WONCA News

An International Forum for Family Doctors

Contents

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From the President: The world of rural family medicine -"Any patient with any problem, anytime and anywhere"

Photo: Members of the multidisciplinary family medicine clinic team at the at La Ecuatoriana Family Medicine Clinic in Quito, Ecuador, with WONCA President, President-elect & CEO

WONCA held our 12th International Conference on Rural Health in April in the rural town of Gramado in the mountains in the south of Brazil. This is the first time WONCA's rural health conference has been held in South America. Over 600 rural family doctors from all regions of the world came together to discuss the challenges facing the delivery of health services to the people of the world living in rural areas.

Why is rural family medicine important? The answer is simple. Half the world's population lives in rural areas. But half of the world's doctors do not. As we all know, most of our colleagues in other specialties are based in cities or in large regional centres. It is the family doctors who are based in rural communities and who work with the members of their health care teams to provide medical care and advice to half the world's population.

WONCA has a long tradition of supporting rural practice, through the activities and impressive achievements of our WONCA Working Party on Rural Practice.

Our WONCA Working Party on Rural Practice was established in 1992 at the WONCA World Conference held that year in Vancouver and right from the outset comprised rural family doctors from both developed and developing countries; rural family doctors who shared a vision of health for all rural people around the world.

I pay tribute to our WONCA Working Party on Rural Practice, which, for the past 22 years, has been such a strong and effective advocate for training and supporting sufficient numbers of skilled rural family doctors to meet the health care needs of the people living in rural areas in all nations of the world.

The WONCA Working Party on Rural Practice has been highly influential through close work with the World Health Organization (WHO) in the development of global health policies on rural health and in the roll out of programs to support rural practice.

The working party has developed a number of important policies which have shaped global thinking on rural health care, including the 1997 WONCA Durban Declaration on the "Health for All Rural People", the 1998 WONCA Policy on Rural Practice and Rural Health to assist governments around the world to better meet the health care needs of their rural populations, and the 2002 WONCA Melbourne Manifesto which is a code of practice for the international recruitment of health care professionals and which emphasises the responsibility of each country to ensure it is producing sufficient health care professionals to meet its own current and future needs, and that those countries that can afford to do so, train more health care professionals than they need and so help to redress the shortages in many parts of the world.

Our WONCA Working Party on Rural Practice has also developed policies on women in rural practice, on the health care of Indigenous People, on the use of information technology to improve rural health care, and on quality and effectiveness issues in rural health care; policies which cover the breadth of the key issues affecting the provision of rural medical care.

Michael's keynote address to the WONCA International Conference on Rural Health is available online.

And in 2012 our rural working party, along with other global partner organisations and institutions at the last WONCA Rural Health Conference, released the Thunder Bay Communiqué, calling for new ways of thinking to ensure equity in the delivery of health services to the people of the world living in rural areas.

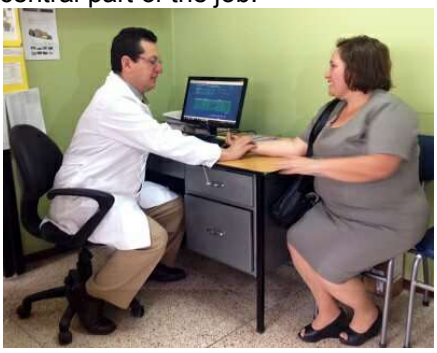
Our rural working party has organized a series of 14 successful WONCA Rural Health Conferences on all continents, including two conferences in Africa, in South Africa in 1997 and in Nigeria in 2006. The very first WONCA Rural Health Conference was held in Shanghai in 1996, at a time when China was first discovering the potential of family medicine to transform health care delivery to the vast population of that country, half living in rural areas.

Over the past few weeks I have had the opportunity to read the new WONCA Rural Medical Education Guidebook, written by members of the WONCA Working Party on Rural Practice. The book is available free of charge on our WONCA website and I commend it to you.

The book is a wonderful contribution to the medical literature and captures the essence of rural medical practice around the world and the key principles that underpin the work we do as family doctors and medical educators and primary care researchers based in rural areas in each of our countries. The editorial team of Bruce Chater, Jim Rourke, Ian Couper and Roger Strasser has done a marvellous job bringing together so many viewpoints from our colleagues from around the world.

In the opening chapter of the new WONCA Rural Medical Education Guidebook, Steve Reid from South Africa and his co-authors state, “The unique characteristic of rural medicine is the very wide scope of practice that is demanded of rural doctors” and how “over and above the wide minimum scope of skills, rural practice in different places demands different skills sets for specific needs” and how “beyond the skills set, there is a choice of a long term commitment to a rural community, that develops into a sense of identity, which is linked to a working lifestyle, a network of relationships continued over time, and a particular landscape.”

Steve also reminds us how “Working in a rural community where resources and technology are not immediately accessible requires practitioners to make the most of whatever is available, often under challenging circumstances. The unique preserve of the rural practitioners is the flexibility demanded by the principle of ‘any patient with any problem, anytime and anywhere’. Dealing with uncertainty and balancing relative risks is a central part of the job.”



Dr Adbel Robayo with Dra Erica Tinoco at La Ecuatoriana Family Medicine Clinic in Quito, Ecuador

It was timely that this conference was held in Brazil. Brazil is one of the countries leading the world in strengthening family medicine to ensure that health care is available to all people. Brazil has become a global leader in addressing universal health coverage through family health teams of doctors, nurses and community health workers. These family medicine-led primary care reforms are ensuring health care for all people in this large, complex and populous nation.

Following the WONCA Rural Conference, I travelled to Quito in Ecuador to participate in the 5th Iberoamericana Summit (or *Cumbre*) on Family Medicine, convened by the Ministry of Health of Ecuador and Municipality of Quito, in partnership with the Pan American Health Organization (PAHO) and WONCA’s Iberoamericana Region, CIMF (the Iberoamericana Confederation of Family Medicine).

Night lights in the old city of Quito, a UNESCO World Cultural Heritage Site

I always knew the Summit was going to be exciting with representation from 20 WONCA member organisations and their governments from across the Iberoamericana region. Delegates shared details of the family medicine-based health reforms and developments underway in many countries across the region. The health system in Ecuador in particular is undergoing some impressive reforms based on strengthening access to family medicine for all people in that country.

The summit ended with the presentation of "*The Quito Declaration*" (*Carta de Quito*), a strong statement expressing commitment to the ongoing development of family medicine across the region. It is notable that the letter was signed by the Ecuador Minister of Public Health, Carina Vance, as well as by PAHO and WONCA.

Minister for Public Health of the Republic of Ecuador, Carina Vance, speaking at the 5th Iberoamericana Summit on Family Medicine

I congratulate our WONCA Iberoamericana Regional President, Inez Padula, and our colleagues from across the region for the success of the summit and for their enduring commitment to the role of family medicine in strengthening the health systems in each of their countries.

Michael Kidd

Family Medicine trainees in Ecuador, with WONCA President, President-elect & CEO

From the CEO's Desk: May 2014

Greetings again from Bangkok.
As predicted, April was a very busy – but very productive – month for WONCA, and May is likely to be even more active.

Rural Issues
By all accounts the Rural Health conference in Gramado was a tremendous event, with all sorts of vibrant and exciting presentations and activities. A fuller report appears elsewhere in this newsletter, but two key highlights of the conference were the inaugural presentation of the WONCA Rural Practice Award to Professor Bruce Chater and the launch of the Rural Medical Education Guidebook, also reported on more fully elsewhere.

Next year's rural health conference will take place in Dubrovnik, Croatia, from 15th to 18th April, so please note those dates in your diary.

CIMF (Iberoamericana) V Cumbre
Our colleagues in Latin America also held their fifth Cumbre (summit) on family medicine in Quito on 11th and 12th April, and Michael Kidd, Amanda Howe and I were honoured to be there. Twenty countries were represented, several at very high level, and there were many excellent presentations and discussions. At the end of the summit a "Quito Declaration" was drafted, agreed and signed by key participants, including WONCA, with Professor Michael Kidd signing on our behalf. The Declaration, a copy of which is available on the WONCA website, in English, Spanish, and Portuguese covers five key areas:

1. Universal coverage and family medicine
2. Participation and social communication for family and community medicine and primary health care
3. The training of family medicine physicians in Iberoamericana
4. Certification and professional accreditation
5. Production and dissemination of knowledge in family and community medicine in Iberoamericana

It was fantastic to meet with so many colleagues and friends from the region and to

learn at first hand about the many great things happening in family development in Latin America.

Photo taken in Quito of (l to r) WONCA leaders (L to r) Garth Manning; Inez Padula; Amanda Howe; Michael Kidd; with, (centre), Carina Vance, the public health Minister of Ecuador

World Health Assembly and Family Doctor Day

I put these two topics together because WONCA World Family Doctor Day was declared by WONCA in 2010, and was timed deliberately to coincide with the annual World Health Assembly in Geneva. I featured it in last month's column, but it's still not too late to let us know your plans for the day and to write to us afterwards with an account, in words and pictures, of your activities. Previous reports can be found on the WONCA website.

To help to celebrate Family Doctor Day, and reduction in Direct Member fees for anyone applying for the first time. Applications received before 19th May will qualify for a reduced three-year fee of $120 (normally $140) whilst applicants from developing countries will pay only $60 (reduced from ($75). Further details, and application process, can be found here.

The World Health Assembly will take place in Geneva from 19th May, and Professors Michael Kidd and Amanda Howe, together with Dr Luisa Pettigrew and I, will attend. It's a great opportunity for us not just to network with other colleagues and agencies and organizations (including the World Medical Association and the International Federation of Medical Students Association) but also to meet with the many colleagues within WHO with whom we are forging ever closer collaboration. Luisa, as our WHO Liaison, has been hard at work arranging a very busy schedule of meetings to make best use of the few days that we are there. A fuller report will appear in a future *WONCA News.*

WONCA Asia Pacific Region Conference

Finally for May, the WONCA Asia Pacific conference will take place in Kuching, Malaysia, from 21st to 24th May and Michael Kidd and I are very much looking forward to meeting friends and colleagues from this WONCA region. I'll mention more about Kuching in next month's column.

Until next month.
Dr Garth Manning
CEO

Family Doctor Day - May 19

Dear colleagues,

WORLD FAMILY DOCTOR DAY – 19TH MAY 2014

World Family Doctor Day – 19th May - was first declared by the World Organization of Family Doctors (WONCA) in 2010 and it has become a day to highlight the role and contribution of family doctors in health care systems around the world. The event has gained momentum globally each year and it is a wonderful opportunity to acknowledge the central role of our specialty in the delivery of personal, comprehensive and continuing health care for all of our patients. It's also a chance to celebrate the progress being made in family medicine and the special contributions of family doctors all around the world.

Last year many of our colleagues across the globe celebrated the day by organising a variety of events and activities, and we received reports from countries as diverse as Bolivia, Croatia, Egypt, Ethiopia, Indonesia, Jordan, Kenya, Lebanon, Nepal, New Zealand, Nigeria, Pakistan, Republic of Srpska, Romania, Serbia, Slovenia, Switzerland, Taiwan and Trinidad and Tobago. WONCA News highlighted many of the events held previously.

This year we want to encourage even more organizations to celebrate in appropriate style on 19th May. We would love Member Organisations to tell us in advance of their plans – so that we can promote at least some in WONCA News – and then we look forward to receiving reports after the events to show and tell. WONCA News will publish as many reports as we can, to highlight the really wonderful work done by so many of our great Member Organisations. All news and reports should be sent to editor@wonca.net.

So…get your thinking caps on and drop us an email to tell us of your plans.

Dr Garth Manning

send your proposed activities to editor@wonca.net

Policy bite: Applying definitions of FM - lessons from regions, rural, and residents

Photo: Amanda Howe with residents in Gramado

As the President reports, we were both privileged recently to attend the WONCA Rural Health conference (in Brasil) and the IberoAmerica (CIMF) summit meeting (in Ecuador). The debates between us, the formulation of policy statements based on the meetings, and the experiences and concerns of younger doctors frequently centred on questions about how we define our discipline, and ensure its unique characteristics are recognised by others.

At one level, I am surprised this seems difficult – I have been arguing this cause for my whole career, and WONCA has a number of statements and policies which address this: some are translated, all are translatable, and we have been discussing definitions (see last month's policy bite). But of course, it is different to apply something to real life – as our students find when their knowledge of respiratory conditions has to be applied to the undiagnosed breathless patient! ….

Some of the questions being asked were:

- **Who is a family medicine (FM) specialist?**

There were examples of people being called 'family doctors' within some countries who had not had speciality training, or were seen as not having had enough speciality training to merit the name. A survey presented in Quito from the Ibero-America member countries showed that almost half do not currently have an recognised accreditation of their training for FM.

- **What is needed for practising FM?**

There has been a long running debate about the additional skills needed to make rural and remote practice safe and effective: looking across the world, the breadth of clinical practice does vary enormously. Some FM doctors do maternity work, some cover trauma and surgical or medical emergencies, some do other extended roles (working in substance misuse or palliative care services, for example). This diversity of practice needs us to be clear about what is and is not FM within the system.

- **Why is FM training important?**

Some countries (not only in South America) are trying to provide medical access in all communities by:
(a) sending newly qualified young doctors to the most under-served areas,
(b) using doctors with no postgraduate qualifications for community service, or
(c) using doctors imported from other countries to increase medical capacity.

All these strategies may make sense if your main aim is 'a doctor for every community', but these doctors often do not do the job that an FM specialist would do. Similarly, some steps towards universal coverage are focusing on upskilling of 'non-doctor' health professionals. This approach again needs us to be clear about what FM would add to the health care system in a way that these other valuable colleagues cannot.

So, how can you tell if FM is being practised in a clinic, or being designed into a new service?

Here are a few criteria you can use to discuss the extent to which a particular model is (or is not) reaching a minimum standard for FM to be present. These are broadly derived from the WONCA Guidebook,(The contribution of FM to improving health systems).

- **What is the training of the doctors?**

Do they have an FM qualification - and if so what did it involve (length of training, source of accreditation, etc)

- **What is the scope of practice of the doctors?**

Do they focus on problem solving and diagnosis – or only symptom relief? Are they seeing patients on a reactive / walk – in / one off basis – or do the records show that there is some continuity? Can the doctor or patient book forward for follow up, and does the 'system' bring people back to a particular doctor most of the time?

- **Do they see patients of all ages and conditions? Or is their case mix narrower?**

If the latter, how long have they been seeing this more limited group of patients, and do they have any other clinical work where they do the 'whole' FM role?

- **Would their routine practice be objectively seen as person – centred?**

Do they relate to the patients as people, or to specific technical or disease-oriented activities?

- **Is their clinic offering a non-communicable disease management service**,

with planned follow up for reviews of e.g. diabetics, hypertensives: **and do they offer screening and preventive work** (women's health checks, child development, vaccines etc) as PART of the routine service?

- If they are working in hospital, or with access to hospital beds, **what is the routine balance of their work**?

Offering emergency care or in-patient care as well as the comprehensive ambulatory services above denotes an added role, but a doctor who is spending most of their time covering surgical emergencies may not really be working as an FM doctor any more.

- **Finally, are they the first point of access to medical contact for their patients,** and do the hospital specialists need a referral to see their patients?

This is the 'signpost and gatekeep' function, as used for example in the U.K. NHS, which makes FM cost effective in the system.

These questions can be posed for formative or political purposes, for discussion and for debate.

Amanda's quick checklist

How can you tell if FM is being practised in a clinic, or being designed into a new service?

- What is the training of the doctors?
- Is there some continuity?
- What is the scope of practice of the doctors? Do they see patients of all ages and conditions?
- Is their clinic offering a non-communicable disease management service, and screening and preventive work?
- Would their routine practice be objectively seen as person – centred? Is it integrated?
- If they are working in hospital, or with access to hospital beds, what is the routine balance of their work?
- Finally, are they the first point of access to medical contact for their patients, and do the hospital specialists need a referral to see their patients?

In Rio, I saw residents in one of the new favela (shanty town / poorest housing) public service clinics being given their own patients, for whom they would care for the duration of their training there. The clinic was offering a fully comprehensive service, and the supervising doctors there were FM qualified.

I also heard from doctors who were running their own private clinics – with continuity of care, but with less consistent contact with patients (who can access hospital and diagnostic services direct), and who were struggling to provide a full range of services. I met doctors who were doing a huge range of services in rural and remote settings – skills I gave up twenty years ago because I worked within three miles of a major hospital.

Photo shows Amanda with residents at the favela clinic.

And elsewhere I have met non-FM qualified doctors running their own clinics with nurses

and pharmacists, well loved by their patients with good continuity, but without the full 'preventive to palliative' offer that would define a mature FM service.

My conclusions –

- include, support, and upskill any colleagues and services which have some of these components and are aiming at others;
- use case studies to show hospital colleagues and politicians how FM's offer differs from other models
- keep your focus on creating and maintaining FM within all health systems.

I had an interesting conversation with one ministry official where there was a 'light bulb moment' as they heard how we run all the NCD primary and secondary prevention services from FM in the U.K. – they had not understood that this work could be done outside hospital, at community level, integrated with other clinical care, and potentially at lower cost. "So that's why we need to have FM specialists?" Well, yes, plus a few other reasons too.

Amanda Howe
President Elect

FEATURE STORIES

The Iberoamerican Summit of Family Medicine and Quito Declaration

On April 12, at Quito, Ecuador, the V Iberoamerican Summit of Family Medicine concluded after two days of intensive and productive work, including exchange of experiences and participatory activities. Approximately 150 strategic health professionals from more than 24 countries of the world, especially from the Iberoamerican region, participated.

The balance was quite positive. It was an important space in which to reflect and to propose feasible solutions for the structural problems of the Iberoamerican Health Systems. We had the opportunity to have the support and active participation of Carina Vance, the Public Health Minister of Ecuador, as well as other health workers of the Ministry; the major and other representatives of the Health Secretariat of Quito; and Vice-Ministers and/or managers of the health ministries from various countries of Iberoamerica.

The Panamerican Health Organization (PAHO) was, along with CIMF/WONCA and the Ecuador Government, co-promoter of the Summit. The delegation of PAHO, in Quito, included representatives from Washington DC and, also, from the bureau of PAHO in South America and Ecuador. Last, but not least, we had the pleasure to count on the presence of the leaders of WONCA: Michael Kidd, the current president, the CEO, Garth Manning and Amanda Howe, the president elect.

From CIMF, we had the participation of a delegation from 16 of the 20 countries that constitute the Confederation. Besides that, other heath professionals and professors from universities in Ecuador, USA and Canada, as well as members of organized societies had enjoined us. The Summit has been covered in different media: radio (on and off line); Face Book; the Summit page . We estimate that almost 1,000,000 people had access to some information about the Summit, during the event.

The recommendations provided by the V Summit are summarized in the *Quito Declaration* (*Carta de Quito* in the original Spanish). The *Quito Declaration* approaches the theme that currently occupies the agenda of the World Health Organization (WHO) and its 193 countries, namely, Universal Health Coverage. As expected, Primary Care and Family Medicine are two aspects of this objective. One consequence of the *Quito Declaration* is that it brings concrete statements to deal with this challenge and presents new indicators to measure the actions that have to be enacted for this purpose.

Photo: Michael Kidd, WONCA President, adds his signature to the "Carta de Quito" - Quito Declaration.

The *Quito Declaration* was the result of work that took place before and during the event. For the last six months, five working groups have done studies, read texts, written and discussed comprehensive documents on the five central themes of the Summit: Universal Coverage and Family Medicine (FM); Social Participation and Social Communication and FM; Education and Certification on FM; Knowledge and Investigation on FM. During the event, these groups had the opportunity to discuss on a deeper level some relevant issues.

Some aspects of the *Quito Declaration* can be considered especially interesting: bringing definitions on Universal Coverage and Family Medicine, and then bringing forward actions and adequate indicators to follow up and to evaluate the quality and the extent of the Universal Health Coverage (UHC) in Iberoamerica.

CARTA DE QUITO

(Quito Declaration)

Quito Declaration (English)
Carta de Quito (español)
Declaração de Quito (Português)

I would like to highlight that the document points out that a special quality indicator of UHC, is the percentage of family doctors a country has to have (50% of all doctors being considered a good level). Besides that, the *Quito Declaration* brings the good idea to create an Observatory on Family Medicine that could foment, guide and follow up the evolution of the initiatives that will be undertaken.

I think that the Summit and the *Quito Declaration* reinforce the role of WONCA-Iberoamericana – CIMF as a scientific entity, interested in the quality of life and the wellbeing of the population. It is an example of the collaborative and technico-political role that WONCA/CIMF wants and can develop along with health and education professionals, managers, as well as representatives of organized society. That role could promote changes and constitute health systems more fairly and equally.

Nowadays, unfortunately, we see a big influence of commercial interests on the way of people think about health and disease, promoting a wrong idea that stimulates the consuming of health services, medicines and tests. This way of thinking can bring good results to big companies and industries, but brings bad results to people, increasing the risk of morbidity and mortality, just for the abusive and inadequate use of unnecessary industrialized technologies. Without a good Primary Care system with good Family Doctors, health systems will become progressively further from the real health necessities of people, and have the concrete risk of financial failure.

So, the V Iberoamerican Summit of Family Medicine can be seen as an important contribution to the necessary changes that heath systems need to make in order to reach Universal Health Coverage.

Dr Inez Padula
WONCA Iberoamericana President

Global Health and Young Family Doctors - VdGM Forum 2014

Earlier this year, the first Vasco da Gama Movement Forum, held between WONCA Conferences, gave trainee and new Family Doctors an opportunity to meet and participate in workshops, present posters, hear a variety of speakers and generally exchange views and experiences on being a Family Doctor.

One such session was the World Café workshop on the subject of 'Global Health'. Over 50 enthusiastic Family Doctors moving to the beat of *Azonto*, danced between tables where they discussed and illustrated different themes.

These themes provided a framework to facilitate discussion on the sometimes tricky subject to define, contain and conceptualise 'Global Health'. The themes included the global burden of disease, socioeconomic and environmental determinants of health, cultural diversity and health, health systems and workforce, global health governance, and human rights and ethics. Discussions that drew on the experiences of new and trainee Family Doctors from diverse countries including Albania, Denmark, Egypt, France, Greece, Ireland, Luxembourg, Netherlands, Portugal, Spain, Turkey and UK proved to be rich and inspiring. Summaries and photographs from a selection of the tables are outlined here as a collective effort by the participants in order to share some of the discussions which took place with the wider WONCA network.

The theme of *Cultural Diversity and Health* facilitated by Ana Nunes Barata (Portugal) generated discussion on the significant role that culture has on how disease is perceived and how different health beliefs often have cultural origins. There was acknowledgement that globalisation has led to greater cultural diversity within many countries, but also that there are relevant cultural differences between individuals in the same country (different age groups, socioeconomic status, etc.). Whilst making work more interesting this also increases the challenges for Family Doctors in terms of being able to understand and holistically care for patients from diverse cultural backgrounds.

Discussion on the theme of the *Global Burden of Disease* facilitated by Sandeep Geeranavar (UK) highlighted the emergence of new (and old) health challenges that could be considered a result of growing social, economic and political interconnectedness, globally. Examples included the non-communicable diseases 'epidemic' , the influenza pandemic, the role of the media and multi-national pharmaceuticals in influencing public perceptions, the rise in mental health problems, HIV, Malaria and TB rates in Greece due to the financial crisis, and the impact of economic and political instability such as the war in Syria on individuals and their families, as well as on the countries in which they seek refuge.

Participants who discussed *Socioeconomic and Environmental Determinants of Health*, facilitated by Liliana Laranjo (Portugal), acknowledged health literacy, education, and socioeconomic status as major determinants of health, and concluded that more policies should exist to address them. Accordingly, bottom-up community-based interventions to promote health education, as well as facilitate access to primary care, were seen as crucial elements in improving health outcomes. On the other hand, the group discussed that recent developments in health information technology may have the unintended consequence of increasing health inequalities, which should be closely monitored. Finally, participants recognised how environmental factors such as pollution, global warming, neighbourhood walkability and access to fresh produce stores have the potential to influence the health of populations worldwide.

The participants of the topic on *Global Health Governance* facilitated by Lisa Gambhir (Luxembourg) focused on the complexity of the roles of governmental, international organisations, the commercial sector and civil society in health. The political and economic

stability of countries as factors affecting the security, empowerment and therefore health of women and their families were explored. The role of World Health Organisation in influencing national government policy was discussed, as well as how health-related research is conducted and governed globally. Participants concluded how important the existence of multiple organisations was in order to represent different groups, yet recognised that unnecessary competition and fragmentation of efforts could also arise as a result - the example of the emergency response in Haiti after the 2010 earthquake was given.

The *Health Systems and Workforce* themed table facilitated by Peter Sloane (Ireland) explored the diversity of function of health systems across the globe, and the diversity and mobility of the EU workforce with its associated impact within Europe and elsewhere. There was consensus that the doctor-patient relationship should be at the heart of all health systems and that Family Doctors had an important gatekeeping role (perhaps better referred to as 'gate-facilitating') to play. However, numerous structural, financial and cultural factors impact on how this plays out in different countries. There was recurrent discussion about the need to shift the focus of healthcare and resources from secondary and tertiary care to primary care, and to encourage and develop systems of working together through primary care teams.

In conclusion, the huge spectrum of healthcare systems and of factors which influence health globally was recognised. It was agreed that being able to design a one size fits all health system model was likely to be neither achievable nor desirable. However, there was an appreciation that much can still be learnt from one another, and it was agreed that globalisation is playing an increasing role in the health of communities worldwide. Therefore if Family Doctors of the future are to be able to effectively rise to the challenges that this brings, family medicine training will need to better prepare us to do so.

Workshop coordinators: Luisa Pettigrew (UK), Per Kallestrup (Denmark) & Laminu Kaumi (Spain/Nigeria) (all pictured at left)
Workshop facilitators: Sandeep Geeranavar (UK), Liliana Laranjo (Portugal), Peter Sloane (Ireland), Ana Nunes Barata (Portugal), Lisa Gambhir (Luxemburg), Sara del Olmo (Spain).
With special thanks to all the participants who generated stimulating discussion and creative drawings to capture this.

Working Party on Rural Health reports

Report on 12th World Rural Health Conference, Gramado, Brazil

WONCA World Rural Health Conferences are always exciting and enjoyable events. We have the opportunity to meet as one large Rural Global Family once a year. Despite the many contextual differences that the word 'rural' describes across the world, there is so much more that binds us all together, than separates us.

I am just back from the very successful and enjoyable 12th World Rural Health Conference in Gramado, Brazil. I must start by congratulating Leonardo Targa and his team for putting on one of the best conferences to date. It was an inspiring event and just right to celebrate WONCA's first conference in South America.

Photo: fun in Gramado

It was my first visit to South America and the first time for many of the international delegates who attended. We were all amazed

by the beauty, cultural diversity and energy that we came across. Brazil is frantically preparing for the World Cup and I hope that the many football fans that who travel there in the next few months will receive the same warm reception.

The WONCA Working Party on Rural Practice (WWPRP) met prior to the conference and we were privileged to have the President Elect of WONCA, Amanda Howe join us. We have set ourselves an arduous workload before we meet again in Dubrovnik next year.

The WWPRP is total committed to equity and diversity (gender, age, geography and race) in its membership and we believe that by achieving these goals we can extend the working party's global influence and impact on rural health around the world. Other commitments include involvement in the WHO post 2015 debate on universal health coverage; an initiative on "*Rural Proofing for Health*"; developing an on-line WONCA rural resource; a joint statement on the impact of environmental challenges and climate change with the WONCA Working Party on the Environment; a review of our previous documents and initiatives; and much more!

As with so many conferences, it was over too soon. I agree with many of my colleagues that the excellent organisation from Juliana Rupp of Oceano Eventos, ensured that it was relaxed and provided an environment conducive to learning, debate and discussion.

The next WONCA World Conference will be in Rio de Janeiro from November 2-5, 2016, if its anything like Gramado, you can't miss it! So put it in your diaries now.

One of the conference highlights was the launch of our Rural Medical Education Guidebook. This is one of our most important initiatives to date. A huge undertaking and congratulations to the editorial team (especially Janet Giddy, Penny Morrell and Bruce Chater) .

Plans are being drawn up to translate it into Portuguese and we are keen to translate it into Spanish as well.

I would also like to congratulate Bruce Chater, the recipient of the first ever "WONCA Working Party on Rural Practice Award for Outstanding Service to Rural Practice". His contribution has been immense over the years and I am sure that the much of the success of the WWPRP is down to his outstanding and loyal contribution. Please take a look at the citation. Well done Bruce!

Congratulations also to Professor Roger Strasser who gave the annual John Macleod Oration entitled "*Improving the health of rural people through health workforce policies*". More on this in the future!

Roger is pictured at right with Leonardo Targa (left) and John Wynn-Jones (right)

I enclose a link to WONCA President, Michael Kidd's inspiring keynote address at Gramado. It was wonderful to have both the President and the President elect of WONCA attend the conference. Thanks to you both for your support.

We as a working party need your help and your support even more over the next 12 months before we meet in Dubrovnik in April 15-18, 2015, for the 13th WONCA World Rural Health Conference. (Put it in your diaries now!)

Finally, please promote the WWPRP wherever you go and whoever you talk to. Please send me email addresses that I can add them to the Google group. WPrural@wonca.net

Wishing you all the best for the forthcoming year and see you in Dubrovnik

John Wynn-Jones
Chair WONCA Working Party on Rural Practice

WONCA rural practice award presented to Dr Bruce Chater

The WONCA Working Party on Rural Practice Award for Outstanding Service to Rural Practice presented to Dr Bruce Chater, of Queensland, Australia, at the WONCA World Rural Health Conference, Gramado, Brazil, April 2014. Pictured above is Bruce (Centre) with from (l to r) Dr Leonardo Targa, Dr John Wynn-Jones (chair WWPRP), Prof Amanda Howe (WONCA President Elect), and Mrs Anne Chater

The WONCA Working Party on Rural Practice Award for Outstanding Service to Rural Practice is given to working rural family doctors who have made an exceptional contribution to rural health on both a global and local perspective.

This award recognises a clinician's exemplary service to their rural communities, to their professional colleagues and to the next generation of doctors.

Recipients are champions for those who they work with and role models for those who follow them. The WONCA Working Party on Rural Practice wishes to acknowledge rural family doctors who make a difference.

Bruce Chater is one of these doctors. He is a founder member of the WONCA Working Party on Rural Practice and has contributed actively to every statement, document, and strategy produced over the last 23 years. He has attended every conference and has coordinated the discussions and recommendations at each gathering. It is often the case that it is his presence and his enthusiasm that assures success. One cannot imagine a Working Party Meeting without his presence.

He has also made a massive contribution in his own country and in his home state of Queensland. He remains one of those iconic rural multi-skilled doctors that only Queensland can produce. He was one of the founding fathers of the Australian College of Rural and Remote Medicine (ACRRM) and subsequently became its president. I do not have the time to list his many roles in Australian Rural Health Care but I do know that he never stops and is still working with the Queensland Government.
He is committed to educating the next generation of rural doctors both as a trainer and as Associate Professor at the University of Queensland.

Despite all these accolades, I know that Bruce is most proud of his role as the local doctor in Theodore where he combines holistic patient centred care with emergency medicine, surgery and obstetrics.

Above everything Bruce is a family man who is proud of his equally outstanding family.

I have known Bruce for nearly 20 years and I can think of no one better to receive this inaugural award.
Dr John Wynn- Jones

RESOURCES FOR FAMILY DOCTORS

WONCA Rural Medical Education Guidebook launched

An international, open access guidebook on Rural Medical Education was launched on 5 April at the 12th WONCA World Rural Health Conference in Gramado, Brazil. The *Guidebook*, which has been six years in the making, is a special project of the WONCA Working Party on Rural Practice.

Consisting of 71 chapters written by 74 authors, it represents a unique collaboration, with contributions from every continent. It is intended to be a free resource for doctors, educators and others wanting to obtain practical ideas on implementing aspects of rural medical education and to learn from the experience of colleagues in different contexts. As stated in the preface, "Despite the increasing literature and growing evidence for RME [Rural Medical Education], … colleagues around the world expressed the need for a

how-to book of practical strategies and ideas for training health care workers for rural practice."

The material in the book has been arranged into five themes:

- Framing and resourcing of rural medical education and practice;
- Medical education in rural settings;
- Professional and technical support for rural medical educators;
- Undergraduate medical education; and
- Postgraduate medical education.

Issues covered within these themes include resourcing rural health; gender and cultural considerations in rural practice; rural medical schools and colleges; teaching, learning and assessment in rural medical education; clinical research in rural settings; undergraduate student recruitment and selection; and advanced clinical skills training.

Though the chapters in the book have a common standard and similar format, authors were given the leeway to express themselves in ways that would enable readers to understand both their challenges and the efforts required, often in contexts of considerable difficulty. The focus of the guide is medical, but it also includes a range of insights about education and social processes that are intrinsic to all learning.

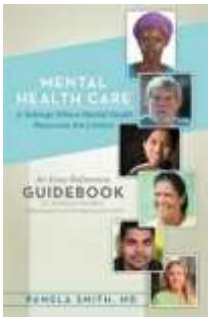
Commenting on the launch, Associate Professor Bruce Chater, from Queensland, Australia, who is the editor in chief, expressed his great satisfaction with the final product, because it represents the efforts of so many different people, in particular of hard-working and enthusiastic rural practitioners. "*This is an amazingly generous effort by so many rural doctors, academics and others. It is a gift from those who pioneered the development of rural medical education over the last 20 years. We look forward to the guide being organic and growing as the next generation take these initials steps further for the health and wellbeing of our rural patients and friends*."

The President of WONCA, Professor Michael Kidd, lauded the new Guidebook. "*This book is a wonderful contribution to the medical literature and captures the essence of rural medical practice around the world and the key principles that underpin the work we do as family doctors and medical educators and primary care researchers based in rural areas in each of our countries. I urge you to read this book and be inspired about the contributions made by each of the world's rural family doctors to the health and wellbeing of their patients and their communities.*"

The *Rural Medical Education Guidebook* has been published on the web as a set of open-source documents. It is intended to be easily downloadable and accessible around the world. Access the Guidebook .

Ian Couper
Ian.couper@wits.ac.za

Mental health care in settings where mental health resources are limited



WONCA has been informed that a recently published handbook, "*Mental Health Care in Settings Where Mental Health Resources are Limited*" by Pamela Smith MD, is able to be made available to family doctors electronically. Thanks to the generosity of the author for this permission.

The author is a psychiatrist and former UCLA Medical School faculty member who has coordinated training projects in association with WHO, UNICEF, UNHCR, and other humanitarian aid organizations. The handbook is written specifically for GPs and Family Practice physicians who encounter individuals suffering from mental distress and have little or no access to mental health professionals, services, or resources.

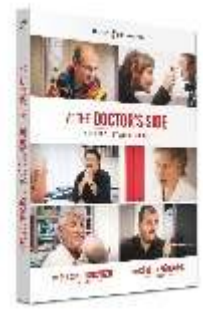
The guide addresses conditions recognized globally such as depression, schizophrenia, post-traumatic stress, substance abuse, child & adolescent issues, violence, and HIV/AIDS & mental health. Insights on the recent state of mental health worldwide and the means for increasing access to care in resource-limited areas are provided as well.

The book may be viewed and purchased in hardcopy here.

Family doctors may download the following for free:
English version (complete e-book)
abridged French
abridged Arabic

"At the doctor's side"- a documentary trilogy

Well known Swiss family doctor, Dr Bruno Kissling is this month's featured doctor (next page). His work as a family doctor was recently filmed in one of three documentaries made by Dr Sylviane Gindrat about the working life of six Swiss family doctors - "At the Doctor's Side"



About the films
In these three documentary films by Sylviane Gindrat of Switzerland (2013) we accompany six family doctors, four men and two women in their daily round and obtain an insight into the hidden realm of their surgeries. In town, in the country and in a mountain valley, the trilogy takes us right into the heart of the consultations and give us a close experience of the sum of their complexity. In confidence with the filmmaker, herself a family doctor for twenty years, the exponents do not only speak about the joys of their professions, but also about their hopes and fears, pinpointing the crisis the profession of family doctor is encountering at present. And yet they affirm their faith in the essential role played by family medicine.

Stéphane & Franziska tells of life in a mountain-village practice. The Zuffereys, both doctors, are a married couple with four children. Together they ensure the medical care in the Val d'Anniviers. Their work extends from traumatology to paediatrics and includes internal medicine and mountain rescue. There are organisational problems too, especially in winter, when the tourist season brings a tenfold increase in population.

Gabi & Bruno shows a face to face of two strong characters. Aged 28, lively and enthusiastic, Gabriela Rohrer is starting to 'wear her doctor's white coat'. Very motivated, she is training to be a family doctor, while being highly critical of the system. Bruno Kissling, 62, has been practising for 30 years as an independent doctor in a residential district in Bern. He is a calm and thoughtful man, highly committed to his patients. His outlook has been moulded by his long experience in a surgery, numerous writings and activities in the training of young doctors.

Paul & Sébastien: Here we have two generations of family doctors in very different types of practice. Sébastien Martin, a young family doctor, works in a city group-surgery in Lausanne, and is responsible for his own patients and emergency cases in the group's outpatient department. Sébastien's manner of working, give us an insight into tomorrow's family medicine. Paul Affentranger, 65, a man with incredible energy, is a perfect example of the type of family doctor now becoming extinct. He knows all the inhabitants in his area in Entlebuch and is on call day and night. He pinpoints the serious problem of his succession.

Original version: French and Swiss German,
Subtitles: English/French/German

We offer you the three films on one DVD for different purposes:
For private use: You can order the DVD with all three films for CHF 35.- (USD 40.-, EUR 30.-) from our online DVD-shop: www.atthedoctorsside.ch
For educational use: We grant permission to institutions to use the 3 films on their own premises for teaching purposes and for unlimited screening within their institution without entry or participation fees for a period of five years. This licence fee is CHF 500.- (USD 570.-, EUR 420.-). Please contact: info@ghornuti.ch
For public screenings: Please contact us and we will provide you with the films according to your use: info@ghornuti.ch

A word from Bruno Kissling about being chosen for this role.

Sylviane Gindrat the filmmaker of '*At the Doctors Side*' and I, have known each other for many years. We are members of the same quality circle, where Sylviane – she also studied social anthropology and film sciences - got inspired to make her film to visualize the complexity and quality of family medicine.

As a first step she visited my clinic to learn, if the patients would accept a person with a camera being

present within a real consultation. Sylviane liked my kind of consultation. After casting visits of 30 other family doctors in different parts of Switzerland, she favoured me together with five other doctors, for the film roles.

It was easy for me to accept the role of a protagonist in her film for several reasons:
- I felt good about her presence in my consultation, during her casting visit.
- My patients gave her a warm reception.
- Having seen her two other award winning films I knew how respectfully and empathetically she filmed the protagonists.
- And furthermore, I'm a curious person and I won't miss the chance to participate at this unique endeavour.

I'm not an actor. I cannot play roles following a script. I'm a protagonist in a documentary and can only "play" myself with my own behaviour, my own authenticity.

Furthermore I learnt to remain authentic even when being observed. This the main precondition for a protagonist in a documentary. And Sylviane found that my appearance, mimics, presence, voice and behaviour etc are 'filmogenic'. I cannot estimate this. I trust her. But looking at the film you can judge if Sylviane is right. It is my first movie and it will remain my only one, I suppose.

Read more about Bruno below

FEATURED DOCTORS

Dr Bruno KISSLING - Switzerland, family doctor

Where are you currently working?
For 31 years I have been working as a family doctor in the same solo doctor practice in the city of Berne, the capital of Switzerland.

I have cared for many of my patients for decades. Together we have undergone many illnesses, or crises, leading to increasing mutual confidence and trust, within a long-lasting doctor-patient relationship. Getting older, we struggle together against a rising number of chronic diseases.

Despite their illnesses, many patients feel really well. "Thank you, I feel fine, and how are you, doctor? Take care of yourself. We still need you. You know." Many of my patients have passed away, most of them at a very advanced age. Of course, I care also for younger patients, but they need my help only occasionally.

What other interesting work have you done or do you do?
After more than 30 years I still like being a family doctor. A very important contribution to maintain this delight, is a good balance between my profession, my private life, and other occupations and interests.

I was a member of the executive board of our Swiss Society of General Practice for eight years and also the Swiss delegate to WONCA (2000 – 2009). In 2009, Switzerland organised the WONCA Europe conference, in Basel, and I was the president of the host organizing committee.

I'm teaching medical students in my practice. I like to see their development from a student to a doctor.

Further, I'm a co-founder and co-editor of our Swiss Journal of Family Medicine www.primary-care.ch . It is very satisfying to work on this journal, together with an enthusiastic team of editors, for more than ten years now.

What is it like to be a family doctor in Switzerland?
To be a family doctor in Switzerland is one of the best professions - like everywhere in the world. The work with patients is very satisfying. However, there are some stressful situations - like everywhere, I suppose.

Switzerland has a highly developed and very expensive health system. It is privately organised but strongly regulated, by law.

Accessibility, accountability, equity and solidarity are legally guaranteed to all citizens. No referrals are needed for access to secondary and tertiary care. To have private health insurance is mandatory. People with low income are financially supported to pay the fees. Managed care is an option to better control the system.

About 25% of all doctors are family doctors. The majority of us work in a one or two doctor practices, with a rising number of group practices. All practices have a laboratory and ECG; a lot of them have an x-ray and spirometry; many have ultrasound.

The number of family doctors is literally "crashing". Our mean age is about 57 years. The interest of young doctors to become a family doctor has been low for many years. With the help of the Swiss association of young doctors (which was founded 2006, under the influence of the 'Vasco da Gama Movement'), and strong political initiative, family medicine gets stronger and the number of family doctors is rising slowly.

Only since 2005, has Switzerland had institutes of family medicine and therefore an academic status.

What are your passions outside work?
Writing is another passion. About 20 years ago, I discovered my capability and my love to write. I was really surprised by that. Before, I was convinced that I was a bad writer and I had no reason to change that idea.

Besides political and professional essays, I started to write short poems with 20 to 35 words each, one word on each line. These poems start with a simple impression or feeling, with an observation in nature or in society, with a sudden inspiration or any idea. And these first thoughts get interwoven with further and deeper reflections on different philosophical levels. These little poems with their few words are condensations of my reflections about life. They become like the eye of the needle to the world of the reader, who can continue the reflection with his own thoughts.

Of such poems, I created text sculptures for an exhibition, together with my sister who is a painter. People could walk through 1000 words getting touched virtually by the words and conversely, being able to touch the words physically. Recently I did another art exhibition in an old Roman church, together with a friend who is a painter. We created some very abstract objects to the theme of 'seeing differently'. The next planned art exhibition will play with the 'aesthetics of the ennui'.

You see there is no worry for me to be bored in the future…

Editor's note: below is one of Bruno's poems and at right part of an art installation using the poem. When asked to explain it to the WONCA editor, Bruno comments: "It reflects the k-ein: kein means 'no one' - ein means 'one' . The poem cannot be translated in other languages, because this dense words play often with different meanings of the words. Read from top down it gives a sense but there is also sense or different sense or the contrary, if you start to read it anywhere… "

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ewiges
vergehen
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to contact Bruno Kissling
bruno.kissling@hin.ch
Berne, Switzerland

Dr Nagwa HEGAZY: Egypt - leader Al Razi young doctors

Dr Hegazy is the inaugural convenor of the Al Razi movement for young doctors in the East Mediterranean region.

Can you tell us about your current work?

Currently I'm working as a lecturer in the family medicine in the department of family medicine, Faculty of Medicine, Menofiya University.
Also I am a part-time fellow in Munshsaat Sultan PHC that is affiliated to the Menofiya University Hospitals. In addition of being attached to the exam committee of the Egyptian fellowship of family medicine and health.

The choice of my career as a family practitioner has evolved from a solid belief that that the family practitioner is the corner stone in any health service in my society. I was really disappointed by the marginalization of the potential & important role of family medicine in so I devoted my time and effort to put the role of family medicine in the lime light. for East Mediterranean region young doctors.

I am member of the Egyptian Family Medicine Association (EFMA). This association was established in 2006 aiming at awareness augmentation of family physicians regarding continuous medical education through workshops& scientific meetings . In addition to social activities that includes commemoration in the orphan day & medical care to special needs schools.

What do you do to relax?

I usually spend my free time in reading & walking . I believe that reading is the window for knowledge & books summarize the experience of the past & the future. I consider walking and contemplation the best way to release tension.

What do you hope to achieve as leader of the Al Razi movement for young doctors?

Boosting of family physicians potentials in the training & research areas is my main plan as a leader of Al Razi movement . I hope to contribute in the broaden of family medicine concepts in EMR and increase the recognition of patients to this specialty.

read more about the Al Razi movement

Español

Del Presidente: el mundo de la medicina de familia rural

Foto: Los miembros del equipo de la clínica de medicina familiar multidisciplinaria en La Clínica de Medicina Familiar Ecuatoriana de Quito, Ecuador, con el Presidente de WONCA, la Presidenta electa y el Consejero Delegado.

"Cualquier paciente con cualquier problema, en cualquier momento y en cualquier lugar"
WONCA celebró nuestra 12ª Conferencia Internacional sobre Salud Rural en el mes de abril, en la localidad de Gramado, en las montañas del sur de Brasil. Esta era la primera vez que la conferencia de salud rural de WONCA se celebró en América del Sur. Más de 600 médicos de familia rurales de todas las regiones del mundo se reunieron para discutir los desafíos que afronta la prestación de servicios de salud a los habitantes del mundo que viven en estas zonas.

¿Por qué es importante la medicina de familia rural? La respuesta es simple: la mitad de la población mundial vive en áreas rurales, pero la mitad de los médicos del mundo no lo hacen. Como todos sabemos, la mayoría de nuestros colegas de otras especialidades están en las ciudades o en los grandes centros de las regiones. Se trata de que los médicos de familia que estén localizados en comunidades rurales y que trabajan junto a los miembros de sus equipos de atención sanitaria puedan brindar atención médica y asesoramiento a la mitad de la población mundial.

WONCA tiene una larga tradición de apoyo a la práctica rural, a través de las actividades y los logros impresionantes de nuestro Grupo de Trabajo sobre Práctica Clínica Rural de WONCA.

Nuestro Grupo de Trabajo sobre la Práctica Clínica Rural de WONCA se creó en 1992, durante la Conferencia Mundial de WONCA, celebrada ese año en Vancouver, y desde el primer momento comprende a los médicos de familia rurales, tanto de los países desarrollados como en desarrollo. Son los médicos de familia que comparten una visión de la salud para toda la población rural del mundo.

Quiero rendir homenaje a nuestro Grupo de Trabajo sobre la Práctica Clínica Rural de WONCA, que durante los últimos 22 años ha sido un gran defensor, además de muy eficaz, de dar formación y apoyo a un número suficiente de médicos de familia rurales cualificados, para poder satisfacer las necesidades de salud de las personas que viven en zonas rurales de todos los países del mundo.

El Grupo de Trabajo sobre la Práctica Clínica Rural de WONCA ha tenido una gran influencia a través de un trabajo próximo a la Organización Mundial de la Salud (OMS), en el desarrollo de políticas de salud global en la salud rural y en el despliegue de programas de apoyo a la práctica clínica en el ámbito rural.

El grupo de trabajo ha desarrollado una serie de políticas importantes, que han configurado el pensamiento global en el cuidado de la salud rural, incluidas la Declaración de Durban de 1997 WONCA sobre la "Salud para toda la población rural"; la Política de WONCA de 1998 sobre Práctica Rural y Salud Rural, para ayudar a los gobiernos de todo el mundo en satisfacer mejor las necesidades de salud de sus poblaciones rurales; y el Manifiesto de WONCA en Melbourne, en 1992, que es un código de prácticas por la contratación internacional de profesionales de la salud, que hace hincapié en la responsabilidad de cada país para asegurarse de que está produciendo suficientes profesionales de la salud que atiendan a sus propias necesidades actuales y futuras, y que los países que pueden permitirse el lujo de hacerlo, formen a más profesionales de la salud de los que necesitan y así contribuyan a la corrección de las carencias en muchas partes del mundo.

Nuestro Grupo de Trabajo sobre la Práctica Clínica Rural de WONCA también ha desarrollado políticas sobre la mujer en la práctica clínica rural, en el cuidado de la salud de los Pueblos Indígenas, en el uso de las tecnologías de la información para mejorar la atención de salud rural, y en temas de calidad y eficacia en la atención de salud rural. Todas ellas son políticas que cubren la amplia variedad de cuestiones clave que afectan a la prestación de asistencia médica rural.

Y en 2012 nuestro grupo de trabajo rural, junto con otras organizaciones asociadas e instituciones globales, en la última Conferencia de Salud Rural de WONCA, publicó el Comunicado de Thunder Bay, llamando a nuevas formas de pensar para asegurar la equidad en la prestación de servicios de salud a las personas del mundo que viven en zonas rurales.

Nuestro grupo de trabajo rural ha organizado una serie de 14 exitosas Conferencias de Salud Rural de WONCA en todos los continentes, incluyendo dos conferencias en África: en Sudáfrica, en 1997 y en Nigeria, en 2006. La primera Conferencia de Salud Rural de WONCA se celebró en Shanghái en 1996, en un momento en que China estaba descubriendo por primera vez el potencial de la medicina de familia para transformar la prestación de la atención de salud a la vasta población de ese país, pues la mitad de ella vive en zonas rurales.

El discurso de apertura de Michael en la Conferencia Internacional sobre Salud Rural de WONCA se encuentra disponible

Durante las últimas semanas he tenido la oportunidad de leer la nueva Guía de WONCA para la Educación Médica Rural, escrita por miembros del Grupo de Trabajo sobre la Práctica Clínica Rural de WONCA, que está disponible gratis en nuestro sitio web de WONCA y que os recomiendo.

El libro es una maravillosa contribución a la literatura médica, capta la esencia de la práctica médica rural en todo el mundo y los principios fundamentales en los que se basa el trabajo que hacemos como médicos de familia, educadores médicos e investigadores de atención primaria en las zonas rurales de cada uno de nuestros países. El equipo editorial de Bruce Chater, Jim Rourke, Ian Couper y Roger Strasser ha hecho un maravilloso trabajo que reúne muchos puntos de vista de nuestros colegas de todo el mundo.

En el primer capítulo de la nueva Guía de WONCA para la Educación Médica Rural, Steve Reid, de Sudáfrica, y sus co-autores afirman: "La característica única de la medicina rural es el muy amplio alcance de la práctica clínica que se exige a los médicos rurales" y cómo "más allá del amplio alcance mínimo de habilidades, la práctica rural en diferentes lugares exige diferentes conjuntos de habilidades relacionadas con necesidades específicas" y cómo "más allá de las competencias establecidas, hay una opción de compromiso a largo plazo en una comunidad rural, que se desarrolla en un sentido de identidad, que está vinculada a un estilo de vida en el trabajo, a una red de relaciones continua en el tiempo y a un paisaje particular."

Steve también nos recuerda cómo "trabajar en una comunidad rural donde los recursos y la tecnología no son inmediatamente accesibles, requiere de profesionales que saquen el máximo provecho de lo que hay, a menudo, en circunstancias difíciles. La única forma de preservar a los médicos rurales es la flexibilidad que exige el principio de "cualquier paciente con cualquier problema, en cualquier momento y en cualquier lugar. Hacer frente a la incertidumbre y al equilibrio entre los riesgos relativos es una parte central del trabajo."

Foto: El Dr. Adbel Robayo con la Dra. Erica Tinoco en La Clínica de Medicina Familiar Ecuatoriana en Quito, Ecuador.

Era oportuno que esta conferencia se celebrara en Brasil. Brasil es uno de los países líderes del mundo en el fortalecimiento de la medicina de familia y en garantizar que la atención médica esté disponible para todas

las personas. Brasil se ha convertido en un líder mundial en la cobertura universal de salud a través de los equipos de salud de médicos de familia, enfermeras y trabajadores de salud comunitarios. Estas reformas de la atención primaria con el liderazgo de la medicina de familia garantizan servicios de salud para todas las personas en un país grande, complejo y numeroso.

Foto: La noche se ilumina en la ciudad vieja de Quito, declarada Patrimonio Cultural de la Humanidad.

Después de la Conferencia Rural de WONCA, viajé a Quito, en Ecuador, para participar en la quinta Cumbre Iberoamericana de Medicina de Familia, convocado por el Ministerio de Salud de Ecuador y el Ayuntamiento de Quito, en colaboración con la Organización Panamericana de la Salud (OPS de la Región Iberoamericana) y de WONCA, CIMF (la Confederación Iberoamericana de Medicina Familiar).

Siempre supe que la Cumbre iba a ser emocionante con la representación de 20 organizaciones miembro de WONCA y los gobiernos de toda la región Iberoamericana. Los delegados compartieron detalles de las reformas en salud que se están produciendo y que están basadas en la medicina de familia, así como de su desarrollo en muchos países de la región. El sistema de salud de Ecuador en particular, está experimentando algunas reformas impresionantes sobre la base de fortalecer el acceso a la medicina familiar para todas las personas de ese país.

La cumbre concluyó con la presentación de "La Carta de Quito", una contundente declaración que expresa el compromiso con el desarrollo continuo de la medicina de familia en toda la región. Cabe destacar que la carta fue firmada por la Ministra de Salud Pública de Ecuador, Carina Vance, así como por la OPS y WONCA.

Felicito a nuestra Presidenta de la Región Iberoamericana de WONCA, Inez Padula, y a nuestros colegas de toda la región por el éxito de la cumbre y por su compromiso constante con el papel de la medicina de familia en el fortalecimiento de los sistemas de salud en cada uno de sus países.

Foto: La Ministra de Salud Pública de la República de Ecuador, Carina Vance, en su discurso en la quinta Cumbre Iberoamericana de Medicina Familiar en Quito.

Michael Kidd
Presidente

Foto: Residentes de medicina familiar en Ecuador, con el Presidente de WONCA, la Presidenta electa y el Consejero Delegado.

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

Fragmentos de Política con Amanda Howe -mayo 2014

La aplicación de las definiciones de la medicina de familia: lecciones de las regiones, las zonas rurales y los residentes

Como informa el Presidente, ambos tuvimos el privilegio de asistir recientemente a la conferencia WONCA de Salud Rural en Brasil y a la reunión de la Cumbre Latinoamérica (CIMF) en Ecuador. Los debates entre nosotros, la formulación de declaraciones políticas basadas en las reuniones, las experiencias y las preocupaciones de los médicos más jóvenes, se centraron con frecuencia en preguntar sobre cómo definimos nuestra disciplina y en asegurar que sus características únicas son reconocidas por los demás.
De alguna forma, me sorprende que esto parezca difícil, pues he estado argumentando sobre este aspecto durante toda mi carrera y WONCA tiene una serie de declaraciones y políticas que abordan esta cuestión: algunas están traducidas, todas son traducibles y hemos estado discutiendo las definiciones (ver el Fragmentos de Política del mes pasado)

Pero, por supuesto, es diferente aplicar algo a la vida real, como ocurre cuando nuestros estudiantes se encuentran con que su conocimiento de los problemas respiratorios se deben aplicar ¡a un paciente no diagnosticado y que no puede respirar!

Algunas de las preguntas que se hicieron fueron:
• ¿Quién es especialista en medicina de familia?

Hubo ejemplos de personas que están siendo llamados "médicos de familia" dentro de algunos países y que no habían tenido formación en la especialidad o eran vistos sin suficiente formación en dicha especialidad como para merecer ese nombre. Un estudio presentado en Quito a partir de los países miembros de Latinoamérica mostró que, en la actualidad, casi la mitad no tiene una acreditación reconocida de su formación como Médico de Familia.

• ¿Qué se necesita para la práctica de la Medicina de Familia?

Ha habido un debate prolongado sobre las habilidades adicionales que se necesitan para la práctica clínica rural, remota, segura y eficaz: mirando hacia el otro lado del mundo, la amplitud de la práctica clínica varía enormemente. Algunos médicos de familia trabajan en maternidad, algunos en trauma o en urgencias quirúrgicas o médicas, otros desarrollan otros roles extensivos (trabajan con el abuso de sustancias o en los servicios de cuidados paliativos, por ejemplo). Esta diversidad en la práctica necesita que aclaremos qué es y qué no es un médico de familia dentro del sistema.

• ¿Por qué es importante la formación del médico de familia?

Algunos países (no sólo en América del Sur) están tratando de proporcionar acceso médico en todas las comunidades a través de:

(a) el envío de médicos jóvenes recién titulados a las zonas más insuficientemente atendidas.
(b) el uso de médicos sin titulación de postgrado para el servicio comunitario, o
(c) el uso de médicos de otros países para aumentar la capacidad médica.

Todas estas estrategias pueden tener sentido si su objetivo principal es "un médico por cada comunidad", pero a menudo, estos médicos no hacen el trabajo que un especialista en medicina familiar haría. Del mismo modo, algunos de los pasos hacia la cobertura universal se están centrando en aumentar la capacitación de los profesionales de la salud "no médicos". Este enfoque necesita de nuevo que dejemos claro lo que suma un médico de familia al sistema de salud de una forma que estos otros valiosos colegas no pueden hacerlo.

Así que, ¿cómo puedes saber si la medicina de familia se está desarrollando en la práctica clínica o está siendo diseñada como un nuevo servicio?

Aquí hay algunos criterios que puedes utilizar para analizar el grado en el que un modelo en particular está (o no está), llegando a un estándar mínimo en el que la medicina de familia esté presente. Estos criterios derivan en líneas generales de la Guía de WONCA (La contribución de la medicina de familia en la mejora de los sistemas de salud).

• ¿Cuál es la formación de los médicos?

¿Tienen una cualificación como médicos de familia, y si es así, ¿qué implica? (duración de la formación, fuente de la acreditación, etc.).

• ¿Cuál es el alcance de la práctica de los médicos?

¿Se centran en la resolución de problemas y su diagnóstico, o solo en aliviar los síntomas? ¿Están viendo pacientes de forma reactiva, o muestran los registros muestran que hay una cierta continuidad? ¿Pueden el médico o la historia clínica propiciar el seguimiento y hacer que el "sistema" lleve a la gente de nuevo a un médico en particular la mayor parte de las veces?

• ¿Ven a pacientes de todas las edades y con cualquier problema de salud, o por el contrario, su casuística es más estrecha?

En este último caso, ¿por cuánto tiempo han estado viendo a este grupo más limitado de pacientes? Y, ¿tienen algún otro trabajo clínico donde hacen el papel de médico de familia “completo”?

• ¿Su práctica rutinaria es vista objetivamente centrada en la persona? ¿Se relacionan con los pacientes como individuos, o la relación se basa en técnicas determinadas o actividades orientadas hacia las enfermedades?

• ¿Su práctica clínica ofrece un servicio de gestión de las enfermedades no transmisibles, con el seguimiento planificado para las revisiones de, por ejemplo, diabéticos, hipertensos, etc.? Y, ¿ofrecen pruebas de detección y trabajo preventivo (revisiones de salud para las mujeres, para el desarrollo del niño, vacunación, etc.) como PARTE de la rutina de su servicio?

• Si se está trabajando en el hospital, o con acceso a camas de hospital, ¿cuál es el equilibrio habitual de la carga de trabajo?

Ofrecer atención de emergencia o atención ambulatoria, así como los servicios ambulatorios integrales anteriores denota un papel adicional, pero un médico que está dedicando la mayor parte de su tiempo a cubrir las emergencias quirúrgicas, en realidad, no está trabajando como médico de familia.

• Por último, ¿son el primer punto de acceso al contacto médico para sus pacientes y los especialistas de los hospitales necesitan de esa misma referencia para poder ver a sus pacientes?

Esta es la función de 'poste indicador y guardián', tal como se utiliza por ejemplo, en el Sistema Nacional de Salud del Reino Unido, que hace que la Medicina de Familia sea coste-efectiva para el sistema.

Estas preguntas se pueden plantear con fines formativos o políticos para su discusión y debate.

Foto: Amanda Howe con algunos residentes en Gramado

En Río, vi a los residentes en una de las nuevas favelas* clínicas de servicio público, a los que se les daban sus propios pacientes que ellos iban a cuidar durante la duración de su formación allí. La clínica estaba ofreciendo un servicio totalmente integral y los médicos que supervisaban eran médicos de familia cualificados.

También supe de médicos que estaban haciendo funcionar sus propias clínicas privadas con la continuidad de la atención, pero con menos contacto constante con los pacientes, (quienes pueden acceder a los servicios hospitalarios y de diagnóstico

directo), y que estaban luchando por proporcionar una gama completa de servicios.

Conocí a médicos que estaban ofreciendo una enorme variedad de servicios en zonas rurales y remotas, habilidades que abandoné hace veinte años porque trabajaba dentro del radio de cinco kilómetros de distancia respecto a un gran hospital.

Y en otros lugares he conocido médicos de familia no cualificados que hacen funcionar sus propias clínicas junto a enfermeras y farmacéuticos, muy queridos por sus pacientes, con una buena continuidad, pero sin la oferta completa "de la preventiva a la paliativa" que definiría a un servicio de medicina de familia maduro.

Mis conclusiones:
(1) incluir, apoyar y mejorar las cualificaciones de cualquier colega y servicios que tienen algunos de estos componentes y que están destinados a los demás;
(2) utilizar estudios de casos para mostrar a los colegas del hospital y a los políticos cómo la medicina de familia ofrece diferencias respecto a otros modelos.
(3) mantener el enfoque en la creación y el mantenimiento de los médicos de familia dentro de todos los sistemas de salud.

Tuve una interesante conversación con un funcionario ministerial, donde hubo un "momento de iluminación" al escuchar este la forma en que ponemos a funcionar todos los servicios de prevención primaria y secundaria de las Enfermedades No Transmisibles de medicina de familia en el Reino Unido, pues no habían entendido que este trabajo podría realizarse fuera del hospital, a nivel comunitario, integrado con otro tipo de atención clínica, y, potencialmente, a un coste menor. "Así que, ¿por eso debemos tener especialistas en medicina de familia?". "Bueno, sí, además de por algunas otras razones."

Amanda Howe

*(chabolas / viviendas pobres)

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

Lista de comprobación rápida de Amanda:

¿Cómo se puede saber si la medicina de familia se practica en una clínica o se está diseñando un nuevo servicio?

• ¿Cuál es la formación de los médicos?

• ¿Hay alguna continuidad?

• ¿Cuál es el alcance de la práctica clínica de los médicos?

¿Se ve a pacientes de todas las edades y con cualquier problema de salud?

• ¿La práctica clínica ofrece un servicio de gestión de las enfermedades no transmisibles, de pruebas y de trabajo preventivo?

• Objetivamente, ¿la práctica habitual se percibe como centrada en la persona? ¿Es integral?

• Si se está trabajando en el hospital, o con acceso a camas de hospital, ¿cuál es el equilibrio habitual de la carga de trabajo?

• Por último, ¿se es el primer punto de acceso al contacto médico para el paciente?

¿Los especialistas de los hospitales necesitan de esa misma referencia para poder ver a sus pacientes?

Fragmentos de Política con Amanda Howe - abril 2014

Atención primaria (de salud): ¿cuál es la importancia de un nombre?

Cada mes, la presidenta electa de WONCA, Prof. Amanda Howe, escribe una columna sobre fragmentos de política en WONCA News. Este mes presenta el siguiente texto, resultado de un esfuerzo conjunto con Monica Burns y Luisa Pettigrew.

Existe un amplio apoyo internacional para el establecimiento de una cobertura universal de salud, con frecuentes referencias a la función esencial de la atención primaria de salud y con el fin de lograr este objetivo. Sin embargo, ¿qué significa realmente la atención primaria de salud? ¿Es lo mismo que la atención primaria? ¿Dónde encaja la medicina de familia? La respuesta no es sencilla, ya que la evidencia sugiere que estos términos pueden significar diferentes cosas para diferentes personas y que los términos se usan a menudo indistintamente.

La Declaración de Alma Ata de 1978, identificaba originalmente cinco principios básicos de la "atención primaria de salud", que incluían: (i) la equidad en el acceso, (ii) la participación comunitaria, (iii) el uso efectivo y apropiado de la tecnología, (iv) la colaboración intersectorial y (v) la prestación de atención de salud asequible y sostenible. Sin embargo, las diferencias de interpretación sobre la declaración condujeron a “programas selectivos de atención primaria de salud”, que hoy existen en paralelo con programas "verticales", que se han traducido en una inversión limitada para el fortalecimiento del sistema de salud en favor de los programas específicos de enfermedades… ¡Apenas el alcance previsto en Alma Ata!

El Informe sobre Salud Mundial de 2008, Atención Primaria de Salud: Ahora más que nunca, volvió a revisitar el concepto, identificando: (i) la cobertura universal, (ii) el liderazgo, (iii) la política pública y (iv) las reformas de la prestación del servicio, como esenciales para ofrecer una "atención primaria de salud". El informe identifica las características distintivas de la "atención primaria" como los mecanismos para procurar este tipo de atención más equitativa, centrada en la persona, con mejores resultados de salud y el papel del "equipo de atención primaria" como el centro de coordinación, la creación de redes con la comunidad y los colaboradores externos.

En base a esto, podríamos considerar el término "atención primaria" como el apropiado para referirse a los aspectos de prestación de servicios de salud en el más amplio concepto político, social y económico de la "atención primaria de la salud". Sin embargo, a menudo, los dos términos se usan indistintamente. Recientemente, una consulta pública europea sobre la definición de "un marco de referencia en relación con la atención primaria", liderada por un grupo de expertos, usa los términos indistintamente y, al mismo tiempo que propone una definición que está en línea con gran parte de la investigación internacional anterior a la definición del concepto, también describe que la atención primaria no es un concepto estático.

La clave de este fragmentos de política es tener en cuenta que, mundialmente, los grupos de atención a los que nos referimos como "atención primaria" son a menudo muy variables y, a veces, tan limitados que sería poco probable que se proporcionase una atención accesible, basada en la comunidad, integral, de manera coordinada y continua. Esto ocurre a menudo, debido a que por una serie de razones políticas, económicas y sociales, los responsables políticos, proveedores de fondos e incluso los profesionales de la salud, han tendido a buscar soluciones para el cuidado orientadas a la atención secundaria en lugar de soluciones orientadas a la atención primaria.

Con el fin de trabajar hacia un objetivo común, el desafío urgente de cara a todas las partes interesadas, incluidos los gobiernos individuales, multilaterales, organizaciones no gubernamentales de desarrollo, así como profesionales de la salud es asegurarse de que las etiquetas utilizadas y los servicios asociados a dichas etiquetas están siendo entendidas de la misma manera, que tienen el mismo sentido para todas las partes y utilizar realmente los cinco pilares de la atención en los que se basa la atención sanitaria efectiva para la población.

Amanda Howe,
Monica Burns,
Luisa Pettigrew.

La V Cumbre Iberoamericana de Medicina Familiar y la Carta de Quito

Carta de Quito (español)

El 12 de abril, en Quito, Ecuador, la V Cumbre Iberoamericana de Medicina Familiar se ha concluida después de dos días de un trabajo intenso y productivo, incluyendo el intercambio de experiencias y actividades participativas. Aproximadamente 150 profesionales de la salud estratégicos de más de 24 países del mundo, especialmente de la región iberoamericana, participaron.

El balance fue muy positivo. Fue un importante espacio para reflexionar y proponer soluciones viables para los problemas estructurales de los Sistemas de Salud de Iberoamérica. Tuvimos la oportunidad de contar con el apoyo y la participación activa de Carina Vance, la Ministro de Salud Pública del Ecuador, así como otros trabajadores de salud del Ministerio; el alcaide y otros representantes de la Secretaría de Salud de Quito; Viceministros y / o directivos de los ministerios de salud de varios países de Iberoamérica.

La Organización Panamericana de la Salud (OPS) fue, junto con la CIMF / WONCA y el Gobierno Ecuador, co-promotora de la Cumbre. La delegación de OPS, en Quito, incluyó a representantes de Washington DC y, también, de la oficina de la OPS en América del Sur y Ecuador. Por último, pero no menos importante, tuvimos el placer de contar con la presencia de los líderes de WONCA: Michael Kidd, el actual presidente, el consejero delegado, Garth Manning y Amanda Howe, la presidenta electa.

Desde CIMF, contamos con la participación de una delegación de 16 de los 20 países que conforman la Confederación. Además de eso, otros profesionales de la salud y profesores de universidades de Ecuador, EE.UU. y Canadá, así como los miembros de las sociedades organizadas participaran con nosotros. La Cumbre se ha tratado en diferentes medios de comunicación: radio (on y off line); Face Book; la página web de la Cumbre. Estimamos que cerca de 1.000.000 personas tuvieron acceso a alguna información acerca de la Cumbre, durante el evento.

Las recomendaciones formuladas por la V Cumbre se resumen en la Carta de Quito. La Carta de Quito se acerca al tema que actualmente ocupa la agenda de la Organización Mundial de la Salud (OMS) y sus 193 países, a saber: la Cobertura Universal de Salud . Como era de esperar, la Atención Primaria y la Medicina Familiar son dos aspectos de este objetivo. Uno de las conclusiones de la Carta de Quito es que trae directrices concretas para hacer frente a este reto y presenta nuevos indicadores para medir las acciones que tienen que ser realizadas para tal efecto .

Foto: Michael Kidd, presidente de WONCA , añade su firma a la Carta de Quito.

La Carta de Quito fue el resultado del trabajo que se llevó a cabo antes y durante el evento. Durante los últimos seis meses, cinco grupos de trabajo han hecho estudios , leído textos , escrito y discutido los documentos amplios sobre los cinco temas centrales de la Cumbre : la Cobertura Universal y la Medicina de Familia (MF); Participación Social y Comunicación Social y MF ; Educación y certificación de MF ; El conocimiento y la investigación en MF . Durante el evento, estos grupos tuvieron la oportunidad de discutir en un nivel más profundo algunas cuestiones relevantes.

Me gustaría destacar que el documento señala que un indicador especial de la calidad de la CUS, es el porcentaje de médicos de familia que un país tiene que tener (el 50% de todos los médicos siendo considerando un buen nivel). Además de eso, la Carta de Quito trae la buena idea de crear un Observatorio de la Medicina de Familia que podría fomentar, orientar y dar seguimiento a la evolución de las iniciativas que se van emprendiendo.

Creo que la Cumbre y la Carta de Quito refuerzan el papel de WONCA - Iberoamericana - CIMF como entidad científica interesada en la calidad de vida y el bienestar de la población. Es un ejemplo del papel colaborativo y técnico- político que WONCA / CIMF quiere y puede desarrollar junto a los

con los gerentes y profesionales de salud y educación, así como representantes de la sociedad organizada . Ese papel podrá ayudar a promover los cambios necesarios para que se constituyan sistemas de salud más justos y equitativos.

Hoy en día, lamentablemente, vemos una gran influencia de los intereses comerciales que afectan la manera de la gente pensar acerca de lo que es salud y lo que es la enfermedad, promoviendo una idea equivocada que estimula el consumo de servicios de salud, medicamentos y pruebas. Esta forma de pensar puede traer buenos resultados a las grandes empresas y las grandes industrias, pero trae malos resultados a la gente, aumentando el riesgo de morbilidad y mortalidad, justamente por el uso abusivo e inadecuado de las tecnologías industrializadas innecesarias. Sin una buena atención primaria, con buenos médicos de familia, los sistemas de salud serán cada vez más lejos de las reales necesidades de salud de las personas, y tienen el riesgo concreto de fracaso financiero .

Por lo tanto, la V Cumbre Iberoamericana de Medicina Familiar puede ser vista como una importante contribución a los cambios necesarios que los sistemas de salud tienen que hacer con el fin de alcanzar la Cobertura Universal.

Dra Inez Padula
Presidente de WONCA Iberoamericana

WONCA CONFERENCES 2014

May 21 – 24, 2014	WONCA Asia Pacific Region Conference	Sarawak MALAYSIA	Nurturing Tomorrow's Family Doctor www.WONCA2014kuching.com.my
July 2 – 5, 2014	WONCA Europe Region Conference	Lisbon PORTUGAL	New Routes for General Practice and Family Medicine http://www.WONCAeurope2014.org/
August 16-17, 2014	WONCA South Asia Region conference	Chennai, INDIA	Hope healing and healthy nation through family medicine. www.woncasar2014.com

See WONCA website conference page for updates.

WONCA CONFERENCES 2015

February 13-14, 2015	WONCA South Asia Region conference	Dhaka, BANGLADESH	For more information on these conferences as it comes to hand go to the WONCA website conference page:
February 18-21, 2015	WONCA Africa region conference	Accra, GHANA	
March 5-8, 2015	WONCA Asia Pacific Region Conference	Taipei, TAIWAN	
April 15-18, 2015	WONCA World Rural Health conference	Dubrovnik, CROATIA	
October 22-25, 2015	WONCA Europe Region conference	Istanbul, TURKEY	

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May 08-11 2014	EGPRN Spring meeting	Barcelona, Spain
May 22-24 2014	Uruguayan Congress of Family Medicine	Punta del Este, Uruguay
June 09-20 2014	Toronto International Program in Strengthening Family Medicine & Primary Care	Toronto, Canada
June 12-14 2014	XXXIV Congreso de la semFYC	Gran Canaria, Spain
June 21-22 2014	Fiji College of General Practitioners conference	Sigatoka, Fiji
June 28-28 2014	Kenya Association of Family Physicians Annual Meeting	Nairobi, Kenya
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