WONCA News

An International Forum for Family Doctors

Wonca
World family doctors. Caring for people.

Contents

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From the President: What happens next? The role of family doctors in supporting their communities following a disaster

Young family doctor, Dr Hiroshi Takayanagi, at the Kitakata Centre for Family Medicine in Fukushima Prefecture in Japan

We all remember the tragedy of the March 2011 tsunami that hit the Pacific coastline of Japan following an earthquake, killing thousands of people and destroying coastal towns and villages. And the global fears that followed when the damaged Fukushima nuclear power plant exploded releasing radiation into the atmosphere. The radioactive contamination resulted in over 100,000 people being evacuated from their homes and a 50 kilometre exclusion zone was established around the damaged nuclear plant and the path of the radiation fallout.

Last month I was invited to visit communities in the Fukushima region of Japan affected by the tsunami and the nuclear reactor disaster. I was keen to learn about the role local family doctors and their teams are continuing to play in assisting in the recovery of the surviving members of the devastated communities. It was a sobering week.

Three years later, the evidence of the damage caused on that terrible day remains. Many people still live in temporary housing and are prohibited from returning to their abandoned homes. Many people, especially young families, have moved away to other parts of Japan. Many elderly people left behind grieve for their missing families, their lost homes and their lost way of life. 200,000 affected people are being followed up regularly in special clinics set up to screen for problems related to radiation exposure.

Photo: Empty coastline with a reconstructed graveyard as the sole reminder that a village community once thrived in this location before the 2011 tsunami

The coastline is stark, having been cleared of the ruins and debris that was all that remained of coastal cities and rural communities and the surrounding forests destroyed by the tsunami. The villages have gone, the farms have gone, the forests have gone. It is like there has never been anything there. The exception is the exclusion zone around the nuclear reactor where the damage from the tsunami is still visible with damaged buildings, upturned cars and fallen trees. Whole villages that survived the tsunami but were subjected to radioactive fall out are now ghost towns with deserted homes and shops with empty windows and no sign of life. Parts of the exclusion zone are being deemed less dangerous now and have been opened for people to visit during the day but not return to live.

Photo: Makeshift memorials to loved ones lost during the 2011 tsunami, on the Pacific Coast at Minami-soma in Japan

While in Fukushima Prefecture I visited the damaged towns of Soma and Minami-soma, a number of family medicine community clinics and a community support centre for residents in temporary accommodation.

This visit was a stark reminder of the challenges people face in rebuilding their lives

and their communities following catastrophic events. And the huge impact such events have on the physical and mental health of each affected person.

The people of these communities have been supporting each other as they come to terms with the dramatic changes in their lives. Community health programs are assisting people still living in temporary shelter accommodation. Activity programs bring people together and foster a continuing sense of community. The family doctors of this region have been a core part of this work.

Photo: WONCA president with Professor Ryuki Kassai and young family doctors attending the Winter Education Seminar of the Japan Primary Care Association, February 2014

I was in Japan as the guest of the Government of the Fukushima Prefecture. My visit was organized by Professor Ryuki Kassai, Professor of Family Medicine at the Fukushima Medical University.

Ryuki is a well-known and respected member of WONCA. His series of reports for the British Medical Journal in the aftermath of the disasters provided an extraordinary insight into the impact on individuals, families and communities, and the roles that family doctors and the members of our teams can play in supporting our communities during and after such devastating events.

Ryuki and I also discussed the wider challenges of provision of support for the very old in Japanese society. Japan, like many nations, is examining how to best care for the increasing number of elderly people in their community, realising that continuing to place very large numbers of people in nursing homes or hospitals is not a feasible option, and looking at the increased role primary care services can play in supporting keeping people in their own homes or living with family members. There is also awareness that, while many people in Japan may be living to a great age, for many the quality of life in their last years, sometime decades, is not good due to problems related to the impact of co-morbid chronic disease, infirmity, sensory loss and dementia. And there are concerns about inappropriate investigations and procedures being carried out by doctors on very old people at the end of their lives. There is also the challenge of providing care to people at the end of their lives, and especially home-based palliative care, something that is a core part of our work as family doctors in many countries. Just as we specialise in the provision of ”first contact care”, family doctors also specialise in the provision of “last contact care” for many of our patients.

In Japan I learned that many very old people, even those with advanced dementia, can still have a sense of purpose as valued members of the community. They may be responsible for keeping part of the street outside their home swept or clear of debris. Or being part of after school programs caring for children. Or caring for small garden plots which enhance the beauty of their local area. For many of the elderly survivors of the tsunami and those relocated from villages affected by the radiation fallout and now living in temporary accommodation, this sense of purpose has been lost and many people are depressed and withdrawn and have become housebound. This is compounded because many of the young families with children in the radiation affected areas have left and do not return to visit their aged parents and grandparents because of fear of exposing the children to radiation. The local family doctors tell me that, for many elderly survivors, the impact of lifestyle risks may be worse than the radiation risks, due to increased alcohol use, poor diet and obesity, and related mental health problems and risk of self-harm and suicide.

I was privileged to meet with many young family doctors working across the Fukushima Prefecture with Ryuki. I also had the opportunity to meet with a large number of young family doctors taking part in the Winter Education Seminar in Tokyo of the Japan Primary Care Association, the WONCA member organization in Japan. I was inspired by the enthusiasm of the young family doctors of Japan who are working together to tackle the many health care issues facing their local communities and their nation.

Michael Kidd
WONCA President

Del Presidente : ¿Qué pasa después? El papel de los médicos de familia en el apoyo a sus comunidades después de un desastre

El médico de familia joven, Dr. Hiroshi Takayanagi, en el Centro de Kitakata de medicina familiar, en la prefectura de Fukushima, Japón

Todos recordamos la tragedia del tsunami de marzo 2011 que afectó a la costa del Pacífico de Japón tras un terremoto, y que mató a miles de personas y destruyó ciudades y pueblos de la costa. Y los temores globales que siguieron, cuando la central nuclear de Fukushima dañada, explotó liberando radiación a la atmósfera. La contaminación radiactiva se tradujo en más de 100.000 personas evacuadas de sus hogares, una zona de exclusión de 50 kilómetros que se estableció alrededor de la planta nuclear dañada y la trayectoria de lluvia radioactiva. El mes pasado me invitaron a visitar las comunidades de la región de Fukushima, en Japón, afectada por el tsunami y el desastre del reactor nuclear. Yo tenía muchas ganas de aprender sobre el papel que los médicos de familia locales y sus equipos siguen desempeñando para ayudar en la recuperación de los supervivientes de las comunidades devastadas. Fue una semana aleccionadora.

Tres años más tarde, la evidencia del daño causado en ese día terrible permanece. Muchas personas aún viven en viviendas temporales y se les prohíbe volver a sus casas abandonadas. Muchas personas, especialmente familias jóvenes, se han alejado hacia otras partes de Japón. Muchas personas mayores dejaron de llorar a sus familiares desaparecidos, sus hogares perdidos y su modo de vida destruido. 200.000 personas afectadas son objeto de seguimiento regular en clínicas especiales establecidas para la detección de problemas relacionados con la exposición a la radiación.

Foto: Costa vacía con un cementerio reconstruido como único recordatorio de que la comunidad de la aldea prosperó una vez en este lugar antes del tsunami de 2011.

La costa es agreste, tras haber sido limpiada de las ruinas y los escombros, que era todo lo que quedaba de las ciudades costeras y las comunidades rurales y de los bosques de los alrededores destruidos por el tsunami. Los pueblos ya no existen, las granjas se han esfumado, los bosques han desaparecido. Es como si nunca hubiera habido nada allí. La excepción es la zona de exclusión alrededor del reactor nuclear en el que el daño causado por el tsunami sigue siendo visible en los edificios dañados, los coches doblados hacia arriba y los árboles caídos. Pueblos enteros que sobrevivieron al tsunami, pero fueron sometidos a lluvia ácida, son ahora ciudades fantasma con casas desiertas y tiendas con aparadores vacíos y sin señales de vida. Partes de la zona de exclusión se consideran menos peligrosas ahora y se han abierto a la gente para que sean visitadas durante el día, pero no se vuelve a vivir allí.

Mientras, en la prefectura de Fukushima visité las ciudades dañadas de Soma y Minami-soma, una serie de clínicas de medicina familiar de la comunidad y un centro de apoyo a la comunidad para los residentes en alojamientos temporales.

Esta visita fue un crudo recordatorio de los retos que enfrentan las personas en la reconstrucción de sus vidas y sus

comunidades después de eventos catastróficos. Y los impactos enormes que tales eventos tienen en la salud física y mental de cada persona afectada.

Foto: Memoriales improvisados a los seres queridos perdidos durante el tsunami de 2011, en la costa del Pacífico en Minami-soma, Japón.

Los habitantes de estas comunidades se han apoyado los unos en los otros, ya que han llegado a asumir los cambios dramáticos en sus vidas. En los programas de salud de la comunidad colaboran personas que siguen viviendo en alojamientos refugio temporales. Los programas de actividades unen a la gente y fomentan un sentido continuo de la comunidad. Los médicos de familia de esta región han sido una parte fundamental de este trabajo.

Estuve en Japón como invitado del Gobierno de la Prefectura de Fukushima. Mi visita fue organizada por el profesor Ryuki Kassai, Profesor de Medicina Familiar de la Universidad Médica de Fukushima.

Foto: El Presidente de WONCA con el profesor Ryuki Kassai y médicos de familia jóvenes, que asistieron al Seminario de Educación de invierno de la Asociación de Atención Primaria de Japón, febrero de 2014.

Ryuki es un miembro muy conocido y respetado de WONCA. Su serie de informes para el British Medical Journal con las consecuencias de los desastres proporcionó una visión extraordinaria sobre el impacto en las personas, familias y comunidades, y los roles que los médicos de familia y los miembros de nuestros equipos pueden desempeñar en el apoyo a nuestras comunidades durante y después de este tipo de eventos devastadores.
http://blogs.bmj.com/bmj/2011/03/21/ryuki-kassai-from-fukushima-the-first-seven-days-of-the-disaster/

Ryuki y yo también debatimos sobre los desafíos más amplios de la prestación de apoyo a los ancianos en la sociedad japonesa. Japón, al igual que muchas naciones, está examinando cómo cuidar mejor del creciente número de personas mayores de su comunidad, al darse cuenta de que seguir colocando un gran número de personas en hogares de ancianos u hospitales no es una opción factible, y mirando el papel cada vez mayor que los servicios de atención primaria pueden desempeñar en el apoyo al mantenimiento de las personas en sus propias casas o viviendo con familiares. También existe la conciencia de que, si bien muchas personas en Japón pueden vivir hasta una edad avanzada, para muchos, la calidad de vida en sus últimos años -décadas a veces-, no es buena, debido a los problemas relacionados con el impacto de la enfermedad crónica concomitante, la debilidad, la pérdida sensorial y la demencia. Y existen dudas acerca de las investigaciones y los procedimientos inadecuados que llevados a cabo por médicos en las personas de edad muy avanzada al final de su vida. También está el reto de proporcionar atención a las personas al final de su vida, y sobre todo, cuidados paliativos a domicilio, algo que es una parte fundamental de nuestro trabajo como médicos de familia en muchos países. Igual que nos especializamos en la prestación del "primer contacto", los médicos de familia también nos especializamos en la prestación del "último contacto de atención" para muchos de nuestros pacientes.

En Japón me enteré de que muchas personas de edad muy avanzada, incluso aquellos con demencia avanzada, todavía pueden tener un

sentido de propósito, como miembros valiosos de la comunidad. Pueden ser responsables de mantener parte de la calle frente a su casa barrida y libre de escombros. O formar parte de los programas de cuidado de los niños después del colegio. O cuidar de pequeños huertos que realzan la belleza de su área local. Para muchos de los ancianos supervivientes del tsunami y de los que se trasladaron desde aldeas afectadas por la lluvia radioactiva y que ahora vive en un alojamiento temporal, este sentido de propósito se ha perdido y muchas personas están deprimidas y retraídas y se han convertido en confinados en el hogar. Esto se agrava porque muchas de las pequeñas familias con niños en las zonas afectadas por la radiación se han ido y no volverán a visitar a sus padres y abuelos mayores, debido al temor de exponer a los niños a la radiación.

Los médicos de familia locales me dicen que para muchos supervivientes de edad avanzada, el impacto de los riesgos del estilo de vida puede ser peor que los riesgos de la radiación, debido al aumento de consumo de alcohol, la mala alimentación y la obesidad y los problemas de salud mental relacionados, así como los riesgos de autolesiones y suicidio.

Tuve el privilegio de reunirme con muchos médicos de familia jóvenes que trabajan a través de la Prefectura de Fukushima con Ryuki. También tuve la oportunidad de conocer a un gran número de médicos de familia jóvenes que participan en el Seminario de Educación de invierno en Tokio, de la Asociación de Atención Primaria de Japón, la organización miembro de WONCA en Japón. Me inspiré en el entusiasmo de los jóvenes médicos de familia de Japón, que están trabajando juntos para hacer frente a los muchos problemas de salud que afectan a sus comunidades locales y su país.

Michael Kidd
Presidente

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

From the CEO's Desk: March 2014

Greetings again from Bangkok. Yet another month flies by – where does the time go? This month I want particularly to focus on my recent meetings with Member Organizations, the WHO Executive Board meeting, a significant health policy conference in Thailand and our continuing promotion of WONCA Direct Membership.

Meetings with Member Organizations

In early February I was in Dhaka, Bangladesh, to attend the annual conference of the Bangladesh Academy of Family Physicians (BAFP) and to deliver the inaugural Professor Nural Islam Memorial Lecture. Professor Islam was National Professor and a giant of Bangladeshi medicine. He had received many national and international honours, many related to his stance against tobacco, and he was a strong proponent of family medicine. BAFP, together with the Bangladesh College of GPs (BCGP) will be hosting the 2015 South Asia Region conference, and I also had a chance to sit with both groups to discuss their plans.

From Bangladesh I then travelled to Myanmar, to take part in a seminar and workshop organized by the Society of GPs of the Myanmar Medical Association. The Society are working to improve the training and standards of family medicine, with the aim of establishing a College of Family Medicine in Myanmar. Amanda Howe, Dada Leopando and Daniel Thuraiappah were also there, along with colleagues from RCGP and from several USA institutions. Congratulations to Drs Tin Aye and Myint Oo for the excellent

work they have accomplished so far, and we will do what we can to continue to support their endeavours.

WHO Executive Board

WONCA's WHO Liaison, Dr Luisa Pettigrew, has written elsewhere in this issue about the WHO EB meeting, to provide information and feedback to all our members on the valuable collaborations we have with WHO, and I highly recommend her report to you. The links with WHO are extremely highly valued by our members, and we are collaborating more and more with WHO, especially through various Working Parties, and it's good to hear more about some of the great work that is going on.

Prince Mahidol Award Conference

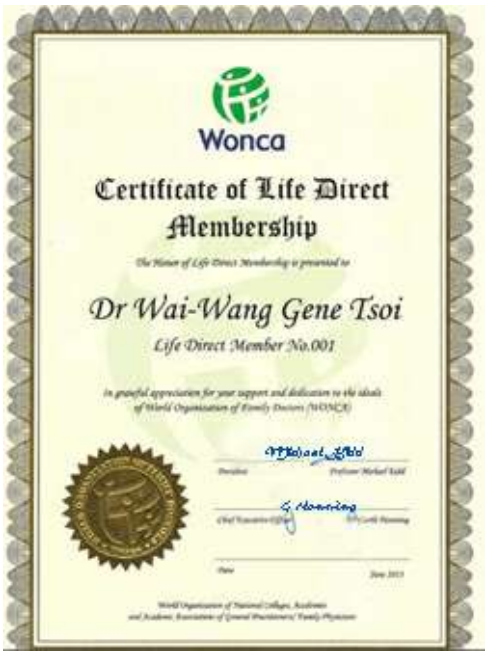
Dr John Wynn-Jones also reports on the Prince Mahidol Award Conference (PMAC), held each year in Thailand to honour Prince Mahidol, the father of modern family medicine in the Kingdom. The conference is held annually, focusing on a policy-related health issue of global significance. It is an international policy forum that Global Health Institutes, both public and private, can co-own and use for advocacy and for seeking international perspectives on important global health issues

The theme of this year's conference was "Transformative Learning for Health Equity" and there were many fascinating presentations, with a most prestigious line-up of speakers including Jim Yong Kim, President of the World Bank, Julio Frenk, Dean of Harvard School of Public Health, and many other key academics and policymakers. I was there, along with John Wynn Jones and Professors Ian Couper and Roger Strasser of the WONCA Working Party on Rural Health. The announcement for next year's conference has just been received. The theme for 2015 is "Global health post-2015: accelerating equity" and abstracts are being sought, with a deadline of Friday 28th March. More details about the PMAC conference can be found online

Direct Membership

We have also started on a concerted promotion of Direct Membership, and especially Life Direct Membership. I have mentioned this before, but make no apology for returning to the subject. We are trying to encourage as many WONCA members as possible to connect more directly with us through Direct Membership (DM). We have written to all our Member Organizations asking them to highlight this promotion to their members, and have been most gratified by the very positive response we have had from them so far. We are trying to connect much more regularly with our MOs, and we want to encourage greater two-way communication, so that they too let us know of their organizations' conferences and events, which we are then able to advertise to a wider audience through the WONCA website. This two-way link is thus a great way to strengthen the bonds between us all.

Life Direct Membership, as I have mentioned before, is a new category of membership which provides the opportunity for individuals to make a special gift to the World Organisation of Family Doctors in return for waiver of annual direct membership renewal requirements. Life Direct Member status is open to any health professional who has an interest in supporting the vision, mission and goals of WONCA. The contribution level required for Life Direct Member status is a minimum of US $750. Life Members receive the same benefits as Individual Direct Members.


Wonca

Certificate of Life Direct Membership

Dr Wai-Wang Gene Tsoi

Life Direct Member No.001

Our thanks to the first three members to sign up for life:

- Dr Gene Tsoi of Hong Kong (LDM 001)
- Professor Nabil Qureshi of Kingdom of Saudi Arabia (LDM 002)
- Dr Matie Obazee of Nigeria (LDM 003)

We hope that many more members will take the opportunity to sign up in support of World WONCA. For more details of how to apply, please go to the WONCA website.

WONCA Conferences

Finally a brief reminder about forthcoming WONCA conferences in 2014:

- WONCA Rural Health conference in Gramado, Brazil, from April 2-6.
- WONCA Asia Pacific Region conference in Kuching, Malaysia, from May 21-24
- WONCA Europe Region conference in Lisbon, Portugal, from July 2-5
- WONCA South Asia Region conference in Chennai, India, on August 16-17.

Further details are, as ever, on the WONCA website conference page.

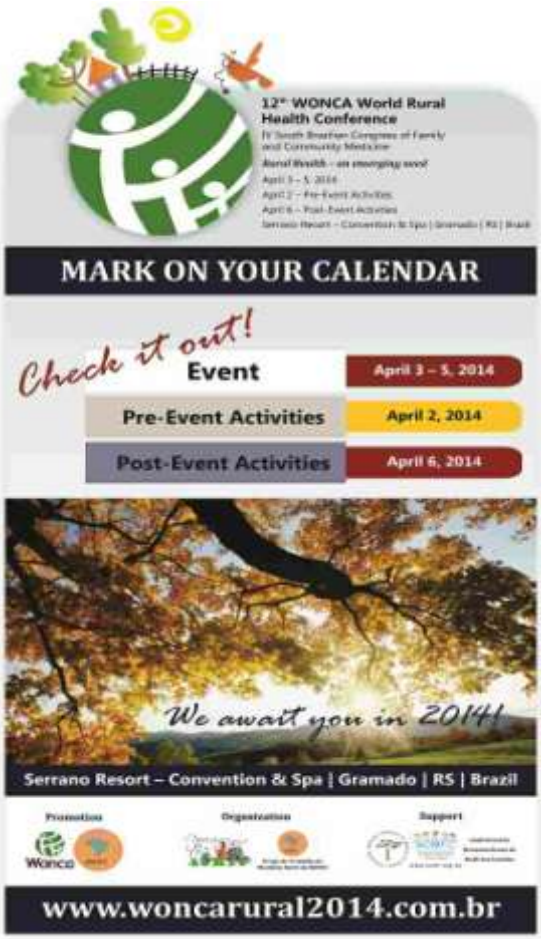
And 2015 will feature many other great conferences including Dhaka, Bangladesh (February); Accra, Ghana (February); Taipei, Taiwan (March); Istanbul, Turkey (October); and the rural health conference in Dubrovnik, Croatia in April.

Until next month.
Dr Garth Manning
CEO

The next WONCA conference

Gramado, Brazil

April 2-6, 2014



Policy Bite from Amanda Howe

Data collection from primary care – difficult, dangerous, and definitely needed!

The U.K. has had a stormy time recently – large parts of southern England are flooded: but today's headlines are awash with a different issue – the public response to our government's attempt to collect routine data from general practice records. This plan was part of the recent national health reforms, and makes routine the collection of anonymised 'patient level' data (age, sex, locality, attendance, medical problems…) unless the patient chooses to opt out.

The rationale is to allow a full population profile for service planning, quality assurance, and new research. The data is meant to be held securely, and anyone who wishes to utilise the data outside the core NHS staff working with the database has to apply to a committee and

assure both legitimate purpose and appropriate data safeguards.

WONCA and its family medicine organizations have championed the need for our members to collect data on what they do. With others from WONCA, I recently visited Myanmar, where their GP Society is trying to create a College of Family Physicians with a properly accredited postgraduate qualification. I saw clinics where doctors were keeping personal written records, allowing continuity of information over time – but there was no way of collating that information, to audit care for particular groups. The advent of computerised records in some countries facilitates our ability to quality assure care, and also to investigate health needs – for example, which women in a population are not attending for well women checks? As a researcher myself, I am delighted that I can get a list of people to receive invites for studies at the touch of a button, rather than spending hours wading through paper records to identify suitable patients. And it is clear that FM must be able to show what we do for politicians to believe we are core to the system – numbers of consultations, effective outcomes, cost effectiveness measures all need data to demonstrate impact.

So why the storm? Three reasons – concern about confidentiality, misunderstanding of the value of the data, but also concern about the choices (or lack of them) for patients. For example, you cannot opt out of your data being released to commercial providers if their request is deemed legitimate.

So if you are happy for the NHS and university researchers to use the data, but not for insurance companies or pharmaceutical companies, you cannot specify this. This was debated when the issue first passed into law, but patients only began to understand when the deadline approached for the opt-out choice to be made. People also really worry about confidentiality since the Edward Snowden affair, and there are misunderstandings about technical aspects around anonymisation.

Why would this matter to other countries, especially those struggling to provide core services in resource – poor situations? I think because, as FM practitioners, we all need to commit to collecting data on what we do, in order to make a difference. But we must explain to the patients why we do this, and who gets the data: make sure they support us in this effort: and make sure that their data cannot be accessed by anyone who will not use it properly. This applies to research and pharmaceutical studies – managing the ethics of patient consent, data protection, and data quality are all part of high quality practice, and our patients trust us to negotiate this with third parties, including governments. The storm today in the U.K. has the potential to damage the relationship between GPs and patients, and between government and the people; learn from it.

Fragmentos de Política con Amanda Howe

La recolección de datos desde la atención primaria: difícil, peligrosa, ¡y definitivamente necesaria!

El Reino Unido ha sufrido tiempos convulsos recientemente: una gran parte del sur de Inglaterra se inundaba… Pero los titulares de hoy están inundados de una cuestión diferente: la respuesta pública al intento de nuestro gobierno de recopilar datos rutinarios de los archivos de los médicos generalistas. Este plan fue parte de las recientes reformas nacionales de salud y rutiniza la recogida de datos anonimizados “a nivel del paciente” (edad, sexo, localidad, asistencia, problemas médicos, etc.), a menos que el paciente decida que no desea ser incluido en esto. La razón fundamental es permitir un perfil completo de la población para la planificación de servicios, el aseguramiento de la calidad y la nueva investigación. Se entiende que los datos se custodiarán de forma segura y que cualquier persona que desee utilizarlos fuera de la plantilla básica del NHS, tiene que solicitarlo a un comité y garantizar tanto un propósito legítimo como realizar las salvaguardas apropiadas de los datos.

WONCA y sus organizaciones de medicina de familia han defendido la necesidad de nuestros miembros de recopilar datos sobre lo que hacen. Junto a otras personas de WONCA, he visitado recientemente Myanmar, donde su Sociedad de Médicos Generales está tratando de crear un Colegio de Médicos de Familia con un título de postgrado debidamente acreditado. Allí vi clínicas donde los médicos guardan historias clínicas personales, lo que permite la continuidad de la información en el tiempo, pero no había

manera de recopilar esa información para auditar la atención a grupos particulares. La llegada de las historias computarizadas en algunos países facilita nuestra capacidad de asegurar la calidad de la atención y también la de investigar las necesidades de salud: por ejemplo, ¿qué mujeres en una población no están asistiendo a las revisiones periódicas? Como investigadora, me alegro de poder obtener una lista de personas que puedan recibir invitaciones para realizar estudios solo tocando un botón, en lugar de pasar horas vadeando a través de los registros en papel para identificar a los pacientes adecuados. Y está claro que la Medicina de Familia debe ser capaz de mostrar lo que hacemos para que los políticos crean que somos fundamentales para el sistema: número de consultas, resultados efectivos y medidas de efectividad de costes… Todo eso necesita datos para demostrar su impacto.

Entonces, ¿por qué la tormenta? Hay tres razones: la preocupación por la confidencialidad, por la incomprensión del valor de los datos y también la preocupación por la elección (o la falta de ella) de los pacientes. Por ejemplo, no se puede optar por que tus datos sean entregados a los proveedores comerciales, aunque tu solicitud se considere legítima. Así que si usted es feliz de que el NHS y los investigadores universitarios utilicen los datos, pero no de que lo hagan las compañías de seguros o las empresas farmacéuticas, no puede especificarlo. Esto se debatió primero cuando el tema pasó a convertirse en ley, pero los pacientes empezaron a entenderlo solo cuando se acercaba el plazo para optar por quedarse fuera. También las personas se han empezado a preocupar realmente por la confidencialidad desde el asunto de Edward Snowden y hay malentendidos acerca de los aspectos técnicos de todo el anonimato.

¿Por qué esto importa a otros países, sobre todo aquellos que luchan para proporcionar servicios básicos en situación de falta de recursos o de empobrecimiento? Creo que es porque, como médicos de familia, todos necesitamos comprometernos a la recogida de datos sobre lo que hacemos con el fin de marcar una diferencia. Pero hay que explicar a los pacientes por qué hacemos esto y quién recibe los datos: asegurarnos de que nos apoyen en este esfuerzo y asegurarnos de que no pueden acceder a sus datos personas que no vayan a utilizarlos correctamente. Esto se aplica a la investigación y a los estudios farmacéuticos: la gestión de la ética del consentimiento del paciente, la protección de datos y su calidad son parte de la práctica de alta calidad y nuestros pacientes confían en nosotros para negociar esto con terceros, incluyendo los gobiernos. La tormenta de hoy en el Reino Unido tiene el potencial de dañar la relación entre los médicos y los pacientes y entre el gobierno y el pueblo; aprended de ello.

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

Rural Round-up – the Prince Mahidol Award conference

Dear Colleagues

I was invited to represent you all at the Prince Mahidol Award conference in Thailand two weeks ago and I am keen to feed back my experiences.

This was an impressive and inspiring conference co-sponsored by the Thai Government, WHO, World bank, USAID, Rockefeller Foundation, China Medical Board and Japan International Cooperation Agency.

Prince Mahidol was a royal prince who trained as a doctor in Harvard and returned to his homeland as the father of modern medicine and public health. The conference and award was established in 1992 to honour individuals and explore issues related to medicine and public health from a global perspective. This year's conference was entitled "Transformative Learning for Health Equity".

It will come as a surprise to some of you that the importance of the education and training for health professionals has not had the profile that it deserves in many countries.

Things appear to be changing and the WONCA Working Party on Rural Practice (WWPRP) are engaged in this process.

In 2008-9, a number of us were involved in a programme, run through the Human Resources Section of WHO entitled "Increasing Access to Health Workers in Remote and Rural Areas through improved Retention". Despite the success of this programme, WHO however restructured soon after and dismantled the Human Resources of Health Directorate . However the die was cast and the Global Health Workforce Alliance (WHO Sponsored) and the Global Consensus on Social Accountability in Medical Education have ensured that Transformative Medical Education is seen as an essential tool in delivering the current goal of achieving Universal Health Coverage in the foreseeable future.

The WWPRP has been a champion of the transformative approach. Those of you who attended the very successful Rendez-vous Conference in Thunder Bay, in 2012, will know how the WWPRP is in the forefront of this movement - through its links with innovative pioneers and rural medical schools such as Memorial University of Newfoundland and the Northern Ontario School of Medicine, in Canada; Flinders & James Cook Universities, in Australia; Ateneo de Zamboanga School of Medicine and the University of Philippines School of Health Sciences, Leyte, in the Philippines; and Walter Sisulu University Medical School, in South Africa.

Special congratulations to Roger Strasser, Ian Couper and Krys Crystobell who were presented with Prince Mahidol Awards for their contribution to medical education. Well deserved!

The Prince Mahidol Award Conference was an impressive conference with some very high profile contributors including the President of the World Bank, Deputy Director General of the WHO, the Dean of the School Public Health at Harvard and many more.

I learnt a lot and had some important take home messages as well as useful contacts for the future, which included
• I was able to connect with the International Federation of Medical Student Associations (IFMSA). We have decided to work together to highlight and promote Rural Practice and I hope that we can have medical student representatives on the WWPRP. We hope to have a group join us in Dubrovnik, in 2015. I will keep you informed.
• We need to involve medical students when we develop innovative curricula. I was inspired by one of Krys Cristobell's students from Zamboanga who had set up a milk bank for premature babies. Jan de Maeseneer from the Network: Towards Unity for Health (TUFH) emphasised the importance of engaging with students.
• We already have a strong relationship with TUFH and Jan de Maeseneer and I discussed developing a MOU for future collaboration
• Emphasis on new ways of learning using interactive IT solutions. I came across MOOCs (Massive online open courses). These are free university courses up to and including masters level available on the internet. This will open up education opportunities for countless students and professionals who have been unable to access health based education. Great presentation from Julio Frenk, Dean School Public Health Harvard - available here.
• The majority of the delegates were economists, NGO technocrats, or academics. We are not going to change the world without engaging with those working on the shop floor. I think that I came across one other family doctor! The professional organisations and bodies need to be there and up on the podium.
• Made contact with World Medical Association and looked to connections in the future.
• Much discussion of international migration of doctors and nurses. The WHO code has no teeth. There is a place for the professionally based codes such as the Melbourne Manifesto that can take advocacy role and demand changes that WHO can not make politically. We still have a lot to do!
• I met with Professor David Williams from London who is professor of Global Oral Health at St Bartholomews and the London Hospital. I had not thought of Oral Health in such a way before yet it remains an area of health inequality worldwide. We have much in common with our dental colleagues. David is a member of World Dental Federation Vision 2020 Task Group and is going to see how they can link and work with WWPRP.

There are probably many more take home messages. I felt privileged to be part of this conference and am very thankful to the organisers, sponsors and particular Ian and Roger for ensuring that I was invited.

Hope to see you all in Gramado, in April. Our next stop!

Dr John Wynn-Jones
Chair Wonca Working Party on Rural Practice

Latest on WONCA and the WHO

World Health Organization Executive Board Meeting 2014

The World Health Organization's (WHO) Executive Board meeting which takes place every January and World Health Assembly in May in Geneva stand out as crucial events during the course of the year to mark the agenda for future WHO activities and bring together representatives from the 194 member states' ministries of health as well as other stakeholders. WONCA as a non-governmental organisation in official relations with the WHO is invited to participate in WHO meetings, amongst these the Executive Board meeting and World Health Assembly, with the aim of furthering collaborative efforts towards common objectives.

134th WHO Executive Board Meeting – January 2014

This year's WHO Executive Board meeting had the highest number of items ever scheduled for a non-budget year with 67 items on its agenda, 17 resolutions and a record-breaking number of registered participants. Margaret Chan, the WHO's Director General, during her opening speech outlined the significant demands on the WHO secretariat and the need to be strategic about the work it undertakes, as well as the need to increase the capacity and self-reliance of member states themselves. She made reference to the growing challenges around non-communicable diseases and dementia, as well as the need to continue to work towards achieving universal health coverage in many countries and reduce inequities.

Technical issues covered during this year's Executive Board meeting included; antimicrobial resistance, essential medicines, hepatitis, international health regulations, Millennium Development Goals, newborn health, non-communicable diseases, poliomyelitis, smallpox, TB, universal health coverage, vaccines, violence and violence against women. Numerous resolutions were presented including;

- Strengthening of palliative care as a component of integrated treatment within the continuum of care;
- Contributing to social and economic development- sustainable action across sectors to improve health and health equity;
- Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage.

During the meeting new regional directors were appointed for South-East Asia, Dr Poonam Khetrapal Singh, and Western Pacific, Dr Shin Young-soo. Full details of the WHO Executive Board meeting including all the agenda papers and resolutions can be found here.

Meetings with WHO Staff & other NGOs

Attendance by a WONCA delegation at the WHO Executive Board meeting also offered an opportunity to introduce new members of the WONCA executive to existing WHO contacts, establish new contacts with WHO staff and with non-governmental organisations also in official relations with the WHO, such as the International Federation of Medical Student Associations and World Medical Association. Michael Kidd, Amanda Howe and Luisa Pettigrew met on behalf of WONCA with WHO staff across various departments including; the classifications team, the department of mental health and substance abuse, occupational health and radiation safety teams, department of reproductive health and research, as well as a meeting with Carissa Etienne the Regional Director for the Pan-American Health Organisation (PAHO), and participating a meeting specially coordinated for WONCA by Hernan Montenegro, WONCA's liaison point at the WHO, with 10 key members of the Health Systems and Innovation cluster including Marie-Paul Kieny, Assistant Director General.

These meetings proved extremely valuable in order to review the great work that is being led by many of WONCA's working parties and special interest groups, as well as to identify areas and mechanisms for future collaboration. As a result of this visit further opportunities for collaboration have emerged in the areas of gender and family violence, occupational health, radiation and health, safety in primary care, leadership/management competencies for

quality and patient safety, as well as with PAHO.

Next step in analysis of WHO Survey responses

One of WONCA' current projects in collaboration with WHO is the online Consultation on Primary Care Providers' Experiences with Health Services which ran during October and November last year. We received over 250 detailed responses from family doctors and other primary care providers in 70 countries, and wish to thank all of you who responded. Responses have undergone initial review by WHO for incorporation of narratives into the upcoming WHO Strategy on High Quality, Integrated People-centred Services. Further thematic analysis of responses is planned, with a view to producing a collaborative paper later this year. If you have any questions about this project or any other WHO related activity, please do not hesitate to contact WONCA's WHO liaison person Dr Luisa Pettigrew whowonca@wonca.net

Luisa Pettigrew

Young Doctors' news

Al Razi movement for young doctors

Background

In late 2013, the WONCA East Mediterranean region formed a group specifically for young doctors in their region. The movement is called Al Razi. Al Razi Movement is the WONCA East Mediterranean Region (EMR) working group for new and future family physicians / general practitioners. It has been officially endorsed by the Wonca EMR council and officially launched at the region after the Wonca EMR executive board meeting Razi was the preeminent pharmacist and physician of his time. Muhammad ibn Zakariyā Rāzī (Arabic: أبو بكر محمد بن يحيى بن زكريا الرازي Abu Bakr Mohammad Bin Yahia Bin Zakaria Al-Razi) (Persian: محمد زکریای رازی Mohammad-e Zakariā-ye Rāzi) was born in 854 in Persia, and died in 925. He was a physician and teacher and is credited with several "firsts", most notably the clinical distinction between smallpox and measles.

Mission

Our mission is contributing in the improvement of family medicine specialty in our region by promoting leadership, medical education, training & research

Contact Al Razi movement

Al Razi Convenor - Dr Nagwa Nashat Hegazy (Egypt)

Nagwa is a lecturer in family medicine at the Faculty of Medicine, Menoufyia University, in Egypt. She is a young general practitioner who is not only a lecturer but also a member of the exam committee of the Egyptian fellowship of family medicine and health. She is a member of the Egyptian Family Medicine Association

AL Razi Objectives

- Providing a forum, support and information for trainees and new GPs through access to WONCA EMR regional conferences.
- Establishing a communication network among EMR trainees and new GPs and identifying their concerns, doubts and needs and helping to address them.
- Establishing a communication network among EMR trainees, new GPs and senior GPs to share experience.
- Promote research skills .
- Community awareness of the importance of the family doctor and the advancement of this branch of medicine, which is still blurred in many of our countries and the Arab Bank.
- Collaborating with national colleges and associations in general practice, and actively participation in the seminars & conferences.
- Promoting the formation of national representation of new and future GPs
- Collaboration with international organizations of general practice and the representation of the movement at international meetings.

- Promote training in family medicine according to the modern protocols
- Explore possibilities of exchanges with other movements.
- Promote the Importance of the family doctor in the provision of services for all segments of society and all age groups

Amanda Howe on the Vasco da Gama forum - Barcelona Feb 2014

I was privileged to attend the first independent young doctors' meeting organised by the Vasco da Gama (VDGM) movement, in Barcelona, in early February. VDGM have previously met at WONCA Europe conferences (and we don't want that to stop!), but decided they wanted more time and space to run their own meeting. It was co-hosted by the Spanish WONCA member organisation SemFYC, was very well attended (including one delegate from East Mediterranean region), and had a real 'buzz' .

One thing that is really important is that, we develop policy awareness and analytic skills in our young leaders so that they can use the growing influence effectively, and can become solution focused. The programme at Barcelona really contributed to this - I spoke about health inequalities, there was a panel on different health care systems, and also a general discussion about different member organisations including the work of WONCA World. Hopefully such meetings can continue the VDGM group will continue to support the new young doctor movements in other regions, and we shall see more activity from all of you over time! Well done to the organising committee, many thanks to our hosts at SemFYC, and remember, as I said at the close of my keynote –

"Whenever you make time to listen – to try to help – a patient who is old, sick, poor, difficult, damaged, afraid, vulnerable, or a stranger in your place, you are beginning to act on health inequalities. Whenever you convene a team meeting to discuss how to get better care for your less advantaged patients, or go to a meeting with health service managers or politicians to try to get better funding and services, you are tackling health inequalities. When you go to work in a tough practice, or train students and doctors on how to enjoy working in such places , you are tackling health inequalities. We are not all equal – but we can be part of each other's journey, and we can make a difference. So, as Pablo Picasso is widely quoted as saying, ***"acción es la clave fundamental de todo éxito"*** *- Action is the fundamental key to success".*

Editors note:
At the forum Amanda delivered the keynote speech *"We are not one - how health inequalities in Europe afflict healthcare, patients and healthcare professionals".* She has kindly made this available.

Download Amanda Howe's presentation
Photos of the forum can be accessed here

Amanda Howe en el Forum Vasco da Gama – Barcelona

Tuve el privilegio de asistir a la primera reunión independiente de jóvenes médicos, organizada por el movimiento Vasco da Gama (VDGM) en Barcelona, a principios de febrero. VDGM se ha reunido previamente en las conferencias de WONCA Europa (¡y no queremos que paren de hacerlo!), pero decidieron que querían más tiempo y espacio para celebrar su propia reunión. El acto fue co-organizado por la organización española miembro de WONCA, semFYC, estuvo muy concurrida (incluyendo un delegado de la región del Mediterráneo oriental), y realmente había tenido una gran difusión.

Una cosa realmente importante es que desarrollemos la conciencia política y la capacidad analítica en nuestros jóvenes líderes para que puedan utilizar la creciente influencia de manera eficaz y puedan convertirse en una solución definida. El programa en el Forum de Barcelona ha contribuido mucho a esto: hablé sobre las desigualdades en salud, hubo un panel sobre los diferentes sistemas de atención de salud y también un debate general sobre las diferentes organizaciones miembro, incluyendo el trabajo de WONCA Mundial. Esperemos que este tipo de reuniones puedan seguir, que el grupo VDGM continúe apoyando los nuevos movimientos de jóvenes médicos en otras regiones y ¡que veamos más actividad de todos ustedes en un tiempo! Bien por el comité organizador, muchas gracias a nuestros anfitriones en semFYC, y recordad, como dije al final de mi discurso:

"*Siempre que haya tiempo para escuchar - para tratar de ayudar– a un paciente que es viejo, enfermo, pobre, difícil, que está dañado,*

asustado, vulnerable, o a un extraño en tu propia casa, estarás empezando a actuar sobre las desigualdades en salud. Cada vez que se convoca una reunión de equipo para discutir cómo conseguir una mejor atención a los pacientes menos favorecidos, o que vas a una reunión con los directores de los servicios de salud o con políticos, para tratar de conseguir una mejor financiación y servicios, estás abordando desigualdades en salud. Cuando vas a trabajar en una clínica difícil, o a formar a los estudiantes y los médicos sobre cómo disfrutar de trabajar en esos lugares, estás abordando las desigualdades en salud. No somos todos iguales, pero podemos ser parte del viaje de unos y otros, y podemos marcar una diferencia. Así que, como reza la cita ampliamente difundida de Pablo Picasso: ***"la acción es la clave fundamental de todo éxito***".

Nota del editor:
En el foro, Amanda dio el discurso principal *"No somos uno: cómo las desigualdades en salud en Europa afectan a la salud, pacientes y profesionales de la salud*". Ella amablemente, ha dejado disponible la presentación.

Descarga la presentación de Amanda Howe.
Fotos del foro accesibles aquí.Special Interest Groups
Traducción: Eva Tudela, Spanish Society of Family and Community Medicine (semFYC) Director

Special Interest Group news

SIG Point-Of Care testing survey

Point-of-care testing refers to pathology testing performed in a clinical setting (such as a family practice) at the time of patient consultation, generating a test result that is used to make an immediate informed clinical decision. In the past decade, point-of-care testing has devolved rapidly away from the hospital sector and is now firmly embedded within the primary care setting (including family practices). As more and more point-of-care testing devices and test systems become available on the global market for the detection and management of chronic, acute and infectious diseases, it is important that family doctors have a sound knowledge and awareness of the scope and application of available devices, as well as their benefits and limitations.

The WONCA Special Interest Group on Point-of-Care Testing provides a forum for family doctors of all countries to meet, discuss, learn about, promote, advocate and research the clinical utility and effectiveness of point-of-care testing. The Special Interest Group, administered by the Flinders University International Centre for Point-of-Care Testing in Australia, provides leadership and direction to realise the benefits of this technology for interested WONCA family doctors.

As a new initiative of the Special Interest Group, a short online survey on point-of-care testing has been developed and is now available for family doctors to complete. The purpose of this survey is to obtain a wide understanding of the clinical use, availability, needs, advantages, and limitations or barriers to the implementation of point-of-care testing across all WONCA regions of the world. This information will inform the Special Interest Group on priorities for education and research. We welcome responses from all family doctors and health professional staff with an interest in point-of-care testing.

Please click here to access the survey

To email the SIG convenor for more information SIGpointofcare@wonca.net

Professor Mark Shephard
(Chair and pictured)
Lara Motta (Secretary)
WONCA SIG on Point-of-Care Testing

New SIG on Health Equity

A new WONCA Special Interest Group on Health Equity was approved by the WONCA Executive in January 2014. Dr William Wong of Hong Kong, is the convenor.

"Inequity is built into health systems- especially western health systems that are based on a view of health needs disease by disease. Therefore, the benefits of primary care, which is in person- and population- rather than disease-focused, are underappreciated. Data provide evidence not only of its benefit to populations but also of its preferential benefit to the socially disadvantaged." (Barbara Starfield 2011)

With this vision, a Special Interest Group (SIG) on health equity was approved. Health Equity SIG hopes to bring the essential experience, skills and perspective of interested GPs around the world to address the differences in health that are unfair, unjust, unnecessary but seemingly avoidable. It aims to provide a focus of support, education, research, and policy on issues relating to promotion of health equity within primary care settings.

Therefore we call on any interested doctors working within primary care to join us on:
• Understanding and utilising the current evidence base for promoting health equity in primary care;
• Exchanging ideas for developing new initiatives for primary care health equity promotion; and,
• Encouraging education and training for primary care health equity promotion.

General membership is open to interested family doctors.

For more information email convenor or see the SIG Health Equity website to find out about objectives, resources etc.

Featured doctor

Dr William Wong (Hong Kong) - Convenor SIG Health Equity

Dr William Wong is the Convenor for the Special Interest Group (SIG) on Health Equity.

Graduated from The University of Edinburgh in 1993, Dr Wong completed his GP Training in London having worked in the UK, Australia, China and Hong Kong. In 2007-10 he was appointed Director of GP and Primary Care Education at The University of Melbourne, Australia and a member of RACGP National Standing Education Sub-committees on Education and Quality Assurance. He is currently Clinical Associate Professor & Chief of Research at Department of Family Medicine & Primary Care, The University of Hong Kong.

Dr Wong conducts research on sexual health and health equity amongst marginalised groups such as sex workers and African refugees, and published over 100 manuscripts in peer-reviewed journals including BMJ, Social Science & Medicine, Sociology of Health & Illness, Epidemiology & Community Health, Family Practice etc. He is Associate Editor for Sexually Transmitted Infections and BMC Infectious Diseases. He was appointed Temporary Advisor for WHO on HIV issues (2012-2014). He is a board member for WONCA Research Working Party representing the Asia-Pacific region. In 2012 he was elected Council Member of Hong Kong College of Family Physicians and now chairs its Research Committee. In 2004 he was awarded Hong Kong Medical Association Community Service Gold Award in recognition of his contribution to the profession and the marginalised groups in the community.

He believes, having the SIG platform in WONCA and, shared experience and forces from GPs around the world, together we could support and sustain continuing engagement to make a difference presented by the challenges of health equity at structural, interpersonal and individual levels.

Member Organization news

XXXIII Spanish Society of Family and Community Medicine (SemFYC) Conference

español

Iona Heath warns of the consequences of austerity for health in the XXXIII Spanish Society of Family and Community Medicine (SemFYC) Conference

This prestigious doctor gave an opening speech on '*Medicine in times of austerity*'. As more are impoverished, there is more sickness. This was one of the key messages left by Iona Heath in her speech Medicine in times of austerity, with which she opened the XXXIII semFYC Conference, held in Granada, last June. Heath is one of the most influential researchers in primary care, former president of the Royal College of General Practitioners (UK), and former member of the Executive Committee of WONCA.

Heath wanted to make clear that austerity is generating inequality and "it is at the root of many social problems." The end of the consequences of this inequality we find it precisely on health, as Heath said: "the lives lost will not return when markets recover." This prestigious family physician reviewed data and quotes from recognized professionals, the impoverishing effects of austerity, its biological effects, the pressure and burden on the family doctor and the commercial exploitation of health issues. Finally, she gave some options and alternatives to the difficult times we are living.

The attendees enjoyed the opening speech of the XXXIII semFYC Conference. Heath insisted that "the medicine needs a broader approach that allows us to reveal the causes of the disease" and recalled that "good professionals should ask their patients about their experiences," although this does not appear in any clinical book. Sharing these experiences with governments and society maybe will make possible a reaction.

You can see the presentation that Heath used during the keynote, with her own comments, by clicking the following link, and read the interview conducted from the Blog of the XXXIII semFYC Conference.

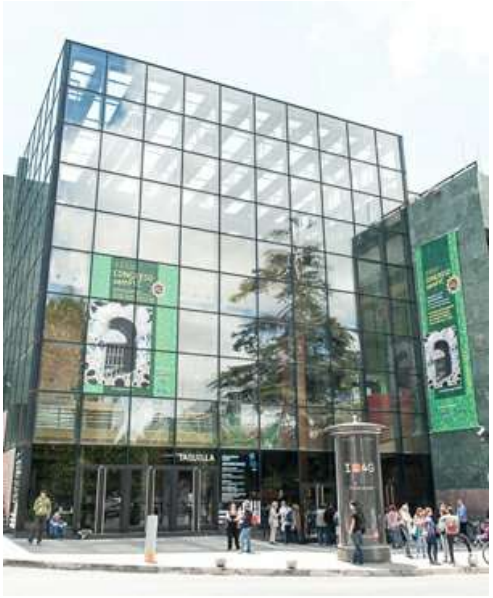
(Link to the complete presentation)

Summary of congress SemFYC XXXIII

The semFYC XXXIII Congress was held last June in the city of Granada. 2,545 doctors attended the Congress, of which 698 were family medicine residents (27.4 %). In addition to direct 'in person' participation at the conference, there was significant distance participation, primarily through the *blog* made specifically for the Congress, and social media. A total of 14,000 visits to the *blog* (11,000 views before the Congress and 3,000 visits during the Congress) were received. The Facebook page regularly received about 1,000 daily visits, reaching peaks of 3,000 views, and with an average of 200 followers. Likewise Twitter account reached 300 followers in a few weeks, with more than 1,000 tweets generated, 200 active participants, 70,000 people in the audience precongresual phase, 100,000 people in the congressional hearing phase. The total expansion during the Congress was half a million people.

It was the Congress in the history of semFYC with the highest number of scientific abstracts received (2,288) and the highest number of accepted scientific abstracts (1,723 - 75%), which also included first abstracts on clinical cases.

About seven streams were provided (Enhancing the resolution capability of the family doctor; medication management in times of crisis; Things about which we always ask "What can I do now?"; Neurological diseases; and emergency care and a specific program for Young GPs). With them there was a space for Updates and semFYC Working Groups and also an important number of parallel activities: Classroom Teaching,



Research Forum, Activity of Programs and Sections of semFYC, A Workshop in Health Communication, Preventive Activities Program Forum, Updating in Family Medicine Forum and a Solidarity semFYC Space.

Together with the Congress, important parallel Congresses were held. Among them, the IV Iberian Congress Subregional WONCA Region Ibero - CIMF and also the IV semFYC in Cardiovascular Clinical Congress, the XV Meeting Community Activities Program in Primary Care (PACAP) or the Forum on Health Education Food and Nutrition.

The inaugural speech with the title "*Family Medicine in times of crisis*", was delivered by Dr Iona Heath, who at the time, was President of the Royal College of General Practitioners and a member of WONCA World Executive. Dr Heath had the courtesy to also participate in a meeting with medical students, residents and young physician family members from Vasco de Gama Movement.

The two Fora in the Subregional WONCA-CIMF Congress addressed two field analysis: in first place, "Family medicine, more than ever", a view of the international situation with the participation of the President of CIMF, Inez Padula, the President of the Portuguese Association of General and Family Medicine, Joao Sequeira and the President of semFYC, Josep Basora. The second panel made an Overview on the practice of the family doctor with the participation of three family physicians with caring responsibilities: Virginia Hernández Santiago (in United Kingdom), Tiago Villanueva (in Portugal) and Salvador Casado (in Spain).

Vasco da Gama Movement invites Young Family Medicine Physicians and residents to get involved in Europe

The group held a roundtable in the XXXIII SemFYC Conference to explain their new challenges

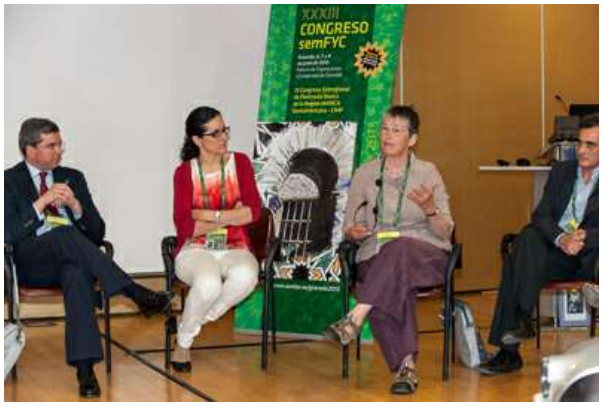
The international representative Vasco da Gama Movement (VdGM) of Spain, Raquel Gómez Bravo, was in charge of presenting the roundtable on this group of WONCA Europe: the Youth Organization of Family Physicians and Residents. Gómez Bravo explained the diversity of work areas within the VdGM and invited people into it. She emphasized the effort that was being done in the dissemination and social networking activity, as well as professional and personal wealth that provides professional exchanges through Hippokrattes program.

Karen Adriana, VdGM international representative of Spain, made her presentation on preconferences that are performed before each WONCA World Congress. She insisted that it is about sharing experiences and draw positives from workshops, in which they struggle with people from different countries about their experiences, after preparing some different issues about them. The goal is “to think globally and to act locally." Meanwhile, Veronica Parent, a member of VdGM Spain, reviewed her different experiences via exchange Hippocrates program and summarized: "The idea comes from Hippocrates program: you're making a difference to the place where you go and this brings something to you." Parent explained how to apply to a Hippocrates program and her professional and personal experience. In the same vein intervened Catherine Tarazone Belisa, who explained her exchange experience in the UK Royal College Conference and insisted that this type of program provides some extraordinary personal experiences.

Support from semFYC

Gómez Bravo wanted to take the opportunity to thank the support from semFYC to VdGM and cited this conference attendance from residents of other countries. In question time the roundtable responded various doubts from the attendees. For example, in front of the problems for carrying out the exchange

program in specific regions, since they have different operation, the member of the Executive Board of semFYC, Pascual Solanas, proposed to take this issue through semFYC to the National Commission specialty for a method or certificate providing criteria to join or at least overcome these bureaucratic barriers more easily. There were also tutors of residents in the room that asked for their own VdGM exchange, although this has not been yet contemplate it from the VdGM. The head of the International Section of semFYC, José Miguel Bueno announced that he is already in contact with other scientific societies to carry out exchanges of tutors in the future.



Dr. J. Sequeira, Dr. Gómez Bravo, Dr. I. Heath and Dr. S. Minué during a meeting.

A conference roundtable compares the situation of the family doctor in Spain, the UK and Portugal

Three GPs were responsible for exposing the different situations in Spain, UK and Portugal during one of the meetings of the Sub-Regional IV Iberian Conference of the Iberoamerican WONCA Region.

The economic crisis affects all of Europe but the specialist status of Family and Community Medicine is different depending on the country and its health system. One of the roundtables in the Sub-Regional IV Iberian Conference of the Iberoamerican WONCA Region held in Granada together with the XXXIII SemFYC Conference, compared the situation in Spain, the UK and Portugal through the exposures of three speakers. The first speaker was Virginia Hernandez family physician in the UK, where the system has some similarities with the Spanish, such as the primary care level solves 90% of health problems. To find the big differences you have to understand the management of health centres that work "as a mini-business." That is, "the government does not hire family physicians, so do the partnerships, family physicians responsible and / or founders of the health centre." Therefore, there "the family doctor is a self contained" but "they have part of their research hours assigned, minor surgery, teaching... as they choose". As great advantages to the Spanish system, the specialist in Family and Community Medicine in the UK "serves patients of all ages, there is a good relationship with the specialist, flexibility, great importance is given to training...". But instead, "they have more bureaucracy than in Spain" and "doctor-patient relationship is very weak", because it is assigned a family physician for each patient, so it is no longitudinal. After this comparison, Hernandez explained that the recent health care reform passed by the UK Prime Minister, David Cameron, "will destroy 2,500 jobs."

Tiago Villanueva, from the Portuguese Society of Family Medicine, was commissioned to draw the scene in Portugal, where he warned that “the big difference with Spain is that when you finish the residence, you will have virtually guaranteed a permanent position." Although, the thing that most surprised those present in the room in the end was that the Portuguese system of family doctors have approximately 2,000 patients per doctor and 20 minutes per visit, and also attend to pregnant women and children. But obviously there are also certain disadvantages compared to the Spanish system: for example, there is more bureaucracy, more limited use of some techniques in consultation and an assessment of the specialty very low, because the general impression is that anyone can do it.

After learning a little more about systems in the UK and Portugal compared with Spain, Salvador Casado was instructed to put on the table the current situation of the family doctor in Spain. For Casado, the specialist of Family and Community Medicine is currently suffering "a crisis of identity and prestige", because there is an economic crisis, cuts and a precarious situation for younger specialists. But Casado did not stay to a bleak, instead, he focused on explaining the strengths that family doctors have in Spain, as "the excellent training" and "the longitudinality: we get into patient’s homes, we know their families... ". He encouraged those present to join and collaborate on all those projects that help the specialty: "we have to collaborate one with each other." In short, Casado said that "we

must assert Family Medicine" even in these times of crisis, as it means a big "challenge for any physician, inside and outside the office."

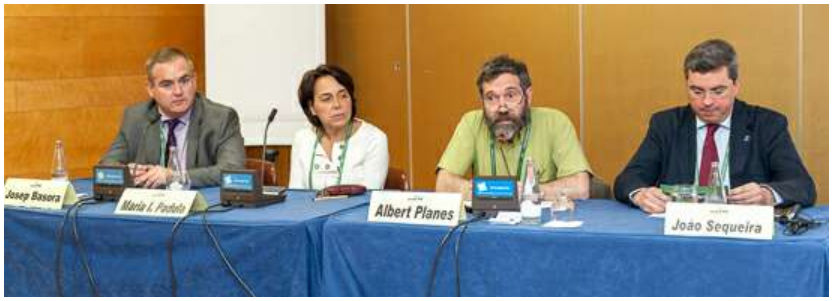


Photo: Dr. Josep Basora, Dr. Inez Padula, Dr. Albert Planes and Dr. Joao Sequeira exposing the different situations in Spain, UK and Portugal during the Sub-Regional IV Iberian Conference of the Iberoamerican WONCA Region.

Region news

South Asia region activities

Prof Pratap Prasad recently reported on WONCA South Asia region (SAR) activities to the Wonca executive. Items mentioned include:

Coming Conferences:

- 16th to 17th August 2014 in Chennai
- 1st week of February (probable 4th or 5th 2015) in Dhaka
- Feb or March 2016 in Kathmandu

Meeting with WHO Representative to Nepal Dr Lin Aung on 13th February 2014. Meeting agenda were

- Workshop: Primary health care for 'Reach to Unreach' strategy plan for SAR.
- 2nd workshop: Role of general practice/family physician in primary care at Maldives
- Link with Bhutan: Deputy WHO Representative from Nepal has been transferred to Bhutan as WHO Representative, Bhutan. He promised to provide link with him too. There will be a large scale workshop organized by WHO on 3rd week of April 2014 in Bhutan on the topic "Universal Health Coverage". I have requested him to include representation of WONCA SAR

SAR WONCA President with WHO Representative, NEPAL Dr. Aung Lin at WHO office in Kathmandu

Resources

WHO Mental Health Gap Action Programme

Mental Health Gap Action Programme (mhGAP) aims to **scale up care** for priority mental, neurological and substance use conditions (depression, psychosis, epilepsy, developmental disorders, behavioural disorders, dementia, alcohol use, drug use, and suicide/self-harm).

mhGAP Intervention Guide (mhGAP-IG), developed based on WHO recommendations, contains **clinical protocols for management of priority conditions by non-specialist** health care providers:
(http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en)

To assist with capacity building and the delivery of care, a **training package** (slides, handouts, videos and facilitator guides) has been developed to train non-specialist health care providers. It focuses on training the skills and knowledge needed to provide assessment and management for people with each mhGAP priority conditions. Other mhGAP related **guides and tools** to assist implementation of mhGAP have been developed (see box).

mhGAP related materials (Draft or field test version available upon request)

- **mhGAP Training Package**
- Training materials based on mhGAP-IG: includes slides, facilitators guides, and participants guide
- **mhGAP Manual for Programme Planners**
- Guide providing practical support for planning, developing, managing and monitoring mhGAP
- **mhGAP Situation analysis tool**
- Baseline situation analysis tool at national, regional, district and facility level
- **mhGAP Adaptation Guide**
- Guide to adapt mhGAP-IG and training materials to the local context
- **mhGAP Support and Supervision Guide**
- Guide on supervision with forms for use
- **mhGAP Training of the Trainers and Supervisors Guide (ToTS guide)**
- Guide to provide ToTS to future trainers and supervisors
- **mhGAP Monitoring and Evaluation Toolkit**
- Guide and tool for monitoring and evaluation

Please email to mhgap-info@who.int with your name and affiliation to receive invitation to a website where you can download the draft materials.

Notices

Farewell Robert Hall – Truly One of a Kind

On 13 February 2014, the worlds of academic general practice, community health and rural health lost an extraordinary contributor with the passing of Robert Hall.

I first came to know Robert in the early 1970s when I was a Monash medical student and he was a National Medical Educator for the RACGP Family Medicine Programme (FMP). Robert quickly became a mentor to me and I felt I never stopped learning from him. He introduced me to the Tune In Empathy Training course which I studied for my Bachelor of Medical Science with Robert as a supervisor. After I graduated, I worked for a time with Robert in the Hall Medical Centre in Box Hill.

When he was Director of Vocational Training at Box Hill Hospital, Robert organized my placement at the hospital in Taunton, Somerset where I met Sarah who was to become my wife and life partner.

Subsequently, Robert moved to Gippsland as a goat farmer's husband and was instrumental in recruiting Sarah and me to Moe. He succeeded me as FMP Gippsland Regional Coordinator and subsequently was a major driving force in establishment and development of the Monash University School of Rural Health. After my move to Canada, Robert visited and provided invaluable assistance with curriculum development for the Northern Ontario School of Medicine.

Over the years, Robert Hall was involved in developing a range of new models of community health/general practice services, always with an emphasis on education and research. Robert provided significant leadership in education, particularly vocational training, and in research/development projects including the Rural Hospital Quality Assurance Project with the West Vic Division of General Practice, the Extended Latrobe Valley Injury Study, the Rural Men's Health Project, and the Moe After Hours Medical Service.

A true family physician, Robert was passionate about providing holistic, team-based care and educating medical students and young doctors to be resourceful, caring and effective health promoters. At the official opening of the Monash Rural Health facilities at Latrobe Regional Hospital in 1998, I recall describing Robert as epitomising the spirit of rural health in recognition of his pivotal role in developing academic rural health not only for Monash but at national and international levels.

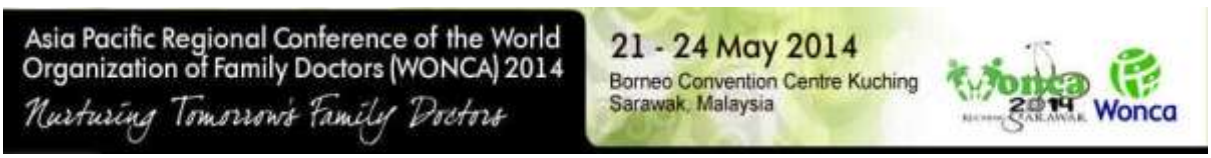
Robert Hall was remarkable for his irrepressible creativity, boundless enthusiasm for innovation, and tendency always to think outside the box. His passing is a sad loss for us all.

Professor Roger Strasser
Dean and CEO
Northern Ontario School of Medicine
Canada.

WONCA CONFERENCES 2014

April 2 – 6, 2014	WONCA World Rural Health Conference	Gramado BRAZIL	Rural health, an emerging need http://www.sbmfc.org.br/WONCArural/
May 21 – 24, 2014	WONCA Asia Pacific Regional Conference	Sarawak MALAYSIA	Nurturing Tomorrow's Family Doctor www.WONCA2014kuching.com.my
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

http://www.globalfamilydoctor.com/Conferences/MemberOrganizationEvents.aspx

April 11-12 2014	V Cumbre Iberoamericana de Medicina Familiar Quito, Ecuador
April 29-02 2014	The 10th JSFM International Conference Amman, Jordan
May 08-11 2014	EGPRN Spring meeting Barcelona, Spain
June 12-14 2014	XXXIV Congreso de la semFYC Gran Canaria, Spain
June 21-22 2014	Fiji College of General Practitioners conference Sigatoka, Fiji
July 25-27 2014	RNZCGP conference for general practice Christchurch, New Zealand
September 01-02 2014	EFPC 2014 Bi-annual conference Barcelona, Spain
October 02-04 2014	RCGP annual primary care conference Liverpool, United Kingdom
October 09-11 2014	RACGP GP '14 conference Adelaide, Australia
October 21-25 2014	AAFP annual scientific assembly Washington DC, USA
November 13-15 2014	Family Medicine Forum / Forum en médicine familiale Québec, Canada
November 19-23 2014	The Network: Towards Unity for Health conference Fortaleza, brazil
June 16-18 2015	19th Nordic Congress of General Practice Gothenburg, Sweden