in Family Medicine Education-The Israeli Experience

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The Family History has been recently rediscovered, thanks to the breakthroughs in Genetics, with scores of papers, a US National family History day and a unique website, where one can compose your genogram and use it to get advice on familial predispositions(1,2) . In Family Medicine (FM) the importance of the Family is reflected in the discipline's name. A debate on the actual implementation of a family orientation can be seen in the title: The family in family practice- is it a reality? (3) , to which Medalie et al (3) answer positively by finding that 10% of visits in FM are devoted to family issues, in 32% other family members are present and in 18% another member problems are discussed . In this sample genograms are found on 11% of charts. In the present paper the focus is on educating for such a family orientation within the FM residency program.

### Family medicine training in Israel

After a seven year Medical School (inc. a year of internship) the newly registered physicians that choose to specialize in Family Medicine (FM) go into four year training. They spend a year and nine months in FM settings, nine in a tutors practice under close supervision and a final year in their own practice with mentoring. In between they will rotate for two years and

three months in hospital and outpatient settings (a year in internal medicine, six months in Pediatrics, three months in Psychiatry and six months electives). During the four years they will meet once a week for a day release course where large and mostly small group instruction occurs. The residents take an MCQ knowledge test half way through the four years and a final oral examination. Within the final, a family presentation session (one out of four testing portions, 40 minutes out of 3 hours and 20 minutes testing time and 25% of the final score) is allocated to evaluating the family orientation of the examinee.

### Family orientation education in one FM Israeli Department

The Rappaport Medical School of the Technion University in Haifa, Israel is one of the four medical schools in Israel. 12 departments of FM are affiliated to these four institutions and in this section the training in the Haifa one (Chair: Dr Khaled Karkabi) is described. All departments teach according to a common syllabus, but translate it into a local interpretation of the particular instruction activities. 200-300 residents are in training in any point in time. 50-60 train in the Haifa Department. They are divided into four groups by their seniority. The Family is a central domain of the day release course and the instruction includes the following (All small group obligatory modules):

1. A first year introductory session.( 2 hours)
2. A second year personal family presentation (12 two hours meetings)
3. A third year family issues module (12 two hours meetings)

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**Table 1: Intended learning Outcomes****Knowledge(cognitive)**

1. The trainee will possess sociological knowledge of definition , different present compositions and the ethnic ,religious and social multiple faces of the family in Israel
2. the trainee will know the normative and non normative development of families (the family life cycle)
3. The trainee will learn about crisis and its influence on individuals and families.
4. The trainee will be able to describe and analyze the role of the family in its members health, and the impact of disease on the family.
5. The trainee will be able to use basic techniques of family description and analysis.
6. The trainee will know the different approaches to understanding, evaluating and intervening in families.

**Attitudes (affective)**

1. The trainee will be aware of the triangle Doctor-patient-family in the Patient-Doctor encounter and clinical care.
2. The trainee will demonstrate his commitment to" family –thinking" in his care of patients
3. The trainee will engage empathically and with deep listening in his communication with patients and families, including discussion of emotions.
4. the family physician is going through the same steps of information gathering , diagnosis, plan of intervention ( therapy) , intervention execution and finally follow-up and assessment of effect as with any clinical problem . The difference is in addressing the clinical problem(s) within a contextual view. For each portion of the clinical method the family orientation adds the respective aspects.
5. The trainee will be aware of his own family history and his place in his own family life cycle and its' influence on his doctoring
6. the trainee will demonstrate comfort in working with individuals and families in different stages of the life cycle and in different crisis situations

**Skills (psychomotor)**

1. The trainee will relate to and engage the patient's family in the diagnostic and therapeutic plan.
2. The trainee will demonstrate capacity to collect, describe, analyze and integrate family data in the encounter with patients and families.
3. The trainee will maintain communication with the necessary number of family members in order to enlarge understanding, diagnosis and treatment , when appropriate.( hold family conferences when appropriate)
4. The trainee will, elicit the concerns and feelings of all the family members when appropriate and necessary.
5. The trainee will be able to identify a family dysfunction that impacts on the care of the patient and will skillfully refer when necessary.
6. The trainee will use ways to intervene in crisis situations as well as mobilize support systems  
The trainee will be able to undertake multiple roles in family care from case manager to team member to just "on need to know" participant.

4. A fourth year tools in Family orientation course.( 12 two hours meetings)

5. Live and video enhanced personal mentoring (range 6-30 hours).

The intended Learning Outcomes for the "family "course are spelled out in the three customary categories of Knowledge, skills and attitudes (4, see table 1)

The recommended teaching methods are small group discussions, supervised reading, extended workshops, role play, supervised experiences and house calls.

The teaching team includes a Family Physician and a behavioral sciences person, who have knowledge and interest in the family – centered approach in Primary Care. (Such as a Family

Therapist, Social Worker or Health Psychologist).

Features of the above-mentioned curriculum that we feel strongly about (yet, have not empirically demonstrated) are:

-Working on your own family stuff (second year) centers on assessing learners' family patterns using their genogram. The extreme variations of ethnic and family patterns in Israel (in every group Jews and Arabs are represented as well as immigrants from the former Soviet Union) are the backbone of a diversity that serves as a strength and developmental enhancer. Participants also engage with the question why did I become a physician? (Family influences?)And what do I bring to the clinical encounter from my family?

The semester long sharing fosters group bonding and a cross-cultural sensitivity that is quite unique.

**Table 2: Family examination score sheet**

1. The patient and family narrative (data collection)
2. Genogram ,psychofigure, life events
3. Stage in life cycle, family system, cultural influences, support system(s), psychosocial influences condition. (data analysis)
4. Diagnosis, problem list (working hypothesis)
5. Treatment plan and prognosis
6. Intervention ( D&B III)
7. Evaluation of intervention
8. Theoretical background
9. Collaboration ( team work, supervision, consultation, community resources)
10. Overall evaluation and self-awareness

10 points for each entry- tot: 100 points.

-A gradual introduction of constructs and tools that is elaborated upon as the group progresses from triangulation (5) to area of questioning that promote family-oriented approach in Primary Care (6)

-Combined with the third and fourth year modules the curriculum spans a spectrum of diversity and family narratives that enhances awareness and reflection. These senior years are also characterized by emphasis on longitudinal care of families.

#### **The final family examination**

The author was instrumental in drafting this syllabus, is actively teaching and chaired the re-formulation of the final examination family portion (7). This rendition is intended to normalize family orientation and facilitate its integration into the daily FM work. The family orientation is emulated on the usual clinical method of data gathering (history), examination, diagnosis, plan, intervention and evaluation /follow-up. Thus, part of information gathering will be asking about data that enable the construction of a genogram, part of diagnosis is a family diagnosis and interventions are in the sphere of facilitating family change. This is naturally manifest in the examinations' score sheet (table 2). This approach was broken in through focused workshops that span the entire examiners body and are implemented in the last 4 years already.

#### **Assessment**

Nevertheless, fundamental questions are left relatively unanswered, including:

What do the trainees transfer from the classroom to patient care in the real world? Does family teaching make a difference?

When posed with Launer's questions (Where are you on the individual-family axis? Are you using genograms? How do you do with more than one patient in your room? Would you like to expand the family dimension in your work? How? (8)) graduates of the residency program voice a perspective of difficulty in implementations (sparse use of genograms as a marker) and a gradual attrition of skills.

#### **Conclusion**

A feature of a living profession is its ability to reinvent itself and redefine its' own role according to changes in the environment. The domain of the family in FM seems to be an arena where the vitality of FM is enacted. As this paper demonstrates while a strong educational agenda exists and is taught its implementation, retention and impact remain to be documented. Thus, in Israel and elsewhere an emphasis on documentation, evaluation and constant adaption is called for. The unique opportunity of the growing interest in the family history and genograms should be seized for enhancing the cause of a family-orientation in Medicine at large.

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**Evidence based Guidelines in COPD Management and Current Treatment Options**Thys van der Molen<sup>1</sup>, Janwillem Kocks<sup>1</sup><sup>1</sup> Department of General Practice and Primary Care, University Medical Center Groningen, Groningen, The Netherlands

Chronic Obstructive Pulmonary Disease (COPD) is a condition of increasing public health significance. According to WHO estimates, COPD will rank 5<sup>th</sup> on the global burden of disease in terms of disability adjusted life years (DALY's) by the year 2020 (1). COPD is an insidiously developing disease, in which clinical symptoms are presumed to be preceded by an asymptomatic decline in lung function. This may lead to an iceberg phenomenon in which a considerable proportion of COPD patients remains undiagnosed until advanced stage of disease. Most published data on the epidemiology and treatment of COPD deal with populations with severe to very severe disease, focussing on secondary levels of care, representing the surfacing part of the iceberg of COPD patients. However, in primary care practices we will encounter merely patients with more mild disease as measured by spirometry. The GOLD (Global Initiative for Chronic Obstructive Lung Disease) initiative has developed a classification of the disease based on the impairment in level of lung function. GOLD I meaning mild disease (FEV<sub>1</sub> > 80% predicted) GOLD II meaning moderate disease (FEV<sub>1</sub> > 50% but < 80%) GOLD III meaning severe

disease (FEV<sub>1</sub> > 30% but < 50%) and GOLD IV very severe disease (FEV<sub>1</sub> < 30%). Based on the airflow limitation the GOLD committee recommends to treat patients in GOLD I and II with bronchodilators such as short or long acting beta agonists and/or the anticholinergics ipratropium bromide or tiotropiumbromide. ([www.GOLDCOPD.com](http://www.GOLDCOPD.com))(1). In addition to those patients with more severe disease (GOLD III and IV) especially when they suffer from frequent exacerbations should also be treated with high dose inhaled corticosteroids. The GOLD-committee recognizes that defining the severity of COPD by the level of airflow limitation alone does not cover the full spectrum of COPD. Other variables of relevance to the classification of COPD include measurements of symptoms, health status, smoking history, body mass index, physical condition, airway inflammation, findings on pulmonary CT-scans, and the frequency of exacerbations.

Health status has become a central feature of studies in COPD in recent years because the treatments for the condition are largely symptomatic, and clinical trials are now required to incorporate a symptomatic measure. The importance of the evaluation of health status in COPD has been demonstrated by a primary care study that shows the poor correlation between health status and FEV<sub>1</sub>. (Figure 1)

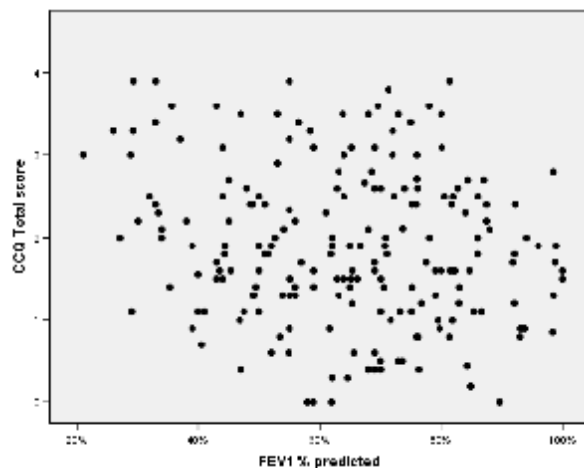
Poor scores on health status, are strongly associated with mortality, hospital readmission and increased healthcare resource consumption.(2-5) For primary care, health status might even be more important as an alternative or secondary determinant of

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severity, since the evidence for treatment of patients with mild and moderate disease (GOLD I and GOLD II) is scarce. Therefore the treatment of patients with mild disease largely depends on the clinical impact of the disease on the patients which is reflected by the health status. This has led to the need for a short and validated method to measure health status in order to assess clinical control in daily clinical practice. The Clinical COPD Questionnaire (CCQ) has been developed to address this need(6;7). (figure2)

**Figure 1:** Relation between health status as measured by the Clinical COPD Questionnaire ((CCQ) range between 0 (best)-6(worst)) and



FEV<sub>1</sub> in patients with COPD (Tiffenau < 70%) . Each dot(n=203) represents one patient.

With measuring health status on top of spirometry, primary care has an extra tool to support the clinical decisions that have to be made to give the best available treatment to the patients. Primary care physicians have to be aware that despite the lack of evidence in patients with mild disease these patients have the right of an optimal treatment. A decision making tree such as proposed in figure 3 may help the primary care physician to evaluate his clinical decision or may support the nurse or nurse practitioner in proposing COPD management plan based on both the GOLD severity but also the needs of the patient as expressed by health status. The most important advantage of such a decision tree is that the treatment plan of each patient is strongly individualised, based on both the lung function impairment and the patient health status. Moreover, the health status as measured with the CCQ is divided in its three

important clinical domains, symptoms, mental health and functional status. Although the overall score of the CCQ reflects the general impact of the disease on patient's health status, the individual domains gives us additional information that is very useful in our clinical decision making. Patients with COPD who report a high score on the symptom domain (cough, sputum, dyspnea in rest and during exercise) as compared to the other domains, very often have these symptoms due to their current smoking behaviour. Therefore smoking cessation is the first option next to pharmaceutical treatment. Patients who report a high score on the mental health domain (fear for exacerbation and feeling depressed) probably deserve extra attention for the treatment of a depression or anxiety disorder. Last but not least patients who report a bad functional status (exercise and daily functioning limitation) should be encouraged to do at least some exercise or be referred for pulmonary rehabilitation. All these suggestions are of course next to the pharmaceutical treatment as recommended by the GOLD guidelines.

**Conclusion:** With incorporating both lung function measurement and health status in the diagnosis and evaluation of COPD in primary care we are able to individualise the treatment of COPD and make a more appropriate management plan. This method may result in better outcomes for the patient with COPD without burdening the health care system or the individual primary care physician.

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**Figure 2:** The English version of the Clinical COPD Questionnaire (CCQ) Translations available on [www.ccq.nl](http://www.ccq.nl).

Patient number:  
Date:

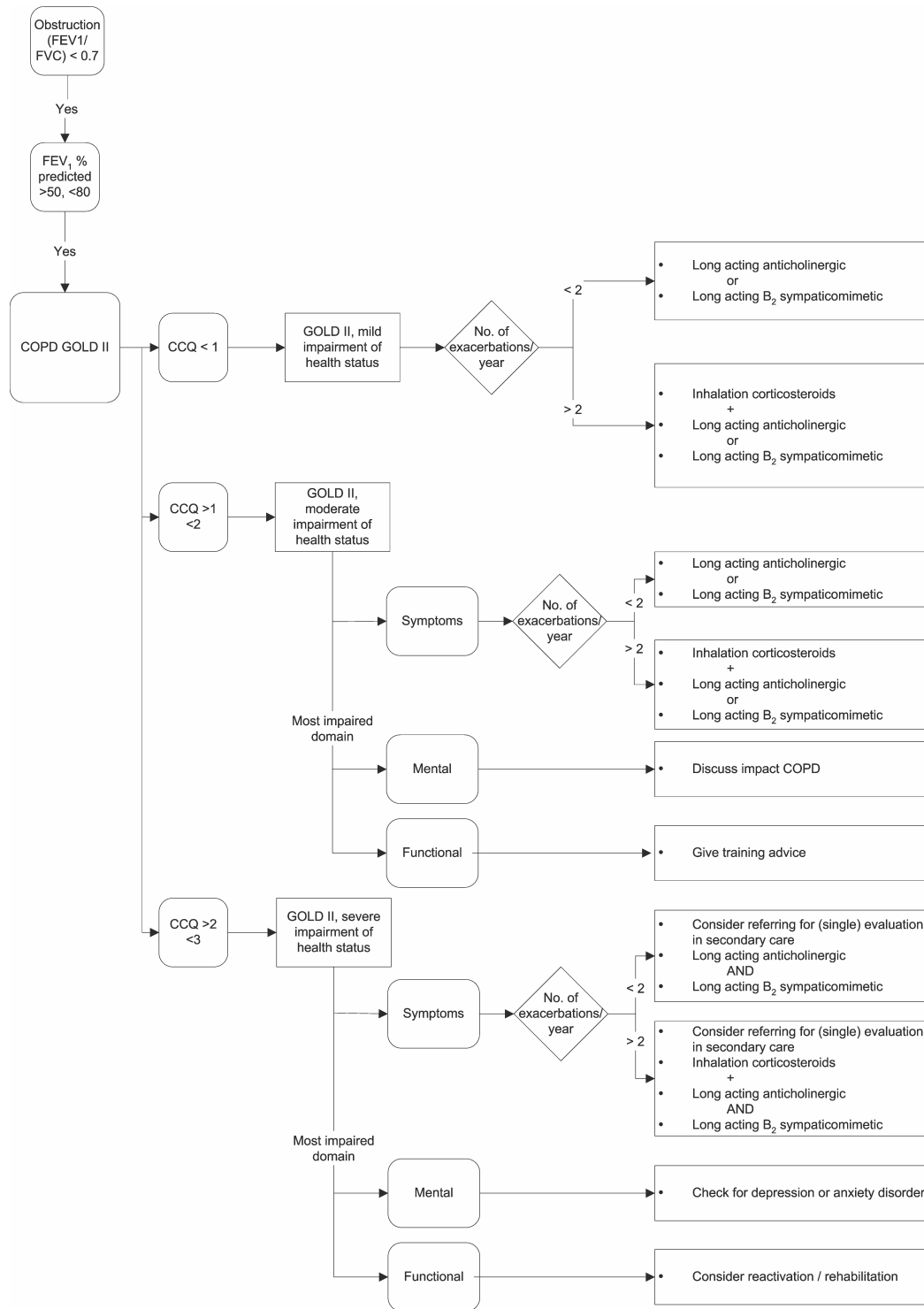
**CLINICAL COPD QUESTIONNAIRE**

Please circle the number of the response that best describes how you have been feeling during the past week.  
(Only one response for each question).

On average, during the past week, how often did you feel:	never	hardly ever	a few times	several times	many times	a great many times	almost all the time
1. Short of breath at rest?	0	1	2	3	4	5	6
2. Short of breath doing physical activities?	0	1	2	3	4	5	6
3. Concerned about getting worse if your breathing getting worse?	0	1	2	3	4	5	6
4. Depressed (down) because of your breathing problems?	0	1	2	3	4	5	6
I feel, during the past week, how much of the time:							
5. Did you cough?	0	1	2	3	4	5	6
6. Did you produce phlegm?	0	1	2	3	4	5	6
On average, during the past week, how limited were you in these activities because of your breathing problems:	not limited at all	very slightly limited	slightly limited	moderately limited	very limited	extremely limited	totally limited (unable to do)
7. Strenuous physical activities (such as climbing stairs, hurrying, doing sports)?	0	1	2	3	4	5	6
8. Moderate physical activities (such as walking, housework, carrying things)?	0	1	2	3	4	5	6
9. Daily activities at home (such as dressing, washing yourself)?	0	1	2	3	4	5	6
10. Social activities (such as talking, being with children, visiting friends/relatives)?	0	1	2	3	4	5	6

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**Figure 3:** Decision tree for patients with COPD in primary care based on both health status outcome as measured by CCQ (range 0 (best)-6 (worst)) and GOLD stage.



**The integration of PHC with behavioural sciences: talking treatments by GP's for emotional symptoms as alternative for pills**E.M. van Weel-Baumgarten<sup>1</sup><sup>1</sup>Department of General Practice, UMC St Radboud University Nijmegen, The Netherlands**Background**

In primary care many patients present with emotional symptoms<sup>i,ii,iii</sup>. Sometimes patients have a depressive or anxiety disorder but more often the symptoms do not fulfil the criteria of a full-blown mental illness. Psychological distress is frequently presented through physical symptoms and persisting medically unexplained symptoms (MUS) are very common in general practice<sup>iv</sup>. In most cases watchful waiting is justified for some time, but if symptoms persist and the patient turns to the general practitioner (GP) for help, the question arises which of the available treatment options is best for that specific patient.

Medication could be an option. However, in General Practice the effectiveness, for instance of antidepressants for depression, is less than often believed, and for 'depressive symptoms' and in MUS and the milder end of the spectrum there is no indication to prescribe them at all<sup>v</sup>.

Even if there is an indication, for instance a depression, many patients don't want medication. They often experience too many side effects, the medication has interactions with other medications or the patient has other diseases with contraindications for antidepressants. For these patients the various psychological treatments are an alternative as they can be as effective as medication.

But for many of these treatments a referral is needed. Furthermore, therapists are not always available or accessible for patients.

It would therefore be welcome if more GP's themselves could deliver effective 'talking treatments' for frequently presented symptoms and syndromes.

*Brief Psychological treatments*

In this context one of the options for patients presenting with more chronic MUS is reattribution, a Cognitive Behavioural (CB)-technique that can be used by GP's effectively as a first step of treatment<sup>vi,vii</sup> [ref]. Another brief psychological treatment for GP's is Problem Solving Treatment (PST), also derived from CBT, which is effective for a variety of emotional or psychosocial problems in primary care<sup>viii,ix,x</sup>. It can be used as treatment for depression, but also as part of programmes for management of chronic illness<sup>xi,xii,xiii,xiv</sup> and as a preventive strategy<sup>xv</sup>. It can be delivered GP's, if they are motivated for psychological treatment and trained properly [ref].

*Reattribution for MUS*

The first step in MUS is to ensure the patient, who is worried and experiences symptoms he or she does not understand, feels understood. This can be achieved by taking a full history and carrying out a focussed physical examination. If nothing abnormal is found, the physician reassures the patient. Frequently, in addition to going through all normal test results, it is also necessary to explain how problems or unfavourable conditions in one's life can lead to physical symptoms.

For more chronically somatising patients this explanation is not enough. In those cases the first step of the reattribution technique also contains negotiating and some further testing before moving on to the next step: changing/broadening the agenda. In this step a link is made between physical and psychological/emotional symptoms. To be able to do this effectively it is better not to talk about

(emotional) problems but about 'circumstances', or 'life-style matters' or 'what is going on in your life'. For patients who cannot see a link themselves it might help to try and find a link together. The patient is invited to keep a journal which should include data of 'when the symptoms are present' and 'what the patient was doing/thinking' as well as 'how he or she reacted to the symptoms' and is invited for a follow-up visit bringing the journal. GP and patient look at the journal together in order to find patterns and make the links needed to change the agenda together. If the patient accepts a link the GP explains how stress and tension lead to physical symptoms again. If this explanation is not reassuring enough it is important to then discuss how to move from there and negotiate further (psychological) treatment. The results of research about the effectiveness of reattribution alone are modest, but as first step to help patients accept further treatment it offers patient and GP support. In MUS patients with practical every-day life problems PST could be one of the options for further treatment.

### Problem Solving Treatment

This treatment is certainly an option in patients with mild to moderate depression.

The technique is used to (further) increase the patient's understanding of the link between their current symptoms and their everyday problems as an expected part of everyday living, and to show that effective resolution of such problems will help to improve how they are feeling. It is a brief psychological treatment consisting of 4 – 6 sessions of about 30 minutes each over a period of approximately 9 weeks total. For patients with a mild to moderate depressive disorder the treatment is as effective as antidepressants (and therefore a good alternative), and more effective than care as usual<sup>7</sup>. There is also evidence that PST is effective as part of various (self) management programmes for chronic illness for instance Diabetes and Rheumatoid arthritis, as prevention and for various other indications<sup>8-13</sup>.

During every PST-session and at home between sessions a specific problem-solving procedure is used in an attempt to solve problems in a structured way<sup>xvi</sup>.

The patient learns seven steps of problem solving, initially working together with the GP on one of his or her current problems, but gradually taking over control and doing the same thing on his own. The patient regains control and having a more positive experience

regarding his or her own ability to solve problems is empowering.

There are 7 stages in problem solving treatment, with 7 clear steps for the patient

### Problem Solving Treatment

1. Explanation and rationale
2. Problem definition
3. Establishing achievable goals
4. Generating solutions
5. Evaluation and choice of solution
6. Implementation
7. Evaluation

In stage one the therapist, in this case the general practitioner, makes an inventory of current symptoms and problems, makes sure the patient understands and accepts a link between the symptoms and these problems in every day life, and explains the treatment. When the patient is motivated for this treatment the steps the patient takes for every problem he or she wants to work on are: 1. making a clear problem definition of one specific and current problem, 2. setting achievable goals, 3. brainstorming about possible solutions, 4. weighing the pros and cons of every possible solution 5. to choose the best option to solve that problem with the least negative effects and 6. to make an implementation plan to ensure the chosen solution will be carried out. In the seventh step the results are evaluated, and the impact of the success on the patient's symptoms is discussed. At the end of 4-6 sessions many patients are able to cope better with their every-day problems and the treatment is ended.

### *The workshop and conclusions*

During the workshop at the 4th National Family Medicine Days and 2nd European Systemic Family Conference participants practised part of the reattribution technique and 3 steps of problem solving treatment using a patient vignette.

This practice session was followed by a discussion between participants from various countries. Cultural differences were mentioned in patient expectations and attitudes towards psychological treatments and medications, but also in the possibility to take more than a few minutes and enough time to use these structured talking treatments with patients. Nevertheless participants agreed that these

talking treatments should be used more and these treatments could be an alternative.

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