

# WONCA News

An International Forum for Family Doctors



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**World Organization of Family Doctors**  
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## From the President: Strong family practice & universal health coverage in the Middle East

On World Family Doctor Day this year, 19 May 2014, the Regional Director for the World Health Organization (WHO) Eastern Mediterranean Region, Dr Ala Alwan, released a media statement underscoring the importance of family medicine in the delivery of quality primary health care, and accelerating progress towards universal health coverage, in the nations of the WHO Eastern Mediterranean Region.

The Eastern Mediterranean Region covers 22 nations from Morocco to Somalia in Northern Africa, and from Lebanon to Pakistan in the Middle East and South Asia. It is a region that includes countries with great wealth, countries with great poverty and inequity, and countries affected by serious civil conflict.

*Photo: Al-Watayyah health center in Muscat with Dr Najlaa Jaafar, seen here with Dr Ahmed Al-Wehaibi, a family physician working for the Ministry of Health in Oman*



In his statement, Dr Alwan advised that improving access to quality health care services is one of the key priorities for health system strengthening in his region and that the WHO is committed to “expanding the provision of integrated people-centered health services that address the major burden of ill-health and are based in primary health care.” Family practice is seen as “a cost-effective model that ensures delivery of comprehensive, continuous and coordinated health care services for all members of the family.”

I was invited recently by the World Health Organization to assist the Oman Ministry of Health in a review of the rollout of that nation’s national primary health care strategy.

The achievements of Oman over the past forty years in reforming the nation’s health care system, and tackling the major health care challenges facing its population of four million

people, have been a remarkable success. So much so, that in 2010 the United Nations Development Programme ranked Oman as the most improved nation in the world in terms of development during the preceding 40 years.

This has been the result of strong policy-led development with a focus on health promotion and disease prevention, on the training of a workforce of skilled family doctors, community nurses and other health care professionals, and on the construction of community health centers across the country to meet local primary health care needs.

These primary health care developments have been successful in improving child and maternal health, tackling infectious and chronic diseases and increasing life expectancy. Primary care has become the gatekeeper in Oman to other health services thereby containing health care expenditure. The system of primary health care in Oman has resulted in a health system with fewer health inequalities and better health outcomes including lower morbidity and mortality rates.

*Photo: Public health campaign in Oman aimed at preventing the spread of Middle East Respiratory Syndrome-coronavirus (MERS)*



The new national primary health care strategy provides the opportunity to further strengthen the health system in Oman to meet current and future community needs. It enables Oman to continue to develop high quality, safe, evidence-based primary care services and ensure these services are person-centred and integrated across the health system. It continues the training of a skilled workforce of caring, competent, compassionate and trustworthy health care professionals who are accessible and well supported in their important roles. And it ensures the safety and quality of primary care services to the people of Oman through the provision of excellent practices and

infrastructure that meet current and future community needs. It also continues the existing strong focus on health promotion, disease prevention, screening and early intervention, and the management of non-communicable diseases and comorbidities.

In Oman, as in many countries, one of the biggest challenges is the shortage of trained family doctors and the fact that existing training programs need more support to meet the need for family doctors to support the population's needs of primary care. The WONCA member organization in Oman, the Oman Family and Community Medicine Society, is working with the national government on strengthening the training of family doctors.

*Photo: Public health campaign in Oman on the health risks of smoking a*



*shisha ("hubbly bubbly"), which can be the equivalent of smoking up to 200 cigarettes*

Dr Alwan and his colleagues in the WHO have recognized that new strategies and approaches are needed to address the gaps in primary care provision in the nations of the Eastern Mediterranean Region, and that each nation needs clear policies and strategies, based on evidence and community engagement, to ensure strong family practice in each nation.

In November, WONCA representatives will be meeting with the WHO and representatives of the 22 nations of the region in Cairo to assist in examining ways to strengthen service provision through a family practice approach, with the goal of achieving universal health coverage, access to health care for all people, in all nations of the region.

Michael Kidd  
WONCA President

## From the CEO's desk: Member Organizations information



Hello again from Bangkok – though at the time that this newsletter is sent out I shall be in Rio de Janeiro, along with Drs Bohumil Seifert and Dan Ostergaard, taking part in a Conference Planning Committee

meeting for the Rio 2016 conference. More on that in next month's newsletter.

It has been a fairly quiet month, but there are a few items that I'd like to report on.

### Membership declaration

We have recently written to all Member Organizations (MO) asking for their annual declaration of membership numbers. Each MO pays a per capita levy to WONCA on each full member in its organization, and this is WONCA's main income for the year ahead. The per capita levy has not risen since 2007 – remaining at \$1.72 for all of that time. However at World Council in Prague last year

we drew attention to the fact that a number of MOs had been under-reporting their numbers, mainly because of some confusion about the requirements.

Council voted to keep the per capita levy unchanged, but with the proviso that MOs gave a more accurate and up to date report on their numbers. I'm pleased to say that MOs responded very positively, and WONCA's income from MOs rose by about 10% last year. Many MOs continue to grow, and so income will hopefully continue to rise year on year. MO votes at the WONCA World council are proportional to the number of members declared, so it pays to make sure your MO numbers are accurate. Some MOs were surprised in Prague to find their votes are not as many as they expected - because their declared member numbers were out of date.

We ask that all MOs make sure that their 2015 declaration is completed and signed off by their CEO, President or Chair, and returned to the Secretariat by 28th November.

### Member Organization survey

Back in 2009, WONCA commissioned a company, MCI, to carry out a survey of member organizations, to get MO feedback on WONCA as an organization and to help to prioritise activities. We thought that it was time to repeat this exercise, and so we will soon be sending out a further short survey to all MOs. We do ask organizations to complete this survey, which can be done on line, as the information it will provide to Executive is extremely important in helping us to listen to our members and to respond to their needs. If at all possible we ask that each MO's WONCA Council representative complete the survey, as he or she is likely to have best knowledge of WONCA as an organisation.

### Annual report

Finally for this month, we are just finishing WONCA's first Annual Report, covering the period from July 2013 to June 2014, and hope to distribute it during November. The report has been produced to keep our Member

Organizations, Organizations in Collaborative Relationship, Direct Members, and other interested organisations and individuals informed of the progress of WONCA between World Council meetings. The report will outline highlights in the work of your elected executive members, our CEO and secretariat staff, and our working parties, special interest groups and representatives, over the past year. It will also include our most recent annual financial statement and auditor's report.

Inevitably this short report can only provide a snapshot of the huge amount of work that is carried out by WONCA and our members around the world, but more news and details can always be found via the WONCA website – [www.globalfamilydoctor.com](http://www.globalfamilydoctor.com).

With best wishes until next month.

Dr Garth Manning  
CEO

## Policy Bite with Amanda Howe Involving patients in family medicine – towards a WONCA policy position

At the end of October, Dr Luisa Pettigrew represented WONCA at a meeting at W.H.O. in Geneva which aims to help develop thinking around modern good practice in patient and public involvement (PPI) in health care. The workshop considered issues such as:

- “Meaningful and effective engagement – What does it look like? And how do we measure it?”
- “The roles, responsibilities and expectations of public involvement for patients, family, health-care providers and policy-makers”
- “Creating supportive environment for meaningful and effective engagement – What can we do to make the engagement easier and better?”
- “Initiating and sustaining engagement – different ways for different contexts”.

Colleagues may want to have a working definition of PPI – one popular one says: “PPI is the process of engaging with the needs and expectations of patients and putting the public and members at the heart of decision making, to ensure that the services and care

provided are outcome driven and patient centred.

Specifically it is concerned with exchanging information, mutual listening, and accepting that people should be allowed to influence their own care and the services they receive. This can work during an individual's clinical care; by consulting on and evaluating current services; and by involving the public in new plans and developments for their community.i”



Family doctors are natural advocates for patient involvement – since we are close to our patients and their communities, and we can see the need to empower people to help themselves where possible, the idea that extra effort may be needed to ensure patients have a voice in their own care may seem strange to us. However, research on this issue has found that organizations which give good care to individuals do not necessarily ask patients as a group for their views and feedback on

services. While we often know that an individual patient seems satisfied with their care, it is only when we seek systematic input from patients who are confident enough to tell us if there are problems that we start to get a full picture of what we could do better. Feedback on our services is now a routine part of family medicine in many countries, including the U.K; although taking feedback does not routinely result in change - that needs health care providers to want to respond and care about patients' views, and to have the resources to make the changes needed.

There is also evidence that PPI can improve research and education<sup>iii</sup> – recent work found that key factors include academic staff having an inclusive approach; getting funding for patients' travel and time to come to meetings; providing named links and training to help members of the public understand what their contribution can be; and being committed to support them playing such roles<sup>iv</sup>.

Finally there are complex issues around different types of PPI – engaging with homeless and vulnerable populations may need quite different approaches to enabling a member of the public to contribute effectively to an ethics committee or a governance board. And models of community engagement and development are usually at a different level from personal facilitation or engagement – a population's voice rather than those of

individuals with a focus on factors that can improve the health and wellbeing of local people.

The debate in WONCA about patient and public involvement has not been a very loud one so far – hopefully this policy bite and feedback from the W.H.O. meeting will begin more discussions about how committed we are as FM practitioners to this agenda in its different forms. Amanda Howe and Luisa have also recently met with representatives from IAPO ('International alliance of Patients' Organizations', see [www.iapo.org.uk](http://www.iapo.org.uk)) to begin to map areas of potential common ground. Looking forward to it!

[Read more of Amanda Howe's Policy Bites](#)

## References

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## FEATURE STORIES

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### Michael Kidd honoured by his peers

WONCA President, Professor Michael Kidd was today honoured by his Australian peers. He received the Rose-Hunt Award - the highest accolade awarded by the [Royal Australian College of General Practitioners \(RACGP\)](#).

#### The Rose-Hunt Award

The Rose-Hunt Award is awarded to the RACGP Fellow or Member, who has rendered outstanding service in the promotion of the objects of the RACGP, either by individual patient care, organisation, education, research or any other means.

Prof Kidd received his award for service to the profession and leadership within the profession - examples given were his current

position as President of WONCA and his past position as President of the RACGP. Prof Kidd also serves on the boards of a number of NGOs and Advisory Boards; is the Executive Dean of the Faculty of Health Sciences at Flinders University, based in Adelaide; and he has continued to work part-time as a general practitioner with a special interest in the primary care management of HIV/AIDS. To see a longer list of Prof Michael Kidd's substantial achievements [click here](#).

The Rose-Hunt Award is a gift from the Royal College of General Practitioners (UK) to the RACGP. On 5 October 1972, the British College presented twelve silver medals to the Australian College (RACGP) commemorating two of its own founding members, Lord Hunt of Fawley (the first Honorary secretary) and Dr Fraser Rose. The first Rose-Hunt Award was

made in October 1974 to Dr William Arnold Conolly, a founding father of the RACGP.

*WONCA Executive congratulates its president on receiving this prestigious award - well deserved Michael.*

## Michael Kidd delivers William Arnold Conolly Oration

Prof Michael Kidd also delivered the oration (pictured) at the Academic Session of the RACGP conference. The oration is named after William Arnold Conolly, the first recipient of the Rose-Hunt Award. The oration was considered one of the most outstanding of recent times and was well received by those present. An excerpt of the oration where Prof Kidd discusses WONCA follows.

*You might think that WONCA is a funny name for a global health organization, and you would be right. It started out as the first five letters of our official name, the World Organization of National Colleges and Academies of Family Medicine and General Practice, now shortened to the World Organization of Family Doctors. But the thing about a funny name is that everybody remembers it. In the clamour of confusing acronyms of global health organisations, our global organization's name is highly recognizable, highly memorable and highly respected.*

*Our strongest global supporter is the Director-General of the World Health Organization, Dr Margaret Chan, who recently stood up at an international meeting of the Hong Kong Academy of Medicine and proclaimed "I love family medicine", which didn't impress the members of the other medical specialties present in the room.*

*WONCA was formed by 18 colleges and academies from around the world. WONCA now has Member Organisations representing over 500,000 family doctors in 131 countries around the world.*

*The 500,000 family doctors represented by WONCA, and including all those of us here, each year have over 2 billion consultations with our patients. Two billion. That's the scope of our current work and our influence.*

*But we need to do more. We need to work to ensure that every family doctor, every GP, every primary care doctor in the world, joins us in our commitment to education and training and to the delivery of high quality primary care to our patients and communities. Through WONCA we need to continue to support primary care research to provide the evidence on the best ways to deliver health care to the people of our nations.*

*And we need to ensure that high quality primary care is made available to all people in the world. At the moment there are one billion people who have no access to any healthcare at all. Access to healthcare for yourself and your family is a human rights issue, and yet it is denied to 1/7th of the world's population. In 2014 this is inexcusable.*

*So through WONCA we need to expand our commitment to the education and training of family doctors and the provision of quality care to the 80 nations of the world where WONCA does not yet have a presence, which includes many low income nations and lower middle income nations, including some of our nearest neighbours.*



To read the full oration transcript [click here](#)



## WONCA WHO liaison

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### WONCA's written contribution to World Health Organization's hearing on ending childhood obesity

*WONCA was invited to a meeting at WHO Headquarters on October 14 for a discussion on childhood obesity. Dr Luisa Pettigrew, WONCA WHO liaison person prepared this statement which was endorsed by WONCA Executive.*

The World Organization of Family Doctors (WONCA) is grateful for the opportunity to submit a written contribution to the World Health Organization's hearing with nongovernmental organizations on the Commission on Ending Childhood Obesity which will take place on 14th October 2014. WONCA hopes to be able to contribute further to future consultations and ongoing work in this area.

WONCA represents around half a million family doctors in over 130 countries and territories across the world. The mission of WONCA is to improve the quality of life of people through fostering high standards of care in family medicine/general practice.

Primary care is a key mechanism through which to achieve universal health coverage and reduce the global burden of non-communicable diseases, including childhood obesity. Primary care at its best delivers high quality, community based, comprehensive, continuous, coordinated care to people of all ages. This holistic approach to care means that primary care is ideally placed to contribute to the goal of ending childhood obesity through the ongoing care of children, from the antenatal period through to adulthood, and importantly of their carers and of the community in which they live. Family doctors with the support of multi-disciplinary primary care teams should therefore play a fundamental role in identifying, treating and helping prevent childhood obesity globally [1-5].

While the evidence is clear that family doctors and family practice teams can play an important role in contributing towards national efforts to reduce childhood obesity, in some countries there may be country-specific and community-specific barriers to an effective

response. Documented barriers can include; inadequate training (undergraduate, postgraduate and continuous professional development) with regards to the early identification of risk factors, diagnosis and interventions [2-4, 6-14]; lack of clarity and inconsistency of relevant guidelines and definitions [15, 16]; inadequate access to allied healthcare professionals in the community e.g. nutritionists, psychologists [12, 16]; limited primary care based research regarding which interventions work best in primary care to prevent and treat childhood obesity, notably from low and middle income countries [8, 16-21]; relative underfunding of primary care in order to provide sufficient resources and incentives for primary care professionals to deliver the required services [12, 16]. In addition poor integration of care between primary care, secondary care, schools and social services is likely to undermine the effectiveness of primary care based interventions.

It should also be emphasised that although primary care can play a valuable role in advising families about the risks of childhood obesity and effective ways to avoid or treat this problem, the main causes lie outside their control. Suitable actions must be taken at a public health and governmental level to reduce advertising and consumption of foods and drinks that are rich in sugar and fat, and to encourage exercise during childhood.

Success would be measured by a reduction in prevalence of childhood obesity and associated morbidity. In order to ensure accountability policymakers, funders of primary care, primary care professionals and patients should explore the role of indicators and other methods to assess and feedback on the quality of care delivered in primary care aimed at tackling childhood obesity.

[References available online](#)

## The Science & Practice of People-Centred Health Systems - report from the 3rd Global Symposium on Health Systems Research



by Luisa Pettigrew -  
WONCA WHO Liaison  
person

The [Third Global Symposium on Health Systems Research](#) took place in Cape Town during the first week of

October. The event was hosted by the [Health Systems Global](#) and co-sponsored by the World Health Organization (WHO), [Alliance for Health Policy and Systems Research](#) as well as various national and international health related institutions. The symposium aims to bring people together to work towards delivering more evidence-based policy making in health, with a focus principally on low and middle income countries.

The theme of this year's event was the Science and Practice of People-Centred Health Systems. Close to 2000 participants from across the globe took part. These included policy-makers, activists, community representatives, managers, researchers and educators. Many were from universities, non-governmental organisations, ministries of health and in particular from the WHO and World Bank.

Satellite sessions with key relevance to primary care included a workshop on the World Bank's and Bill and Melinda Gates Foundation's new Primary Health Care Performance Initiative; a project aiming to understand, as they described, 'the black box' of primary care processes through the development of universal indicators (*see photo - World Bank's and Bill & Melinda Gates Foundation's Primary Health Care Performance Initiative satellite session*).



Stakeholder consultation also took place during the symposium's satellite sessions on the first draft of eight thematic working groups' papers which will inform the upcoming Global Strategy on Human Resources for Health. [Online public consultation](#) on this continues until 24th November 2014, therefore please take a look and respond as an individual or on behalf of your family medicine organisation. This document is likely to be highly relevant for primary care and family medicine worldwide over the coming years.

Plenary discussions during the symposium raised challenging questions such as: What facets of people-centred health systems strengthen accountability for improved quality of care? What role do health professionals play in promoting people-centred health systems? What are the challenges in initiating, doing, disseminating and funding health systems research for people-centred health systems? Presentations and workshops covered subjects including: How to engage individuals, families, communities and service providers in health-sector decision making; Health worker motivation; Strategies for improving the quality of primary care; Research methods in complex health systems; Health systems financing and how to achieve universal health coverage.

So what does a 'People-Centred' health system look like? On the ground it seemed complex, many participants were not quite sure and views were not always consistent. Was it a reframing of the declaration of Alma Ata, or a reiteration of the 2008 World Health Report on Primary Health Care? To some degree it seems it is. Therefore could this result in another case of policy aiming to strengthen primary health care lost in translation for many? Hopefully not.

The upcoming WHO strategy on [Person-Centred Integrated Health Services](#) presents five strategic directions which include concrete examples of what 'people-centred integrated' health services should look like. This includes a much greater role for civil society and local communities in shaping health systems and health services. Amongst other areas it also includes strengthening the gatekeeping role of primary care and improving the prestige of family doctors (*see photo - WHO's Person-*

*Centred Integrated Health Services strategy session, 'Strategic Direction 3').*

Yet, although during the symposium there was some recognition of the challenges many countries face to train and retain high quality family doctors, discussions on human resources focused largely on scaling up the role of community health workers and 'mid-level' workers (midwives, nurses and health workers somewhere between these and a doctor). It could be argued rightly so as mid-level workers play a vital role in the delivery of primary care and the capacity of many countries worldwide to invest in a workforce of family doctors is still limited. However there are many good examples where countries have and continue to successfully invest in family medicine [1]. Moreover the evidence of a strategy focusing solely on mid-level workers, in particular without proper supervision or training, to delivery to high quality comprehensive deliver primary is poor [2]. In the long run aiming for a family doctor, for every multidisciplinary primary care team, for every person in the world seems the most likely way to achieve the delivery of equitable, high quality, comprehensive, coordinated, continuous people-centred primary care. Unfortunately discussions on how to achieve this long-term goal seemed faint at the symposium.

So how can family doctors help contribute towards the Science and Practice of People-Centred Health Systems? Family medicine by its very nature aims to deliver patient and person centred care [3]. Delivering people-centred primary care involves also taking a population based approach with a focus on prevention, multi-sectorial collaboration and vitally on active community participation. Many family doctors and their multidisciplinary primary care teams already do this. However notably there were few family doctors at the symposium. A number of factors, not least clinical commitments, are likely to have contributed to this. However it is also a reflection of the limited opportunities that exist for family doctors globally to formally develop expertise in research and policy-making in order to participate in these.



The closing [Cape Town statement from the Third Global Symposium on Health Systems Research](#) highlighted the need to continue to strengthen efforts to nurture the future generations of the health systems community. In order to strengthen primary care to support integrated and people-centred health systems, this must include investment in a future generation of family doctors from across the world that can bridge and help shape the three, often disparate, worlds of front-line service delivery, academia and policymaking.

**To respond to the online public consultation on the post 2015 Global Strategy on Human Resources for Health, before 24th November 2014 click [here](#).**

[Webcasts](#) and [reports](#) from the symposium are available online.

Special Editions of [Health Policy and Planning: The Science and Practice of People-Centred Health Systems](#) and [PLOS One: Monitoring Universal Health Coverage](#) are freely available through online open access.

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## Interested in an internship at the World Health Organization?

The World Health Organization (WHO) recruits twice a year for interns. Being a WHO intern is a great opportunity for medical students and family doctors in training to develop academic and policymaking skills, as well as to understand how the WHO works. For (Northern Hemisphere) Summer of 2015 the intake will run from December 1st 2014 to January 31st 2015. Details on the programme from the WHO website are as follows:

### What does an Internship offer?

The WHO Internship Programme offers a wide range of opportunities to gain insight in the technical and administrative programmes of WHO. The duration of WHO internships is between six to 12 weeks. Exceptionally, internships may be extended up to a maximum of 24 weeks depending on the needs of the WHO technical unit and your availability. WHO internships are not paid and all costs of travel and accommodation are the responsibility of the intern candidate.

### Who is the WHO looking for?

- You are at least twenty years of age on the date of application.
- You are enrolled in a course of study at a university or equivalent institution leading to a

formal qualification (graduate or postgraduate) (applicants who apply for an internship within six months of completion of their formal qualification may also qualify for consideration).

- You have completed three years of full-time studies at a university or equivalent institution prior to commencing the assignment.
- You possess a first degree in a public health, medical or social field related to the technical work of WHO or a degree in a management-related or administrative field.
- You are fluent in the working language of the office of assignment.

### How can you apply?

- You are invited to complete an application for internship through the WHO. This questionnaire includes providing details about your education and experience. You will be able to indicate the area of work within WHO that you are hoping to intern.
- You will be asked to write about your motivation for applying for a WHO Internship.
- You will find additional information on WHO's Internship Programme and how to apply throughout the website [here](#), additional queries can be addressed to here [interns@who.int](mailto:interns@who.int)

## Region news

### WONCA EMR meeting with Kuwait Society of Family Practice



(left to right), Lt Dr Huda Alduwaisan (Kuwait Academy), Dr Nabil Kurashi, Immediate past WONCA EMR past president, Dr Mohammed Tarawneh, WONCA EMR president, Dr Khaled Alabdallah, Kuwait SFP Vice chairman, Dr Mohammed Alotaibi, Chairman of KSFP, Dr Anwar Alnajjar, member of KSFP

WONCA EMR president Dr Mohammed Tarawneh was invited to visit Kuwait to participate in the MRCGP International as a quality assurance observer. While in Kuwait, WONCA leaders, Dr Mohammed Tarawneh, WONCA East Mediterranean region president and Prof Nabil Kurashi, Immediate past

WONCA East Mediterranean region president, had an official meeting with the Kuwait Society of Family Practice (KSFP) section of the Kuwait Medical Association (KMA).

The leaders of the Kuwait Society of Family Practice who attended the meeting were: Dr Huda Alduwaisan (Kuwait Academy which is a WONCA member Academic Organization), Dr Mohammed Alotaibi, KSFP chairman; Dr Khaled Alabdallah, KSFP vice chairman; Dr Anwar Alnajjar, member.

WONCA leaders discussed with the Kuwait colleagues how they can join WONCA and what documents they need to prepare, and we are pleased to report that they will link soon with WONCA secretariat,

Mohammed Tarawneh  
WONCA EMR President

## Working Parties and Special Interest

### Rural round-up: the proofing is in the practice

*This month Rural round-up comes from the USA. David Schmitz, MD FAAFP, is Chief Rural Officer and Program Director of Rural Training Tracks, Family Medicine Residency of Idaho. Dave is also this month's featured family doctor. Find out more about Dave and his work in Idaho elsewhere in this newsletter.*



The phrase "The proof is in the pudding" became increasingly popular in the United States during the 1950s while its origins can be traced abroad and to as early the 14th century. Here in the US family physicians find themselves in times of unprecedented political, technological and social change in the midst of healthcare reform.

Recent posts of the WONCA Working Party on Rural Practice discussion forum have considered the amount of time or "exposure" which results in students' determination to be located in rural practice following completion of training. Perhaps we too need to ask a similar question regarding our own ability to be effective leaders and have the desired impact in shaping policy, education and these young learners' careers.

Practicing for six years in a very rural area of Northern Idaho, I developed the passion for and an understanding of both the joys and the challenges of providing care to my patients and my community. As I write to you today I am in our nation's capitol of Washington DC at the annual meeting of the American Academy of Family Physicians (AAFP) working to craft policy which will benefit my patients back home.

Serving as the Chief Rural Officer and Program Director of Rural Training Tracks for the Family Medicine Residency of Idaho is a stretch from my rural roots of practice. Bridging the gaps between education, policy and practice is a challenge I must work hard to address. Recently, 34 US Senators signed a letter to the administrator of the Centers for Medicare and Medicaid Services (CMS), asking her to provide comprehensive details about the CMS rulemaking process and how rural health care concerns are addressed.

As the founding chair of the new Member Interest Group for Rural Health at AAFP, we will have our first meeting tomorrow ( October 23) to hear directly from rural practicing family physicians. Our leadership team must have the exposure and the connection to rural practice allowing those of us in education, research and advocacy to better "Rural Proof" the policies of our future. We must stay vigilant in our focus on rural patients and the physicians who care for them. As for the impact of good policy and its improvement of rural health and rural practice, the proof is in the pudding.

**JOIN the WONCA Working Party on Rural Practice discussion forum**  
email [WPrural@wonca.net](mailto:WPrural@wonca.net)

**FIND out more about the [WONCA Working Party on Rural Practice](#)**

**Follow the WWPRP @ruralwonca on Twitter and Google+**



### Kuching sparks interest in men's health

*In this article, Alan White, Professor of Men's Health, Leeds Beckett University writes on Men's Health resources and a workshop held in Kuching:*

At the recent WONCA Asia Pacific region conference in Kuching, there was a lot of interest in the presentation on Men's Health

that had been organized in collaboration with the International Society for Men's Health (ISMH). Family physicians tend to see men when they are ill, whereas they have a much more on-going relationship with women – covering prevention, screening, mother and child care alongside disease management. Recent reports on men's health are suggesting that perhaps we need to recognize that there is a cost to men's relative invisibility.

Lower life expectancy in men is a widely known and accepted fact, but with most of these premature deaths occurring within the working age male population there is a significant knock on effect to the family, employment and the wider society. Higher treatment costs of the mostly avoidable heavy impact diseases that affect men are revealed in the data that shows how much more likely they are to end up as an in-patient than women.

What is surprising is the breadth of the health challenges that seem to affect men to a greater extent, at an early age, than seen in women. Cardiovascular disease, those cancers that are not sex specific, respiratory disease and digestive disorders amongst others all compete with men's higher death rates from accidents and other external causes to raise their rates of premature death above those of women.

With the increasingly aged population we are also entering into a new era of male health problems that have not previously been seen. The health challenges of the very old are dominated by, but not limited to, the diseases of the prostate. With growing awareness of the significance of erectile dysfunction as an early marker of cardiovascular disease and the uncertainty of the significance of low testosterone warranting greater debate within the profession on how we manage the older man.

How men manage (or not) their mental and emotional health is also an area of growing concern – with higher rates of suicide in men seen as a global failure for both men and health professionals to recognize the warning signs and manage male distress effectively. Many a family have also suffered at the hands of a man who has failed to deal with a deteriorating mental and emotional state.

A feature of most countries is that in those sections of society where there is the greatest degree of socio-economic deprivation or social change it is the men that have the biggest drop in their life expectancy. Suggesting that when the going gets tough the women suffer, but the men are more likely to die.

This is not to say that men are a lost cause! There is growing evidence that men do care

about their health, but that services have not been configured in a way that allows them to access them or they have been too associated with the care of women and children or the elderly. One example of this is finding ways of managing males who are overweight in a world where nearly all services, both commercial and within the health sector are geared towards a female audience. When the services become male focused men not only are willing to attend, but they lose weight and are more likely to sustain that loss. Many countries are now also finding that men will engage in health care that has a direct impact on the health of women, such as testing for Chlamydia, and HPV vaccination in boys.

Next year sees the completion of a major new report on men's health and infertility ([www.icud-mhi.org](http://www.icud-mhi.org)), this may act as a stimulus for all family doctors to rethink their practice in relation to men.

## Resources

There are some good resources that can be a useful guide for practitioners wanting to know more about men's health:

The International Society for Men's Health [Foundation for Men's Health](#) [Journal of Men's Health](#) [Trends in Urology and Men's Health](#) (A very accessible journal aimed at the needs of the GP).

The next [World Congress on Men's Health](#) is in New Delhi, India 9th-11th October

There are a number of national and international reports on men's health that offer a detailed picture of the issues men face with their health including:

- [The State of Men's Health in Europe](#)
- [The Asian Men's Health report](#)
- [The Health of Australia's Males](#)

**WONCA would like to establish a Special Interest Group on Men's Health. If you are interested please contact the WONCA CEO, Dr Garth Manning [ceo@wonca.net](mailto:ceo@wonca.net).**

## Member Organization news

### RCGP publishes "Being a doctor: understanding medical practice"

*Being a doctor: understanding medical practice*

The Royal College of General Practitioners has just published *Being a doctor: understanding medical practice*, a book which explores the role of the modern doctor beyond the clinical knowledge – a 'must-have' teaching and learning resource for any medical professional, wherever you work.

Being a doctor is much more than simply providing medical care. This book aims to increase the resilience and wellness of doctors, helping the profession to provide better care for patients, through a deep and thoughtful approach to clinical work. It explores areas that can challenge clinicians in all stages of their career:

- the doctor–patient relationship

- adverse outcomes
- the 'heartsink' experience
- functional illness.

*'It will seek to help doctors at every career stage bridge the gap between the personal and the impersonal. In elegant easy-to-read prose they [the authors] lead us on a comprehensive journey through general practice's landmark concepts, explaining and illustrating as they go. Disease, they remind us, can be understood through the methods of science; but to understand the felt experience of illness calls in addition for narrative competence and emotional intelligence on the part of the doctor.'*

From Roger Neighbour's Foreword

Read a free sample chapter, reviews and more [here](#).

### Chinese Medical Association meeting hears of WONCA standards

Dr Donald Li, WONCA Executive member-at-large was recently invited to speak on the WONCA educational standards for accreditation at the Annual General Meeting and conference of the Society of General Practice of the Chinese Medical Association (SOGP CMA), the member organization of WONCA of China.

His plenary was titled : "[WONCA Global Standards for Postgraduate Family Medicine Education](#)". He elaborated on the standards we used in the accreditation of the Shanghai Family Medicine training program so that others around the nation knew more about what WONCA was looking for when assessing family medicine training programs. He also commented on the emerging high standards of family medicine training around the nation and encouraged those established centers to undergo WONCA accreditation so that trainees will feel encouraged and recognized that their standards were up to International level and take pride in being a family doctor.

Chen Zhu, a vice-chairman of the Standing Committee of the National People's Congress and immediate past Minister of Health made a keynote address at the conference. He is also the President of the Chinese Medical

Association and he made an excellent statement that "the top hospitals in China do not deserve the highest 3 A grading if they did not have department of family medicine". This was received with loud applause. This is a most important and encouraging remark from a state leader.

Dr Li also met with Prof Zeng Yik San new chair of the SOGP CMA who takes over from Prof Zhu of Shanghai.



*In the photo, Dr Donald Li (second from left) lunches with senior medical leaders in the People's Republic of China. To the left of Donald Li is Chen Zhu; to the right of Donald Li is Prof Zeng Yi Xin newly elected President of the Society of General Practice of the Chinese Medical Association. He is also the head of the Peking Union Medical School. Joining them is Prof Qi Guoming, Vice President of the Chinese Medical Association*

## Biennial elections of the College of Family Medicine Pakistan



*photo of the general body meeting that formally endorsed the elections*

The Biennial elections of the College of Family Medicine Pakistan 2014-2016, took place on 21st August 2014 and were endorsed by the General Body of College of Family Medicine Pakistan as per the constitution on 6th Sept. 2014. Those elected were:

Chairman: Dr Muzaffar Ali Uqaili  
 Vice Chairman: Dr Mohammad Amin Kharadi  
 Secretary General: Dr Shehla Naseem  
 Joint Secretary: Dr Abdul Ghafoor Shoro  
 Treasurer: Dr Altaf Hussain Khatri

The Elected Executive Body Members include:

1. Dr Waris Qidwai
2. Dr Ali Salman
3. Dr Lt Col. Rtd. Rashid Iqbal Khan
4. Dr Ahmed Bhimani
5. Dr. Allah bux Memon
6. Dr. Diniar Kapadia
7. Dr Abdul Hafeez Qureshi
8. Dr Faheemuddin
9. Dr Najam F.Mehmmudi
10. Dr Naseer A. Baloch
11. Dr Usman Ghani
12. Dr Asadullah
13. Dr Khalil Mukadam

For more details please check our new website

Dr Shehla Naseem  
 Secretary General, College of Family Medicine Pakistan.



## Featured Doctors

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### David SCHMITZ MD - USA : rural family doctor

*David Schmitz MD is a rural family physician from Idaho in the USA. He is the author of WONCA News [Rural round-up for November 2014](#).*



#### **What work do you do now?**

The road to rural health seems to be as unique as our rural communities themselves. For me, I am still striving to derive access to quality healthcare in rural areas as the meaning for my daily work.

After graduating family medicine residency, I practiced for six years in St Maries, Idaho, USA; a town with 2302 persons and no traffic light. In this mountainous state our communities are often isolated and ensuring access to emergency care services, mental health, obstetrical care and primary care and prevention are all encompassed in the role of family physicians – but each community is unique.

I returned to the Family Medicine Residency of Idaho, in Boise, as a rural faculty member, in 2005. From curricular development focused on preparing family physicians for competent and confident careers in rural practice, to outreach and policy development, I have continued to have opportunities to grow. I am now the Program Director for two Rural Training Tracks which meld a year of training in the urban hospitals, with the second and third years taking place in rural communities. These “RTT programs” are an exception to the typical accreditation rules and have outstanding graduation rates placing physicians into rural and underserved practices.

I also help to advise a federally funded project with the National Rural Health Association supporting RTTs across the United States. In my role as director, I see patients, precept and mentor residents, take medicine call and deliver babies – I get to be a family doctor.

I am also an active researcher. I have found that research allows us to form a foundation of evidence that, when combined with a story,

provides what we need to have a convincing conversation about improving access to quality healthcare in rural areas. By reaching out and cooperating with other rural communities and providers we stay connected to what the key issues are in education and patient care. These environments and relationships are often changing due to everything from economics to use of technology. Working with partners such as our State Office of Rural Health, we have published in the areas of [Rural Family Physicians Scope of Practice](#), [Rural Physician Satisfaction and Grit](#), and Rural Community Recruitment of Family Physicians, the “[Community Apgar Program](#)”.

#### **What other interesting activities that you have been involved in?**

I have found that we can learn much from each other through cooperation in advocacy and in making a difference reaching out for rural health. The American Academy of Family Physicians (AAFP) recently allowed for the first time, formation of Member Interest Groups. I was able to found our group on Rural Health at AAFP, and many members have begun to interact on various topics from practice issues to workforce shortages.

I am also on the board of the National Rural Health Association, as the Clinical Services Chair. Connecting these organizations in policy and advocacy is a powerful tool to affect regulation and necessary steps in improving rural health and workforce in the United States. I have served in additional leadership roles within the AAFP, as president of our state medical association and with our state rural health association.

Becoming a part of WONCA and the Working Party for Rural Practice has been a fantastic opportunity for us. I have felt the kinship of my peer family physicians and while I am relatively new, I have been encouraged to share my experiences and my effort in our aligned mission of better health for rural patients worldwide.

#### **What are your interests as a family physician and also outside work?**

These activities keep our family very busy and in fact, my wife Shannon has joined the cause for rural health in several ways as well. Shannon is the Executive Director of the Idaho Rural Health Association and is also involved with our volunteer outreach activities to rural communities including patient education, drug use prevention and suicide prevention. Our family also enjoys camping and the outdoors. My individual interests include flying kites, trying to understand physics, philosophy and a historical approach to differential theology.

### What is it like to be a rural family doctor in USA?

The United States is undergoing varying degrees of transition in healthcare delivery and at a very real level, healthcare access. Some states but not all have chosen to participate in an expansion of healthcare insurance to the economically disadvantaged (Medicaid). Public health and mental health are clearly seen as areas of need, but it is unclear how this will be organized and

administered going forward. The role of the family physician is also changing to the leading of Patient Centered Medical Homes, while some family physicians are more often providing a set of services exclusively in hospitals, or emergency room settings.

There is a great deal of variety in the context of a great deal of change. Technologies such as telemedicine and the electronic medical record are still varied and their use can be seen as both innovative and disruptive to the usual way of practice. Some family physicians are employed by large systems of healthcare facilities and others have joined a new increased interest in providing direct primary care to enrolled patients separate from any outside system at all.

For rural health, we can each find our unique road to making a contribution. Mine has been as a provider, educator, researcher and advocate – and it's a great job.

## 2015 conference notices

*Deadlines for WONCA 2015 conferences are approaching fast ... Have you ever thought of attending a WONCA conference? Maybe you have been to many? Make new friends while you enhance your skills and increase your knowledge. Most conferences have preconference meetings for young family doctors.*

*Early bird registration deadlines for Taipei (Taiwan) and Accra (Ghana) are within the next couple of weeks. Don't forget the ultra early bird registration for our [2016 world conference](#) being held in Rio, in Brazil is November 3, 2014 (yes next month).*

**A special news item has been created showing all the latest information. Items included are listed below. To see full details on any item listed here [click here](http://www.globalfamilydoctor.com/Conferences/2015conferences.aspx)**  
<http://www.globalfamilydoctor.com/Conferences/2015conferences.aspx>

### Early bird and Abstract deadlines

Capitalise on Early Bird registration to get the best deal when attending WONCA conferences. Submit your abstract for posters and presentations by the deadline.

[More](#)

### Conference Updates

- Family physician is a member of the family in WONCA South Asia - Dhaka, Bangladesh: February 12-14, 2015.
- Akwaaba. Welcome to Ghana, Africa : February 18-21, 2015.
- New Horizons and Challenges in Asia-Pacific Region - Taipei, Taiwan : March 4-8, 2015
- Calidad y Equidad en el Cuidado a la Salud en Montevideo, Uruguay : 18 a 21 de Marzo 2015 [Mas](#)
- Breaking down barriers, bringing people together in Dubrovnik, Croatia : April 15-18, 2015.
- 2nd WONCA East Mediterranean conference in Dubai, UAE : April 30-May 2, 2015.
- Being young and staying young in Istanbul, Turkey : October 22-25, 2015.

### Scholarships Grants etc

- Montegut Global Scholarship Program 2015
- Family Medicine Research Award - Call for Applications
- Grants for young GPs to attend Istanbul

## 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 <a href="#">WONCA website conference page</a> :
February 18-21, 2015	WONCA Africa region conference	Accra, GHANA	
February 21-22	Vasco da Gama Movement forum 2015	Dublin IRELAND	
March 5-8, 2015	WONCA Asia Pacific Region Conference	Taipei, TAIWAN	
April 15-18, 2015	WONCA World Rural Health conference	Dubrovnik, CROATIA	
April 30 – May 2, 2015	WONCA East Mediterranean Region conference	Dubai, UAE	
October 22-25, 2015	WONCA Europe Region conference	Istanbul, TURKEY	

## WONCA CONFERENCES 2016

June 15-18, 2016	WONCA Europe Region conference	Copenhagen, DENMARK	<a href="http://www.woncaeurope2016.com">www.woncaeurope2016.com</a>
November 2-6, 2016	WONCA WORLD CONFERENCE	Rio de Janeiro, BRAZIL	<a href="http://www.wonca2016.com">www.wonca2016.com</a> <b>ULTRA EARLY BIRD Registration ends November 3 2014</b>

## Early bird registration closing soon

CLOSING NOVEMBER 3: WONCA WORLD CONFERENCE Rio de Janeiro, Brazil. November 2-6, 2016

CLOSING DECEMBER 31: Dhaka, BANGLADESH conference February 13-14

WONCA Direct Members enjoy *lower* conference registration fees.

To join WONCA go to:

<http://www.globalfamilydoctor.com/AboutWONCA/Membership1.aspx>

Membership for  
Individuals and  
Organizations



## WONCA ENDORSED EVENTS

For more information on WONCA endorsed events go to

<http://www.globalfamilydoctor.com/Conferences/WONCAEndorsedEvents.aspx>

April

28-30

2015

**Mental Health for All**

Lille, France

## MEMBER ORGANIZATION EVENTS

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For more information on Member Organization events go to  
<http://www.globalfamilydoctor.com/Conferences/MemberOrganizationEvents.aspx>

- |                            |  |
|----------------------------|--|
| 13 Nov<br>- 15 Nov<br>2014 | <b>Family Medicine Forum / Forum en médecine familiale</b>  |
|                            | Québec, Canada   |
| 19 Nov<br>- 23 Nov<br>2014 | <b>The Network: Towards Unity for Health conference</b>     |
|                            | Fortaleza, Brazil  |
| 06 Mar<br>- 08 Mar<br>2015 | <b>RCGP Global Health Conference</b>                          |
|                            | London, United Kingdom   |
| 25 Apr<br>- 29 Apr<br>2015 | <b>STFM Annual Spring Conference</b>                          |
|                            | Orlando, Florida, USA  |
| 07 May<br>- 10 May<br>2015 | <b>EGPRN Spring meeting</b>                                 |
|                            | Timisoara, Romania   |
| 29 May<br>- 30 May<br>2015 | <b>IPCRG scientific meeting</b>                             |
|                            | Singapore  |
| 13 Jun<br>- 14 Jun<br>2015 | <b>6th conference of Japan Primary Care Association</b>   |
|                            | Tsukuba, Japan   |
| 16 Jun<br>- 18 Jun<br>2015 | <b>19th Nordic Congress of General Practice</b>           |
|                            | Gothenburg, Sweden   |
| 31 Jul<br>- 02 Aug<br>2015 | <b>RNZCGP conference for general practice</b>             |
|                            | Hamilton, New Zealand  |
| 01 Oct<br>- 03 Oct<br>2015 | <b>RCGP annual primary care conference</b>                 |
|                            | Glasgow, United Kingdom  |

## Del Presidente : Medicina familiar fuerte y cobertura universal de salud en Oriente Medio

El Día Mundial del Médico de Familia de este año, que se celebró el 19 de mayo de 2014, el Director Regional de la Organización Mundial de la Salud (OMS) de la Región del Mediterráneo Oriental, el Dr. Ala Alwan, dio a conocer un comunicado de prensa que subraya la importancia de la medicina familiar en la prestación de una atención primaria de la salud de calidad y de acelerar en el avance hacia la cobertura universal de salud en los países de la Región del Mediterráneo Oriental de la OMS.

La Región del Mediterráneo Oriental abarca 22 países, desde Marruecos a Somalia, en África del Norte, y desde el Líbano a Pakistán en Oriente Medio y Asia del Sur. Es una región que incluye países con grandes riquezas, países con una gran pobreza y desigualdad y países afectados por conflictos civiles graves.



*foto: Centro de salud Al-Watayyah en Muscat, con la Dra. Najlaa Jaafar, aquí con el Dr. Ahmed Al-Wehaibi, un médico de familia que trabaja para el Ministerio de Salud en Omán.*

En su declaración, el Dr. Alwan aconsejó que mejorar el acceso a servicios de salud de calidad es una de las prioridades clave para el fortalecimiento del sistema de salud en su región y que la OMS se ha comprometido a "la ampliación de la prestación de servicios de salud centrados en las personas, integrados, que aborden las principales cargas de

problemas de salud y se basen en la atención primaria". La medicina de familia se ve como "un modelo económico que garantiza la prestación de servicios de salud integrales, continuos y coordinados para todos los miembros de la familia".

Fui invitado recientemente por la Organización Mundial de la Salud para ayudar al Ministerio de Sanidad de Omán en una revisión de la implantación de la estrategia de atención primaria de ese país.

Los logros de Omán en los últimos cuarenta años en la reforma del sistema de salud del país y el afrontamiento de los grandes desafíos de atención que recibe su población de cuatro millones de personas han sido un éxito notable. Tanto es así, que en 2010 el Programa de las Naciones Unidas para el Desarrollo clasificó Omán como la nación que más ha mejorado en el mundo en términos de desarrollo durante los 40 años precedentes.

Este ha sido el resultado de un importante progreso basado en las políticas con un enfoque de promoción de salud y prevención de enfermedades, en la formación de una fuerza de trabajo de médicos de familia, enfermeros/as cualificados en la comunidad y otros profesionales del cuidado de la salud, y en la construcción de centros de salud comunitarios en todo el país para satisfacer las necesidades de atención primaria locales.

Estos desarrollos en la atención primaria han tenido éxito en la mejora de la salud infantil y materna, en la lucha contra las enfermedades infecciosas y crónicas y en el aumento de la esperanza de vida. La atención primaria se ha convertido en puerta de entrada en Omán a otros servicios de salud, conteniendo de este modo el gasto sanitario. El sistema de atención primaria en Omán ha dado lugar a un sistema con menos desigualdades en salud y mejores resultados, incluyendo las tasas de morbilidad y mortalidad más bajas.

La nueva estrategia nacional de atención primaria ofrece la oportunidad de fortalecer aún más el sistema de salud de Omán para satisfacer las necesidades actuales y futuras de la comunidad y permite continuar el desarrollo de alta calidad, seguros y servicios de atención primaria basada en la evidencia, garantizando estos servicios centrados en la persona e integrados en todo el sistema de salud.



*foto: Campaña de salud pública en Omán destinada a prevenir la propagación del Síndrome Respiratorio-coronavirus (MERS) en Oriente Medio.*

Esta estrategia continúa con la capacitación de una fuerza de trabajo de profesionales de la salud formados, que cuide, que sea competente, compasiva y fiable, que sea accesible y con un buen apoyo en sus tareas importantes. Y garantiza la seguridad y la calidad de los servicios de atención primaria a la población de Omán, a través de la provisión de excelentes consultas e infraestructuras que satisfagan las necesidades actuales y futuras de la comunidad. También continúa el potente enfoque existente sobre promoción de salud, prevención de enfermedades, detección e intervención temprana y el manejo de enfermedades no transmisibles y comorbilidades.

En Omán, como en muchos otros países, uno de los mayores retos es la escasez de médicos de familia formados y el hecho de

que los programas de formación existentes necesiten más apoyo para cumplir con la necesidad de los médicos de familia para responder a las necesidades de la población en atención primaria. La organización miembro de WONCA en Omán, la Sociedad de Medicina de Familia y Comunitaria de Omán, está trabajando con el gobierno local en el fortalecimiento de la formación de los médicos de familia.

*foto: Campaña de salud pública en Omán sobre los riesgos para la salud de fumar una "shisha" (pipa de agua), que puede ser el equivalente a fumar hasta 200 cigarrillos.*



El Dr. Alwan y sus colegas de la OMS han reconocido que se necesitan nuevas estrategias y enfoques para abordar las deficiencias en la prestación de atención primaria en los países de la región del Mediterráneo Oriental y que cada país necesita políticas y estrategias claras, basadas en la evidencia y la participación de la comunidad, para asegurar una práctica de la medicina de familia firme en cada país.

En noviembre, los representantes de WONCA se reunirán con la OMS y con los representantes de las 22 naciones de la región de El Cairo para examinar formas de fortalecer la prestación de servicios a través de un enfoque de medicina familiar, con el objetivo de lograr la cobertura universal de salud y el acceso a la atención sanitaria para todas las personas en todos los países de esa región.

Michael Kidd  
Presidente WONCA

## Fragmentos de política: La participación de los pacientes en medicina de familia: hacia una posición política de WONCA

**Fragmentos de política de Noviembre de 2014, por Amanda Howe**



A finales de octubre, la Dr. Luisa Pettigrew representó a WONCA en una reunión de la OMS en Ginebra, que tenía como objetivo ayudar a desarrollar el pensamiento en torno a la moderna buena práctica hacia el paciente y la

participación de la población (PdP)) en el cuidado de la salud. Los temas tratados en el taller fueron:

- "El compromiso significativo y eficaz: ¿Qué aspecto tiene? Y, ¿cómo lo medimos?"
- "Las funciones, responsabilidades y expectativas de la participación pública de los pacientes, familiares, proveedores de atención de salud y responsables políticos".
- "Creación de un ambiente de apoyo para la participación significativa y efectiva: ¿Qué

podemos hacer para que la participación sea más fácil y mejor?".

• "Poner en marcha y sostener el compromiso: diferentes maneras para diferentes contextos". (1)

Nuestros colegas pueden querer tener una definición de trabajo de PdP. Una de las más populares dice:

"La participación de la población es el proceso de comprometerse con las necesidades y expectativas de los pacientes, poniendo a las personas y a la ciudadanía en el centro de la toma de decisiones, para garantizar que los servicios y la atención proporcionada sean dirigidos a resultados y centrados en el paciente. Específicamente, se refiere al intercambio de información, la escucha mutua y a la aceptación de que la gente debería poder influir en su propio cuidado y en los servicios que recibe. Esto puede funcionar durante la atención clínica a un individuo, a través de la consulta y la realización de una evaluación de los servicios actuales, y a través de la participación de la población en los nuevos planes y desarrollos para su comunidad."

Los médicos de familia somos los defensores naturales de la participación de los pacientes, ya que estamos cerca de nuestros pacientes y de sus comunidades, y podemos ver la necesidad de empoderar a la gente para ayudarse a sí mismos cuando sea posible. Esta idea de esfuerzo extra puede ser necesaria para asegurar que los pacientes tengan voz en su propio cuidado, aunque pueda resultarnos extraña. Sin embargo, la investigación sobre este tema ha puesto de manifiesto que las organizaciones que dan una buena atención a las personas no preguntan necesariamente a los pacientes como grupo por sus opiniones y comentarios acerca de los servicios. Mientras que, a menudo, sabemos que un paciente individual parece satisfecho con su atención, es solo cuando buscamos de forma sistemática información en los pacientes que tienen la suficiente confianza como para decirnos si hay problemas, cuando empezamos a tener una imagen completa de lo que podríamos hacer mejor. (2) Los comentarios sobre nuestros servicios son ahora una parte rutinaria de la medicina de familia en muchos países, incluyendo el Reino Unido, aunque tener retroalimentación no se traduce habitualmente en un cambio, pues se necesitan profesionales de la salud que deseen responder, que se preocupen por las

opiniones de los pacientes y que tengan los recursos para poder hacer los cambios necesarios.

También hay evidencia de que la PdP puede mejorar la investigación y la educación. (3) Un trabajo reciente evidenció que los factores clave son que el personal académico tenga un enfoque inclusivo, conseguir fondos para los viajes de los pacientes, así como tiempo para que puedan asistir a las reuniones. También proporcionar referentes con nombres propios y entrenamiento para ayudar a la población a entender cuál puede ser su contribución, además de estar comprometido a apoyarles en el desarrollo de estos roles. (4)

Por último, hay cuestiones complejas en torno a diferentes tipos de PdP. Por ejemplo, la colaboración con las poblaciones indigentes y vulnerables puede necesitar de diferentes enfoques para capacitar a un ciudadano/a a contribuir eficazmente en un comité de ética o en una junta de gobierno. Y los modelos de participación y desarrollo comunitario están generalmente en un nivel diferente de asesoramiento o compromiso: es la voz de una población, en lugar de la del individuo con la visión de los factores que pueden mejorar la salud y el bienestar de la población local.

El debate en WONCA acerca del paciente y la participación de la población no ha sido muy relevante hasta ahora. Espero que este fragmento de política y la información de la reunión de la OMS consigan iniciar más debates acerca de cómo estamos de comprometidos como médicos de familia en este punto de la agenda sanitaria en sus diferentes formas.

Amanda Howe y Luisa Pettigrew también se reunieron recientemente con representantes de IAPO ('Alianza Internacional de Organizaciones de Pacientes', ver [www.iapo.org.uk](http://www.iapo.org.uk)), para comenzar a cartografiar posibles áreas de trabajo en común. ¡Y esperando poder trabajar en ellas!

#### [1. Parliament publications](#)

2 Howe, A. Can the patient be on our team? An operational approach to patient involvement in interprofessional approaches to safe care. *Journal of Interprofessional Care*. 2006; 20(5): 527-534.

3 Howe, A. Patient-centred medicine through student-centred teaching— a student perspective on the key impacts of community-based learning in undergraduate medical education. *Medical Education* 2001; 35:666-672.

4 Mathie E, Wilson P, Poland F, McNeilly E, Howe A, Staniszewska S et al. Consumer involvement in health research: a UK scoping and survey. *International Journal of Consumer Studies* 2014;38(10): 35–44.

## Fragmentos de política: ¿Qué entendemos por "atención integrada" y cómo podemos comprobar su integración?

"Integración" se ha convertido en la palabra de moda en la agenda política de la Salud: la OMS(i), la Fundación King(ii), y el Nuffield Trust(iii) tienen todos ellos grandes programas de trabajo sobre este tema y en el Reino Unido los manifiestos preelectorales de los partidos políticos están inundados de la necesidad de la atención "integrada". Pero hay muchas definiciones de modelo que se están debatiendo, y estas tienden a depender de la naturaleza del sistema de salud y el nivel de integración previsto. Por ejemplo, el RCGP del Reino Unido ha utilizado la definición de "integración horizontal" como "centrada en el paciente, liderada por la atención primaria, a cargo de los equipos multiprofesionales, donde cada profesión conserva su autonomía profesional, pero funciona a través de fronteras profesionales y de organización para ofrecer los mejores resultados de salud posibles"(iv), pero el modelo de EE.UU. de organización de atención integrada se define como "una organización formal o virtual integrada verticalmente desde la primaria hasta los niveles de servicio de agudos, a menudo sirviendo a una población definida". Las diferencias pueden ser profundas, con una medicina de familia que trabaja para un proveedor hospitalario, en lugar de a través de una comunidad, pero lo más importante es si la integración de la atención se enfoca a los pacientes. Nuestra organización miembro del Reino Unido, el Royal College of General Practitioners, ha publicado recientemente 'Cinco pruebas de integración' en un manifiesto con el que dirigirse a todos los partidos políticos(v). Estas pruebas nos ayudan a saber si la integración está orientada hacia la atención primaria y dicen que:

"Los modelos propuestos para la atención integral deben:

- (i). Asegurarse de que los servicios situados en la comunidad son dirigidos por médicos de esa comunidad con una perspectiva centrada en la persona.
- (ii). Sustentar una atención segura del paciente, asegurando que [los médicos de familia] pueden seguir actuando como defensores independientes de sus pacientes, con énfasis en la persona, no en la institución.

- (iii). Evitar el exceso de medicalización y la perpetuación de los tratamientos clínicos que dependen excesivamente de la perspectiva de los especialistas en patologías específicas.

Los modelos propuestos para la atención integral no deben:

- (iv). Producir una importante reorganización estructural de arriba hacia abajo, lo que llevaría a la creación de nuevas estructuras burocráticas y apartar millones de libras de la atención al paciente.

- (v). Conducir a la desviación de la financiación del NHS para tapar la brecha de la atención social. (Esto se refiere a la atención residencial de personas mayores dependientes y es la preocupación de que la financiación de servicios de salud se pierda)."

Esto puede parecer muy abstracto y a muy alto nivel cuando estás viendo al paciente número 40 en una consulta desbordada y cuando la energía eléctrica acaba de irse. Pero cada día, los líderes de la medicina de familia se ven obligados a discutir la prestación de servicios en su localidad de su región o país y están tratando de marcar una diferencia en las decisiones tomadas por los políticos, quienes serán más conscientes de los grandes modelos corporativos que de los orientados a la comunidad. Un servicio que aporta un buen cuidado cercano e integral en casa, y donde las diferentes partes del equipo de apoyo clínico y social se coordinen para sacar lo mejor de su tiempo en contacto con los pacientes, será a la vez coste-eficiente y popular. Un paciente que tiene que hacer varias visitas a diferentes consultas y hospitales diferentes (costosas en tiempo y dinero) para cada uno de los distintos fragmentos de su cuerpo y la mente, no asistirá o llegará agotado y confundido en el proceso, como lo harán sus amigos y familiares. Así que cuando encuentres a alguien en tu red que esté hablando de la "atención integral", haced las pruebas, y hablad hasta la integración horizontal, que tendrás las políticas de la OMS y de la WONCA apoyándote!

Referencias (vi)

i [WHO](#)

ii <http://www.kingsfund.org.uk/topics/integrated-care>

iii [Nuffield trust](#)

iv [RCGP media files 1](#)

v [RCGP media files 2](#)

vi todas descargadas el 27/9/14.

## Más de 2.500 especialistas en Medicina Familiar y Comunitaria asistieron a la XXXIV Reunión Anual semFYC



foto: SemFYC Junta Directiva

Se llevaron a cabo 80 actividades científicas, incluyendo algunas conferencias internacionales como la celebrada por el Movimiento Vasco Da Gama (MVdG)

Más de 2.500 especialistas en Medicina Familiar y Comunitaria asistieron del 12 al 14 de junio de este año al XXXIV Congreso de la semFYC. El 35% de los asistentes a esta actividad fueron residentes y jóvenes médicos de familia y comunitaria. Durante el Congreso, se ofrecieron 80 actividades científicas (sesiones clínicas, más de 25 talleres y reuniones mantenidas con los expertos...), y se presentaron 2.000 comunicaciones, de las cuales 1.350 fueron aceptadas.

Todas estas actividades cubrían temas de interés para los especialistas en Medicina Familiar y Comunitaria, con presentaciones a cargo de expertos en cada uno de los temas, así como de miembros de los diversos grupos de trabajo y programas de la semFYC. Las consecuencias de la crisis económica en el sistema de salud y en las consultas de atención primaria, con los peligrosos efectos de la aplicación del Real Decreto 16/2012, fueron dos de las cuestiones que más aparecieron en muchas de las sesiones y actividades. Además, se presentaron estudios sobre la salud de la población española y se llevaron a cabo varias actividades con la comunidad.

### Un congreso internacional

El XXXIV Congreso de semFYC tuvo un marcado

carácter internacional por la presencia y liderazgo del Movimiento Vasco da Gama (MVdG), que celebró su propia mesa. Algunos de los asistentes eran prestigiosos ponentes, encabezados por el Presidente del MVdG, Harris Lygidakis. El editor de la revista British Medical Journal (BMJ), Tiago Villanueva, así como Luisa Pettigrew, miembro de la Junta Ejecutiva WONCA y enlace con la OMS, también estuvieron presentes y fueron dos de los oradores más destacados. Esta mesa fue moderada por Raquel Gómez Bravo, quien asistía a su última conferencia como representante de MVdG en España, ya que un mes más tarde, durante el 19º Congreso de WONCA Europa, cesó en su cargo y recibió un homenaje de sus colegas. El responsable de este ámbito es ahora Enrique Álvarez, de España.

La conferencia del MVdG trató de la innovación y la supervivencia en tiempos de crisis y se estructuró en dos partes: una revisión previa a través de conversaciones breves sobre las experiencias individuales de cada uno de los oradores en tres áreas diferentes, y un segundo grupo de trabajo sobre las preguntas que fueron apareciendo. Además, Luisa Pettigrew asistió a una reunión con La Junta Directiva de la semFYC durante esos días.

