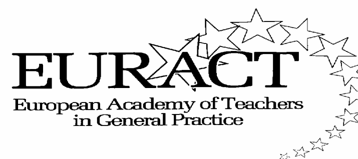


Network organisation within WONCA Region Europe - ESGP/FM

EGPRN Co-ordination Centre: Mrs. Hanny Prick
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# European General Practice Research Network

# Copenhagen & Malmö – Denmark & Sweden

# 8th – 14th May,2006

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## SCIENTIFIC and SOCIAL PROGRAM

## *THEME:* Research into Medical Education

**Research Methods Course**
**Pre-Conference Workshops**
**Freestanding Papers**
**One slide/Five minutes Presentations**
**Posters**

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**Place**
**The Panum Institute**
**Blegdamsvej 3; 2200 Copenhagen N (Nørrebro) - Denmark**

The meetings of the European General Practice Research Network (EGPRN) have earned accreditation as official postgraduate medical education activities by the Norwegian, Slovenian, Irish and Dutch College of General Practitioners.

Those participants who need a certificate can contact Mrs. Hanny Prick at the EGPRN-Coordinating Office in Maastricht, The Netherlands.

**"RESEARCH INTO MEDICAL EDUCATION".**

Welcome to the EGPRN meeting in the Öresund Region in May 2006. Since 1658 this sound has been the border between Denmark and Sweden, and since 2000 the cities of Copenhagen and Malmö are joined by a 16 km long bridge/tunnel. Our meeting is the first one using the new format: 3 days research methods course, 1 day pre-conference workshops and 2 days conference. The theme is "Research into Medical Education", and it is the first meeting planned in collaboration with EURACT. Finally, it is the first bilateral EGPRN meeting, and therefore we are looking forward to seeing you in both Denmark and Sweden.

Arvid Frank Jørgensen
Head of research unit

Hillerød
Denmark

Anders Håkansson
Professor of general practice

Malmö
Sweden

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Dear friends and colleagues,

It is our great pleasure to invite you to the joint EGPRN-EURACT meeting in Copenhagen & Malmö. The theme of the meeting "Research into medical education" was found to have high priority with regard to our discipline and the content of a research strategy for Europe. Both research and educational implications will be discussed on many topics such as: effectiveness of undergraduate and postgraduate medical education, vocational training, problem solving and communication skills training, assessment of competences, audit and feedback, long distance learning including ICT use and effectiveness of different educational methods, effective interprofessional education and many others. Experts from two organizations collaborated closely to develop a program consisting of the research methods course, pre-conference workshops and the conference itself. This event is important in itself as the first complex project of collaboration between the European General Practice Research Network (EGPRN) and the European Academy of Teachers in General Practice (EURACT) and we hope that in future this collaboration will continue, influencing the further development of our discipline. However, even more important is the fact that joining the expertise existing in both networks will allow us to develop a more comprehensive approach to the important question of research on education in general practice. During this meeting considerable time will be allocated to discussions, various formalized forms of feedback from senior to junior researchers as well as educators, and a low threshold for informal exchange of ideas and expertise with colleagues from both networks. We hope you will enjoy this challenging, lively and interactive event.
Looking forward to see you in Sweden and Denmark.

Paul van Royen,
Chairman EGPRN

Egle Zebiene,
EURACT President

# MEETING EXECUTIVE BOARD

# GENERAL COUNCIL MEETING

***Executive Boardmeeting***
***Thursday 11th May, 2006***

**09.30 - 10.00: Welcome and Coffee for Executive Board**
**09.30 - 12.00: Executive Board members**

**(location : The Panum Institute, Copenhagen)**

***General Council meeting with the National Representatives***
***Thursday 11th May, 2006***

**15.00 - 16.45 : Executive Board members and National Representatives**

**(location : The Panum Institute, Copenhagen)**

# REGISTRATION FOR ALL PARTICIPANTS:

**Friday 12th May 2006:**

**08.00 – 08.30 h.** **Location: The Panum Institute**
**address: Blegdamsvej 3, 2200 Copenhagen N.**

**Non-EGPRN-Members are asked to pay the undermentioned membershipfee**

## For non-EGPRN-members:

**The following payments are requested:**

► **EGPRN Membership fee for 3 years 120 € or congress fee 50 €**
- **Eastern European countries: 45 or 20 €**
- **WONCA direct members: 60 or 50 €**

**Lunches and coffee breaks can be registered for beforehand.**
**Participants who have not registered beforehand are requested to attend to the registration unit to pay for lunches and coffee breaks.**

**Social night dinner in a Restaurant in Copenhagen: €40,=**

**Please address to EGPRN Registration Desk.**

E G P R N 8th – 14th MAY, 2006

# PROGRAMME OF THE EUROPEAN GENERAL PRACTICE RESEARCH NETWORK IN COPENHAGEN & MALMÖ – DENMARK & SWEDEN

**MONDAY, TUESDAY, WEDNESDAY 8-9-10th MAY, 2006:**

**in Malmö-Sweden**

**Location :** **Medicinskt forskningscentrum (Medical Research Centre)
Ingång 59 (Entrance 59) Universitetssjukhuset MAS
(Malmö University Hospital)**

**EGPRN – EURACT Course in Educational Research Methodology**

**THURSDAY 11th MAY, 2006:**

**in Copenhagen-Denmark**

**Location :** **The Panum Institute, Copenhagen
Address: Blegdamsvej 3, 2200 Copenhagen N.**

**09.30 - 12.30 :** **Executive Board Meeting in: The Panum Institute, Copenhagen.
(only for Executive Board Members)**

**09.30 - 16.00 :** **Pre-Conference Workshops (only for participants who have registered beforehand)**

**09.30 – 12.00 :** **2 EGPRN - EURACT Pre-Conference Morning Workshops**. (€25 each).
Parallel workshops:

***"The implementation of evidence based medicine in clinical practice";***
Teachers: Frans Boch Waldorff & Christian Hermann from Copenhagen-Denmark.
and

***"Teaching communication skills";*** Teachers: Prof. Anders Baerheim and Torild Jacobsen from Bergen-Norway.

**13.30 – 16.00 :** **2 EGPRN - EURACT Pre-Conference Afternoon Workshops**.(€25 each).
Parallel workshops:

***"The cancer journey – analysing the general practitioner's role, using both qualitative and quantitative research methods";*** Chairs: Jens Søndergaard from Århus-Denmark and Hans Thulesius from Växjö-Sweden.
and

***"Analysis of qualitative material"***; Teachers: Prof. Paul van Royen, Kristin Hendrickx , Lieve Peremans from Antwerp-Belgium

**15.00 - 17.00 :** **EGPRN General Council Meeting.**
**Meeting of the Executive Board Members with National Representatives (only for Council Members).**

## Social Program:

**17.00 – 19.00 :** **For ALL EGPRN-EURACT participants of this meeting who are present at this time.**
**Welcome Reception at Copenhagen Town Hall, Rådhuspladsen.**
**(Entrance Free)**

**FRIDAY 12th MAY, 2006:**
*Location: The Panum Institute, Copenhagen*

**08.00 - 08.30 : Registration at EGPRN Registration Desk.**

**08.30 - 08.45 : Welcome.**
**Opening of the EGPRN-meeting by the Chairman of the EGPRN, Prof. Dr. Paul van Royen.**

**08.45 - 09.05: 1st Keynote Speaker Prof. Anders Baerheim, Bergen-Norway.**
**Theme: "What is special in research in medical education?"**

**09.05 – 09.25: 2nd Keynote Speaker Prof. Anders Håkansson, Malmö-Sweden.**
**Theme: "Research methods training for general practice – experiences from Sweden and Denmark".**

**09.35 – 10.35 : 2 Themepapers**

1. **Matic Meglič (Slovenia)**
   The RIGHT project in Slovenia: Self-education of general practitioners through use of intelligent EHRs.

2. **Kristin Hendrickx (Belgium)**
   Intimate examinations, simulated patients and effects on students' performance.

**10.35 - 11.00 : Coffee Break**

**11.00 – 12.30 : Themepapers –** Undergraduate medical education

3. **Andreas Sönnichsen (Germany)**
   Case-Studies of general practice for preclinical medical students – E-learning compared to presentation in lectures.

4. **Katrien Bombeke (Belgium)**
   Patient-centredness in medical students determinants and the effect of communication skills training and hospital internships.

5. **Uta-Maria Waldmann (Germany)**
   Simulating a general practice consultation with virtual patients and using this for assessment of medical students – a dream or possible?

**12.30 - 14.00 : Lunch**

**After lunch, the meeting continues with parallel sessions till 17.30 h.**

**14.00 – 15.30 : A. Parallel session Themepapers –** Undergraduate medical education

6. **Teresa Pawlikowska (United Kingdom)**
   Why do science graduates want to read medicine?

**7.** **Martina Torppa (Finland)**
Literature and basic medical education – a case study.

**8.** **Emma Hopgood (United Kingdom)**
Medical student electives: education or vacation?

**14.00 – 15.30 : B. Parallel session Themepapers** – Postgraduate medical training

**9.** **Joe Rosenthal (United Kingdom)**
Modernising medical careers. The impact of general practice attachments for all doctors during basic postgraduate medical training in the UK.

**10.** **Roger Ruiz Moral (Spain)**
The effect of patients' met expectations on consultation outcomes. A study with family medicine residents.

**11.** **Alain Mercier (France)**
Script concordance test: Taking faulty discordances into account?

**15.30 – 16.00 : Coffee/Tea Break**

**16.00 – 17.30 : C. Parallel session Freestanding papers**

**12.** **Edward van Rossen (Belgium)**
Suicide risk and prevention: An exploratory prospective study.

**13.** **Lieve Peremans (Belgium)**
Quality improvement for contraceptive health in general practice.

**14.** **Ferran Galí (Spain)**
Spanish gp's who come to work in Durham and Tees Valley, UK: exploring their cultural and professional experience in clinical consultations.

**16.00 – 17.30 : D. Parallel session Freestanding papers**

**15.** **Jürgen in der Schmitten (Germany)**
What does the "control rate" of patients with treated hypertension tell us? Time for a term to be discarded.

**16.** **Jean-François Chenot (Germany)**
How objective is assessment of basic clinical skills by student tutors with an OSCE?

**17.** **Heidi Bøgelund Frederiksen (Denmark)**
Continuity in general practice.

**19.00 – 20.00 :** **Meeting of EGPRN Working Groups**

- **Research Strategy Committee**
- **Electronic Website Committee**
- **Educational Committee**

*Location:* **Lægerne i Bartholinsgade**
**Address: Bartholinsgade 6, Opgang R, 1356 Copenhagen K.**
**Located 10 minutes away from the Panum Institute by foot**
*Meeting point:* **outside The Panum Institute**

**Social Program :**

**19.00 – h. :** **Practice Visits to local family doctor's practices in Denmark and Sweden.**
**For participants going to Sweden (maximum of 20 persons) there will be a registration form to sign up on the registration desk.**

*Location in Denmark:* **Lægerne i Bartholinsgade**
**Address: Bartholinsgade 6, Opgang R, 1356 Copenhagen K.**
**Located 10 minutes away from the Panum Institute by foot**

*Meeting Point:* **outside The Panum Institute**

**SATURDAY 13th MAY, 2006:**
*Location: The Panum Institute, Copenhagen*

**08.30 – 08.50:** **3rd Keynote Speaker Prof. Knut Aspegren, Odense-Denmark.**
**Theme: "Suggestions for effective and efficient training in communication skills in medicine"**

**08.50 – 09.10:** **4th Keynote Speaker Prof. Jakob Kragstrup, Odense-Denmark.**
**Theme: "Units for research and development in primary care – experiences from Denmark and Sweden".**

**09.10 – 10.40 : Theme Papers** – about general practice

**18. Ingrid Bakker (The Netherlands)**
Teaching gp's to deliver the minimal intervention for stress-related mental disorders with sickleave (MISS) in general practice: effects on recognition and treatment.

**19. Rachel Dahan (Israel)**
Using the low back pain guidelines: The intellectual and mental challenges faced by Israeli family physicians caring for low back pain patients.

**20. Jørund Straand (Norway)**
A cluster randomized educational intervention to reduce inappropriate prescription patterns for elderly patients in general practice.

**10.40 - 11.10 :** **Coffee Break**

**11.10 – 12.55 :** **Posters**
**In four parallel sessions (4 groups of 5/6 posters)**

**11.10 – 12.55 :** **Parallel group Posters 1**

**21. Sandra Dunkelberg (Germany)**
Health beliefs in Turks, Germans, and Turks living in Germany.

**22. Ferdinando Petrazzuoli (Italy)**
The experiences of family carers with palliative care services in Italy: differences between rural urban population.

**23. Dominique Gras (France)**
Oral anticoagulant therapy: What do our patients know? How do they manage their treatments? How to improve it?

**24. Marie-France Le Goaziou (France)**
Patients' behaviours and knowledge about emergency.

**25. Pinar Topsever (Turkey)**
The psychological status of the parents of disabled children correlates with their coping strategies.

## 11.10 – 12.55 : Parallel group Posters 2

**26. Martina Kelly (Ireland)**
Movie Magic: a learning outcomes approach to Film Studies for Medical Undergraduates.

**27. Donka Dimitrova (Bulgaria)**
Educational needs of postgraduate students in general practice.

**28. Pinar Topsever (Turkey)**
Medical students' knowledge on health risk of smoking: what do they know? Where do they know it from?

**29. Ian Ward (United Kingdom)**
What do student's value in their experience of the curriculum? A study of the "fast track" course at Warwick Medical School.

**30. Erik Kegels (Belgium)**
Medical students' approaches to learn: does it change after a semester of PBL learning.

**31. Marcel Reinders (The Netherlands)**
Introducing patient-feedback in vocational training in general practice.

## 11.10 – 12.55 : Parallel group Posters 3

**32. Anni Nielsen (Denmark)**
Self-rated general health and its association with mortality after 10, 20 and 29 years' follow-up among middle-aged Danes.

**33. Liina Pilv (Estonia)**
Assessing the treatment of cardiovascular risk factors in diabetic patients.

**34. Martin Scherer (Germany)**
Disease specific quality of life in primary care patients with heart failure.

**35. Marie-France Le Goaziou (France)**
Identification of chronic kidney disease patients above fifty years old, in general practice.

**36. Buono Nicola (Italy)**
Influence of chronic NSAID use on BP control in patients under anti-hypertensive treatment.

## 11.10 – 12.55 : Parallel group Posters 4

**37. Uta-Maria Waldmann (Germany)**
Simulating a general practice consultation with virtual patients. Does the Online Assessment Tool produce valid results?

**38. Martina Kelly (Ireland)**
Learning style and problem solving – is there a cultural difference?

**39.** **Pinar Topsever (Turkey)**
Process of learning needs assessment and emerging themes in an academic department of family medicine.

**40.** **Stella Argyriadou (Greece)**
Is feasible for the gp's to face obesity? A short-term management program.

**41.** **Magdalena Esteva (Spain)**
Diagnostic delay.

**12.55 – 14.00 : Lunch**

**14.00 - 14.40 : Chairman's report : Report of Executive Board and Council Meeting. Introduction on the next EGPRN-meeting in Kavala/Greece by the Greek national representative.**

**14.40 – 15.30 : 5 One-Slide/Five Minutes Presentations**

**42.** **Jean-Francois Chenot (Germany)**
Vomiting in primary care, a worrisome symptom?

**43.** **Sofica Bistriceanu (Romania)**
Love disruption affects us.

**44.** **Alain Moreau (France)**
Education strategy for 'councelling' intervention in diabetes type 2 treatment in primary care.

**45.** **Saskia Mol (The Netherlands)**
One-to-one education during the general practice clerkship: two perspectives.

**46.** **Pemra Cöbek Unalan (Turkey)**
Evaluation of an undergraduate history taking course.

**15.30 – 16.00 : Coffee/Tea Break**

**16.00 – 17.30 : E. Parallel session 1 Theme paper & 2 Freestanding papers**

**47.** **Bettine Schreuders (The Netherlands)**
Education in problem solving skills; outcome of the problem solving treatment (pstj) project Amsterdam.

**48.** **Nadine Kacenelenbogen (Belgium)**
Study of the follow-up by the general practitioner of the children of separated parents.

**49.** **Caroline Huas (France)**
Is there a specificity regarding young occasional marijuana smokers?

**16.00 – 17.30 : F. Parallel session 1 Theme paper & 2 Freestanding papers**

**50.** **José Ramón Loayssa (Spain)**
Can action science provide some insight in the behaviour of doctors and enhance their education?

**51.** **Antonius Schneider (Germany)**
Difficult asthma patients in general practice: suboptimal treatment combined with low burden of illness.

**52.** **Peter Leysen (Belgium)**
Implementing the evidence: is it self-evident? Quality improvement project: application of the WVVH-guideline "Prevention of Influenza".

**Social Program :**

**20.00 - :** **Social Night**
**Dinner in a restaurant in Copenhagen.**
**Entrance fee: Euro 40,= per person.**

**SUNDAY 14th MAY, 2006:**
*Location: The Panum Institute, Copenhagen*

**09.30-11.30 2nd Meeting of the EGPRN Executive Board**

| | | |
|---|---|---|
| PRESENTATION 1: | Friday 12st May, 2006<br>09.35 – 10.05 h. | THEME PAPER |

TITLE: The RIGHT project in Slovenia: Self-education of general practitioners through use of intelligent EHRs.

AUTHOR(S): Matic Meglič, Rade Iljaž, Andrej Marušič

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*Background*: On a national level, ensuring use of unified up-to-date clinical guidelines by general practitioners (GPs) proves to be a difficult task.

*Research questions:* One of the aims of the RIGHT project is to address a question whether upgrading of electronic health records (EHR) with expert tools and information infrastructure can increase takeover and adherence to guidelines of diagnostics and therapy, included in this upgrade.
*Methods:* The RIGHT project, as funded by the European Commission 6th Framework Programme, aims to develop through cooperation of European partners an intelligent information infrastructure, including expert systems such as decision support of diagnostics and therapy, semantic information retrieval, drug prescription guidance, follow-up etc. This infrastructure will serve as an upgrade of the existing EHRs and will be based on needs and demands of GPs from different EU countries.
In a follow-up study various aspects of adherence to included diagnostic and therapeutic guidelines for depression and hypertension before and after addition of RIGHT infrastructure will be measured.

*Results:* Change in adherence will show whether upgraded EHRs can be used effectively for implementation of clinical guidelines through self-education of GPs.

*Conclusions:* By comparing efficiency of various methods of guideline implementations role of EHR and their upgrades will be stated.

*Points for discussion at EGPRN:*

1. Research methodology
2. Ways to promote self-learning

PRESENTATION 2: Friday 12st May, 2006 THEME PAPER
10.05 – 10.35 h.

TITLE: Intimate examinations, simulated patients and effects on students' performance.

AUTHOR(S): Kristin Hendrickx, B.Y. De Winter, W.A.A. Tjalma
G. Peeraer, D. Avonts, J.J. Wyndaele

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Phone: +323-820-2518
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*Background:* Medical curriculum in Antwerp was reformed since 1998. For fifth-year's undergraduates, a project with simulated patients (Intimate Examination Associates, IEA) was implemented in 2002. In this project students learn uro-genital, rectal, gynecological and breast examination in healthy, trained volunteers. The setting consists of 2 students, 1 IEA and 1 medical doctor. Students receive immediate feedback after each session with focuses on personal attitude, technical skills and communication skills. In the former curriculum students trained these skills during their internship in the 6th year after a single training on manikins.

*Objective/Aim:* To assess the effect of learning intimate examinations with IEA's by comparing the results of students from former and renewed curriculum.

*Method:* Performances of 3 groups were compared: former curriculum students (FC/IEA-/internship+) after internship, renewed curriculum students(NC/IEA+/internship+) after internship, and fifth year NC students immediately after the IEA training (NC/IEA+/internship-). Four assessment instruments were used: an OSCE using detailed checklists and global rating scales, a score list on students attitudes filled in by the IEA's, a student questionnaire on self-esteem, and a questionnaire containing 72 items on the performing of gynecological and urological skills during internships. Statistical analysis was performed with SPSS version 12.

*Results:* Both groups of NC students scored globally better in the OSCE, with significance for male examination. Sub scores for « completeness » and « systematic approach » were significantly higher in both NC groups for male and female examinations. NC/IEA+/internship+ have better self-esteem and self-confidence concerning gynecological and urological clinical and communication skills.
The best results were scored after IEA training AND internships.
IEA's are influenced by the « experienced » students after internships: FC/IEA-/internship+ and NC/IEA+/internship+ have both good scores, better than the NC/IEA+/internship- students.

*Conclusion:* Learning intimate examinations with IEA's has a positive effect on the performance of medical students that is even strengthened and reinforced during their internship.

*Questions to EGPRN:*
1. Is similar research performed in other countries?
2. Are there similar projects in other European countries?

PRESENTATION 3: Friday 12st May, 2006 THEME PAPER
11.00 – 11.30 h. Work in Progress/Ongoing Study

TITLE: Case-Studies of General Practice for Preclinical Medical Students – e-Learning Compared to Presentation in Lectures

AUTHOR(S): Andreas. C. Sönnichsen[1], Silvia Höper[1], Dirk Höper[1]
Jochen Gensichen[2], Horst Christian Vollmar[3], Uta-Maria Waldmann[4],
Norbert Donner-Banzhoff[1], Erika Baum[1]
1 Department of General Practice, Philipps-University Marburg, Germany
2 Institute for General Practice, University of Frankfurt a.M., Germany
3 Evidence.de, University of Witten/Herdecke, Germany
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*Background:* Medical education in Germany is changing towards a more practical approach. This includes a move towards the introduction of clinical aspects at a very early stage of preclinical education. Universities are confronted with the problem that direct access to patients for these students can often not be provided. E-learning may be a possible solution.

*Research Questions:* Is it feasible to introduce clinical cases to preclinical students by an interactive online-teaching-programme? Is such a programme accepted by the students as equivalent or superior to a classical lecture? Is the outcome of the online-programme regarding acquisition of knowledge equivalent or superior to classical lectures?

*Methods:* We developed an interactive online-teaching-programme comprising 6 clinical cases from a general practice surgery (painful swollen leg, chest pain, hypertension, lower back pain, cardiovascular prevention, abdominal pain). The cases are presented on the k-med-platform that has been developed to offer interactive online-courses in biochemistry and other preclinical subjects. In the fall-semester 2005/06 the course was offered to 720 preclinical medical students of the University of Marburg on a voluntary basis. 84 students enrolled in the programme. They were randomly allocated to two groups. The first group studied cases 1-3 online. Cases 4-6 were presented to them in 3 lectures of 90 min. each. The second group studied cases 4-6 online and 1-3 in lectures. Both groups will participate in a written final examination about all 6 cases and fill out an evaluation questionaire.

*Results:* The study is ongoing. The final exam will be held February 15. Directly after the exam the students will be asked to fill in the evaluation questionaire. Results of the exam and the questionaire will be available for the conference in May.

*Conclusions:* It will be discussed whether an e-learning-version of clinical case-studies is suitable for preclinical students.

PRESENTATION 4: Friday 12st May, 2006 — 11.30 – 12.00 h. — THEME PAPER — Work in Progress/Ongoing Study

TITLE: Patient-centredness in medical students: determinants and the effect of communication skills training and hospital internships.

AUTHOR(S): Katrien Bombeke, Luc Debaene, Sandrina Schol
Linda Symons, Paul Van Royen

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E-mail: Katrien.Bombeke@ua.ac.be

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*Background:* Recently, an extensive body of literature has emerged concerning 'patient centred care'. In a literature review 5 conceptual dimensions were identified: biopsychosocial perspective; 'patient as person'; sharing power and responsibility; therapeutic alliance; and 'doctor as person'. This growing interest in patient-centredness is reflected in medical education; communication skills training has become part of the basic curriculum. In spite of these efforts, there's still a decline in patient-centredness as students progress through medical school. Several causal factors have been suggested, but there's a lack of research into stimulating and inhibiting factors of patient-centredness in medical students, a prerequisite for educational changes to improve this important competence.

*Research questions:* 1. What is a valid and reliable instrument to measure competence in patient-centredness in medical students, based on the determinants of patient-centredness? 2. How does competence in patient-centredness evolve as students progress through medical school? 3. What is the effect of communication skills training and hospital internships on competence in patient-centredness in medical students?

*Methods:*

- Focus group research with medical students and their teachers investigates experiences with, attitudes to and determinants of patient-centredness, with special attention to the influence of medical education. Based on the analysis, a measurement scale for patient-centredness is developed.
- A prospective longitudinal study with the new scale follows one yeargroup through medical school. A cross-sectional measurement compares year 1-7.
- Qualitative research (in-depth interviews) on inner development of patient-centredness in medical students, with a special focus on communication skills training and hospital internships.
- A pre-post design with two cohorts of medical students (one group with, one group without communication skills training), measured before and after hospital internships, investigates the effect of communication skills training and hospital internships.

*Results:* The focus groups will take place in february '06, results will be presented at the conference.

Discussion topics:

1) What are the experiences of other researchers with this kind of research?
2) How is education in patient-centredness implemented in the medical curriculum in other universities?
3) How do other researchers evaluate the methodologies used in this research?

PRESENTATION 5: Friday 12st May, 2006 THEME PAPER
12.00 – 12.30 h. Finished Study

TITLE: Simulating a General Practice consultation with virtual patients and using this for assessment of medical students – a dream or possible?

AUTHOR(S): Uta-Maria Waldmann, Petra Ritschi,
Markus Gulich, Hans-Peter Zeitler

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E-Mail: uta-maria.waldmann@uni-ulm.de

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*Background:* Medical teachers need to assess their students' knowledge and skills – a demanding and time consuming task. Testing not only knowledge, but also competence often means to use more extensive and even more time consuming assessment settings. A simulated consultation with students acting as GPs assessing and treating virtual patients – and computer generated scores – could be an option.

*Research question*: Is it possible to simulate a GP consultation and assess the chosen diagnostic way automatically with valid results?

*Method:* With "docs'n drugs", an interactive programme for hospital patient simulation, three clinical scenarios in primary care setting were created. By peer review all possible actions (medical history, physical examination, technical and laboratory tests) were categorized regarding their value for each specific case, to enable the online assessment tool to calculate a score out of all selected actions. All (147) students of the General Practice seminar participated in an exam simulation: they solved the three cases and answered a questionnaire. To validate these test results they were compared to the scores of the regular written exam at the end of the term.

*Results:* Although limitations remain the computer simulations of case scenarios are realistic and allow differentiated history taking, physical examination and investigations. There where only minor technical problems during the assessment and students were able to use the programme without prior training. No marking by hand was necessary – scores where fully computer generated, according to the case adapted evaluation formula. The test results show a significant correlation to the scores of the regular General Practice course exam.

*Conclusions:* It is possible to simulate a General Practice consultation on the computer sufficiently well to use it for student assessment. There seems to be sufficient validity.

*Points for discussion at EGPRN:*
1. Which role could this assessment format play in regular General Practice course exams?
2. Which barriers could occur and need to be addressed?

PRESENTATION 6: Friday 12st May, 2006 14.00 – 14.30 h. THEME PAPER Finished Study

TITLE: Why do science graduates want to read medicine?

AUTHOR(S): Teresa Pawlikowska, Jag Sihota
Debbie Biggerstaff, Jane Kidd

ADDRESS: Institute of Medical Education, Warwick Medical School
The University of Warwick, Gibbett Hill, Coventry
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Phone: 02476 574512
E-mail: Teresa.Pawlikowska@warwick.ac.uk

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*Background:* Until recently scientists wanting to read medicine in the UK have joined school-leavers on a 5-year course. Leicester-Warwick medical school was the first to offer graduate entry to a "fast track" course, for biomedical science graduates with at least an upper second degree.
Current UK Government initiatives are designed to address the shortage of qualified doctors and create a profession that increasingly mirrors society. Graduate entry programmes are thought to increase diversity of access, but they require significant additional practical, emotional and financial commitment.

*Aim:* This qualitative study aims to explore what motivated science graduates to undertake a second degree in medicine.

*Method:* All (n=64) students in the first cohort (2004) at Warwick Medical School were invited to participate.40 semi-structured interviews were conducted after final exams and were then analysed thematically. Motivation and experience of the application process were explored.

Results: *Reasons for studying medicine divided into three groups.*
One group had not considered medicine previously and were empowered by their degree or contact with medical students. Others came to a realisation that they wanted to apply their science in working with people.
Most of the first cohort under the new fast-track scheme had always wanted to become doctors, had failed to get a medical place leaving school, and hence read a science degree first.
Issues of personal development, self-efficacy and "thresholders" were important for these students.

*Conclusions:* Graduate-entry schemes can be said to be widening access to medical school, allowing a second chance to those who mature later and achieve good science degrees.

*Points for discussion at EGPRN:*
1. What is the European experience of examining the motivation of those who attend medical school?
2. Do other countries have graduate entry programmes, and what is their experience of them?

PRESENTATION 7: Friday 12st May, 2006 THEME PAPER
14.30 – 15.00 h.

TITLE: Literature and basic medical education – a case study.

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*Background:* A Medical Humanities course "Arts and Medicine" was organised in 2001-2002 in the medical faculty at the University of Helsinki. Sixteen medical students in their basic education completed the course. It consisted of eight seminars of four hours, each with a humanistic or artistic topic. In this paper we focus on the literature seminar.
The text dealt with in the seminar was Thomas Mann's short story "The Black Swan" (1953). Before the seminar the students read the story and wrote a free-form reflective essay about the reading experience. In the seminar a tutored group discussion was held.

*Research Questions:* What were the themes that emerged in a literature seminar in basic medical education? What did the findings tell about medical students as readers?

*Material and methods:* Material for this study consists of the students' reflective essays and of the transcribed group discussion. Thematic content analysis was performed independently by two researchers and a consensus of findings was negotiated.

*Findings:* The students' took two positions as readers: personal and professional. In the group discussion the students showed more emotional than rational responses to illness and suffering. The themes relevant for professional growth that emerged were doctor-patient relationship, subjectivity in medicine, causality in medicine, body –mind relationship. The theories of literature reading that suggest that in the transaction between the reader and literary text readers construct meanings both in uniquely personal and in shared and culturally dictated ways are in line with our findings.

PRESENTATION 8: Friday 12st May, 2006 THEME PAPER
15.00 – 15.30 h. Finished Study

TITLE: Medical Student Electives: Education or Vacation?

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*Background:* Medical student electives were introduced in UK medical schools in the 1970's, and are now a standard and popular part of the curriculum. Is their appeal the lure of sun, sea and sightseeing or are students benefiting academically?
Warwick Medical School's "accelerated" medical degree is for science graduates. With mounting pressure on the curriculum, electives are under scrutiny.

*Aims:* This qualitative study explores Warwick Medical School students':

- opinions of electives,
- type of placement chosen,
- perceived benefits and barriers.

*Methods:* Sixty-four students in the first cohort at Warwick Medical School were invited to participate in one-to-one semi-structured interviews. Forty students responded and interviews conducted with thematic analysis of the responses.

*Results:*

- Electives were valued as an intrinsic component of the medical course.
- Students reported increased knowledge and professional development together with additional learning about different countries, cultures and health systems.
- Students also reflected on their own personal development.
- Choice of placement was determined by students' drive to increase specialist medical knowledge and to gain experience in diverse medical systems: from the US to the 3rd world.
- Another motivator for location was if a student had 'always wanted to go there' or a place perceived to hold particular expertise in a specific condition of interest.
- Workload, supervision and teaching varied significantly between placements.

*Conclusions:* Electives were seen as a valuable opportunity for students to experience diverse health care systems and illness in different settings. Learning had more dimensions than solely knowledge acquisition, with the development of students both professionally and personally.

Choice of location was driven mainly by student's medical or personal interests.

This study demonstrates the benefits students attach to their elective period and the significant multi-dimensional learning experience that is achieved. It reinforces the electives ongoing relevance and value within the current medical curriculum.

*Points for discussion at EGPRN:*
1. What is the experience across Europe of the learning aims and objectives of elective placements and how do they differ between countries?

2. How can we ensure standards and quality of student’s elective placements?
3. How much do language and cultural differences impact on choice of elective location?

PRESENTATION 9: Friday 12st May, 2006 — 14.00 – 14.30 h. — THEME PAPER, Study proposal / idea

TITLE: Modernising Medical Careers": The impact of general practice attachments for all doctors during basic postgraduate medical training in the UK.

AUTHOR(S): Joe Rosenthal, Paul Wallace

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*Background:* "Modernising Medical Careers", a radical reorganisation of the early years of postgraduate medical training was introduced in the UK in August 2005. Following graduation, all new doctors are now required to enter a Foundation Programme which comprises a series of varied clinical attachments over two years preceding entry to any programme of specialty training in hospital or general practice. It is proposed that by August 2008 90% of trainees will include a 3 or 4 month placement in general practice in their Foundation Programme. This is a new and exciting development in postgraduate medical education, which is likely to have significant implications for general practice in the UK and beyond. We therefore believe it is essential to evaluate its impact in some detail.

*Research Questions:*
A: How do trainees, trainers, (and hospital specialists) perceive the experience of Foundation Programme placements in general practice?
B: What is the nature of the Foundation training undertaken in general practice?
C:How are participants influenced in their future career choices?
D How does the Foundation Programme influence hospital specialists' perceptions of general practice?

*Methods:* Participant questionnaire survey and/or interview study
Training log book analysis
Longitudinal career follow up

*Results:* The results will take the form of quantitative and qualitative data on participants' experiences of and views towards GP Foundation placements. We will also follow up the group in terms of their eventual career choices.

*Conclusions:* The challenge of this study will be to ensure that we use methods which will provide valid evidence about positive and negative impacts of these new programmes. The most difficult task will be to determine the degree to which exposure to general practice in this way can provide trainees with a more rounded clinical experience and inform their decisions about future career options. We will be especially interested in sharing views with EGPRN members about the most appropriate approach to the study.

*Points for discussion at EGPRN:*
1. What is the most appropriate methodology to use in evaluating the training programme described?
2. What other potential research questions could be usefully developed around this initiative?
3. What are the implications for the UK Foundation Programme for doctors trained in other parts of Europe?

PRESENTATION 10: Friday 12st May, 2006 THEME PAPER
14.30 – 15.00 h. Finished Study

TITLE: The effect of patients' met expectations on consultation outcomes. A study with family medicine residents.

AUTHOR(S): Roger Ruiz Moral, L. Pérula de Torres, I. Jaramillo Martín
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*Background:* To address patients' visit expectations is being considered as an important task for the physician but its influence on consultation outcomes still remain controversial. There are no many information in consultations among residents and patients in educational setting.

*Research Questions:* Which are the patients' expectations when they attend family medicine residents surgeries? In which extend are these expectations met? To met patients' expectations, does it affect some consultation outcomes?

*Methods:* Observational prospective study. Patients attending family medicine surgeries held by 38 resident: 1301 eligible patients, 702 filled in all questionnaires. Measurements: Before each visit, the patients´ expectations about that consultation were registered. Right after it, their perception about several aspects of the communicative interaction with the doctor was measured, and later, patients were interviewed on the phone to know how their expectations had been fulfilled, how satisfied they were about the consultation, how they had followed the resident's suggestions, if they seek care for the same cause later and the evolution of their clinical problem. Logistic regression was the main analysis used.

*Results:* The most common expectations were: Showing interest and listening (30.5%), getting some information about the diagnosis (16.3%) and sharing problems and doubts (11.1%). 76.5% of the main expectations were met. Satisfaction with the encounter was associated to the clinical evolution (OR 2.23; CI: 1.32-3.75) and the fulfilling of the patients' main or two main expectations was significantly related to all the measured outcomes (satisfaction OR 3.51, CI: 1.73-7.8; adherence OR 1.80 CI: 1.11-2.92; clinical evolution OR 1.54 CI: 1.01-2.35 and seeking for further care later OR 0.54 CI:0.36-0.81).

*Conclusions:* Patients prioritise expectations of a more general sort when they attend primary care surgeries and residents fulfill these acceptably. The fulfilment of expectations seems to affect the studied outcomes more than other factors.

*Points for discussion at EGPRN:*
1. Methodological consideration of measuring patients' expectations
2. Patients' expectations and residents fulfilment of these expectations
3. The relationship between the fulfilment of expectations and consultation outcomes

PRESENTATION 11: Friday 12st May, 2006 THEME PAPER
15.00 – 15.30 h. Finished Study

TITLE: Sript concordance test : Taking faulty discordances into account?

AUTHOR(S): F. Roussel, P. Nguyen-Than, P. Olombel
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*Background:* A Script Concordance Test (SCT) has been currently used in Rouen medical school for certification of future General Practitioners. This classical SCT sums concordances with what experts considered as adapted answers, but neglects discordances and especially faulty discordances, of potential interest in a certification process.

*Research question:* To investigate an alternative marking process, taking equally into account correct script concordances and erroneous script discordances

*Method:* We took opportunity of the 60 questions SCT taken by 52 students for the 2004 General Medicine certification, to adjunct to the usual positive marking process a symmetrical negative one based on concordance with what the experts agreed to consider inadequate.

*Results:* Both SCT versions appeared valid and reliable. The "extended" SCT was feasible and well accepted, and was completed by the experts within 60 minutes. It was more difficult (+20%) for student, and more discriminating with a greater variance (x3). The différence between student and faculty was greater (+60%). The Cronbach's alpha coefficient was increased by 16%, in coherence with a better experts agreement on errors to avoid, than on solutions to bring. Despite a good overall correlation between the two SCT (r=0.86), the intraclass correlation appeared poor (=0,29), as a few students revealed an hazardous reasoning.

*Conclusion:* If SCT is a Clinical Reasoning Assessment Test, this "extended" SCT appears more adapted as it highlights a small population (6%) of students unable to avoid inadequateness. We plan to use the "extended" SCT next session.

*Relevance to EGPRN /Questions:*
1. What impact on medical education and pedagogy?
2. What possible other uses, e.g. assessing a CME course?

PRESENTATION 12: Friday 12st May, 2006 — 16.00 – 16.30 h. — FREESTANDING PAPER — Work in Progress/Ongoing Study

TITLE: Suicide risk and prevention: An exploratory prospective study.

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*Background:* Past research indicates that about half of the people who commit suicide or make an attempt to it, consult a primary care provider in the preceding month. Along with other research, this suggests a huge potential impact of GPs on suicide rates. However, a lot of crucial questions remain unanswered…

*Research questions:* How are risk patients of (trained) GPs followed up, and what are the main problems faced by their GPs? Do they feel, in particular, that they can make proper risk estimates? And what is the profile of these patients?

*Method:* A prospective study with registrations by over 50 GPs who participated in an accredited web-based training programme on the prevention of suicides. Each GP selected five patients, based on subjective risk estimates, and described these patients, their care network, the estimated risk & their subjective certainty about it, etc. Six weeks later, they filled out a slightly more elaborate questionnaire including more or less the same items plus questions on recently occurred events, risk factors and the problems faced or perceived by the GPs. (Henceforth repeated 4-monthly until January 2007.) In a closely related study, some of these GPs also tested an innovative case finding procedure aiming (1) to detect previously unknown risk patients, (2) to estimate the risk, and eventually (3) to make a start of providing better care. Preliminary results of this field test may be discussed as well.

*Expected results:* We expect that even (or perhaps “especially”?) properly trained GPs will not feel that they can make valid & reliable risk estimates, although applying an overview of risk factors may have a slightly positive effect. Furthermore we expect that our case finding procedure will result in the detection of many patients with previously unknown depressive episodes and/or suicidal ideation, particularly amongst the elderly.

*Points for discussion:*
(1) Our study is situated in Flanders and all our GPs are alumni of the accredited web-based training programme “iTOL Zelfmoordpreventie”. In addition, several other projects on suicide prevention are targeting Flemish GPs. Can we generalise our results?
(2) Could additional training/support/… improve the validity of the risk estimates?
(3) And if so, how?

PRESENTATION 13: Friday 12st May, 2006 16.30 – 17.00 h.

FREESTANDING PAPER
Finished Study

TITLE: Quality improvement for contraceptive health in general practice.

AUTHOR(S): Lieve Peremans[1], Jan-Joost Rethans[2], V. Verhoeven[1]
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*Background:* An evidence- based clinical guidelines for oral contraceptive use was developed and distributed among all Flemish general practitioners (GPs).

*Objectives:* To evaluate the effectiveness of two implementation strategies for an evidence-based clinical guideline on oral contraceptives in daily general practice.

*Method:* We used standardized patients (SPs) to assess the performance of GPs in daily practice, on basis of a validated checklist. The mean score of the GPs in a study in 2003 was 24.01/48 (SD=7.01) and to get an improvement of at least 11 points (+20%) the sample size for the intervention study need to be 45 ($\alpha = 0.05$ and $1-\beta = 80\%$). One hundred fifty GPs, using the same electronic medical record, were invited to participate at the study. Finally 45 at random selected GPs received a first visit by a SP.
Five months later we planned one control and two interventions groups (one group was visited by an 'empowered' patient and one group got an implementation of the contraceptive consult in a new update of their computer software).

*Results:* Forty-three consults could be analysed. GPs score moderately with a mean score of 26.16 (SD=5.76). Less than one fourth asked for contra-indications. The students got enough information about the correct pill use but hardly on factors associated with pill failure and interaction with other medication. Five months later the mean score was 26.39 (SD=6.86). Only the intervention group with the empowered patient scored significant better (score 29.92; SD =7.11), the computer and control group worse (score 24.36 and 24.82). In the empowered patient group 11/13 GPs had a positive ranking and especially on the items were the intervention was planned.

*Conclusion:* Two years after the publication of the guideline former study there is no change in behaviour of the GPs. Implementation in the electronic medical record without additional support did not improve the doctor-outcome, but educating patients can ameliorate the quality of the contraceptive consult.

*Points for discussion:* Which reliable methods could be used in future research to assess performance of GPs?

PRESENTATION 14: Friday 12st May, 2006 FREESTANDING PAPER
17.00 – 17.30 h. Work in Progress/Ongoing Study

TITLE: Spanish GP's who come to work in Durham and Tees Valley, UK: exploring their cultural and professional experience in clinical consultations.

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*Background:* Many Spanish physicians have been recruited by the NHS to work in the UK. Some studies have considered the recruitment and retention of GPs from France and Spain, but none, has yet explored the cultural differences.

*Research Question:* To describe the experience of Spanish GPs, from their cultural and professional perspective, focusing upon the clinical consultation.

*Methods:* This is a qualitative study. Between 9 and 12 out of 27 selected Spanish GPs working in NE England will be interviewed. A previous pilot study has been done to test the style of conducting the interview, the semi-structured schedule and the interim analysis.

*Interim Results:* From the first three interviews and the pilot study:
**Patients**: in UK are more respectful to GPs, polite, stoic/resilience; in Es, noisy, dependant, paternalistic. **Health System** in UK: structured, tight, health triage, 10 minutes consultations, referral letters, professional career development, independent, other professional, in evolution; in Es, open, high demand, too easy access, less time, stress, salaried. **GPs,** in UK, gatekeepers, independent "teams", greater responsibility, business oriented, "family physicians, rational prescribing; Es, "adult doctor-GPs", working as a team, high prescription, stress. **Consultation:** the "blink magical-assessment", improving the language. **Culture**: UK registration, queuing, social classes; Es, pushing, demanding. **Personal**: general satisfaction, confidence with language, enjoyment, opportunities, but also missing Spain.

*Conclusions:* The health care system in UK is in evolution, more flexible, plenty of professional opportunities and Spanish GPs feel satisfied. Personal relationship is closer in Spain and there is more inter-human interaction but the over-crowded system leads to stressed GPs and potential burnt-out.

*Points for discussion:* An opportunity to build a bridge between different health systems and cultures.

PRESENTATION 15: Friday 12st May, 2006 16.00 – 16.30 h. FREESTANDING PAPER Finished Study

TITLE: What does the “control rate” of patients with treated hypertension tell us? Time for a term to be discarded

AUTHOR(S): Jürgen in der Schmitten, A. Mortsiefer
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*Background:* Surveys to report that only a minority of patients with hypertension is “controlled” to “normal” values. Current guidelines, however, recommend risk factor treatment depending on absolute cardiovascular risk (CVR) rather than on limits of “the normal”.

*Research Questions:* What is the therapeutic relevance of the often used term “control rate” in hypertensive patients?

*Methods:* 17 German General Practitioners prospectively collected risk factor and treatment data of 330 consecutively recruited patients with known arterial hypertension. Control rate and, using the European SCORE formula, absolute CVR were calculated. By relating blood pressure control to CVR, we then analysed the indication to intensify anti-hypertensive treatment in subjects with “controlled” and “uncontrolled” hypertension, rsp.

*Results:* 47% of the patients were “controlled” to a BP <140/90mmHg. Of these, 32% had a history of MI or stroke (top CVR), and a further 31% had a high CVR (SCORE ≥ 5%; mean 9%, SD 5%). Mean BP in these two subgroups was 128/77 (SD 8/7) mmHg, mean number of antihypertensive drugs 1.4. According to guidelines, many of these patients with top and high CVR might well benefit from a *further* BP reduction, apart from other risk factor interventions.

Of the 53% with “uncontrolled” BP, 32% had a low CVR (SCORE < 5%; mean 2,5%, SD 1,5%). Mean BP in this subgroup was 146/86 (SD 9/8), mean number of antihypertensive drugs 2,1. There is no evidence for a relevant effect of a more intensive treatment of these patients.

*Conclusion:* Judging in consideration of absolute CVR, the term “control rate” fails to identify whether more or less anti-hypertensive treatment is indicated; it may, however, mislead to over- or undertreatment. We cannot recognise a therapeutic relevance of the term, and therefore suggest it to be discarded.

*Points for discussion:*
1. Does the European audience agree with our procedure, and conclusions?
2. To what extent has the current concept to manage cardiovascular risk factors based on absolute CVR diffused into General Practice?

PRESENTATION 16: Friday 12st May, 2006 FREESTANDING PAPER
16.30 – 17.00 h. Finished Study

TITLE: How objective is assessment of basic clinical skills by student tutors with an OSCE?

AUTHOR(S): Jean-François Chenot, Anne Simmenroth-Nayda
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*Background:* The objective structured clinical examination is (OSCE) is becoming increasingly popular in Germany and considered as most valid method to asses basic clinical skills. Dissemination of OSCE is limited due to high amount of staff needed and significant higher workload required compared to e.g. multiple choice questions. A possible solution is the use of student tutors to asses their peers. Reliability and feasibility of this proceeding has to be established.

*Research Question:* How reliable is assessment of basic medical skills by student tutors compared to teaching physicians?

*Methods:* Teaching physicians (TP) and student tutors (ST) who taught a clinical skills course received a rater training with video samples. We have previously established a good interrater-reliability of TPs. 214 students on 4 OSCE stations were evaluated simultaneously by TPs and STs with a checklist and global ratings. For statistical analysis of the interrater reliability adjusted kappa-tests and paired t-tests were performed.

*Results:* The adjusted interrater-correlations ranged from 0,41 to 0,64 for checklist assessment and global rating, which is considered good. Student tutors gave slightly but statistically significant better ratings which were, however, of no practical relevance.

*Conclusion:* There was no meaningful difference in assessment of basic medical skills by student tutors and teaching physicians. We have some evidence that interrater correlation depends mainly on the construction of the OSCE-station. Since then several OSCEs rated by student tutors under minimal supervision have been successfully completed.

*Points for discussion:*

1. Limitations of students evaluating their peers
2. Amount of supervision necessary to assure objectivity

PRESENTATION 17: Friday 12st May, 2006 FREESTANDING PAPER
17.00 – 17.30 h. Work in Progress/Ongoing Study

TITLE: Continuity in General Practice.

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*Background:* Traditionally continuity of care has been seen as a core element of general practice. But the organization is changing and in larger practices general practitioners are often working with patients who they do not know well. This reduces continuity of care. However no research has been carried out on the significance of continuity according to quality of care. The concept of trust is essential to compliance, but research on how trust is established is lacking and whether trust and compliance are dependent on relational continuity between doctor and patient.

*Research questions:* How does relational continuity affect communication between doctor and patient? How does relational continuity affect patients' assessment of the consultation and their decision according to the prescribed medicine?

*Methods:* It is a qualitative study based on both participant observation and interviews. Observation is carried out in three different types of practices, which are selected from a case study method. 15 patients from each practice are recruited for interviews. The interviews are audio taped and transcribed verbatim. NVivo is used in the coding process. The focus of the study is to gain insight into patients' perceptions related to general practice and the concept of continuity. Data is analyzed from cultural and sociological perspectives.

*Results:* The preliminary results are very interesting. Trust is essential to all the patients, but relational continuity is only essential to seriously ill patients. Trust is established in the concrete consultation and is socially situated. Trust is therefore not dependent on relational continuity but on good communication skills.

*Conclusion:* Relational continuity is often not necessary to create good quality of care. Instead it is essential to be attentive and treat the patient as a person. However there seems to be an important distinction between seriously ill patients and acute patients. Further investigation is needed.

*Points for discussion:*
1. What kind of practices would be relevant to include in the further study?
2. How can general practice focus on the importance of good communication skills?
3. How would you define the core elements of general practice today?

PRESENTATION 18: Saturday 13st May, 2006 THEME PAPER
09.10 – 09.40 h. Work in Progress/Ongoing Study

TITLE: Teaching GPs to deliver the minimal intervention for stress-related mental disorders with sickleave (MISS) in general practice: effects on recognition and treatment

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*Background:* Stress related Mental Disorders (SMDs) range from normal stress or adjustment reactions, through a level of (sub-threshold) mental disorders. Patients having SMDs with sick leave are at risk for prolonged disability and loss of employment. Because of the regularly occurrence, we developed a Minimal Intervention for SMDs with Sick leave (MISS) with the intention to reduce these risks. The MISS involves assessment, education, advice, monitoring and, if necessary, referral.

*Research question:* Does teaching GPs to deliver the MISS improve the management of SMDs with sick leave in general practice?

*Methods:* The design is a RCT, 24 GPs received a MISS training comprising 11 hours of training over a period of 6-10 weeks; 22 GPs were allocated to the UC group. Enrolment of patients took place after screening 20-60 year old primary care attendees. Inclusion criteria were: moderately elevated distress level, having a paid job and sick leave (<3 months). Two months after inclusion, all GPs were asked about diagnoses from the past 3 months and an opinion about the present state of the patient.

*First results:* GPs in the MISS group identified 78% (n=159) of the patients having some sort of SMD versus 67% (n=116) in the usual care group (p=0.018). The recovery rates reported by the MISS-GPs were higher: improvement was 56.7% versus 45.6% in the UC-group (p=0.034). This significant result is due to the fact that the MISS-GPs were more familiar with the current state of the patients. They more often monitored the process of treatment than their UC- colleagues did: in 24% (n=49) of the cases from the MISS-group versus 34% (n=58) of the cases from the UC-group, the GP did not know the current state of being of their patient (p=0.036).

*Conclusions:* The first results support our expectation that the MISS is more effective than usual care in diagnosing and treating patients with SMDs.

*Points for discussion:*
1. How to promote translation of this research evidence on the MISS in a suitable guideline and into daily practice? How willingly are GPs to be trained in the skills of the MISS as an approach on SMDs with sick leave?
2. Should effectiveness be determined by results at the level of the patient or is improved experience of the GP (e.g. suitability and satisfaction) a better focus?

PRESENTATION 19: Saturday 13st May, 2006 THEME PAPER
09.40 – 10.10 h. Finished Study

TITLE: Using the low back pain guidelines: The intellectual and mental challenges faced by Israeli family physicians caring for low back pain patients.

AUTHOR(S): Rachel Dahan*, Shmuel Reis*, Jeffry Borkan **
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*Background:* A new paradigm in Low back pain (LBP) care has emerged in the last decade. Newer concepts based on steadily improving scientific evidence have led to a major shift from the earlier paradigm of routine radiography, strict bed rest, corset and traction. Current clinical guidelines have helped to summarize the scientific evidence and research, but have failed to provide tools and guide family physicians (FPs).
Guidelines for the treatment of low back pain in primary care were widely published internationally from the early 90's and in Israel in 1996. Although these guidelines were widely disseminated, their impact on clinical practice appears to have been relatively limited.
*Research Questions:* What are the barriers and facilitators for the implementation of low back pain(LBP) guidelines from family physicians'(FPs) perspective?

*Methods:* A qualitative approch using focus groups with 38 FPs. Purposeful sampling was used to recruit participants, all of them board-certified FPs from the north of Israel: In and around the city of Haifa.

*Results:* Focus group findings have expanded the understanding of the intellectual and mental challenges faced by Israeli FPs caring for LBP patients and highlighted the many obstacles to implementing LBP guidelines. Physicians' decision-making, pertaining to LBP, functions on three levels simultaneously: The physicians agenda based on familiarity with the guidelines; their need to remain grounded in the context of the specific patient-doctor relationship; and the constraints and demands of the physician's workplace, medical system and environment.

*Conclusions:* Despite an overall positive attitude toward LBP guideline implementation, FPs found it hard to come to terms with the conflicting dimensions of LBP patient care. The patient-doctor interaction determined the outcome of the encounter, whether it complied with the guidelines and whether the encounter lead to a healing process or to a vicious circle of unnecessary utilization of services.

*Points for discussion at EGPRN:*
1. The ways patient-doctor interaction determined whether the encounter ultimately leads to a healing process or to a vicious circle of unnecessary utilization of services.
2. Low Back Pain as a metaphor for much of what is done in primary care in the area of diagnosing and treating clinical problems without a clear pathoanatomical or biological basis.

3. The need for more research on the ways family physicians deal with the conflicting dimensions of patient care.

PRESENTATION 20: Saturday 13st May, 2006 THEME PAPER
10.10 – 10.40 h.

TITLE: A cluster randomized educational intervention to reduce inappropriate prescription patterns for elderly patients in general practice.

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*Background:* Inappropriate prescription patterns and polypharmacy contribute significantly to adverse drug events and drug-drug interactions in elderly patients. The objective of this trial is to identify general practitioners' (GPs') inappropriate prescribing patterns for elderly (≥ 70 years) out-patients, and to evaluate a tailored educational intervention supporting the implementation of safer prescribing-practice for the elderly.

*Methods/Design:* 80 continuing medical education (CME) groups including about 600 GPs in Norway will be recruited to this cluster randomized trial. Participants will either be assigned to an intervention group or a control group. Outcomes will be measured for all eligible patients seen in the participating practices during one year after the initiation of the intervention. A multifaceted intervention has been tailored, where key components are educational outreach visits, work-shops, audit, and feedback. Peer academic detailers (PADs), who are trained GPs, will conduct the educational outreach visits. During these visits, 13 explicit recommendations (quality indicators) for prescriptions to be avoided in elderly patients will be presented.
A software will be installed in participants PCs to enable collection of prescription data (baseline and one year after the intervention). Outcome data will also be obtained from the Norwegian Prescription Database (NorPD) including corresponding prescription data from GPs not involved in the study.
Individual prescription data according to the explicit recommendations will be fed back to the individual participating GPs and subsequently addressed in a PAD-led CME group- session.

*Main outcome measures:* GPs' prescription patterns with respect to the explicit quality indicators before and after the intervention.

*Results:* The study is currently undertaken. Training of PADs, inclusion and randomisation of CME-groups completed by December 2005. Intervention launched January 2006. Baseline data (before intervention) will be available by May 2006.

PRESENTATION 21: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h.

TITLE: Health beliefs in Turks, Germans and Turks living in Germany

AUTHOR(S): Sandra Dunkelberg, Dilek Güldal, Nuray Can
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*Background:* Looking at health beliefs, the focus of interest often is on the special features in different nationalities. In the Antwerp meeting of EGPRN in 2004 Dilek Guldal et al presented the results of a study about health beliefs in Turkey. The perceived great amount of similarity therefore led to a following project, in order to explore the differences and similarities between the two nations.

*Research question:* To compare the health beliefs in three groups: (1) Turks in Turkey, (2) Turks in Germany (which represent the biggest ethnic minority in Germany) and (3) Germans in Germany.

*Method:* In 2003 a questionnaire was developed in Turkey. It included short phrases about health beliefs collected by Turkish family physicians. In Izmir 431 patients in Primary Care setting were asked whether they agree or disagree to 57 such statements. The questionnaire was thoroughly translated in 2004 and administered to 208 Turks living in Hamburg and 205 Germans, all in Primary Care.

*Results:* In 49 of 57 items the difference between Germans and Turks in Turkey was statistically significant. The size of the differences varied. For 10 health beliefs the agreement level of the Germans were similar, for 33 health beliefs the agreement level of the Germans was considerably lower and in the remaining 12 health beliefs the Germans agreed considerably more often. The level of agreement in the group of Turks in Hamburg often is in between those of the other two groups, with a tendency to greater proximity to the Izmir Turks. The influence of socio demographic characteristics has to be taken into account.

*Conclusion:* Health beliefs vary in different cultures. But only about one third of health beliefs collected in Turkey can be regarded as typically Turkish. One fifth are even more widely distributed in Germany. Many other health beliefs show significant statistical differences in frequency, but since their distribution is high in both countries, they have to be regarded as relevant. Can we hypothesise a set of basic health beliefs in the western world? Point for discussion at EGPRN: Would it be of interest to repeat the study in other countries?

PRESENTATION 22: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h. Study Proposal / idea

TITLE: The experiences of family carers with palliative care services in Italy: differences between rural urban population.

AUTHOR(S): Ferdinando Petrazzuoli [1,2,3], Francesco Carelli [2,3,4,5]
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*Background:* In Italy previous observations of our Health Authority on the quality of service of palliative care have been inconclusive. Although these studies apparently showed that services were generally perceived as of high quality, the methods of research utilized based on complicated questionnaires and affected from little response rate have brought to unreliable results. GPs' point of view is completely different and these services are generally considered of poor quality. Palliative care services have recently developed mostly in urban areas. In rural areas, primary care professionals, specifically GPs have to undertake most of the palliative care. Little is known, however, about the views of family carers of palliative care.

*Research question:* What is the family carers' view of palliative care and are there any differences (and inequalities) between rural and urban population?

*Methods:* The setting of our study is a rural practice in the Province of Caserta (Southern Italy) and a urban practice in Milan (Northern Italy). 30 family carers recruited: 15 in urban and 15 in rural practices. This is a qualitative study, the research tool will be semi-structured taped interviews. These interviews shall include open questions and allow free answers from the respondents.

*Results:* the degree of satisfaction with local services will be analyzed and compared with previous observation.

*Conclusion:* Most of the work will be done to identify problems in the delivery of palliative care. Whilst primary care professionals are seen as having a key role, we need to see how much we need to develop the secondary and tertiary palliative care services in our areas.

*Points for discussion at EGPRN:*
1. Research methods
2. Relevance of the study.

PRESENTATION 23: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h.

TITLE: Oral anticoagulant therapy: What do our patients know ? How do they manage their treatments ? How to improve it ?

AUTHOR(S): Dominique Gras, Nicolas Bildstein, Michel Kopp
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*Background:* Half a million patients are treated with oral anticoagulant therapy (OAT) in France, which cause about 17000 hospitalizations per year and 13 % of brain haemorrhage. In 2000 and 2003, a French national health agency (AFSSAPS) showed patients' main knowledge deficiencies twice without any improvement and established a follow-up booklet with specific recommendations for the patients.

*Research question:* What are the most important knowledge gaps and the difficulties in managing the OAT by patients in Alsace two years after the new recommendations were published ?

*Method:* We built a questionnaire with 11 closed-questions related to the patient-oriented recommendations, dealing with : drug-interactions, management of INR, screening intervals and diet. The questionnaires were given to 41 voluntary patients and filled-in with the help of a nurse at three laboratories by patients waiting for INR test.

*Results:* The survey was completed by 41 patients , non refused. 42% (CI 95% 28-56) of respondents didn't carry the follow-up booklet with them. 13% (CI : 5-25) din't know their OAT target INR, but 83% (CI : 72-93) knew the screening
15% (CI : 7-28) Ignored the interaction with aspirin and 53% (CI : 30-68) with ibuprofen. Only 20% (IC :10-34) knew how to manage a high INR (6,5), but 73% (CI : 58-84) knew what to do after a forgotten dose. Only 13% knew all the bleeding complications.

*Conclusion:* Only a minority of patients use the booklet, and only one out of 5 is able to manage an INR seriousely high. To give solely a follow-up booklet to the patient is not sufficent to improve his ability to manage his OAT. It is necessary to build an educational program towards the GPs helping them to explain and highlight the preceeding topics to their patients.

*Questions for EGPRN:*
1. What kind of educational program would be efficient?
2. How to asses its efficiency?

PRESENTATION 24: Saturday 13st May, 2006 11.10 – 12.55 h. POSTER

TITLE: Patients' behaviours and knowledge about emergency.

AUTHOR(S): Marie france Le Goaziou, Pierre Girier, Yves Zerbib

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*Background:* The number of people who are going to emergency for benign diseases is always increasing.
What are patients' behaviours when an emergency situation appears?
What knowledge those have and use?

*Method:* A phone inquiry was realised in Rhone alp area near one thousand persons randomised, about four emergency cases.

- Fever on a 12 months baby arrived during the night,
- Vomiting on an adult after eating a sandwich,
- Fall on an old awkward person,
- Breast pain on a fat smoking man about 45 years old

*Results:* First case: 58% of the youngest (< 30 years) wanted a consultation against 27 to 34% of the oldest (P<0,001). 30% of men said they were able to manage the situation against 49% of the women (p<0,001). On one hand 54% of them said to be able to give an answer if other child was at home, on the other hand only 36% of them if they were no other child (p<0,001).
When people lived in town, they consulted more in emergency area
Second case: 16% of the men asked for an emergency consultation but only 6% of women (p<0,001)
Third case: differences appeared with social level: 43% of high social level people didn't asked for emergency advice whereas 55% of low social level people (p<0,001)
Fourth case: only 63% of the youngest (< 30 years old) called the Samu (Service d'aide médicale urgente = emergency service of medical care) against 78% of the oldest (more than 45 years old) (p<0.001)

*Conclusion:* This study found a lack of knowledge through these situations and differences between genders, ages and social level, which would request educational guidelines for frequent emergency situations.

PRESENTATION 25: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h. Finished Study

TITLE: The psychological status of the parents of disabled children correlates with their coping strategies.

AUTHOR(S): Ozlem Cigerli, T. Muge Filiz, Suleyman Gorpelioglu
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*Background:* Having a child who is disabled has social, emotional and financial effects on families. Positive coping behaviors contribute to lessening the anxiety and depressive emotions associated with caregiving.

*Aim and objectives:* This study is designed to investigate the parents' understanding about disability, parents' psychological status and the coping strategies they use.

*Method:* Fifty parents of disabled children, 37 mothers and 13 fathers, living in Kocaeli province were enrolled in this descriptive, cross sectional study. This study was conducted between July 2004 and May 2005. The parents filled a questionnaire and were interviewed by the researcher who also assessed the marital status, social functioning and the parents' ways of coping. The parents were also asked to fill Beck Depression Inventory, State-Trait Anxiety Inventory and Ways of Coping Questionnaire. Student t test was used for parametric variables. Nonparametric variables were compared with chi-square test, Pearson correlation test.

*Results:* The coping strategy most frequently used by both mothers and fathers was problem solving-optimistic approach. Mothers were more prone to "helplessness" approach than fathers (p=0,007). Parents who had Beck Depression Inventory scores of 17 or higher (moderate/severe depression) were more frequently using "escape" and "helplessness" approach for coping. Low educated parents more frequently resorted to the "fatalistic" approach (p=0,004). Total Beck Depression inventory score was found to be negatively correlated with the problem solving approach , but positively correlated with the helplessness and escape approache. Trait anxiety inventory score showed a positive correlation with both the helplessness and escape appraoch, while the state anxiety inventory score showed a positive correlation with only the helplessness approach.

*Conclusion:* High levels of depression and anxiety in the parents of handicapped children who were trying to solve the disability problem by means of "escape" and "helplessness" approaches may indicate the deficits in the areas of medical counselling, continuous care and social support.

*Relevance to EGPRN:* Immediate professional counselling is important for the parents to help them find out positive and functional ways of coping in order to solve their own problems and maintain healthy developmental period for their handicapped children.

PRESENTATION 26: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h. Work in Progress/Ongoing Study

TITLE: Movie Magic: A Learning Outcomes approach to Film Studies for Medical Undergraduates

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*Background:* There is increasing recognition of the value of medical students undertaking study in the humanities. One such form of study is via the critical appraisal of film. This poster outlines a proposed module for film studies as part of student selected options in an undergraduate medical curriculum. Module design has taken a learning outcome approach.

*Research Question(s):*
Why should medical students study film?
Why adopt a learning outcomes approach?

*Method:* A literature review was undertaken to assess the potential value of introducing such a module. A Learning outcomes approach was used to aid in module design

*Results:* The literature supports a role for film studies for medical students; most of the current literature relates to postgraduate medical studies. Film studies are especially effective in the integration of the scientific, emotional and experiential aspects of clinical practice. A learning outcomes approach facilitates clarity of student centred outcomes and helps the selection of course material, course delivery and assessment method(s).

*Conclusion:* This poster outlines a proposed module on film studies for medical undergraduate students. The rationale for the module is outlined and a learning objective approach has been adopted in terms of module design. Apart from making explicit course goals, focusing on learning objectives has directed the selection of course material, teaching methods and assessment process. The purpose of this approach is the promotion of the merits of learner centred and problem oriented approaches to learning, which aim to produce doctors better equipped with the adult learning skills necessary for them to adapt to, and meet, the changing needs of the community they serve.

*Points for discussion at EGPRN:*
1.Is anyone else using film studies at undergraduate level? If YES, what are their experiences to date? Can we collaborate?
2.If NO, what do GP teachers think of this idea in general?

PRESENTATION 27: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h. Finished Study

TITLE: Educational needs of postgraduate students in general practice.

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*Background:* The current level of implementation of information technologies in general practice requires certain skills and knowledge that need to be addressed in the educational programs in general practice.

*Research question:* Do general practitioners enrolled in the PG program of the Medical University - Plovdiv possess the necessary skills, knowledge and attitudes to effectively make use of IT in their practice?

*Methods and material:* Two focus group discussions with 24 general practitioners attending educational modules in the department of general practice were held. The discussions were conducted by a member of the academic staff and the data capturing included moderator notes and records. Several questions were placed for discussion and at an appropriate time the participants were asked to consider a short adapted instrument for evaluation of computer literacy with respect to general practice starting with basic knowledge and skills to use office and communication applications and ending with literature searches and using electronic EBM resources and EPR.

*Results:* All of the participants reported some previous experience using specific software for keeping patient records, compliant with the requirements in their contract with the National Health Insurance Fund. The degree of confidence in using other office and communication applications was limited to moderate. Only 17% (4) of the participants were acquainted with electronic and web versions of bibliographical and full-text databases and none had actually used evidence based electronic resources.
The main obstacles that prevented GPs from making use of modern IT solutions were the language barrier and the lack of specific training in the undergraduate programs.

*Conclusions:* The discussions preceded the beginning of the educational sessions and the information obtained was used to evaluate the specific training needs of the participants. However limited the study revealed the need for changes in both undergraduate and postgraduate programs in general practice.

PRESENTATION 28: Saturday 13st May, 2006 11.10 – 12.55 h. POSTER

TITLE: Medical students' knowledge on health risks of smoking: What do they know? Where do they know it from?

AUTHOR(S): T.Muge Filiz[1], Pinar Topsever[1], Nursan Cinar[2], Ismail Cakar[2] Cemile Dede[2], Ebru Celik Guzel[1], Funda Sevgi Aktuna[2] Suleyman Gorpelioglu[1]
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*Background:* Among modifiable health risks worldwide smoking is still killer number one. Education is crucial in order to prevent smoking. The last 25 years are characterized by large scaled public anti-smoking campaigns in media and education.

*Research question:* What do medical students know about health risks of smoking and what are their sources of knowledge?
AIM: We investigated smoking habits, knowledge, and source of knowledge among phase 1, 2, and 3 undergraduate medical students.

*Method:* A 15-item questionnaire, investigating sociodemographics as well as family and personal smoking behaviour, developed by the researchers was piloted and applied to students in the first 3 years of undergraduate medical education at Kocaeli University. Students were asked to name any health risks of smoking and their sources of knowledge for that in an open-ended, qualitative manner. The emerging main themes were rated independently by two researchers. Sosciodemographic and epidemiologic data are descriptively presented as mean±standart deviation and percent.

*Results:* The study population consisted of 190 medical students (female 98 (51.6%), male 92 (48.4%); mean age 19.8±1.3 years). Most of them (n=172, 95%) were non-smokers, 19 (10%) were current smokers. According to the Fagerstrom scale, 8 (42.1%) smokers had a low addiction score, 9 (47.3%) had a medium addiction score, and one (11.1%) was highly addicted. Although, 173 (91.1%) students claimed that they were aware of health risks of smoking, only 116 (61.1%) students could name at least one health risk of smoking. First line risks named were cancer (n=81, 69.8%; 48 students indicated "lung cancer" explicitely) and respiratory disorders (n=16, 13.8%). Second line risks were respiratory disorders (n=4, 12.1%) cancer (n=6, 5.2%; none mentioned "lung cancer"), and cardiovascular diseases (n=3, 2.6%). First line sources for knowledge were reported to be education, including school and medical faculty (n=62, 34.1%), and media (n=30, 16.5%). Second line sources were media (n=43, 23.6%), education (n=19, 10.4%).

*Conclusion:* Smoking prevalence was moderate among medical students. Awareness about smoking being a health risk was high, also nearly everyone named a source for information. However, when asked to specifically name health risks, the proportion of students who could do so was low.

*Relevance to EGPRN:* In undergraduate medical education specific information about health risks of smoking should be stressed.The author would like to discuss methods to

obtain this goal, for example assessment stategies to reinforce knowledge about prevention and health risks of smoking.

PRESENTATION 29: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h. Finished Study

TITLE: What do student's value in their experience of the curriculum? A study of the "fast track" course at Warwick Medical School.

AUTHOR(S): Ian Ward, Teresa Pawlikowska.

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*Background:* Leicester-Warwick medical school offers graduate entry to a "fast track" course in medicine for biomedical science graduates .It now has the largest course of this kind in the UK. Graduates are thought to be more focussed and demanding, bringing with them transferable knowledge. This four year accelerated course was adapted from the established Leicester medical school course and focussed on these particular learner's presumed needs.

*Aim:* This qualitative study aimed to evaluate individual student's experience and perceptions of the new "fast track" curriculum.

*Method:* All (n=64) students in the first cohort at Warwick Medical School were invited to participate.40 semi-structured interviews were conducted after final exams in 2004 and were analysed thematically. Students were asked to comment on how the medical course had met their initial expectations in terms of content, and style of delivery.

*Results:* Themes emerged in terms of subject matter, timing within the course and mode of teaching.
Content: the emphasis on early and increased clinical contact was highly valued, although there was a perception of imbalance of workload, the preponderance of sociology drew comment.
Delivery: students were concerned about their management of self- directed learning, and the use of group work The modular systems teaching was favourably received but IT and travel arrangements needed improvement.

The role of physician and team in terms of availability and learning support was acknowledged, along with recognition for the need for increased self-direction.
A generic module on consultation skills delivered by General Practitioners with content relevant to all specialities, was singled out for praise in terms of: greater responsibility, patient contact and feedback.

*Conclusions:* Emphasis on early and increased patient contact was valued. The modular approach was appreciated but imbalance had been created by adjusting for students' biomedical background. Concerns about study methods and skills were raised by students themselves.

*Points for discussion at EGPRN:*
1. What is the European experience of increasing patient contact in the curriculum?
2. Can we discern common benefits and barriers?
3. Do other countries have an accelerated curriculum for graduates?

PRESENTATION 30: Saturday 13st May, 2006 11.10 – 12.55 h. POSTER Work in Progress

TITLE: Medical students' approaches to learn: does it change after a semester of PBL learning.

AUTHOR(S): Erik Kegels, M. Vandekerckhove, R. Remmen
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*Background:* To accomplish the hypothesis that medical students need to adopt a deep approach of learning to become 'more active and profound continuing scholars' in their future professional lives, we developed a new vocational Problem Based Learning (PBL) programme.

*Research question:* In this study we determined medical students' approaches to learning at the end of the core curriculum, as well as whether the approaches to learning of the future general practitioner (GP) students changes after having undergone the new PBL learning programme.

*Method:* The new PBL programme includes 17 weeks and consists of seminar weeks and training weeks in an alternating schedule. From a total of 85 students, 27 started the programme for GP, and 58 for specialist (SP) training programmes. All students were asked to complete the revised two-factor Study Process Questionnaire (Biggs 2001), to assess deep or surface learning approaches of GP and SP, at the start (pre-test) and at the end (post-test) of their programme. Results were analysed in SPSS.

*Results:* A total of 67 students participated in the pre-test, (25 GP and 42 SP). The mean students' score (SD) for deep approaches (GP: 3.06 (0.63); SP: 2.96 (0.65)) and surface approach (GP: 2.01 (0.56); SP: 2.21 (0.71)) were moderate low. A total of 42 students participated in the post-test (24 GP and 18 SP). The mean scores (SD) for deep approaches for GP and SP were 3.51 (0.63) and 2.96 (0.70) respectively and for surface approaches 1.99 (0.79) and 2.19 (0.72). The score for deep learning approaches is significantly higher in GP compared to SP at the end of the vocational programme (mean difference (95%CI)= 0.56 (0.14 - 0.97)).

*Conclusion:* Our results show that training within a PBL learning environment can deepen medical students' approach to learning and support the importance of implementation of more active self-directed learning strategies within medical curricula to promote the desired learning attitude.

PRESENTATION 31: Saturday 13st May, 2006 11.10 – 12.55 h. POSTER

TITLE: Introducing patient-feedback in vocational training in general practice.

AUTHOR(S): Marcel Reinders, Nettie Blankenstein, Harm van Marwijk

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*Background:* A majority of Dutch patients (64%) think that doctors are not able to comprehend patients' needs, although the majority of doctors think they can. In meeting societal needs, we are evaluating the use of patient-feedback as a self-directed learning tool for consultation skills, by means of a combined validated consultation checklist for patients and GP-trainees.

*Research Question(s):* How comprehensible and useful is the checklist for both patients and doctors? How do their views on consultation skills relate?

*Methods:* This study is preliminary to a RCT that will investigate effects of patient feedback on consultation skills of GP-trainees. In the present study, eighteen third-year GP-trainees volunteered to hand out the checklist to five consecutive patients each. They simultaneously filled in their own version. Structured interviews with patients and trainees were held to investigate the comprehensibility and usefulness of the checklist, the responsiveness and burden on the doctor's schedule.

*Results:* Sixty-five checklists were filled in, 18 GP-trainees and 50 patients were interviewed. Two patients refused to participate. Both doctors and patients generally approved of the idea of patient-feedback and endorsed its usefulness. In addition, they did not consider completion a time burden. Some patients were unable to complete the checklist, mostly because of intricacy of the questions or when their health problem was relatively simple. The checklist was modified because of patients and doctors' comments. Patients were more positive on consultations skills than doctors were about themselves.

*Conclusions:* Although patients and doctors' views followed a similar pattern, differences were more pronounced than expected and compared to literature. Patient-feedback by use of a checklist was received well, and therefore has real opportunities. The results encourage us to start a randomised controlled trial in September 2006.

PRESENTATION 32: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h. Work in Progress/Ongoing Study

TITLE: Self-rated general health and its association with mortality after 10, 20 and 29 years' follow-up among middle-aged Danes.

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*Background:* Poor self-rated general health (SRH) has shown to predict mortality through 2-28 years, although the association between SRH and mortality tends to be weaker in studies with a long follow-up period. SRH is hypothesised to capture characteristics not encapsulated by physiological and pathological covariates. Most studies are, however, based on self-reports and the information may be biased in the same direction as SRH. The association between SRH and mortality is suggested to weaken when more objective health indicators are included.

*Research questions:* Does the association between SRH and mortality a) persist when objective information is included? b) depend on the length of follow-up time?

*Methods:* Follow-up study of 1198 healthy suburban Copenhageners, aged 40 years, who in 1976 participated in a health study which comprised a questionnaire, a medical examination, clinical tests, and an interview about psychosocial conditions. The follow-up period regarding all-cause mortality was 29 years (N=246). SRH was assessed by: How would you characterise your own health during the last year? The responses were dichotomized into extremely good or good (=good) versus poor or miserable (=poor). With proportional hazard models we analysed the relation between risk of mortality after 10, 20 and 29 years follow-up and poor SRH at baseline, adjusted for relevant covariates and for interactions between SRH and covariates.

*Results:* 153 of 1045 reported poor SRH. Participants who died after 10-, 20- and 29-years' follow-up totalled 36, 96, and 207. For poor SRH the hazard ratio for mortality (adjusted analyses) was 2.91 [CI: 1.19-7.13], 1.89 [1.17-3.07] and 1.61 [1.14-2.27] after 10-, 20- and 29 years' follow-up. No covariates interacted with SRH.

*Conclusion:* GPs should be aware of persons with poor SRH as SRH adds information about risk of future mortality beyond objective measurements of typical risk factors, both after a short and long follow-up time.

*Points to discuss at the EPGRN meeting:*

1. The validity of people's self-rated general health vs. so-called objective measurements.
2. Could a dialogue between the GP and the patient about the patient's view on his/her self-rated general health contribute to patient empowerment?

PRESENTATION 33: Saturday 13st May, 2006 11.10 – 12.55 h. POSTER Work in Progress

TITLE: Assessing the Treatment of Cardiovascular Risk Factors in Diabetic Patients.

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*Background:* There is a substantial amount of evidence in the literature demonstrating the poor control of numerous cardiovascular risk factors in treated diabetics. Diabetic patients are at increased risk for both macrovascular and microvascular complications compared with nondiabetic patients. Eighty percent of patients with type 2 Diabetes will die of cardiovascular disease.

*Research Question:* To assess the achievement of the goals in treatment of cardiovascular risk factors in diabetic patients proceeding from the Estonian Guideline for Type 2 Diabetes (2000) which has been adapted to IDF Europe Guideline for Type 2 Diabetes (1999). Does the number of visits influence the cardiovascular risk level in diabetic patients?

*Methods:* We conducted a retrospective analysis of the GP`s medical record to assess the control of multiple predetermined cardiovascular risk factors, medication and the number of visits at outpatient department in ninety-nine treated diabetic patients who visited two GP surgeries in Tartu between January 01, 2004 and December 31, 2005.
The following parameters were used to define optimal treatment in these patients: haemoglobin (Hgb) A1c <7%, cholesterol (Chol) < 4,8 mmol/L, low-density lipoprotein cholesterol (LDL-c) <3,0 mmol/L, high-density lipoprotein cholesterol (HDL-c) > 1,2 mmol/L, triglyceride (TG) level <1,7 mmol/L, blood pressure (BP) <140/85 mm Hg and current non-smoking status. The use of beta-blockers, angiotensin-converting enzyme inhibitors and lipid-lowering agent was also evaluated.

*Patients:* Ninety-nine diabetic patients who have visited the GP`s surgery between January 01, 2004 and December 31, 2005 for any reason were retrospectively enrolled in this study. We defined diabetes if the patient was currently being treated with oral hypoglycaemic medication or insulin.

*Results:* Baseline Characteristics. There were 99 diabetic patients retrospectively enrolled in this study. A total of 27 (27%) were male, and 72 (72%) women.
All other results are in analysing process.

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| PRESENTATION 34: | Saturday 13st May, 2006<br>11.10 – 12.55 h. | POSTER<br>Finished Study |

TITLE: Disease specific quality of life in primary care patients with heart failure.

AUTHOR(S): Martin Scherer, Beate Stanske, Dirk Wetzel
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*Background:* Quality of Life (QoL) is an important predictor for mortality and re-admission in patients with heart failure (HF).

*Research Question/Aim:* Analysis of disease-specific quality of life and its relationship with psycho-social factors and HF severity.

*Methods:* Quality of life (MLHFQ), anxiety, depression (HADS), negative affectivity (DS-14), disease coping (FKV) and social support (F-SozU) were measured by validated questionnaires in primary care patients with HF. Severity of HF (according to NYHA-classification and Goldman's Specific Activity Scale) and sociodemographic characteristics were documented by self-report instruments.

*Results:* 363 patients from 44 general practices participated in the study (191 [52.6 %] female). Women had more physical but not more emotional problems than men. Increased emotional and physical problems and global disease-related impairment in QoL ($F[2,310] = 63.29$; $p < 0.001$) correlated with higher HF classes. Using regression analysis, more than 50 % of QoL values were predicted by psychological variables and perceived severity (significant for depression [HADS; $p<0.001$], coping by dissimulation and wishful thinking [FKV; $p=0.027$], HF severity [NYHA, Goldman; $p<0.001$].

*Conclusion:* Disease specific QoL is an important endpoint in primary care patients with heart failure, which is strongly influenced by psychosocial distress, coping patterns and perceived HF severity. QoL should be considered an important amendment to clinical information in every-day practice.

*Points for discussion:*
1. Clinical relevance of quality of life in every-day practice
2. Therapeutic options in heart failure patients with psychosocial distress

PRESENTATION 35: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h. Finished Study

TITLE: Identification of chronic kidney disease patients above fifty years old, in general practice.

AUTHOR(S): Marie France Le Goaziou, Celine Chopin Gheorgiev

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*Background:* Early detection of chronic kidney disease (CKD) and application of therapeutic measure have been proved to retard progression and improve positive outcomes. But the prevalence was not yet studied in a primary care population

*Research question:* How many patients above fifty years of a general practitioner population had a CKD?

*Method:* Ten students who were in training course during six months in twenty GP's surgery carried out this study. All persons above fifty have been included, until fifty persons by GP.
A form with gender, age, weight, chronic disease, blood pressure, creatinine level was filled by the students.
Creatinine clearance with Cockroft Gault equation was calculated.
At the same time forms were filled by fifteen randomised GP for theirs patients.

*Results:* 1000 patients were included by the trainees however only 916 were studied. 140 patients were included by GP's and only 118 were studied.
No differences were found between the two groups (age, gender, disease) as a consequence the analysis was carried out on 1034 persons.
324 patients (31%) had a clearance between 30 and 59 ml/min/1,73m² and 26 (3%) between 15 and 29 ml/min/1,73m²).
70% of the patient above 80 years old had a CKD.
Hypertension was the more frequent chronic disease associated and was under treated: only 21% were treated by IEC and only 17% had ARA2 when they had diabetes mellitus and hypertension.
GP's didn't explore correctly these patients: albuminuria was tested only for 17% of patients, 42% of them had a controlled blood pressure and 4% of them received a toxic medication (AINS).

*Conclusion:* In primary care population in France, this study has displayed an important prevalence of CKD.
Some questions appeared about the recognition of these patients by their doctors, the best management of the patient and the lack of guidelines about old patients.
Further studies seem to be necessary to improve these results.

PRESENTATION 36: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h. Study Proposal / idea

TITLE: Influence of chronic NSAID use on BP control in patients under anti-hypertensive treatment.

AUTHOR(S): Buono Nicola 1,2,3; Petrazzuoli Ferdinando 1,2,3; D'addio Filippo 1,3; Sauro Alfonso 1; Scalzitti Fausto 1; Correra Alessandro 1; Massara Giorgio1; Jean Karl Soler 2,3.4
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*Introduction:* Given the high prevalence of hypertension, concomitant use of anti-inflammatory drugs and antihypertensive medication is commonly encountered in clinical practice. Several studies show that COX 2-inhibitors and NSAIDs increase CV risk, but while COX2-inhibitors may increase blood pressure , NSAIDs seem not to increase BP.

*Research question:* Is there clinically significant increase of blood pressure (BP) in patients who chronically use non steroidal anti- inflammatory drugs?

*Methodology:* We have designed an observational prospective case control study on a simple of 200 subjects 45-84 aged randomly selected from a hypertensive population attending 20 GPs office.
Duration of survey: 6 months starting from 01/04/2006.

*Outcome measures:* good blood pressure control according to the ESH -ESC guidelines 2003.
We have divided patients in two groups:|
NSAID group:
ı Patients who received three or more prescriptions of any NSAID in the last three months
Non NSAID group:
ı Patients who received less than three prescriptions of NSAID
Exclusion: Criteria are chronic renal disease, congestive heart failure and liver disease.
Sample size justification: With a statistical power of 80%, a significance level of 95%, a hypothesised minimal acceptable difference of 25 percentage points (50% well-controlled in non-NSAID group and 25% well-controlled in NSAID group), and assuming that for 4 hypertensive subjects only one is treated chronically with non steroidal anti inflammatory drugs, we should examine about 164 patients in the non-NSAID group and 41 in the NSAID group.
Statistical analysis will be made with a Chi square test for significant difference in blood pressure control between NSAID and non-NSAID groups.

*Conclusion:* This study should determine whether there are clinically significant differences in BP in our patients using COX 2 inhibitors as against NSAID drugs.

*Points for discussion at EGPRN:*
1. Could be of interest to know if there are similar experiences in other European Countries.

PRESENTATION 37: Saturday 13st May, 2006 11.10 – 12.55 h. POSTER Finished Study

TITLE: Simulating a General Practice consultation with virtual patients – Does the Online Assessment Tool produce valid results?

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*Background:* Computer based exams might be an option to assess students' knowledge and skills. The online assessment tool, based on simulated consultations with students acting as GPs assessing and treating virtual patients, provides automatic scores. Since every assessment format tests different aspects of the training – how can these results be validated?

*Research question*: How can test results of a new assessment format in General Practice be validated? Does the online assessment tool produce valid results?

*Method:* Based on "docs'n drugs", an interactive programme for hospital patient simulation, an online assessment tool was developed which allows to test the approach and way students choose to solve a clinical scenario in a General Practice setting. The computer generates scores which are based on peer reviewed ratings for all possible actions and calculated by a case adapted evaluation formula. Since dealing with (virtual) patients might assess different skills and knowledge a triangulation is planned: a correlation with the written exam of the theoretical General Practice course and the scores achieved in the General Practice placement.

*Results:* All (147) students of the General Practice seminar participated in the exam simulation. The results of the online assessment tool show a significant correlation with the scores of the regular General Practice course exam of the end of the term. Results of the General Practice placement are expected to be complete on April 18th 2006 for correlation analyses to be performed.

*Conclusions:* Scores of regular assessment methods might be used to validate the new assessment format of the online assessment tool. Results so far seem to show sufficient validity.

*Points for discussion at EGPRN:*
1. Which skills and knowledge do our General Practice exams assess?
2. Testing validity of new assessment formats – how valid are the "old exams"?

PRESENTATION 38: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h. Work in Progress/Ongoing Study (ongoing struggle!)

TITLE: Learning style and problem solving – is there a cultural difference?

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*Background:* Fifty percent of medical undergraduates in Ireland are of non-EU origin. In any medical class, there is likely to be at least four, if not more, ethnicities present.. These factors have important implications for teachers and students. Anecdotally teachers may report differences in student expectations, class participation or the use of non-structured learning. Using Kolb's Learning Style Invetory we addressed the following questions in a third year medical class, commencing their clinical training:
Is there an association between learning style and ethnicity?
Is there an association between learning style, ethnicity and problem solving ability?
Is there an association between learning style and assesement results?

*Methods:* As part of a module on problem-solving, students were asked to complete Kolb's learning style inventory and given a series of questions on assessment methods. They were then set an MEQ style problem on the assessment of chest pain.
Results were linked to age, gender, nationality, native English speakers and exam results (MCQ, oral, MEQ).

*Results:* Out of a class of 100, 59 students completed the inventory. The predominant learning style was that of thinker (28/59), followed by observers (12/59), feelers (12/59) and doers (7/59). Learning style was not associated with ethnicity.
Learning style was examined in relation to problem solving (i.e. ability to assess chest pain). Interestingly, doers were more likely to have a definite plan of action. They were likely to use diagrams in the approach to problem solving. In contrast, few of the thinkers had any resolution to the problem. They were more likely to have listed key words in their assessment but these were not related to the specific problem. They were also more likely to spend more time on history taking and examination.

*Conclusion:* Within this class there is a range of learning styles represented. There is no association between learning style and ethnicity. These results challenge the idea that international students differ in their approach to learning. It supports Biggs' belief that it is the responsibility of the teacher to develop methods which recognise diversity in learning style.

PRESENTATION 39: Saturday 13st May, 2006 11.10 – 12.55 h. POSTER

TITLE: Process of learning needs assessment and emerging themes in an academic department of family medicine

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*Background:* With the introduction of Evidence Based Medicine practitioners began to question the validity of traditional continuing medical education (CME). Thus, the shift from classical, didactic CME to continuing professional development (CPD) was initiated. The ideal medical education program should be linked with quality and must be built into daily clinical practice and occur at the point of care. It should also be learner focused, addressing the needs of the clinician.

*Aim:* To describe a methodology for identfying seminaire topics of interest as a part of CPD, based on professional learning needs assessment and to identify priorities in resulting themes.

*Research question:* which priority themes emerge as educational needs among members of an academic unit/department for family medicine? Are they mainly practice based or focussed on research?

*Materials and methods:* For this cross-sectional study, 8 (7 females, 1 male, 2 academics, 2 specialists, 4 residents) out of 10 department members took part in a brain storming where they were asked to spontaneously express all professional topics they would be interested to learn/hear more about. After duplications had been removed, the resulting list was categorized and compared with the topics of the previous years in order to add missing topics. All topics on the final version of the list were rated with a 5 point Likert scale (0 "not at all necessary" – 4 "very necessary", range 31-0) by all present department members. All topics ranging ≥60% (=19) of the maximum Likert score were categorized and evaluated.

*Results:* Twenty eight topics reached a score above 60%. The top 20 topics could be categorized as follows: 11 practice based topics including disease and symptom management and care for special groups, 5 research based topics (all in the top10), 1 topic related to principles of family medicine (patient centered care, biopsychoscial and holistic approach), 1 management topic (medical records), 2 preventive care topics (vaccination, periodic health examination/screening).

*Conclusion:* Learning needs assessment among members of an academic family medicine department revealed topics that were practice based and thus, linked to daily clinical practice and, as well matched the six core comptencies of family medicine. Topics related to research methodology and EBM seem to be an emerging educational need as they are prerequisites of modern, effective high quality primary care.
(370 words)

*Relevance to EGPRN:* The authors would like to discuss similar experiences and methodologies applied for learning needs assessment. Is it poosible to establish a network for CPD (continuing professional development) in FM/GP within the EGPRN?

PRESENTATION 40: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h.

TITLE: Is feasible for the GPs to face obesity? A short- term management program.

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*Background:* A Multicenter epidemiological study held by the Greek Working Party on Research, related to risk factors of Cardiovascular disorders to 2,993 adult health users, result that the mean of their BMI was 27.46kg/$m^2$ (sd=4.67), and consequently, they defined as overweight. Weight and obesity are associated with serious medical comorbidities that afflict older people, including hypertension, diabetes, dyslipidemia, and coronary artery disease.

*Research Question:* What is the effectiveness and its impact of GPs' interventions, on weight loss in elderly women, with obesity- related comorbidity?

*Methods:* Among the health users of the Health Center of Chrisupolis, 24 women were selected, mean age 64.42years (sd=2.46), BMI>30kg/$m^2$, and multiple obesity-related comorbid diseases. Participants were enrolled in a 3-month weight loss program, consisted of a baseline assessment by GPs (physical examination, laboratory analyses, a Short-Form 36 Health Survey (SF-36), 6 counselling visits and the follow up visit on completion. Interventions included diet of 1200-1500 kcal, behaviour modification, physical activity (30 mins walking/day) and three times a week, self –monitoring their blood pressure and body weight. In the follow up assessment, the same control was repeated. No alterations had been made on their medication therapies.

*Results:* The difference of the mean body weight loss was 5.31kg [CI: 4.21-6.41 p<0.001], and the mean BMI decreased 2.33kg/$m^2$ [CI: 1.93-2.74, p<0.001]. Considering the other risk factors, hypertension reduced 17mmHg [CI: 13.06-20.94, p<0.001], $HbA_{1c}$ diminished 1.1% [CI: 0.78-1.41, p<0.001] and triglycerides 25.42mg/dl [CI: 13.7-37.13, p<0.001]. No significant differences were observed in the means of total cholesterol. Self-rated physical functioning and feelings (SF-36 subscores) were also significantly improved.

*Conclusions:* It is essential to face obesity as a complex disorder. The intervention in weight loss by GPs, at least on selected obese elderly women, seems to be effective, with the impact on improvement of associated comorbid conditions.
Points for discussion at EGPRN:
1. Barriers of facing obesity in Primary Health Care Units

PRESENTATION 41: Saturday 13st May, 2006 POSTER
11.10 – 12.55 h. Work in Progress/Ongoing Study

TITLE: Diagnostic Delay.

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*Background:* Causes of Delay in the diagnosis of colorectal cancer could be derived from patient conditions and beliefs or from health system doctors and organization. This is a research project with several spanish regions participating on it.

*Objectives:* 1) To describe the diagnostic process of colorectal cancer (CRC) from the onset of the first symptom to diagnosis and treatment. 2) To establish the time interval from initial symptom/s to diagnosis and treatment, globally and considering patient and doctor's delay. Doctor's delay will also be described considering the one due to family physician and thouse atributed to hospital services. 3) Identify the factors related with defined types of delay. 4) To asses the concordance about the onset of the first symptom/s between information included in primary health care and hospital clinical records.

*Design:* Descriptive study, coordinated, with 5 participant groups of 5 different regions. Setting: 5 Health Districts of 5 Spanish Regions 8 hospitals and 180 health centers.

*Subjects:* Incident cases of CRC during the study period. Cases will be identified from hospitals pathology services. A minimum of 896 subjects are necessary for the whole study and a mínimum of 150 subject sfor each participant group.
Information will be collected throug patient inteview, primary health care and hospital clinical records with a questionnaire and a separate card for personal identification data.

*Measurements:* Patient variables (sociodemographic variables, cancer in relatives, comorbidity) about tumor (tumor site, histological type, grade and stage); on symtoms (data of onset, check list of symptoms present at the onset); health system variables (number of contacts with family physician, type of referral, content of the referral, hospital services which attended patient, investigations and results) and different delay intervals (global, patient delay, family physician and hospital delay).

*Points for discussion at EGPRN:*
1. Which is the rol of GP's on cancer diagnosis ?
2. Homogeneity of information from hospital and primary health care clinical records

PRESENTATION 42: Saturday 13st May, 2006 14.40 – 14.50 h.

ONE-SLIDE/FIVE MINUTES
Study proposal / idea

TITLE: Vomiting in primary care, a worrisome symptom?

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*Background:* On the one hand vomiting is a symptom associated with serious disease like myocardial infarction, increased intracranial pressure, but on the other hand in practice it is mostly self-limiting and benign. To our knowledge no studies on the frequency and the clinical outcome of vomiting in primary care have been done.

*Research question:* How frequent is vomiting part of the clinical presentation in primary care? How often is it associated with serious disease?

*Methods:* A small prospective observational study will be done. A group of 10 general practitioners (GP) using electronic patient records agreed to document vomiting and a list of associated symptoms each time patients give a history of vomiting associated with the consultation. Patient will be retrieved by a filter function. The outcome will be assessed for a two month period pragmatically. If the outcome is unknown to the GP, patients will be shortly contacted by the GP.

*Results:* In a small Pilot study 25 from 38 patients' had self-limiting disease. 5 patients consulted repeatedly and one patient was hospitalized for digitalis poisoning, 5 patients were lost to follow up.

*Conclusion:* We expect that vomiting is rather infrequent symptom in primary care and mostly self-limiting and benign due to viral gastroenteritis. Most cases in which vomiting is associated with a serious pathology will be readily recognized by GPs.

*Points for discussion:*
1. Limitations of the pragmatic methodology
2. Estimation of the Denominator, since there is no list system in Germany

PRESENTATION 43: Saturday 13st May, 2006 ONE-SLIDE/FIVE MINUTES
14.50 – 15.00 h.

TITLE: Love disruption affects us.

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*Background:* Love is essential for the beauty of life.
Love disruption by separation, death, divorce- usually lead to mental then to physical diseases, depending on the time in suffering and on each individuality in variable ambient.
Relevant data obtained in this field can help us to understand in deep the power of the loss of the bright thoughts generated by love upon our instability.

*Aim and objectives:* To define the diseases initiated, maintained, accelerated by lack of love, how much it can influence each of them.

*Setting and Methods:* Qualitative prospectiv study for 1- 3 years in 40 GP offices - 7-12 data set registered for each variable-separation, death, divorce.
Death of a person is registered on the list of patients .
Divorces monthly registered for our patients.
Separation is usually known if affected persons solicit from us conselling, drug terapy.
The persons affected by these conditions and selected for the study will be invited monthly for 3 - 6 months after that every three months to an unstructured interview in connection with direct observation of researcher to get some details such as the light of the face, the attitude during conversation .Open ended Questions will be addressed as well.All diseases in evolution for each patient included in the study will be registered.
Data will be statistically analysed and interpreted .
-analysed stratified variables.
-the correlation between variables in the study, mainly between the intensity of suffering from lack of love and diseases stages.

*Conclusion:* We 'll generate a theory about the significance of love disruption for us.
Depression, cardiovascular diseases, diabetes mellitus, thyroid diseases- seem to be more common pathological entities determined, accelerated by lack of love.
Family physician will improve the understanding of the light of the thoughts on the body, preferably as the rise in darkness, for our stability.

PRESENTATION 44: Saturday 13st May, 2006 ONE-SLIDE/FIVE MINUTES
15.00 – 15.10 h.

TITLE: Education strategy for "counselling" intervention in diabetes type 2 treatment in primary care.

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*Background:* The main result of DIAD study ( DIfficulties of ADherence of type 2 diabetics patients), communicated during Tartu Congress, concluded that the major problem in primary care was the bad treatment adherence (chiefly diet and exercise advice adherence more than medication adherence). This study displayed that patients expected more explanation about the disease and advice about treatment. General Practitioners, on the other hand, did not trust the listening for detecting patients difficulties about adherence. A primary care "counselling" intervention C-E-A (based on a Comprehensive centred patient approach, Explanation and Advice) may improve the management of diabetics type 2 treatment. This intervention needs a medical education for GPs.

*Research question:* What is the most effective education strategie to improve GPs knowledge, skill and attitude about "counselling" intervention in type 2 diabetes?

*Method:* Review of literature and French recommendations (ANAES) relating to the effectiveness of education strategies to change GPs performance.

*Results:* The most effective education strategy include practice based intervention, educational outreach visit, reminders and opinion leader ( alone and in combination ). Formal CME and conferences without enabling, interaction or practice based intervention are less effective.

*Conclusion:* A combination of CME intervention to train GPs for "counselling" intervention is proposed to the discussion during the EGPRN Malmö congress: before the study starting, a 2 days session of practice based educational intervention, an outreach visit 3 months after the beginning of inclusion ( made by general practice opinion leader) and "reminders" during all the study duration.

*Points for discussion at EGPRN:*
1. Is the combination of education strategy more relevant than a single choice?
2. Do we know the best cost/effectiveness between each strategy?
3. Have you personal experience of medical education strategy combination?

PRESENTATION 45: Saturday 13st May, 2006 15.10 – 15.20 h. ONE-SLIDE/FIVE MINUTES

TITLE: One-to-one education during the general practice clerkship: two perspectives.

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*Background:* Of all the clerkships during medical training, the clerkship in general practice offers the best circumstances for one-to-one teaching. Theoretically it is a good environment for a gradual increase in responsibilities, for direct feedback after observing the student at work, and for discussing patient reports made by the student. To what extent are these opportunities being used during clerkships at our university?

*Research questions:*
1. How many consultations do students perform (independently)?
2. From the perspective of the GP-trainers and the students:
    a. what is the time spent on and the content of the daily feedback sessions?
    b. how do they judge the written patient report as a teaching instrument?

*Methods:* Descriptive study: 47 students were asked to fill out a one-week logbook about consultation frequencies and feedback sessions with the trainer. 57 students and 63 GP-trainers from previous groups received a postal evaluation form about feedback sessions and written patient reports.

*Results:* Response: student logbook: 43 %, GP questionnaire: 71%, student questionnaire: 51%,
Per day, students do 6 consultations on their own, one of which is observed by the trainer. Three-quarters of the independent consultations are discussed; this happens in-between consultations.
Feedback sessions for which the GP trainer and the students sit down take up 15 minutes per day, on average.
The satisfaction about the patient reports that have to be written by the students was not very high; more so among students than among GP-trainers. Many suggestions for enhancement of the format of these reports were given.

*Conclusion:* Students see enough patients on their own, but the feedback about their work is insufficient. All independently performed consultations should be discussed with the trainer, and more time should be spent on feedback sessions. Regarding the patient reports: we must change the format and then re-evaluate this teaching instrument.

*Points for discussion:* Little has been published on time reserved for giving feedback during clerkships, making comparison with other undergraduate programmes difficult. What is considered sufficient at your faculty? And is that time indeed being spent by the trainers?

Many students at our faculty complain about writing (and discussing) patient reports (one or two pages about the diagnostic process of a patient they have just seen), feeling that they do not contribute to their learning process. We are not sure whether this is a generic type of complaint, or whether there is really little effect of this teaching instrument. Except for

measuring the effect on student satisfaction after changing it’s format, it would be interesting to find another way of evaluating the patient report’s effectiveness. I would like suggestions on this topic.

PRESENTATION 46: Saturday 13st May, 2006 15.20 – 15.30 h. ONE-SLIDE/FIVE MINUTES Finished Study

TITLE: Evaluation of an Undergraduate History Taking Course.

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*Background:* It is known that the quality of physician-patient relationship influences the patient satisfaction and compliance. Teaching history taking with an emphasis on patient centered approach and skill education methods could be a fruitful way to increase this quality.

*Research question:* How effective is a competency-based, 6 session *History Taking and Introduction to The Physical Examination Course (HxPhx)* in teaching history taking at undergraduate level?

*Method:* HxPhx course, aims to develop a patient-centered approach by integrating *Communication Skills* and *History Taking* courses to demonstrate effective interpersonal skills and apply the outline of medical interview in the second year of Marmara Medical School undergraduate curriculum. The educational methods used during the course are short lectures on the core content, small group discussions with facilitators, role plays, simulated/standardized patient exercises, videotaping. A 30 item questionnaire, consisting 5 subscales (Patient centered approach–PCA, biopsychosocial approach- BPSA, Communication skills-CS, Difficult topics–DT, Competency–C), was formed by 4 lecturers to evaluate the effectiveness of the course. Students scored this questionnaire according to a 5 point Likert scale before and after HxPhx course. The questionnaire results were analyzed using paired samples t-test and also a reliability analysis was performed.

*Results:* 153 students (female 82; %53.6), scored pre-course and 168 students (female: 80; %47.2) post-course evaluations. There was an increase in the mean subscale scores of the post course evaluation except for DT. BPSA, PCA, C pre- (23.66±3.49, 27.16±3.48 and 13.82±2.71 respectively) and post-course (25.14±3.35, 28.96± 3.75 and 14.81±2.75 respectively) mean score differences were statistically significant ($p<0.002$). A non-significant increase in the CS subscale mean score ($p=0.058$). Cronbach's alpha was found as 0.70 for the pre-course and 0.81 for the post-course evaluation.

*Conclusions:* There are few known applications for effective teaching of physician skills with humanism. A course aiming to teach history taking, that has the characteristics described in the method section, seems to be able to reach the target of building competency in patient centered approach within the concept of biopsychosocial model.

*Points for discussion at EGPRN:*
1. What are the possible methods to evaluate the effectiveness of such a course?
2. Are the assessment methods used in the study valid and reliable?
3. What could be done to improve the quality of the course for the realization of the teaching objectives?

4.

PRESENTATION 47: Saturday 13st May, 2006 THEME PAPER
16.00 – 16.30 h. Work in Progress/Ongoing Study

TITLE: Education in problem solving skills; outcome of the problem solving treatment (pstj) project amsterdam.

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*Background:* Patients suffering from psychological problems are frequent attenders in general practice. Problem Solving Treatment (PST) is an effective brief psychological treatment tailored for use in primary care and educates these attenders problem solving skills. Earlier research in the UK showed PST can be delivered by suitable trained nurses as effectively as by GPs for patients suffering from a major depression. This paper describes the outcome of a randomised clinical trial on the educational effects of PST provided by nurses on frequent attenders in general practice.

*Research question*: To what extent can nurses teach problem solving successfully to frequently attending patients suffering from psychological problems?

*Method:* A total of 125 patients of 18 years and older, who presented psychological problems and were frequent attenders in general practice (at least three visits in the last six months) were recruited. These patients were randomly assigned to the PST condition (N=58) or care as usual group (N=67). In the PST group the patients received four to six PST treatment sessions within twelve weeks. Successful education in problem solving by patients was measured by the Social Problem Solving Inventory -Revised (SPSI-R) before and after the intervention. The SPSI-R is a reliable, validated and self-rated scale to measure different components of problem-solving skills.

*Results*: There is an improvement in the total score of problem solving skills for the experimental group. The scores on multidimensional scales of the SPSI-R will be presented, as well as the relationship with psychological disorders.

*Conclusions*: Our results support earlier research, which showed frequent attenders with psychological problems can learn PST skills from nurses. Patients' problem solving skills improved during the time of the trial.

*Points for discussion*:

1. From an earlier study about PST given to patients with emotional disorders 30% remained having problems after six months. We included patients after six months of suffering of psychological problems. What could be an alternative explanation for the progression in problem solving skills or decline of psychological problems? What does this mean for research in the general practice?
2. The SPSI-R is a quantitative self-report questionnaire designed for measuring problem solving skills of patients. Specific skills have improved, demonstrated in this

trial. To further evaluate the project we require more information. Can qualitative data be of meaning in this research and which method would be required?

PRESENTATION 48: Saturday 13st May, 2006 — 16.30 – 17.00 h.

FREESTANDING PAPER
Work in Progress/Ongoing Study

TITLE: Study of the Follow-up by the General practitioner of the Children of Separated Parents.

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*Context:* In Belgium, 600.000 children are experiencing separation of their parents and grow up in alternated guard, with a single-parent or in a recomposed family. The general practitioners are therefore confronted with the medical or psychological problems particularly to these young patients. While certain authors observe that these children do not develop any particular disorder, many works describe parental separation as an experiment with traumatic risk and possibility of disorder of adaptation for the young person in the waning of the divorce.

*Objectives and method of research:* This qualitative research in “focus-groups” with analysis assisted by software (QSR N5), aims to establish a first inventory of the consequences of the divorce for the child revealed in 1st line and the professional implications for the family practitioner. This has never been the subject of a study so far. One of the objectives was also to propose recommendations usable in general practice.

*Results:* Between September 2004 and September 2005, we analyzed 242 cases of divorce touching children age 0 to 15, reported by 120 general practitioners from cities of Brussels and Mons. Our study reveals the following elements:

1. Children of separated parents risk psychological disorders, school difficulties, somatoform or of behavioural problems and difficulties related to the management of their physical health.
2. The conflicts between the parents after separation are a factor of major risk of disorders for the child and present difficulties of follow-up for the general practitioner.
3. The environment of the child after the separation and in particular the type of guard also influence the evolution of the young patient.
4. The main professional difficulties for the general practitioner are the fact “of being used” by the families with its corollaries, as well as the parcelling out of the medical follow-up.
5. Certain attitudes of the general practitioner are likely to influence positively the evolution of these children:
   - To inform the parents on the risks for the children in the continuations of a parental separation as well as the factors on worsening such as the chronic exposure to the conflict.
   - To propose the choice of only one general practitioner and in the event of parcelling out of the follow-up, to communicate the files between doctors if possible.
   - To diagnose the conflict by actively collecting the necessary information.
   - To avoid being “used” by the parents.
   - If possible, to restore a communication between the divorced parents in conflict.
   - To listen to the complaint of the child while directly talking to him.
   - To support the child psychologically .
   - To refer the child towards other useful lines of care.

- To listen to the complaint of the parents and to support them psychologically if necessary.

*Conclusions:* This study made it possible to produce a first argued inventory of problems concerning the children experiencing a parental separation that are observable in practice of 1st line. If our results do not have any statistics, they however support the international literature and moreover imply a relatively important prevalence as expected in primary care. The particular difficulties encountered by the general practitioner could be objectified. Certain professionnal recommendations could also be established. This exploratory study could be used as a basis for later quantified studies.

PRESENTATION 49: Saturday 13st May, 2006 17.00 – 17.30 h. FREESTANDING PAPER

TITLE: Is there a specificity regarding young occasional marijuana smokers?

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*Background:* Marijuana is commonly used by young people, especially in France. However it is uncertain if this drug causes immediate harm and what the appropriate prevention message is.

*Research questions:* What are characteristics of young (12 to 19 years old) occasional marijuana smokers compared to regular users or non users? Is there a link between marijuana and tobacco consumption?

*Methods:* Data from the representative European study ESPAD 2003 were used: 16 934 French youngsters filled out questionnaires on substances consumption (tobacco, marijuana, alcohol and others), habits psychopathology, sociodemographics, school, and neighbourhood relationship quality. Uni- and multivariate analyses (chi-square, logistic regressions) were performed with SAS 8.2 software.

*Results:* At 18 years, 60% of the young people had tried marijuana and 80% tobacco. The average age of marijuana initiation was 14,5 (girls) and 14 years old (boys).
Even occasional tobacco smoking increased the risk to have tried marijuana (OR: 8,7 95% CI [7,5-10,1], adjusted for age, gender and alcohol consumption). Occasional users of marijuana substances showed significantly more risk-markers than non-users. For example, the OR of suicide attempt is 2.93 [2.5-3.5] for occasional compared to non users of marijuana; and (1.29 [1.03-1.61]) comparing regular and occasional users. Concerning multiple acts of violences, the OR is 7.47 [6.5-9.0] for occasional compared to non users of marijuana; and 2.6 [2.0-3.3] comparing regular and occasional users.
Smokers of both substances seemed to be worse off than users of a single substance.

*Conclusion:* The profile of occasional marijuana users is closer to that of regular users than to that of non-users. These results warn against underestimating the risks associated with marijuana consumption, even occasionally.

*Points for discussion at EGPRN:*

- Does occasionally smoking marijuana justify to be a warning message in general practice?
- If yes, is a prevention programme effective and feasible?

| PRESENTATION 50: | Saturday 13st May, 2006<br>16.00 – 16.30 h. | THEME PAPER |
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TITLE: Can Action Science provide some insight in the behaviour of doctors and enhance their education?

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*Background:* The adoption of behaviour by doctors when relating to patients and how they are modified through experience remain unanswered. This work intend to test if Action Science and its constructs theory declared and theory in action , is able to contribute to respond to these questions.

*Research Question(s):* Can the theory in action of doctors about the relation with the patient be identified and can it represent the behaviour of doctors in a helpful and understandable way?

What are the consequences of the content of the theory on the methodology of doctor's education

*Methods:* We observed and recorded 30-40 consultations from ten family doctors. We inferred their theory on action using qualitative methodology based on "grounded theory" and following the ideas and indications from Argyris and Schon´s theories of action. The propositions of the theory in action were described and the possible use of the theory in doctor education examined

*Results and Conclusions:* A number of strategies to explain coherently the main components of doctor behaviour and its "governing variables" could be defined for all doctors. The strategies may be considered to be a representation of personal knowledge (Eraut) and the format in which experience is incorporated. The theory in action of the doctors suggest that there the content and methodology of the education in doctor-patient relationship should be reconsidered. The methodology of education should made doctors define and discuss their theory of action. The "governing variables" can be an instrument to clarify the real motivations of doctors.

*Points for discussion at EGPRN:*
1. Is theory in action a way to represent the doctors' behaviour in an valid way?
2. Is the development of self-awareness in doctor's theory in action an essential educational methodology?
3. Can theory in action be related to the idea of personal knowledge and experiential learning?

PRESENTATION 51: Saturday 13st May, 2006 16.30 – 17.00 h. FREESTANDING PAPER Finished Study

TITLE: Difficult asthma patients in general practice: suboptimal treatment combined with low burden of illness

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*Background:* Many surveys are pointing out to a large amount of under-treated patients with asthma. However, the reason why many patients seem to tolerate suffering from suboptimal treated asthma remains unclear.

*Research questions:* Is it possible to develop a profile of patients at risk? What is the impact of guideline adherence on quality of life of patients with asthma?

*Methods:* 256 asthma patients from 43 primary care practices in Saxony-Anhalt filled in a questionnaire including the Asthma Quality of Life Questionnaire (AQLQ), the Patient Health Questionnaire (PHQ-D) and questions evaluating the asthma severity, medication and self-management.

*Results:* 43.4% suffered from moderate to severe asthma. Drug treatment accorded to guidelines in 36.9%, drug dosage of inhaled steroids was too low in 34.3%, 21.5% were not treated according to guidelines. 7.3% of the patients received end-of-dose therapy. AQLQ declined and depression rose with asthma severity and guideline non-adherence ($p<0.001$). Only 29.1% received asthma education. However, 64.5% of the patients without education did not want to receive education. They had a higher quality of life, lower depression ($p<0.001$) and lower use of steroids ($p=0.016$). Higher depression scores where related with hospital admission (OR 3.29; 95% CI 1.57 to 6.87 for each quartile of PHQ-D) and unscheduled home visits or ambulatory care (OR 1.58; 1.07 to 2.33).

*Conclusions:* There is a large variation of asthma severity which can partly be explained by the guideline adherence of medication and deficits of patients´ management. The perceived burden of illness plays a more important role for education and self-management than the real severity of disease. Therefore, target-oriented interventions are needed to identify and motivate patients at risk for treatment adherence.

*Points for discussion:*
1. Why are so many patients suffering from moderate to severe asthma despite receiving inhaled
   steroids?
2. Is the state of the disease really reflected by the asthma steps or is it some kind of arbitrary
   classification?
3. Is it really possible to achieve the goals set by the guidelines?

PRESENTATION 52: Saturday 13st May, 2006 FREESTANDING PAPER
17.00 – 17.30 h.

TITLE: Implementing the evidence: is it self-evident ?
Quality improvement project: application of the WVVH-guideline "Prevention of Influenza"

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*Background:* Yearly influenza vaccination is recommended for groups at risk. A systematic approach yields better results than an opportunistic one. Last year, our general group practice reached a vaccination coverage of 55% in diabetics and people older than 65. This is far beneath the WHO target of 75%, recommended in response to the avian influenza pandemic threat.

*Research questions:*
1. Can we incline the influenza vaccination coverage in groups at risk by implementation of the WVVH-guideline "Prevention of Influenza" (Flemish Scientific Association of General Practioners)?
2. Which practical difficulties do gp's deal with implementing this guideline?
3. Why do our patients refuse influenza vaccination?

*Methods:*
1. The statistical program (StatDPro®) of our electronic medical record (Medidoc®) selected groups at risk, based on the ICD-10 codes. In the family paper file of this groups, a prescription for vaccination was added. Meantime, influenza vaccination was planned in the electronic record as a reminder at 15-10-05. Every selected patient not yet vaccinated at 15-11-05 received a letter at home, in which we adviced influenza vaccination or asked reasons for refusal.
2. All colleagues' practical difficulties were discussed with and registered by the gp researcher.
3. Every gp discussed and registered the reasons for patient refusal.

*Results:*
1. Influenza vaccination coverage and refusal: total intervention group: 394/485 (81,2%) and refusal 38/485 (7,9%), >65 : 274/335 (81.8%) and 30/335 (9,0%), diabetics 87/100 (87%) and 1/100 (1%).
2. Practical difficulties: time consuming, selection of groups at risk, inter-registrator confounding, bug in electronic medical record.
3. Patient's barriers: bad experience, unconvinced of advantages, use of complementary medicine.

*Conclusion:* Implementation of the WVVH-guideline "Prevention of Influenza" is effective to incline vaccination coverage in groups at risk, but is time consuming and requires good electronical skills.
Our patient's barriers correlate with the international knowledge about this subject.

*Points of discussion:*
What can be done to facilitate the implementation of this guideline at level of:
1. the electronical medical record?
2. the gp?
3. the authoritities?