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European General Practice Research Network

Nijmegen – The Netherlands

10th – 13th May, 2007

SCIENTIFIC and SOCIAL PROGRAMME

THEME: Gender Matters!
(in general practice research, education, and health care)

Pre-Conference Workshops
Theme Papers
Freestanding Papers
One slide/Five minutes Presentations
Posters

Place
UMC St Radboud
Geert Grooteplein Noord 15
6525 EZ Nijmegen – The Netherlands

This EGPRN-meeting in Nijmegen-The Netherlands has been made possible through contributions of the following sponsors:

-

City of Nijmegen, The Netherlands
-

N.H.G., the Dutch College of General Practitioners
- **K.N.A.W., the Royal Netherlands Academy of Arts and Sciences**

The meeting is co-hosted by:

- **Dept. of General Practice, UMC St. Radboud Nijmegen**
- **N.H.G., the Dutch College of General Practitioners**
- **City of Nijmegen, The Netherlands**

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.

"GENDER MATTERS !" (in general practice research, education and health care)

Dear friends and colleagues,

The Department of General Practice of UMC St Radboud in Nijmegen, the Dutch College of General Practitioners (NHG) and the Dutch EGPRN members have the great honour to invite you to the EGPRN Spring Meeting 2007. We welcome all EGPRN members and other interested primary care researchers, to this invigorating event. Our motto is: *'Gender matters!'*. The city of Nijmegen, the oldest city in The Netherlands, is delighted to host this meeting.

The conference will focus on three major themes:

A Male/Female in health, morbidity and daily practice

Many studies have reported that physicians investigate and treat women differently from men without evidence-based reasons. In daily practice there seems to be little attention to sex differences in risk factors, course of disease, clinical decision making, diagnostic investigations, treatment, drug treatment, and side effects. Furthermore, there are relevant differences in the ways male and female patients and doctors communicate, and this can influence the patient's satisfaction and compliance with therapy. *We invite you to submit your work on clinical topics, like sex differences in morbidity, diagnostic end treatment decisions, use of health services, and approach of preventive measures, but also on topics like sex differences in communication or the specific vulnerability of women to violence and sexual harassment.*

B Male/Female and the medical profession

Medicine and health care are structured and organized by gender and the gender order: male and female doctors work in different sectors of the profession. Women cluster in fewer fields than men (horizontal segregation) partly due to the difference in status among medical specialties. The proportion of women in family medicine in Europe will increase to more than 50%. At the same time the proportion of women in senior positions in Europe is lower than expected in relation to the number of women in medicine: men are over represented in positions with more status, power and income (vertical segregation). Also in academic medicine women are largely under represented in top positions ('glass ceiling'). *We encourage you to present your research in this field, e.g. on the process of 'feminization' of general practice, ways to facilitate career chances of female GPs etcetera.*

C Male/Female and medical education

During the last decades research has disclosed gender differences and gender bias in different fields of academic and clinical medicine. Consequently, a gender perspective has been asked for in medical curricula and medical education including vocational training of general practitioners. Several international studies on gender and medical education have indicated that gender influences the way medical students acquire skills, gain knowledge, experience tutoring and think about cooperation and ethical issues. Since medical school not only is the breeding ground for medical knowledge but also for professional development, the attitude of teaching physicians towards the role of gender in professional relations is very important. Awareness of gender issues and regarding these important is an attitude that will lower the risk of gender discrimination and sexual harassment. *We invite you to present your studies on teaching 'gender sensitive medicine' to our medical students and GP trainees.*

Like always, we also provide the opportunity to present research on other topics. Nijmegen - the city of the medieval tale of *Mariken* (f) who stood up against the devil (m) – welcomes GPs and other primary care researchers, male and female, to share experiences in a challenging but friendly atmosphere, in an old and historical city where *Frans Huygen* founded one of the first academic departments of family medicine in The Netherlands. We are certain you will enjoy the highly accessible venues, the nice city, the scientific and social program, and the research workshops of this highly relevant meeting.

We look forward to meeting you in Nijmegen !

Dr. Harm van Marwijk,
EGPRN National Representative for The Netherlands

Prof. Dr. Toine Lagro-Janssen,
professor of Women Studies Medical Sciences and Chair of the NHG working party 'Women and General Practice'

MEETING EXECUTIVE BOARD

GENERAL COUNCIL MEETING

Executive Boardmeeting
Thursday 10th May, 2007

09.30 - 10.00: Welcome and Coffee for Executive Board
10.00 - 12.30: Executive Board members

(location : Conference Venue Holthurnsche Hof, Berg en Dal – Nijmegen)

General Council meeting with the National Representatives
Thursday 10th May, 2007

14.00 - 17.00 : Executive Board members and National Representatives

(location : Conference Venue Holthurnsche Hof, Berg en Dal – Nijmegen)

REGISTRATION

► Thursday 10 May 2007

REGISTRATION FOR PARTICIPANTS OF PRE-CONFERENCE WORKSHOPS ONLY

Location: **Conference Venue Landgoed Holthurnsche Hof**
Address: Berg en Dal, Nijmegen-The Netherlands

On arrival, every participant pays €25,= per person for each pre-conference workshop

► Friday 11 May 2007

REGISTRATION FOR ALL PARTICIPANTS

Time: **08.00 – 08.30 h.**

Location: **UMC St Radboud**
Geert Grooteplein Noord 15
Nijmegen

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

For non-EGPRN-members:
The following payments are requested:

► **EGPRN Membership fee for 1 year 80 € or congress fee 50 €**
- Eastern European countries: 35 or 20 €
- WONCA direct members: 40 or 25 €

FOR ALL EGPRN PARTICIPANTS

Social night on Saturday 12th May 2007
(Dinner, speeches and dance, music with DJ Bram Wilders)
at the UMC St Radboud 'Huize Heyendael' : €40,=

Please address to EGPRN Registration Desk.

Unfortunately, we have **NO** facility for electronic payments (credit card, Maestro). We only accept **EUROS**.
We do **NOT** prefer pay cheques, given the extra costs. If you have no other option we will charge € 20 extra.

E G P R N 10th – 13th MAY, 2007

PROGRAMME OF THE EUROPEAN GENERAL PRACTICE RESEARCH NETWORK IN NIJMEGEN–THE NETHERLANDS

THURSDAY 10th MAY, 2007:

Location : **Conference Venue Landgoed Holthurnsche Hof**
Address: Berg en Dal, Nijmegen-The Netherlands

09.30 - 12.30 : **Executive Board Meeting**
(only for Executive Board Members)

10.00 - 12.30 : **Pre-Conference Workshops (only for participants who have registered beforehand)**
10.00 – 12.30 : **1 EGPRN Pre-Conference Morning Workshop** (€25 each p.p.)

"Rethinking clinical practice guidelines delivered to general practitioners"
Chairs: Luc Martinez (France) and Christos Lionis (Greece)

12.30 – 13.30 : **Lunch (price not included in fee pre-conference workshops)**

13.30 – 16.00 : **4 EGPRN Pre-Conference Afternoon Workshops** (€25 each p.p.)
Parallel workshops:

"Qualitative Research/Focus Group in Action"
Chairs: Petra Verdonk en Peter Lucassen (The Netherlands)

"Sex and Gender in Epidemiological Analyses"
Chairs: Joke Haafkens and Jan van Lieshout (The Netherlands)

"Searching the literature using a Gender Filter"
Chair: Marjolein Berger (The Netherlands)

"Open Research Market-Marketplace for Research Proposals"
Chairs: Pinar Topsever (Turkey) and Christos Lionis (Greece)

14.00 - 17.00 : **EGPRN General Council Meeting.**
Meeting of the Executive Board Members with National Representatives (only for Council Members).

Social Program: **For ALL EGPRN-participants of this meeting who are present in Nijmegen at this time. (Entrance Free)**
18.00 – 19.30 : **Welcome Reception for all participants at Nijmegen City Hall.**
Speakers:
- **Prof. Dr. Patrick Bindels, of the Dutch College of General Practitioners (NHG), and**
- **Drs. Thom de Graaf, Mayor of the City of Nijmegen.**

FRIDAY 11th MAY, 2007:

Location: UMC St Radboud - Auditorium
Address: Geert Grooteplein Noord 15, Nijmegen

08.00 - 08.30 : Registration at EGPRN Registration Desk.

08.30 - 08.50 : Welcome.
Opening of the EGPRN-meeting by the Chairman of the EGPRN, Prof. Dr. Paul van Royen.

08.50 - 09.10: 1st Keynote Speaker Prof. Dr. Chris van Weel, The Netherlands.
Theme: "Research in general practice in the Netherlands."

09.10 – 09.30: 2nd Keynote Speaker Prof. Susan Phillips, Canada.
Theme: "Gender in medical education".

09.30 – 10.30 : 2 Theme Papers

1. **Sylvie Lo Fo Wong (The Netherlands)**
   Abused women's views on disclosure of partner abuse and its influence on handling the abuse situation.

2. **Iris Nijrolder (The Netherlands)**
   Gender-specific baseline characteristics of patients presenting with a new episode of fatigue.

10.30 - 11.00 : Coffee Break

11.00 – 12.30 : 3 Theme Papers

3. **Jean Yves Le Reste (France)**
   Women GP of the finistere (West Brittany) in 2005. Conciliation between private and professional life.

4. **Gunilla Risberg (Sweden)**
   How can we implement a gender perspective into medical education? An overview study among men with influence on medical education in Sweden.

5. **Shlomo Vinker (Israel)**
   Gender differences in quality indicators of medical care – a change or a pattern, results from the quality indicators program in our district

12.30 - 14.00 : Lunch

After lunch, the meeting continues with parallel sessions till 17.20 h.

14.00 – 16.00 : A. Parallel session 4 Freestanding Papers 'Clinical'
in: Auditorium

6. **Berend Terluin (The Netherlands)**
Teaching a minimal intervention for stress-related mental disorders to gen.practitioners: effects on sick-leave duration in distressed patients.

7. **Marinda Spies-Dorgelo (The Netherlands)**
Hand and wrist problems in primary care: characteristics and determinants of severity of the problem.

8. **Daniela Kempkens (Germany)**
Perceived obstacles to the delivery of services to people with depressive symptoms. Preliminary results from the German segment of an international study.

9. **Annette Becker (Germany)**
Evaluation of two guideline implementation strategies, effects on patient outcomes. A cluster randomised controlled trial.

14.00 – 16.00 : B. Parallel session 4 Freestanding Papers 'Miscellaneous'
in room: Laënnec E/F

10. **Karin van Rosmalen-Nooijens (The Netherlands)**
Lesbian sexual problems unraggeled.

11. **Jean-Pierre Aubert (France)**
Screening for diabetic retinopathy: the first telemedical approach in a primary care setting in France (DODIA study).

12. **Sita Nys (The Netherlands)**
Diagnostic tests and antimicrobial susceptibility of uropathogens in boys and girls with UTI in The Netherlands.

13. **Nettie Blankenstein (The Netherlands)**
Lasagna's law: determinants of unsuccessful and successful patient recruitment for research in general practice.

16.00 – 16.20 : Coffee/Tea Break

16.20 – 17.20 : C. Parallel session 2 Theme Papers 'Obesity and Nutrition'
in: Auditorium

14. **Denis Pouchain (France)**
Prevalence of abdominal obesity in primary care in France: results of ORNICAR transversal study.

15. Imre Rurik (Hungary)
Nutritional differences between elderly men and women.

16.20 – 17.20 : D. Parallel session 2 Theme Papers 'Elderly'
in room: Laënnec E/F

16. Tineke van Geel (The Netherlands)
Fractures cluster in time: timing of a previous fracture is the most important risk factor for fractures among postmenopausal women.

17. Doreth Teunissen (The Netherlands)
'It can always happen': the impact of urinary incontinence on elderly men and women.

17.20 – 17.40 : **Plenary Session in Auditorium.**
Closing of the day by Prof. Susan Phillips, keynote speaker, who will Summarize today's theme papers.

18.00 – 19.00 : **Meeting of EGPRN Working Groups**
- **Research Strategy Committee**
- **Electronic Website Committee**
- **Educational Committee**

Location: **Practice of Prof. Toine Lagro-Janssen, Groesbeekseweg 12, Nijmegen (nearby Keizer Karelplein, opposite of Concerthall 'De Vereniging'.**
Meeting point: **Outside the conference location colleagues will be waiting for you.**

Social Programme :

18.00 – 19.30 : **Practice Visits to local Health Centres in and around Nijmegen.**
Meeting point: **Outside the conference location colleagues will be waiting for you.**

SATURDAY 12th MAY, 2007:

Location: UMC St Radboud - Auditorium
Address: Geert Grooteplein Noord 15, Nijmegen

08.45 – 09.05: **3rd Keynote Speaker Prof. Dr. Toine Lagro-Janssen, The Netherlands.**
Theme: "Research in Gender and Medicine".

09.05 – 09.25: **4th Keynote Speaker Prof. Dr. Joke Denekens, Belgium.**
Theme: "Gender in daily practice".

09.30 – 11.00 : E. Parallel session 3 Theme Papers 'Violence, Hypertention, COPD'
in: Auditorium

18. Kristof Hillemans (Belgium)
Domestic violence: What is in Pandora's box?

19. Pemra Unalan (Turkey)
Hypertension in school adolescents.

20. Tiny van Merode (The Netherlands)
Gender specific differences in complaints in mild to moderate COPD patients in general practice.

09.30 – 11.00 : F. Parallel session 3 Freestanding Papers 'Miscellaneous'
in room: Laënnec E/F

21. Marc Frarier (France)
One-year-follow-up of acceptability and compliance to semi-rigid hip protectors in the community.

22. Patrick Dielissen (The Netherlands)
Gender awareness in general practitioners' vocational training.

23. Frances Griffiths (United Kingdom)
How do general practitioners diagnose coronary heart disease: a German/UK collaborative study.

11.00 - 11.20 : **Coffee Break**

11.20 – 13.00 : **Posters**
In seven parallel sessions (7 groups)

11.20 – 13.00: **Parallel group 1: 6 Posters Theme (1)**

24. Katinka Dirken-Heukensfeldt Jansen (The Netherlands)
Women have gout too.

25. **Erik Bischoff (The Netherlands)**
Women with low socioeconomic status deserve specific attention in preventing and managing COPD.

26. **Amanda Howe (United Kingdom)**
How do the early career aspirations of medical students differ between male and female students?

27. **Marianne Schoevers (The Netherlands)**
Evaluating patient-held records for female undocumented immigrants.

28. **Janez Rifel (Slovenia)**
Demographic differences between detected and undetected patients with depression or anxiety in primary care in Slovenia.

29. **Helena Galina Nielsen (Denmark)**
How do GPs benefit from supervision?

11.20 – 13.00 : Parallel group 2: 6 Posters Theme (2)

30. **Maria van den Muijsenbergh (The Netherlands)**
Sexual harassment of medical students during their clerkships.

31. **Nicole Jaunin-Stalder (Switzerland)**
Gender changes: consequences for Switzerland.

32. **Peter Torzsa (Hungary)**
Health status, health behaviour, gender differences and sleeo of Hungarian general practitioners.

33. **Maren Abu Hani (Germany)**
Chest pain in general practice – are there gender differences?

34. **Witold Lukas (Poland)**
Adherence to self-care recommendations among men and women targeted for the primary prevention of initial coronary/cardiovascular events.

35. **Selcuk Mistik (Turkey)**
Medical students' gender-specific examination performance: clinical skills of future general practice residents is insufficient.

11.20 – 13.00 : Parallel group 3: 6 Posters Theme (3)

36. **Barbara Lent (Canada)**
If, when and how to ask the question(s): assessing screening approaches to identify women abuse in health care settings.

37. **Pemra Unalan (Turkey)**
Gender in procedural skills learning.

38. Marijke Botden (The Netherlands)
How do GP trainees evaluate a gender specific programme.

39. Yvonne Winants (The Netherlands)
Gender specific analysis of the development over time of burnout among general practitioners.

40. Thomas O'Dowd (Ireland)
A general practice experiment in addressing men's health.

11.20 – 13.00: Parallel group 4: 6 Posters 'Clinical'

41. Primož Kušar (Slovenia)
Influences on doctor's decision for antibiotic treatment of acute upper respiratory tract infection.

42. Djurdjica Lazic (Croatia)
Chronic diseases multimorbidity in GP population over ten year's period.

43. Johannes Hauswaldt (Germany)
'Something doesn't fit here!' Sensation of alarm in clinical decision making.

44. Jeanet Blom (The Netherlands)
Migraine patients' wish for prophylaxis.

45. Marinda Spies (The Netherlands)
Impact of physical symptoms on perceived health in the community.

46. Nelly Jäger (Germany)
Attitude and practice of case managers in German general practices – a qualitative study.

11.20 – 13.00 : Parallel group 5: 6 Posters 'Methods'

47. Martin Scherer (Germany)
Opinions on registering trial details: a survey of academic researchers.

48. Marco Clerici (Italy)
The palliative care service in the opinion of caregivers.

49. Carsten Kruschinski (Germany)
Expectations and needs of elderly dizzy patients in general practice.

50. Maaike Lange (Germany)
EGPRN abstracts June 2001-May 2006 Content and study design.

51. **Andreas Eberbach (Germany)**
Evidence-based medicine: quick and dirty. A randomised controlled trial evaluating acceptance and efficacy.

52. **Yie-Man Chong and Jill Devriese (Belgium)**
Living with diabetes: How can we get insight in a complex reality.

11.20 - 13.00 : **Parallel group 6: Discussion session (1)**
in room: Laënnec E/F

53. **Chair: Hendrik van den Bussche (Germany)**
Discussion on: Consequences of the 'feminization' of medicine for the supply of family physicians in national health systems.

11.20 - 13.00 : **Parallel group 7: Discussion session (2)**
in: Auditorium

54. **Chair: Zaida Azeredo (Portugal)**
Discussion on: Collaborative Studies: From obstacles to strategies.

13.00 – 14.15 : **Lunch**

14.15 - 14.45 : **●● Chairman's report by Prof. Paul van Royen : Report of Executive Board and Council Meeting.**

●● Introduction on the next EGPRN-meeting in Vilnius-Lithuania by the Lithuanian national representative.

14.45 – 15.35 : **One-Slide/Five Minutes Presentations in 2 parallel sessions**

14.45 – 15.35: **Parallel group One-slide/five minutes presentations 1**
in: Auditorium

55. **Virginie Lebas Gilles (France)**
Caregivers for old dependent people: how many are depressed when patients are at home or in an institution?

56. **Caroline Huas (France)**
Are GPs concerned about adolescent cannabis use?

57. **Radost Asenova (Bulgaria)**
Interprofessional collaboration. A pilot study and proposal for international survey.

58. **Erik Stolper (The Netherlands)**
Research into GP's non-analytical decision-making process.

59. **Maria Luisa Agnolio (Italy)**
Female and male GPs feeling about criticisms in their practice during their work life.

14.45 – 15.35: **Parallel group One-slide/five minutes presentations 2**
in room: Laënnec E/F

60. Attila Altiner (Germany)
How can we evaluate the appropriateness of cardiovascular prevention therapy in general practice?

61. Mette Marie Koefoed (Denmark)
Improving general practitioners' care for COPD patients by an intervention program using computerised checklists and feedback.

62. Vaidile Strazdiene (Lithuania)
Evaluation of CV diseases development risk according to gender.

63. Imre Rurik (Hungary)
Does the doctor's illness influence his/her behaviour towards the patients suffering from the same illness?

64. Christophe Attencourt (France)
Gender in instant aging system.

15.35 – 15.50 : **Coffee/Tea Break**

15.50 – 17.20 : **3 Theme Papers**
in: Auditorium

65. Jean-Francois Chenot (Germany)
Gender differences in presentation and management of low back pain in primary care.

66. Monika Peitz (Germany)
Gender aspects in symptoms and treatment of patients with major depression in primary health care.

67. Martina Kelly (Ireland)
Screen sirens: teaching gender issues using film in medical undergraduate education.

17.20 – 17.50 : **Plenary Session.**

- **Closing of the day by Prof. Joke Denekens, keynote speaker, who will summarize today's theme papers.**
- **Presentation of the EGPRN Poster prize by Dr. Harm van Marwijk, Dutch national representative.**
- **Closing of the conference by Prof. Christos Lionis, EGPRN vice-chairperson.**

Social Program :

20.00 - : **Social Night**
Dinner, speeches and dance! with D.J. Bram Wilders
Entrance fee: Euro 40,= per person.
Location: **UMC St Radboud, 'Huize Heyendael'**

SUNDAY 13th MAY, 2007:

Location: **The Belvoir Hotel**
Graadt van Roggenstraat 101, Nijmegen.

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

PRESENTATION 1: Friday 11th May, 2007 THEME PAPER
09.30 – 10.00 h.

TITLE: Abused women's views on disclosure of partner abuse and its influence on handling the abuse situation.

AUTHOR(S): Sylvie Lo Fo Wong, Fred Wester, Saskia Mol, Renée Römkens
Toine Lagro-Janssen

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Background:
Female patients, abused by an intimate partner, visit their family doctor more often than non-abused women. Both family doctor and abused women experience barriers in discussing the abuse. Asking about abuse, leads to an increase of disclosures. (Lo Fo Wong SH, Wester F, Mol SSL, Lagro-Janssen ALM. Increased awareness of intimate partner abuse after training. A randomised controlled trial. BJGP 2006;56(525):249-57.)

Research question:
What do women value most in disclosing partner abuse to their doctor and does disclosure play a role in handling their abuse situation?

Method:
A qualitative method was used to gather abused women's views and experiences with disclosure of abuse to their family doctor. In-depth interviews took place with thirty-six women.

Results:
Most women went to see the doctor for a physical or mental complaint. Only three women had planned to disclose the abuse. Twenty-five women valued most their doctor's communicative approach providing empathy or empowerment and nine women valued most the instrumental approach with a physical examination, medication or referral. Eight women of the latter group wanted this approach combined with a communicative approach.
After disclosure to the family doctor, a group of women (n=20) perceived a real change in their possibilities to handle their situation. They appeared to be in a position we named: 'in transition', a state in which they started or continued a process of change. Another group of women (n=13) appeared to be in a 'locked-up' position, a state without any prospect on change, feeling out of control and fearing the abuser. Three women reacted with reserve towards change.

Conclusions:
A communicative approach is what most abused female patients value. Doctors should acknowledge the advantage of their position as a professional confidant and should encourage women to talk, bearing in mind the role of disclosure in handling the abuse situation.

Points for discussion:
The interviewed women were enrolled by their own family doctor. This is a possible source of bias.
The interviews were not recorded on tape and not offered for member check for safety reasons.
Are there suggestions to validate the findings more thorou

PRESENTATION 2: Friday 11th May, 2007 THEME PAPER
10.00 – 10.30 h. Ongoing study with preliminary results

TITLE: Gender-specific baseline characteristics of patients presenting with a new episode of fatigue.

AUTHOR(S): Iris Nijrolder, H.E. van der Horst, H. de Vries
D.A.W.M. van der Windt, W.A.B. Stalman

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Background:
Fatigue is a non-specific symptom commonly presented in primary care, more often by women than by men. More knowledge is needed about predictors of the course of fatigue in order to determine which patients deserve special attention. As women present fatigue to a physician more often than men, these predictors might well be gender-specific.

Research question:
Do baseline characteristics of patients presenting with a main symptom of fatigue vary according to gender?

Method:
We conducted a prospective cohort study in 156 practices with one-year follow-up. Included were consecutive patients who were 18 years or older and not pregnant, post-partum, or under treatment for a malignancy. Primary outcome is fatigue, measured with the Checklist Individual Strength. Variables measured at baseline and during follow-up include characteristics of fatigue, demographic characteristics, physical and social functioning (SF-36), other symptoms (4-DKL, IPQ-R), cognitions (IPQ-R), physical activity (SQUASH), life events and coping. Baseline cross-sectional results are presented, analysed with Pearson's Chi-square test.

Results:
Of 641 included patients, 73% were women. Almost half of the participants were under the age of 40, among those 81% were women. Women had a higher level of fatigue, more co-occurring symptoms, elevated scores of distress, anxiety and somatisation, and more long-lasting difficulties on various areas. They attributed their fatigue more often to stress, worries, family problems, their emotional state, altered immunity or chance. No gender differences were found in social support, amount of life events, sleep problems, physical activity, absenteeism, localisation of fatigue, or cognitions. Women more often visited the GP with a request for blood tests.

Conclusions:
Women presenting with fatigue evidently more often report co-occurring symptoms of distress, worry and experienced difficulties. This is in agreement with their own perceived causes of their fatigue, however in seemingly contrast with the high percentage of blood test requests.

Points for discussion:
1. What are implications of gender-specific characteristics for the policy of the GP?
2. What could explain the higher percentage of women visiting the GP for fatigue, considering research findings of a more equal gender ratio of fatigue symptoms in the

PRESENTATION 3: Friday 11th May, 2007 THEME PAPER
11.00 – 11.30 h.

TITLE: Women GP of the finistere (West Brittany) in 2005. Conciliation between private and professional life.

AUTHOR(S): Jean Yves Le Reste, Ingrid Saint Léger, Eva Hummers Pradier Philippe Bail

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Background:
In France, women represent now 60 % of admissions to medical school. The activity of a woman GP is actually 70 % of a male. Presumed reasons for this lower activity are variable but conciliation between professional and private life seems to be pivotal

Research question:
Analysis of the difficulties of women GPs in finding a balance between professional and private life.

Method:
Postal enquiry send to all women GPs (in active private practice) in Finistere (n=210), consisting of 32 questions on 4 subjects: (demographics, professional life, family, perceived adequacy of professional and private life). 99 answered and all were usable. Descriptive analysis was done with epi-info 6.

Results:
The average woman GP in Finistere is 42 years old, married with 2 children in semi rural practice, she works in association with 2 GPs, 4.25 days a week, with 6.5 weeks of holidays per year. She pays to be helped for housekeeping. She is highly sensitive about out of hours service but 62 % does it. She had to manage working time because of her family. She does little post graduate training because of children education. She has chosen her work for its attractiveness, quality and husband career. But 11 % live alone with no children. 33 % feel that they did not find a good balance between professional and private life. Half would not change much their actual organisation, half would like to modify their professional activities to have a better private life.

Conclusions:
Woman GPs in finistere assume their professional duties but half of them seem to have professional difficulties caused by maternity, out of hours duty, children education and husband career. This could be one explanation of their lower activity.

Points for discussion:
1. Women are now a majority group in medical school through Europe, This study could be done through Europe to find how professional and private life is balanced for European women gp.

PRESENTATION 4: Friday 11th May, 2007 11.30 – 12.00 h. THEME PAPER Ongoing study with preliminary results

TITLE: How can we implement a gender perspective into medical education? An interview study among men with influence on medical education in Sweden.

AUTHOR(S): Gunilla Risberg, Eva E. Johansson, Katarina Hamberg

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Background:
One way to minimize gender bias in medicine bias would be to introduce a gender perspective in medical education. Teachers are in a position to influence the success of this kind of work. But studies have shown resistance to gender issues among physician teachers. Also, gender issues tend to be considered as women's issues. This study therefore explores male teachers' ideas on how to implement a gender perspective into medicine

Research question:
How do the teachers understand "gender perspective"? What obstacles and what strategies for implementation do they identify? How engage men?

Method:
Qualitative analysis of transcriptions of tape-recorded semi-structured telephone interviews with 20 male key persons of the medical education boards and faculties of the six medical schools in Sweden. Open coding concerning content has been conducted so far. Rereading, selective coding and search for summarising themes is planned.

Results:
The interviewed teachers identify differences and inequity between women and men as important aspects of gender perspective. Some mention gender attitudes. To use actual examples of gender bias shown in positivistic scientific research and to appeal to logic and reason are some of the strategies suggested, both to engae men and for implementation work. Sentimentality and emotions are strongly advised against. Students' requests and institutional responsibility have opened the interviewees' eyes for a gender perspective in medical education. They say they find gender important, but, at the same time, since the subject of gender has a low status and gives no credits in your CV, it is seldom prioritized.

Conclusions:
The interviewed male teachers have many ideas about how to implement gender in medical education and how to engage men in this work. However, their statements and reasoning include contradictions that might help explain the resistance to gender issues in medicine.

PRESENTATION 5: Friday 11th May, 2007 THEME PAPER
12.00 – 12.30 h.

TITLE: Gender differences in quality indicators of medical care – a chance or a pattern, results from the quality indicators program in our district.

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Background:
Our HMO run a program of quality indicators (QIs) measurement and improvement for almost a decade. Every year more QIs are added to the program making now a total of 53. There are QIs in the domains of: primary and secondary prevention, follow up, treatment, and control of chronic diseases. There are specific indicators for children, adults and the elderly.

Research question:
To look for gender differences in the QIs of adults and elderly patients.

Methods:
Study populations: All members of the Clalit Health Services in the Central District (about 500,000 members, 330,000 adults, about 28,000 diabetic patients, about 40,000 hypertensives).
Data extraction: All the medical records are fully computerized and data to calculate QIs is automatically extracted from the medical files and from the central database of the HMO. We choose the 30 QIs that represent management of the above population.
Main outcome measure: Differences in the QI scores between men and women.

Results:
The differences between the scores of most of the QIs were small but due to the large population reached statistical significance. Of 30 QIs 12 were significantly higher score in women. The relative risks were 1.01 (annual LDL cholesterol to diabetics) to 1.11 (annual TSH to the elderly). Only 7 were higher in men, relative risks 1.02 (annual microalbumin to diabetics) to 1.40 (percentage of patients with LDL cholesterol<100mg%). In 11 there were no differences. Of 15 QIs of screening and follow up 10 were better among women and only 2 among men, and of the 15 QIs of treatment and control of chronic diseases 2 were better among women and 5 among men ($p<0.05$).
Conclusion: Gender differences in QIs are relatively small but women tend to have a better follow up and screening while men have better treatment and control of chronic diseases.

Points for discussion:
Is there a real gender difference in health care quality in the community?
Is the method of quality indicators score evaluation answers this question?

PRESENTATION 6: Friday 11th May, 2007 FREESTANDING PAPER
14.00 – 14.30 h.

TITLE: Teaching a minimal intervention for stress-related mental disorders to general practitioners: effects on sick-leave duration in distressed patients.

AUTHOR(S): Ingrid M. Bakker, Berend Terluin, Harm W.J. van Marwijk
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Background:
In working people a breakdown of coping with stress can result in alarmingly long-lasting sick-leave; absence exceeds 6 months in 50%, and 12 months in 20%. Most of these patients visit their GP in the early stages of sick-leave.

Research question:
Does teaching GPs to deliver a minimal intervention to distressed patients reduce their sick-leave duration, and does the effect depend on the GP's diagnosis and the patient's gender?

Method:
46 GPs were randomised in a cluster-randomised trial. The intervention group was taught to deliver a minimal intervention focussed on accurate assessment, education, advice for active coping, monitoring, and referral if necessary. The control group delivered usual care. Patients (aged 20-60) who had visited their GP were screened for distress and sick-leave. They were followed up by telephone interview for 12 months. The primary outcome was the duration of sick-leave. Cox regression (survival analysis) with correction for the clustered design was used to compare sick-leave duration in both groups. Interactions between the intervention and the GPs' diagnoses and the patients' gender were tested.

Results:
We include 433 distressed patients on sick-leave. The GPs diagnosed a "stress-related mental disorder" (SMD) in 42% of the patients and other mental disorders in 31%, but did not identify a mental disorder in 27%. The intention-to-treat analysis showed no significant differences between intervention and control (hazard ratio HR 1.06, p=0.562). The intervention showed a significant interaction with the diagnosis (p=0.033). Stratified analyses showed a significant reduction of sick-leave in the SMD subgroup who had received the minimal intervention (HR 1.72, p=0.005). Gender did not matter.

Conclusions:
Teaching GPs to deliver a minimal intervention to distressed patients on sick-leave results in a significant sick-leave reduction, but only in women and men who have been recognised with a stress-related mental disorder.

Points for discussion:
1. Is long-lasting sick-leave with its risk of loss of employment and social marginalisation a GPs' concern?
2. Is it feasible to reduce sick-leave further by giving GPs a more comprehensive training?

PRESENTATION 7: Friday 11th May, 2007 FREESTANDING PAPER
14.30 – 15.00 h.

TITLE: Hand and wrist problems in primary care: characteristics and determinants of severity of the problem.

AUTHOR(S): Marinda Spies-Dorgelo, Daniëlle van der Windt
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Background:
A good hand and wrist function is indispensable for performing activities of daily living. Therefore, the impact of hand and wrist problems is considerable. Little is known about the characteristics of these patients in primary care. Because of this lack of information, GPs may encounter difficulties in managing these problems.

Research question:
1) What are the characteristics of patients across different diagnostic categories? 2) What determines the severity of hand or wrist problems?

Method:
We conducted an observational study in general practice in the Netherlands. From July 2004 to December 2005, GPs recruited patients with a new episode of hand or wrist problems. They were sent a questionnaire containing questions on sociodemographic variables, characteristics of the complaint, physical activity and psychosocial factors. The GP recorded information on symptoms, signs and medical diagnosis. The characteristics of the study population were summarized using descriptive statistics. We studied the association between potential determinants and the severity of hand or wrist problems by performing univariable and multivariable linear regression analyses, using the Symptom Severity Scale as the outcome measure.

Preliminary results:
Response rate was 89% (n = 267). Mean age was 50.8 years and 74% were female. The three most frequently recorded diagnoses were tenosynovitis (19%), osteoarthritis (18%) and nerve entrapment (14%). The characteristics of patients (including gender) varied slightly across different diagnostic categories. Patients who were not employed, had a higher body mass index, longer duration of symptoms, diagnosis of entrapment, higher pain intensity, and higher scores on worrying reported significantly higher scores on severity of hand or wrist problems (p-value <0.10).

Conclusions:
Primary care patients with hand or wrist problems report significant pain and reduction in function. Severity of the problem seems to be determined not only by disease characteristics, but also by sociodemographic, physical, and psychosocial factors.

Points for discussion:
1: The characteristics of patients across different medical diagnostic characteristics showed only minor variation. How does our population differ from secondary care populations with hand or wrist problems?
2: A variety of factors determined the sev

PRESENTATION 8: Friday 11th May, 2007 FREESTANDING PAPER
15.00 – 15.30 h. Ongoing study with preliminary results

TITLE: Perceived obstacles to the delivery of services to people with depressive symptoms—preliminary results from the German segment of an international study.

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Background:
Caring for people with depressive symptoms in primary care takes place in the context of systemic structures. To describe the helping or hindering effects of these as well as the attitudes of general practitioners (GPs) in different health care systems a comparative investigation is performed in Germany, Canada, England, Estonia, Finland, and the Netherlands.

Research question:
What obstacles do GPs perceive in the provision of care for people with depressive symptoms? In the GPs' view, what primary care structures might improve the quality of care for this patient group?

Method:
A quantitative survey was performed in a random sample of 300 GPs in each of the six countries. The questionnaire focuses on GPs perceived possibilities, problems, and obstacles in providing services for patients with depressive symptoms.

Results:
An overview of the current status of the project will be given. Only German data is currently available and some preliminary results will be presented: 48 of 300 (16%) German GPs returned the questionnaire. Most GPs (n=45) felt that overall they provide good care for this particular group of patients. Not having enough time, difficulties in accessing referral services, and too much work were cited as the main obstacles in providing care for patients with depressive symptoms. From the GPs' point of view, factors that could contribute to improve care included better remuneration for services (n=43), increasing the importance of mental health issues in continuing medical education (n=43) and vocational training (n=35), improving cooperation between GPs and office-based specialists (n=33), and strengthening the GPs' role in the health care system (n=32).

Conclusions:
These preliminary results identify areas for improvement in the primary care structures for patients with depressive symptoms in Germany. However, the low response rate will make further investigations necessary and results can thus only be used to generate hypotheses.

PRESENTATION 9: Friday 11th May, 2007 FREESTANDING PAPER
15.30 – 16.00 h.

TITLE: Evaluation of two guideline implementation strategies, effects on patient outcomes – a cluster randomised controlled trial.

AUTHOR(S): Annette Becker, C. Leonhardt, S. Keller, K. Wegscheider
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Background:
Much research has been done on management of low back pain (lbp) summarized in evidence based guidelines like the German lbp guideline released by the German society of general practice and family medicine. Until now evidence on the guidelines´ effectiveness, especially regarding patient outcomes, is lacking.

Research question:
Does a multifaceted general practitioner (GP) education alone or in combination with motivational counseling by practice nurses change patients´ functional capacity (main outcome), days in pain / year or physical activity (secondary outcomes) compared to a control group?

Method:
We designed a randomized controlled trial with three study arms: a multifaceted GP education (GI), the same education plus training of practice nurses in motivational counseling (MC) and the pure dissemination of the guideline (C). Patients who consulted for lbp on day of recruitment were consecutively asked to participate. Data were collected on the index visit (questionnaire), during a baseline interview (within 2-4 weeks) and after 6 and 12 months. Covariate analysis was used to adjust for clustering of data and potential confounders (e.g. sociodemographic characteristics, fear avoidance believes).

Results:
GP response rate was 14%. They recruited 1378 patients. After 6 months functional capacity was higher in the intervention groups with an adjusted mean difference of 3.405 between MC group and controls (p=0,032) and 2.947 between GI group and controls (p=0,066). Interventions effects were even more pronounced regarding days in pain/year, there were no effects regarding physicial activity. Females gained more from both interventions than males.

Conclusions:
Effects on functional capacity are small and clinically not relevant. However trends are visible. Interesting is the observed gender bias which should be counted for in future research.

Points for discussion:
- May we actually change patient health behaviour by GP based interventions?
- Why did we achieve effects in days in pain, but not in physical activity; what works if not changes in physical activity?

PRESENTATION 10: Friday 11th May, 2007 FREESTANDING PAPER
14.00 – 14.30 h.

TITLE: Lesbian sexual problems unraggeled.

AUTHOR(S): Karin A.W.L. van Rosmalen-Nooijens
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Background:
In the Netherlands few studies to the sexual health of lesbian women exist. From earlier studies, sexual problems seem to be equal to heterosexual women. Bed death seems to be an important problem though. For a GP, treating a lesbian patient can give difficulties when it concerns sexual problems.

Research question(s):
Which problems (including causes) experience lesbian women in their sexual relation and how do they deal with them?
Which wishes do they formulate concerning health care?

Methods:
The research existed of semi-structured interviews. The target group included lesbian women with a relation with a woman of minimum 6 months. The women were approached in several manners. The interviews were carried out by a trained researcher. The interview was typed out Ad Verbatim and the files were anonymised. The interviews have been analyzed by subject in themes. The main themes have been chosen for further study.

Results:
Thirty women have participated. The women indicated few sexual problems, except bed death, which means sex (almost) stops to exist. Twenty-three women have experienced bed death in this or a former relationship. The women indicated several causes: environment factors, symbiosis, hormonal factors and reduced initiative. Women, who experienced bed death as a problem, in general find it hard to talk about this with their partner and GP. The women indicated that they want a GP to be neutral, to have knowledge about homosexuality and to be able to recognise lesbian feelings.

Conclusion:
Lesbian women have few sexual problems, except for bed death. Bed death and fewer sexual desire do not seem to be caused by sexual orientation, but by gender: woman-specific characteristics. Lesbian women find it hard to talk to their partner or GP about sexual problems. Therefore, GP's must have a neutral attitude and a general knowledge of lesbian homosexuality.

Points for discussion:
Can we use Bed death as a term for lesbian women?
How are these results applicable in the everyday practise?

PRESENTATION 11: Friday 11th May, 2007 FREESTANDING PAPER
14.30 – 15.00 h.

TITLE: Sreening for diabetic retinopathy: the first telemedical approach in a primary care setting in France (DODIA study).

AUTHOR(S): Jean-Pierre Aubert, G. Audran, A. Ben Mehidi, B. Bernit, S. Bouée J.C. Bourovitch, P.J. Guillausseau, M. Marre, P. Massin, M. Nougairède
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Background:
Guidelines have been developed in France to increase the awareness of diabetes complications, but patients still fail to undergo periodic eye examination. The efficiency of non mydriatic cameras to diagnose diabetic retinopathy and the possibility or transmitting photographs by Internet for centralized analysis led the authors to test such a strategy among French primary care practitioners.

Research question:
Is eye fundus photography taken by a nonmydriatic camera and transmitted trough Internet to an ophthalmological reading centre an efficient method of screening for Diabetic Retinopathy (DR) compared to dilated eye examination performed by an ophthalmologist?

Method:
456 and 426 diabetic patients were included in two different groups of primary care physicians (PCPs). Among those, 358 were screened with the camera (experimental group) and 320 with the dilated eye fundus exam (control group).

Results:
The PCPs received a screening report of eyes examination within the 6-month follow-up period for 74,1% of screened patients for the experimental group and 71,5% for the controls. Screening for DR was negative in 77,6% of patients with eye photographs vs 89,6% with dilated eye examination. DR was diagnosed for 62 patients (17,3%) with eye fundus photographs and for 31 patients with dilated eye examination (10,4%). Referral to an ophthalmologist was required in 59 reports of patients with photographs (16.5%), 23 of them due to high grade DR. Finally, the camera was found of little inconvenience by patients.

Conclusions:
The telemedical approach to DR screening was efficacious in providing information on patient's eye status to the primary care practitioners . This screening method identified patients requiring prompt referral to the ophthalmologist for a further management. This study provided successful results of DR screening using fundus photography for primary care patients, and strongly supports the need to further this screening program in a larger number of French sites.

PRESENTATION 12: Friday 11th May, 2007 FREESTANDING PAPER
15.00 – 15.30 h.

TITLE: Diagnostic tests and antimicrobial susceptibility of uropathogens in boys and girls with UTI in The Netherlands.

AUTHOR(S): Sita Nys, A.I.M. Bartelds, G. Donker, E.E. Stobberingh

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Background:
In children urinary tract infections (UTIs) are one of the most common infections encountered by the general practitioner (GP). To minimise renal damage early diagnosis and adequate empiric antimicrobial therapy are essential. Therefore, this study evaluated the nitrite and leukocyte-esterase (LE) test in childhood UTI and determined the antibiotic susceptibility of the isolated uropathogens.

Research question:
Are the diagnostic tests available for the confirmation of a suspected UTI effective in children? What micro-organisms are the most prevalent uropathogens in this population and what is the susceptibility for the most common antibiotics to treat a UTI?

Method:
During 2003-2004 GPs from the NIVEL included children (<13 years) presenting with complaints of an acute uncomplicated UTI. The nitrite and/or LE-test were performed by the GP and a dipslide was subsequently sent to the Medical Microbiology Laboratory for identification and antibiotic susceptibility testing of the uropathogens.

Results:
Forty-two boys and 231 girls participated in the study. The PPV of the nitrite test was 75% and 82% respectively in boys and girls, with an NPV of 78% and 75%. For the LE-test the NPV were 81% and 82% respectively for boys and girls. The antimicrobial agents most frequently prescribed in girls were amoxicillin (37%) and co-amoxiclav (30%). Escherichia coli was more prevalent in girls (71%) compared to boys (44%; p<0.01). All E. coli were susceptible for nitrofurantoin and resistance for co-amoxiclav was observed once. The lowest susceptibility percentage was found for amoxicillin (61%).

Conclusions:
The diagnostic tests available are helpful for the GP to confirm or rule out infection in pedeatric patients. Due to the relatively high prevalence of resistance for amoxicillin the empiric choice will now include co-amoxiclav and nitrofurantoin.

Points for discussion:
Diagnostics in UTI
Empiric antimicrobial therapy
Antimicrobial susceptibility

PRESENTATION 13: Friday 11th May, 2007 FREESTANDING PAPER
15.30 – 16.00 h.

TITLE: Lasagna's law: determinants of unsuccessful and successful patient recruitment for research in general practice.

AUTHOR(S): J.C. van der Wouden, A.H. (Nettie) Blankenstein
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Background:
Many research projects in general practice face recruitment problems. Lasagna's Law states that investigators overestimate the number of patients available for a study.

Research question:
We aimed to assess determinants for success or failure of patient recruitment in general practice research, by systematically assessing potentially relevant factors in a large number of studies.

Method:
From all departments of general practice in the Netherlands and two other primary care research institutes, 125 projects were identified, 85 of which were selected. Investigators of 78 of the projects were interviewed on study design, recruitment strategies, planned and actual fieldwork period, remuneration, piloting, and planned and actual numbers of GPs and patients included. Success parameter was the number of participating patients as proportion of the planned number.

Results:
Forty-six percent of the studies had recruited the planned number of patients within the planned time period.
Studies that focussed on prevalent cases were more successful than studies that required incident cases (57% versus 28%, p=0,04). Studies in which GPs had to be alert during consultations were half as successful as studies were this was not the case. When the GP or practice assistant informed the patient about the study, patient recruitment was less successful than when the patient was informed by mail. These three factors were strongly related.
Studies with simple inclusion procedures were more successful than studies with complex procedures (54% versus 19%, p=0.02). Adjusting the study procedures according to the wishes of the practices showed a positive relation with success (63% versus 38%, p = 0.02).

Conclusions:
Lasagna's Law holds in Dutch primary care research. A checklist of study characteristics affecting participation of GPs and patients may help investigators to improve their study design.

Points for discussion:
We provide a checklist that may help investigators to avoid Lasagna's Law. We would like to discuss content and implementation of this checklist.

PRESENTATION 14:	Friday 11th May, 2007 16.20 – 16.50 h.	THEME PAPER

TITLE: Prevalence of abdominal obesity in primary care in France: results of ORNICAR transversal study.

AUTHOR(S): Denis Pouchain, Ph. Amouyel, J. Dalongeville
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Background:
Obesity is increasing in Western European Countries. Patients with abdominal obesity are at higher risk for type 2 Diabetes (T2D) and cardiovascular diseases (CVD). Therefore, the identification of patients with abdominal obesity in primary care setting is crucial to improve the management of their cardio metabolic risk factors.

Research question:
What is the prevalence of abdominal obesity in general practice and its relationships with cardiovascular risk factors?

Method:
Multicentre, cross-sectional study performed in France in January 2006. Two consecutive patients aged 18 or more whatever the cause of the consultation were recruited by a representative sample of French general practitioners. To reduce recruitment bias, each physician had to include his next 2 patients at a given random time and day. Abdominal obesity was defined as a waist girth > or = 102/88 cm in men/women.

Results:
1 125 GPs enrolled 2 292 patients (51 % females). The patient's main characteristics were:

	Male n = 1 114	Female n = 1 178
Age (years, m+/-sd)	56 +/- 14	54 +/- 16
BMI (kg/m2, m+/-sd)	28 +/- 4	27 +/- 6
Waist circum (cm)	101 +/-13	90 +/- 15
HTA (%)	46.5%	36.9%
Type 2 Diabetes (%)	16.3 %	9.4%
Dyslipidaemia (%)	44.1%	33.5%
CHD (%)	14.6%	5.8%
Smokers (%)	24.5%	17.2%

The prevalence of abdominal obesity was 44.3% in men and 53.1% in women. When comparing subjects with and without abdominal obesity, prevalence of diabetes, hypertension, low HDL and hypertriglyceridemia were 3.3 ($p < 0.0001$), 1.7 ($p < 0.0001$), 1.9 ($p < 0.0001$) and 2.2 ($p < 0.0001$) fold higher, respectively.

Conclusions:
The prevalence of abdominal obesity among French patients in primary care is remarkably high. Waist circumference measurement is a simple and reliable assessment to identify such at risk patients and should be largely spread in primary care.

Points for discussion:
1. Do you know such studies in primary care in your country?
2. What do you think about several definitions of abdominal obesity in the world?

PRESENTATION 15: Friday 11th May, 2007 16.50 – 17.20 h. THEME PAPER

TITLE: Nutritional differences between elderly men and women.

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Background:
Many differences are existing between the two genders, biological, sociological, and also behavioral; often depending from the age.

Research question:
Are they characteristic differences between nutritional habits of elderly men and women?

Method:
266 elderly people (109 men, 157 women over 60y) were consecutively selected from primary care patients, in Budapest, Hungary. A questionnaire was filled up on life style and eating habit, including food frequency questionnaire. Medical check-up,anthropometriy, and laboratory tests were also performed. Fifty-three people of them were involved in a 3-day dietary recall.

Results:
The meal frequency was increased during aging in both genders, especially by men. Lunch was preferred by most of women as a principal meal, but one quarter of men had a filling dinner instead of lunch. Alcoholic beverages were consumed more and frequently by men. The fluid intake was low, especially in women. Milk and diary products, fresh fruit, bread, biscuits, chocolate, coffee and vitamin supplements were consumed more frequently by women. Almost all type of meats, egg, vegetables were more preferred by men and their energy intake was also higher (9.75MJ vs. 8.78MJ). In both gender fat represented a high ratio (39%) in energy intake than recommended. The increase of body weight from the youth to elderly was greater in women (14.04kg vs. 10.65kg). The price had a higher impact on food purchase by women.

Conclusions:
High energy intake during decades led to overweight in both genders (BMI > 27kg/m²). It seemed that the eating habits and food choices of women were closer to the healthy one and recent recommendations, although due to metabolic reasons and to the lower energy expenditure they gained more weight. The elderly are the target-population on every level of medical care. Further evaluations needed to discover the differences in nutrition to establish public health suggestions.

Points for discussion:
1./ Are they similar differences in other countries ?
2./ Are they existing similar differences in other age cohorts?
3./ Should the family physician give different advices for men and women regarding nutrition?

PRESENTATION 16: Friday 11th May, 2007 THEME PAPER
16.20 – 16.50 h.

TITLE: Fractures cluster in time: timing of a previous fracture is the most important risk factor for fractures among postmenopausal women.

AUTHOR(S): Tineke van Geel, P. Geusens, I. Nagtzaam, C. Schreurs
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Background:
Only few studies investigated the short-term absolute risk (AR) of fractures and its timing in relation to a previous fracture among postmenopausal women.

Research question:
What is the influence of timing of a previous fracture plus other risk factors on the AR for fractures among postmenopausal women?

Method:
Ten general practice centres participated in this prospective study. Five and 10-years after baseline assessment, which included bone-mineral-density (BMD) measurements, 759 and 2372 postmenopausal women between 50 and 80 years, completed a questionnaire about their fracture history. Cox regression analyses provided significant determinants for a new clinical fracture and algorithms were constructed.

Results:
Of the women, 12.5% and 16.0% had a new clinical fracture after 5- and 10-years, respectively.
A previous clinical fracture and low BMD (T-score <-1.0) were significant predictors in the 5-year study. In the 10-year study, a previous fracture, osteoporosis (T-score < -2.5), and age > 60 years were significant predictors.
For women with a previous fracture, a recent previous fracture (5-year AR: 50.1, 95% confidence interval (CI): 42.0-58.1; 10-year AR: 41.4, CI: 35.6-47.3) contributed significantly more to a new clinical fracture than an older one (5-year AR: 21.2, CI: 20.7-21.6; 10-year AR: 25.1, CI: 21.1-29.2).
In women without a fracture history, the 5-year AR was 13.8% (CI: 10.9-16.6) if BMD was low and 7.0% (CI: 5.5-8.5) if BMD was normal; and the 10-year AR, which was based on osteoporosis and age > 60 years, was in the lowest risk-group 9.8% (CI: 8.6-10.9) and in the highest risk-group 23.0% (CI: 20.5-25.5).

Conclusions:
In postmenopausal women, clinical fractures cluster in time. The AR of a new clinical fracture is highest immediately after a fracture. The AR for a first clinical fracture is lower and increased by low BMD (5-year AR) or osteoporosis and age over 60 (10-year AR).

Points for discussion:
1. In postmenopausal women, clinical fractures cluster in time. For women without a fracture history the AR is much lower and increased by osteoporosis and age over 60.
Is the influence of timing of a previous fracture and osteoporosis and age the same in men aged over 50 years as in women?
2. What are the reasons why fracture risk is higher immediately after a fracture in postmenopausal women?
3. Is there a relation between developing a fracture as a child and developing a fracture as an adult, aged over 50? And if there is a relation, is this relation different in men than in women?

PRESENTATION 17: Friday 11th May, 2007 THEME PAPER
16.50 – 17.20 h.

TITLE: 'It can always happen': The Impact of Urinary Incontinence on Elderly Men and Women.

AUTHOR(S): Doreth Teunissen, W.J.H.M. van den Bosch
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Background:
Urinary incontinence (UI) is a common condition in the general population, especially in the elderly. The literature presents conflicting information on the importance of UI as a health problem for those afflicted.
Research question: to determine the impact of uncomplicated UI on quality of life in elderly men and women in the general population and to identify factors with the greatest effect.
Method: All independently living patients aged 60 and over from the nine family practices of the Nijmegen University Research Network with uncomplicated UI were interviewed at home using the Incontinence Impact Questionnaire and open-ended questions.

Results:
In total, 56 men and 314 women were interviewed. A majority does not have such impact. In the Incontinence Impact Questionnaire (IIQ) emotional well-being was most affected. Half to one third of the patients felt nervous, embarrassed or frustrated because of their incontinence. In the social domain 'clothing' and 'fear of odour' scored the highest impact. The most affected practical consequence in the IIQ was 'going to places where you are not sure about the availability of a toilet' followed by 'travelling longer than 20 minutes' and 'entertainment'.
Men reported higher impact scores than women, despite the fact that incontinence was less severe in men. Most important effect of incontinence reported in men was 'being out of control' while most women considered 'feeling impelled to take several precautions' the most important consequence of UI.

Conclusions:
UI affects nearly half of the patients, particularly in their emotional well-being and in public activities. Men experienced more impact compared to women and experienced loss of control more often than women.

PRESENTATION 18: Saturday 12th May, 2007 09.30 – 10.00 h.

THEME PAPER
Ongoing study with preliminary results

TITLE: Domestic Violence: What is in Pandora's box?

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Background:
Domestic violence (DV) has a high prevalence and 80% of all victims are women. It often remains undetected and untreated in general practice. A European network is created to improve this. One of it’s goals is to develop a registration tool for DV in primary health care to describe actual practice, identify problems and evaluate carepathways.

Research question:
How can a GP best register data in the medical record of (suspected) victims or patients at risk of DV in order to deliver and evaluate care adequately?

Method:
A literature search was performed using Medline. We included international primary health care guidelines using Tripdatabase. Finally we compared registration documents used in Belgium.

Results:
We selected 56 articles, 8 international guidelines and 2 Flemish consensus reports that include sections about documenting DV.
Most relate to DV in emergency care.
Many documents study requirements of information for later use in court. This puts the focus on DV as a criminal act. Less is written about registering data on DV for clinical use.
A small minority of the articles suggests a structured form for documentation of DV in order to raise the awareness of doctors.
We identified 132 possibly important items to describe DV. Main categories are: information about the victim, the suspect, the violence and the care that is given.

Conclusions:
A review of the available literature shows the need for development of an operational registration tool for DV to be used in everyday clinical general practice. Our project has developped a prototype for a structured registration form which will be submitted in a qualitatively research protocol to primary care workers with special expertise in dealing with DV and to a representative sample of male and female GP’s.

Points for discussion:
Are there GP's from organisations of other countries interested in joining our network and colaborating on developing this kind of tool?
What registration tools for DV are used in other European countries?

PRESENTATION 19: Saturday 12th May, 2007 THEME PAPER
10.00 – 10.30 h.

TITLE: Hypertension in school adolescents.

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Background:
It is known that some of the hypertension cases in adults are diagnosed in the childhood. For this reason detecting high blood pressure (BP) levels in children and adolescents and applying preventive care in that early stage are important features. As the childhood obesity is increasing, it is estimated that hypertension will increase, too.

Research question:
What is the prevelance of BP in adolescents and what is the relation among obesity, hypertension, weight, height and gender?

Method:
A cross sectional research that was conducted with the all students of the 6th, 7th and 8th classes of 2 schools in a county of Istanbul. After the ethical commitee approval, total 370 students who didn't drink tea or coffee, smoke and eat in the last 1 hour are included. Three consecutive BP, besides heights and weights were measured by the same researcher with reliable and valid methods. Average of the last 2 BP measures was accepted as the accurate BP level. ≥95th percentile depending on sex and height was accepted as hypertension. Independent t-test, chi-square and pearson correlation analyse were applied for statistics.

Results:
Mean age of the participants was 13 ±1,02years and 188 were boys. There was no difference between the ages of two sexes. Systolic BP rates were higher in girls (109 ± 12,93 mmHg vs 105 ± 10,99 mmHg p=0.004). Boys were taler (1,55 ±0,10 m vs 1,53 ± 0,07 m, p = 0,019). There was no significant difference in diastolic BPs, weights, BMI and gender. in 14.9% (n = 55) of the students were diagnosed as hypertensive and 36 of them were girls. 20% of the girls and 10% of the boys were hypertensive (p =0,012).

Conclusions:
In this study 15% of the adolescents were diagnosed as hypertensive and this case was more common in girls.

Points for discussion:
What are the limitations of the methodology of this study?

PRESENTATION 20: Saturday 12th May, 2007 10.30 – 11.00 h.

THEME PAPER
Ongoing study with preliminary results

TITLE: Gender specific differences in complaints in mild to moderate COPD patients in general practice.

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Background:
Chronic Obstructive Pulmonary Disease (COPD) is widespread in Europe, and the incidence is rising. The impact of gender on complaints presented by patients with COPD has not been studied in detail.

Research question:
Is there a gender specific difference in complaints presented by patients with mild and moderate COPD in the general practice?

Method:
Data from patients that were seen in a systematic protocolled way in general practice for COPD were analysed for gender specificity in complaints, linking those to clinical data like pulmonary function parameters by spirometry. 448 men and 360 women with mild to moderate (GOLD 1 and 2 classification) COPD were included in this analysis.

Results:
Women and men showed no difference in frequency of coughing, phlegm, wheezing and nightly complaints. There was, however, a statistically significant higher dyspnoea score (Medical Research Council MRC scale) in women as compared to men ($p=0.01$). When objectivating this difference, we found that in the same category of (subjective) dyspnoea, women had significantly higher predicted FEV1 and FVC compared to men.

Conclusions:
Although women and men with similar COPD classifications presented no difference in complaints of coughing, phlegm, wheezing and nightly complaints, women reported significantly more often of subjective dyspnoea. When compared in the same dyspnoea classification, however, women had significantly better FEV1 and FVC values as compared to men, suggesting a gender specific difference in perceived dyspnoea. We suggest that subjective dyspnoea scores should be linked to objective pulmonary function (spirometry) tests for better COPD treatment and medication.

Points for discussion:
1. Subjective versus objective complaints
2. Perceived somatic complaints in men and women

PRESENTATION 21: Saturday 12th May, 2007 FREESTANDING PAPER
09.30 – 10.00 h.

TITLE: One-year follow-up of acceptability and compliance to semi-rigid hip protectors in the community.

AUTHOR(S): Marc Frarier, Jean-Pierre Aubert, Stéphane Bouée, Anne Marie Bouvier Chantal Brigaudiot, Mélanie Germond,Véronique Jouis, Françoise Lecompte Olivier Margelisch, Céline Pellet, Yves Wolmark Philippe Zerr, and the PARACHUTES investigators

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Context:
Hip protectors decrease the risk of hip fracture. Their rates of acceptability and compliance are not well known among community-dwelling people.

Question:
What is the acceptability of hip protectors and compliance of patients to such devices?

Methods:
67 GP included 553 frail, community-dwelling elderly, with risk of fall. They presented to the patients semi-rigid KPH hip protectors and proposed them to wear such devices. Patients were randomized into two groups, one group receiving monthly a phone call from a nurse, to stimulate the compliance.

Results:
The acceptability was 64.9% (359/553). Among the patients who accepted, the mean age was 85, 79% were women, the mean number of falls during past year was 2, 12% had a previous history of hip fracture. 277 patients have completed one year of follow up. We defined low day-time compliance (LDTC) as wearing the device at least sometimes, and high day-time compliance (HDTC) as wearing it at least "more than one day out of two". After one month, the LDTC rate was 85.5%, and the HDTC rate 50%. After three months, rates were respectively 76.5% and 37%, and after 12 months 70.4% and 33.2%. None of the following factors have shown significant influence upon the rate of observance: age, gender, weight, height, previous history of falls, previous history of hip fracture, psychotropic drug treatment, dementia. Nurse phone contact had no effect on observance. At one month 45% of patients found the protectors easy to wear, vs 32.5% at twelve months.

Conclusion:
65% of community-dwelling elderly with risk of fall accept to wear semi-rigid hip protectors. Among people who accept the wearing, after three months two out of three people go on using them (one out of three very often). These rates remain stable at one year, and are not improved by nurse phone calls.

Points for discussion:
Do people who don't wear their hip protectors every day wear them in the situation of risk of fall?

PRESENTATION 22: Saturday 12th May, 2007 FREESTANDING PAPER
10.00 – 10.30 h.

TITLE: Gender awareness in General Practioners' vocational training.

AUTHOR(S): Patrick Dielissen , P. Verdonk, A. Lagro-Janssen

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Background:
Gender is an essential determinant in health and illness. Gender awareness contributes to equity and equality in health. Increasing evidence in literature supports the role of gender in patient cure and care. So far the knowledge gained on gender matters has been poorly incorporated in vocational training. Insight in how to transfer gender knowledge is important for a succesful uptake in vocational trainingscurricula.

Research question:
Does a training in gender-specific medicine increase GP-residents and their trainers' gender awareness?

Method:
A literature search was performed to formulate gender relevant items for three Dutch practice guidelines: depression, angina pectoris and urine incontinence. A training in gender-specific medicine was developed based on these guidelines. The training was offered to 9 couples of GP-trainers en GP's in training from the vocational training of the St. Radboud University Medical Centre. During a 6-month study period the couples made a registration of the use of these recommendations. Results were measured with the Nijmegen Gender Awareness in Medicine Scale: covering sensitivity, gender role ideology and knowledge. Statistical analysis was performed with SPSS 12.0.

Results:
Seventeen doctors completed the training: a respons rate of 94%. The control group consisted out of 19 couples of residents and their trainers. The gender sensitivity increased due to the training; this was significantly on gender sensitivity items dealing health issues (p= 0.008).
On group level the participants showed no differences in thinking on gender role ideology after the training.
Knowledge increased significantly (p=0.005).

Conclusions:
To achieve a gender perspective in vocational training a training in gender was effective. Doctors became more gender aware: they became more sensitive of gender differences and their knowledge on gender items improved significantly.

Points for discussion:
Other experiences achieving a gender perspective in vocational training and/or medical education.
Opinions on how to achieve an gender perspective in vocational training.

PRESENTATION 23: Saturday 12th May, 2007 FREESTANDING PAPER
10.30 – 11.00 h.

TITLE: How do general practitioners diagnose coronary heart disease: a German/UK collaborative study.

AUTHOR(S): Frances Griffiths, Matthew Baines, Joanna Cherry, Martin Been Norbert Donner Banzhoff, Maren Abu Hani

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Background:
When general practitioners see a patient with chest pain they must make a reliable diagnosis of coronary heart disease (CHD) or not, as early intervention for CHD improves outcome. Suspecting CHD starts a chain of health service activity. Low prevalence in general practice of CHD and non-typical pain-patterns makes reliable diagnosis difficult. How GPs diagnose chest pain in general practice in the 21st century has not been described. This exploratory study will inform a survey.

Research question:
How do GPs diagnose CHD?
Are there differences between Germany and UK?
Are differences attributable to medical ‘culture’ or health service configuration?

Method:
Semi-structured interviews with GPs (Germany 23, UK 9) explored their assessment of two identified patients seen recently with chest pain. Interviews were undertaken by GP researcher in Germany and medical students in UK using similar interview schedule. Data was coded and categorised by theme.

Results:
German study: 39 patients were described of which 17 were considered CHD or needing emergency assessment. GPs assessed person specific discrepancy, risk factors, past illness behaviour and classic text book diagnostic criteria. UK study: data analysis ongoing with 16 patients described. Initial analysis indicates GPs assess overall impression of patient rather than person specific discrepancy. Service configuration influenced decision making. German interviewees were reflective. UK interviewees responded as a teacher with a theatrical style.

Conclusions:
GPs use established diagnostic criteria for CHD plus assessments that are more implicit, based on their past knowledge of the particular patient or experience of many patients. The planned survey will need to include these aspects of assessment. There are indications that differences exist between Germany and UK attributable to service configuration. Differences in medical ‘culture’ may be reflected in or disguised by the interview style.

Points for discussion:
1. The diagnosis of chest pain and how it changes over time
2. Comparative qualitative research on ‘cultural’ differences in general practice and the interaction with researcher style or culture
3. Potential for developing international collaborative res

PRESENTATION 24: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Women have gout too.

AUTHOR(S): Katinka J.M. Dirken-Heukensfeldt Jansen, H. Jansen, M. Janssen
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Background:
Gout affects around 1% of European people, most aged over 45 years. The condition, presented as a painful inflammatory monoarthritis is five times more common in men than women. Research about gout arthritis in general practice is rare; even less is known about women with gout arthritis.

Research question:
What is known in medical literature about the clinical characteristics of female patients with gout arthritis compared to male ?

Method:
For this explorative study we performed a pubmed search. Using (MeSH and text) "Gout or gout* AND female or women" we found 3311 hits. "Gout/gout* AND gender" gave 41 hits. "Gout/gout* AND female/women AND sex characteristics OR sex factors OR sex distribution OR sex differences OR gender" rendered 247 hits. In this set we first selected the articles giving specific differences between men and women as results and second assessed the quality of the article.

Results:
We found 15 qualified articles with information on the characteristic differences. Premenopausal women with gout either use diuretics or have renal problems. A positive family history is relatively prevalent among these females.
With a postmenopausal onset, the incidence of diuretic-associated gout is high compared to a premenopausal onset. The incidence in elder women is almost equal to men. Primary gout patients over 80 years are mainly women.
Hypertension and coronary heart disease are common coexisting conditions, as in males. In women, in contrast to men, we found a polyarticular onset of gout with hand involvement, an earlier development of tophi, a high association with the use of diuretics and less gout medicine treatment.

Conclusions:
This review is a unique specimen and a start for further research, in order to realize a better diagnosis in female patient with gout arthritis, a more serious approach and better treatment.

PRESENTATION 25: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Women with low socioeconomic status deserve specific attention in preventing and managing COPD.

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Background:
Trend studies in COPD have shown an increase in the prevalence and COPD-related mortality and morbidity in both sexes in the past three decades. Also, COPD exacerbations have shown a steady rise since the early 1990s. Although socioeconomic status (SES) is related to COPD mortality, no trend studies describe the relation of SES with COPD prevalence and exacerbation rate.

Research question:
Do trends in COPD prevalence and exacerbation rates differ between men and women in different socioeconomic classes in Dutch general practices?

Method:
We used data from the Dutch Nijmegen Continuous Morbidity Registration (CMR) to analyse trends in COPD prevalence and exacerbation rates. SES was determined by classifying the occupation of the patient using the Netherlands Standard Classification of Occupations 1992.

Results:
In line with previous studies the CMR records showed an increase in COPD prevalence in the last 20 years. However, the prevalence rates in women with low SES doubled from 15 to 30 per 1000 patient years, while the COPD prevalence in women with high SES was much lower and remained stable. In men with low SES and in men with high SES COPD prevalence rates definitely seem to have had their peak. The occurrence rate of exacerbations increased strongly in women with low SES during the last twenty years, while a decrease of exacerbation prevalences was observed in men with low and high SES. In women with high SES exacerbation occurrence rates remained stable.

Conclusion:
Our results indicate that women with low SES deserve more and specific attention by health care professionals in preventing and managing COPD.

Points for discussion:
How can health care professionals pay more and specific attention to women with low SES in order to prevent and manage COPD?

PRESENTATION 26: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: How do the early career aspirations of medical students differ between male and female students?

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Background:
In the UK female doctors will outnumber male by 2012 and the need to understand career aspirations of medical students to assist future workforce planning has been identified. Previous research focused on graduate or senior undergraduate choices. Research question: Do the early career aspirations of medical students reflect the needs of the UK medical workforce? Aim: To describe and compare the early career aspirations of male and female medical students at each stage of an undergraduate training and the factors that may influence those aspirations

Method:
A cohort cross-sectional study using whole undergraduate population at University of East Anglia's School of Medicine in 2006-7. Students voluntarily completed a self-addressed questionnaire at start of academic year, modified from the BMA's Cohort Study of 1995 Medical Graduates questionnaire. A focus group in February, 2007 will explore student experiences, opinions about and influential factors. Statistical (binary and bivariate) and framework analysis will be used.

Results:
Response rate 44.5% (271). Questionnaire completed by178 females and 93 males
Career Choice: Hospital medicine is most popular career choice (58%), compared to general practice (21%); 20% undecided, 1% academic medicine. No students chose public health
o Gender: Similar numbers of males and females prefer hospital medicine versus general practice although more females are undecided
Working patterns: When asked 'Have you considered working less than full-time?' 51% said yes
o Gender: Less than a third (28%) of males said they considered working less than full-time, compared to 63% of females

Conclusions:
Career choice does not change significantly when gender and stage of degree are considered. Even a modern course is not enticing sufficient candidates into family medicine for the UK's workforce needs.

Points for discussion:
Influence of family medicine on career aspirations in medical school.
Why do more women than men want to be GPs?
Does this matter?

PRESENTATION 27: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h. Ongoing Study with preliminary results

TITLE: Evaluating patient-held records for female undocumented immigrants.

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Background:
General practitioners consider the care for undocumented women as burdensome, partly because of lack of medical record information. Availability of medical record information might improve the care for undocumented women. Therefore, we investigated the potential benefit of a patient-held record (PHR).

Research question:
Do undocumented women keep and use a PHR? What are their experiences with a PHR and their GP?

Method:
Semi structured interviews and questionnaires were conducted in 100 illegal women to obtain insight in their problems and experiences with Dutch medical care. All women received a PHR based upon medical examination. Diversity in the undocumented women was sought according to age, country of origin and reason for being undocumented. After 3-6 months semi-structured interviews were held to evaluate the use of the PHR. We decided to evaluate the experiences of the women through focus group discussions as well. Three groups of 6-8 women will participate in these discussions.

Preliminary Results:
Unfortunately, surprisingly most women did not use the PHR. Reasons why they did not use the PHR were hardly given in the individual interviews. Because we felt the women answered the questions mainly in a social desirable way, we decided to evaluate the PHR through focus group discussions as well. In the first focus group-discussion most women were more explicit in their views and opinions as compared to the individual interviews. Most common reasons for not using the PHR were “forgotten” and “do not want to bother the doctor”. Surprisingly most women in the first focus group preferred a male general practioner, even for gynecological problems.

Conclusions:
PHR’s are not widely used by undocumented women. Reasons for not using the PHR are not clearly given in individual interviews. Focus group discussions might be a more efficient way to explore opinions and views of these patient group.

Points for discussion:
1. Focus group discussion can be effective as a method , even for exploring views of immigrant women
2. The assumption immigrant (muslim) women prefer a female doctor needs further examination.

PRESENTATION 28: Saturday 12th May, 2007 11.20 – 13.00 h. POSTER

TITLE: Demographic differences between detected and undetected patients with depression or anxiety in primary care in Slovenia.

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Background:
Primary care physicians miss many patients with depressive or anxiety disorder that visit their office. Undetected patients with broadly defined depressive disorder are younger and better educated with no differences regarding gender. However when considering only major depression no significant demographic differences were found between the undetected and detected patients with depression. Data for anxiety are lacking.

Research question:
Do undetected patients with depression or anxiety in the population of Slovenian primary care attendees differ in gender, age and education from detected patients?

Method:
Datasets from two independent studies were analysed. First study is a cross-sectional study in which patient consultation data in Slovenia was collected (42 GPs, 10710 cases). During study GPs wrote down all the current diagnoses of the participating patients. Second dataset is the first round of longitudinal study PREDICT (82 GPs, 1118 cases). Depression section of the CIDI (Composite international diagnostic interview) was used to diagnose the depression and PHQ (Patient health questionnaire) to diagnose anxiety.

Results:
Although GPs and patients were randomly assigned to both studies there were significant differences between two samples in gender, age and level of education. Prevalence of depression was roughly twice as high and prevalence of anxiety was more than seven times higher in PREDICT than in cross-sectional study. Logistic regression showed no significant differences between two modes of detection of major depression and anxiety for gender, age and level of education.

Conclusions:
Our results show large proportion of patients with depression or anxiety that go by undetected in the primary care in Slovenia. There are no differences between detected and undetected patients with major depression or anxiety regarding gender, age and level of education.

Points for discussion:
1. How to proceed when two representative samples of the population significantly differ?

PRESENTATION 29: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h. Ongoing Study with preliminary results

TITLE: How do GPs benefit from Supervision?

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Background:
Danish GPs have been joining supervision groups for more than 30 years. In the last 15 years the activity has been supported by the NHS. Many GPs have stayed in the same group for more than 15 years. In vocational training supervision groups will be implemented in the last year of training. Supervision is a widespread activity in many helping professions but poor defined in the context of general practice

Research question:
What is supervision for GPs in Denmark, and how do they benefit?

Method:
This is a qualitative study with participant observation, in depth interviewing of key informants and group interviews. The material is the notes from the observation and the transcribed text of the tape recorded interviews. These texts are analysed in a phenomenological perspective a.m. Giorgi, a method modified by Kirsti Malterud

Results:
The results of the first part of the study, which will be extended to a PhD study, show that the GPs benefit a lot at different levels. Joining the supervision group gives knowledge, better communicative skills, personal and professional development. Some of the changes seem to be thoroughly, others seemingly more superficial. The relation to the group and the relation to the supervisor are both very important.

Conclusions:
The study is not yet completely analysed, but these preliminary results show important benefits for GPs to join supervision groups.

Points for discussion:
What does supervision mean in a General Practice context?
Does frame of reference mean anything?
Does gender matter?

PRESENTATION 30: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Sexual harassment of medical students during their clerkships.

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Background:
This study focuses on sexual harassment of medical students. Sexual harassment is the unwelcome sexually colored attention by patients, colleagues or supervisors. International studies reveal prevalence rates between 18 to over 60%. The prevalence in the Netherlands has not been investigated before.

Research question:
What is the prevalence, the nature and consequences of sexual harassment of medical students during their clinical clerkships at Nijmegen University?
Is there a need for more attention to this problem in medical education?

Method:
183 medical students in the 5th of 6th year received a semi-structured questionnaire with questions about their experiences with sexual harassment during clerkships. The questionnaire contained questions about potential experiences, the reaction of the student to this incident, possible consequences and the way the case was handled. Students who had experienced sexual harassment were asked to participate in a semi structured in depth interview.

Results:
The response rate to the questionnaire was 61,7%. Of all female students 20% had experienced sexual harassment compared with none of the male students. Most common were unwelcome sexual colored remarks. Very few students discussed their experience in formal circles. Half of the offenders were not called to account for their behaviour. 40% of the victims were unsatisfied about the way the incident was handled. 7 students were interviewed. Most of them had experienced negative emotional or behavioural consequences. They found it important that someone listened to them and took them seriously. They thought it useful to give attention to this problem in medical education.

Conclusions:
Sexual harassment of medical students during their clerkships should not be underestimated as a problem with negative consequences for the personal well being as well professional functioning. Occurrence of and dealing with these incidents should be an important topic in the training of medical students and their supervisors.

Points for discussion:
- discrepancy with other studies
- consequences for medical education

PRESENTATION 31: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Gender Changes: Consequences for Switzerland.

AUTHOR(S): Nicole Jaunin-Stalder, Gabrielle de Torrenté de la Jara

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Background:
In the last 15 years, there has been a major increase in the number of women studying medicine in Switzerland. This has an important sociologic and political impact for the country.

Research question:
What are the present changes in demographics and their impact on the future of medicine in Switzerland?

Method:
We used statistics of the Federal Office of Public Health, the Swiss Medical Association and the Faculty of Biology and Medicine of the University of Lausanne. To better understand the problem in Switzerland and in other countries, we also reviewed the international and national literature on Pubmed searching for "feminisation of medicine in primary care" and "part time" from 1990 to 2005.

Results:
The feminisation of medicine and gender issues are poorly studied in Switzerland, with a recollection of only 4 local articles.
In 2004, 52% of medical students, 39% of doctors obtaining a specialist title and 24% of doctors (total 15'199) in private practice in Switzerland were women. Only 17% specialize in internal or family medicine. 80 % of women practice in cities, preferably in a group practice (64,8 %). 79 % of women in private practice work part time.
Nevertheless the possibilities of part time training in the hospitals are poor, with only 26% of women working part time at the University Hospital of Lausanne.
These facts expose an important health care problem; without an adaptation of the possibilities of training and an increase in group practices, Switzerland might lose competent family doctors in the future and increase the shortage in primary care doctors.

Conclusions:
There is a big discrepancy between the actual trend for feminisation and the offers for adapted training and job opportunities in Switzerland, meaning a loss of competent primary care doctors in the future.

Points for discussion:
- How to promote the status of women doctors in a conservative country like Switzerland?
- How to convince the teaching hospitals to create part time jobs?
- How to loose less women during their training?

PRESENTATION 32: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h. Ongoing study with preliminary results

TITLE: Health status, health behavior, gender differences and sleeo of Hungarian general practitioners.

AUTHOR(S): Peter Torzsa, Maria Kopp, Laszlo Kalabay, Marta Novak

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Background:
During their daily activities medical professionals often do not care about their own health status, and they frequently complain of sleep problems because of their heavy workload and stress.
Research question:
Do GPs care about their health status? Do they have any sleep problems? Is there any difference between the two genders?

Method:
150 GPs completed a battery of questionnaires regarding their health, their life style, psychological condition, sleep problems.

Results:
The mean age of the doctors was 55.6 ± 10.6, there were 80 females and 70 men. One third of the GP do not have their own GPs, they treat themselves. In the sample, 36.6% of the GPs were overweight, 15.3% were obese. The prevalence of hypertension was 17.8%, elevated cholesterol level was 64%, increased fasting glucose was 10%. The frequency of regular alcohol consumption (more than 3 times a week) was 40%, 50% of them drink liquor. The Beck Depression Inventory showed 18.6% borderline clinical depression, 4.7% moderate depression and 6% severe depression. Severe depression occurred frequently among men. 4% of the doctors (1 female and 5 men) have loud snoring with frequent episodes of breathing pauses during sleep and they have excessive daytime sleepiness, which may suggest significant sleep apnea. 19.7% of the female doctors and 32.8% of the male doctors have difficulty in initiating sleep, while complaints about maintaining sleep occur among 38.2% of the females and 54.4% of the men. The sleep disorders were associated with the severity of depression ($r = 0.40$, $p < 0.001$) in every age group.

Conclusions:
Our survey shows that Hungarian GPs don’t pay enough attention to preserve their health, they have several psychosocial risk factors and health-risk behaviours, which they sometimes resort to in order to reduce their daily stress.

Points for discussion:
1. Women are twice as likely to suffer from insomnia than men. Why did we find higher prevalence of insomnia among male doctors?
2. How can we screen medical professionals’ health condition easily?
3. What could be the most effective cognitive behaviour.

PRESENTATION 33: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h. Ongoing study with preliminary results

TITLE: Chest pain in general practice - are there gender differences?

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Background:
It is now well known that women and men suffering from coronary heart disease present in different ways. Studies show that only about a third of women with myocardial infarction do present with chest pain, 42 % complain of shortness of breath and 39 % of stomach trouble. Doctors tend to use different investigations for chest pain dependency on whether they see a female or male patient. However most publications refer to the hospital or other high-prevalence settings. Evidence from general practice is rare. Having in mind these gender differences in presentation of chest pain, differences in management of pain seem likely.

Research question:
Do diagnostic processes to investigate chest pain differ between women and men?

Method:
This analysis is a part of an ongoing diagnostic cross-sectional study with “delayed-type” reference standard. 74 GPs recruited consecutively 1355 patients with acute and chronic chest pain. They documented symptoms and findings at the day of presentation. Patients were interviewed by phone to measure health care utilization, e.g. practice visits, referral to cardiologists and/or hospital, medication as well as symptoms and disease outcomes for six months.

Results:
First results will be presented at the EGPRN conference.

Conclusions:
The results will inform a symptom-based guideline for chest pain in general practice. If the analysis shows different investigations of women and men with the same presentation of chest pain, further analysis has to examine if these differences are appropriate with regard to disease outcomes.

PRESENTATION 34: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Adherence to self-care recommendations among men and women targeted for the primary prevention of initial coronary/cardiovascular events.

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Background:
Patients' compliance with guidelines for self-care behaviours and primary prevention of cardiovascular events is determined by both health state and multiple cognitive, emotional and social factors. While men have higher calculated coronary risk values, these are women who perceive bigger symptoms' burden. To date, the research remains equivocal about how these gender differences affect adherence to self-care regimens.

Research questions:
1. Are there any differences in the adopted self-care behaviours between men and women?
2. Does the patient's cognitive assessment and emotional reaction associated with being informed about the coronary/cardiovascular risk change across gender?
3. What underlies the process of adopting health behaviours in men and women.

Method:
114 Family Practice's patients (W:M, 67:47) without manifest vascular disease participated a cross-sectional, questionnaire-based study. Score function, Frammingham equation, Health Behaviours Inventory, Coping Inventory for Stressful Situations, Cognitive Situation Assessment Inventory and the Spielberger State-Trait Anxiety Inventory were applied to evaluate an individual's perception of their coronary/cardiovascular hazard.

Results:
Women revealed to follow self-care guidelines more frequently than men ($p<0,001$), regarding both dietary habits ($p<0,01$), preventive measures ($p<0,01$), health behaviours ($p<0,05$) and mental attitude ($p<0,05$). Women were more inclined to recognize their cardiovascular hazard as a challege ($p<0,05$). In men, the regression model's parameters (coronary/cardiovascular risk values, cognitive assessment's determinants, coping styles and anxiety's level) accounted for 52% of the variance in adherence to self-care recommendations while the "appraisal of the situation as a harm" proved to have reached highest significance. In women the above parameters explained 61% of variance and their risk's values were most idicative of adopting the self-care regimens.

Conclusions:
There is significant discrepancy in both adherence to self-care recommendations and motivational factors for adopting health behaviours across gender. Different, gender-adjusted psychosocial interventions need to be implemented when handling a patient at cardiovascular risk.

Points for discussion:
1. What other culturally-determined or environmental factors, not included in our analysis, could interfere with the patients' compliance with self-care recommendations?
2.The study did not confirme any significant differences in the emotional reaction.

PRESENTATION 35: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Medical Students' Gender-Specific Examination Performance: Clinical Skills of Future General Practice Residents is Insufficient.

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Background:
There are few studies reporting gender-specific examination performance of medical students.

Research question:
Are final-year medical students competent in performing pelvic, breast, male genital and prostate examinations?

Method:
In 2006, all students in the final year of medical school at the University of Erciyes were administered a questionnaire comprised of 17 questions on gender-specific examinations. The examinations included pelvic, breast, male genital, and prostate examinations. The students were also asked to state their confidence performing these examinations. Chi-square analysis, univariate and multiple logistic regression analysis were performed.

Results:
A total of 200 (94%) students completed the questionnaire. Female students performed significantly more breast examinations than male students ($p=0.039$). In addition, female students had performed more prostate examinations under supervision ($p<0.001$). Thirty-one percent of pelvic examinations, 30% of breast examinations, 37% of male genital examinations, and 27% of prostate examinations were supervised greater than 75%. The percentage of examinations repeated by a supervising physician was 67% for pelvic, 77% for breast, 73% for male genital, and 69% for prostate examinations. Female students were less confident in performing male genital and prostate examinations ($p=0.040$ and $p=0.030$, respectively).

Conclusions:
This study demonstrated that there was suboptimal exposure for performing gender-specific examinations, particularly resulting in unconfident female students. Student logbooks should be used more efficiently to eliminate gender disparity in opportunities to perform gender-specific examinations.

Points for discussion:
1. Are medical students expected to be competent in performing gender-specific examinations when they finish school?
2. How many examinations should be performed before considering a medical student competent?
3. Are we checking our residents' competencies.

PRESENTATION 36: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h. Ongoing study, no results yet

TITLE: If, When and How to Ask the Question(s): Assessing Screening Approaches to Identify Woman Abuse in Health Care Settings.

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Background:
Many organizations, representing family physicians, other physician specialists, other health care providers and/or women's groups, favour universal screening of women patients for intimate partner violence, based on the prevalence and consequences of abuse. A wide range of tools has been shown to increase identification rates. However, several systematic reviews have found insufficient evidence to recommend for or against universal screening.

Research question:
Does screening all women upon entry to the health care system for intimate partner violence do more good than harm?

Method:
Women seeking health care in various community-based and hospital-based primary care settings in rural and urban communities in Ontario, Canada, are randomly allocated to be screened for intimate partner violence (or not) using a validated paper-and-pencil self-report tool shown to be valid, and acceptable to patients and physicians. Women will be followed for 18 months to determine if the benefits are greater than their experiences of harm. The outcome measures will assess improvement in quality of life; reduction in repeat violence; potential harms of screening; physical and mental health measures; health service use; and social support, use of information, specific strategies and safety behaviour.

Results:
Data collection is underway, but much slower than anticipated because the vast majority of women who entered the 25+ health care settings involved in the trial were not eligible for recruitment. A very large number of women must be screened to identify a woman who discloses intimate partner violence in the previous year.

Conclusions:
This trial will provide evidence about whether universal screening for intimate partner violence improves women's health and wellbeing more than "usual care", which typically involves case finding or a lack of recognition of the impact of abuse on women's health and wellbeing.

Points for discussion:
1. How could we clarify for the lay public and other health care providers our committment to addressing IPV as a health issue but our need as clinicians to ensure our clinical practices reflect existing evidence?
2. How can we better clarify for the lay.

PRESENTATION 37: Saturday 12th May, 2007 11.20 – 13.00 h. POSTER

TITLE: Gender in procedural skill learning.

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Background:
Learning outcomes of many undergraduate medical programmes include a statement of the competencies required for general practice. After the declaration of this mision, universities became familiar with variable education methods that would help in teaching and assessing. Clinical skills laboratories are the mile-stones of procedural skill teaching.

Research question:
Comparison of overall clinical competence, its specific components and pass rates for men and women were very interesting. It was shown that ratings of overall competencies in procedural skills were used to be higher in men. Are the ratings of procedural skills influenced by gender in an OSCE in year 2 medical students as the beginners?

Method:
This descriptive study involved 422 second year students who followed a structured 5-sessioned course completed in 6 weeks. The course was conducted in Clinical Skills Lab with groups of 16 students in each station. The course assessment was made by an OSCE that includes hand washing, drug administration routes, intraveneous blood sampling and suturing stations. t-test is used to explore the relation between the scores of procedural skills and gender.

Results:
Total of 422 student assessed. 52% of the students were male. Total maximum score of the OSCE was 3.00 and mean score was 2.75 (SD:0.48) for females and 2.86 (SD:0.34) for males. Comparison of the mean of the OSCE results among male and female revealed statistical significance ($p=0.011$).

Conclusions:
Procedural skills can be assessed only by observing the performance of the student. Reasons of lower female students' performance will be evaluated by the teachers to find more interesting tools for them and the period that this deficit in female students is covered must be studied by the teachers.

Points for discussion:
What may be the possible reasons of this difference?
What may be other research plans to check the results of this study?

PRESENTATION 38: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: How do GP Trainees evaluate a gender specific program.

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Background:
Gender specific aspects are very important for the quality of healthcare.
This makes it necessary to become part of the educational program.
To this end in Nijmegen in the Department of General Practice a gender specific module has been developed.

Research question:
How do GP Trainees evaluate this education program?

Method:
The postgraduate program takes three years, in which five workshops have to be followed.
In the first year the themes " socialisation " and "communication" are educated.
The second year the trainees can make a choice between the themes partner abuse, alcoholism and leadership.
In the third year the trainees are educated on gender differences in cardiovascular diseases, and problems related to sexual and physical abuse in the past
After each program the GP Trainee fills in an evaluation form with a five point score:
1 = less… 5 = very …

Results:
Roughly 110 GP trainees have had an education by a teacher with gender specific attention.
In the two years in which the program has been evaluated they followed three workshops.
The response for the evaluation form was 100% .We gathered 327 evaluation forms.
85% of the GP trainees were positive in their evaluation: 4 on the scale 1 through 5.
Nearly 80% reported an increase in knowledge about gender specific items, such as:
Gender differences in presentation of chest pain and communication between doctor and patients.
Gender awareness and reflection about their own socialisation were obvious learning points.

Conclusions:
GP trainees gave a positive evaluation on knowledge sharing and attention to attitude related to gender specific aspects.
The most important eye opener of the GP trainees was gender awareness and reflection on their own gender.

Points for discussion:
Trainees appreciate gender-specific programs in postgraduate training as useful and necessary. This makes it necessary to become part of the educational program of GP trainees.
In our opinion there should be more attention for genderspecific aspects in l

PRESENTATION 39: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Genderspecifc analysis of the development over time of burnout among general practioners.

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Background:
The amount of women physicians is increasing, faster then professional or societal norms and ideas can keep up with. Also modern gender ideology has changed the professional identity and preferences of the young male and female GP's and will influence the stresses they face in their professional life. In our research we focus on the development of burnout among GP's in the period 2002-2004-2006.

Research question:
-How does burnout develop over time among Dutch male and female GP's in the period 2002-2006 (genderspecific)?
-How are risk factors related to burnout (genderspecific)?

Method:
The study population consisted of random sample of 700 working Dutch GP's, (350 male and 350 female). The study has a full panel design in 3 waves (2002, 2004 and 2006), using self-report questionnaires. To assess burnout the Maslach Burnout Inventory was used; risk factors were measures with various validated questionnaires. Statistical analyses used were correlations, t-tests and linear regression analysis.

Results:
In 2002, 19,2% of the Dutch GP's reported clinical burnout; this percentage decreased to 8,5 % in 2004. The third wave however showed an increase of clinical burnout to 12.8% with a genderspecific pattern: prevalence of clinical burnout increased significantly in female GP's only.
Most important risk factor for burnout were workload and appreciation for both sexes. Work-family interference and an inappropriate coping style appeared to have a genderspecific impact.

Conclusions:
The fluctuation in scores of burnout in GP's in the Netherlands suggest that after a positive change in working conditions for Dutch GP's in the period 2002-2004, a disturbing negative trend on the stress level of female GP's was found. This underlines the need for genderspecific analysis of risk factors for burnout and specific actions in addressing these risk factors.

Points for discussion:
Explanations for the fluctuation in the levels of stress and burnout among the Dutch population of GP's.
What preventive actions can be implemented to reduce risks for burnout for female and male GP's.

PRESENTATION 40: Saturday 12th May, 2007 — 11.20 – 13.00 h. — POSTER

TITLE: A general practice experiment in addressing men’s health.

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Background:
Men are generally reluctant users of primary care and take few preventative health measures. There is increasing interest in adopting more effective ways of encouraging men to take care of their health.
Research question:
Are deprived men interested in looking after their health

Method:
A well man programme in a general practice in Dublin targeted 116 men between 50 and 55 years. 60% attended and 90% of both attenders and non attenders subsequently surveyed disclosed concerns about stress and anger. A course was devised to respond to these concerns.

Results:
Predictable high levels of ill health were discovered.
A qualitative evaluation of the courser attenders revealed a number of themes :
Stress was triggered by work and family with feelings of anger causing mistakes at work and difficulties at home. Men resorted to alcohol, food and tobacco to help them cope but rarely to family or friends. Emotional isolation was the norm resulting in both inability to communicate and growing fears about the impact of slowing down, ageing and ill health. Increasing age lead to fears about maintaining a job or finding work.
They were reactive in addressing health issues with strong fears of the doctor's diagnosis and its consequences. They had few ideas about how to target men’s health or about how to improve attendance. They did not associate general practice with health promotion. Subsequently many men became evangelical about its benefits and about recruiting other men.

Conclusions:
The health of deprived middle aged men is a justifiable concern. Published studies from general practice in men’s health are uncommon. Men’s attitudes to their health and expectations of healthcare are barriers to the provision and uptake of services. Finding effective ways to encourage men to care for their health requires consciousness raising among men and healthcare providers.

Points for discussion:
Men are interested in their health.
Men have low expectations of health promotion in general practice.
Stress and anger management are important issues for middle aged men.

PRESENTATION 41: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Influences on doctor´s decision for antibiotic treatment of acute upper respiratory tract infection.

AUTHOR(S): Primož Kušar, Igor Švab, Marija Petek-Šter, Gordana Živčec-Kalan

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Background:
Acute infection of upper respiratory tract (AURTI) is one of the commonest reasons for patients' visits in family practice and antibiotics in such cases are often prescribed unfounded and not necessary.

Research question:
Which are the reasons influencing the doctor's decision for prescribing an antibiotic in case of AURTI.

Method:
Our survey consisted of quantitative and qualitative part. Quantitative part was cross-sectional survey of different factors concerning characteristics of a doctor, a patient, GP practice and contact between the doctor and the patient. A cross sectional survey was done with a representative sample of 42 Slovenian general practitioners. In order to find out additional factors we interviewed ten doctors who took part in the cross-sectional study, according to the highest and lowest part of their prescribed antibiotic pattern.

Results:
522 cases were analyzed. An antibiotic was prescribed in 62.6% of cases. Doctors older than 50 years had almost twice higher odds for prescribing antibiotics than younger ones. Doctors who measured CRP had one fourth lower odds for prescribing antibiotics than those who didn`t. Doctors who took more than 8 minutes for consultation with the patient had half smaller odd for prescribing antibiotic than those who took less than 8 minutes. Patients having a control checkup after 4-7 days and more than 7 days had several times grater odds to get an antibiotic at first visit, than those who had a control checkup from 0-3 days. Qualitative statistic revealed additional reasons like doctors' knowledge, fear of complications and skepticism towards the guidelines and postponed prescription.

Conclusions:
We found that doctors younger than 50 years, those who were more profound and took more time for consultation, those who had a better knowledge, used more laboratory tests, made more control checkups and were not afraid of complications prescribed less antibiotic.

Points for discussion:
1. Are there similar reasons influencing antibiotic prescribing in other countries?
2. What could be practical implications of the study?

PRESENTATION 42: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h. Ongoing study with preliminary results

TITLE: Chronic diseases multimorbidity in GP population over ten year's period.

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Background:
The burden of chronic morbidity in the GP population has risen with the ageing of population. Studying multimorbidity and comorbidity over time requires optimal and continuing patient care, making general practice the best setting for it.
Research question:to analyse the burden of multimorbidity of chronic diseases (CD) in a GP's patient population, and to assess the changes in multimorbidity over the 10 years period.

Method:
A 10-year cohort retrospective study (1994.-2003.) has been performed in 17987 GP patients in 11 teaching GP practices in Zagreb. Sample inclusion criteria were the presence of at least one chronic disease in the patient's medical record in 1994 according to the International Classification of Diseases, X revision (ICD-X).
In 1994, 8952 patients with one or more CDs were identified. Data on patients, CDs registered in these patients and data on health care utilisation were collected by their GPs. Multimorbidity was defined as the presence of two or more CDs per patient. Data from 950 patients (37% men and 63% women) of all age groups were analysed using SAS.

Results:
Significant differences in the number of CD in 1994. and in 2003. were found (Spearman 0, 36, p<0.0001). In the 0 – 44 years age group, the mean number of CD in 1994. was 1, 29 and 2, 51 in 2003. In the older than 65 years, the mean number of CD rose from 1,89 in 1994. to 4,19 in 2003. During 10 years period, proportion of patients with multimorbidity was significantly higher than proportion of patients with monomorbidity (McNemr's 374.16, DF 1 p<0,0001).

Conclusions:
Study results show high prevalence of CDs in GP population and increasing trends in CD multimorbidity over the research period.
The high presence of CD multimorbidity in GP population requires new qualities of the health care, different from care for one chronic disease.

Points for discussion:
Caring for patients with CD multimorbidity is our presence and future. Suggestions from the EGPRN forum in analyzing CD multimorbidity will contribute to the quality of this study and to the future care for these patients.

PRESENTATION 43: Saturday 12th May, 2007 11.20 – 13.00 h. POSTER

TITLE: "Something doesn't fit, here!" - Sensation of Alarm in Clinical Decision Making.

AUTHOR(S): Johannes Hauswaldt, C. Kruschinski, E. Hummers-Pradier

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Background:
In clinical decision making, physicians combine non-analytic elements ("gut-feeling") with deliberation. Occasionally, GPs observe an internal sensation of alarm when caring for patients. A discrepancy realised in comparison with a previous encounter has been described as one of GPs' most important diagnostic instruments.

Research questions:
To define "sensation of alarm" and its elements.
To describe triggers, causes and favourable conditions.
To understand better its value, limits and reliability for the decision making process.

Methods:
9 single-person interviews with German GPs have been audio-taped, verbatim transcribed, coded by two researches independently using Grounded theory, and analysed for concepts.

Results:
On little or no prompting, GPs gave between two to five personal examples for this feeling in a quick row. Quite uniformly GPs described that "something does not fit" in a given clinical situation, and that this flashed off the background of their individual knowledge of patient's history, of triggering situational circumstances, or of GP's anticipation which was not met.
Several GPs reported no or positive emotions co-notated with this sensation and took it as a turning point for re-directing the further course of clinical encounter. Others experienced negative emotions and strong vegetative reactions, along with self-doubt. Reflection on physician's own practice was triggered frequently.

Summary:
The existence of a "sensation of alarm" has been established beyond doubt.
GPs used the words "Something does not fit, here!" quite uniformly. Nevertheless, they described non-analytical processes in their decision making which were quite different from each other.
Emotional and vegetative connotations differ considerably for physician and situation, also.

Conclusion:
If this sensation is a homogeneous entity, remains doubtful and needs further research, as well as its emotional and vegetative connotations.
To alert junior doctors for this "sensation of alarm" during their self-reflection should be introduced into medical education.

Points for discussion:
(1) Research into non-analytical elements as gut feelings and clinical intuition of GPs' clinical decision making: is it of relevance and interest in your country?
(2) Which elements of it may be useful to introduce into medical students' and postgra

PRESENTATION 44: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Migraine patients' whish for prophylaxis.

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Background:
Most patients with two or more migraine attacks per month do not use prophylactic medication, although the Dutch Headache Guideline do advise offering prophylactic medication to these patients.

Research question:
To investigate how many patients use prophylaxis or would like to use prophylaxis, and which aspects of migraine contribute to the choice for prophylaxis.

Method:
Cross-sectional survey in 3 general practices. We selected patients who were diagnosed with migraine or had prescriptions for migraine medication. The reasons for and against using prophylaxis and by whom patients want to be informed about prophylaxis, were explored by means of the questionnaire. We assessed frequency, duration and severity of migraine attacks, related symptoms, medication use by means of a questionnaire and data from the practice Electronic Patient Records (EPR). To investigate which aspects of migraine contribute to the choice for prophylaxis, the impact headaches have on the patient's ability to function on the job, at home, at school and in social situations, was assessed with the HIT-6 questionnaire.

Results:
The questionnaire was sent to 283 patients. We included 140 women and 26 males, median age of 41 years (response 58.7%). Most patients had two or more attacks per month (67.3%). Fifty-five percent of patients with two or more attacks per month wanted to use prophylaxis, only eight percent actually uses it. Migraine frequency is associated with patients' wish for prophylaxis: with more attacks, more patients want to use prophylaxis.

Conclusions:
Although more than half of our patients with two or more attacks per month would like to use prophylactic therapy, only 8% uses this therapy. All of these patients should be offered prophylactic therapy according to the Dutch Headache Guideline. To get more insight in the ideas for or against prophylaxis, qualitative research in this subject would be informative.

Points for discussion:
Are these results applicable ot other countries?
How to improve the usage of prohpylaxis in migraine patients?
Do GP's not follow the guidelines and if not, why not?

PRESENTATION 45: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Impact of physical symptoms on perceived health in the community.

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Background:
Physical symptoms, such as musculoskeletal pain, dizziness or headache are common. People with more symptoms are reported to use more healthcare and have higher sickness absenteeism. Most studies on unexplained physical symptoms have been performed among patients with chronic functional syndromes, and these results may not be generalisable to primary care or the community.

Research question:
What is the impact of the number of physical symptoms on perceived health in a community sample of adults?

Method:
Between June 2005 and March 2006 a random sample of 4741 adults was selected from the records of five general practices in The Netherlands. They were sent a questionnaire regarding the frequency and impact of physical symptoms, and other factors that may influence health (potential confounders or modifiers), including demographics, lifestyle factors, childhood illness experiences, and psychological factors. We studied the association between an increasing number of physical symptoms and perceived health using the SF-36 as the outcome measure, and investigated which factors influenced this association.

Results:
Response rate was 53.5% (n = 2447). Fatigue was the most commonly reported symptom with a prevalence of 57%, followed by headache (40%) and low back pain (39%). More than half of responders reported three symptoms or more. Responders with multiple symptoms were more often female, had lower educational level, less often paid work, higher body mass index, more negative childhood health experiences, and higher scores for psychological factors. Multiple symptoms were strongly associated with perceived health, especially among responders with negative illness perceptions, and those reporting family members with a chronic illness during childhood.

Conclusions:
Physical symptoms are common and often seem to be mild. However, increasing number of symptoms is strongly associated with poorer physical, emotional and social functioning.

Points for discussion:
1: There is a strong association between physical symptoms and perceived health, but symptoms seem to be mild in most people. So how big of a health problem is this?
2: Learned processes, whereby illness experiences may lead to higher symptom awarenes

PRESENTATION 46: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h. Ongoing study with preliminary results

TITLE: Attitude and Practice of Case Managers in German General Practices – a qualitative study.

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Background:
Case management is an essential element of collaborative care for patients with chronic conditions (e.g. Type 2 diabetes, congestive heart failure, depression). Most of the evidence was produced in high structured care settings – particularly in US HMOs. Before translating the evidence into the German health care system, the perspectives of the local case managers need to be evaluated comprehensively.

Research question:
The study explores the case managers' perspectives (attitudes and practice) concerning: acceptability, feasibility and barriers to a collaborative model for the treatment of patients with depression in German general practices.

Method:
We interviewed 38 female case managers (trained practice nurses) of a large scale RCT on case management for patients with depression in primary health care (n=620 patients). Two "focus groups" and additional semi-structured individual interviews were conducted. Analysis: Transcription of all recorded interviews. Content analysis (according to Mayring) was used to analyse: themes, clusters and key concepts.

Results:
Preliminary results show: practice nurses feel competent and comfortable to fulfil their new role in a collaborative care approach. Limiting factors are: 1) "dealing with difficult situations", as there is e.g. communication with patients reporting suicidal ideations, 2) "male patients prefer male professionals". Details will be presented at the conference.

Conclusions:
Practice nurses fell competent to work as case managers in primary health care. Further research is needed to compare these results to patients' and General Practitioners' perspectives and patients' clinical outcomes.

Points for discussion:
- We kindly would like to ask the audience for recommendations on data interpretation

PRESENTATION 47: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Opinions on registering trial details: a survey of academic researchers.

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Background:
Since 2005 the International Committee of Medical Journal Editors requires prospective registration of clinical studies in order to be considered for publication in one of their journals. In the same Year the Ottawa Group published principles of trial registration and a minimum data set for registration is currently developed. This set includes more details about a study than the established WHO Trial Registration Data Set. Nothing is known about the willingness of academic researchers to disclose study details in a trial registry.

Research question:
To determine whether academic researchers are willing to disclose study details proposed by the Ottawa Group in a study registry.

Method:
This study was a survey of academic researchers currently running an investigator-initiated clinical study which is registered with clinicaltrials.gov. In July 2006, 1299 principal investigators were contacted by e-mail explaining the purpose of the survey and a link to access the questionnaire. Participants were asked whether they would be willing to publicly disclose specific details about their study based on the proposed minimum data set by the Ottawa Group.

Results:
Overall response was low as only 282/1299 (22%) principal investigators participated in the survey. Disclosing study documents, in particular the study protocol and financial agreements, was found to be most problematic with only 31% of respondents willing to disclose these publicly. Consequently, only 34/282 (12%) agreed to disclose all details proposed by the Ottawa Group. Logistic regression indicated no association between characteristics of non-responders and willingness to disclose details.

Conclusions:
Principal investigators of non-industry sponsored studies are reluctant to disclose all data items proposed by the Ottawa Group. Disclosing the study protocol and financial agreements was found to be most problematic. Future discussions on trial registration should not only focus on industry but also on academic researchers.

Points for discussion:
How to deal with the reluctance of academic researchers to disclose study details?

PRESENTATION 48: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: The palliative care service in the opinion of caregivers.

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Background:
The palliative Care Service was established in the District of Trento (Italy) in 2000. GPs are directly involved in the team, composed by specialists in palliative care and dedicated nurses. In these six years of activity cancer patients' hospital death rate fell from 70% to 45%.

Research question:
In the context of GPs' vocational training activity we focused the importance to set up a qualitative study aiming to identify opinions among caregivers on the specific role of each member of the palliative care team, and particularly of GPs.

Method:
Qualitative focus group study. 43 cancer patients (of 126 who died at home from december 2005 to may 2006) were randomized and their caregivers and GPs identified. Only one patient for each GP was then selected. 20 caregivers were then invited to attend at 2 focus groups. The meetings were audio taped with participants' consent and transcribed for analysis.

Results:
19 caregivers attended the meetings,17 of them were middle-aged women . The most critical aspect perceived by the caregivers was the lack of coordination with out-of- hours services.
Nurses have a recognized central role in coordination and in affective support. Palliative care specialists are perceived as more "distant" professionals but with adeguate knowledge and expertise. GPs are perceived in a variety of ways, depending on their personal attitudes and their previous relationship with the patient and the family. They have recognized specific skills when comorbidities are still important.

Conclusions:
Nurses and palliative care specialists are perceived as a service, GPs as individuals. Initiatives are probably needed to enhance GPs' homogeneity in knowledge of palliative care and attitudes towards it.

Points for discussion:
1. Sampling criteria: how is considered our decision to combine random samplig with "convenience" technique?
2. Importance of research activity in vocational training for GPs

PRESENTATION 49: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Expectations and needs of elderly dizzy patients in General Practice.

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Background:
In the elderly, dizziness has been described as a frequent multifactorial "geriatric syndrome", which makes it necessary to identify potentially treatable contributing factors. However, there is a lack of evidence-based therapy options.

Research question:
To reveal the expectations and needs of elderly patients suffering from dizziness in order to develop a patient-orientated treatment concept.

Method:
9 general practitioners addressed patients above 65 years currently complaining of dizziness. 20 patients (12 females, 8 males, mean age 79 years) who were willing to participate were interviewed. The analysis was performed according to grounded theory by two of the authors independently. Codes and categories were compared and discussed until a consensus was reached.

Results:
Preliminary results show that the patients' expectations and needs were related to six categories: Explanation of dizziness (own concepts of aetiology), the doctor's role and action such as routine observation (care), treatment proposals (cure), maintenance of mobility, the physician-patient relationship such as being taken seriously, and the patient's role. Some described their role as passive (not to bother the doctor, resignation), some were self-motivating. Many respected the doctor as expert, but some accused their doctor of not doing enough for them.

Conclusions:
Fear of falling and related needs were one of the most constantly mentioned topics. To integrate patients' priorities in the management of dizzy elderly might be a concept worth to be further investigated.

Points for discussion:
1. How can these results be rephrased as questionnaire items for a now starting prospective cohort study?
2. What does the auditorium think are the expectations and needs of elderly dizzy patients and have they been integrated in dizziness management els

PRESENTATION 50: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: EGPRN abstracts June 2001-May 2006 Content and study design.

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Background:
One aspect of the promotion of primary care research is the development of a European research agenda to provide a base for a structural strong research field in primary care. In 2002, EGPRN started working on a European general practice research agenda. Part of this task is to review what has been done in the recent past.

Research question:
What are the themes of research and the study designs used in EGPRN abstracts of the last 5 years?

Method:
Descriptive and retrospective study. Accepted EGPRN abstracts during the period June 2001 to May 2006 were classified and described on the basis of content and methodology. Data was analysed from all meetings in the period June 2001-May 2006. EGPRN abstracts were classified with regard to their themes through use of research question and content. A keyword scheme was created. Second, all EGPRN abstracts were classified on study design on several levels to get a review of most common study designs of the last 5 years.

Results:
A total of 438 abstracts were analysed. The main topics of research of the last 5 years were clinical research themes mainly focussing on therapy, quality of care, prescribing behaviour of general practitioners and patient perceptions/ attitudes.
With regards to study design, the largest group is observational studies of which the cross sectional survey is the most used method of data collection. Frequent use of qualitative study design was also visible.

Conclusions:
The main themes of the last 5 years are identified. Clinical themes are common, but contrast with mainly observational and descriptive methodology. Interventional research, like randomised controlled trials, is rare, but present. Research themes and methods which deserve more attention can now be extracted.

PRESENTATION 51: Saturday 12th May, 2007 POSTER
11.20 – 13.00 h.

TITLE: Evidence-based Medicine: quick and dirty. A randomised controlled trial evaluating acceptance and efficacy.

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Background:
General practitioners often have unanswered clinical questions. In most of them GPs don't even attempt an answer. On the other hand, there is an enormous amount of medical information on the Internet available. We have developed a learning programme (PERLEN) to enable GPs to find rapid answers to their questions. There is an emphasis on easy, processed sources as opposed to original research publications. We explain their strengths and weaknesses, and show simple heuristics to judge the validity of information and to guide further search.

Research question:
The goal of this study is to determine the level of acceptance, applicability and efficacy of our learning programme.

Method:
The PERLEN-project is a randomised, stratified, complex intervention study: A total of 136 physicians (43 women and 93 men) were trained via 2 interactive small group courses in a computer centre. Control- and Intervention-group answered the same search-questions before or after the CME. We evaluated acceptance, process and outcome, i.e. skills.

Results:
Participants were approximately 50 years old and had 15 years experience as a GP. They particularly appreciated the learning environment, with a computer workspace, practical exercises and helpful handouts. 88% of the participants considered the course material to be relevant to their daily work. However, only half of them intended to apply what they had learned due to lack of time (60%) and uncertainty in computer handling (40%). Final results will be presented at the EGPRN conference.

Conclusions:
General practitioners often have unanswered clinical questions. PERLEN supports individually adapted, evidence-based medical decisions. The acceptance of the CME strategy is very high. However, the relevance with re-gard to its long-term use is not clear.

Points for discussion:
We asked GPs to collect unanswered clinical questions. Their skill to answer these self-generated questions was our original efficacy criterion. However, they generated far too few questions so that we had to switch to standardized questions to evaluate p

PRESENTATION 52: Saturday 12th May, 2007 — 11.20 – 13.00 h.

POSTER — Ongoing study with preliminary results

TITLE: Living with diabetes: How can we get insight in a complex reality.

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Background:
Successful diabetes management requires that health care providers understand the lifestyle, beliefs and attitudes of their individual patients. The unique character of each individual (health-journey) is the result of complex interactions within themselves and with their environment.

Research question:
Is it feasible to use different methods of data collection and analysis over a longer period of time to better understand these complex interactions?

Method:
Combination of qualitative and quantitative data collection methods with 6 patients over a longer period.
In an initial semi-structured interview participants talk about living with diabetes and issues they feel related to it. Afterwards individuals undertake intensive data collection with the research team over 6 to12 months: diary keeping, follow-up interview (clarifying details of the first interview), audio-recorded consultation with a health-care provider.
In a final interview the patients reflects on the synthesis of the collected data.
Information on HbA1c, blood pressure, BMI and emotional well-being (PAID) is collected.
Interviews are audio-recorded and transcribed. Thematic analysis of the individual data is followed by cross-case analysis of the emerging big themes.

Results:
Data-collection is finished in 4 patients and ongoing for two patients.
A ‘step by step’ analysis approach is used. Three researchers read and coded independently one interview, yielding a list of 30 codes. The other data (interviews, consultations and diaries) were analysed with this lcode-list. When necessary, new codes were added and related subjects were put together.
Further analysis (per case and cross-case) should allow to construct a map of interactions impacting on an individual health journey.

Conclusions:
Intensive longitudinal data collection by/from people with diabetes type 2 about ‘living with diabetes’ seems possible provided adequate supervision. Sufficient experience in interviewing techniques is necessary to acquire information about psychosocial aspects.
Data-analysis is ongoing. Mapping of interactions will be a challenge.

Points for discussion:
We would like to discuss the analysis process: feedback and experiences of other reseachers. The analys proces will be elaborated on during the presentation.

PRESENTATION 53: Saturday 12th May, 2007 11.20 – 13.00 h. DISCUSSION SESSION

TITLE: Collaborative Studies: From obstacles to strategies.

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Introduction:
Collaborative study is defined as a complex study which involves many persons working together in several sectors, disciplines and/or regions or countries.
The main aims of this kind of study is to exchange and compare data or information to better understand the complexity of a multiple causality, to improve and exchange the development of ideas and new methodologies, and to have a strong impact on political decisions. From its unique characteristic, there are many obstacles in conducting the collaborative study.

Aims:
The aims of this poster are to analyse obstacles and to propose some significant strategies to properly conduct collaborative studies in order to improve the collaborative studies among European countries.

Target:
The target is to improve the collaborative studies among European countries

Development:
The authors would like to present some definitions of collaborative studies and analyse the importance of collaborative studies for the European countries. Additionally, the authors also propose some common obstacles and present some strategies in order to develop a good collaborative study.

Conclusion:
Collaborative research is one of good research strategies and permit to have larger and more comprehensive researches. In order to successfully and effectively conduct collaborative studies, the participants must not forget the Authors suggestions.

PRESENTATION 54: Saturday 12th May, 2007 DISCUSSION SESSION
11.20 – 13.00 h.

TITLE: Consequences of the “feminization” of medicine for the supply of family physicians in national health systems.

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Background:
The percentage of women in medical education is increasing rapidly in most European countries, arriving at up to 70% nowadays. This development will probably cause dramatic changes in the supply of health services in all areas and disciplines, including family medicine. It is largely unclear, however, to which extent this development will affect family medicine in a positive or negative way. Also, cultural differences between countries may provoke a uniform picture in the future, showing countries with favourable and others with less favourable supplies of GPs.

Research question:
- Which will be the consequences of the growing feminization of medicine for the supply of general practitioners?
- Which factors do contribute positively or negatively to a sufficient supply and an even distribution of future family physicians?

Method:
The study id based on an international expert panel moderated by the Institute of General Practice of Hamburg University, encompassing Austria, Germany, Norway, Spain (Catalonia), Sweden, Switzerland, Turkey, United Kingdom and the USA. For each country, reports on the questions listed above are written by national experts on the basis of a compulsory item list. These reports are subjected a comparative analysis. The results will be discussed and the con-clusions drawn by the expert panel during a joint seminar in Hamburg.

Results:
This procedure will allow to depict actual and future developments in primary care attributable to feminization and to identify promoting factors and barriers with regard to an optimal supply of family physicians in the nine countries. A review of the literature and preliminary findings of the study will be presented.

Points for discussion:
1) Which additional factors promoting or impeding a sufficient supply of (female) family physicians are seen in other countries than those presented?

PRESENTATION 55: Saturday 12th May, 2007 ONE SLIDE/FIVE MINUTES
14.45 – 14.55 h. Ongoing study with preliminary results

TITLE: Caregivers for old dependent people: how many are depressed when patients are at home or in an institution?

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Background:
A few GPs are worried about the depressive syndrome seen in many caregivers accompanying dependant old people. It probably has a detrimental impact on the quality and the continuity of the care provided.

Research question:
To assess the incidence of caregivers suffering from depression, according to the workload assumed at home or in institution

Method:
Transversal epidemiologic study including caregivers of patients aged 65 or more, dependent by loss of physical and/or mental autonomy followed up by one of the 126 ambulatory clinician teachers of the medical university of Lille.
Once the starts date, each doctor has included the first two institutionalized dependent patients, and the first two home dependant patients, irrelevant of the needs in care during one month. The definition of caregivers is given within the framework of an institutionalization as those who profits from confidence, and for home keeping as the spouse or the first person of the family or friendly entourage with the patient at the time of the doctor's visit.
The questionnaire is the Mini International Neuropsychiatry Interview (MINI).
Every doctor fills out the questionnaires, with the details of the caregivers of the first patients met, either by interviewing them, or if the doctor is treating them, basing it on his record.

Results:
This is the first level of a geriatric research program. We expect to show the incidence of the depressive syndrome in caregivers coping with dependant old people living in their usual residences or in an institution

Conclusions:
will be published in April 2007

Points for discussion:
- The next level is to show the difference of the depression in caregivers between the two ways of life of the old dependant patients they assume, and to establish a correlation between institutionalization, maintenance in residence of the dependent old people.

PRESENTATION 56: Saturday 12th May, 2007 ONE SLIDE/FIVE MINUTES
14.55 – 15.05 h. Study proposal / idea

TITLE: Are GPs concerned about adolescent cannabis use?

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Background:
In most European countries, rates of cannabis use have tremendously increased over the last 10 years, particularly in France. Relationship between chronic and acute cannabis use and health problems is quite well established in the literature, especially concerning the risks of dependence, psychotic disorders, fatal road crashes, unprotected sex and medical care increase.
On the one hand, even if it is an illegal drug in France, cannabis is so usual among adolescents that the word "smoking" has become ambiguous, particularly for GPs in their practice. The French data of ESPAD 2003 (school survey) showed that 18% of girls and 25% of boys have used cannabis during the previous month. Moreover, even a cannabis use of 1-5 times during the previous month was associated with negative risks markers (Suicide attempts, acts of violence, etc.).
On the other hand, 1 patient consulting a GP in France out of 7 is 11 to 20 years old. Whereas brief interventions with adolescents using substance seemed to be efficient; those delivered in non school settings have not yet proved any efficiency, except maybe for cannabis use.
The final goal of this study is to create a brief intervention in general practice. Above all, we must know if GPs are concerned by adolescent cannabis use.

Research question:
- Is the prevalence of adolescent cannabis use at school the same as in GP's office?
- Do the GPs ask adolescents about their cannabis use?

Method:
- Retrospective quantitative study to evaluate how many GP's have asked (or not) adolescents about their cannabis use.
- Prospective study to get the prevalence of adolescent cannabis use in general practice.
- Focus Groups with GP's to evaluate:
    - how do they feel concerned by adolescents and cannabis use.
    - how do they manage questions about cannabis use.

Points for discussion:
- Do EGPRN attendees get figures about adolescent and cannabis use in general practice?
- Do preventive programs in general practice concerning adolescent cannabis use exist in European countries?

PRESENTATION 57: Saturday 12th May, 2007 15.05 – 15.15 h. ONE SLIDE/FIVE MINUTES Study proposal / idea

TITLE: Interprofessional collaboration /a pilot study and proposal for international survey.

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Background:
Across Europe delivering and financing care in health sector is quite differently organized. Since middle of the year 2000, in Bulgaria were established three levels structure – GP, out-hospital consultant and hospital – and one main finance flow – National health insurance fund.
The collaboration between primary and secondary health care is a challenge.

Research question:
The idea of the study is to describe the type of relationship, the doctors' attitudes and to find out how doctors behave towards this relationship.

Method:
Data on doctors' view will be collected in a self filled questionnaire survey with closed replies among a representative sample.
Essential elements of collaboration, advantages and barriers to collaborative affiliation, impact of collaborative practice and changes in practice patterns among professionals of various disciplines are some of the issues in the form.

Results:
The starting hypothesis is that the nature of relationship between GPs and outer specialists affects job satisfaction in an increasingly complex world of health care.

PRESENTATION 58: Saturday 12th May, 2007 15.15 – 15.25 h. ONE SLIDE/FIVE MINUTES

TITLE: Research into GPs' non-analytical decision-making process.

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Background:
In GPs' clinical decision-making process non-analytical steps like gut feelings or "sensation of alarm" and clinical intuition play an important role as well as analytical steps do. We conducted qualitative research into those non-analytical aspects in two countries: the Netherlands and Germany.

Research question:
How are "gut feelings" or "sensation of alarm" described by GPs; what are triggering cues and favourable conditions? (Definition)
For the clinical decision making process: what are the value, limits and reliability of "gut feelings" and "sensation of alarm" for GPs in daily practice? (Diagnostic value)

Method:
We gathered data applying two different techniques: four focus group discussions with 28 GPs about gut feelings and 9 single person interviews with GPs about sensation of alarm.
Data were analysed with the Grounded Theory analysis technique.

Results:
With both methods we gained more insight into the non-analytical aspects of the GPs' decision-making process. We were able to formulate definitions of gut feelings and sensation of alarm and found major determinants. Most GPs recognized the value of gut feelings and sensation of alarm in the clinical decision-making process. There were also differences in our results.

Conclusions:
Qualitative research into some aspects of GP's non-analytical decision making process in two different countries produced comparable results and some differences. We are very interested in how those might relate to differences in the used methods or between Dutch and German GPs. Similar research in other countries is a good possibility to gain more in-depth knowledge.

Points for discussion:
(1) Research into non-analytical elements as gut feelings and clinical intuition of GPs' clinical decision making: is it of relevance and interest in your country?
(2) Which elements of it may be useful to introduce into medical students' and postgraduates.

PRESENTATION 59: Saturday 12th May, 2007 ONE SLIDE/FIVE MINUTES
15.25 – 15.35 h. Study proposal / idea

TITLE: Female and male GPs feeling about criticisms in their practice during their work life.

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Background:
Gender has a central role in the practice of Family Medicine from three points of view: the point of view of doctor, the point of view of communication between doctor and patient, and the point of view of patient.
In 2005 I did a literature research about Family Medicine and gender, based on an historic point of view.
The growing number of female GPs allows deeper reflection on what has changed in the last decades in the daily practice.
Parallel to this fact there has been a change in the attitude of the family physician from disease centred medicine to patient centred medicine.
At time there is some confusion on what a family doctor is expected to do.

Research question and methods:
Video recorded interviews to female and male GPs will analyze the changes of the work of family physician in the last twenty years
Open questions on how they feel these changes, how they perceive their actual work and also their physical status, how much they have reached their objectives, will be recorded.
A different meaning of our profession is expected by the different gender.
Critical issues and new problem arising from the interview may help to better explain the new challenges that our society is bringing in these last years.
The use of open questions during the interview has been chosen to utilize the skillness coming from our profession during the daily practice
The analysis of the video taped interviews will allow to focus on the non verbal communication with our colleagues.
A linguistic analysis may emphasize the differences between different genders and the new problems coming from the societal changes.

Points for discussion:
Do you think that female and male GPs feel the changes of their actual work in a different way?
May a gender point of view about our profession gives a change in the confusion on what a family doctor is expected to do?

PRESENTATION 60: Saturday 12th May, 2007 14.45 – 14.55 h.

ONE SLIDE/FIVE MINUTES
Study proposal / idea

TITLE: How can we evaluate the appropriateness of cardiovascular prevention therapy in General Practice?

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Background:
Over the last few years the scientific view of cardiovascular risk has changed radically. Instead of dealing with solitary risk factors and target-values for blood pressure, cholesterol etc. it has become evident that patients' individual overall (or global) cardiovascular risk should be the main parameter to decide on any therapy. However a certain risk can mean very different things to different patients. A very simplified example: A 5% 10y risk of cardiovascular mortality could be a clear indication to start a preventive therapy for a woman of 50 years whereas there are good reasons to accept such a risk for a man of 75years and not start to treat.

Research Question:
We developed an educational intervention – including an advanced computer-based risk-calculator - that aims to help GP and patients to decide on a therapy based on the individual cardiovascular risk. As in conclusion the decision about a preventive therapy becomes highly depending of the individual context, we wonder how to assess the appropriateness and in conclusion the effectiveness of the educational intervention other than by qualitative parameters (like patient satisfaction)?

Points of Discussion:
We would like to discuss possible parameters and methods of building algorithms to assess the appropriateness of a preventive cardiovascular therapy, for example:
- Dichotomising patients into patients with high and low risk (omitting patients at moderate risk)
- Use the comparison of individual risk vs. average risk of patients of same sex and age group
- Use of "risk-adapted" control rates
- Inclusion of patient preferences

PRESENTATION 61: Saturday 12th May, 2007 ONE SLIDE/FIVE MINUTES
14.55 – 15.05 h. Study proposal / idea

TITLE: Improving general practitioners' care for COPD patients by an intervention program using computerised checklists and feedback.

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Background:
There is a gap between evidence based recommendations and clinical practice. Several interventions to improve professional performance are available, but none have proved to be consistently effective. Systematic registration of patients' diagnoses is increasingly being used in general practice in Denmark. Combining this with reminders and feedback may improve implementation of evidence based recommendations in general practice. The intervention will be targeted at improving care for patients suffering from chronic obstructive pulmonary disease (COPD).

Research question:
To assess the effectiveness of systematically registering patients, using computer based checklists as decision support and reminders, and feedback with clinical data at the level of the individual patient.

Method:
Randomised controlled trial. All general practices in the Region of Southern Denmark (1.4 million inhabitants) will be invited to participate. Each practice will be randomised to one of three interventions 1). registering patients, 2). registering patients and filling out checklists and 3). registering patients, filling out checklists and receiving feedback. Follow up after two years. Primary outcome measure will be changes in hospital admissions. Secondary outcomes will be changes in the practitioners' use of spirometry, their prescribing of corticosteroids, β2-agonists, antibiotics and influenza vaccinations.

Points for discussion:
1. Study design
2. Outcome
3. Generalisability

PRESENTATION 62: Saturday 12th May, 2007 — 15.05 – 15.15 h.

ONE SLIDE/FIVE MINUTES
Ongoing study with preliminary results

TITLE: Evaluation of CV diseases development risk according to gender.

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Background:
CV pathology is the main reason of mortality and the big part of morbidity in Lithuania. In comparison to other groups of diseases, CV diseases are the main reason of disability and economics loss. We are working on new CV diseases prevention program in Lithuania, which was created in 2006 year, on February.

Research question:
To establish correlation between risk factors and development of CV diseases. To compare risk of CV diseases according to gender.

Method:
The data set of our research work (1 general practice centre, n= 242, male n= 126, female n=116, male age is between 40 -55, female age is between 50 – 65) is analysed for this purpose. The main measurements include screening,
physical examination, risk factors evaluation, laboratory tests, instrumental tests. We use SCORE table to evaluate CV diseases risk.

Results:
242 individuals were investigated. The clear risk factors distribution between male and female is observed: BMI, smoking, metabolic syndrome cases, total cholesterol, LDC are bigger in male group.

Conclusions:
We don't have final results yet, but our current results demonstrate, that male are influenced by more risk factors, have higher CV disease risk than female.

Points for discussion:
1. Experience in other countries.
2. Special primary prevention tools according to gender.

PRESENTATION 63: Saturday 12th May, 2007 15.15 – 15.25 h.

ONE SLIDE/FIVE MINUTES
Study proposal / idea

TITLE: Does the doctor's illness influence his/her behaviour towards the patients suffering from the same illness?

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Background:
The doctors may have different view toward the patients having the same diagnoses.

Research question:
Does the doctors attitude depend from,
-the type of illness (cardiovascular, endocrine, tumour, etc.),
-course of illness (acute, chronic),
-expected prognosis of illness,
-severity,
-the gender of doctor's and patient's
-the country and/or cultural/religious background?

Method / Results / Conclusions:
How to estimate it?
- with qualitative study?
- by follow up, or cross sectional way?

How to organize the study?
How to find participants among doctors, because the often neglect their worries?

Ideas and suggestions expected!
Possible participants from different countries expected!

Points for discussion:
Ideas and suggestions expected!
Possible participants from different countries expected!

Application for EGPRN Research Funding

PRESENTATION 64: Saturday 12th May, 2007 ONE SLIDE/FIVE MINUTES
15.25 – 15.35 h. Study proposal / idea

TITLE: Gender in instant aging system.

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Background:
Instant aging has been developed by Leon Patalan in 1974. It was designed to develop empathy for nurse training. A preliminary study has found that there is a difference between male and female in the success of this training for medical students.

Research question:
Is there a gender difference in the effects of instant aging system?

Method:
5 European universities would like to do this interventional study, with undergraduate and postgraduate medical students. 15-20 in each group with 2 facilitators. Use of spielberger's state plus trait anxiety scale. Pre intervention assessment (quantitative) fill the spielberger's scale (with a nickname). Short brain storming (what is empathy, is empathy important in medicine, if yes why). Intervention: students in pairs will switch role (first role disabled person walking, climbing, reading a drug description, putting on and off shoes, listening radio, second role helper). Then in post intervention assessment (quantitative) fill in the spielberger's scale with the same nickname, and in post intervention qualitative assessment answer to the following questions: did this experience make a difference for you, if yes please describe it in one sentence.

Universities of Brest (France), Göttingen (Germany), Hamburg (Germany), Marmara (Turky), Koceali (Turky) are involved in this project.

Results:
study proposal, no result yet.

Conclusions:
study proposal, no conclusion yet.

Points for discussion:
1. Is there any point we should include in this study?
2. Will EGPRN give fund to us to do this study?

PRESENTATION 65: Saturday 12th May, 2007 THEME PAPER
15.50 – 16.20 h.

TITLE: Gender differences in presentation and management of low back pain in primary care.

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Background:
Epidemiologic surveys consistently show that women not only suffer more frequently from low back pain (LBP), but they are also more affected by LBP. It is unknown if this affects health care service utilization.

Research question:
Is presentation of LBP by women different from men? Do women use more health care services for LBP than men?

Method:
This is a prospective cohort study. Data from 1342 (778 (58 %) women) patients presenting with LBP in general practice (GP) was collected. 116 practices recruited on average 11,8 (SD ±5,8) patients. Patients filled standardized questionnaires before and after consultation and were contacted by phone 4 weeks, 6 month and 12 month later for standardized interviews by study nurses. Logistic regression models to investigate the effect of gender adjusting for sociodemographic and disease related data for the use specific health care services are calculated.

Results:
Women had on average a lower functional capacity at baseline and after 12 month. They were significantly more likely to have reccurrent or chronic LBP and to have a positive depression score. Also women in univariate analysis had higher uses of multiple health care services those differences disappeared after adjustment for sociodemographic and disease related covariates.

Conclusions:
Our findings confirm that women are more severely affected by LBP, but we have no evidence that women receive different treatment compared to men.

Points for discussion:
Given the comparatively worse prognosis of LBP in women, is the finding of no difference in health care utilization evidence under treatment?
Should we develop a specific approach for women?

PRESENTATION 66: Saturday 12th May, 2007 THEME PAPER
16.20 – 16.50 h. Ongoing study with preliminary results

TITLE: Gender Aspects in Symptoms and Treatment of Patients with Major Depression in Primary Health Care.

AUTHOR(S): Monika Peitz, M. Torge, K. Mergenthal, H. Wendt-Hermainski F. Gerlach, J. Gensichen

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Background:
A clear finding in epidemiological research is that female sex is a risk factor for depression. It has also been reported, that there are gender differences e.g. in symptoms, co-morbidity, treatment and course of the disease.

Research question:
The aim of this study is to show differences in severity, symptoms and treatment strategy between female and male patients with major depression in primary health care.

Method:
Secondary data analysis form a sample of 620 patients enrolled for a RCT on Case management. Comparisons of self-reported depression symptoms (PHQ-10, BDI) and clinical interview (ICD-10), psychiatric co-morbidity, anti-depressive treatment and referrals (from the records). Statistics: Chi-Square-Tests and T-Tests.

Results:
Preliminary results show little differences between female and male patients in symptom severity and treatment strategy. Further analysis will be presented at the conference.

Conclusions:
Methodological cultural characteristics may account for heterogeneity in research findings.

Points for discussion:
- Methodological characteristics (study design) may account for heterogeneity in research findings.
- We kindly would like to ask the audience for recommendations on data interpretation.

PRESENTATION 67: Saturday 12th May, 2007 THEME PAPER
16.50 – 17.20 h. Ongoing Study with preliminary results

TITLE: Screen Sirens: Teaching gender issues using film in medical undergraduate education.

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Background:
Teaching gender issues using traditional techniques is challenging. Gender issues may be perceived as 'women's issues' exclusively; male students feel the subject has no relevance for them. There is confusion between gender issues and a feminist approach. It is also difficult to explore underlying attitudes.

Research Question:
Is film a useful vehicle for teaching gender issues?

Methods:
As part of an optional module in film studies, first and second year students cover two sessions on gender. In one session students are asked to critically evaluate the work of director Jane Campion. During the session parallels are drawn between gender issues in film and medicine by discussing themes within the movies, the role of women as workers and by comparing and contrasting the idea of 'chick flicks' and 'women's health' as consumer products.
A second session addresses the issue of domestic and sexual violence. During the session role play and small group discussion with viewing of film clips is used to explore student's knowledge and attitudes, whilst developing basic skills in this area.
Case vignettes are given to students before and after the sessions to explore their prior awareness and attitudes to gender issues.

Results:
Film has the benefit of engaging the students' attention and highlighting that gender is an important issue within society as a whole. The Campion session allows them to come to this conclusion themselves and then relate the issues to medicine. Film also has the benefit of enabling difficult areas to be covered in a protected environment. Students have the opportunity to explore their own issues prior to clinical exposure.

Conclusion:
Film is a useful method for teaching gender issues in undergraduate medical education.

Points for discussion:
Use of film in medical education
Exploring attitudinal shift in medical education