The European General Practice Research Workshop

Israel meeting presentation abstracts

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PRESENTATION 1:

TITLE: Only old people die. Mortality distribution and causes of death in 2 Kibbutzim in northern Israel.

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Quality assurance in Family Medicine has recently been attrac-ting more attention. Constant audit should be the res-pon-sibil-ity of every family physician. Self-audit is relative-ly simple and is non-threatening.

We would like to present as an example of self-audit: causes of death, mortality rate and

distribution among my practice of 1300 people in two kibbutzim in northern Israel.

Death is, of course, a natural and unavoidable phenomenon. However, it may also result from poor medical treatment.

We carried out a study of all cases of death in my practice during the 3 year period 1990 to the end of 1992. We noted the age, sex and causes of death. We would like to point out that of the population of the practices, 17% is aged 65 years and over.

During this period 29 people died; 15 men and 14 women. Except for a 10-day old infant who died of DIC, the death roll was composed of people of ages 65 to 92.

The crude mortality rate in my practice is 7 to 1000, whilst the crude mortality rate in the Kibbutz movement as a whole in 5.6 to 1000 (in 1989).

In 1990 and 1991 age adjusted death rate was 5.3 in my practi-ce. Age adjusted death rate in Israel is 7 to 1000.

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PRESENTATION 2:

TITLE: Functional assessment of the elderly in Irish General Practice.

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The aim of this study is to examine the place of functional assessment of the elderly in Irish General Practice. There are two objectives. Objective (1) is to examine the usefulness of functional assessment of the elderly with particular reference to four areas: (1) mobility, (2) hearing, (3) vision, (4) incontinence. Objective (2) is to examine whether the functio-nal assessment leads to actions which improve the ability of the elderly person to function independently.
The methodology is as follows: A pilot project has rum from March 1st to March 31st

1993. Then GPs were recruited for each topic under study, i.e. forty GPs in all. Each of these 10 GPs was asked to see 10 patients over 75, randomly selected from their own practice lists. Each GP administered a questionnaire concerning their designated topic to these patients. The design of the questionnaires is based on the work of Williams and Wallace (Ref.1). Each questionnaire contains a short test of cognitive function, that is the Abbreviated Mental Test Score. If the elderly person fails this test questionnaire was delivered to a carer.
There is an outcome assessment proposed for the pilot project patients in October 1993. This will probably take the form of re-administering the functional assessment questionnaire in order to determine:
(1) Whether there is any change in the person's level of functional ability.
(2) Whether actions proposed in March 1993 by GPs have taken place.
(3) If proposed actions have not taken place the reasons for this will be examined.
These will then be analysed in order to detemine the best form of outcome measurement for the nationwide study, the first phase of which is planned for October 1993, which will involve approximately 400 GPs and 4000 patients.

Ref.1: "Recommendations the of Royal College of General Practitioners - The Screening Questionnaire". Lecture plus notes by Dr. Paul Wallace* at Joint Conference on measures of Functional Status of Elderly People, at Royal College of Physicians, London.
*Head of Helen Hamlyn Research Unit, Dept. of General Practi-ce, St. Mary's Hospital, London.

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PRESENTATION 3:

TITLE: Community prevalence study of symptoms of be-nign prostatic hypertrophy (BPH) in men aged 65 years and over - also comparing subjective symptom scores with objective assessment of urinary flow rate.

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Aims: To determine the prevalence of BPH in men aged 65 and over. To compare patient's subjective assessment of symp-toms of urinary dysfunction with objective assessment using uroflowmetry.

Methods: All men aged 65 and over registered with the practi-ce were invited to attend for screening of prostatic symptoms. Each patient completed a general health questionnaire (GHQ), two prostatic symptom questionnaires and had maximum flow rates (Q max - emptying a full bladder) assessed using urof-lowmetry. The urine was tested for blood, protein and glucose.

Results: 127 men participated (n=182), a response rate of 70%. Reported symptom prevalence included 16% daytime frequen-ce, 21% night time frequency, 27% occasional urge incontinen-ce, 28% always ended micturition with dribbling, 9% needed to change underwear for urine leakage. 63% had symptoms and signs of BPH with Q max < 15 mls/sec. 38% had Q < 10 mls/sec and 34% maximum output volume < 150 mls. Yet 88% were happy to conti-nue with current symptoms. 5% wanted referral for interventi-on. According to the GHQ 38% said they were in excellent health and 41% in good health. Symptom scores did not correla-te with urinary flow rates. Only 25% of those with Q max < 15 mls/sec were identified through symptom scores. Although 11% had trace of heamaglobin in the urine, only 1 patient had red blood corpuscles and he had normal investigations. 5% had glucose in the urine and 2 new diabetics were revealed. 84 men with significant urinary dysfunction were offered hospital referral (3 had previously a turp) - 4 accepted.

Conclusions: The prevalence of symptoms and signs of BPH in the elderly is high (64%) as found by Garraway et al (1). Patients significantly under - report symptoms: symptom scores identified 25% the patient suffering from significant urinary dysfunction as uroflowmetry. Symptoms, mostly present for > 12 months, are generally accepted - majority of patients prefer-red the 'wait and see/review' treatment option with 5% reques-ting referral. Urinary heamaglobin is a common and unimportant finding. Uroflowmetry is a useful assessment in primary care and more reliable than subjective assessment when evaluating urinary function.

References:

1. Garraway W., Collins, G. & Lee, R. High prevalence of benign prostatic hypertrophy in the community. Lancet. 1991: 338:469.

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PRESENTATION 4:

TITLE: Some factors influencing the quality of ageing.

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Factors influencing the quality of ageing were investigated and consideration given to the GP's ability to detect them and guide his patients towards a balanced and healthy old age. A triaxial survey was used and 447 patients over the ages of 40 were examined somatically, psychologically and sociologically. All patients over the age of 75 in the practice were included in the survey (149). Matching controls were set up for the 60 to 74 and 40 to 59-year-old patients; the results were elabo-rated using a personal computer and evaluated using the F test, x2 test and variability analysis. The somatic state was characterized as being one of the following: healthy, balan-ced, chronic, psychosomatic or neurotic. Using biaxial corre-lation studies, a typical personality pattern was found for each of these somatic states. There was also found to be a rough correlation between the adult health state and childhood upbringing. A 'loving, but demanding' or 'demanding, but just' upbringing proved to be the most favourable in respect of adult health states. An inconsistent, moody home atmosphere was the least favourable, as 80 per cent of this group was psychosomatically diseased or neurotic in adulthood. Those who experienced an unfavourable childhood (overdemanding upbrin-ging, neglected, spoilt, and so on) showed a negative persona-lity pattern, an unhealthy somatic state, had few friends and did not feel in charge of their lives. These were regarded as experiencing 'deviant ageing'. The prevention of deviant ageing, it is concluded, has to begin in babyhood.

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PRESENTATION 5:

TITLE: General Practitioners' fear of agression at work and resultant changes to practice.

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A study to survey the levels of intimidation in a variety of clinical situations experienced by general practitioners who suffered previous episodes of aggression and to record changes made to practice due to aggression.
Methods: Retrospective survey of 2694 general practitioners in the West Midlands using a piloted postal questionaire.
Results: 687 doctors who had suffered aggression in the previous 12 months reported on intimidation and 1093 general practitioners responded with changes made to practice. Some degree of intimidation was experienced by 565 (74,2%) respon-ding doctors. Most fear was reported on visits out of hours with severe fear being occasionally experienced by 316 (56%) doctors between 7 and 11 pm. and 286 (50,6%) after 11 pm. Levels of intimidation were greatest on night visits with frequent fear reported by 8 (1,4%) doctors and permanent fear by 31 (5,5%). Changes to practice included striking off more patients recorded by 128 (11,7%); dicsussing the problem at practice meetings by 122 (11,2%); installing panic buttons by 94 (8,6%) and increasing the use of deputising service by 76 (7%). 73 (6,7%) felt less committed to medicine and 40 (3,7%) less confident as doctors, feelings which were significantly more likely to be volunteered by women and asian trained practitioners.
Conclusions: Some three quarters of doctors expressed on-going fears for their safety (severe and inevitable for a significant minority) during the course of professional du-ties.

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PRESENTATION 6:

TITLE: Referral and advice outcomes following a Gene-ral Practice 75+ Screening Programme

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The introduction of universal screening of 75+ population from general practice in the UK in 1990 has been considered to be controversial. The controversy was based on the ambiguous outcomes in terms of mortality and morbidity of previous studies carried out on screening an older population from a general practice base. While not taking exception with these well established findings this paper will suggest that outco-mes measured in terms of service receipt and needs met are more appropriate in this current climate of care in the commu-nity, particularly for older people.

This paper will present findings from a universal screening programme of a 75+ population. The main results to be presen-ted are on referrals made and the advice given following the assessment. The distinction will be drawn between referral and advice, particularly in terms of the empowerment of the older person within the interaction.

The referral and advice data are stored on a data base which is related to the assessment data. There are approximately 6000 assessment records and 450 referral/advice records some of which contain more than one referral or piece of advice. The data can be categorised by type of agency (local authori-ty, health authority, voluntary agency and commercial organi-zation) agency location and response time.

The following themes which have emerged from analyzing this data will be discussed:
- The role of voluntary agencies and commercial organizati-ons in the care of older people and the extension of the GP's gate-keeping role to these arenas;
- The relationship between functional status, both physical and mental and the referral and advice data;
- The relationship between unmet need and referrals and advice;
- The potential of aggregated general practice referral and advice data in local health service planning.

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PRESENTATION 7:

TITLE: The effects of age and bodymass index on con-ventional and ambulatory blood pressure measu-rements in older people from one family practi-ce.

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Recent studies in middle-aged subjects demonstrated that the increase in blood pressure with age and body mass index was steeper using the conventional method of blood pressure measu-rement than with the ambulatory recording. This cross-sectio-nal study investigated in 449 subjects of 60 years and older (42% men) recruted from one general practice whether the technique of blood pressure measurement used (conventional sphygmomanometry vs. ambulatory monitoring) affects the rela-tion bewteen blood pressure and age, body mass, index and skinfold thickness. Age ranged from 60 to 100 years, body mass index (weight (kg)/height(m)2) ranged from 17 to 44 and the sum of four skinfolds from 16 mm to 139 mm.
Twenty-four-hour ambulatory blood pressure was lower than blood pressure measured by the doctor at the subjects'home (126/73 mmHg versus 143/75 mmHg).
When blood pressure was measured by the doctor, the well-established relations between systolic and diastolic blood pressure and both age, body mass index and skinfolds thickness were evident. When the analyses were repeated using 24-hour measurements, the increase of the systolic blood pressure and the decrease of diastolic blood pressure with advancing age were reduced. For body mass index and skinfolds thickness the positive relationship is attenuated.
The conclusion is that advancing age and obesity in the elder-ly are not as strongly correlated with blood pressure as mentioned before, when blood pressure is measured by ambulato-ry monitoring.

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PRESENTATION 8:

TITLE: Health checks for people aged 75 and over in general practice: An International Package for Assessment?

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In the UK, General Practitioners are now required to perform a throrough annual assessment on all their patients aged 75 and over. At the time of introduction of the requirement, no guidelines were available to General Practitioners as to how to carry out the assessments and few materials were published to assist in this process.
In order to maximise the effectiveness of the screening requi-rement, a package has been developed on behalf of the Royal College of General Practitioners, designed for use by General Practitioners throughout the country. The structure and con-tent have been informed by previous research, extensive consu-lation and field testing. A staged approach to screening is adopted using a limited number of standarised screening ques-tions to identify those elderly people likely to require more indepth assessment. The package employs a number of standari-zed scales including the Abbeviated Mental Test Score, the Geriatric Depression Scale and the Barthel Functional Asses-sment Scale.
The Pack has been field tested in a central London locality and there are plans for its further testing in a large multi-centre national study. Plans for national distribution of the Pack will be discussed as will the potential for evaluating its usefulness in a variety of European settings.

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PRESENTATION 9:

TITLE: First steps towards a new method for detection of dementia in general practice

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It is accepted that general practitioners should participate in the process of diagnosing dementia. Untill now there exists no good instrument or strategy for the diagnosis of dementia in general practice.
We first want to present shortly the results of two explora-tive and descriptive research projects trying to answer the following questions: "When do General Practitioners recognise dementia? To what triggers GP's are sensitive, so that the differential

diagnostic process can start?"
General practitioners are sensitive to changes in Activities of Daily Living (ADL), disturbances of behaviour and informa-tion of caregivers.
Knowing that the desintegration in the course of dementia is nearly the reverse of the psychomotor evolution of a child (de Ajuriaguerra and Paiget), we are convinced that some fine psychomotor and neurological test procedures, could be very usefull for the gp to detect serious cognitive problems at an earlier stage.
We will present some test procedures to get some critical remarks and ideas for the development of the research proto-col.

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PRESENTATION 10:

TITLE: How to teach geriatrics to family medicine residents? A model of geriatric assessment teaching.

AUTHOR(S): Sophia Eilat-Tsana'Ni
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The fact of population aging constitutes a diagnostic and treatment challenges for the primary care physician. Neverthe-less, graduates of the medicine schools in this country, as well as in others, are not educated to give care for the elderly. Being aware of that, a course in geriatrics has been established in the purpose to give the residents the basic skills to care for their elderly patients.
The residents attend a weekly academic course. The main topic in first trimester of 1992 was geriatric assessment. Other topics were understanding the multidisciplinary team work for rehabilitation, meeting the elderly outside the health center in the centres they are referred to.

Teaching methods: lectures, videocassets demonstrating a mini-mental test, small group teaching and demonstration in the nursing home and day center.
The instructors were: geriatrics, family physicians and the team members in the nursing

home and day center.
Subject of the lecturers: methods of geriatric assessment and their use, assessment for depression, instability and falls, impairment of cognitive function.

The teaching topics in the nursing home dealt with immobility and its consequences. The method used was bedside teaching.
In the day center the teaching topics dealt with the elderly person living within the community. The residents joined the attending elderly in the rehabilitation and social activities.
Each resident interviewed an old person and practiced a mini-mental test in the presence of a preceptor who gave feedback and evaluation.
Residents evaluation was composed of the preceptor evaluation and the results of a final exam.
The course was attended by 30 residents, it consisted 5 lectu-res in the classroom and 4 whole days in the nursing home and day center.
The course evaluation was high (marked by 5 out of 6 points for the lecturers and 3-4 out of 4 for the teaching in the nursing home and day center. The feedback remarks stressed the good experience of joining the elderly during the day, part of whom were the resident's patients.
In the light of the positive experience we are in the opinion that this model constitutes an efficient way of teaching to-pics in geriatrics as well as in other subjects. We recommend to develop this kind of teaching to residents and medical stu-dents to overcome the challenge which lies before us.

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PRESENTATION 11:

TITLE: Management of memory complaint and dementia in general practice

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Objectives and methods:
To study the management of organic psychosyndroms in the elderly, we designed written case simulations and tested them in 16 psychiatrists and 13 general practitioners. One case described a 70-year old widowed but otherwise healthy woman with memory complaint, another a multimorbid, clearly demented patient. Two versions for each case were used: with or without the request of the patient for medication (case 1a/b) and with a history indicative for senile dementia (SDAT) or multi-infarct-dementia (MID) (case 2a/b). We obtained complete data for 56 of 58 vignettes distributed.

Results:
The most frequent initial diagnosis made was dementia (case 1:59%, case 2: 82%), memory impairment in 34% (case 1) and 7% (case 2), depression in 7% (case 1 only) and other disease in 6% (case 2 only). This response pattern to the two simulated was significantly different at the 0.01 level. As expected, age associated memory impairment was more likely to be consi-dered as differential diagnosis in case 1 than in case 2 (55% vs. 11% $p < 0.01$). Physical disease as possible cause of memory impairment was mentioned by 14% of physicians in case 1 in contrast to 31% in case 2 (ns). Signi-ficantly more physici-ans would use dementia tests in case 1 (57%) than in case 2 (30%) where signs and symptoms of demen-tia were mentioned. There were no significant differences with regard to diagnos-tic and therapeutic actions taken in the two case reports besides the therapy of potentially underlying organic patho-logy (41% vs 86%, $p < 0.01$). Only few physicians would check medication for potential adverse reactions on cognitive status (case 1: 4%, case 2: 14%), whereas a large number would pres-cribe vasodilatators or nootropic drugs for treatment of memory disorder (case 1: 52%, case 2: 30%).

Conclusions:
Although case studies have been shown to be accurate measures of recall and application of medical knowledge, their validity as proxy measures of actual clinical practice must be determi-ned at hoc. As there were significant differences in response pattern to the two simulated cases, this study corroborates the usefulness of this research instrument. Some other surpi-sing findings of our study which will be reported at the meeting, deserve further investigation: 1) all physici-ans tended to diagnose dementia in patients with memory com-plaint. 2) if cardiovascular risk factors are present, doctors tended to diagnose MID in the demented even if the history suggests SDAT. Psychiatrists were not more accurate than general prac-titioners in their assessments. 3) only few physicians consi-dered the most important reasons of reversible disorders such as depression and adverse drug reactions as differential diagnoses. 4) noot-ropic drugs were recommended for treatment by a considerable number of doctors despite undocumented effica-cy.

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PRESENTATION 12:

TITLE: Building a feedback instrument for Primary Care: A joint task of community representatives and the clinic staff in a patient satisfaction survey.

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The most popular tool used for quality assurance in the health care system is a survey of patient satisfaction. In our study, the patients and the clinic staff cooperated in developing the questionnaire and in conducting the survey. In this paper, the conceptual background and the process of developing the ques-tionnaire and conducting the survey are presented. We conclu-ded that in order to determine patient satisfaction with care, the patients must also be part of the process of develo-ping the instrument used and of supervising the survey.

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PRESENTATION 13:

TITLE: Prevalence of cardiovascular morbidity and risk factors in a Dutch population aged 60 years and older.

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Prevalence of cardiovascular morbidity increases with age. In view of the central role of Dutch general practitioners in primary and secondary prevention of cardiovascular diseases we studied the prevalence of morbidity and risk factors among the elderly population.
A random sample of 200 of all people aged 60 years and older of three general practitioners was taken. Of these 200, 141 (71%) attended for a health check.
Besides medical records were checked and a structured inter-view took place. Results were as follows:

Cardiovascular morbidity and risk factors (N = 141)
Myocardial infarction 9%
Congestive heart failure 2%
Angina pectoris 9%
Atrial fibrillation 2%
Stroke 4%
Transient ischemic attack 6%
Hypertension (DBP>95 and/or SBP>160 mm) 39%
Isolated systolic HT(DBP<95 and SBP>160) 12%
Diabetes 7%
Cigarette smoking 29%
Hypercholesterolemia (N = 55) 47%

Given the high prevalence of risk factors and morbidity in the elderly we conclude that regular assessment of cardiovas-cular risk factors and morbidity is warranted.

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PRESENTATION 14:

TITLE: The ICGP Research Adviser Scheme - Fostering Research in Rural Single-handed Practice.

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The Irish College of General Practitioners set up a Pilot Regional Research Adviser Scheme in November 1992. A GP Re-search Adviser is employed for two half-days per week to give advice and organise research education for all members of the Irish College in the West and North-West quarter of the coun-try. An area 400 km long and 140 km wide with 300-400 doctors is covered.

Initial results from first contacts and meetings in each of the five Faculties of the College in the area has revealed 17 projects at Protocol stage, and five projects at Data Collec-tion stage. Two doctors are planning to register for MD de-grees.

The Irish College is appointing two further Research Advisers this year. The scheme will cover the whole country with one additional Adviser and a National Director of Research.

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PRESENTATION 15:

TITLE: A Curriculum for Teaching Geriatrics in Family Practice Residency Abstract.

AUTHOR(S): Lea Aharony, MS, MSc

ADDRESS:

Medical educators and health policy makers have became aware in the last decade of the importance of educating physicians to meet the clinical medicine is strongly tied to the concepts of family medicine. Many essential ingredients of family practice are of the utmost importance in treating elderly patients, i.e., compassion and humanism, communication and counseling, preventive medicine, and understanding of psychosocial and family problem.

Recognizing that family physicians provide a major portion of the medical care to the

elderly in ambulatory, longterm, and acute care settings, the need to include geriatrics training in residential programs not as a distinct speciality, but rather as an inseparable constituent of family medicine, should be obvious.

The goals of a family medicine geriatric curriculum should be to include the body of knowledge that undergids the scientific field of gerontology and the clinical field of geriatric medicine; the skills that are essential for the care of the elderly, such as the ability to work in an interdisciplinary team, rehabilitative techniques, and psychiatric diagnosis and treatment. Also, attitudes are crucial. The positive aspects of caring for old people should be emphasized, mainly by expo-sure to healthy elderly.

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PRESENTATION 16:

TITLE: Prospective study of the factors determining prognosis in the aged entering institutions.

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217 elderly persons were followed prospectively over a maximal period of 60 months following entry into an old aged institu-tion (a total of 5,468 person months of follow-up). All were interviewed and examined (physical, physiological, biochemi-cal, haematological, psychological and other tests) on intake and at 6 monthly intervals.

Survival analyses were done using the Cox Proportional Hazards Model and controlling (amongst others) for age and sex). The only factors found to significantly determine mortality at the end of the first year was the Activities of Daily Living (ADL) on intake and the degree to which they took part in communal (social) activities. After the first year the only signifi-cant factor was the ADL at the beginning of each year. The findings

suggest possible intervention strategies for improving the prognosis of institutionalised elderly.

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PRESENTATION 17:

TITLE: Video analysis of a consultation in general practice.

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The aim is to ask different observers to analyse consultations with the tools of linguistic, sociology, etc...
The observations will be used at first for the teaching of medicine. The consultation by a patient who does not feel well, or who does not want to become ill, could seem to be a simple event.
The doctor, a technician of health, analyses the symptoms, makes a diagnosis, and proposes a treatment or rules for every day life to avoid disease. This model serves as a theoritical basis for the teaching of general practice. This way of look-ing at things is insufficient. What really happens during a consultation is not easy to analyse. It is a private event, as a rule without any witness. Both, doctor and patient, feel that each consultation is unique.

Does the teaching in general practice take this unique aspect into account?
To try to answer, it could be useful to look at and to analyse consultations while the necessary confidentiality is preser-ved. The video recording, easy to handle, not very disturbing, allows to remain anonymous, the patient being seen from be-hind.
The concerned doctors are necesseraly volunteers. To choose them is difficult. It could be easy to select according to preconceived ideas of the authors of this research. The ideal of drawing losts is not realistic. The choice of the records to analyse will be done by drawing lots. The interest of this work depends on the observers who could be a sociologist, philosopher, ethnologist, general practitioner, linguist, psychoanalyst, semiotician, specialized physician, social worker. All the observers must study all the selected docu-ments.

How will the observers work?
Either each of them makes a free report in which he says what he saw, heard or felt, or, to increase efficacy, the observers will have to fill a chart:
- according to you, what happened during this consultation? In comparison with what you know about a general practice consul-tation, what remarks can you make? Which kind of places do you think have non biomedical events: cultural, linguistic, poli-tic, financial...?

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PRESENTATION 18:

TITLE: A study of the quality of life of 157 'over-65s' in an Arab village in the Galilee.

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Hypothesis: The quality of life of old Israeli Arabs is better than that of old Israeli Jews.

Method: Structured interviews are being administered to all 157 'old' people (9%) in an Arab village.

Purpose of presentation: To stimulate a. discussion of the method (at the data-collection stage); b. possible cross-cultural participation.

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PRESENTATION 19:

TITLE: Introduction of a basic geriatric documentation in general practice

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Poor record keeping is one obstacle of preventive care in the elderly. A survey in six practices revealed that major risk factors for institutionalization such as poor informal sup-port, living status, disablement and memory impairment are not part of routine documentation. Therefore a study was underta-ken to evaluate a standardized geriatric assessment chart (SILDE), where sociodemographic data, impairments and disabi-lity status, cognitive status and provision of ambulatory care are filled in by the GP. The reliability and validity of assessments has been proven in earlier studies.
Within the documentation period of three months, 885 patients aged 70 years or older were recorded by 6 GPs. The documenta-tion rate (all patients recorded/all patients at risk) of six GPs included in the survey varied from 21% and 94%. 2% of sociodemographic data (e.g. age, sex) 1,4% of medical data (e.g. diagnosis, impairment), 2,1% to 6,5% of social data (civil status, social support), 0,6% of process data (e.g. number of house calls), 1,6% of specialist referrals and 2,5% of referral to community services were missing. The total amount of time required to record data, to build up a compute-ri-zed database and to analyse and report the survey was 215 hours (21 minutes per case). This would cost some 19 german marks per patient if calculations were based on the salaries of german research assistants and doctors. In summary, the study revealed that a detailed assessment of elderly people is feasible. The chart used proved to be applicable to general practice and yielded valuable data. This stadardized documen-tation could be used as an epidemiological framework, which allows a quantitative monitoring of outcome (e.g. mortality, institutionalization rates, functional decline). Stratified random subsamples can be drawn for detailed geriatric audit involving qualitative methods. Pilot studies with this asses-sment chart in other countries are recommended in order to establish its usefulness for geriatric research in different health care systems.

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PRESENTATION 20:

TITLE: How to say no - student - training in roll play to explain patients that drugs they aks for are not necessary to prescribe

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How to handle rational prescribing, is not a usual subject in German medical education. In pharmacology lessons the main items concern drug-effects, side-effects, interactions and dosis-questions. Examples for the various influences from many sides - not at least from the patients - are not regularly given, because the professor for pharmacology does not pres-cribe himself during this normal daily work.
Experts for prescribing could be only critical GP's. What would help to become a critical doctor in that aerea, should be trained in roll-plays with doctor (student) 'vs' patient (pharmacological expert). After an analysis of the possible strategies from the (German) patients to get what they want (to have prescribed) we find out, how difficult it is to hold on the (prepared) strategy of saying NO, if 'clever' patients struggle with the doctor. One explanation is that doctors often have a big lack in their informations about drugs, which they mainly get from pharma-company-agents visiting them in their practices and that they do not enough efforts to get the offered neutral informations.

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PRESENTATION 21:

TITLE: Nocturnal Penile Tumescence (NPT) - use by a Family Medicine Center. First year review.

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Background: Impotence is one of the most common sex dys-functional problems in males. The NPT is a useful tool to try and differentiate between organic and non-organic impotence. The interpretation is simple and can easily be done by general practitioners. The goal of our study was to summarize the first year referrals.

Results: One hundred and ten patients were referred to the service. Fifty eight percents were referred by urologists about a third by psychiatrists and only 11% by primary care physicians. The mean age of referred patients as 58.5 + 8.5. 9.2% were elderly. Two thirds of them suffered of the sexual problem for more than a year, 4% for more than 10 years.
About 34% had a Delta Tumescence less then 2 cm. and more than two thirds had a tip or base rigidity abnormality.

Conclusion: NPT is a useful tool in the general practitio-ner's management of impotence. Awareness to its use had to be encouraged.

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PRESENTATION 22:

TITLE: Once daily Amoxicillin therapy for streptococ-cal pharyngitis.

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Objective: To evaluate treatment of Group A B-hemolytic streptococcus (GABHS) pharyngitis with amoxicillin once daily, compared to penicillin VK tid or gid.

Design: Randomized controlled study of consecutive patients presenting with symptoms suggestive of GABHS pharyngitis and positive throat culture.

Setting: Five family medicine practices.

Subjects: One hundred and fifty seven patients presenting with clinical symptoms of GABHS pharyngitis and positive throat culture.

Main outcome measures: The clinical response, bacteriologi-cal response, work and school days lost and compliance.

Results: During the period of the study 393 patients presen-ted with symptoms suggesting GABHS pharyngitis; 157 of them had a positive throat culture. Eighty two were assigned to the pencillin VK group and 75 to the amoxicillin group. No diffe-rence was observed in the clinical response, in the residual positive cultures ($p > 0.4$ after 14 days); and in the work and school days lost ($p < 0.7$).

Conclusion: These findings support the hypothesis that amoxicillin once daily is as effective as penicillin VK in the treatment of GABHS pharyngitis.

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PRESENTATION 23:

TITLE: An IBM compatible computer programme for sta-tistical analyses in research in general prac-tice.

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A lot of computer programmes for data-handling in research are available. They are often very comprehensive and often quite complicated to use and demand experience and

extensive manual reading, and this they can be an emotional obstacle for GP's wish to be involved in research. The comprehensive data-hand-ling can at the same time make the researcher "loose contact" with his data.
Most planning and analyses for minor research projects in General Practice can be done with quite few tools and tests.

A computer programme was developed being able to do these tests. The programme also had a chapter defining the most usual principles in epidemiological research. It is based on examples from General Practice and each programme is explained on line without any necessary manual. The programme has a total of 12 tests. The most important are calculation of sample size, calculation of confidence limits, calculation of relative risks and odds rate, chi-square test, Fishers test, Students-t and Mann Whitneys test.

The programme is presented and the participants will have the opportunity to test it during the workshop.
The programme is distributed nearly costless in Denmark due to a sponsorship from the drug company Rhône-Poulenc Rorer. It is intended to be done the same way in the international version.

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PRESENTATION 24:

TITLE: Physician referrals to alternative healers.

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Western physicians are often faced with a myriad of alternati-ve health practitioners in their communities and a high level of patient initiated requests for such services, yet there is little information about referral patterns and no guidelines or accepted standards to help

direct them. This study, carried out in three sites in Israel and United States, was designed to investigate the scope, nature and reasons for such refer-rals and the level of provider knowledge about alternative therapies and providers. Physicians were also asked to gauge the effectiveness of alternative practices and to disclose which therapies they personally performed or had tried.

Methods: A pretested questionnaire was distributed simultane-ously to all physicians at sites in southern Israel, Washing-ton State, and New Mexico. Data entry was done centrally, after coding, with statistical analysis utilizing SPSS-PC (3.0).

Results: Despite the great demographic and professional variations represented by this sample, an overall pattern emerges. Physicians do refer to a wide range of alternative providers for a variety of reasons, often based on the cultu-ral beliefs or requests of their patients. Referral rates are similar among older and younger physicians and between Israeli and American physicians. Knowledge both about alternative techniques and about where to acquire services is approximate-ly the same among all physicians, irrespective of location, specialty, age, sex, or type of practice. Statistically signi-ficant differences, which will be described, are noted in regard to the New Mexican physicians, female physicians, primary care physicians, and community-based practitioners.

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PRESENTATION 25:

TITLE: Confounders in international health services comparisons - the example of hypertension con-trol.

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In a study comparing treatment outcomes of fee for item of service and capitation fee based systems of renumeration we chose blood pressure control and remembered interventions against smoking as main endpoints. We are currently completing a cross-

sectional survey on a sample of patients attending General Practitioners (GP) in the UK and Germany.
Although comparisons like this offer the advantage of exami-ning long term effects of different health care systems, there are confounding variables.

Taking blood pressure constitutes not only a simple preventive activity. It serves other purposes as well. It is part of clinical investigation of symptoms and has symbolic functions. In any of these contexts its use may differ in both countries. This is demonstrated in a separate study of blood-pressure measuring behaviour reported by GP's taking part in the main study. This behaviour is related to long different guidelines for the diagnosis of high blood pressure. These may be influ-enced by the economical background as well.

There is probably also a different distribution of blood pressure within different populations in both countries. In Britain for example hypertension prevalence rises the lower the social class. This had not been demonstrated for Germany to the same extent. The overall prevalence of hypertension is likely to be similar, however.
Strictly speaking differences in attending patterns - especi-ally doctor initiated - and specialist referrals are input variables rather than confounders. Data to estimate these will be presented as well.

Alternatives to cross border studies of the impact of diffe-rent health care organisations on outcome variables are rando-mised controlled trials in countries with pluralistic health care systems (such as the USA). These, too, have their inhe-rent drawbacks. Therefore international comparisons of health services remain an important research too. But awareness of confounders and their consideration in the planning of studies and the interpretation of their results are of prime importan-ce.

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PRESENTATION 26:

TITLE: Do clinical notes of general practitioners reflect medical performance?

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Objective: To find out to what extent medical records of consultations reflect the actual performance of general prac-titioners during consultations.

Setting: General practice.

Design: 39 general practitioners were each visited by four different standardized (simulated) patients, indistinguishable as such, presenting four different medical stories to each general practitioner. The standardized patients reported on these consultations using checklists based at accepted stand-ards of care. 35 of the 39 general practitioners were contac-ted two years after these visits to forward us with the medi-cal records created for those patients. The incoming records were retyped at our institute and the written content of the consultations were scored against the same checklists which the standardized patients had used.

Main outcome measures: An index (the Content Score) was calculated as a measure of agreement for actions between what had been noted in the medical records and what had been done according to the standardized patients. Frequency calculations were obtained for the Content Score for each complaint and across four complaints and observed correlations were calcula-ted in order to establish the relationship between medical records and actual performance.

Results: 72% of all records were received. Of all actions undertaken in a consultation in general only 30% are being recorded. The categories 'therapy' and 'laboratory' show better recording with respectively 68 and 64% of actions taken registered in the medical records. Further there is a moderate correlation between 'performing' and 'recording'.

Conclusions: One has to be very careful to draw conclusions about what doctors actually do during consultations out from what doctors actually write down in their records.

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PRESENTATION 27:

TITLE: A quality circle to improve the management of pa-tients with acute sore throat in General Practice.

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Objective: In 1989 a new law was introduced in Germany which obliges all physicians to take part in quality assurance activities. The "Association of Panel Doctors" is favorising a model of regi-onally organized peer review groups (quality circles) for carrying out quality assurance activities in general practice. This paper reports about a pilot-phase in which a concept for the moderation ans the evaluation of the work of such quality circles is being tested. The quality circle based in the city of Kassel chose the topic of the management of acute sore throat for its first meetings.

Methods: 9 general practitioners volunteered to work together on a regulary basis with monthly meetings for a period of two years. A baseline documentation of the management of acute sore throat was carried out. 15 consecutive patients were included in each practice. The data consisted of symptoms, diagnostic procedures, medication, days out of work and influ-ence of patients on therapy as percieved by the GP. Addition-ally all patients were interviewed by telephone two weeks after initial encounter. Questions were about duration of symptoms, present data, satisfaction with encounter and satis-faction with therapy received.

Results: 120 patients could be included into the baseline survey (data analysis not yet finished). After reviewing the present state of management of acute sore throat goals for the improvement will be defined by the members of the quality circle. The effect of this peerreview approach will be evalua-ted by a follow-up-study.

Discussion: The cooperation of general practitioners in the quality circle is very promising. Methodological issues about the evaluation of such group-work will be discussed.

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PRESENTATION 28:

TITLE: Multivariate analysis of the reasons for refer-ral from General Practice

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The variability of referrals has been a problem for many researchers of physician behaviour. It is well known that the variability is very high if one compares the highest and lowest referres. The referral study used standarized referral ratio as a measure of variability. A comparision of "high" and "low referres" by means of "classical" statistical methodology was used as a means in explaining the differences between GP's in referrals.

Multivariate analysis was used as an alternative approach in the Slovenian sample. The standarized referral ratio was selected as the dependent variable. This kind of approach has produced some methodological dilemmas regarding the selection of the method. Logistic regression was accepted as the most appropriate method for this kind of data, although other methods could be taken into the consideration if the sample was bigger. Several different appoaches have been tried in order to explain the variability of the standarized referral ratio, each one with slightly different results. All the approaches will be presented together with the reasons for the selection of one of them.

This kind of method can easily be tested in other countries which participated in the study. Because of the selection of the standarized referral ratio as the dependent variable a comparison of different countries is also possible.

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PRESENTATION 29:

TITLE: Ethiopian parents' participation of their chil-dren's health: a focus group study of recent immigrants to Israel.

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Background: The Etheopian jawich community presents a valua-ble opportunity and challenge to health care workers in Israel because of its rich cultural heritage, including unique health practices, attitudes and knowledge. The purpose of this study was to learn about parents' perception of the health of their children among a group of recent immigrants to Israel from Ethiopia in order to facilitate daily clini-cal encounters between staff and patients.

Method: Parents of children under the age of three years in a popu-lation of 650 recent Ethiopian immigrants to Israel and regis-tered as patients in the Family Medicine Unit of the Kityat Hayoval Health Centre, Jerusalem, Israel were invited to participate in two focus groups. The interviews conducted by a family physician, social worker and translator from the Family Medicine Unit. Interviews were audiotape, translated and transcribed. Transcripts were analyzed using qualitative methodology to determine major themes relating to children's health knowledge, attitudes and practices that were new to the researchers.

Results: Eleven parents (6 fathers and 5 mothers in separate groups) participated in two separate focus group interviews. Five major themes emerged from the discussions. Issues inclu-de: recognition of illness in children and the special meaning of common symptoms, the role of traditional medicine in the care of children, gender-specific and other family roles in the care of children, decision making in seeking outside help when ill and notion of prevention and resistance to illness.

Conclusions: The focus group method proved to be valuable in providing a large amount of relevant material in a brief period of time. The material obtained complemented the daily situation expe-rience of the researchers with the study popula-tion, found application in their clinical work and enriched their under-standing of their patients. Suggestions for appli-cation of this method and these findings in other settings and their implications for other populations are presented.

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PRESENTATION 30:

TITLE: Usefulness of the red blood cell distribution width (RDW).

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In general practice, it is common to deal with patients pre-senting microcytic anemia. Then we must establish a differen-cial diagnosis (DD) among the most frequent causes that in our population are iron deficiency and B-thalassemia minor.
The RDW represents an objective value of anisocytosis and with the England-Fraser Index (EFI) constitutes two underused parameters despite their usefulness.
We designed a propective study which objective was to esta-blish the diagnostic utility of the RDW and the EFI in the DD of microcytic anemia.

Methodology: We reviewed all the analysis applied in our Prima-ry Health Centre from March to October 1992. Diagnostic crite-ria of microcytic anemia: hemoglobine (Hb) (gr/l) < 11 in pregnants, < 12 in females, < 13 in males as well as mean cell volume (MCV) < 80 fl. Gold standard: feiitin < 15 ng/ml for iron deficiency and quantification of Hb A2 for thalassemia.

Control group: 179 patients with normal values of Hb and MCV >80 and <99 fl. Determination of the RDW by Coulter (model STKF).
EFI = MCV - [no erythrocytes in millions + {Hb x 5 + 8.7}].
The values of the RDW are expressed in means and one standard deviation. The comparison among groups was made by the analy-sis of variance (Kruskal - Wallis test).

Results: We found thirty-three patients with the following RDW values according to diagnosis: twenty-one with iron defi-ciency (17 ± 1.8). Nine thalassemics: seven ß-thalassemics (14.4 ± 0.8) and two aß-thalassemics (21.4 ± 0.28). Another ß-thalassemic with iron deficiency (18.6). And two anemias of chronic disease (17 ± 0.5). The RDW of the control group was 12.7 ± 0.7. The differences among groups were significant (p <0.000).
Considering the RDW cuttoff point at 15.5 we obtained: sensi-tivity 86%, specificity 58%, positive predictive value 78%, negative predictive value 70% and accuracy 76%.
The EFI gave: sensitivity 100%, specificity 87,5%, + PV 75%, -PV 100% and accuracy 91%.

Conclusions: The RDW and the EFI are two useful parameters to the initial diagnostic orientation of microcytic anemias. Thalassemia minor is not infrequent in our population.

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PRESENTATION 31:

TITLE: Quality assurance of communication between hos-pital doctors and GPs - the start of a pilot project.

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Unsatisfactory communication between hospital and non-hospital physicians is one of the chronic maladies of health care systems. A working group was established in a large teaching hospital. The group consists of self-selected hospital physi-cians and administrators and GPs representing primary care in the area served by the hospital. The aims of the group are to identify problems of communication and rectify them, the key work being reciprocity. Both written and spoken communication are being considered: Written communication - mainly letters to and from the emergency room, outpatient clinics and depart-ments (referral letters, progress reports and discharge let-ters); spoken communication - face-to-face and by telephone.

The programme of the group's activities is based on the five components of quality assurance: 1. Resources. The hospital has established a department of quality assurance, run by a physician and office staff. The health Insurance Institution (primary care) is making time available for GPs to participate in the scheme during their paid working hours. 2. Guideline development. The group has circulated draft guidelines for referral and discharge letters for use in audits and for further discussion. 3. Training and teaching in audit methods. Not yet implemented, but a representative of the faculty participates in the group to plan QA teaching to medical students. 4. Audit of letters and 5. Feedback. This will be done jointly by the hospital department of QA and GPs.
In addition, the group is developing ways of improving perso-nal contact between hospital and non-hospital doctors. Updated lists of telephone numbers have been exchanged between hospi-tal and primary care and arrangements are being made for GPs

to spend time in the emergency room (as mentioned above, under resources).
It will take at least one year before outcomes can be evalua-ted.

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PRESENTATION 32:

TITLE: Depression in general practice patients 65+ years old.

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Objectives were to estimate the prevalence of depression in patients 65+ years old in general practice, to evaluate cut-off points for self-reports, and to describe management stra-tegies.
In a two-phased, observational study in six practices, 384 consecutive patients 65+ years old (116 males and 268 females) completed Zung's Self-rating Deparession Scale (SDS) and the Geriatric Depression Scale (GDS). Patients scoring above cut-offs points or patients assessed depressed at the time by the doctors were interviewed (n=70).
The SDS indicated depression in 42 patients (11%); the GDS in 48 patients (13%). The general practitioners (GPs) assessed 53 patients as depressed (14%). Interviewers showed a depressive disorder in 34 patients (9%). A supportive ear was offered to 27 of 53 patients considered depressed by the GP. 9 patients received psychotropic medication. 4 patients were referred. Choice of management options was associated with severity of depression and length of episode.
Self-reports suggest depression in at least 11% of patients over 65 years of age in general practice; GPs observe depres-sion in 14% of cases, while depressive disorder as measured with an interview was prevalent in 9%. Differences between depression assessment groups will be presented. We propose a new general practice SDS cut-off point. GPs need to raise their index of suspicion for depression among the elderly.

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PRESENTATION 33:

TITLE: Study of the Life Conditions for homeliving elderlies and their needs for Care.

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120 elderly persons with home care were interviewed. According to the interview the respondents were placed on different steps on a 'stairs of needs'. In our first study-report we have looked for characteristics for persons on each step. The aspects grounding the description of the life conditions of the respondents are besides needs for service and care also lifestyles, networks, experience of health, functioning power, strategies of coping and alternatives. In our second report we discuss home care and holism. Social service and nursing are given in two different organisations. Cooperation is important from the caretakers point of view. We also discuss the concept of holism as a base for quality of home care.
In our third report we are discussing research dealing with service in a field of expanding needs of care facing a stagna-ting economy and demands for productivity, rationalisations and reduction of standard.

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PRESENTATION 34:

TITLE: Hip fracture Rehabilitation in Primary Health Care.
Early discharge to Home Care in Blekinge County Sweden.

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A project was started based on an education of district nurses focusing general knowledge about hip fracture rehabilitation and how to make an early planning of home care on the hospital in three days after fracture. Earlier to the project hip fracture patients in 57% were discharged from the orthopaedic clinic to the rehabilitation department after a mean time of 14,3 days from the fracture. Discharged directly home were 27% of the patients. In the following year patients discharged directly home in a mean time of 14,5 days on hospital raised to 59% and those discharged to rehabilitation clinic fell to 22%. In total there was a change in days of hospital care for hip fracture from 9805 days before to 5436 days in a year after the start of the project. This means a saving of about 500.000 US $ a year in a population of 90.000 inhabitants.
Our work is now continuing as a cooperation project between the Orthopeadic department and primary Health District of Lyckeby in Blekinge County of Sweden and the Orthopaedic De-partment and primary Health District of Klaipeda in Lithua-nia. This further work will also be described.

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PRESENTATION 35:

TITLE: Seasonal changes in mood and functional impair-ment among primary care elderly patients.

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Seasonal changes in behaviour and physiology have been recog-ni-zed since ancient times. Recent studies have provided strong validation for this notion, identifying a substantial minority population who report recurrent mood-related problems each autumn

and winter followed by spontaneous improvement each spring. Daily exposure to artificial bright light can rapidly relieve the wintertime symptoms in affected persons. In this study a sample of elderly (aged 85+ year) patients in a prima-ry care clinic were assessed during January and February, focusing specifically on mood changes and functional status impairment. At the same time an attempt was made to assess the degree to which these problems could be attributed to the specific effects of season on elderly patients.

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PRESENTATION 36:

TITLE: Mortality rate among EC elderly population.

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Introduction: Diagnosis is important both in clinical medici-ne and community medicine, to management of illness/health.
While the diagnosis and treatment of an individual patient is an isolated skirmish in the battle against disease and one part of the whole campaign to improve health, the community medicine is concerned with the strategy of this campaign.
To characterize the illness/health of a population (or popula-tion group) it is necessary to measure mortality, symptomatic burden and disability. While the first is reasonably well documented the other two needs surveys and routine statistics improvement. Knowing that, the Author decided to look at the mortality rate among the EC elderly population.

Aims: - To study the specific mortality rate among the population between 65 - 74 years old in EC countries.
- To look at differences.

Conclusions: Although there are not great differences on: percentage of elderly; life expectancy at birth and at age 65, the specific mortality rate by dead cause is not similar among EC countries:
- Ischaemic heart disease mortality rate is higher in United Kingdom, Ireland, Denmark,

The Netherlands and West-Germany;
- In southern European countries is much lower;
- Portugal has the highest mortality rate by strokes (much higher than in the other countries);
- Malignant neoplasms is not a great problem in Spain, Portugal and Greece, compairing to United Kingdom, The Nether-lands, Luxembourg and Belgium;
- Portugal has the highest mortality rate by stomach cancer, followed by Italy and East-Germany;
- Lung cancer has a high mortality rate in United King-dom, The Netherlands, Luxembourg and Belgium, comparing to the other countries. The same to female breast cancer (adding Denmark);
- While Denmark and Belgium have the gighest mortality rate by suicide and self inflicted injury, Portugal has the highest by traffic accidents;
- France and Portugal have the highest mortality rate by injury and poisening.

The Author finish asking questions about these differences and suggesting further collaborative studies.

This page was last updated on June 7, 1998