

International Family Medicine Education

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Feature Editor

The goal of the International Family Medicine Education column is to bring our readers information about developments in family medicine education in countries outside the United States. We will abstract relevant literature from journals published throughout the world that address issues relevant to medical student education and graduate training in family and general practice. The issues may relate to changes in medical education or in medical care organization or delivery. Topics may also address health and illness issues relevant to family physicians throughout the world. To help abstract literature, I have asked a few "foreign correspondents" to identify relevant articles from the medical literature in their region. I hope this column will become an important resource for those interested in what's happening in family medicine education outside the United States. Contact me at 415-476-3409. E-mail: rodnick@itsa.ucsf.edu. University of California, San Francisco, Department of Family and Community Medicine, UCSF Box 0900, San Francisco, CA 94143-0900. Your comments regarding this column are welcome.

Greece

Community-oriented Primary Care in Crete

(Lionis C, Trell E. Health needs assessment in general practice: the Cretan approach. European Journal of General Practice 1999;5:75-7.)

A primary health care network in Crete has been established. One of their first tasks was to conduct a formal survey of medical problems of people living on the island. The network included the Department of Social Medicine at the University of Crete, a university hospital, and 10 rural health centers. The assessment of the population in the catchment areas of these health centers included collecting demographic, morbidity, and mortality data by a local health team. Two of the health centers have computerized medical records that provided encounter data.

The authors noted several findings, including: 1) Disease incidence/prevalence in rural Crete is similar to that in Western Europe. Hypertension and bronchitis/COPD are the most common diagnoses in men ages ≥ 65 . Hypertension and

diabetes are the most common diagnoses in women ages ≥ 65 , 2) A high prevalence of atrial fibrillation is present; however, most are not on appropriate treatment, 3) Morbidity from ischemic heart disease is lower than in the rest of Greece, which is lower than that in Western Europe, 4) Cardiovascular risk factors are common, especially smoking, hypertension, and high cholesterol, even in the areas with the lowest morbidity from coronary artery disease, 5) Hepatitis C is common and comprises a serious public health problem, 6) There is a low level of coverage of childhood vaccinations, including pertussis and MMR, 7) Childhood neurodegenerative metabolic diseases (especially organic acidurias) and urogenital development anomalies are not rare, and 8) Homebound elderly have a high prevalence of depression and dementia.

The authors conclude that with a commitment from both the university and rural practices, a community health needs assessment can be done, and this can lead to many community-oriented projects to improve health.

Ireland

The Feminization of General Practice

(Cassidy M. Women and general practice: are they compatible? Journal of the Irish College of General Practitioners 2000;17:12-6.)

In Ireland, more than half of all medical students, three out of four general practitioner (GP) trainees (residents), and 43.5% of GPs under the age of 40 are women. This feature story reviews the changes in attitudes and practice affecting general practice as more women enter the field.

A recent survey found that 60% of women GPs were in full-time partnerships (practice), compared with 89% of men. The desire to be with their families and do less out-of-hours call is the primary reason more women do locums or part-time practice. In Ireland, as in the United States, part-time positions often lack benefits, and one needs to be a partner in the practice and have a "list" of one's own patients to be granted such things as study leave (CME) or maternity leave.

A number of solutions are being implemented in Ireland to change how GPs work in their practices in response to the changing workforce. These solutions include job sharing, part-time partnerships, use of GP cooperatives or deputizing to cover after-hours call, and formal retraining courses for those who have been out of the workforce for some time.

United Kingdom

Do We Really Know What Patients Want?

(McKinley RK, Middleton JF. *What do patients want from doctors? Content analysis of written patient agendas for the consultation. Br J Gen Pract* 1999;49:796-800.)

Probably the most important task for the physician to do in an office visit is to discover why the patient came and what the patient wants. The authors had previously developed a patient agenda form to be completed by the patient before being seen by the doctor. The form asks four questions: 1) Please make a list of the points you wish to make. 2) Do you have any thoughts about these points? (for example, the cause of your problem), 3) Do you have any questions? 4) What would you like the doctor to do? (prescribe, explain, investigate, write a note, or other).

Forty-six randomly selected general practitioners (GPs) in the United Kingdom agreed to participate in this trial. Two or three half-day office sessions of each GP were randomly allocated to asking the patient to complete the agenda form and hand it to the doctor on entering the consultation room. Completed forms were handed in by 756 patients (92% of those given the forms).

Ninety-six percent of the respondents had one or more points they wanted to raise to the doctor during the visit (question #1). There

was an average of 1.6 problems (points) on each agenda form. These were analyzed by content analysis with good intra-rater reliability.

Forty-two percent of patients consulted their GP because they were at their limit of anxiety about their symptoms, and 60% had ideas about why they developed their problems. Forty-nine percent had questions they would like answered by the physician.

Ninety-seven percent wanted the doctor to do something (question #4). Seventy percent of these wanted an explanation, 55% a prescription, and 44% wanted investigation of their symptoms. Thirteen percent had negative comments they wanted to make, usually about previous management, communication with doctors, or time spent with the doctor.

This study shows that most patients in the United Kingdom, as in the United States, have clear ideas about what is wrong and what they want from their doctor. The authors conclude that failure to elicit a patient's agenda is likely to adversely affect the outcome of many office visits.

Research in Our Offices: Pointers and Pitfalls

(Ward E, King M, Lloyd M, Bower P, Friedli K. *Conducting randomized trials in general practice: methodological and practical issues. Br J Gen Pract* 1999;49:919-22.)

Randomized trials in general practice are increasingly used to evaluate a wide range of treatments, including drug trials and psychotherapy interventions. This article reviews several issues of importance to the patient, the physician, the practice, and the researcher. In part, the authors discuss:

1) Randomization versus patient choice. Patients may not accept randomization when considerable

differences exist between the arms of the trial. Patients may prefer one treatment arm and may drop out of the trial or become less compliant if they do not receive their preferred choice.

2) Recruitment of patients. Physicians may lack the time needed to explain the treatment in detail. If the physician lacks confidence in one or more treatments, they may not approach eligible patients. A further issue is that patients may hesitate to refuse their doctor's request. Sometimes, researchers, working with the practice, may be more appropriate to carry out patient recruitment.

3) Cluster randomization. It may be easier to randomize practices, so that all patients in one practice receive one treatment. However, this creates difficulties in that the unit of analysis becomes the practice rather than the patient. This has important effects in the sample size required to show efficacy for the treatment.

4) Recruiting practices. Practices or physicians may not wish to participate because of lack of time or space, perceived interruption of patient care, because they are undergoing structural or personnel change, or because of increased costs. Payments for practice staff time or research infrastructure are often appropriate. The benefits of participation, such as access to a new treatment or service, may offset the costs of participation.

5) Keeping in touch. There should be one person in each practice who coordinates the trial. Maintaining good communication between the research group and the practice coordinator is of utmost importance. Regular phone calls or short visits from the researcher or one-page research updates are valuable.

6) Maintaining momentum. Even enthusiastic physicians and staff become fatigued. The authors find it helpful for practices to recruit patients for only 1 month at a time.

Recruitment early in the trial predicts overall patterns. Persistently low recruiting practices may need to leave the study so that the cost effectiveness of the trial is maintained.

The authors conclude that running a successful randomized trial in general/family practice depends on cooperation between physicians and researchers and addressing the above factors that are likely to affect practice and patient recruitment.

A Formula to Estimate Costs of Drugs Prescribed by GPs

(Rice N, Dixon P, Lloyd DC, Roberts D. Derivation of a needs-based capitation formula for allocating prescribing budgets to health authorities and primary care groups in England: regression analysis. BMJ 2000;320:284-8.)

In the United Kingdom, capitation-like payments to general practitioners (GPs) have been used for years.

With the advent of “fund holding” in the early 1990s, these payments were expanded for many practices to include the costs of most outpatient-prescribed drugs, many specialty consultations, and some nonemergency hospitalizations. (In the United States, these payments might be considered halfway between professional and global capitation.)

The previous formulas to calculate budget payments for office-prescribed drugs accounted for only 25%–40% of the variance between different GPs. To develop a more accurate prediction, the authors examined the correlation between prescribing costs and almost every available statistic and database reflecting the demand (patient characteristics) and the supply (physician and practice characteristics). A wide variety of models were considered.

The model finally adopted used only four variables plus an age and gender weighting. The variables

were all based on patient characteristics, and the model was capable of explaining 62% of the variation in prescribing expenditure at the practice level.

The four variables included the percentage of the adult population in the area who were on disability and unable to work, the percentage of households in the area with unrelated dependents, the percentage of the practice who were newborns, and the percentage of the working-age population in the area who were students. (The last had a negative correlation.) These variables intuitively reflect high users of medical services, except for students, who tend to be low users.

The formula has now been implemented by the National Health Service to set target allocations to primary care groups (groupings of 50 to 100 GPs who have a unified budget) for 1999–2000. One wonders if a similar formula would work with managed care patients in the United States.