WONCANews

An International Forum for Family Doctors

Wonca
World family doctors. Caring for people.

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From the President: The whole is greater than the sum of its parts.

 **Whole > Σ [Parts]** *"The whole is greater than the sum of its parts"*

Some truths need repeating, often using different language until we better understand. A recent meeting to plan a workshop for family doctors on multiple morbidities reminded me of this. Convened by the Dialogue on Diabetes and Depression (DDD), Prof Jan de Maeseneer hosted the planning session at the University of Ghent. The DDD is an international multi-disciplinary effort started in 2007 to improve the care and outcomes of those with both diabetes and depression. WONCA was a founding member of the DDD. The DDD plans to offer a series of workshops on diabetes and depression for diabetes specialists, family doctors and primary care workers, nurses, and mental health workers around the world.

Our task at the planning session was to develop the overall framework and goals for a family doctor workshop. We were a dozen experts from six countries. We represented behavioral health, diabetes, family medicine, internal medicine, nursing, psychiatry, and psychosomatic medicine. We reviewed the experience of the very first workshops on diabetes and depression that DDD conducted for nurses in Africa over the past year. We noted that the nurses preferred small group discussions that focused on local issues.

Encouraged by the success of the nurse workshops, we enthused that we would pioneer a new kind of thinking. We would solve the problem of fragmented care for those with multiple morbidities. We would begin by weaving several conditions into a single workshop that would be relevant to and centered on learners. We envisioned a future in which the multiple disciplines would bring their collective expertise together to address more effectively the comprehensive needs of the patient. We imagined that our workshops would stimulate interdisciplinary insights and cooperation to better serve the patient.

Then, reality set in. As we got into the details of exactly what the workshop should accomplish, it became obvious that we were speaking different languages. Our conflicts seemed to center around two key questions. Who should do what in the care of those with diabetes and depression or other multiple morbidities? What should be done to provide the best care for those with diabetes and depression or other multiple morbidities?

It seemed ironic that these basic questions could result in divergent opinions. How could such fundamental disagreement occur among bright, thoughtful, and well intended professionals? My service on more than three dozen national and international guideline panels has taught me that such conflicts arise with every guideline. My 30 years of practice experience has confirmed that such disagreements happen every day in practice. What follow are my reflections on ways to resolve these important disputes.

Who should do what versus what should be done

We each view the world through our own professional lens. We spend many years absorbing the language and culture of our respective disciplines. It is therefore understandable that those of us from a particular profession develop a uniform sense of what our roles are and should be in our various health care delivery systems. Thus, with every guideline we write and with every course we teach, we attempt to reinforce the idealized version of the role that we believe our profession should play in health care. Yet, our actual roles in the health system do not flow directly from our own perspectives and preferences. They are the result of the unique mix of resources, population needs, other professions, politics, and other competing forces that shape every health system.

An example is the declining role of cardiothoracic surgeons in the care of coronary artery disease (CAD). In the early days of interventional therapies for CAD, when coronary artery bypass graft surgery was the primary invasive treatment, surgeons dominated discussions on CAD therapy. The disruptive technology of angioplasty and stents changed that, with cardiologists becoming the dominant force in CAD treatment. The shrinking influence of surgeons in the management of CAD caused reductions in the number and economic power of those choosing cardiothoracic surgery as a profession. That is not the end of the story however, as surgeons respond to the changing

and competitive landscape with their own innovations, such as minimally invasive surgery.[1]

We find proposals to limit or modify our roles as threats to our professional identity and to our livelihood. A substantial portion of meeting time for multidisciplinary groups consists of teaching other each what their group actually does, could do, and should do in the provision of health care. Consequently, we should expect that diverse groups of professionals will spend much of their time writing guidelines and developing courses in a power struggle for primacy.

If we turn to science as the dispassionate arbiter to resolve these professional disputes, we will be sorely disappointed. The science on what should be done for the individual patient is remarkably scant, almost shockingly inadequate. The science on who should do what is practically non-existent. From the point of view of the patient or the objective observer, these professional power struggles seem scientifically unwarranted and professionally self-serving. In the end, the needs of the patient and population are best served by coming to agreement on what should be done. After agreement is reached on what should be done, who should do it is often decided with less controversy.

What should be done, and who decides

Deciding what should be done can be very difficult. At a population level, our most influential studies produce findings that are accurate and enduring less than half the time.[2] At the level of the individual patient, it is even worse. Unless the patient was actually enrolled in a study, we can never be certain that the study population's demographics, setting, and findings are relevant for that particular patient.

Even more vexing is the challenge of coming to agreement on the outcomes that are viewed by the patient as most important. For example, while death is assumed to be an unwanted outcome, it is preferred by many to the outcome of a seriously disabling stroke.[3] Especially disconcerting is the fact that decisions regarding the value of various outcomes are often left to those who specialize in a particular disease. Their expertise in a particular condition is assumed to confer expertise in the values and preferences of those with that disease, and that is often wrong.

One could just as easily argue that the ongoing relationship and more comprehensive knowledge of a specific patient place the family doctor in a better position to know the patient's values and context. Too often, when trying to balance the competing views of a granular approach to a disease or a comprehensive approach to a patient, the more atomistic view prevails. This is because the more narrow perspective more likely provides the illusion of achievable precision (eg, get the hemoglobin A1c below 7% for 80% of those with diabetes), when contrasted against the less numerical aims of holistic care (e.g., respect people's wishes to not have their lives revolve around a medical condition).

Additive versus substitutive or integrative

Once decisions are made as to what should be done, and who should do it, there remains the practical task of recommending how to best implement the decisions. Traditionally, such recommendations are additive rather than substitutive or integrative. In other words, when considering recommendations for best practices for those with both diabetes and depression, expert panels commonly add current recommendations for diabetes to those for depression. This often results in an impossibly long list of tasks to be accomplished in primary care that may not reflect patient values and may even conflict with one another (e.g., the treatment of diabetics with severe depression by using newer atypical anti-depressants, which may in turn worsen glucose control).

Conclusions

The most successful efforts to train family doctors in multiple morbidities will be mindful of several factors. What is acted on will inevitably be a reflection of professional biases and local circumstances. Science is often wanting when it comes to the care of an individual patient. Particular attention should be given to developing clinical recommendations that are integrative rather than additive.

Our planning group was able to arrive at a number of decisions. The first family doctor workshop will be in Ghent in October 2013. Its primary objective will be to improve the care and outcomes of those with multiple conditions, such as diabetes and depression. The workshop will promote a move from disease-oriented to goal-oriented care. Much of the workshop will consist of discussion among participants and invited patients, rather than lectures by narrowly focused experts. Small group sessions will train participants on how to empower patients to make better decisions and to develop skills at goal setting and shared decision making. Building on the

success of the initial workshop, the plan is to conduct a number of similar workshops around the world in 2014 and beyond.

I learned several important lessons at the planning session. I learned that we need a new paradigm when it comes to caring for those with multiple morbidities. We need to think more about goals and less about disease. We need to develop better skills in helping people identify and accomplish their goals. As our thinking changes, our language will change. We will move from the language of disease, such as the International Classification of Disease (ICD), to the language of goals and function, such as the International Classification of Function (ICF). I also re-learned an enduring truth: that the whole *is* greater than the sum of its parts.

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Professor Richard Roberts
President, World Organization of Family Doctors

Presidente de WONCA : El todo es más que la suma de sus partes

O > Σ [⌒ + ⌣] = Todo > Σ [Partes]

El todo es más que la suma de sus partes

El todo es más que la suma de sus partes. Algunas verdades es necesario repetirlas, a menudo usando un lenguaje diferente, hasta que las comprendemos mejor. En una reciente reunión para planificar un taller para médicos de familia en múltiples comorbilidades me acordé de ello. Convocada por el *Diálogo sobre la Diabetes y la Depresión* (DDD), el profesor Jan de Maeseneer fue el anfitrión de la reunión de planificación en la Universidad de Gante. El DDD es un trabajo multidisciplinar iniciado en 2007 para mejorar la atención y los resultados de los pacientes con diabetes y depresión. WONCA fue miembro fundador de la DDD. La DDD tiene previsto ofrecer una serie de talleres sobre la diabetes y la depresión para los especialistas en diabetes, médicos de familia y los trabajadores de atención primaria, enfermeras y trabajadores de salud mental en todo el mundo.

Nuestra tarea en la sesión de planificación era desarrollar el marco general y los objetivos de un taller para médicos de familia. Éramos una docena de expertos de 6 países. Representábamos a la salud mental, la diabetes, la medicina familiar, la medicina interna, la enfermería, la psiquiatría y la medicina psicosomática. Se revisó la experiencia de los primeros talleres sobre la diabetes y la depresión que DDD había realizado con enfermería en África durante el último año. Observamos que enfermería prefería pequeños grupos de discusión que se centraban en las cuestiones locales.

Animados por el éxito de los talleres de enfermería, nos entusiasmamos pensando en ser pioneros de un nuevo tipo de pensamiento. Queríamos resolver el problema de la atención fragmentada para quienes tuvieran morbilidades múltiples. Empezaríamos tejiendo una serie de condiciones en un único taller, que sería pertinente y centrado en los alumnos. Teníamos la visión de un futuro en el que múltiples disciplinas aportarían su experiencia colectiva en conjunto para abordar con mayor eficacia las necesidades integrales del paciente. Nos imaginamos que nuestros talleres estimularían conocimientos interdisciplinarios y la cooperación, para prestar un mejor servicio al paciente. Luego, la realidad se impuso.

Cuando entramos en los detalles de exactamente lo que el taller debería cumplir, se hizo evidente que estábamos hablando idiomas diferentes. Nuestros conflictos parecían centrarse en torno a dos preguntas clave: ¿Quién debe hacer qué en el cuidado de las personas con diabetes y la depresión u otras morbilidades múltiples? ¿Qué se debe hacer para proporcionar la mejor atención a

las personas con diabetes y la depresión u otras morbilidades múltiples?

Parecía irónico que estas preguntas básicas pudieran dar lugar a opiniones divergentes. ¿Cómo podía ocurrir tal desacuerdo fundamental entre profesionales brillantes, reflexivos y bien intencionados? Mi experiencia en más de 3 docenas de grupos de expertos internacionales y nacionales y comités de recomendaciones me ha enseñado que tales conflictos surgen con cada directriz. Mis 30 años de experiencia práctica han confirmado que tales desacuerdos ocurren todos los días en la práctica. Lo que sigue son mis reflexiones sobre la manera de resolver estas divergencias importantes.

¿Quién debe hacer ante lo que se debe hacer?

Cada uno de nosotros ve el mundo a través de su lente profesional. Pasamos muchos años absorbiendo el lenguaje y la cultura de nuestras respectivas disciplinas. Por tanto, es comprensible que los que venimos de una profesión determinada desarrollemos un sentido uniforme de lo que se supone que son nuestros papeles y de lo que deben ser en nuestros diferentes sistemas de prestación de salud. Así pues, con todas las recomendaciones que escribimos y con todos los cursos que enseñamos, intentamos reforzar la versión idealizada del papel que creemos que nuestra profesión debe desempeñar en el cuidado de la salud. Sin embargo, nuestros roles reales en el sistema de salud no fluyen directamente de nuestros propios puntos de vista y preferencias. Son el resultado de la combinación única de recursos, las necesidades de la población, de otras profesiones, de las políticas y de otras fuerzas que participan y dan forma a cada sistema de salud.

Un ejemplo es el papel decreciente de los cirujanos cardiotorácicos en el cuidado de la enfermedad arterial coronaria (CAD). En los primeros tiempos de las terapias intervencionistas para la CAD, cuando la cirugía de bypass de revascularización coronaria con injerto fue el tratamiento invasivo primario, los cirujanos dominaban los debates sobre la terapia CAD. La tecnología punta de la angioplastia y los stents cambiaron esto, y los cardiólogos se convirtieron en la fuerza dominante en el tratamiento de la CAD. La influencia cada vez menor de los cirujanos en el manejo de la CAD provocó reducciones en el número y el potencial económico de las personas que elegían la cirugía cardiotorácica como profesión. Sin embargo, ese no es el final de la historia, ya que los cirujanos respondieron al paisaje cambiante y competitivo con sus propias innovaciones, como la cirugía mínimamente invasiva.[1]

Encontramos propuestas para limitar o modificar nuestros roles como amenaza a nuestra identidad profesional y nuestro sustento. Una parte sustancial del tiempo de reunión para grupos multidisciplinares consiste en enseñar el uno al otro lo que su grupo en realidad hace, podría hacer, y debería hacer en la prestación de servicios de salud. Por lo tanto, debemos esperar que los diversos grupos de profesionales le dediquen gran parte de su tiempo a escribir recomendaciones y a desarrollar cursos en una lucha de poder por la primacía.

Si volvemos a la ciencia como árbitro imparcial para resolver estas disputas profesionales, nos encontraremos muy decepcionados. La ciencia sobre lo que debe hacerse para cada paciente individual es muy escasa, casi escandalosamente insuficiente. La ciencia sobre "quién debe hacer qué" es prácticamente inexistente. Desde el punto de vista del paciente o del observador objetivo, estas luchas de poder profesionales parecen científicamente injustificadas y profesionalmente egoístas. Al final, las necesidades del paciente y de la población se cubren mejor al llegar a un acuerdo sobre lo que debe hacerse. Después de llegar a un acuerdo sobre lo que debe hacerse, "quién debe hacerlo", se decide a menudo con menos polémica.

¿Qué se debe hacer, y quién decide?

Decidir lo que se debe hacer puede ser muy difícil. A nivel poblacional, nuestros estudios más influyentes producen resultados que son precisos y duraderos en menos de la mitad del tiempo[2]. A nivel de cada paciente, es aún peor. A menos que el paciente esté inscrito actualmente en un estudio, nunca podremos estar seguros de que la demografía poblacional del estudio, el escenario y los hallazgos sean relevantes para ese paciente en particular.

Aún más inquietante es el reto de llegar a un acuerdo sobre los resultados que se ven por el paciente como lo más importante. Por ejemplo, mientras que la muerte se supone que es un resultado no deseado, es preferido por muchos como resultado, al de un accidente cerebral vascular gravemente incapacitante[3]. Especialmente desconcertante es el hecho de que las decisiones sobre el valor de los distintos resultados son a menudo abandonados por los que se especializan en

una enfermedad particular. Su expertez en una condición particular se supone que confieren competencia en los valores y preferencias de las personas con esa enfermedad, y esto es a menudo erróneo.

Uno podría fácilmente argumentar que la relación permanente y la ampliación de sus conocimientos sobre un determinado paciente sitúan al médico de familia en una posición mejor para conocer los valores del paciente y su contexto. Con demasiada frecuencia, cuando se trata de equilibrar los puntos de vista contrapuestos de un enfoque segmentado de una enfermedad y un enfoque integral del paciente, la visión más atomizada prevalece. Esto se debe a que la perspectiva más estrecha, probablemente proporciona una mayor ilusión de precisión (por ejemplo, obtener la hemoglobina A1c por debajo del 7% para el 80% de las personas con diabetes), comparado con los objetivos menos numéricos de atención integral (por ejemplo, que los deseos de las personas se respeten para que sus vidas no tengan que girar en torno a una situación médica).

Sumativa contra sustitutiva o integradora

Una vez que se toman las decisiones en cuanto a lo que debe hacerse y quién debe hacerlo, queda la tarea práctica de recomendar cómo implementar mejor las decisiones. Tradicionalmente, estas recomendaciones son sumatorias y no sustitutivas o integradoras. En otras palabras, al considerar las recomendaciones sobre buenas prácticas para personas con diabetes y depresión, los comités de expertos, normalmente, añaden las recomendaciones actuales para la diabetes a las de la depresión. Esto a menudo da como resultado una lista increíblemente larga de tareas que cumplir en atención primaria, y que pueden no reflejar los valores del paciente e incluso, entrar en conflicto unos con otros (por ejemplo, el tratamiento de diabéticos con depresión severa utilizan los más novedosos antidepresivos atípicos, que pueden, a su vez, empeorar el control de la glucosa).

Conclusiones

Los esfuerzos más exitosos para capacitar a los médicos de familia en múltiples comorbilidades deberán tener en cuenta varios factores. Sobre lo que se actúa, inevitablemente será un reflejo de los sesgos profesionales y circunstancias locales. La ciencia a menudo tiene carencias cuando se trata de la atención a un paciente individual. Se debe prestar especial atención al desarrollo de las recomendaciones clínicas que son integradoras y no sumatorias.

Nuestro grupo de planificación fue capaz de llegar a una serie de decisiones. El taller de médicos de familia se celebrará en Gante, en octubre de 2013. Su objetivo principal será mejorar la atención y los resultados de los pacientes con varias condiciones, como la diabetes y la depresión. El taller promoverá un paso desde la orientación a la enfermedad hacia la orientación a la atención. Gran parte del taller consistirá en la discusión entre los participantes y los pacientes invitados, en lugar de conferencias a cargo de expertos con estrechez de miras. Las sesiones de grupos pequeños capacitarán a los participantes sobre cómo empoderar a los pacientes para tomar mejores decisiones y desarrollar habilidades en el establecimiento de objetivos y la toma de decisiones compartida. Basándose en el éxito del taller inicial, el plan es llevar a cabo una serie de talleres similares en todo el mundo durante 2014 y posteriormente.

He aprendido varias lecciones importantes durante la sesión de planificación. Aprendí que necesitamos un nuevo paradigma en lo que respecta al cuidado de las personas con comorbilidades múltiples. Tenemos que pensar más acerca de las metas y menos acerca de la enfermedad. Necesitamos desarrollar mejores habilidades para ayudar a las personas a identificar y lograr sus objetivos. A medida que nuestros pensamientos cambien, nuestro lenguaje cambiará. Vamos a pasar del lenguaje de la enfermedad, tales como la Clasificación Internacional de Enfermedades (CIE), al lenguaje de los objetivos y funciones, como la Clasificación Internacional de Función (ICF). También he vuelto a aprender una verdad perdurable: que el todo es mayor que la suma de sus partes.

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

Traducción: Eva Tudela, Spanish Society of Family and Community Medicine (semFYC) Director

From the CEO – Coming soon Family Doctor Day and WONCA Prague

Charles Bridge, the River Vltava flowing underneath, Prague Castle sitting on the hill, some of the most beautiful architecture in the world – and a biting cold wind and frost and snow on the ground. All of this was Prague in the 3rd week of March when Dr Dan Ostergaard and I spent a couple of days with Drs Bohumil Seifert and Vaclav Benes and the Prague conference organising company, to review plans for the 20th World Conference.

The response so far has been fantastic, with nearly 1,800 abstracts received for consideration. Inevitably many have had to be declined, as there simply isn't enough time and space during the conference – even though the number of parallel sessions has been increased from 15 to 17 – but the abstracts that have been selected will ensure an exciting and stimulating and hopefully thought-provoking programme for everyone to enjoy. The conference venue is excellent, the keynote speakers are of the highest quality, the scientific programme is stimulating and Prague is just a wonderful place to visit, especially in June, so we anticipate possibly the best WONCA World conference ever. Spain is currently leading the field with the greatest number of conference registrations, but we hope that there will be over 4,000 delegates at the event. Register here

Of course, Prague will also be the venue for the World Council meeting, which is scheduled for Saturday 22 to Monday 24 June. The call for agenda items has gone out to all our Member Organisations and we have had a number of responses so far. Meetings of the Regional Councils are scheduled for Friday 21 June, with most Working Parties and Special Interest Groups meeting on the afternoon of Monday 24 or some time on Tuesday 25 June, just prior to the conference itself. It will be a busy time for the new Secretariat staff, but Nongluck and her team of Malee and Arisa have been working hard to ensure a successful event. For details of all WONCA meetings as they come to hand please check regularly on the WONCA website.

A plug now for two particular pre-conference events:
Firstly the Cancer and Palliative Care Special Interest Group is holding a half day preconference workshop from 1.30pm on Tuesday 25th June. Anyone with a particular interest in this topic is welcome to attend. More details, including how to register, can be found on the WONCA website.

Secondly a pre-conference meeting for all young family doctors will be held on June 24th and 25th, prior to the WONCA World Conference. This is being 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. It is open to trainees and junior General Practitioners / Family Physicians (GPs/FPs), up to five years after their qualification. Further details can be found on the WONCA website – www.globalfamilydoctor.com

Family Doctor Day - May 19

Finally can I once again remind everyone about World Family Doctor Day on May 19? If you or your organisation have any plans for the day then do please let Karen Flegg (WONCA Editor) know on editor@wonca.net - so that we can publicise the events in advance and for you to report on them afterwards.

Until next month.

Garth Manning

CEO

Email activities to editor@wonca.net

FEATURE STORIES

WONCA Special Interest Group on Cancer & Palliative Care

This group will hold a preconference at WONCA Prague from 1.30 to 4.30 on Tuesday 25 June 2013 before the official opening ceremony.

REGISTRATION FORM

This will be a great opportunity to network with GPs interested in cancer and palliative care from throughout the world and to learn of the key challenges and opportunities in clinical practice, teaching and research in these areas. Members of the international primary palliative care network www.uq.edu.au/primarypallcare/ will also update members about their progress over the last year

Promoting palliative care in primary care: producing a guideline to improve and develop palliative care in the community in different countries.

The SIG meeting will include a workshop to consider how the practice of palliative care may be improved in primary care, so that all people in need of end-of-life care internationally may have access to a general practitioner or nurse who can provide quality palliative care.

To this aim, over 20 countries throughout Europe have already been surveyed and many barriers and facilitating factors have been identified to improved palliative care in the community. Participants will be invited to give perspectives from their own countries from other continents, and mention any examples of successful innovations to make palliative care work well in primary care. These may include national strategies, educational initiatives for GPs and community nurses, integrated care frameworks, and making opioid prescribing more available.

Our output will be a guideline document that can be used by palliative care champions worldwide to advocate for, and guide the development of and training in palliative care in economically developed and resource poor nations. This will be distributed through WONCA and the International Hospice and Palliative Care Association so that national primary care and palliative care organizations can together improve end-of-life care in the community.

Scott A Murray & David Weller (convenor)

UK Doctors in the fast lane on social media guidance

The first-ever practical guide to help UK doctors navigate their way around the ethical and confidentiality dilemmas of social media is published today by the Royal College of General Practitioners (RCGP) in collaboration with Doctors.net.uk and LimeGreen Media.

The Social Media Highway Code is a collation of practical and supportive advice based around a 10-point plan. The advice was provided by a range of people with an interest in social media, including doctors, nurses, journalists, lawyers, students and patients.

It is intended to help and encourage healthcare professionals to communicate effectively using various social media channels, whilst adhering to the conventions that their patients, their colleagues and the public might reasonably expect.

The points in the Code include:

• Recognise that the personal and professional can't always be separated

• Engage with the public but be cautious of giving personal advice

• Respect the privacy of all patients, especially the vulnerable

• Show your human side, but maintain professional boundaries

A first draft of the guide was launched at the RCGP annual conference last October and prompted an exciting online debate joined by doctors across the UK, Europe and Australia, which trended No.1 in the UK on Twitter.

Since then, healthcare professionals from all over the world have been providing feedback on the Code through Twitter, Facebook and the online forums on Doctors.net.uk. The feedback has now been reviewed and the themes incorporated into the Code, which was given an official stamp of approval by RCGP Council in February.

Changes added include more information for GPs working in the Armed Forces and in controlled environments, more on the extra responsibilities that doctors can hold as 'data controllers', and more tips and advice on communicating with the public and with colleagues.

Whilst primarily aimed at healthcare professionals, the comprehensive and common-sense Code is transferable to other professional spheres. There has been interest in adapting the content for education professionals, with the potential to extend this to legal and political spheres and other professions where ethics and client safety are paramount.

The co-authors of the Code – enthusiastic Twitter users Dr Ben Riley [@drbenriley] and Dr Clare Gerada [@clarercgp] – will be participating in a lunchtime Twitter debate on Friday 22nd March. The discussion will cover how social media effects healthcare professionals and patients, and how the benefits could be rolled out to wider society. They invite anyone with an interest in social media and healthcare to take part using the Twitter hashtag #RCGPSoMe.

Dr Riley, lead-author of the Code and Curriculum Director for the RCGP said: "The interest and feedback we have received from healthcare professionals across the globe has been fantastic. There are many opportunities for GPs and other healthcare professionals to take the lead in developing how social media can be used to improve healthcare. At the same time healthcare professionals need to protect their patients and support each other with using these new ways of communicating. The Code has a practical focus and addresses a number of the challenging areas that GPs and other healthcare professionals have been asking about for some time."

Dr Gerada, Chair of the RCGP said: "I am proud to lead a College that consistently puts patient care at the heart of what we do. We were the first Medical Royal College to have an active patient group, the first to trend in the UK on Twitter, and now we are the first to produce positive, practical guidance on Social Media usage in order to protect the interests of both patients and healthcare professionals."

Harvey Ward, Chair of the RCGP Patient Partnership Group said: "The 1931 Highway Code was created to 'educate all road users about their duties and obligations to each other and the whole community' and similarly the College's 2013 Social Media Highway Code can be described as 'a code of good manners to be observed by all courteous and considerate persons'.

"Using the Code's advice, social media offers great potential benefits to all patients and hard to reach groups by, for example, improving access to information about healthcare services. Additionally, the Code is a wonderful step in the right direction for heightening patient safety online, where some patients can be vulnerable."

Dr James Quekett from Doctors.net.uk said: "The Code is about helping individuals navigate social media and attempts to highlight where doctors need to exercise caution based on past experience. It is not about imposing rules on their online behaviour."

further information: The RCGP Social Media Highway Code can be found here- www.rcgp.org.uk/social-media

RCGP Press office- press@rcgp.org.uk

News from Bangladesh

View the March 2013 newsletter of the Bangladesh Academy of Family Physicians, including coverage of the 17th National Conference held on 1 & 2 February 2013.

http://www.globalfamilydoctor.com/News/NewsfromBangladesh.aspx

Bangladesh Academy of Family Physicians meeting

FEATURED DOCTORS

PHAM Thị Ngọc Bích - Vietnam

Dr Bích Phạm, MD, MScFM is a Lecturer, in the Family Medicine Department of Hanoi Medical University, Vietnam

How did you become a family doctor?

Family Medicine is very new field in my university as well as in Vietnam with only 10 years since its development. At that time I had just obtained my medical doctor degree and worked in the department of family medicine of Hanoi Medical University. We very much liked family medicine as a new specialty in our country. It is very much an honour and a source of pride to me, that I became the first Master of Family Medicine, of Vietnam. I graduated. in 2008. at University of the Philippines Manila. After finishing the Masters degree, I worked as a lecturer, with the responsibility to teach students the principles of Family Medicine, both in theory and practice.

Nowadays, I am also a consultant in the Family Medicine Clinic of the Hospital of Hanoi Medical University. I have been lucky enough to have studied three months of Family Medicine in Australia and three weeks in the US.

What is the main part of your work?

I try to apply the knowledge that I learnt in the US, Australia and Philippines to teach students and to treat patients. With the responsibility of being in charge of post-graduate training in the department, I have taken part in the design of the curriculum of the Masters program of Family Medicine and other postgraduate training. All of my work is to promote the development of the Family Medicine department as well as Family Medicine clinic, in Hanoi Medical University Hospital.

I love to take care of and manage patients following family medicine principles: comprehensive care, continuity of care, coordination of care…

What other things have you done?

I have participated in much scientific research: evaluating the patient's level of satisfaction with family physicians; needs assessment, feasibility and necessary conditions for the implementation of family physician services in Vietnam; assess the status and health care needs in the household; to propose application the family medicine model in the care and management of patients at grassroots level especially at community health stations in Vietnam.

I currently participate as a member of the editorial board of the Vietnamese government schemes to develop an experimental model of family doctors' clinic in the community, to reduce the overload in central hospital.

I have been a member of the Vietnam Association of Family Physicians from 2005.

Can you tell me about your involvement in WONCA?

I became a member of the WONCA Working Party on Women in Family Medicine (WWPWFM), in 2008, so that I could have a lot of opportunities to learn and share about patient care and training experiences in family medicine with other women family physicians globally. The WWPWFM has become a common house where we are able to confide in our colleagues and express the advantages and disadvantages in life, especially keeping equality of gender in our workplaces and keeping the balance between family and work. I have two sons and I have to work in hospital from am to Pam. When my WWPWFM colleagues listened to me and I was able to share invaluable experiences in work, it made me more self-confident in the practice of family medicine in my work.

Dr Krishna Suvarnabhumi : Thailand

I was born in 1975 in a small town in Southern Thailand located on the border between Thailand and Malaysia. While growing up, I remember my relatives used to tell me that my head was bigger than that of other children. At that time, however, I was very glad about this because I believed bigger head meant I was going to be smarter when I grew up! After I graduated from high school, I went to medical school at Prince of Songkla University. I am very happy with the training I received there as I firmly believe our teachers trained us well not only to become good doctors, but also help people in need with compassion.

What work are you doing currently?

I am a family doctor and also a lecturer at the Faculty of Medicine, Prince of Songkla University; I teach both medical students and postgraduate trainees. At our faculty, we have set up 2 teaching clinics in the communities. From my 2011 research study, I found out that our medical students benefitted from these clinics as they were able to learn more about disease patterns, management of chronic-disease patients and the use of family folders. Moreover, common problems in communities are relevant to the national statistics.

Other interesting things you have done?

One of my areas of interest is medical education. I have pursued further studies in Academic Family Medicine at the University of Toronto, Canada (2006) and received a Master Degree in Medical Education from Cardiff University, United Kingdom (2012). I use the knowledge I gained from my studies and experiences in Western countries to improve medical teaching and learning in my own setting. I work with my colleagues to improve our family practice to make it be a fruitful learning environment for our medical students and trainees as well as being good role models to them. Moreover, we provide an elective programme in family practice for both Thai and international students; some of medical students apply for postgraduate training in Family Medicine after graduating from medical school.

As a medical educator, I also have a special interest in faculty development. To this end, I have sat up a Thai Medical Education Interest Group on Facebook; it is a social network among Thai medical educators. Moreover, for the past year, I have been cooperating with the Medical Education Unit of my medical school

to develop the “PSU Medical Education Resources” website. It is my intention and hope to help Thai medical educators improve their teaching skills.

Your interests in work and outside work?

Previously, I have worked with the Royal College of Family Physicians of Thailand on curriculum revision for the Diploma Thai Board of Family Medicine. The revision committee worked very hard to make our curriculum meet international standards; it was decided to use more valid and reliable assessment methods for the summative evaluation.

In my free time, I enjoy travelling. In the past 5 years, I have travelled to several countries including Malaysia, Singapore, Laos, Vietnam, Cambodia, Hong Kong, Japan, Canada, United States, United Kingdom, Italy, Switzerland, Sweden and France. My travel experiences have gave me an international perspective, not only regarding my profession, but also life in general. I have been exposed to a lot of new and interesting things and ideas that I can apply to my life and work in Thailand.

What it is like to be a family doctor in your country?

The status of the family doctors in Thailand is not well-established as compared to that of general practitioners in the United Kingdom or the family doctors in Canada. This may be because, in the Thai health care system, people register to primary care without identifying their family doctor. Moreover, the role and salary of family doctor in Thailand are not much different from those of newly graduated doctors from medical school. Nevertheless, this lack of recognition does not bother me. I enjoy my family practice and maintaining a long-term relationship with my patients. The improvement of my patients’ health and the appreciation of my instruction and/or mentoring by my medical students/trainees are sufficient rewards for me.

Resources added this month : PEARLS

PEARL 381: Oral treatments effective for tinea pedis

written by Brian R McAvoy.

Clinical question

How effective are oral treatments for tinea pedis?

Bottom line

Terbinafine and itraconazole were more effective than no treatment, and terbinafine appeared to give a significantly better cure rate than griseofulvin. In addition, terbinafine may require a shorter treatment period (2 weeks), which is preferable for maximising patient compliance. No significant difference was detected between terbinafine and itraconazole, fluconazole and itraconazole, fluconazole and ketoconazole, or between griseofulvin and ketoconazole, although the trials were generally small. All drugs reported adverse effects, with gastrointestinal effects being most commonly reported.

Caveat

Of the included trials, only 5 were published in recent years, with the other 10 trials having been published pre-1996. The quality of reporting of the trials was variable, and, in general, the method of generating the randomisation sequence and concealing allocation was not clearly reported, with the result that the trials were at unclear risk of bias for these domains. A similar omission was the lack of blinding of outcome assessors, especially with respect to the assessment of clinical signs and symptoms, as this outcome is, by its nature, subjective. Only 3 trials assessed the condition beyond 3 months.

Context

About 15% of the world's population suffers from tinea pedis. Oral therapy is usually used for chronic conditions or when topical treatment has failed.

Cochrane Systematic Review

Bell-Syer SEM et al. Oral treatments for fungal infections of the skin of the foot. Cochrane Reviews, 2012, Issue 10. Article No. CD003584.DOI: 10.1002/14651858.CD003584.pub2.

This review contains 15 studies involving 1438 participants.

PEARL 382: Limited evidence for benefit of amitriptyline for neuropathic pain and fibromyalgia in adults

written by Brian R McAvoy.

Clinical question

How effective is amitriptyline for neuropathic pain and fibromyalgia in adults?

Bottom line

Amitriptyline probably does not work in neuropathic pain associated with HIV or treatments for cancer. Amitriptyline probably does work in other types of neuropathic pain (painful diabetic neuropathy, post-herpetic neuralgia, and post-stroke pain, and in fibromyalgia), though we cannot be certain of this. A best estimate is that amitriptyline provides pain relief in about 1 in 4 (25%) more people than does placebo (NNT* = 4.6 [95% confidence interval 3.6-6.6]), and about 1 in 4 (25%) more people than placebo report having at least 1 adverse event, probably not serious but disconcerting.*NNT = number needed to treat to benefit 1 individual.

Caveat

There were no studies that could provide an answer that was trustworthy or reliable because most studies were relatively old, and used methods or reported results that we now recognise can make benefits seem better than they are.

Context

Amitriptyline is a tricyclic antidepressant that is widely used to treat chronic neuropathic pain and fibromyalgia, and is recommended in many guidelines. These types of pain can be treated with antidepressant drugs in doses below those at which the drugs act as antidepressants.

Cochrane Systematic Review

Moore RA et al. Amitriptyline for neuropathic pain and fibromyalgia in adults. Cochrane Reviews, 2012, Issue 12. Art. No.: CD008242.DOI: 10.1002/14651858. CD008242.pub2.

This review contains 21 studies involving 1437 participants.

PEARL 383: Psychological therapies effective for pathological and problem gambling

written by Brian R McAvoy

Clinical question

How effective are psychological therapies (cognitive behavioural therapy [CBT], motivational interviewing [MI], integrative therapies, and Twelve-step Facilitated Group Therapy) for pathological and problem gambling?

Bottom Line

Data from nine studies indicated benefits of CBT in the period immediately following treatment. However, there were few studies across longer periods of time (e.g. 12 months) after treatment, and little was known about whether effects of CBT were lasting. Data from three studies of MI therapy suggested some benefits in terms of reduced gambling behaviour, but not necessarily other symptoms of pathological and problem gambling. There were also few studies that provided evidence on integrative therapies (two studies) and other psychological therapies (one study), and there was insufficient data to evaluate the efficacy of these therapies.

Caveat

A substantial amount of the evidence came from studies that suffered from multiple limitations, and these may have led to overestimations of treatment efficacy. There was variability in the nature of the interventions classified as CBT, and the effects of individual and group CBT were also combined. The data on MI therapy came from few studies and conclusions require further research.

Context

The prevalence of pathological and problem gambling has been found to vary internationally, with studies suggesting anywhere between 0.2% (in Norway) and 5.3% (in Hong Kong) of individuals affected.1 The term 'pathological gambling' is derived from psychiatric diagnostic systems,

such as the Diagnostic and Statistical Manual of Mental Disorders. Problem gambling is also sometimes used to describe a subclinical level of the psychiatric disorder or alternatively, a broader category of severe gambling based on a continuum model of gambling-related harm.

Cochrane Systematic Review

Cowlishaw S et al. Psychological therapies for pathological and problem gambling. Cochrane Reviews, 2012, Issue 11. Art. No.: CD008937.DOI: 10.1002/14651858. CD008937.pub2. This review contains 14 studies involving 1,245 participants.

WONCA MEETINGS IN PRAGUE

Details are correct as at April 3, 2013. Please check the WONCA website regularly for updates and correction. http://www.globalfamilydoctor.com/News/OfficialWONCAmeetingscheduleinPrague.aspx

MEETINGS OF WONCA COUNCIL AND ITS COMMITTEES

WONCA council meeting is to be held at Corinthia Towers Hotel, Prague. Most World Council members will also be attending their regional council meetings which are listed separately (below)

Friday 21st June

WONCA Conference Planning Committee
13.00 - 17.00

WONCA Pre-Council briefing
17.30 – 18.30

WONCA Welcome reception for world Council members
19.00 - 21.00

Saturday 22nd June

WONCA WORLD COUNCIL MEETING
08.30 – 17.30

Sunday 23rd June

WONCA WORLD COUNCIL MEETING
08.30 – 17.30

Monday 24th June

WONCA WORLD COUNCIL MEETING
08.30 – 13.00

lunch for new WONCA Executive and Chairs of Working Parties
13.00 – 14.30

WONCA Organisational Equity Committee
14.00 – 15.30

Tuesday 25th June

Breakfast meeting - new WONCA Executive and chairs of working parties
07.30 – 09.00

Tuesday 25th June

WONCA Executive Meeting with ACG colleagues
09.00 – 10.00

REGISTER NOW

Wonca Prague Conference website

www.wonca2013.com

WONCA REGIONAL MEETINGS IN PRAGUE

All regional council meetings are to be held at the Corinthia Towers Hotel, Prague

Friday June 21

WONCA Africa Regional meeting

09.00-14.00

WONCA Asia Pacific Regional meeting

12.00 – 18.00

WONCA East Mediterranean Regional meeting

10.00-15.00

WONCA Iberoamericana-CIMF Regional meeting

08.30-17.30

WONCA Europe regional meetings

08.00 – 11.00 WONCA Europe Executive Board

11.00 – 13.00 WONCA Europe Council Meeting - Part 1

13.00 – 14.00 *Lunch*

14.00 – 17.15 WONCA Europe Council Meeting - Part 2 & 3

WONCA North America Regional meeting

09.00 – 12.00.

WONCA South Asia Regional meeting

14.00 – 18.00

PRAGUE SPECIAL AND SOCIAL EVENTS

Tuesday June 25

Opening ceremony and WHO Director–General Dr Margaret Chan.
1700 -1900
Venue – Prague Congress Centre (PCC)

Welcome cocktail party
1900 - 2100
Venue – Prague Congress Centre (PCC)

Thursday June 27

Run through generations
0700 -
Venue - Vyšehrad castle
Information - Unique run in the corners of historical centre of Vyšehrad castle (situated next to the conference venue).
Cost USD10 (proceeds donated to charity)

Thursday June 27

WONCA awards ceremony
0930 – 1000
Venue – Prague Congress Centre (PCC)

Czech evening
1930 - 2330
Venue- Žofín Palace

Saturday June 29

Closing ceremony
1215 -1245
Venue – Prague Congress Centre (PCC)

MEETINGS OF WONCA WORKING PARTIES & WONCA SPECIAL INTEREST GROUPS IN PRAGUE

These meetings are preceding WONCA Prague will be held at the Corinthia Towers Hotel, Prague. Most are open to interested colleagues. For further information contact the chairs of the committee by email

Sunday 23rd June

WONCA International Classification Committee (WICC) Workshop (2 days)
08.30 – 17.30
wicc@wonca.net

Monday 24th June

lunch for new WONCA Executive and Chairs of Working Parties 13.00 – 14.30

WONCA International Classification Committee (WICC) Workshop (2 days)
08.30 – 17.30
wicc@wonca.net

WONCA Organisational Equity Committee
14.00 – 15.30

WONCA Working Party on Women and Family Medicine
16.00 – 17.00
WPwomen@wonca.net

WONCA Working Party on Research
14.00 – 17.30
more information
WPresearch@wonca.net

WONCA Working Party on Quality in Family Medicine
1330 – 1630
WPqualitysafety@wonca.net

Tuesday 25th June

Breakfast meeting - new WONCA Executive and chairs of working parties
07.30 – 09.00

WONCA International Classification Committee (WICC)
0830 – 1630
wicc@wonca.net

WONCA Working Party on Education
09.00 – 16.30
more information
WPeducation@wonca.net

Tuesday 25th June (continued)

WONCA Working Party on Environment
1300 - 1630
more information
WPenvironment@wonca.net

WONCA Working Party on Ethics
1300 – 1600
WPethics@wonca.net

WONCA Working Party on Informatics
1330 – 1630 (to be confirmed)
WPinformatics@wonca.net

WONCA Working Party on Mental Health
1330 – 1630
WPmentalhealth@wonca.net

WONCA Working Party on Rural Practice
0830 – 1630
WPrural@wonca.net

WONCA Working Party on Women and Family Medicine
09.00 – 16.30
WPwomen@wonca.net

WONCA Special Interest Group on cancer and palliative care
1330 -1630
SIGcanpal@wonca.net

WONCA Special Interest Group on Complexities
1330 -1630
SIGcomplexities@wonca.net

WONCA Special Interest Group on Elderly Care
1330 – 1630
SIGelderly@wonca.net

WONCA Special Interest Group on Migrant Care and International Health
1330 - 1630
SIGmigrant@onca.net

WONCA CONFERENCES 2013-2014

2013 …. COMING SOON

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 MEETINGS

FMPC 2013 India
Date: April 20-21, 2013
Venue: New Delhi, India
Host; Academy of Family Physicians of India
Theme: Preparing multiskilled and competent primary care physicians
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
Theme: Tackling inequalities, preventing illness, improving health
Venue: Euston Square, London, UK
Web: www.cityhealthconferences.org.uk

EGPRN spring meeting
Host: European General Practice Research network (EGPRN)
Theme: Risky behaviours and health outcomes in primary care and general practice
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
Theme: Family Medicine and community : access to quality
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

21st Fiji College of General Practitioners conference
Host: Fiji College of General Practitioners
Theme: Holistic medicine
Date: June 22-23, 2013
Venue: Sigatoka, Fiji
Web: http://www.fijigp.org
Email: doctordevika18@yahoo.com

RNZCGP conference for general practice
Host: Royal New Zealand College of General Practitioners
Theme: to be advised
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
Theme: Promoting partnership with our patients - a challenge & a chance ..
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)
Theme: Balancing The Primary And Secondary Care Provision For More Integration and Better Health Outcomes
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.
Le Collège de médecins de famille du Canada
Date: November 7-9, 2012
Venue: Vancouver, Canada
Web: http://fmf.cfpc.ca

The Network: Towards Unity for Health annual conference
Host: TUFH
Theme: Rural and Community Based Health Care: opportunities and challenges for the 21st century
Date: November 16-20, 2013
Venue: Ayutthaya, Thailand
Web: http://www.the-networktufh.org/conferences/upcoming