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From the President : The rise and fall and rise of British General Practice

Prof Richard Roberts
WONCA President

Headlines trumpeted the most significant drop in 30 years in public satisfaction with the English National Health Service (NHS), from 70% in 2011 to 53% in 2012.[1] At the same time, the NHS was so admired that it was featured in the 2012 London Olympics ceremonies. Where did the truth lie? Since British general practice is the bedrock of the NHS and since it is also an important leader in global Family Medicine, I was eager to better understand the current and future status of the NHS and British general practice.

To advance my understanding, I was privileged over the past two years to speak with more than 200 people on the state of the NHS and British general practice. My conversations involved general practitioners (GPs), patients attending the GP's surgery, consultants and hospital staff, local and national politicians, and other influence leaders. I visited practices in Glasgow, London, Manchester, and Newcastle, as well as several rural communities. While I do not consider myself an expert on the subject, what follows are some of my thoughts on British general practice. I hope you find my comments to be of value and to provoke thoughtful discussion on what can and should happen as a result of well-intended, but sometimes detrimental, attempts to reform health care. To protect the innocent and the candid, this commentary does not include names or photographs that might identify those who were interviewed.

The British GP

I have long admired British general practice. Revered as trusted advisor, astute diagnostician, and guardian of the community's health, the British general practitioner seemed a paragon. Every major life event, from birth through death, was commemorated by the presence of the family GP. Attending home births, visiting patients in their homes after hours, and offering spot-on counsel, the GP seemed almost a heroic figure – singlehandedly doing battle with disease and combatting despair. Once the family doctor showed up, things were going to be all right. Even if things could not be made right, the GP offered comfort and meaning for the suffering.

Beyond clinical care, the British GP set the pace for many of the advances in general practice. The organized curiosity of Will Pickles, the innovative practice-based research of Julian Tudor Hart, and the uncommonly common sense of John Fry provided much of the philosophical and scientific basis for modern day Family Medicine. Along with others, these giants in our discipline made generalism a pursuit worth pursuing: satisfying, challenging, ennobling, and even fun.

Reflecting the influence of the British diaspora and empire, the reach of British general practice has extended way beyond the shores of the United Kingdom. One important ex-pat was Ian McWhinney, a Brit who relocated to Ontario, Canada. The recent passing of Professor McWhinney is a reminder of the tremendous role he had in shaping Family Medicine, especially in the Americas. Another key figure is Maurice Wood who helped bring longitudinal studies to the USA, codified the work of family doctors into ICPC (International Classification of Primary Care), and founded NAPCRG (North American Primary Care Research Group). Testimony to the global prestige of British general practice is the number of general and family doctors, especially in Asia and the Middle East, who seek to become Members of the Royal College of General Practitioners (RCGP), or MRCGP[INT].

Prof Ian Mc Whinney

British GPs achieved almost mythical status because of the trust placed in them by patients, their commitment to their communities, and their insights on the essentials and joys of general practice. Of course, like most mythical figures, the myth was better than the reality. Serial killers such as Harold Shipman, and John Bodkin Adams before him, abused that trust. Commitment to communities was often fleeting as many GPs tried several practices before settling into a community for an extended period. The job was not always joyful. It was hard work with long hours that could be emotionally exhausting and physically punishing.

A brief history of the NHS[2]

Established in 1948, the NHS assumed that the British GP would serve as the foundation for a universal health scheme that would provide care to all that was financed by taxes, reasonable in quality, and free at the point of entry. The assumption has proved durable with over 90% of all NHS encounters still provided through GP practices. The World Health Report in 2000, the last WHO report to compare health systems, ranked the UK at #18 for its performance and #26 for the portion of its gross domestic product (GDP) spent on health care services, reflecting good value for the money spent.

In the early years of the NHS, the assumption worked well with a growing economy and population to foot the bill. Then, the world started to change. Rising consumerism, an ageing and diversifying demographic, increasing costs of medical technology and medication, recurring recessions, and a shifting global economy began to tear at the fabric of the NHS. The 1970s were marked by decreased tolerance for queues, growing demands for patient choice, and a public desire to reduce government expenditures and taxes. Regional Health Authorities were created in 1974 in an effort to improve local control of and accountability for health services.

The Griffiths Report of 1983 advocated for "internal markets," with the hope that they would promote competition, thereby increasing quality and reducing cost. The Tory government of Margaret Thatcher took these ideas to the next level with the passage of the National Health Service and Community Care Act in 1990. The Act stimulated the development of Primary Care Trusts (PCTs), which represented an evolution of the Regional Health Authorities. The Act also envisioned that GPs would become fund holders and negotiate prices and services with consultants and hospitals on behalf of their patients. In 1997, when Tony Blair and his Labour party were voted in, he promised to remove internal markets and abolish fundholding. By his second term however, Blair's position had shifted to favoring internal markets. In 2004, the NHS began the Quality Outcomes Framework, which would prove to have a profound effect on British general practice, as will be discussed below. The most recent change has been Commissioning, which empowers the PCTs and local Commissioning Boards with the responsibility of providing needed services and commissioning, or contracting, with outside agencies such as hospitals for services not provided by the PCT. Some have described Commissioning as fundholding revisited. About 80% of the £100 billion spent annually by the NHS is controlled by PCTs.

The impact of NHS changes on general practice

Every few years, British GPs sign a General Medicine Services (GMS) contract with the NHS, which describes the expectations, rights, and responsibilities of both parties for the provision of primary care services. Faced with declining student interest in careers in general practice, committed to moving more care to primary care with its better outcomes and lower costs, and determined to better align resources and goals of care, the NHS undertook several important initiatives with the revision of the GMS contract in 2003. It allowed British GPs to opt out of afterhours care, which many did since such services represented only 3% of practice income. More important, the 2003 contract paved the way for the QOF.[3] A voluntary program, QOF can represent up to 25% of a GP's practice income and has helped to raise GP income significantly. The practice is measured against 142 indicators and can accumulate up to 1000 points that can result in a significant rise in GP income. Clinical measures (blood pressure, lipids, etc.) represent 85 of the indicators (maximum of 661 points), 45 indicators involve organizational measures such as training of staff, patient education, medical record keeping, and so on (262 points), one indicator looks at the patient experience by examining the length of the consultation, and nine measures are for additional services such as child health surveillance, maternity care, screening for cervical cancer, and contraceptive care (44 points).

Since implementation of the QOF, several trends have accelerated for GPs. Single handed practices have increasingly given way to 5-10 doctor practices, practice nurses have taken on more duties such as serving as the principal practice resource for specific conditions such as diabetes, and GPs spend an increasing portion of their time providing oversight to other health care professionals who actually provide much of the care. The benefits of the QOF include better collection of practice data, proactive outreach to those with chronic or multiple conditions, and improvement of a number of health care indicators. The detriments of the QOF involve an increasing shift of GPs from providers of care to managers of other professionals, the toxicity of a measurement culture (e.g., focusing on QOF measures rather the patient's agenda), the fragmentation of care across the primary health care team, and the deskilling of GPs who have delegated management of many conditions to other practice professionals.[4]

Some worry that the QOF and other NHS changes undermine the trusted patient-GP relationship on which the NHS was built and depends. The rush to measure can conflict with the patient's agenda.

One telling example was a woman in her 50s with type 2 diabetes and high blood pressure who presented with a headache during the consultation I observed. The GP had been her doctor for nearly 20 years and knew her fairly well despite her infrequent visits to the practice. He was eager to address her diabetes and elevated blood pressure; she wanted only to discuss her headache. As they negotiated back and forth about what they were going to discuss, they both began to laugh at the absurdity of the interaction. They each took a deep breath and worked out a compromise: her headache would be addressed today and she agreed to come in the following week for her chronic conditions (I don't know if she returned).

In another practice, I had an informative conversation with a retired councilman who had served on the local PCT and who had strong opinions about the NHS changes that had taken place. When I asked what effect he felt the 2003 contract had on his health care, he replied, "*my GP drives a much nicer car, but I rarely see him because he has frequent locums doctors and is not available after hours*." Even more profound was a chat I overheard the following week during a car ride to the Barcelona airport. An eminent Spanish surgeon was driving, I was seated in front and two renowned British surgeons shared the back seat. One Brit said to the other, "*I can't ring up my GP after hours. This is intolerable.*" As a family doctor in the USA, which has a very specialist-centric health system, I could never imagine two specialists having such a conversation. Their discussion reminded me of the reliance of many British patients on their GPs, even when those patients are specialist physicians.

The frequent major changes in the NHS make it difficult for patients and doctors to adjust to an ever shifting practice environment. This frustration was captured in the observation a GP when she said, "*the greatest problem with the NHS is that major changes seem to occur about every 15 minutes, without necessarily having a compelling need for change.*"

Final thoughts

Brits take justifiable pride in the NHS, with its emphasis on equity and its promotion of national cohesion. All of the NHS professionals I met were bright, dedicated, and sincerely interested in improving care and health. Many of them however, also seemed ground down by the frequent and often untested changes that were thrown at them. I was struck by the shrinking availability of and declining continuity with the British GP – many of the GPs I observed had only several patient sessions per week and often had consultations with people who were not on their list. It's not that the GPs are not busy. They seem to spend an increasing portion of their work hours engaged in administrative tasks and personnel management. While the GP remains a highly valued and trusted member of British society,[5] my worry is that the practice changes being driven by NHS strategies and GP preferences will over time erode the foundation on which the NHS is built and which enables Britain to achieve better results at lower costs: a therapeutic relationship with a GP who knows the patient and whom the patient knows and trusts. The genius of British general practice has been an unwavering commitment to person and place. British GPs have a long tradition of showing the way for the much of the medical world. My hope is that they marshal their considerable talents to innovate new approaches toward sustaining and satisfying relationships to better meet the needs of patients in a rapidly changing world.

Professor Richard Roberts
President, World Organization of Family Doctors
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Presidente de WONCA : El ascenso, descenso y ascenso de la medicina general británica

Los titulares han pregonado el descenso más significativo de satisfacción con el National Health Service (NHS) inglés en 30 años, que ha ido de un 70 % en 2011 a un 53 % en 2012[1]. Pero al mismo tiempo, el National Health Service fue muy admirado en las ceremonias de los Juegos Olímpicos en Londres 2012. ¿Dónde se sitúa la verdad? Dado que la medicina general británica es el fundamento del NHS y que también es un líder importante para la Medicina de Familia, yo estaba ansioso por conocer mejor el estatus actual y el futuro del NHS y la medicina general británica en su conjunto.

Para entenderlo todo mejor, tuve el privilegio de hablar con más de 200 personas sobre el estado del NHS y la medicina general británica durante los dos últimos años.

Mis conversaciones comprendían médicos generales (GPs), pacientes que asisten a la consulta de cirugía, consultores y personal hospitalario, políticos locales y nacionales y otros líderes influyentes. Visité a profesionales en Glasgow, Londres, Manchester y Newcastle, así como en varias comunidades rurales. Aunque no me considero un experto en el tema, lo que sigue son algunas de mis ideas en cuanto a la medicina general británica. Espero que mis comentarios sean de valor y susciten un debate reflexivo sobre el resultado de las buenas, pero a veces perjudiciales intenciones, en los múltiples intentos de reformar los cuidados de salud. Para proteger a los inocentes y a los sinceros, este comentario no incluirá nombres ni fotografías que pudiesen identificar a aquellos que fueron entrevistados.

El médico general británico

He admirado durante mucho tiempo la medicina general británica. Venerado como un asesor confiable, un diagnosticador certero y un guardián de la salud comunitaria, el médico general británico es el modelo. Cualquier acontecimiento vital importante, desde el nacimiento hasta la muerte, se conmemoraba con la presencia del médico general de la familia. Atendiendo nacimientos en casa, visitando pacientes en sus hogares fuera de horario laboral y ofreciendo consejo certero, los médicos generalistas parecían más una figura heroica que batallaban con una sola mano contra la enfermedad y combatían la desesperanza. Una vez que el médico general aparecía, las cosas iban bien. Incluso si las cosas no podían ir bien, el médico general reconfortaba y daba sentido al sufrimiento.

Más allá del cuidado clínico, los médicos generales marcan el ritmo de muchos de los avances en la medicina general. La curiosidad organizada de Will Pickles, la innovación de la investigación basada en la práctica de Julian Tudor Hart, y el poco frecuente sentido común de John Fry han provisto de muchas de las bases científicas de la Medicina de Familia de la actualidad. Junto a otros, estos gigantes de nuestra disciplina hicieron del generalismo una búsqueda que mereció la pena: satisfactoria, desafiante, ennoblecedora e incluso divertida.

Como reflejo de la influencia de la diáspora británica y su imperio, la consecución de la medicina generalista británica se ha extendido más allá de la costa del Reino Unido. Un expatriado importante fue Ian McWhinney, un británico que se trasladó a Ontario, Canadá. La reciente muerte del Profesor McWhinney es un recordatorio del tremendo papel que ha tenido en la construcción de la Medicina de Familia, especialmente en América. Otra figura clave es Maurice Word, que ayudó a aplicar estudios longitudinales en Estados Unidos, a codificar el trabajo de los médicos de familia en la Clasificación Internacional de Atención Primaria (CIAP) y fundó el Grupo de Investigación de Atención Primaria de Norte América. El número de médicos generales y médicos de familia es testigo del prestigio global de la medicina general británica, especialmente en Asia y Oriente Próximo, que intentan convertirse en miembros del *Royal College of General Practitioners* (RCGP) o MRCGP, en sus siglas internacionales.

Los médicos de familia británicos consiguieron un estatus casi mítico por la confianza que sus pacientes depositaban en ellos, y por su conocimiento de los hechos esenciales y del deleite de la medicina general. Por supuesto, como la mayor parte de las figuras míticas, el mito era mejor que la realidad. Los asesinos en serie como Harold Shipman y John Bodkin Adams antes que él, abusaron de esa confianza. El compromiso con las comunidades se revelaba más rápido cuando los médicos generales realizaban prácticas variadas antes de asentarse en una comunidad durante un largo periodo. El trabajo a veces no era demasiado alegre. Era duro trabajar durante muchas horas, que podían ser emocionalmente agotadoras y físicamente castigadoras.

Breve historia del NHS[2]

Creado en 1948, el NHS asumió que la medicina general británica serviría como cimiento para un plan de salud universal que proporcionaría cuidado universal con una financiación proveniente de los impuestos, razonable en calidad y con entrada libre. Esta suposición ha sido válida para casi el 90 % de todas las visitas que realizan los médicos generales en el NHS. El Informe de Salud Mundial de 2000, el último informe de la Organización Mundial de la Salud (OMS) que compara sistemas de salud, ha situado al Reino Unido en el número 18 por su desempeño y en el 26 por la parte de su producto interior bruto (PIB) gastada en servicios del cuidado de la salud, reflejando así un buen resultado en proporción al dinero gastado.

En los primeros años del NHS, estas premisas funcionaron bien, con una economía creciente y una población que podía hacerse cargo del coste. Luego, el mundo empezó a cambiar. El aumento del consumismo, una demografía que envejecía y era diversificada, los incrementos de costes de tecnología médica y medicamentos, las recesiones recurrentes y una economía global cambiante empezaron a rasgar la tela del NHS. Los años 70 estuvieron marcados por el descenso de la tolerancia a las colas, el aumento de la demanda del paciente para elegir y el deseo público de reducir los gastos e impuestos gubernamentales. Las autoridades regionales de

salud se crearon en 1974 en un esfuerzo para mejorar el control local y de la contabilidad de los servicios de salud.

El Informe Griffiths de 1983 abogó por los "mercados internos", con la esperanza de que la promoción de la competencia aumentara la calidad y redujera los costes. El gobierno conservador de Margaret Thatcher llevó estas ideas al siguiente nivel con la aprobación en 1990 del Decreto sobre Sistema Nacional de Salud y Cuidado de Salud de la Comunidad. Esta normativa estimuló el desarrollo de *Primary Care Trusts* (PCT), lo que representa una evolución de las Autoridades Regionales de Salud. Esta normativa también preveía que los médicos se convirtieran en los titulares de los fondos y que negociaran los precios y servicios con los asesores de salud y con los hospitales en nombre de sus pacientes. En 1997, cuando Tony Blair y su Partido Laborista fue elegido, se comprometió a eliminar los mercados internos y a abolir el *fundholding*.* En su segundo mandato, sin embargo, la posición de Blair se había desplazado a favor de los mercados internos. En 2004, el NHS inició el *Programa Marco de Calidad y Resultados (QOF)*, que tuvo un profundo efecto en la práctica general británica, como se verá a continuación. El cambio más reciente ha sido la creación del *Commissioning*, un sistema que faculta a los PCT y a las juntas locales para tener la responsabilidad de proporcionar los servicios necesarios y la puesta en marcha o la contratación con organismos externos, como los hospitales, por servicios no prestados por el PCT. Algunos han descrito el sistema de *Commissioning* como una nueva versión del *fundholding*. Un 80% aproximadamente de los 100 mil millones de libras gastados anualmente por el NHS está controlado por los PCT.

El impacto de los cambios en la práctica general del NHS

Cada pocos años, los médicos británicos firman un contracto de Servicios de Medicina General (GMS) con el NHS, que describe las expectativas, derechos y responsabilidades de ambas partes para la prestación de servicios de atención primaria. Ante el descenso de interés que los estudiantes tenían en la medicina general durante la carrera, se adquirió el compromiso de trasladar más atención a la atención primaria, que aporta mejores resultados y menores costes, y con la decisión de alinear mejor los recursos y los objetivos de la atención, el NHS emprendió varias iniciativas importantes con la revisión de los contratos GMS en 2003. Esto permitió a los médicos británicos poder optar por la atención fuera de horas, algo que muchos hicieron, ya que los servicios antes mencionados representan sólo un 3% de los ingresos profesionales. Más importante aún, el contrato de 2003 allanó el camino para el QOF[3]. Un programa voluntario QOF puede representar hasta el 25% del ingreso profesional de un médico general y ha contribuido a elevar los ingresos de los médicos significativamente. La práctica profesional se mide con 142 indicadores y se pueden acumular hasta 1.000 puntos, que pueden dar como resultado un aumento significativo de los ingresos de los médicos. Las mediciones clínicas (presión arterial, lípidos, etc.) representan 85 de los indicadores (máximo de 661 puntos); 45 indicadores implican medidas organizativas, tales como la formación del personal, la educación del paciente, registros médicos, y así sucesivamente (262 puntos); un indicador analiza la experiencia de los pacientes mediante el examen de la duración de la consulta, y nueve medidas son para servicios adicionales, tales como el cuidado de la salud infantil, atención a la maternidad, la detección del cáncer de cérvix y el cuidado anticonceptivo (44 puntos).

Desde la implementación del QOF, se han acelerado varias tendencias para los médicos. Las centros de salud en las que el médico de familia ejerce solo han ido dejando paso las centros de salud formados por 5 a 10 médicos: las enfermeras han asumido más funciones, tales como servir de recurso principal a la práctica en problemas específicos como la diabetes, y los médicos dedican una porción creciente de su tiempo a cumplir funciones de supervisión de salud sobre otros profesionales, que realmente proporcionan mucha parte de la atención. Los beneficios de la QOF incluyen una mejor recopilación de datos, alcance proactivo para aquellos con enfermedades crónicas o múltiples y la mejora de un número de indicadores de cuidados de la salud. Los inconvenientes de la QOF implican una conversión cada vez mayor de los médicos desde proveedores de atención hacia un perfil de gestores de otros profesionales, la toxicidad de la cultura de la medición (por ejemplo, centrándose en QOF, que mide más bien la agenda del paciente), la fragmentación de la atención de todo el equipo de atención primaria y la descalificación de los médicos que han delegado la gestión de muchos problemas de salud a otros profesionales.[4]

A algunos les preocupa que el QOF y otros cambios del NHS socaven la relación de confianza entre el paciente y el médico, sobre la que el NHS se construyó y de la cual depende. La prisa por medir puede entrar en conflicto con la agenda del paciente. Un ejemplo revelador es el de una mujer de unos 50 años con diabetes tipo 2 e hipertensión arterial, que se presentó con un dolor de cabeza durante una consulta en la que estuve de observador. El profesional que la atendía había sido su médico durante casi 20 años y la conocía

bastante bien a pesar de sus pocas visitas a la consulta. Estaba ansioso por afrontar su diabetes y presión arterial elevada, pero ella sólo quería hablar de su dolor de cabeza. A medida que fueron negociando una y otra vez sobre lo que iban a discutir, los dos se echaron a reír ante lo absurdo de la discusión. Cada uno de ellos hizo una inspiración profunda y llegaron a un acuerdo: el dolor de cabeza se abordaría ese día y ella accedió a volver la semana siguiente para sus enfermedades crónicas (no sé si regresó).

En otra consulta, tuve una conversación informativa con un concejal retirado que había servido en el PCT local y que tenía firmes opiniones sobre los cambios que habían tenido lugar en el NHS. Cuando le pregunté qué efecto había notado que tenía el contrato del 2003 en su salud, él contestó: "*mi médico conduce un coche mucho más bonito, pero rara vez se le ve porque frecuentemente tiene médicos suplentes y no está disponible fuera del horario laboral*." Aún más impactante fue una conversación que oí la siguiente semana durante un viaje en coche hacia el aeropuerto de Barcelona. Un eminente cirujano español conducía, yo estaba sentado junto a él y dos cirujanos británicos de renombre compartían el asiento trasero. Uno de los británicos le dijo al otro: "*No puedo llamar a mi médico de cabecera fuera del horario laboral. Esto es intolerable*." Como médico de familia en los EE.UU, que tiene un sistema de salud muy centrado en la especialización, nunca habría podido imaginar a dos especialistas manteniendo esta conversación. Su debate me recordó la confianza de muchos pacientes británicos en sus médicos de familia, incluso cuando los pacientes son los médicos especialistas.

Los cambios frecuentes e importantes en el NHS hacen difícil para los pacientes y médicos adaptarse a un entorno siempre cambiante de la práctica médica. Esta frustración se refleja en la observación de un médico de familia que dijo: "*el mayor problema del NHS es que los grandes cambios parecen ocurrir más o menos cada 15 minutos, sin necesidad de tener la necesidad imperiosa de un cambio*."

Reflexiones finales

Los británicos se enorgullecen justificadamente del NHS, que pone énfasis en la equidad y en la promoción de la cohesión nacional. Todos los profesionales del NHS que he conocido eran brillantes, dedicados y sinceramente interesados en la mejora de la atención y la salud. Muchos de ellos, sin embargo, también parecían aplastados por los cambios frecuentes y no probados que tantas veces se les lanzaban. Me llamó la atención la disponibilidad cada vez menor de la continuidad del médico general de Gran Bretaña (muchos de los médicos que observé tenían solo algunas visitas con pacientes a la semana y a menudo tenían consultas con personas que no estaban en su lista). No es que los médicos no estén ocupados. Parece que gastan una parte creciente de sus horas en trabajo dedicado a tareas administrativas y de gestión de personal.

Ya que el médico de familia sigue siendo un miembro muy valioso y de confianza de la sociedad británica,[5] mi preocupación es que los cambios profesionales impulsados por las estrategias y las preferencias de los médicos del NHS, acaben a la larga erosionando la base sobre la que se construye el NHS y que permite a Gran Bretaña lograr mejores resultados a costes más bajos: una relación terapéutica con un médico de familia que conoce al paciente y al que el paciente conoce y en quien confía. La genialidad de la medicina general británica ha sido mantener un firme compromiso con la persona y el lugar. Los médicos británicos tienen una larga tradición de mostrar el camino a la mayor parte del mundo médico. Mi esperanza es que puedan dirigir sus considerables aptitudes hacia la innovación de los nuevos enfoques que conduzcan a relaciones mantenidas y gratificantes que sirvan para satisfacer mejor las necesidades de los pacientes en un mundo que cambia rápidamente.

Profesor Rich Roberts
Presidente de la Organización Mundial de Médicos de Familia

Traducción: Eva Tudela

**Nota de la traductora: Fundholding es el sistema que se ha descrito en las líneas precedentes, en el que el médico tiene responsabilidad sobre la gestión de fondos presupuestados para su zona.*

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From the CEO's Desk : Weather, working parties and WONCA world

Bangkok in January – bright blue skies, daytime temperatures in the low to mid 30s (mid 90s), evening temperatures a very pleasant low 20s (low 70s)….. Apologies to all those currently suffering from a very cold northern hemisphere winter, but it's a great time to be in Thailand and I'm sure it's mere coincidence, that our President, Rich Roberts, and President-elect, Michael Kidd, will arrive here in early February for the next Core Executive meeting! The agenda is fairly packed, but hopefully they will have time to enjoy the really lovely conditions at this time of year. Rich will be visiting some young Thai doctors in their practice and will also meet with some of the primary health care policymakers and strategists during his visit, in addition to several Thai family practitioners, and I'm sure he will report more fully in next month's newsletter.

The period leading up to the triennial World Council has traditionally been fairly quiet, as most Working Parties (WP) and Special Interest Groups (SIG) conserve their time and budgets for attendance at the World Council and Conference. However it was great to hear of a really successful research workshop held in Colombo in mid-January, organised by the South Asia Primary Care Research Network and supported by the WONCA Research WP and by the WONCA Regional President. A total of 48 doctors took part in what I'm told was a really dynamic and lively workshop, and we look forward to hearing more from Dr Basharat Ali when he reports through WONCA News in a future edition.

Another WONCA WP which is working hard in relative anonymity is the WONCA International Classification Committee, or WICC. This is WONCA's oldest and longest-standing committee, and it has continued work over the years to develop and revise and improve classification methods for primary care encounters. It is, inevitably, a field littered with acronyms, but WICC has developed the International Classification for Primary Care (ICPC), now in its second iteration (ICPC-2) and work has already commenced on building the conceptual framework for ICPC-3. WICC's work ensures that ICPC closely maps other international standards such as SNOMED (Systemized Nomenclature of Medicine Clinical Terms) and ICD (International Classification of Disease) and the Working Party is developing ever-closer links with WHO, through WHO-FIC (the WHO Family of International Classifications…I told you it was fraught with acronyms!) to ensure robust family medicine inputs into the development of ICD-11.

WICC at work in Barcelona in 2011

In fact the issue of more proactive WONCA engagement in the development of ICD-11 was raised by the WHO Director General, Dr Margaret Chan (pictured) , when the key WONCA Executives of Rich Roberts, Michael Kidd, Iona Heath (WHO Liaison) and Alfred Loh met her last August as the culmination of a series of very productive meetings in Geneva over two days with WHO senior staff. It has now been confirmed that Dr Chan will deliver the keynote speech during the opening ceremony of the World Conference in Prague on 25 June which is a huge fillip for them and for us, as it will be the first ever attendance by a WHO Director General at a major WONCA event.

Finally, for this month, I return to the 2013 World Council. In the next couple of weeks the Secretariat staff will be contacting all Member Organisations and Chairs of WPs, SIGs and Committees regarding the arrangements for the Prague World Council. We will be asking for submission of any items for the agenda, so please do encourage your own MO or group to raise any issues which you think are important – it's your once-every-three-years opportunity to get an issue highlighted and debated and discussed. And don't forget that the extra-early bird conference registration fee for WONCA Direct Members expires on 19 February, so this is your last chance to take advantage of this very good deal.

Until next month.
Garth Manning

FEATURE STORIES

WONCA Prague approaches

The next WONCA World conference is fast approaching and if you have not registered it is time to consider doing so. A reminder that the extra early bird registration for WONCA Direct members ends on February 19. To take advantage of this offer you need to join WONCA as a direct member go to the membership information page.

Prof Igor Švab (pictured) , keynote speaker and immediate Past President of WONCA Europe, features in a welcome video message on the conference page.

Last month *WONCA News* included a special feature on the Prague keynote speakers. If you missed this article *Unveiling the speakers for WONCA Prague 2013* it can be viewed here.

To register go directly to the registration page of the conference website.

Karen Flegg (WONCA Editor)

Prague Preconference for young family doctors

The Vasco da Gama Movement for new and young family doctors welcomes you to the World Preconference, which will be held in Prague on June 24–25, 2013, prior to the WONCA World Conference.

The event is organized jointly by the Vasco da Gama Movement, the Rajakumar Movement, the Waynakay Movement, the Spice Route and the First Five Years in Family Practice in Canada and is open to trainees and junior General Practitioners / Family Physicians (GPs/FPs), up to five years after their qualification.

The information in this page will help you to get an idea of what the Preconference entails. For registration please head to: http://www.wonca2013.com/en/world-preconference

What is the aim of the World Preconference?

The Preconference participants have the great opportunity to receive an introduction to the idea of being a GP/FP in a World context and to exchange experiences and visions. Discussions with colleagues from all over the globe will widen your perspectives and horizons and will help you to *"think globally and act locally"*.

What's the content of the Preconference?

The theme of this year's preconference is ***"Care for Generations"***.

The Preconference participants will have the opportunity to:

a) meet trainees and juniors GPs/FPs from other WONCA regions;

b) become acquainted with several national profiles and be able to compare different primary care systems at various levels: health systems organization, status of GP/FM and vocational training programs;

c) discuss and elaborate visions for the future of GP/FM, considering:

- The improvement of practice, quality, teaching and research of GP/FM in all countries.
- The development of GP/FM to meet the needs of patients in the increasingly complex and diverse world, characterized by raising demands and afflicted by inequalities and an ageing population.

- The working conditions corresponding to the needs of the upcoming generation of GPs/FPs.

d) understand the importance of international peer networks and be able to define aims for such networks on a national and international level.

The Preconference will conclude with two visionary speeches by Professor Richard Roberts (WONCA President) and Professor Michael Kidd (WONCA President Elect). A plenary session will follow with the presentation of all group works.

When Preconference will take place?

The Preconference starts on 24 June 2013 with registration at 9am and will end on 25 June. After the end participants will be invited to attend a joined speech with the WONCA Working Party on Women and Family Medicine.

The registration fee for the Preconference is $80.

Who are the preconference participants?

The preconference is open to every trainee or new GP/FP, up to five years after his/her qualification, who wishes to participate. However, there are 100 places available and registrations will be carried out in a first-come, first-served basis.

Where can I get further information?

Information is available online on www.wonca2013.com and will be updated regularly. Please don't hesitate to contact us for any questions by e-mail: preconference@vdgm.eu

Vasco da Gama Junior researcher award

This year's Vasco da Gama junior researcher award finalist winners will present their work at the WONCA world conference in Prague. Nominations close February 15.

What purpose?

- General practice (GP) and Family Medicine (FM) is known to be an emerging field for research activities all over the world
- It's comprehensive, population based scope implies special demands for multi-methodological research skills
- VdGM aims to promote a generation of junior GP/FM doctors who include research skills with patient care as a life time career
- VdGM therefore provides an annual junior researcher award
- This award honours outstanding research and researchers careers who are GP/FM trainees or junior GP/FM with up to five years working experience after graduation

Who can apply?

- GP/FM trainees, junior GP/FMs (up to 5 years after graduation from vocational training)
- A proposed research project with an impact on the field of general practice
- One application per candidate is accepted
- Every VdGM national representative can propose one researcher for his/her country, using the selection grid as proposed by VdGM (annexe)

Practical considerations

Application only through VdGM national representatives (Europe council members)

Documents to be sent:

1. a copy of passport or identity card

2. a copy of student registration or document of graduation

3. a short letter of presentation from the candidate (max. 500 words)

4. the national grid as filled out by the national representative or person responsible for national selection

5. a copy of the project proposal as submitted by the candidate

Deadline for application to the national representatives is 15th February 2013, deadline for the proposal of the national candidate is 28th February 2013 prior to the WONCA World 2013 conference.

Jury will define three final candidates before April 1st 2013

The three final winners will be invited to present their project proposal during a VdGM workshop in the WONCA World 2013 conference in Prague in June. The entrance fee will be covered by VdGM. The final winner(s) will also be pronounced during the closing ceremony.

The winner will allow VdGM to publish CV, portrait photography and research abstract on the VdGM website as examples of Champions of Research as general practice clinicians.

For further information please download both documents

Full information

Project proposal information

Primafamed Network - Africa statement

Scaling up Family Medicine (FM) and Primary Health Care (PHC) in Africa:

Statement of the Primafamed network (23 November 2012, Victoria Falls, Zimbabwe).

This document reflects the work at the 5th annual conference of the Primafamed-network. It provides an analysis of the PHC context in sub-Saharan Africa and strategic ways to strengthen PHC. Taking into account the diversity in Africa, not all issues, proposals, topics are relevant to all African countries. The document was adopted by consensus.

From 21 to 23 of November 2012, participants from 20 countries convened at the Fifth Annual Primafamed conference (www.primafamed.ugent.be) at Victoria Falls, Zimbabwe. The participants want to support fully the realization of the World Health Assembly (WHA) resolution 62.12, by contributing:

> *"to train and retain adequate numbers of health workers, with appropriate skill-mix, including primary health care nurses, midwives, allied health professionals and family physicians, able to work in a multidisciplinary context, in cooperation with non-professional community health workers in order to respond effectively to people's health needs".*

The participants recognize the importance of the worldwide demographic and epidemiological transitions and the impact on health of the global economic crises, which give rise to new challenges for healthcare providers in Africa. Moreover the participants stress the need for an integrated approach to comprehensive PHC in order to address the fragmentation of care and health systems as a consequence of vertical disease-oriented programmes (HIV, malaria, COPD, diabetes, etc.). They confirm their commitment to the realization of the WHA resolution 62.12[1]: "*to encourage that vertical programmes, including disease-specific programmes, are developed, integrated and implemented in the context of integrated primary health care",* the WHO Global Health Workforce Strategy[2] and the WHA resolution 59.23: "*Rapid Scaling Up of Health Workforce*"[3].

Family physicians fully support African governments' implementation of universal health coverage that is oriented towards guaranteeing the right to health for all. This includes implementing the Abuja Declaration of allocating 15% of budget to health; developing nationally socially oriented health insurance systems to provide universal access; single risk pools and adjusted capitated systems to ensure resources go to those who need it most; strong decentralized district health systems responsive to local communities; the inclusion and regulation of the private for-profit and non-for-profit sector as contracted providers; and innovative payments systems to drive improvement of quality in integrated primary healthcare teamwork to achieve *Health for All*.

The participants define the future of FM in the framework of the PHC system: a community-based team approach including nurses, family physicians, mid-level care workers (associate clinicians), health promoters and community health workers, that focuses on accessibility, connectedness, health promotion and disease prevention, comprehensiveness, continuity, and coordination, in the context of families and communities (as described in the Consensus Statement, Rustenburg 2009[4]).

Family physicians in Africa take responsibility for specific tasks in the district and in district/community hospitals, and need to be trained accordingly. The training of family physicians has to take place mainly in an inter-professional PHC-team-context in the district health system. Family physicians share responsibility for training of other health care workers in PHC.

Increasingly, PHC will have to address the problems arising in the context of multi-morbidity, and providing appropriate person- and people-centered care. Community oriented primary care (COPC) is an appropriate strategy embraced by African PHC-teams, to address upstream causes of ill-health, including behavioural, social and environmental determinants.

The departments and training institutions for FM commit to a socially accountable approach in order to respond to the workforce needs and to the requirements of the health care system. Training in family medicine is based on the acquisition of appropriate knowledge, skills and attitudes in the context of the community, with dominance of community based training in the programmes.

In terms of scaling up FM, a reflection is ongoing on the optimal duration of postgraduate training, which will vary in relation to the relevance of the undergraduate training and contextual factors such as the need to work in the district/community hospital[5]. One example that inspired the participants was the experience reported by Sudan (Faculty of Medicine of Gezira University and the Ministry of Health), that addresses the needs of the local population through a two-year training programme in the community, supported by e-learning, that involved 200 candidates. This is one example on which we need to reflect in order to develop optimal training programmes in each country. The reflection will include determination of the need to learn procedural skills

(surgical, anaesthetic, etc.) in each country. These and other topics will be addressed in the process of mutual learning and exchange in the Primafamed network.

In order to scale up FM, concrete strategic actions should be developed, including the following:

- Convince Ministers of Health and Education, and leadership of medical schools that a significant proportion of the graduates (between 40 and 60 %) should be trained in FM and PHC;
- The existing community service period should be integrated into the training programme of FM, in order to fast track the scaling up at a lower cost;
- Define appropriate content and duration of the training programme in each country;
- Prepare for lifelong learning and develop appropriate Continuous Professional Development.

Essential conditions to make this happen are:

- Ensure that all countries have training in family medicine and establish networks, synergies and collaborations to support African standards;
- Integrate exposure to PHC and FM in the undergraduate curriculum and provide role models for FM;
- Establish well-equipped training complexes for PHC teams (PHC centres and related clinics, with the district hospital for referrals); creating an environment for transformative learning
- Offer sufficient funded posts for residents/registrars;
- Provide appropriate remuneration for family physicians and PHC-teams and attractive career-paths;
- Develop training the trainer programmes, taking advantage of South-South cooperation;
- Increase the budget for PHC;
- Encourage NGOs and donors to invest in strengthening local PHC-systems (www.15by2015.org);
- Implement population-oriented campaigns to promote FM and PHC and stimulate cost effective use of health care services by the population.

If these conditions were fulfilled from today onwards, it is possible to train 30,000 new family physicians and tens of thousands of PHC professionals for PHC teams in sub-Saharan Africa in the next 10-years[6].

The participants stress that appropriate research in FM and PHC in Africa is essential, in order to substantially enlarge the evidence base for the issues highlighted in this document. This should be facilitated by the provision of specific funding by governments and NGOs, by building research capacity in academic departments of FM and PHC, and by developing an African FM and PHC-research network to support researchers and promote cross-country collaboration.

The delegates from the Primafamed-Network Conference want to engage in a regional strategy through dialogue at different levels: local level, the community, stakeholders, provinces, national government (Ministers of Health). Moreover at the international level they call upon the WHO-Africa region, African Union, WONCA, MEPI and other organisations to strengthen the commitment to the development of PHC and FM.

By doing so, the delegates are convinced that they can make a difference where it really matters, to contribute to a healthier future for Africa.

At the Primafamed Network-conference 2012 participants were coming from the following African countries: Botswana, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria Rwanda, South Africa, Sudan, Swaziland, Uganda, Zambia, Zimbabwe and from countries from other continents: Belgium, Canada, Denmark, England, Ireland, Norway, The Netherlands, Scotland, USA.

Acknowledgement: the participants thank VLIRUOS, funded by the Belgian Government, and ICHO, the Flemish Interuniversity Cooperation for Training in Family Medicine, and Global Health through Education Training and Service (GHETS) for the sponsoring of the Primafamed-workshop in Vic Falls.

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For more information on Primafamed, visit: www.primafamed.ugent.be

[1] http://www.who.int/hrh/resources/A62_12_EN.pdf
[2] http://www.who.int/hrh/documents/en/workforce_strategy.pdf
[3] http://www.who.int/workforcealliance/knowledge/resources/wha_scalingup/en/index.html
[4] Mash B, Reid S. Statement of consensus on Family Medicine in Africa. *Afr J Prm Health Care Fam Med*. 2010;2(1), Art. #151, 4 pages. DOI: 10.4102/ phcfm.v2i1.151 www.phcfm.org
[5] In a study on the principles of FM in Africa the need to perform common clinical procedures and operations appropriate to the district health system was a reality in 70% of the settings. Mash R, Downing R, Moosa S, De Maeseneer J. Exploring the key principles of Family Medicine in sub-Saharan Africa: international Delphi consensus process. *SA Fam Pract* 2008;50(3):60-65 www.safpj.co.za
[6] In the Sub-Saharan African Medical School Study, the authors calculated that: "The data suggest an estimated 10,000-11,000 graduates per year from medical schools in sub-Saharan Africa"(Mullan F et al. Medical schools in sub-Saharan Africa. *The Lancet* 2011:377:1113-1121). In the hypothesis that from 2013 onwards 50% of the graduates would be trained in Family Medicine, this would lead to 30000 new Family Physicians in Sub-Saharan Africa by 2020 in a 2-year programme and by 2022 in a 4-year programme (at higher cost). In Europe, the required post-graduate training for family medicine is 3 years (EC Directive 2005/36/EU).

Featured Doctors

Lucy Candib – WONCA North America Five Star Doctor

WONCA North America region Five Star Doctor for 2012 is Dr Lucy Candib.

She was nominated by colleague, Dr Cheryl Levitt. In her letter of nomination, Dr Levitt said "Lucy is a 5 Star doctor, a serving physician who has practiced for 35 years and who in addition to providing regular family physician comprehensive service including obstetrics, also provides innovative services to her community, to her colleagues in other countries such as Ecuador and through WONCA, and performs academic work (teaching, research, quality assurance) of exceptional quality and relevance. Lucy serves as a role model to family physicians throughout the world and her work extends well beyond Worcester, Massachusetts."

Dr Candib addresses the attributes of a five star doctor as follows:

★ A **care provider**

Dr Candib is a family physician who has taught and practiced family medicine, including obstetrics, at the Family Health Center of Worcester since 1976. She works three days a week at the health center and spends two days on other academic pursuits. She works with a vulnerable population in a community health centre environment, she practices comprehensive family medicine including obstetrics, she is passionate about patient-centred care and continuity of care, she teaches medical students and residents, and she mentors a following of young physicians. Also, Dr Candib integrates regular scholarship and writing into her busy routine and she writes about a broad range of topics raising issues well before they became commonly discussed in family medicine.

Although Dr Candib's interests cover deeply theoretical perspectives of feminism and family medicine, her clinical expertise extends well beyond this topic. She has implemented innovative group visits for English and Spanish speaking patients with diabetes at the Family Health Center, and researched the use of massage therapy for low income women in chronic pain. She has developed novel exercise programs for health center patients at the YWCA and YMCA of Worcester, and continues working in community activities around the issues of obesity and exercise for low income and Latino families.

★ A **decision maker**

Dr Lucy Candib, MD, is Professor of Family and Community Medicine at the University of Massachusetts Medical School and a faculty family physician at the Family Health and Social Service Center in Worcester, MA, USA. This community health center is a residency training site within the University of Massachusetts Family Practice Residency Program.

Dr Candib's paper "Ways of knowing in family medicine: contributions from a feminist perspective" in *Family Medicine* 1988; 20:133-136, and later her book called *Medicine and the Family: Feminist Theory and Family Medicine* are seminal influences on scores of family doctors. She is a pioneer in family medicine, she simply and effectively described the plight of women and helped generations of family doctors understand the unique contribution that women make to the discipline by integrating feminist theory with modern concepts of family medicine.

She has lectured widely on the topics of sexual abuse and violence against women. Over her career, she has also focused attention on the concerns of women trainees and practitioners in her work with family practice residents. Dr Candib has delineated thirteen principles she calls the "Tenets of Women's Health." for the Women's Health Project at the University of Massachusetts residency program.

Dr Candib has recently co-authored, with Dr Sara Shields, a new text on *Woman-Centered Care of Pregnancy and Birth* (Radcliffe Medical Press, 2010. It applies the powerful, proven model of patient-centered care to pregnancy and birth - an expansion beyond previous applications to various chronic illnesses.

★ **A communicator**

Dr Candib has written dozens of peer reviewed papers, two well regarded books and taught many students and residents. She is a highly sought after speaker on topics such as women's health, feminism and family medicine, cross cultural medicine and family medicine in developing nations, rape, sexual abuse and domestic violence, contraception, depression screening, post-traumatic stress disorder, somatization,

sexual problems, incest, exercise, and working in cross disciplinary setting with physiotherapy

★ A community leader

Dr Candib is the recipient of numerous honors and awards including an Honorary Doctorate of Humane Letters, from Worcester State College in 2006, and the Community Health Center Physician of the Year Award from the Massachusetts League of Community Health Centers in 2006.

In 1995, Dr Candib received a Fulbright grant to teach family medicine in Ecuador and spent a year as a visiting professor at Pontifica Catholic University.

In 1993 she received the Society of Teachers of Family Medicine (STFM) Excellence in Education Award, which recognizes leadership within STFM in support of teaching, teaching, research, curriculum development, or other aspects of medical student or resident education. Dr Candib also received the Outstanding Primary Care Research, Generalist Physician Initiative Award in 1997, from the University of Massachusetts Medical School.

Dr Candib won the Fulbright Senior Specialist Award to consult at the National University of Loja, Ecuador, in 2004 and 2005; and was selected in 2003 as one of forty six generalist physicians in the National Library of Medicine exhibit: *Changing the Face of Medicine - Celebrating America's Women Physicians.*

★ A team member

Dr Candib is a wonderful team player, reliable, responsive and supportive. She has excellent inter-professional relationships with her colleagues, and is admired by them enormously for mentoring, teaching and leadership. As attested by her colleague, Suzanne Cashman, a public health practitioner and academic, Dr Candib is a role model, who walks the talk, engages with colleagues and has built a team that has gained notoriety as a model for health care centres.

Dr Candib lives with her life partner, Richard Schmitt, with whom she has raised her now adult children Addie and Eli.

WONCA congratulates Dr Lucy Candib on her award as WONCA North America region Five Star doctor.

Leonardo Vieira Targa : Brazil – rural family doctor

What work are you doing currently?

I've been working and living for ten years in the same rural area in South Brazil, as a family and community physician. It is an area of German immigration of small farmers (for about a century). Here I have the excellent opportunity of working with medical students and residents of family medicine. I am also Assistant Professor in the Universidade de Caxias do Sul, which has a good community engagement and supports our rural work and some research in the area.

I am coordinating the Brazilian Working Party on Rural Health of the Brazilian Society of Family Medicine. We are hosting the next WONCA Rural Health Conference, in Gramado, 2014. (please see www.sbmfc.org.br/woncarural). This group are doing great work in Brazil: bringing new perspectives on national and regional production in rural health; stimulating discussions at conferences; uniting remote professionals; translating WONCA rural documents to Portuguese. I am very happy and honoured to represent this group and the Scientific Society on the WONCA Working Party on Rural Health which qualifies our national work and serves as an inspiration.

Other interesting things you have done previously?

I worked a short time in the Amazon region with the indigenous peoples. Besides being a great professional and life experience, helped me to understand the challenges of rural medicine in situations with great diversity and difficulties. I also worked for some years in very poor regions, on the outskirts of cities. These regions share some problems with rural areas and also present major challenges, especially in developing countries such as Brazil.

Recently, I finished a Masters in Social Anthropology with a Health and Culture focus. This is very important to my everyday work since intercultural competence is essential to primary care and community work.

What are your interests in work and outside work?

In work, rural health and medical anthropology are my main interests. Outside work, I spend time with my family, I read a lot, play guitar and work in

garden and orchard, as I am living now, on a small rural property, like my patients.

What do you like about your interactions in WONCA?

My connection with WONCA occurs predominantly through the WONCA Working Party on Rural Practice and WONCA conferences. It is wonderful to feel part of a large group of family doctors worldwide and to exchange experiences with rural doctors from the most diverse and remote places on our planet.

In 2014, WONCA will give us (in Brazil) the opportunity to host the WONCA World Rural Health Conference, the first in Latin America.

This will be very important to raise issues and deepen themes like retention and recruitment of rural health professionals, quality of care in rural areas, rural training, indigenous health, tropical diseases, etc. All these topics have local peculiarities and Latin America has some important experiences to share and also a lot to learn from other countries. We hope this will be a great opportunity to study and learn but also to celebrate our work.

What can you tell us about being a rural family doctor in Brazil?

We work in health teams in Brazil. The rural teams are usually small with one doctor, one nurse, two nurse assistants and five health community workers. We have a dentist half time, and support from a physical educator, psychologist and social worker.

My health unit is 17km from a small city (of 19,000 habitants) with a small hospital and 40km from medium urban centres with more resources. The community we serve is 2000 people. The activities in the community besides individual and family consults consist of home visits, small ambulatory surgeries, educational activities in schools, community centres and places of work based on epidemiologic data and local health needs. Students and residents have the opportunity to do all the activities listed and know more about the health system of a smaller city. They do short rotations of three to four weeks.

Living near my patients helps me to be more adequate as a physician and to understand better the local problems and has also advantages and a good quality of life. Cultural issues are very important in a country like Brazil, with enormous human diversity and two of my challenges were to learn how to speak a little German to better communication and also to study traditional medicines and herbs.

People who wants to know more about our situation will be welcome to visit my health unit and community, in 2014. We are planning some visits to many services in different settings in conjunction with the WONCA Rural Health Conference.

Dr Mohammed Tarawneh: Jordan - WONCA Leader

Current work

Dr Mohammed Tarawneh is a Family Medicine consultant with 31 years of experience, from the Hashemite Kingdom of Jordan. He received his Bachelors degree in medicine, from Italy, in 1980; and the Jordanian Board of Family Medicine (JBFM) in 1988. In 1980, he joined the Jordan Military Royal Medical Services (RMS), and remained with the RMS until he retired as a Major General in 2011, to practice in his private clinic.

Dr Tarawneh has a vast experience in leading humanitarian emergency medical teams / field hospitals in areas stricken by manmade and natural disasters; with United Nation Peace Keeping Forces - in former Yugoslavia 1993-1994, Sierra Leone 2000, Afghanistan 2002, Congo 2002, and Lebanon 2006; or as humanitarian aid missions organised by the RMS in areas of earthquakes - as in Iran 2003 and Pakistan 2005; and as a medical inspection officer in disaster areas preceding each humanitarian mission, with excellent knowledge of tropical diseases.

What other interesting work he has done?

During the period 1990 – 2011, Dr Tarawneh was tutor, examiner and coordinator of the family medicine residency program in the RMS. In addition, he was the co- founder for the First Military Family Medicine Center in Eastern Amman, in 1991-1993, which was accredited by Jordan Medical Council (JMC) which is the authorized institution to supervising and providing medical license to all physicians from different medical specialties in the country including family medicine.

In 1990, he attended various courses in USA, such as in emergency medicine, field hospital administration, and in medical management of patients affected by nuclear warfare.

From 2008 to 2010, Dr Tarawneh was a member in the scientific committee of the Jordan Medical Council (JMC) as a tutor and examiner of family

medicine residents, Also he was a member of the scientific committee in the faculty of medicine of Muta' University, from 2009 to 2010.

He has a wealth of experience in management as he worked as a director for the south region military medical, in RMS, from 2004 to 2005; chief of the department of family and emergency medicine, from 2005 to 2009; and was twice, the director of a 200 bed hospital, for two years each time (RMS has more than eight peripheral hospitals with capacity from 200 to 600 beds and one main 1500 bed hospital; as well as more than ten primary health care centers, providing care to military personnel and their dependents).

Dr Tarawneh has been a member of Jordan Medical Association (JMA) since 1981; a member of the Jordan Society of Family Medicine (JSFM) since 1993. He was chairman of the JSFM from 2006 to 2008, and is currently the general secretary of JSFM. He has also been a member of the Society of Teachers of Family Medicine (STFM) since 2005, and the Society for Academic Primary Care (SAPC) since 2008.

He has been a direct member of WONCA since 1996 and is the representative of the JSFM on WONCA World Council and Honorary Treasurer of WONCA Eastern Mediterranean region from 2010 to 2013. He has attended most of WONCA world and WONCA regional conferences.

Dr Tarawneh is also an author of different published papers of primary health care and has attended many workshops in different areas of primary care. In 2005, he had the privilege to work with Prof Edward Shahedy, from University of Florida, in the diabetes master clinician program. He shared this knowledge through the internet to the majority of physicians colleagues in his country.

What he likes about his interactions in WONCA?

As noted above Dr Tarawneh has been a regular attendee at WONCA conferences over many years and is a member of the WONCA Eastern Mediterranean region (EMR) executive.

He aims to work hand in hand with the JSFM members: to attract new graduate physicians to join the family medicine specialty in Jordan; to strengthen the scientific ties with local medical societies and health institutions; to extend the duration of the curriculum of family medicine in the faculties of medicine of the four Jordanian universities which are teaching medicine; and to encourage family physician residents to join the JSFM and WONCA.

He enjoys the joint team work with the other executive members of WONCA EMR to encourage more countries in the Middle East and North Africa to join WONCA EMR, spreading the existing experience of family medicine locally and regionally, to other countries in WONCA EMR, who are yet to join WONCA.

A final word.

Family medicine is the specialty I like. It's the comprehensive, continuity of care for all family members. The main challenges this new specialty faces is still the lack of knowledge in the community of family medicine; regardless of the great attempts and the promotions being done by colleagues through the media and in organised meetings with local communities. We are all optimistic that in the near future we will see our specialty spread more and more.

Resources

WHO persisting pain in children package

The World Health Organization (WHO) has announced the availability of its *WHO guideline on the pharmacological treatment of persisting pain in children with medical illnesses.*

These guidelines have been developed to support countries to relieve pain in their paediatric populations. They address persisting pain in children caused by conditions such as cancer, HIV/AIDS, sickle-cell disease, burns, trauma, and phantom limb pain. Recommendations, developed following a careful and transparent appraisal of available evidence, are presented for the pharmacological treatment of mild, moderate and severe pain.

The guidelines include chapters on the various systems used to classify pain and on the evaluation of pain, which reviews the available tools for routine pain measurement in children. Provision of sustainable pain relief within health care systems is covered in a separate chapter.

To download the guidelines (166pp)

For more information and hard copy package order form

Notices

WONCA Gramado 2014 - invitation to attend

Dear colleagues,

For the first time South America will host a world conference on family medicine and rural health, the 12th WONCA World Rural Health Conference, that will be held in Gramado, Rio Grande do Sul State, May 21–25, 2014.

The theme is: *Rural Health: An Emerging Need*.

The fact of hosting the event fills us with pride and responsibility. It represents a great opportunity to put on evidence relevant aspects of the health situation of large masses of population that often has unequal access to health resources, and for this reason, sets an important concern for the organisation of health systems and professional practices.

In addition, it will be a great opportunity to study the multiple relationships between rural and urban health, a current and challenging issue in a world increasingly interconnected. The Congress will feature the participation of national and international speakers, workshops, presentation of experiences and research as well as visits to local health services, and an interesting social and cultural agenda.

Gramado is a beautiful city, located in the mountain regions of South Brazil, which has an excellent tourist infrastructure. Added to this, a rich inner landscapes such as valleys, rivers and waterfalls, where the history of this region is preserved by the descendants of the colonizers Germans and Italians. From Gramado, several itineraries will be available for the State of Rio Grande do Sul and the rest of Brazil.

The 12th WONCA World Rural Health Conference will occur along with the 4th Congress of South Brazilian Family Medicine and Community through a partnership between the institutions representatives of the specialty worldwide, continental, national and state.

We are counting on your participation in this important event!

Leonardo Vieira Targa

President of the 12th World Congress of Rural Health WONCA

WONCA CONFERENCES 2013-2014 AT A GLANCE

2013

26 – 29 June 2013	20th WONCA WORLD *CONFERENCE*	Prague CZECH REPUBLIC	Family Medicine: Care for Generations www.wonca2013.com

2014

May 21 – 24, 2014	WONCA Asia Pacific Regional Conference	Sarawak MALAYSIA	Nurturing Tomorrow's Family Doctor www.wonca2014kuching.com.my
May 21 – 24, 2014	WONCA World Rural Health Conference	Gramado BRAZIL	Rural health, an emerging need http://www.sbmfc.org.br/woncarural/
July 2 – 5, 2014	WONCA Europe Regional Conference	Lisbon PORTUGAL	New Routes for General Practice and Family Medicine http://www.woncaeurope2014.org/

WONCA Direct Members enjoy *lower* conference registration fees. See WONCA Website **www.globalfamilydoctor.com** for updates & membership information

MEMBER ORGANIZATION & RELATED MEETINGS

FMPC 2013 India
Date: April 20-21, 2013
Venue: New Delhi, India
Host; Academy of Family Physicians of India
Web: www.fmpc2013.com
Email: dr_raman@hotmail.com

City health conference
Host: The Royal College of General Practitioners (England)
Date: April 24-26, 2013
Venue: Euston Square, London, UK
Web: www.cityhealthconferences.org.uk

EGPRN spring meeting
Host: European General Practice Research network (EGPRN)
Date: May 16-19 2013
Abstracts close: January 15, 2013
Venue: Kusadasi, Turkey
Web: www.egprn.org

12th Brazilian Congress of Family and Community Medicine
Venue: Belem, Brazil
date: May 30-June 2, 2013
Website**:** www.sbmfc.org.br/congresso2013
Email: juliana@oceanoeventos.com.br

XXXIII Congreso de la semFYC
Host**:** SemFYC
Date: June 06-08 2013
Venue: Granada, Spain
Web**:** www.semfyc2013.com

RNZCGP conference for general practice
Host: Royal New Zealand College of General Practitioners
Date: July 11-13, 2013
Venue: Wellington, New Zealand
Web: www.rnzcgp.org.nz

18th Nordic Congress of General Practice
Host**:** Finnish Association for General Practice
Date: August 21-24, 2013
Venue: Tampere, Finland
Web: http://nordicgp2013.fi

European forum for primary care conference
Date: September 9-10, 2013
Venue: Istanbul, Turkey
Host: European forum for Primary care (EFPC)
Web: http://nvl007.nivel.nl/euprimarycare/efpc-conference-istanbul-9-10-september-2013
Email: dr_raman@hotmail.com

AAFP annual scientific assembly
Host: The American Academy of Family Physicians
Date: September 24–28, 2013
Venue: San Diego, USA
Web: www.aafp.org

RCGP annual primary care conference
Host: Royal College of General Practitioners
Theme: Progressive Primary Care
Date: October 3–5, 2013
Venue: Harrogate, United Kingdom
Web:www.rcgp.org.uk

RACGP GP '13 conference
Host: The Royal Australian College of General Practitioners
Date: October 17-19, 2012
Venue: Darwin, Northern Territory, Australia
Web: www.gp13.com.au/

2013 Family Medicine Global Health Workshop
Host: American Academy of Family Physicians (AAFP)
Date: October 10-12, 2013
Abstracts close: May 15, 2013
Venue: Baltimore, Maryland, USA
Web: www.aafp.org/intl/workshop
Email: Rebecca Janssen or Alex Ivanov

Family Medicine Forum / Forum en médicine familiale 2012
Host: The College of Family Physicians of Canada.
Date: November 7-9, 2012
Venue: Vancouver, Canada
Web: http://fmf.cfpc.ca

The Network: Towards Unity for Health annual conference
Host: TUFH
Date: November 16-20, 2013
Venue: Ayutthaya, Thailand
Web: http://www.the-networktufh.org/conferences/upcoming