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Theme Presentation

PRESENTATION 1: Friday 6th May, 1994
9.30 - 10.00

TITLE: The clinical standards of General Practice in Russia.

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In present Russian situation of transfer to medical insurance there is a necessity of medical standards design concerning quality health care evaluation, formation of health care costs, volume and quality of medical care for each patient.
Our institute is dealing with the analysis of quality stan-dards which are in the use in different areas of Russia. A set of regions (Kemerovo, Althai region, Nijnii Novgorod, St. Petersburg and others) have their own quality standards and the latest may be divided into two large groups: medical-organisational and medical-economic standards.
Medical-organisational standards are the algorithms of pa-tient's passing through all stages diagnosis-cure process in the frame of certain disease (nosology) and determination of patients recovery criteria.
The standards of this kind define volume, time and results of diagnostic and treatment

measures on each stage. They fix the consistent actions of medical personnel, succession of stages and health offices during patient treatment and functional links between them.
The second group of standards are the medical-economic stan-dards concerning the cost of medical care volume. In these standards there are guarantees of certain volume of medical care for each patient on the base of cost.
The volume of received medical care depends on nosology form and seriousness degree of the case but it must be not less than determined in standards and it also concerns and the results.
During the design of medical-economic standards one takes into consideration nosologies (clinic-statistic groups), level of seriousness and type of medical offices which are obliged to deliver relevant care.
It should be remarked that standards now presented are of "hard" character because they regulate without any choice the use of medical technology on the whole or partially and eva-luation according to the scale. This approach to our mind restricts the freedom of physician in making decision concer-n-ing the patient and leads to formal control for doctor's activity.
More perspective way is the design of "soft" standards (cri-teria) which allows any physician the needed freedom and professional information in the frame of adopted medical technology.

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PRESENTATION 2: Friday 6th May, 1994
10.00 -10.30

TITLE: The clinical use of scoring models for gastrointestinal disease.

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Scoring models may be helpful for the general practitioner to decide upon the value of separate elements from history and physical examination for an efficient diagnostic strategy.

Scoring models have been developed to discriminate patients with non-organic gastrointestinal disease from those with an organic disease. Although these models have a high diagnostic accuracy in the population in which they have been developed, their value in other populations has not been established yet.
We tested earlier developed models in validation populations defined in unselected general practice and outpatient popula-tions. The diagnostic performance of the models is expressed in odds ratio, sensitivity and specificity for the classifica-tion of patients as 'organic' or 'non-organic'.
It could be shown that the predictive performance of all models was rather low in the validation populations.
It is concluded that the diagnostic value of scoring models was not reproduced in comparable and unselected populations. Therefore, they should not be used in clinical practice.

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PRESENTATION 3: Friday 6th May, 1994
10.50 - 11.20

TITLE: Do GP's adhere to the 'Imminent Miscarriage' standard?

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In the Netherlands prenatal care is mainly given by midwives and GP's. Both are independent medical professionals in pri-mary health care. Generally speaking, symptoms of imminent miscarriage, i.e. bleeding in the first trimester, are not considered an indication for obstetrical referral. Consequently, the majority of women will either see their GP or the midwife in the case of a haemorrhage.

As part of a quality of care maintenance program, the Dutch College of GP's (NHG) drew up a national standard in 1989 giving guidelines to GP's on care in the case of imminent

miscarriage. One of the aims of the standard is to discourage unnecessary medical intervention. The standard formulates guidelines on history taking and diagnostics enabling detec-tion of complications, such as an incomplete miscarriage or an ectopic pregnancy that should be referred to an obstetrician. The standard maintains that a spontaneous miscarriage is generally a self-regulating process. Curettage and medication are seldom thought necessary. Unnecessary use of ultra-sono-graphy, an ultrasound scan to reassure the patient, should be avoided as it has no medical role.

A questionnaire was sent to a random sample of 495 GP's (8% of all GP's in the Netherlands) to evaluate the use of the stan-dard and the practical problems GP's are confronted with when adhering to the standard. The response rate was 63%. During the workshop the results will be presented on the attitude of GP's to the guidelines of the standard. Furthermore the extend to which the performance deviates from the standard will be outlined, paying attention to the reasons for this deviation, such as the patients' wishes or the interference of obste-tricians. The results of the study will serve as a starting point for updating the standard.

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PRESENTATION 4: Friday 6th May, 1994
11.20 - 11.50

TITLE: Criterias for diagnosis and treatment of uri-nary tract infection among three different medical specialities.

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Introduction: Most doctors have basic strategies for diag-nosis and treatment of a disease, named criterias. Agreement on criterias is a necessary but not sufficient precondition for a certain standard of treatment. Doctors criterias are a result of pregraduate and postgraduate education, CME and a lot of other factors.

Research shows that the best CME is based on establishment of "ownership" to new knowledge and skills, and this is best obtained by establishing a small group-based CME

at a local level.
The importance of scientific developed guidelines as a precon-dition for local CME activities is sometimes questioned. Some doctors have stated that GP's could use a specialist as a scientific consultant in a local CME-process.
The aim of this study is to describe the criterias proposed by GP's, microbiologists and urologists for treatment of a fre-quent condition in general practice.

Methods: A group of doctors has been asked to describe their usual routine or advice to GP's about routine for diagnosis, treatment and control of a 10-year old, a 30-year old, and a 60-year old woman with symptoms of urinary tract infection. The women were supposed to be well-known by the GP.

Results: All together 199 GP's, 89 urologists and 89 microbiologists received the questionnaire resulting in response percentages of 77, 61 and 50. The results show that all 3 specialities have a remarkable big variation in the chosen diagnostic strategy. There were great agreement as to which drug to choose. There was big disagreement on recom-mended after-treatment control.

Discussion: The results show that both GP's and the two specialist groups have very big internal differences in crite-rias for good clinical practice. It is therefore questionable to base a local CME on scientific input from specialists who attend the meetings as a scientific consultant. Scientific input in a local CME must be based on scientific evidence for instance guidelines developed in a multidisciplinary scien-tific working group.

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PRESENTATION 5: Friday 6th May, 1994
11.50 - 12.20

TITLE: Assessing the reliability, validity, and appli-cability of criteria for the evaluation of family doctors' performance.

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Health care professionals put emphasis on the development of guidelines and standards. Relatively little attention has been given to the evaluation of the scientific value of these instruments. Aim of our presentation is to raise some methodo-logical issues related to the evaluation of the scientific value. Which conditions must be met and which strategies can be used?

By means of the Delphi technique we developed criteria for the evaluation of the performance of family doctors towards patients having non-specific upper abdominal complaints. The criteria were developed by groups of experts (N > 12) consis-t-ing of family physicians and medical specialists. After having developed the criteria, several strategies were applied to assess their reliability, validity, and applicability. Two groups of experts independently developed criteria under equal conditions. To assess the reliability of the criteria these two sets were compared. To assess their validity the criteria were compared to the practice guideline "Stomach Complaints", developed by the Dutch college of family physicians. The criteria were also tested against existing evidence from the literature. Their applicability was tested by applying the criteria on a population of 216 patients with non-specific upper abdominal complaints. From our findings we concluded that the criteria were reliable and applicable. They also met the conditions for face validity, criterion-related validity, and construct validity. They did not meet all conditions for content validity.

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PRESENTATION 6: Friday 6th May, 1994
14.00 - 14.30

TITLE: Application of medical evaluation for audit of the influenzae and tetanus vaccines from general practitioners network of the French National Agency for the Development of Medical Evaluation (ANDEM).

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The network of general practitioners (GP) working with ANDEM was created in 1990. One of the first formal organized efforts of this network was to evaluate clinical standards and guidelines in general practice through a medical audit. A priority project on the national network agenda was to evalu-ate the immunization status of influenzac and tetanus in a patient population over 60. This topic was selected after two general meetings which confirmed, one, there was very limited information and, two, that there was a consensus among all physicians and national health community leaders of the impor-tance of this area.

Importantly there was existing recommendations from the Natio-nal Social Security Medical Council. 102 physicians partici-pated and included approximately 3.000 patients according to a methodology established by the ANDEM GP network, "Medical Audit for Physicians Working in the Ambulatory Sector". All performance criteria and methods for collection of data were adopted by all GP participants during the project development meetings. The first consecutive 30 patients above 60 years of age were included in the study. A vaccination data sheet was completed for all patients (age, sex, vac-status, date, origin of information, medical record status, vaccin record status). This information was collected with the patients medical history, risk factors, and social security status.

Results: The comparison of the first evaluation (December 1991) presented a clear difference between the objectives of the performance and the standards defined in the project and GP compliance. The participants decided to change their prac-tice and thus to implement two guidelines: "firstly, to associate the influenza and the tetanus vaccines and, secondly to better inform their patients in order to increase the rate of vaccination". One year later, the audit process was repeated with the same physicians and clearly demonstrated an improve-ment of the immunization status for these two vaccines in elderly patients. The general rate of influenza vaccination in the first year was 76,6% (+ 2,2) and second year 80,9% (+ 2,3) and the rate of tetanus increased from 55,8% (+ 3,6) to 66,5% (+ 3,6). Importantly the analysis of change according to each physician significantly increased in the group of less com-pliant physicians during the first year. This change was directly related to the audit project.

This study suggested that when an important subject of practical and national interest was developed using guidelines and standards adopted by GP in collaboration with medical evaluation specialists (methodologists) a national network GP project was feasible. Moreover that physicians who wanted to improve the quality of their practice would participate acti-vely in this type of program.

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PRESENTATION 7: Friday 6th May, 1994
14.30 - 15.00

TITLE: Development and testing of a low back pain guideline: moving beyond rhetoric to patient and provider outcomes.

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Low back pain (LBP) rates among the most common pain syndromes in Europe, Israel, and the United States and is a health problem of tremendous medical and socio-economic dimensions. As reported at previous EGPRW meetings, our research group has been involved in a multiproject research program on LBP in primary care. Our efforts have included a qualitative study on patients' and providers perceptions of LBP, a multi-practice network epidemiologic research, and now, guideline development and the submission of a grant for guideline testing.

In this presentation, the method of developing the guideline will be discussed, as well as the proposal for clinical testing. The LBP guideline is an attempt to form a national collaborative standard, with participation of family physicians, orthopaedic surgeons, an occupational physician, a primary care internist, a physical therapist and a neurosurgeon. The proposal for testing this guideline focuses on outcome measures such as the real behaviour of physicians, as reflected in habits and costs, and improvements in clinical states of LBP patients.

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PRESENTATION 8: Friday 6th May, 1994
15.00 - 15.30

TITLE: Towards a clinical standard for the GP care of Epilepsy.

AUTHOR(S): George Freeman
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Epilepsy is a chronic condition with important consequences for patients, notably including stigmatisation and the need for concealment.

In this research we originally chose Epilepsy to demonstrate that personal continuity (seeing the same GP in a group rather than different GPs) would be associated with improved care of an important condition. Ninety-nine adult patients with active Epilepsy from four practices were interviewed at home. The study showed inadequate discussion of important aspects of the care of Epilepsy including also the planned duration of treatment. The better levels of discussion were not associated with more personal continuity.

However, as a result, we were able to make some firm recommendations for improved general practice care of Epilepsy. So we devised an audit project to encourage a number of practices in a different district to record and hopefully improve their own care, with the support of a part time 'audit fellow'. We expect that the experience of these practices will form the basis for the definition of a district-wide standard for the ongoing general practice care of patients with Epilepsy.

Each of the audit practices has been offered a list of head-ings to record aspects of epilepsy care over the two years before the audit and again over the following six months. Patients can either be seen opportunistically or at special sessions, at the choice of the practice. We anticipate that the audit will show an improvement in recorded care after the six month review period, even so we expect that sociological aspects such as stigmatisation will still be less complete than information about prescriptions.

Our presentations will summarize findings from the audit study and discuss our experience of how to minimize the barriers to the adoption of agreed clinical standards in general practice. A crucial feature appears to be the early involvement of the practice nurse(s) in the process.

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PRESENTATION 9: Friday 6th May, 1994
15.50 - 16.20

TITLE: Can qualitative research methods inform our decisions about the promotion of hormone replacement therapy for the prevention of cardiovascular disease and osteoporosis?

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There is growing evidence that hormone replacement therapy (HRT) may prevent osteoporosis and cardiovascular disease if taken long term, and guidelines have been produced for pres-cribers. Effective prevention requires women to be prepared to start HRT and continue it for ten years or more. In Britain the main providers of HRT are general practitioners. Women and GPs each have their own knowledge and attitudes to HRT. They interact with each other in relation to HRT as well as the prevailing culture and the media.

To increase our understanding of women's attitudes to HRT a postal questionnaire survey has been completed. It was sent to 1.650 women, a sample of women from the lists of patients for forty GPs in Stockton-on-Tees, England. A 74% response rate was achieved. The results of this survey will be summarised with particular attention to the benefits and limitations of the method.
To add further meaning to the results of this survey, a propo-sal for further qualitative research, using semi-structured interviews has been developed. The sample of women for this study would be taken from those who have already completed a postal questionnaire.

To complement the study of women's attitudes it is proposed to use a similar staged research method to increase our under-standing of the attitudes of GPs to HRT for prevention, and what barriers there may be to its promotion. The study would focus on the forty GPs whose patients have been surveyed so comparisons can be made. Interest in the use of group inter-view in qualitative research is growing. This could provide a low cost method for finding out about peoples ideas and atti-tudes. The proposal includes trying out this method. This additional method will also provide some methodological tri-angulation for the project.

These research proposal will be presented for discussion
The prospect of promoting HRT for prevention raises questions about whether women want to take HRT for prevention and whether its promotion is a realistic and effective option. This presentation explores the ways we may answer these ques-tions.

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PRESENTATION 10: Friday 6th May, 1994
16.20 - 16.50

TITLE: To prescribe - or not to prescribe - anti-biotics. District physicians' habits vary greatly, and are difficult to change.

AUTHOR(S): Anders Hakansson
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Objective: To study how different doctors at a primary health care centre prescribe antibiotics for respiratory tract infections, and to identify possible reasons for differences in prescribing habits.

Design: All medical visits to the health centre because of respiratory tract infections made during January and February in four consecutive years (1990-1993) were studied. The prin-ciples for prescribing antibiotics were discussed continuously to obtain more uniform routines.

Setting: The health centre of Teleborg serves a suburban district with about 10.000 inhabitants, and rural surroundings with another 2.000 inhabitants.

Subjects: All 2.150 visits because of respiratory tract infec-tions (except acute otitis media) made during the studied eight months. All physicians employed at the health centre (five physicians were employed for the whole study period).

Main outcome measures: Percentage of visits resulting in antibiotics prescriptions, and diagnoses given.

Results: Antibiotics were prescribed to 76% of the patients by the most generous doctor, but only to 21% by the most restrictive one. The use of diagnoses suggesting bacterial infections varied in a similar way. Otherwise, the patients of the various doctors looked very much the same, and the therapeutic failures were about 5% for all doctors. In spite of the on-going policy discussions, the doctors kept their positions as generous or restrictive prescribers throughout the study period.

Conclusion: Doctors have an individual and very constant pattern of prescribing antibiotics, and the diagnoses are often given to justify the treatment, rather than the other way round.

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PRESENTATION 11: Friday 6th May, 1994
16.50 - 17.20

TITLE: Evaluation of a Health Check-up for Adults.

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Norbert Donner-Banzhoff
Heinz-Dieter Basler

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Since 1988 all members of German sick-funds above 35 years have been offered a regular check-up. This includes a family and medical history with an emphasis on risk factors, a full medical examination, blood tests (lipids, glucose, creatinine, uric acid), urinalysis and an optional ECG. Patients usually get advice on the abnormalities detected, e.g. to quit smok-ing, to loose weight etc.
Only 20% of the population accepts the invitation for this check-up.

The program was put into practice without thorough evaluation. German Government is now asking for research proposals to assess its effectiveness.

We suggest to evaluate the process and outcome of the program by a cohort study over one year. 600 patients from 60 prac-tices who have a cardiovascular risk factor detected

at the check-up will be recruited. Practices will be assigned to a 'structured care' or a control group. GPs working in the former will take part in seminars to improve their skills at assessing motivation and health related behaviours, communica-tion and counselling to help patients modify risky behaviour. Endpoints of the trial are combined cardiovascular risk factor index, motivation for healthy behaviour, and quality of life. Process data concerning risk factor interventions and costs will also be analyzed. 20-30 of the practices will be recruited in former Eastern Germany to evaluate the program under the special situation of a primary care system that has been changed substantially over few years.

We will present results of a preliminary study on risk factors detected by the new check-up. We would also be happy to discuss the methodology of the main study.

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PRESENTATION 12: Friday 6th May, 1994
17.20 - 17.50

TITLE: The use of clinical tests and renography to establish the early functional damage of kidney in everyday practice.

AUTHOR(S): Graziena Zvinkliene
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Clinical renal function tests (BUN, serum creatinine, creatinine clearance) discussed are often of great help in evaluating the severity and progression of kidney disease in everyday practice. The range of 'normal' values of plasma concentration of urea or creatinine in normal individuals may vary greatly among different subjects. This relatively wide normal range may prevent recognition of early changes in renal function.

For the detection of early functional impairment urea, creatinine, GFR, renography of 49 nephritic patients (20 males and 29 females) year by year were performed and special empha-sis was taken to the borderline stage of renal function.

Each of the clinical tests at times gave evidence of func-tional damage when the results of other tests were normal, but taken together by a considerable amount of empiric informa-tion they provided an adequate overall view of kidney function in clinical renal disease.

More informative as renal function was declining were changes in renograms. With the progression of real damage of renal function the isotopic curves became more and more 'flat' (67,3% of patients). Another type of renogram-'rising' were noticed (while the same level of the clinical tests) in the cases of exacerbation of renal disease (22,7% of patients). Prognostically at this stage renal function was reversible. The ability to obtain quantitative functional data distinguishes radionuclide studies from other, radionuclide imaging procedures are relatively noninvasive and do not require hospitalisation.

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PRESENTATION 14: Saturday 7th May, 1994
9.30 - 10.00

TITLE: An interventional model for improving quality of diabetes care in general practice.

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Anne Helms Andreasen
Poul A. Pederson

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The purpose of the Danish Diabetes Care in General Practice Study is to see if optimizing treatment in general practice results in reduced morbidity and mortality of diabetic patients >40 years of age. In this clinical trial 675 diabetic patients in the intervention group are newly diagnosed by 250 general practitioners. The intervention includes regular follow-up and screening for diabetic complications and propos-ing and pursuing one of three categories of quality of dia-betes care with well-defined goals for blood glucose, HbA1c, diastolic blood pressure, total cholesterols, triglycerides and weight. For example category 1 = "good control" implies an HbA1c <0.07 (fract.), 2 = "acceptable control" <0.085 (fract.) and 3 = "poor control" >0.085 (fract.) (normal range for HbA1c: 0.054-0.074). Similarly, the following categories are chosen for diastolic blood pressure:

<90/<100/>100 mmHg, fasting triglycerides: <2/<5/>5 mmol/1, total cholesterols: <6/<7/>7 mmol/l.
These efforts are supported by educational initiatives as e.g. folders and seminars for the participating general practi-tioners.

At the first follow-up after diabetes diagnosis the following categories are chosen: 1/2/3: 67% / 30% /3%. At 1-year follow-up the observed levels of HbA1c, diastolic blood pressure and lipids are as shown in the figure.

The interventional model has proven to be fit for implement-ing into a general practitioner's daily clinical work.
Scheme N. de Fine Olivarius

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PRESENTATION 15: Saturday 7th May, 1994
10.00 - 10.30

TITLE: Diagnose GPS and community psychiatrists the dementia syndrome according to existing guidelines?
Results of an quasiexperimental study using case vignettes.

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The recently introduced new health legislation in Germany obliges doctors to document ICD-codes in daily practice. To study the accuracy of diagnostic assessment of organic psycho-syndromes in the elderly we designed written case simulations and interviewed all community psychiatrists and primary care physicians in a defined area in Southern Lower Saxony (one of the 21 counties of Germany). One vignette (case 1) described a

70-year old widowed, otherwise healthy woman with memory complaints, another (case 2) a multimorbid, clearly demented female patient. Two versions of the second case were randomly assigned to the participating doctors: one case with a history fulfilling diagnostic criteria for senile dementia (case 2a), the other suggesting vascular dementia (case 2b). 159 doctors - 14 neuropsychiatrists and 145 primary care physicians (response rate 83.2%) - were interviewed.

We found (Table 1) that neurologists and GP's had a signifi-cantly different diagnostic pattern in case 1, probably influ-enced by daily experience in different populations. Dementia seems to be underdiagnosed even if clear criteria are present (case 2). The majority of physicians could not differentiate vascular dementia from SDAT (case 2a vs case 2b). The severity of symptoms was correlated with the ability to make a clear cut diagnosis (case 1: 14.4% vs case 2: 41.5%, p,0.01). In conclusion the presence of guidelines to assess organic psy-chosyndromes in elderly patients had little impact on physi-cians responsible for ambulatory geriatric care in Lower Saxony. Coding ICD-diagnoses in an ambulatory setting might be of limited value with respect to early, mainly ill-defined pathology. Recognition of dementia etiology - although clearly described by the ICD-guidelines - may be of little practical importance as both GPs and specialists could not differentiate these syndromes well enough even when presented with a typical case.
Scheme H. Sandholzer

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PRESENTATION 16: Saturday 7th May, 1994
10.50 - 11.20

TITLE: The use of guidelines in General Practice: a qualitative study.

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The Hackney collaborative Clinical Guidelines Project is running a randomised

controlled trial of chronic disease management guidelines involving 25 inner London practices. Each practice received either an asthma or diabetes management guideline with an educational programme. A qualitative study, running in parallel to this trial, aims to clarify and explore the way in which practices have perceived and implemented the role of guidelines in practice. Specific objectives of this study include a clarification of general practitioners' and practice nurses' views of guidelines, the extent to which guidelines are incorporated into practice and views on the implementation method.

Twenty unstructured interviews (30-60 minutes) were held with general practitioners and practice nurses taking part in the main trial eight months to one year after intervention. Stratified purposeful sampling was used to illustrate subgroups and to facilitate comparisons. We will discuss the feasibility and acceptability of clinical guideline implementation at the practice level. Using an in-depth qualitative method we were able to address issues central to guideline implementation. These include the context in which guidelines were used, practitioners' perceptions of their own needs and strategies employed by practices to implement guidelines. We discuss our results in relation to social influence strategies and practitioner behaviour change.

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PRESENTATION 17: Saturday 7th May, 1994
11.20 - 11.50

TITLE: Counting the cost of quality control in struc-tured clinical care. A General Practice study.

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Calls for structured clinical care are becoming increasingly widespread. Structured care is usually administered through standards and guidelines for chronic or recurring conditions, such as diabetes, hypertension or epilepsy, and also for the management of specific presentations, such as dyspepsia.

Setting up these protocol systems and monitoring the results need time and additional

resources. These may include non-clinical personnel for data gathering and analysis for peri-odic performance review. These costs seem to have been taken for granted although they may represent a significant amount of time, manpower and money.

This paper reports on the costs to a four-person practice in the North of England which has had, for six years, a protocol based structured-care system for diabetes, hypertension, hypothyroidism and hormone replacement therapy (HRT).

The costs are reviewed in terms of TIME, FINANCE and MANPOWER and analyzed at the following stages:

1. Setting up the standard and guideline based system.
2. Adhering to the system: consultations and investigations.
3. Maintaining the system: administration.
4. Performance monitoring: periodic review and modifications.

If standards and guidelines are seen as the way forward for clinical management in primary health care their cost elements need to be incorporated into judging their feasibility.

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PRESENTATION 18: Saturday 7th May, 1994
11.50 - 12.20

TITLE: The project 'Landscape 2000' in Flanders.
From the development of clinical standards to
improvement of performance and quality of care.

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Remy Maes

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The aim of the project 'Landscape 2000' is to improve perform-ance of general

practitioners in daily practice. A standardised methodology is followed.
In a first stage, a 'state of the art' text is made from literature and research material in general practice. Each step of the physician consultation and process of clinical problem-solving needs specific data and can be subjected to appropriate investigation in primary health care. We must investigate how people think about their complaint, how they experience it and which questions they formulate for their GP. The validity of diagnostic strategies is studied, so that standards for the diagnosis with minimum effort for the GP can be developed. Therapeutic acting (including therapy, giving advice and health education), can only be possible after knowing natural history of disease and pathogenic mechanisms. As an example, research data about the different consultation steps for the complaint vaginal discharge are presented.

From survey and registration material, description is made of what physicians are doing in their day-to-day practice. Per-formance of general practitioners is often not in agreement with standards. Examples from this research are presented:
- GP's do prescribe often antibiotics and peristaltic-inhibitors in the case of acute diarrhoea, although guidelines only advice diet therapy as a treatment to uncomplicated acute diarrhoea.
- General practitioners do not use the microscope as a diagnostic tool in the diagnosis of vaginitis.

In this stage the local GP-group enters into the project. By which motivational and situational variables are general prac-titioners influenced in diverging from ideal standards? The validity and importance of these variables are studied.
After this evaluation, topics and actions to improve quality of care in family medicine are proposed.

The Landscape 2000 guidelines do consist of stands for prac-tice management of different complaints and problems in daily practice. There is much attention to acceptable and motivated divergence among GP's. Evaluation between standards and performance in daily practice does contribute essentially to clarify the difference between guidelines and real quality improvement in primary health care.

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PRESENTATION 19: Saturday 7th May, 1994
14.00 - 14.30

TITLE: Attitudes of primary care doctors towards the use of a drug formulary.

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Hagen Sandholzer
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Germany

Background: Although hospital lists of medicines are known for decades published drug formularies for general practitioners are used only since the beginning of the eighties. The drugs in such formularies are selected on the basis of scientific perceptions of clinical pharmacology, specific needs of primary health care and deliberate limitation to necessary, approved, and reasonably priced medicines with as few side effects as possible.

Methods: The "Göttingen Drug Formulary" (GDF; a loose-leaf book which contains 284 different pharmacologic substances including 32 pseudoplacebos and is updated four times a year) was sent to 830 interested primary care physicians: 500 of them, practising in a defined area in Southern Germany, received the GDF free of charge: 330 colleagues working in different parts of Germany paid for the formulary. In a postal questionnaire survey we asked the doctors about their experi-ence with and appraisal of the list and about changes of their prescribing behaviour.

Results: From 260 doctors (31.3%) responding until today four did not use the formulary because of various reasons. Overall 68% found the formulary helpful or very helpful and 73% were satisfied with the drugs selected. Two thirds indicated that they had changed their prescribing behaviour due to the use of the formulary: 44% prescribed more generics, 36% issued less prescriptions requested by patients, 26% prescribed less medicines with unproven efficacy and 22% less innovative, expensive drugs. 64% appreciated an administrative restriction of drugs to be prescribed for sick-fund patients ("official positive list") which is announced by the government for early 1996.

Conclusions: Our results suggest that the voluntary use of a drug formulary supports a more rational and economic but also less innovative pharmacotherapy in primary health care. How-ever, use of such a formulary does not seem to obviate the introduction of an official positive list. The most likely reason might be that doctors confide most in an official restriction of prescribable drugs to reduce patients' pressure for costly and/or irrational prescribing.

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PRESENTATION 21: Saturday 7th May, 1994
14.40 - 14.50

TITLE: Management of emergencies in general practice - a retrospective study of initial clinical judgement.

AUTHOR(S): Bengt Mattsson
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The General Practitioner sees patients early in the development of a disease and the symptoms are often difficult to interpret correctly. Do the symptoms reflect a life-threaten-ing disease or just a mild self-curing ailment? The aim of this study was to look back in retrospect at emergency cases seen by GP's and to evaluate whether the symptoms were cor-rectly evaluated.
Method: In two health centres in northern Sweden (one urban and one rural) records from 307 emergency consultations were scrutinized and symptoms/reasons for encounter were recorded. The judgements were compared to what was known five years later - was the initial judgement accurately considered?
The follow up information was collected in two ways. 1) All records were examined five years after the emergency visit and in 148 patients (45%) record data were valid enough to make a sufficient judgement of the development of the initial symptoms. 2) 159 patients (55%) records gave unsatisfactory infor-mation and to these patients a questionnaire was sent. Some patients had moved and parish offices gave new addresses and whether the patient was alive or not (in case of death, a death certificate was received). Sufficient valid information about the symptom development was received from 290 patients (94%). Seventeen persons could not be contacted.
Result: Two hundred and eighty-eight (99%) patients seemed to have had a satisfactory management. Many patients had consul-ted for life-threatening illnesses (e.g. malignant states, coronaries) and were referred to a hospital special-ist. Alto-gether 35 patients (12%) were referred to secondary care. Just two patients (1%) received unsatisfactory manage-ment. A 40-year old man was treated for "pneumonia' which later was diagnosed as a malignant lymphoma and a 67-year old man had a deep vein thrombosis diagnosed not until 16 days after the emergency consultation.
Of course it is difficult to reconstruct in retrospect what is going on in a surgery. Nuances and considerations in the decision process are difficult to evaluate. However all re-cords had a high standard (typed) and the interpretation of data was made relatively easy.
Comment: The results reflect a well adopted diagnostic competence of general practitioners.

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PRESENTATION 22: Saturday 7th May, 1994
14.50 - 15.00

TITLE: Organisation of out of hours General Practitioner care in different European countries.
Should we establish a European survey?

AUTHOR(S): Jacqueline Jolleys
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Making explicit differences and similarities in service delivery between countries is one way to open discussions about alternatives for health care organisations. This paper aims to discuss a possible future EGPRW collaborative study of out of hours service in primary care. When it comes to GP's involve-ment in out of hours service a lot questions can be raised:
* How is the out of hours period defined?
* What are the normal working hours?
* How many hours are GP's contracted for and how many hours do they spend on out of hours service per week?
* Are GP's compelled to participate in out of hours
ser-vice? Who else provides the service?
* Do GP's have time off following an out of hours shift?
* What are the GP's attitudes to and preferences for out of
hours services?
* Do they want a 24 hour medical responsibility which they
can use transform to a locally suited arrangement or do
they want a regionally organised service?
* Is there a national or regional policy in the GP's
in-volvement in the out of hours service?
* Is there a gatekeeping function?
* What types of services are offered? - telephone consul-
ta-tions, consultations and home visits.
* What are the numbers of out of hours contacts per 1000

inhabitants and what is the relative distribution between
the different services and between day and out of hours
services?
* What payment/copayment systems are there and what are the
relative costs between day and night and between the
different services?
* Are there any formal education information systems on
appropriate use of care for patients?

Would it be possible to establish a European General Practitioners Research Workshop study on out of hours service to answer some of these questions in relation to the different countries? We would like to discuss this at the meeting.

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PRESENTATION 23: Saturday 7th May, 1994
15.00 - 15.10

TITLE: Can audit help General Practitioners to become more environmentally friendly?

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United Kingdom

At the 13th World Conference of Family Doctors (1992) a plenary session highlighted the role of General Practitioners in environmental protection. Dr. Donald Irvine gave the following advice to doctors wishing to develop more environmentally friendly practices:
1 Collect glass and paper for recycling.
2 Use recycled paper were possible.
3 Avoid the use of tropical hardwoods in new buildings.
4 Ensure that buildings are heated efficiently.
5 Use bio-degradable cleaning products where possible.
6 Use un-leaded petrol (or diesel) in our cars.
7 Avoid the prescription of CFC containing aerosols.

With these points in mind, the South West Nottingham Medical Audit Group (U.K.) decided to undertake a survey of the seven practices involved in the group to determine

how environ-mentally friendly we were. The results were presented to the group and guidelines for the future were discussed. Each practice was sent detailed information on local facilities for recycling waste together with the addresses of companies which could supply recycled products. A year later the survey was repeated. Some improvements were shown.

The results of this study will be presented with the aim of promoting discussion on the value of using audit principles to encourage general practitioners to be more environmentally friendly.

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PRESENTATION 24: Saturday 7th May, 1994
15.10 - 15.20

TITLE: The patient who "cannot pay" contact General Practitioner.

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The social awareness of the society can be assessed by observing how it cares for those who "can't" (can't walk, can't work, can't pay). Health needs supply has been early recognised as high priority in establishing social security and equality. Ethic of medical profession imposes strict rules to protect those who are unable to pay for service for centuries. All the same, the problem of the treatment of the health uninsured patient became very interesting in the last few years. Interest raised with the progression of economical crisis all along the world. Special interest can be noticed in the USA where the government is concerned with a great number of the uninsured persons and in the Eastern Europe where economical crisis goes together with reconstruction of the social system. It is expected that changes in health system results by increasing number of health uninsured patients in Croatia. This survey is planned to explore how General Practi-tioners are prepared for confrontation to patients who "cannot pay for service" and how they will respond. The four levels of influence on this situation have been recognised: social and economical development of country (determines the portion of

those who "can't pay" in society), health insurance system (determines the alternative ways of payment), role and status of GP in health system (remuneration system and portion of private patients in GP service) and finally characteristics of GP and members of his team. The focus of the survey will be on the last level: how GP's characteristics and characteristics of members of his team influence the solution of the problem. The method of survey will be observation in real situation by simulation of sickness performed by trained observer. In pilot study a woman of about 30 years of age will play the role of a patient with dysuric complaints who noticed blood in the urine. She will also be supplied by the fake urine sample containing blood. The protocol for observation will be pre-pared in the manner to notice if the receptionist allowed her to contact the doctor, what the doctor said/did, whether she was examined properly, whether therapeutical choice was influ-enced by the fact she "can't pay" and how she was treated in general. It is expected that observations from pilot study will provide sufficient material for qualitative analysis of the way GP's respond to the observed problem.

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PRESENTATION 25: Saturday 7th May, 1994
15.20 - 15.30

TITLE: The prevalence of diabetes in females - is parity a factor?

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This presentation concerns the prevalence of diabetes. In a recent practice based study in England and Wales involving more than 5.000 diabetics, I found a prevalence of 1.8% in males and 1.5% in females. In a smaller study in Portugal (2.000 diabetics), the prevalence in males was the same as that in England and Wales but in females it was 2.2%. Perusal of the literature on the subject discloses considerable argu-ment as to whether there are more female diabetics than males and I propose to discuss this and hopefully gain some enthusi-asm for a simple international study to look at one facet of the problem.

The single slide will show the prevalence in the two countries.

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PRESENTATION 26: Saturday 7th May, 1994
15.50 - 16.20

TITLE: Interest in and self evaluation of the influence following health test / mass screening (HT/MS) and health conversations (HC) with the general practitioner (GP). A randomized, prospective trial.

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Aim: To elucidate the interest in HT/MS and HC by GP's and participants self evaluation of influence one year later.

Methods: Invitations were sent at random to 2000 out of 3466 inhabitants living in the municipality of Ebeltoft, age 30-50 years. Respondents were sent a questionnaire (QU) covering life and health conditions, attitudes and quality of life (Goldberg's health QUs participants were randomized into three groups (E1, E2 or E3). E1: no further intervention; E2: HT/MS followed by a written evaluation and E3: as E2 plus 45 min. HC with the GP. HT/MS included measures of height, weight, vision, hearing, cholesterol, liver-enzymes, glucose, urate, exercise test, lung function and EKG. QUs, HT/MS and HC have been repeated one year later. A 5-year follow-up is planed. A control group (C) of 950 people residing outside Ebeltoft were invited to answer the same QUs.

Results: In Ebeltoft 1370 (68%) participated compared to 430 (45%) in group C. Only 24% had a HT/MS without abnormal results. High or very high risk of myocardial infarction was found in 11%, elevated blood pressure in 10%, 37% were smokers, 16% were too fat, elevated lever enzymes were found in 13%, 30% had a poor exercise test and 19% were found to have impaired hearing. Following HT/MS and HC (group E3,

N=456) 66% set up one or more goals for their health behaviour in the coming year. Goals concerned: exercise (34%), weight (29%), tobacco (20%), eating habits (18%), work (11%), alcohol (7%), family (4%), emotional affairs (4%), medicine (2%) and other conditions (9%). One year after the first HT/MS and HC more than 92% in each group completed an anonymous, coded questionnaire including self evaluation of the influence of HT/MS and HC. Only 1% reported a negative influence of HT and HC, whereas a positive influence was reported by 37% in group C, 35% in group E1, 74% in group E2 and 81% in group E3 (-$p<0.001$).

Conclusions: There is a large interest for HT and HC with GP's. Only 24% were without abnormal findings following HT/MS. Goals for health behaviour were set up by 66% of the partici-pants following HT/MS and HC. One year later 1% reported negative influence, whereas positive influence was reported most frequently in the group who had HT/MS and HC (81%). The coming years will show wether people can change health behav-iour and elucidate the consequences for quality of life.

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PRESENTATION 27: Saturday 7th May, 1994
16.20 - 16.50

TITLE: Stopping Treatment of Selected Hypertensives.

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Some patients on treatment for hypertension may not need to continue medication for life.

At least 15 reports, mainly American, have established that patients can have their medication stopped safely and without relapse. In our pilot study, eight out of nine patients (who were highly selected) did not relapse during two years of follow-up.

Aims: This study, which is not a controlled trial, aims to:
* find how many hypertensives in English general practice can
stop their medication without relapse;
* define the characteristics of those remaining normotensive

a-nd of those who relapse;
* formulate guidelines for stopping medication.

Recruitment: 18 practices agreed to enlist patients and supply data. 221 patients were recruited, the main selection criteria being:
* had been on medication for hypertension for at least two years;
* had no medication increase in the past year;
* BP control was optimal, i.e. the average of their last three systolic BP's was less than 160 AND that the dias-tolic was less than 90;
* no major CVS event in the preceding year;
* medication not needed for other reasons, e.g. beta-blocker for angina, diuretic for heart failure or oedema.
The entry procedure involved extracting details from practice records, a history, clinical measurement and blood tests. Patients completed "Quality of Life" questionnaires. Medica-tion was stepped down and stopped. If hypertension recurred, practices restarted medication. The project stressed the importance of "Non-drug" treatment of hypertension.

Follow-up: The project office requested details of BP's, any medication, and any illnesses or symptoms, at three months, six months, and annually up to three years. Patients completed "Quality of Life" questionnaires annually. At the end of follow-up, the entry procedure will be repeated.

Results: So far, 147 patients have completed a year of fol-low-up. 59 (40%) remain off medication and some others are on lower dosages or fewer drugs than previously. Full details of these patients, including quality of life changes and intercurrent cardiovascular events, will be given at this presentation.

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PRESENTATION 28: Saturday 7th may, 1994
16.50 - 17.20

TITLE: Psychiatric consultations in general practice for somatizing patients: a feasibility study.

AUTHOR(S): Dirk Wijkel
Dorine Collijn
Christine M. van der Feltz-Cornelis
Frits J. Huyse

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Introduction: Patients who tend to experience and communicate somatic dis-tress and symptoms, unaccounted for by pathological findings, are common in general practice. These patients are referred to as somatizing patients (Lipowsky 1988) and are high consumers of health services (Excobar, 1987).
The GP can deal adequately with most of these patients, but in some cases the number of consultations and the persistent presentation of not adequately explained somatic symptoms can result in a disturbed doctor-patient relation and even "heart-sick" feelings by the GP. Patients may furthermore insist on a referral to a somatic specialist while the GP may feed this to be unnecessary and a psychiatric referral would be more suit-able. The threshold to see a psychiatrist is generally too high for this patient category.
A study was carried out to investigate whether consultations with a visiting consultation liaison psychiatrist was feasible in everyday practice and could help the GP to deal with soma-tizing patients.

Methods: Structured consultations were performed by two C-L psychia-trists and six GP's in a community near Amsterdam. Somatizing patients were selected by the GP according to a set of cri-teria. For every consultation the GP and the patient filled in an evaluation questionnaire and two interviews were held with the GP's before and after the study.

Results: Data were gathered about 50 consultations. All GP's were satisfied with most consultations, that could easily fit in the every day practice of a GP. All GP's would appreciate regular consultation with a C-L psychiatrist.
Most patients were also positive about their consultation. There was only minimal reluctance to see a psychiatrist together with the patient's GP. We will present more specific evaluation data and will discuss the possible implementation of psychiatric consultations in general practice.

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PRESENTATION 29: Saturday 7th May, 1994
17.20 - 17.50

TITLE: Women's longterm recollection of their birth experience.

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In Britain the controversy surrounding homebirths remains a major issue in the debate concerning the delivery of maternity care, although at present they represent less than three percent of all births in the UK. But following the recent publication of an important government document (The Cumberlege Report) attitudes towards domiciliary confinements appear to be changing. The importance of ensuring that a woman has a positive memory of her birth experience of over 500 births, dr. Zander has observed a high recall capacity of the event many years later, frequently with long-term effects. The aim of this pilot study was to explore memories and experience of deliveries at home and in hospital, three to five years after childbirth.

Method: In-depth interviews were undertaken in London with eight women who had a home confinement and four having hospi-tal births. The following three open key questions were asked:
a) Do you have any specific memories of the birth?
b) What was the impact of the delivery on the child and the
family?
c) What do you say to other women when talking about the
birth?

Results: The following main themes were identified:
1. "To be in control". Home deliveries give women opportun-ities to make their own decision and this enhanced self-esteem. In hospital control is difficult to achieve and a more dependant attitude is encouraged.
2. Pain. This appeared to be more temporary and endurable at home, requiring much less analgesia.
3. The need for privacy. During labour there is a tendency towards introvertism and this need more readily satisfied at home than in a hospital setting.
4. Relationship to child/family. At home all the family can be included in the experience which reinforces the family
bond-ing.

Comment: The needs and wishes of women appeared to be more satisfied at home than in the hospital setting. The implications of these findings in a longer perspective is not known and need to be further elucidated.

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PRESENTATION 30: Sunday 8th May, 1994
9.30 - 10.00

TITLE: Does the analysis of daily practice in the care for patients with decubitus help to develop guidelines.

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Due to the distorted age pyramid the number of immobilized, bedridden of wheelchair patients is steadily growing. The majority will be looked after at home by their relatives and/or by community nursing care, and in part also in old age and nursing homes, where they are under the care of their general practitioner. Indispensable element in the care for the decubitus patient is smooth cooperation of the patient himself, his relatives, community services, geriatric nurses, physiotherapists, health- and medical suppliers, the GP, possibly a surgeon or a dermatologist. While there is extensive literature available on the prevention, diagnostics and therapy of decubiti in hospital, hardly any publications exist on the decubitus patient being treated on an out-patient basis, and virtually non originating from general practice. Hospital standards are unsuitable for daily practice in family medicine because they do not focus on cooperation.

Since September 1992 we conduct an exploratory study on qual-ity assurance in general practice to examine medical care for the decubitus patient, to identify and analyze problems as well as to suggest first viable and effective problem-solving improvement steps. All 165 GP's in the model region (a medium-size city in the state of Hesse named Offenbach and its rural district) are included in a written mail interview with mainly open questions in two waves backed up by oral interviews with a multiple stratified sample of 17 doctors from the same group. Oral half-structured interviews are effected with senior nurses from a stratified sample of 9 nursing homes (quote 0.5), 10 community care services (0.3) and with some caring families.

About 75% of the GP's care for 0 to 3 patients with decubiti in a nursing home or at home, respectively, with an age peak in the group of 71 to 80 years old. Diseases leading to

decubiti are in most cases stroke and general weakness or cachexia; the leading role in concomitant factors plays dia-betes mellitus. Recommendation of GP's and measures in nursing homes and community services regarding prevention, anti-
de-cubiti devices, local and systemic treatment are polypragma-tic and differ widely, but all interviewed assure to have positive and convincing experiences with their regimen even if they are totally opposite. The reasons for problems in cooper-ation are usually attributed to other groups.
In a next step we will try to filter guidelines for the care for patients with decubitus in general practice from these experiences in quality circles of GP's in the model region. By this participatory, region- and cooperation-oriented concerted action we hope to promote acceptance for the future guidelines.

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PRESENTATION 31: Sunday 8th May, 1994
10.00 - 10.30

TITLE: Does it pay in the long run? Long-term effects of a short CME-course on the clinical standard "Cho-lesterol".

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One of the possible ways to increase the GP's familiarity with the content of a clinical standard is to integrate its key features into a programme for continuing medical education. Yet, does the message such a programme tries to convey actual-ly get across? And if this is the case, what remains of the acquired knowledge in the long run?

We used one of the clinical standards developed by the Dutch College of General Practitioners to research these questions.
To begin with, a group of experts in the field made a selec-tion of the most important elements from the standard on "cholesterol". Next, these key-features were integrated into

both a knowledge test and a CME-course. 29 GP's and 20 trainees took part in the course. They took the 30-item true/false/question-mark knowledge test before and immediately after the course, and once again 8 months later. The reference group consisting of 22 GP's and 22 trainees, took only the pretest and the long-term posttest. All participants were asked to fill out a satisfaction questionnaire about the knowledge test.

From the data available at this point we can conclude that the knowledge increase directly after the course is high, which supports the quality of both the course and the test. However, the data from the long-term posttest - which is still incom-plete - gives reason for concern.

In our presentation we will report the complete results of the participants' test scores on the short and the long term elaborate on explanations for our findings. We will also go into the practical problems we met and suggest some solutions.

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PRESENTATION 32: Sunday 8th May, 1994
10.50 - 11.20

TITLE: Continuity and longitudinality in Europe: a pilot study.

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Longitudinality is the use of a regular source of care regard-less of the nature or type of problem, in which a personal relationship is established and maintained. Continuity is a mechanism to provide information follow-up of problems or type of problems. Longitudinality is person oriented (in general practice, family oriented). Continuity is problem oriented. Longitudinality and continuity differ in that, in the former, the succession of events is time-bound and across the full spectrum of potential problems or reasons for visits. For continuity, the important issue is the succession of events between visits, regardless of where they occur or why.

We have measured longitudinality and continuity in 2.589 visits to 17 general practitioners from France, Norway, Slovenia, Spain, Sweden and the United Kingdom.

The main results are:

Patients

Age: 47 + 23.4 Sex: Male 1,020 (39.4) Female 1,556 (60.1)
Missing 13 (0.5)

The principal problem is: Acute 1,093 (42.2) Subacute 98 (15.4)
Chronic 1,070 (41.3)

Previously seen for this problem: No 877 (33.9)
Yes 1,696 (65.9)
Missing 16 (0.6)

Previously seen for another problem: No 278 (10.7)
Yes 2302 (88.9)
Missing 9 (0.3)

Previously seen a member of his/her family: No 497 (19.2)
Yes 1,954 (75.5)
Missing 19 (0.7)

Type of encounter: Direct 1,849 (71.4)
Indirect 724 (28)
Missing 16 (0.6)
Duration of encounter: < 5 min 1,247 (48.2)
5-9 min 674 (26.0)
10-14 min 358 (13.8)
> 15 min 284 (11.0)
Missing 26 (1)

General practitioners

Age: 38.7 + 5.6 Sex: Female 12
Male 5

Years in practice 10.5 + 4.4

Years in the recording practice: 8.5 + 3.8

Urban: 9 Semi-urban: 4 Rural: 4

Conclusion

Personal and familiar longitudinality is common in Europe.

Participants

France (Senand R. Huas D., Souweine G., Gerche S.), Germany (Baun E.), Norway (Almeland T.L., Dybwad T.B.), Portugal (Callego R.), Slovenia (Keksnik J., Tomazin I.), Spain (López-Miras A., Pastor-Sánchez R., Ripoll M.A., Gérvas J.), Sweden (Cares H., paterson C.), United Kingdom (Pringle M.).

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PRESENTATION 33: Sunday 8th May, 1994
11.20 - 11.50

TITLE: Pharmacotherapy following Opportunistic screening for Hypercholesterolemia. Differences between Official Guidelines and Local Routines among General Practitioners in Southern Sweden.

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A total of 507 man and 686 women were opportunistic screened for hypercholesterolemia and reinvited for a follow-up visit with the nurse after 2 years.

95 patients (46 men and 49 women) had a screening cholesterol > 7,9 mmol/l. At the 2-years follow-up this had declined to 19 men and 28 women.
According to official guidelines in Sweden these patients at that point would be actual for medication but in fact only four men and one (1) woman had got continuous pharmacotherapy. These findings conforms well with contemporary observations that demonstrate a strong hesitance among the south Swedish primary care physicians to treat

these generally lifestyle-related conditions with medication. The results will be discussed as well as an on-going study using deep interviews of general practitioners on decision making in the same issue. In many countries there seems to be a difference between central guidelines and clinical standards on local level.

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PRESENTATION 34: Sunday 8th May, 1994
11.50 - 12.20

TITLE: Situational Disease

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The universe of diseases in general practice is generally believed to be different from the universe of diseases in the hospitals. One explanation for this difference can be found if we view medical diagnoses as model constructions, abstracting certain characteristics of a number of illness-states with the aim of allowing generalisation.
The illness-state in general practice is a contextual case - the context being the social, psychological and cultural traits inherent in the patient's situation and in his presen-tation of symptoms with the GP.
Situational context is reduced and/or changed in hospitals in basically two ways:
1. By selection of patients (thereby increasing clinical
homogeneity).
2. By the institutional isolation from the patient's everyday
life.
The diagnostic system - having been developed in hospitals - provides a better description of the decontextualized cases found in hospitals than of illness-states found in general practice.

The disease concept in general practice can be theoretically reframed as "situational disease" meaning that disease should be understood as an expression of a person-situation interaction. ("Personal disease" or "subjective disease" are other writers' terms for the same idea.)

The concept of "situational disease" calls for a redefinition of quality assurance measures in general practice. Quality assurance measures should be practicebased and patient-centered, that is, they should take into account the specific personal and social situation of the patient at the time of his/her approach.

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PRESENTATION 35: Sunday 8th May, 1994
12.20 - 12.50

TITLE: Hip fractures in the City and Region of
Klaipèda, Lithuania. Fundamental
Epidemiological Data on Hip Fractures giving a
Base for Change of Guidelines.

AUTHOR(S): Arnoldus Jurgutis
Ingvar Ovhed

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The aim of the study was a collection of data on hip fractures (collum-, petrochanteric- and subtrochanteric fractures) in the city and region Klaipeda.
As compared to ordinary western standards, where almost all proximal hip fractures are treated by operations, this group of patients in Lithuania are left unoperated to an unknown extent, probably about 40%. To obtain background to an updat-ing of this treatment an epidemiological study was planned. Exact data about incidence of hip fracture in Lithuania was up till now unknown.

During 1993 a basic epidemiological study has been carried out in Klaipeda City and Region (inhab. 250.000) in a cooperative project between the Primary Health Care and the Orthopaedic Department in Klaipeda, Lithuania and Karlskrona, Sweden. Every hip fractured patient has been registered. The differ-ences in expected age-adjusted incidence compared to the Scandinavian countries have been confirmed. The study has given data for new planning and discussion about future guidelines in caring for these old patients. The study design and the results will be presented. Interesting is that these first basic figures from Primary Health care have created a base for new guidelines in hospital care as well as in General Practice.

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THEME PRESENTATION 1:

TITLE: Guidelines for the consultation.

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Ole Risør

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Denmark

Byrne & Long described 6 phases in the consultation. Pendleton & al. described the 7 tasks. McWhinney emphasized patient- centerednes. Mishler described the quality of doctor's attent-ive listening. Neighbour described 5 checkpoints. Lassen investigated which elements seemed to be decisive for compli-ance and validated his results by predicting compliance after analysing consultation transcripts.

Based on these studies and our own experiences we formed a model consisting of 9 chronological steps. This model combined with video supervision, has been applied in Danish pre- and post-gradu-ate education during the past two years. It has also been utilized to estimate the effect of teaching the consul-ta-tion in the pregraduate course in family medicine.

The 9 steps (PRACTICAL):

Prior to consultation
1. Before seeing the doctor the patient has usually been considering his health problem for some time and may have discussed it with others, tried to cure himself etc. This way, the patient has got a 'head start' over the doctor, who should take advantage- of it by listening.

R elationship
2. The consultation starts with a "hello" whereby the doctor show he's interested and available, thus giving the patient permi-sion to tell whatever he desires. By interrupting at this stage, the doctor may make his job harder.

Assiociations

3. By inquiring after the patient's ideas, concerns and expec-ta-tions the doctor will search for both the emotional and the cognitive aspects of the health problem. 'Key-ques-tions' can elicit the patient's health beliefs.

Common language

4. When the patient has finished his speech the doctors sum-mary will be able to incorporate both the emo-tional and cogni-tive aspects of what the patien-t has told and wants from his doctor.

Translating

5. Now it is the doctors turn to explain and to make the history & clinical.

I nteraction

6. Next the doctor must check how his explanation was understood by the patient. They then may negotiate a shared understanding of the health problem, including an agreement on frames of reference.

Converting insight to action

7. Here the patient may assess doctors' advice: what into action could enhance and promote the implementation of advice - and compliance?

A greement control

8. The effect of the consultation can be extended in time by making another appointment. A follow-up of the consultation works as a safety net.

L et's try it!

9. Finally, the doctor should ask both the patient and him-self whether they remem-bered everything. Finally, for sound housekeeping with his own resources, the doctor should ask him-self if he is ready for another patient.

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