

## Porto meeting presentation abstracts

Go to Presentation Abstract number:

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

[23](#) | [25](#) | [26](#) | [27](#) | [28](#) | [29](#) | [30](#) | [31](#) | [32](#) | [33](#) | [35](#)

---

PRESENTATION 1: Friday 5th May, 1995  
9.20 - 9.50

TITLE: A multi-methods research program for the evaluation and improvement of maternal and child preventive services for Bedouin families in southern Israel.

AUTHOR(S): Jeffrey Borkan  
Ilana Belmaker  
Kathy Abu-Saad  
Yaffa Sitton  
Gillian Hundt  
Susan Beckerleg

ADDRESS: Department of Family Medicine  
Faculty of Health Sciences  
Ben Gurion University of the Negev  
P.O. Box 653  
BEER SHEVA  
Israel

-----  
-----

Maternal and child health (MCH) care are major concerns for the Bedouin minority in Israel. This project attempts to identify, evaluate, and improve models of care for existing MCH services and their impact on health outcomes and behavior for this semi-nomadic, semi-urbanized population. The particular focus is on preventive services, from prenatal care through immunizations and check-ups during the first year of the child's life. The research comes at a time when the structure of health care in Israel is undergoing radical

change and when there are major governmental and societal pressures to reduce the discrepancy between Israeli, Arab and Jewish services. The research, funded by the European Community, also involves a parallel project in the Gaza Strip under the auspices of the Palestinian Authority.

This research will utilize multiple quantitative and qualitative techniques and will involve a multi-disciplinary team of researchers. Techniques will include long interviews, focus groups, surveys, outcome studies, and cost-benefit analyses among both health care consumers and providers. Community involvement will also be sought on several levels - from grass roots advisory committees to involving local Bedouin researchers in the research process.

The data collection technique during the first phase involves focus groups of new mothers and their husbands timed to take place during the traditional forty days after birth. Focus groups were chosen for their ability to quickly orient a research group to a new area and their ability to generate hypotheses and help define variables. The meetings combine elements of ethnographic and survey research and appear to well-suited to the Bedouin cultural milieu where frequent visiting and group interaction is a normal part of the post-natal period.

The presentation will begin by outlining the overall research plan and describe the initial findings from the focus group study. Discussion will then be opened for audience input. I hope to generate suggestions to help direct the ongoing research efforts and to benefit from the accumulated wisdom of those from different countries who have dealt with both the ethical issues of "community action research" and the subject area of preventive services in a changing health care environment.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 2: Friday 5th May, 1995  
9.50 - 10.20

TITLE: An evaluation of a service for adult survivors of child sexual abuse.

AUTHOR(S): P. Smith  
L. Pearce  
Mike Pringle  
R. Caplan

ADDRESS: Department of General Practice  
The Medical School

Queens Medical Centre  
NOTTINGHAM NG7 2UH  
United Kingdom

---

-----  
-----  
Introduction and aims: Child sexual abuse is an under recognised and poorly treated cause of distress in adult life. An innovative primary care service was set up in Lincoln for these patients and this presentation reports its evaluation.

Method: 116 clients were referred in the year. Three psychological measures were used at the start of treatment and at the end of treatment or at the end of the pilot. Patient questionnaires elicited facts and opinions. A case-control study as a subgroup looked at use of health service resources.

Results: These adult survivors of child sexual abuse had previously been high users of the health service with a high suicidal attempt rate, three fold increase in surgical operations with negative findings and high contact rates with primary and secondary care. On entry to therapy the three psychological measures showed them to be highly disturbed, with their levels reducing significantly by the end of the study period. The cost per client was approximately £700,=.

Conclusions: The demand for this service exceeded expectations and the clients were more distressed than was thought previously. They are high users of the health service and previous interventions have offered little benefit. This service appears to offer great benefit at low cost. A longer term follow up will be required to fully establish the effectiveness.

Reason for presenting at EGPRW: This is an evaluation of a health services intervention which may interest the participants and it involves intervention to improve the mental health of women, many of whom have suffering families. I hope to achieve some feedback on similar interventions in Europe and an understanding of how common child sexual abuse is in different countries.

How is this relevant to the GP on an international level: We are all looking to evaluate services and this is one that, I suspect, will be available in time throughout Europe.

---

---  
[Back to the top](#)  
-----  
---

PRESENTATION 3: Friday 5th May, 1995  
10.45 - 11.15

TITLE: General practitioner and his/her family.

AUTHOR(S): \_elimir Jakši\_

Milica Katic

Zaida Azeredo

Igor Švab

ADDRESS: Andrija Štampar School of Public Health

Rockefellerova 4

41000 ZAGREB

Croatia

---

-----  
-----  
Objective researches performed show that working within family medicine gives pleasure but also leads to exhaustion. Also, there is a growing number of suicides, consumption of drugs and alcohol, more divorces among the physicians in general, especially among those who work in a relatively isolated environment and in such situations and tasks where they themselves are "the medicine", where they give their best and where they work in difficult and sometimes hopeless situations in which they cannot always expect neither to have some great successes nor reward for their work. All of these are very frequent characteristics of the family physicians work.

The consequences are not divided only among the patients and the colleagues in professional life of a physician, but they also appear in his private life and within his family. There is an interesting question that arises about the family physician's family: Does he/she transfer his/her experiences from family to patients, and does he/she transfer his/her attitudes from the practice and together with frustrations from professional life to his/her family? To explore this, an anonymous survey has been carried out among younger and more experienced family physicians and among the members of their families. The hypothesis stated that it should be expected from a family physician to be somewhere in the frame of transferring to his home a role of "small God", an inviolable authority for the patient and his professional team, and, on the other hand, that at this home he plays the role of the victim of his profession, seeking protection and security which he would need at this work as an essence of this efficiency.

The preliminary results show that the family physician is at home somewhere in the middle of the described extreme roles, that he/she is a "normal" husband/wife, and that neither he/she nor his/her family members complain or think they should change the profession. As expected, the major problem is lack of time. Thus, for a physician, as well as for his patients, family is an important factor of satisfaction and health.

The same questionnaire was distributed among general practitioners in Portugal and Slovenia. The aim of their comparisons was to explore to which extent the family life itself of general practitioners is determined by his profession in different countries.

---

---

[Back to the top](#)

---

---

PRESENTATION 4: Friday 5th May, 1995  
11.15 - 11.45

TITLE: The welfare-family in a changing context on social modes of provision of elderly care in Portugal.

AUTHOR(S): Pedro Hespanha  
Maria José Hespanha

ADDRESS: Rua Carlos Seixas, 117, 6o esq.  
3030 COIMBRA  
Portugal

---

-----

The social problem of the elderly consists in that fact that families increasingly have less ability to care for them and in the lack of public or private institutions capable of providing for the functions which they cannot. Contrary to other societies in which the State has taken as its responsibility to create or support services which aid the elderly, in Portugese society the involvement of the State has been very low, and, thus, there are not enough institutions or they are insufficiently funded.

Studies carried out in this area show that the family continues to assume a decisive role. At the same time, given the changes which have occurred in the organization and structure of families, the traditional practices of care for the elderly have undergone profound changes.

The aim of this presentation is to discuss the impact of these changes on the different modes of the provision of welfare for elderly on the basis of some research done by a GP and a sociologist in a rural parish.

The main hypotheses states the existence of an informal, permanent, non-state system of social practices oriented to the provision of welfare goods and services, which, in some way, substitute for some of the welfare functions that the State is not able to provide.

The mircrosociological analysis of the different forms of elderly care provision undertaken by the authors of this paper seems to confirm that hypothesis. Care of the old is still, in large part, given within the framework of the relations of traditional solidarity, based in familial relations, the neighbourhood, and paternalism.

The presentation aims also to stress the importance of combining professional experience

of GP doctors with social science approaches for a deeper understanding of social contexts that involve medical practice.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 5: Friday 5th May, 1995

11.45 - 12.15

TITLE: The hands that rocks the cradle: childcare and family networks.

AUTHOR(S): Silvia Portugal

ADDRESS: Centro de Estudos Sociais

Colégio de S. Jerónimo

Apartado 3087

3000 COIMBRA

Portugal

-----  
-----

The paper presents the results of a research on childcare choices of young couples who had their first child. Dealing with the discussion about the relationship between formal and informal care, the paper stresses the role of family solidarity in the transition to parenthood and tries to unravel the dynamics of support networks within the family.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 6: Friday 5th May, 1995

13.30 - 14.00

TITLE: What the adolescents think about their family.

AUTHOR(S): Helena Baía

Carlos Prior

Teresa Lopes

Conceição Garret

ADDRESS: Centro de Saúde Fernão de Magalhães  
Av. Fernão de Magalhães, 620  
3000 COIMBRA  
Portugal

---

-----  
-----  
In relation with The Family's International Year, the General Practitioners of Fernão de Magalhães Health Center in Coimbra, decided to investigate the opinion of the adolescents on their families, bearing in mind that they are fundamental elements of family dynamics.  
To that purpose, they carried out an anonymous and confidential survey on a random sample of adolescents between 14 and 19 years old, based on Smilkstein's Family APGAR.

The results were related with sex, school results and family structure of the adolescents, academic degree and profession of the parents, as well as with the degree of adjustment of the adolescents to school and to work.  
The preliminary results suggest that about one third of the families are dysfunctional, with a similar distribution in both sexes.  
A high score of Family APGAR has a positive influence on the adjustment to school.

---

---  
[Back to the top](#)  
-----  
---

PRESENTATION 8: Friday 5th May, 1995  
14.30 - 15.00

TITLE: Socio-economic factors, chronic morbidity and health services utilization by families.

AUTHOR(S): Esther Gomez-Rodriguez  
Pilar Moreno-Raimundo  
Mariano Hernandez-Monsalve  
Juan Gervas

ADDRESS: Equipo Cesca  
General Moscardó, 7  
28020 MADRID  
Spain

---

-----  
-----  
The prevalence of chronic diseases and disability increases from upper to lower class. Suffering and using health services is not an individual question. Physical environment (housing), working conditions and, the most important factor, lifestyle affects the whole family.

Our hypothesis is that socio-economic factors are associated with chronic morbidity and health services utilization in families living in different urban settings (upper class versus lower class district).

Data were obtained in two practices, in Madrid, practice A attends a wealthy population and practice B a poor one, according to geographic published data of the town. All consultations of patients from 50 to 70 years were recorded during one month in both practices. We obtain data about 1) the socio-economic situation of the patient's family, 2) chronic morbidity in family members, and 3) the utilization of the general practitioners' services by members of the family. Source of data were the medical records and the patient (through a structured interview, of about 15 minutes, after the medical consultation).

119 patients attended the practices (excluding 8 living alone, 6 in whom no enough data can be obtained and 4 who did not like to participate). In A families are larger and with members of more than two generations. In A, also, more family members are employed and more are professionals (university education, 0.5 per family versus 0.03 in B). In B there is 20% more chronic morbidity and 50% more consultations per month, twice number of emergency consultations and 50% more referrals to hospital.

Our data support the hypothesis that socio-economic factors are associated with chronic morbidity and health services utilization.

---

---

[Back to the top](#)

---

---

PRESENTATION 9: Friday 5th May, 1995  
15.15 - 15.45

TITLE: The Hospital Anxiety and Depression Scale as a diagnostic aid in general practice.

AUTHOR(S): Richard Starman  
Linda Gask



ADDRESS: Obrechtstraat 90 B  
2517 VW THE HAGUE  
The Netherlands

---

-----  
-----  
The Hospital Anxiety and Depression Scale is developed for the recognition of anxiety disorders and depression. The scale has been validated for use in general practice. This study looks at the clinical usefulness and impact of this psychological aid. 25 GPs were asked to use five testscales each in patients in whom they were suspicious of the presence of psychiatric disorder or who were at high risk for psychiatric disorder (eg. postnatal). The GPs completed pre- and post-test questionnaires regarding diagnostic hypothesis, changes in diagnoses and treatment plans, the recording of the results in the notes, the patients' remarks on completing the scale. Finally they were asked to make recommendations on future use.

The preliminary results show an reasonable overlap between the GPs' early diagnosis and the testresults. The GPs did mistake anxiety for depression in some patients and the other way around. In both cases this has important consequences for the treatment. The patients were rather enthousiast to complete the list. It is concluded that this test is an useful psychological diagnostic aid in general practice.

---

---  
[Back to the top](#)

---

---  
PRESENTATION 10: Friday 5th May, 1995  
15.45 - 16.15

TITLE: GPs and Specialists' views about hypertension in Avon 1994.

AUTHOR(S): Michael Whitfield  
Anthony Hughes

ADDRESS: Department of Social Medicine  
Canynge Hall  
Whiteladies Road  
BRISTOL B58 2 PR  
United Kingdom

---

-----  
Objectives: To determine doctors' views on managing patients with hypertension.

Methods: A postal questionnaire was sent to all GPs (550) and internal medicine specialists in Avon (64). The general practitioners were asked to answer three questions about levels of blood pressure that they would treat, a question about the investigations they would institute in a patient with hypertension, some questions on frequency of monitoring such patients and some attitude questions. The specialists were asked to complete the same questionnaire as 'they would expect GPs to complete it'.

Results: Sixty percent of the GPs and 70% of the specialists replied after one mailing. There was a wide range of opinion on all answers, both within and between specialty groups. Some of the possible consequences of these variations will be discussed, together with suggestions of methods to reduce the scale of this variation.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 11: Friday 5th May, 1995  
16.15 - 16.45

TITLE: The uses of model development for primary care using attitudes to hormone replacement as an example.

AUTHOR(S): Frances Griffiths  
Dave Byrne  
Kevin Jones

ADDRESS: 243 Darlington Lane  
STOCKTON-ON-TEES TS19 8AA  
United Kingdom

-----  
-----

Data from a postal questionnaire survey about women's attitudes to hormone replacement therapy (1225 respondents, 74% response rate from women aged 20-69 years) provide a descriptive summary of correlations in the population. Through applying theory and logic to the data a model can be developed of what causes women to take hormone replacement therapy. The model tries to contain the processes common to most people, it is an oversimplification for any individual Causation in this sense is not the same as complete determination as women are themselves social actors.

The model that has been developed will be presented and its limitations discussed. The model is based on data about the post menopausal women in the survey (n=301). This

excludes women who have had a hysterectomy.

The model can be used in different ways and this will be influenced by theoretical background. Using scientific method the model could be used as a tool from which to develop social experiments in areas such as health education. GPs and health planners could use it for planning clinical care and provision. They could also develop policy that goes with the social trends described or counters them to some extent. Many social factors will influence this decision, and action based on the decision will itself affect the accuracy of the model and outcome.

The model can help to conceptualise social trends and their complexity. This can help us understand the social processes that influence the development and use of 'scientific' medicine. However the production of the model and its form of presentation are also subject to social influences.

In its discussions of presentations the EGPRW frequently identifies social factors that influence medical care. This presentation will describe one way of using quantitative data to describe social trends and discuss the uses and limitations of the method. We hope the subsequent discussion will further the critique of the method and give feedback on the extent to which we should be concerned with assessing the social factors influencing our research and clinical care.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 12: Saturday 6th May, 1995  
8.45 - 9.15

TITLE: The power of hormone replacement therapy.

AUTHOR(S): Ruth Bridgewater

ADDRESS: 71, Addycombe Terrace  
Heaton  
NEWCASTLE UPON TYNE NE6 5NB  
United Kingdom

-----  
-----

Introduction: Hormone Replacement Therapy (HRT) is becoming recommended for more and more conditions of the menopausal women, both symptomatic and prophylactic, to the extent that some doctors advocate its almost universal prescription. However,

community surveys reveal that only 9% of eligible women actually take HRT. There seems to be a tension between rhetoric and practice. An analysis of the medical discourse in texts aimed at the family doctor (undergraduate and postgraduate books, journals and magazines) reveals contradictions that mirror those in practice. I will argue that it is the conflicting ideologies make HRT problematical. Unless we understand these conflicts, there will be ambiguity in HRT discourse.

Discussion: Medical texts portray a woman as a body, pathologised and reduced to the sum of her parts (uterus, ovaries, hormones...). This objectified menopausal body can be simply understood. Viewing this body disassociates the reader from an actual woman. The stereotypes shown uphold societal norms - starkly shown in the medical adverts for HRT, where a woman is forever feminine, sexy and available. The resisting reader, the family doctor, accepts and understands these images, but probably rejects their applicability to every day practice. There is conflict between the texts showing medical power over women, presented as objective science, and daily contact with a diverse group of women who cannot be so simple categorised.

Conclusion: Inevitably, the work of prescribing and monitoring HRT's use does, and will continue to, fall to family doctors. Analysis of practice is very important; but we should not forget that we are influenced by what we read. We need to consider this with critical insight also. Much of this work is based on literary theory with a European origin, particularly the work of Michel Foucault. I find that interdisciplinary work can teach us much. I value the opportunity for discussion with others about this way of thinking.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 13: Saturday 6th May, 1995  
9.15 - 9.45

TITLE: Patients with psychological crisis in general practice.

AUTHOR(S): Annette Gløe  
Frede Olesen

ADDRESS: The Research Unit for General Practice  
Institute of Family Medicine  
Hoegh-Guldbergs Gade 8, 2nd  
DK-8000 ÅRHUS C  
Denmark

-----

-----

Introduction: It is well-known that patients quite often attend a general practitioner due to a personal psychological crisis including crisis due to family problems.

Aim: The aim of this study is to present the attendance rate to general practitioners due to psychological crisis with special emphasis on crisis caused by family problems and to present that type of problems.

Methods: During a qualitative preregistration period we aimed at a strict definition of psychological crisis and ended up with a definition that aims at a person who is mentally distressed and emotionally disturbed. This reduces his normal social functioning and makes him seek his GP for help. His condition has to be a consequence of an outstanding change in the persons life or has to be seen as a consequence of a straining event.

During a 2 week period 177 GPs registered every newly diagnosed crisis during their daytime consultation at patients aged 18 or older. The GPs fulfilled a questionnaire on the crisis including the following themes:

Death among close friends or relatives, partnership problems, unemployment, problems at work, severe disease, severe disease among relatives, violence/rape/robbery, retirement, birthgiving, traffic accident/fire/other accident, other developmental crisis, other loss or separation, other straining event.

Results: The GPs registered all together 198 patients (149 women, 49 men) with the diagnosis psychological crisis and this was due to 280 reasons (212 at women, 68 at men). In the Danish population (5.2 mill) it can be estimated that about 100.000 people attend GP due to a new episode of crisis every year corresponding to one consultation due to crisis per GP per fortnight.

Partnership problems was the reason for 20.7% of all contacts. Death among close friends and relatives caused 15.7%. Severe disease among relatives was the reason for 9.6%. And newly diagnosed disease at the patients caused 8.6% of all new episodes.

Another 16 episodes (5.7%) were due to different family problems.

Discussion: This survey only includes new episodes and the definition of crisis was quite restrictive. Thus GPs have a considerable workload due to psychological problems or crisis among patients in their practice.

Family problems are the main reason for a psychological crisis in GP.

Although some selection bias can have distorted our results, it can be concluded that GPs have a considerable workload in this field and that health authorities should be aware of that when planning what to offer patients in a personal psychological crisis, and that, at the same time, GPs should be aware of the need for appropriate education in the topic.

-----  
---

[Back to the top](#)

---

---  
PRESENTATION 14: Saturday 6th May, 1995  
9.45 - 10.15

TITLE: Doctor-patient communication in different health care systems.

AUTHOR(S): Peter Verhaak  
Jozien Bensing  
Wiebe Boerma

ADDRESS: NIVEL  
P.O. Box 1568  
3500 BN UTRECHT  
The Netherlands

---

-----  
It is hypothesized that health care system characteristics might influence the way general practitioners and patients are communicating with each other, especially where psychosocial problems are involved.

Features in doctor-patient communication that are thought to be relevant for detection and treatment of mental disorder are partly dependent on conditions that may differ from health care system to health care system. Different health care systems will produce different doctor-patient relationships. For example: in health care systems in which GPs serve as "gate-keepers" for specialist care the GP clearly has a "screening-function"; in health care systems where GPs have fixed lists a GP will be better acquainted with his patients than in systems in which a patient might see a number of different GPs. Differences in reimbursement will lead to different emphasis on therapies, diagnostics and time spent with the patient. The presence and extensiveness of vocational training for GPs is another element.

The studies of health care and general practice across Europe (Boerma et al., 1993) and general practice profiles in Europe (Boerma, 1994) have provided us with comprehensive knowledge of the way European health care systems differ in those respects that might determine doctor-patient communication.

By combining the results of own research and literature review on doctor-patient communication and the European study on health care systems we have developed a model that predicts differences in doctor-patient communication and as a result differences in detection and treatment of mental disorder. We are planning to test this model in a international comparative study. To this end doctor-patient encounters should be gathered in several European countries that differ from each other in health care

system. At the EGPRW we hope to discuss this model and the forthcoming research. Moreover we hope to come in touch with potential participants from different countries.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 15: Saturday 6th May, 1995

11.00 - 11.30

TITLE: Home visits in general practice - An international pilot study.

AUTHOR(S): José António Miranda

Juan Gervas

Meritxell Fiter

Dominique Huas

ADDRESS: Instituto de Clinica Geral da Zona Sul

Edif. C.S.7 Rios, 4o

Largo Prof. Arnaldo Sampaio

1500 LISBOA

Portugal

-----  
-----

There is a great variability of patterns of home visiting among general practitioners in Europe. There is no agreement about the adequacy of home visits. There is little knowledge about their usefulness, their costs and their benefits. Is home visiting really necessary? Is it cost-effective?

Objectives: To characterize the demand of home visits: frequency, characteristics of the requiring patients and families, reasons for the request.

To characterize the offer of home visits: organization of the answer to the demand.

To describe the home visits: professionals concerned, morbidity problems, provided services and procedures.

To study the usefulness and appropriateness of home visiting: degree of problem resolution, costs, results.

Research questions: How many requests for home visiting do GPs receive? Who takes the initiative of home visiting? Which is the reason for the request? Which are the age, sex, social class and household type of the requiring patient? How do GPs answer home visiting requests?

How many home visits do GPs make? Which is their length? Which is the health problem

diagnosed? What did the doctor do during the visit? Has the patient been received in the office/seen at home/treated in an emergency service, prior or after the home visit? Was the visit really indispensable? Which were its results? How was it paid?

Methods: 14 GPs collected data concerning all requests of home visits and all home visits made, during a two week period (Nov.-Dec. 1994) or up to 20 visits, in Andorra(3), France(2), Portugal(7) and Spain(2). Reason for request (ICPC) and Health problem (ICHPPC-2 Def) were centrally coded.

Results: We registered 138 requests and 134 home visits with an average of 9.57 home visits per GP (SD = 4.82). Averages of 16.00 (France), 13.50 (Spain), 8.00 (Andorra) and 7.29 (Portugal) home visits per GP were found. Complete features of the study will be presented.

Conclusion: It is possible to extend this study to a European level with an analytical purpose; the main general hypothesis could be that GP home visiting is a useful and necessary practice in Europe.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 16: Saturday 6th May, 1995  
11.30 - 12.00

TITLE: The use of routinely collected data from general practice in research: a pilot cohort study of the effects of hormone replacement therapy (HRT) in the United Kingdom.

AUTHOR(S): Tim Lancaster  
G. Surman  
M. Vessey, M. Lawrence, M. Thorogood,  
E. Daly, D. Mant, P. Yudkin

ADDRESS: ICRF - General Practice Research Group  
Gibson Building  
Radcliffe Infirmary  
OXFORD OX2 6HE  
United Kingdom

-----  
-----

Title: The use of routinely collected data from general practice in research: a pilot cohort study of the effects of hormone replacement therapy (HRT) in the United Kingdom.



Introduction: Family physicians face uncertainty when counselling women about the long-term effects of post-menopausal HRT, particularly combined oestrogen/progestagen therapy. Randomised trials may not be feasible. The increasing use of electronic records by G.P.'s offers a potential method for performing a large epidemiological study of HRT.

Aims: To determine the feasibility of conducting a large, long-term cohort study using computerised general practice records by: recruiting a representative cohort of women for studying the effects of HRT ; validating electronic records against questionnaires completed by participants; evaluating the recording of confounding factors in routinely collected data.

Methods: 2964 women aged 45-64 were identified in seventeen U.K. general practices who contributed to the VAMP Research Database, and invited to complete questionnaires about their health. Questionnaire data were analysed to determine characteristics of users and non-users. Recording of key diagnoses and referrals in the electronic record were validated against the questionnaires, and the level of computer recording of confounders determined.

Results: The prevalence of HRT use was 14.7%. 1037 users (70%) and 819 non-users (55.3%) participated. Users of HRT were more likely to have undergone hysterectomy (Difference 25.8%, 95% CI 21.9-29.7,  $P < .001$ ). Compared to the general population, participants were of higher social class and exhibited more health-conscious behaviours. Differences between users and non-users were small, though users without a history of hysterectomy were of higher social class, more likely to be past users of oral contraceptives (Difference 7.7%, 95% CI 2.4-13.1%,  $P < .01$ ) and to have had a mammogram after the age of 50 (Difference 7.5%, 95% CI 2.6-12.4%,  $P < .005$ ). Data on validation of electronic records will be presented.

Conclusions: Electronic records can be used to recruit women for studying the effects of HRT. Internal controls are important because women who agree to participate are not representative. A cohort study based in general practice is a feasible alternative to a randomised trial of HRT, and might be suitable for a European collaborative study.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 17: Saturday 6th May, 1995  
12.00 - 12.30

TITLE: What happens to long-term medication when general practice patients are referred to hospital?

AUTHOR(S): Michael Kochen  
Mohamed Tabache  
Wolfgang Himmel

ADDRESS: Georg-August University  
Dept. of General Practice  
Robert-Koch Str. 42  
37075 GÖTTINGEN  
Germany

-----  
-----  
Background and Study-Objectives: Discontinuity of drug treatment in general practice patients on hospital admission and after discharge may cause troubles in primary care pharmacotherapy and in the doctor-patient relationship. According to widespread experience this happens frequently to GPs' patients. The study should determine how often drugs - prescribed by the general practitioner - are changed on hospital admission and how often drugs - recommended by the hospital doctors - are changed in general practice.

Methods: During one year all chronically ill patients of one general practice who were referred to hospital (N=130) were followed up prospectively with regard to long-term medication in general practice, drugs received in hospital and medication after discharge from hospital.

Results: The patients under study were prescribed a total of 420 chronic drugs before hospital admission, 13.5% of them generics. In hospital, 223 of these drugs (53.1%) were changed, most of them cancelled (52%), and about one third was replaced by other drugs. The rate of generic drugs was lowered by 50% (from 13.5 to 6.5%). In general, no reasons were given for the modification. The hospital doctors recommended a total of 496 drugs for continuing treatment of the patients after discharge of whom 33.7% were not accepted by the general practitioner. He changed these drugs by replacement (e.g., with generics) or cancelling.

Conclusions: Hospital doctors seem not to be highly sensitive to general practitioner's drug decisions - this applies to the number and sort of drugs as well as the rate of generic prescribing. Besides differing opinions about the pharmacological efficacy of some drugs unawareness of the general practitioner's difficult situation and different economic conditions between hospital and practice are supposed to be the main reason for changing drugs in hospital. A careful appreciation of general practitioner's decisions with regard to economic strains, patient compliance and drug interactions and information from hospital doctor to GP about reasons for changes in drug treatment are recommended to improve the communication between the two groups.

---

---

[Back to the top](#)

---

---

PRESENTATION 19: Saturday 6th May, 1995  
14.30 - 15.00

TITLE: The elderly people falling: Epidemiological study in general practice. "Up and Go test" validation.

AUTHOR(S): Jean-Claude Casset  
Catherine Descamps  
Jean-Luc Bosson

ADDRESS: 44 Place des Tournelles  
73230 SAINT ALBAN LEYSSE  
France

---

-----

Presentation: This work was entirely realized by data processing (from the data capture in the patient file to the statistic analyse).

- First price of thesis in general practice :BICHAT -PARIS 1994;
- Articles will be published in the geriatric french review (1995) and american geriatric review;
- It was in the front page of the daily newspaper "impact medecin" (november 1994).

Methodology: An epidemiological inquiry was realized in RHONE-ALPES (FRANCE ) by 25 doctors equipped with computers during the first half-year in 1993. each patient (>75 years old) included in the study was seen twice with an interval of 3 months. The examination and the clinical exam gave 24 informations about each patient, at each of the two visits: age, sex, way of life (at home 92 %, in institut 8%), orthostatic hypotension research (>20 mm hg), equilibrium troubles ("up and go test" of MATHIAS PODSIADLO), inquiry on the use of medecines (psychotropes, hypotensive medecines), consequences of the falls (medicalisa-tion, fracture, hospitalization),diabetes....

Results:

· representative sample:

754 included patients (66% women, the age average 82)

only 1,3% lost

· descriptive results:

diabetes 9,6%; orthostatic hypotension 8% (it rises with the consumption of medicine), the daily average consumption of medecine 4,2 (46% have a psychotrop-69% have a

hypotensive medicine)

· falls:

incidence: 13,5% in 3 months, 22,6% in 6 months.

consequences: 6% hospitalization, 3% fractures, 26% medicalisation.

types of falls: 44% accident, 34% equilibrium troubles, 9% uneasiness

· up and go test:

score average: 19 seconds

65% <20 seconds, 13% >30 seconds

excellent feasibility in general practice, reproducible, falls predictive, equilibrium trouble specific .

Conclusions: 3 factors of fall risk are identified: falls antecedents, orthostatic hypotension, UP and test >20 seconds.

4 categories of patients:

category 1: no factor, 6,3 % fall risk

category 2: 1 factor, 15,5 % fall risk

category 3: 2 factors, 26,3 % fall risk

category 4: 3 factors, 71 % fall risk

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 20: Saturday 6th May, 1995  
15.00 - 15.30

TITLE: Dementia in general practice: a qualitative research with therapeutical implication using focus groups.

AUTHOR(S): Jan de Lepeleire

Jan. Heyrman

F. Baro

Roy Remmen

ADDRESS: Katholic University Leuven

Dept. of General Practice

Minderbroedersstraat 17

B-3000 LEUVEN

België

-----  
-----

Introduction: Dementia will become a major concern for general practice due to the growing number of elderly people. Making a good assessment early in the disease is important for diagnosis of treatable causes as well as for support and coping mechanisms of family members.

Research question: What signs and symptoms in the history of dementing people are important triggers for the diagnosis dementia in general practice?

Methodology: In this research project we used focus groups to get the information needed. In eight sessions the history of three dementing patients was analysed by a multidisciplinary group holding family members, nurses, elderly helps, social workers, volunteers and general practitioners.

Results: The group concluded that changes in daily function, disturbed behaviour and memory problems are important triggers. Changing medication, loss of the central carer, acute illness and hospital admission are significant moments. One of the conclusions, not related to the research question, was that this methodology could be used in self help groups.

Discussions: Memory problems are important but not the most important triggers in general practice for the diagnosis dementia.

Aim of the presentation: 1. Discuss the value of focus groups in research and clinical setting in general practice.  
2. Share the experience of the EGPRW participants as to the early triggers for dementia in general practice.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 23: Saturday 6th May, 1995  
16.05 - 16.15

TITLE: Home visits in general practice - A European study.

AUTHOR(S): José António Miranda  
Juan Gervas  
Meritxell Fiter  
Dominique Huas

ADDRESS: Instituto de Clinica Geral da Zona Sul  
Edif. C.S.7 Rios, 4o

Largo Prof. Arnaldo Sampaio  
1500 LISBOA  
Portugal

---

-----  
-----  
The well-known variability of patterns of home visiting is confirmed by our international pilot study in 4 European countries. It is possible to obtain evidence about the adequacy, usefulness, costs and benefits of home visits. It seems also possible to study in some detail the reasons for request, and the morbidity linked to home visits. With a larger sample, we will be able to study relationships between some of those features and data about the doctor and practice profile.  
Therefore we propose an analytical study on home visits, to carry on at a European level.

Objectives: To characterize the demand and the offer of home visits in European practices.  
To describe the home visits.  
To study the usefulness, appropriateness, costs and results of home visits.  
To identify factors associated to the request of home visits, as well as to the answer to that request.  
To study relationships between doctor and practice profiles and home visiting patterns.

Research questions: Is home visiting necessary in Europe, or is it just another expression of health services consumption?  
Do home visits satisfy a true health need of the population? Are they an indispensable offer?

Hypothesis: Request of home visits is associated to the age, sex, social class and household type of the requiring patient.  
Home visiting is associated to the reason for request, the age of the patient, the health problem identified.  
Home visiting pattern is associated to the age and sex of the doctor, the practice characteristics, the reimbursement mechanisms.  
Home visiting is associated to the resolving of the morbidity problem.

Design: An observational analytical transversal study.  
Discussion of this proposal is wished.

---

---

[Back to the top](#)

---

---

PRESENTATION 25: Saturday 6th May, 1995  
16.25 - 16.35

TITLE: Diagnosis of lower respiratory tract infections in general practice.

AUTHOR(S): Paul van Royen  
Peter Dieleman  
Carl Steylaerts

ADDRESS: University of Antwerp (U.I.A.)  
Dept. of Medicine - General Practice  
Universiteitsplein 1  
2610 ANTWERPEN  
Belgium

---

-----  
-----  
Acute respiratory infections (ARI) are among the most common reasons for people to seek medical attention (tween 20% and 30% of all reasons for encounter with general practitioners). About 10% of these are lower respiratory tract infections (tracheitis, bronchitis, pneumonia). Many physicians are making the diagnosis of lower respiratory diseases by patients' history and by a simple clinical examination. Diagnosis is however troubled by many problems: unclear definitions, the varying expression of the disease, the absence of immediate x-ray diagnosis in general practice and the demand for rapid and efficient therapy. The correct use of antibiotics must be based on an etiologic diagnosis. A high prescription rate of antibiotics is associated with a high prevalence of antibiotic resistance among bacteria. Diagnostic strategies appropriate to the general practitioner should be developed.

In this study we want to compare symptoms, clinical signs and examinations with the etiologic diagnosis of lower ARI (based upon a sputum culture, a chest x-ray and a blood sample). In that way we can evaluate the discriminatory ability of symptoms, clinical signs and other examinations in the diagnosis of lower respiratory infections. In about twenty general practices around Antwerp, all new episodes of lower respiratory infections are registered. Data are gathered on symptoms, signs, clinical examination, diagnosis and drug prescriptions by the GP.  
We will present primary results of the pilot study. Discussion on further study will be possible.

---

---

[Back to the top](#)

---

---

PRESENTATION 26: Saturday 6th May, 1995  
16.35 - 16.45

TITLE: Confidentiality and responsibility. The medical dilemma in the diagnosis of HIV patients.

AUTHOR(S): Ma del Mar Valero-Marcet  
Ferran Gali-Gorina

ADDRESS: Teaching Unit of Family and Community Medicine  
Consorei Sanitari de Terrassa  
CAP Terrassa Nord  
25 de Setembre 26  
08226 TERRASSA (Barcelona)  
Spain

-----

-----

We would like to share our experience and ideas about medical responsibility and the patient's rights confidentiality with colleagues from different countries of Europe.

A clinical case will be presented in order to discuss our criteria in the management of HIV patients about testing counseling seropositives and the notification to partner considering the legislation.

Which is the right balance between diagnosis, prevention and legislation?

-----

---

[Back to the top](#)

-----

---

PRESENTATION 27: Saturday 6th May, 1995  
16.45 - 17.15

TITLE: Comprehensive assessment of general practitioners.  
A project to see if it is possible to assess general practitioners in a comprehensive ("integral") way.

AUTHOR(S): Jan-Joost Rethans  
Paul Ram  
Cees van der Vleuten  
Richard Grol



ADDRESS: University of Limburg  
Dept. of General Practice  
P.O. Box 616  
6200 MD MAASTRICHT  
The Netherlands

---

-----  
-----  
Introduction: Assessment of the competence of general practitioners is a current topic in general practice, at least in west-European countries. One of the main problems in planning postgraduate medical education is how to plan courses which are really linked to the needs for or deficiencies in knowledge, skills and attitude of practising general practitioners. In order to try to make courses for participants as profitable as possible, course organisers often send surveys to the target populations in which they ask for the specific clinical interests for postgraduate medical education of these populations. As a result courses are organised which reflect these interests by nature of their clinical content. However, it is unknown whether these content areas indeed reflect the real deficiencies of the general practitioners. Research has even shown that in selecting educational courses physicians tend to follow courses in clinical topics of which they already know a lot in stead of following courses in topics they are not so familiar with. What is missing is a system which in a systematic way (by a series of tests) is able to screen practising general practitioners for their real deficiencies and not for what they think they are deficient in.

Method: By means of literature study and by discussions with leading general practice test-developers a model has been developed. This model aims to assess general practitioners in a comprehensive way, that is assessing both knowledge, skills, attitudes and practice management. In a pilot study to test the feasibility of the model two groups of 9 general practitioners have participated. Each group was assessed in a comprehensive way. However, one group in a laboratory-test situation (a competence model) and the other in their practice (f.e. with video recording of real consultations). This was the performance model.

Results: Both the competence and the performance model proved feasible. The laboratory model however implied more work for the researchers and the general practitioners were inclined to find this model more threatening. The model in the practice was (unexpectedly) good appreciated by the participants and implied less work for the researchers.

Conclusions: It is possible to assess general practitioners in a comprehensive way. This pilot study resulted in a main study where 100 GP's will each take part in the competence model and the performance model. In this way it will also be able to investigate to what extent competence is related to performance.

Aim of the presentation: We hope to raise a discussion at the EGPRW meeting what their

opinion about comprehensive assessment is and to hear if there are other countries where similar initiatives were taken.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 28: Saturday 6th May, 1995

17.15 - 17.45

TITLE: Caffeine-consumption and the Premenstrual Syndrome..

AUTHOR(S): Saskia Mol

Marcelle Wijme

Geert-Jan Dinant

ADDRESS: Nederlands Huisartsen Genootschap

Afd. DKB

P.O. Box 3231

3502 GE UTRECHT

The Netherlands

-----  
-----

Introduction: The premenstrual syndrome (PMS) is a complex of symptoms experienced by many women in the days prior to menstruation. Many causes have been postulated for the occurrence of this syndrome, none of which have been duly proven. There is evidence in the literature that caffeine is one of the possible contributors to premenstrual complaints. If indeed this dietary substance proves to play a role in the etiology, this may suggest a simple solution for PMS.

The reason for presenting this paper in the EGPRW-setting is to demonstrate how, even in a small study, a first step can be taken in answering an etiological question.

Method: The role of caffeine-consumption in PMS was studied in a case-control design. 15 women known by their general practitioner to suffer from PMS, were compared to 37 controls, matched for age and social status. A questionnaire was taken, covering premenstrual symptoms as well as several variables - amongst which caffeine-consumption - that might contribute to the symptoms or might act as confounders. A total score for premenstrual symptoms was calculated. It was related to caffeine consumption and to the other variables in a multiple linear regression analysis.

Results: The response was low, 53% for the cases and 32% for the controls. There was a partial overlap of the PMS-scores of the cases and controls, but the average score differed

considerably: 135 vs. 75 (maximum score: 225). As postulated, there was a significant relation between the severity of the premenstrual symptoms and the caffeine consumption. Physical exercise was the only other variable related to PMS.

Conclusion: It is striking that, although the number of patients in this case-control study was small, a positive relation between caffeine-consumption and the premenstrual syndrome could be demonstrated. It would be interesting to repeat this investigation in a larger study of a prospective nature, using a diary method for more precise registration of caffeine-consumption and mood changes. If indeed the relation holds true, a simple therapy may be close at hand: Decaff please!

-----  
---

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

-----  
---

PRESENTATION 29: Sunday 7th May, 1995  
9.00 - 9.30

TITLE: The blood pressure perception of the health-professionals.

AUTHOR(S): Jan van Dijk

ADDRESS: R. Tomadia, lote 8  
4740 FÁO  
Portugal

-----  
-----

Introduction: A previous study among 185 Portugese patients who frequently visited a local health-center demonstrated that 57% of them had an opinion about the values of the arterial blood pressure which didnot correspond with the medical norms for blood pressure values adjusted for age. Having the determinant: "source of information about the blood pressure values" a significant influence on their blood pressure perception. This implies that either there is something wrong in the emission of information by the health-professionals or in the reception of information by the patients. Therefore a second study was set up to investigate the emission by the health-workers.

Method: An inquiry was held among 29 GP-trainees, 79 GPs and 78 nurses from several health centers in North-Portugal, to evaluate their perceived values of the arterial blood pressure adjusted for age.

Results: The participants have an heterogenous knowledge about the blood pressure values.

The majority of the GP-trainees, about 16% of the GPs and 30% of the nurses, have an opinion about the blood pressure values which differs from norms of the WHO adjusted for age.

Among the health professionals there is more uniformity for the systolic than for the diastolic value.

The most common mentioned blood pressure values by the health-workers was 160/90 mmHg.

Conclusion: This implies that every one has his own values for the blood pressure, which many times doesnot agree with the WHO norms for blood pressure adjusted for age. This can result in several public health consequence like wrong informed patients or a false treatment or untreated hipertensive patients.

Discussion: In a country where the health-professionals don't have an uniform criteria about hipertension, you can ask yourself what is the statistical significance of the citation about the numbers hipertensive patients.

Considering the fact that, many health-workers have their own referential values for the arterial blood pressure and new avialable research information about isolated hipertension and bordeline hipertension, it may be worthwhile to reconsider the actual WHO referential values for the arterial blood pressure values.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 30: Sunday 7th May, 1995  
9.30 - 10.00

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

AUTHOR(S): Jan-Joost Rethans  
Lars Saebu  
Terje Johannessen  
Steinar Westin

ADDRESS: University of Limburg  
Dept. of General Practice  
P.O. Box 616  
6200 MD MAASTRICHT  
The Netherlands

-----

-----

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

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

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

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

-----

---

[Back to the top](#)

-----

---

PRESENTATION 31: Sunday 7th May, 1995  
10.00 - 10.30

TITLE: Evaluation of utilising computerised decision support system (DSS) in the therapeutic management of oral anticoagulation in general practice.

AUTHOR(S): D. Fitzmaurice  
Richard Hobbs  
E. Murray  
C. Bradley

ADDRESS: University of Birmingham  
Dept. of General Practice  
BIRMINGHAM B15 2TT  
United Kingdom

-----  
-----

Study objectives: To test the safety and efficacy of using computerised decision support (DSS) in general practice for the therapeutic management of oral anticoagulation.

Methods: The 12 month study was based at 2 inner city practices with warfarin monitoring provided by hospital clinics. Samples from patients receiving warfarin were sent to hospital to measure INR. In Practice A, following the INR result patients were randomised to either: computer assisted management in the practice; or non-computer management, where dosage continued to be decided by the hospital clinic. In Practice B, all patients were dosed by the practice using computer assistance. Historical data was collected on previous levels of control for each patient. Prospective data collected were cumulative INRs; morbidity data, bleeding or clotting episodes; attendance rates, including recall times and DNA rates; and patient satisfaction ratings, using postal questionnaires.

Results: 50 patients were seen and results are given for practices A and B separately. Practice A: 26 patients were seen in practice A during the study. Mean recall time for the last 3 months was 29 days (range 2 days - 12 weeks). The mean recall time for the first three months was 19 days (3 days to 8 weeks). From back-data, 42% of patients were in range for their condition prior to attending the practice clinic. 12 months following the introduction of DSS, 86% of INRs were within therapeutic range, 14% low and 0% high. This improvement is statistically significant ( $p < 0.001$ ) using the McNemar test for dependant correlates. There are 3 episodes of epistaxis. 24 postal questionnaires were sent of which 19 were returned, with the overwhelming response that the practice clinic gave a superior service. Practice B: 24 patients were seen in practice B during the study. 10 were dosed by the hospital and 14 by computer DSS. From the back-data, 43% of practice dosed patients were in range and 50% of the hospital dosed patients were in range prior to the start of the study. 12 months after computerised DSS, 75% of tests for practice dosed patients were in range, compared to 50% of hospital dosed patients (NS). Average recall time for the first 3 months of the study was 17 days for the practice group and 26 days for the hospital group. For the last 3 months, the figures changed to 28 days and 19 days respectively.

Discussion: This pilot study has shown that it is feasible to devolve oral anticoagulant management from secondary to primary care, utilising computerised DSS. By utilising

near patient testing, in combination, a full oral anticoagulation service can be provided at practice level (MRC grant awarded to investigate this further).

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 32: Sunday 7th May, 1995

10.30 - 11.00

TITLE: Continuity/Longitudinality of care in general practice in Europe.

AUTHOR(S): Raimundo Pastor-Sanchez

Antonio Lopez-Miras

Mercedes Perez-Fernandez

Juan Gervas

ADDRESS: Equipo Cesca

General Moscardó, 7

28020 MADRID

Spain

-----  
-----

General practitioners (GPs) in Europe can identify their population through a patient list (Denmark, Italy, The Netherlands, Spain, United Kingdom), or through a geographic area (Finland, Portugal). In some countries, like Belgium, Germany, France and Switzerland patients have free access to doctors working in ambulatory care (GPs and specialists).

Our hypothesis is that GPs offer more continuity/longitudinality of care when they can identify their eligible population.

We have obtained cooperation in 21 European countries. In January 1995 fifteen have sent their data. Each participating GP recorded all encounters during one normal working week; that is, office and domiciliary encounters and direct and indirect encounters. Three questions are critical: 1) has this patient been seen previously for this principal problem?, 2) has this patient been seen previously for another problem?, 3) has a member of his/her family been seen previously?

Data are received from 172 GPs from Andorra, Croatia, Finland, France, Germany, The Netherlands, Israel, Lithuania, Norway, Romania, Slovenia, Spain, Sweden, Switzerland and the United Kingdom. Family longitudinality varies from 74.6% in France to 57% in Slovenia. Personal longitudinality varies from 88.4% in France to 83.1% in the United

Kingdom. But we have not analyzed all data received neither received all data.

Provisional data do not support our hypothesis that GPs offer more continuity/-longitudinality of care when they can identify their eligible population.

National coordinators: Azeredo Z, Baum E., Bollan U., Borkan J., Dobbs F., Eilat S., Fijten G., Fiter M., Fleming D., Gervas J., Håkansson A., Huas D., Jipa I., Jurgutis A., Katic M., Keinamen-Kinkaanniemi S., Krkenjen ML., Lionis C., Passerini G., Svab I., van Royen P., Vehvilainen A.

-----  
---

[Back to the top](#)

-----  
---

PRESENTATION 33: Sunday 7th May, 1995  
11.20 - 11.50

TITLE: Usefulness of the International Classification of Primary Care (ICPC) as a tool to classify the most relevant health problems.

AUTHOR(S): Ferran Gali-Gorina  
Cristobal Navarro-Navarrete  
Jordi Jiménez-Guirado  
Montserrat Ureña-Tapia  
Ma del Mar Valero-Marcet

ADDRESS: CAP Terrassa Nord  
25 de Setembre 26  
08.226 TERRASSA (Barcelona)  
Spain

-----  
-----

A family physician (FP) deals with literally all kinds of diseases, injuries, and psychological and social problems.

Any patient on a FP's list can present any problem at any time. All this amount of information is carefully stored, during patient's life, in the medical records.

There is a lack of knowledge of all this kind of information that could be very useful for research, management and many other purposes.

Objective: A pilot and prospective study has been designed to assess the usefulness of the ICPC as a tool to classify the most relevant health problems.

Methods: The study has been carried out from 15th June till 15th Septiembre of 1994 with



the participation of 4 FP (with a patient's list of about 1.800 per unit). The selection of the health problems has been realized by a consensus group with the criteria of its clinical relevance.

All the patients attended in the consultation room during this time entered in the study. And from their problem list, all this selected health problems (ICPC codes) were codified and weekly transferred in a database to be analyzed.

Main results and discussion: The ICPC has been easy to use in codifying the problems although time consumption.

The distribution of the "selected" health problems has shown a great number of differences between Units (doctors), mainly because the heterogeneous criteria in concepts and in the use of the problem list.

Because of the lack of specificity of some rubrics and sometimes the excess of "rag bags", we propose some modifications in: L91, L95, P74, R91. We have also added a 4th item (A, B, C and D) in the hepatitis (D72).

Finally the study has generated an internal debate about what, where, and how we should have to register and keep up-dated our records, before extending its use in our centre (PHC).

We conclude: That the ICPC could be very useful in classifying the health problems. It also constitutes an optimal tool to compare data internationally. If we extent its use, it provides the possibility to come near the real prevalences. It also contributes not only in doing research, quality assessment and medical audit but also stimulates internal debate in order to improve the use of proper diagnostic criteria and clinical standards.

---

---

[Back to the top](#)

---

---

PRESENTATION 35: Sunday 7th May, 1995  
12.20 - 12.50

TITLE: The Generalizability Theory: a practical and workable measure-ment theory for use in clinical research in general practice?

AUTHOR(S): Jan Degryse  
Jan De Lepeleire  
Jan Heyrman

ADDRESS: Academisch Centrum voor Huisartsgeneeskunde  
Katholieke Universiteit Leuven  
Minderbroederstraat 17

3000 LEUVEN  
Belgium

---

-----  
The Generalizability Theory (Cronbach et al 1972) provides a flexible practical framework for examining the dependability of behavioral measurement.

This complex statistical theory has been popular amongs psychometricians and has been adopted by educational researchers. It is not widely applied in (socio-)medical research probably because of its mathematical complexity.

However, the Generalizability Theory might become a very practical theory that fits a wide variety of research applications in general practice research.

Generalizability Theory extends classical reliability theory most notably by identifying and estimating the magnitude of the multiple sources of measurement error. The "classical" concept of the reliability of a measurement-tool is replaced by the broader and more flexible notion of the generalizability of a conclusion drawn out of a measurement result.

The GT reveals itself also as a powerful tool that can be used to (re-)model and optimize the design of an experiment. The GT can be used to model the measurement for both norm-referenced and domain-referenced decisions.

The GT is a very useful tool to estimate the magnitude of multiple sources of error and to asses the reliability of measurements tailored to specific clinical applications. The standard error of measurement and the Generalizability Coëfficient are very practical clinical measures to express reliability.

All this is illustrated by several examples that demonstrate the applicability of the GT in different research fields. The GT was used to evaluate the psychometric characteristics of a written test that focuses on Medical Problem Solving skills (J. Degryse 1992). It was used to evaluate and optimize the design of a generic instrument to measure Global Health Outcome (Van Hoeck & Degryse 1992) and it is used a conceptual framework in a research project that evaluates the properties of different assessment tools that focus on cognitive (dys-)functioning in elderly (De Lepeleire & Degryse 1995).

This paper treats with the basic conceptual and statistical issues of the GT. The applicability of the GT as a very practical and useful measurement theory is submitted for discussion.

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