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C O N T E N T

From The President PAGE 3

Features stories: Five stars Wonca Emro 2023 PAGE 4

celebration In The WFDD PAGE 6

Formation of the Bahraini Family Physicians Physicians PAGE 7

Featured topic in family medicine ostoprosis management PAGE 8

Insomnia PAGE 10

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FROM THE PRESIDENT

As the President of the World Organization of Family Doctors Eastern Mediterranean Region (WONCA EMR), I am writing to you today to highlight an issue of paramount importance for our field: health equity.

Health disparities continue to persist in our region, preventing many individuals and communities from accessing the high-quality healthcare they deserve. This deeply concerns us as family physicians, as our fundamental principle is to provide comprehensive, patient-centered care to all individuals, irrespective of their background or socioeconomic status.

Addressing health disparities and promoting health equity requires a coordinated effort from healthcare providers, policymakers, and various stakeholders. We, as family doctors, have a unique position to make a significant impact on this issue. Therefore, I believe it is imperative that WONCA EMR takes a leadership role in advocating strategies that promote health equity in family medicine.

To accomplish this, we must focus on several key areas:

1. Decreasing Barriers to Healthcare: We need to identify and address the barriers that prevent individuals from accessing healthcare services, such as financial constraints, limited transportation, language barriers, and cultural differences. Promoting patient navigation programs, improving interpreter services, and implementing telemedicine initiatives are just a few strategies that can help overcome these barriers.
2. Improving Access to Underserved Populations: It is essential that family doctors reach out to underserved communities, such as rural populations, refugees, and migrants. We should strive to provide equitable healthcare services in these areas, fostering healthcare delivery models that ensure continuity of care, support preventive measures, and tackle chronic diseases by strengthening primary healthcare services.
3. Culturally Sensitive Care: We have a responsibility to provide culturally competent and sensitive care to individuals from diverse backgrounds. That includes understanding patients' cultural beliefs, practices, and values to effectively meet their healthcare needs. Training programs for family physicians should focus on enhancing cultural competency and promoting diversity in the healthcare workforce.

Through the establishment of task research collaborations, and educational initiatives, WONCA EMR aims to foster a robust dialogue on health equity within our region. By sharing best practices and innovative approaches, we can collectively work towards reducing health disparities and ensuring that every individual receives equitable healthcare.

In conclusion, I invite you and your esteemed member organization to join us in our efforts to promote health equity in family medicine. Together, we can make a difference and create a healthcare system that is truly inclusive, fair, and accessible for all.

Prof.Taghreed Farahat
Wonca EMR President

Features stories: Five stars Wonca Emro 2023
Dr. Suha Hamshari : A Visionary Family Doctor

Dr. Suha Hamshari is an exceptional family doctor, educator, and advocate for Palestinian healthcare. As the head of the Palestinian Association of Family Medicine and an assistant professor at An-Najah National University, she has made significant contributions to medical education, patient care, and the advancement of family medicine in Palestine. This essay will explore Dr. Suha Hamshari's accomplishments, including her role in establishing the first family medicine clinic at An-Najah National University, her representation of the EMRO region in WONCA-OEC, and her involvement with the WONCA Women Party.

1. A Distinguished Family Doctor:
Dr. Suha Hamshari's expertise as a family doctor is widely recognized. With her extensive experience and compassionate approach, she has gained the trust and respect of her patients. Her commitment to providing comprehensive and patient-centered care has significantly impacted the health and well-being of individuals and families in Palestine.

3. Establishment of the First Family Medicine Clinic:
Dr. Suha Hamshari's visionary leadership led to the establishment of the first family medicine clinic at An-Najah National University. This clinic serves as a model for comprehensive primary healthcare, offering a range of services to patients of all ages. By integrating family medicine into the curriculum and providing hands-on training, Dr. Hamshari has contributed to the growth and recognition of this vital field in Palestine.

2. Role as an Assistant Professor:
Dr. Suha Hamshari's dedication to medical education is evident through her position as an assistant professor at An-Najah National University. She plays a crucial role in shaping the next generation of medical professionals, teaching both undergraduate and postgraduate medical students. Her knowledge, expertise, and practical experience provide students with a strong foundation in family medicine.

Featured stories WONCA EMR five star doctor 2023

4. Representation in WONCA-OEC and WONCA Women Party:
Dr. Suha Hamshari's influence extends beyond Palestine, as she represents the Eastern Mediterranean Region (EMRO) in the World Organization of Family Doctors' (WONCA) Organization of Emerging Countries (OEC). Her involvement in WONCA allows her to collaborate with international colleagues, exchange knowledge, and advocate for global improvements in family medicine.
Furthermore, Dr. Hamshari's active participation in the WONCA Women Party showcases her commitment to gender equality and women's empowerment in healthcare. By advocating for women's rights and inclusion in the medical field, she inspires future generations of female doctors to break barriers and excel in their careers.

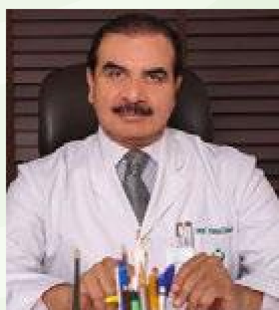
Conclusion:
Dr. Suha Hamshari's contributions as a family doctor, educator, and advocate for Palestinian healthcare are truly remarkable. Her role as the head of the Palestinian Association of Family Medicine, her establishment of the first family medicine clinic at An-Najah National University, and her representation in WONCA-OEC and the WONCA Women Party demonstrate her dedication to advancing family medicine and promoting equitable healthcare. Dr. Hamshari's passion, expertise, and leadership continue to shape the future of medical education and patient care in Palestine and beyond.

JSFM celebrates the WFDD

In the occasion of the World Family Doctor Day (WFDD) which will be on 19 May every year, Jordan Society of Family Medicine (JSFM) members celebrated this occasion by holding its annual scientific activity for one day on 29 April 2023 at Kempinski Amman Hotel, the scientific program is composed of four sessions, with 20 presentations, the theme of this event "Rejuvenating Chronic Disease Management" , more than 150 family doctor specialists and residents attended this activity, included few pictures of the scientific event, AlRazi movement also shared JSFM this event.
In addition, JSFM organized training workshop on IUD insertion and removal on May 1st for 12 family medicine specialists, and residents. this workshop includes both didactic and demonstration part on dolls. This workshop received very positive from all participants.
Dr Mohamed Tarawneh
JSFM Secretary General

Formation of the Bahraini Family Physicians Physicians

The Bahrain Medical Society has approved the activation of the Bahraini Family Physicians Association. The Board of Directors was elected as followsProf Dr Faisal Alnaser President
Dr Amal Dawood Vice President
Dr Ali Albaqara General Secretary
Dr Ali Albaqara General Secretary
Dr Hana Alfayez Board Member


Prof Faisal Alnaser

Dr Amal Dawood

Dr Ali Albqara

Dr Bashayer

Hana Alfayez

Prof Alnaser stated that a few of the most important goals of the association are to consolidate the concept of family medicine in society, improve family medicine services in the Kingdom, strengthen the status of family doctors in the community, and provide family doctors with the latest medical methods and discoveries for the better care of patients. The association will aim in organizing educational courses, conferences, and seminars on a regional and international level. Since scientific research is vital for theprogress and development of Medicine and in particular primary care and family medicine, the association will strive to engage the doctors in such activity and strengthen collaboration with scientific bodies, both regionally and internationally.

It is worth mentioning that the Kingdom of Bahrain is one of the first Arab countries to adopt the Family Medicine specialty when it was established more than 43 years ago the Family Practice Residency Program (FPRP).
It is a high-standard four years training and teaching program to prepare doctors to be qualified family physicians. It continued to graduate family doctors since 1982. These physicians had an important role in improving the health status of Bahrain and its population as well as influenced the promotion of the specialty in the Gulf and the Arab regions. The pioneering Bahraini family physicians held many presidential, educational, and training positions in the Arab Board for Health Specializations and many other national, regional, and international institutions. Moreover, they helped in establishing family medicine training programs in many different Arab countries and supervised the periodic examinations that are held to graduate family physicians in the Arab world.

Osteoporosis Management: The Crucial Role of FamilyPhysicians

Ahmed Khairi Mshari
Consultant of Family Medicine

Introduction:

Osteoporosis is a multifactorial disorder that affects bone mineral density, leading to brittle bones and increased susceptibility to fractures. It predominantly impacts the elderly population and poses a substantial burden on healthcare systems globally. Family physicians, often serving as the primary point of contact for patients, are uniquely positioned to identify, diagnose, and manage osteoporosis efficiently. This article outlines the essential aspects of osteoporosis management by family physicians, highlighting the significance of their role in promoting bone health and preventing fractures.

Recognition of Risk Factors:

Family physicians must be adept at identifying patients at risk of osteoporosis. Age, gender, history of fractures, low body weight, smoking, excessive alcohol consumption, and certain medications are well-established risk factors. Regular assessment of these factors during patient interactions can aid in early detection and proactive management.

Clinical Assessment and Diagnosis:

Accurate diagnosis of osteoporosis is paramount. Family physicians can utilize tools such as dual-energy X-ray absorptiometry (DXA) scans to assess bone mineral density. Clinical risk assessment tools like FRAX (Fracture Risk Assessment Tool) can help in predicting the 10-year probability of major osteoporotic fractures. A comprehensive medical history, physical examination, and laboratory tests are crucial to rule out secondary causes of osteoporosis.

Initiating Evidence-Based Interventions:

Upon diagnosis, family physicians play a pivotal role in initiating evidence-based interventions. Lifestyle modifications, including adequate calcium and vitamin D intake, weight-bearing exercises, smoking cessation, and moderation of alcohol consumption, are essential components of osteoporosis management. Family physicians can offer personalized guidance and monitoring to ensure adherence to these lifestyle changes.

Pharmacological Interventions:

For patients at higher risk, pharmacological interventions are often necessary. Family physicians are responsible for evaluating the patient's fracture risk and selecting appropriate medications. Bisphosphonates, selective estrogen receptor modulators, denosumab, and teriparatide are among the medications that can be considered. Family physicians must be knowledgeable about these medications' mechanisms, potential side effects, and contraindications.

Monitoring and Follow-Up:

Regular monitoring is essential to assess treatment efficacy and address any adverse effects. Family physicians should schedule follow-up appointments to assess bone mineral density changes, review medication adherence, and adjust treatment plans if needed. This ongoing involvement is crucial for optimizing long-term outcomes

Patient Education:

Educating patients about osteoporosis is a fundamental responsibility of family physicians. Patients need to understand the disease, its risk factors, and the importance of compliance with medical recommendations. Providing clear information empowers patients to actively participate in their treatment and adopt a preventive approach.

Collaboration with other Specialists:

While family physicians are central to osteoporosis management, collaboration with other specialists, such as endocrinologists and rheumatologists, can enhance patient care. Referring patients to specialists for complex cases or when specialized treatments are required ensures comprehensive and tailored management.

Conclusion:

Family physicians hold a crucial role in the holistic management of osteoporosis. By identifying risk factors, conducting accurate assessments, initiating evidence-based interventions, and fostering patient education, they contribute significantly to reducing fracture risk and improving patients' quality of life. Family physicians must maintain continuous medical education, stay updated on the latest research, and collaborate with specialists. These efforts are crucial for ensuring optimal care in the realm of osteoporosis management.

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Feature family medicine topic

Insomnia in Primary Health Care Setting

What is insomnia?

1- Prof Abdul Munem Al Dabbagh (moderator)
2- Dr Tuka Younis
3- Dr Shaiama Salah
4- Dr Luma Kareem
5- Dr Abeer Abdul Kareem

insomnia is defined by the presence of an individual's report of difficulty with sleep. For example, in survey studies, insomnia is defined by a positive response to either question, "Do you experience difficulty sleeping?" or "Do you have difficulty falling or staying asleep?".

Most people need around seven to eight hours of sleep every day. And this sleeping pattern may change by growing older

What are the causes for insomnia?

Insomnia can be caused by multiple factors for example:

1. Having stress.
2. Psychiatric problems (e.g., depression, anxiety, medications, or drinking alcohol)
3. Medical problems (e.g., cancer, chronic pain, thyrotoxicosis, Parkinson disease, and Alzheimer)
4. Other sleep disorders (e.g., restless leg syndrome, circadian rhythm sleep-wake disorders, periodic leg movement disorder, Delayed sleep–wake phase disorder, and obstructive sleep apnea.)
5. Lifestyle habits:
- **a.** Excessive caffeine intake.
- **b.** Excessive smoking.
- **c.** Frequent travelling and crossing time zones.
- **d.** Sleeping in noises places or with light turned on.
- **e.** Uncomfortably high or low temperature.

Who are the susceptible group for having insomnia?

1. Gender (Female).
2. Advancing age.
3. Lack of social connection.
4. worry-prone personality.
5. People diagnosed to have depression.
6. People diagnosed to have anxiety.
7. Chronic daily stress
8. Unemployed
9. Lower educational qualification
10. Economic inactivity
11. Familial disposition
12. Tendency to repress emotions.
13. Major life events
14. People living in high altitude.

What are the consequences of insomnia?

A daytime dysfunction can be presented as:
1. Impaired social, family, occupational or academic performance.
2. Impairment in attention, concentration, or memory.
3. Mood disturbance, irritability, impulsivity
4. Reduced motivation.
5. Fatigue, malaise.

How can we diagnose insomnia?

The diagnosis of insomnia as listed in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, revised text (DSM-5-TR). The condition has three primary symptoms that accompanied by **daytime dysfunction:**

•**Challenges falling asleep (onset insomnia):** inability to fall asleep beyond 30-20 minutes.
•**Inability to maintain sleep (middle insomnia):** frequent waking during the night after sleep onset beyond 30-20 minutes, and difficulty returning to sleep after mid-night waking.
•**Early-morning wakefulness (late insomnia):** waking at least 30 minutes before the desired time and before sleep reaches 6.5 hours (often accompanied by an inability to resume sleep at all).

Short sleeper and behaviorally induced insufficient sleep:

The three criteria must be met for a diagnosis of insomnia, if a patient reports trouble sleeping for the expected 8-7 hours but does not have daytime consequences, he/she may be a short sleeper. On the other hand, if there are insufficient hours of sleep and daytime dysfunction, but the patient is able to sleep when provided opportunity, this is likely to be behaviorally induced insufficient sleep. Function during vacations and weekends can be helpful to differentiate these.

Insomnia assessment tools:

1.Sleep diary. (The most important and frequently used tool).
2.Actigraphy. (The gold standard test in insomnia diagnosis)
3.Polysomnography. (The gold standard test in sleep disorders diagnosis).
4.Specific questionnaires (e.g., insomnia severity index).

Ask the patients to fill the sleep diary. In this diary, the patient will document the following

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
I went to bed at							
I fell asleep at							
I woke up at							
I woke up during the night (list all times)							
My sleep was restful	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
I felt tired during the day	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No

Classification of insomnia:

Short-term vs. Chronic
Short-term insomnia: is an episodic insomnia, lasts for at least 1 month but less than 3 months.
Chronic insomnia: insomnia that lasts beyond 3 months and has two additional categories: persistent (≥3 months) and recurrent (two or more episodes within a single year).

Primary vs. Secondary
Primary insomnia: occurs when insomnia isn't linked to a known cause.
Secondary insomnia: accounts for most cases of insomnia. It occurs as a side effect or symptom of other factors, such as medical, psychological, and substances like caffeine, alcohol, or tobacco.

Onset vs. Maintenance
Onset insomnia: affects the ability to fall asleep at the time you wish. It is more common in younger ages.
Maintenance insomnia: is a difficulty to maintain sleep after fallen asleep. It occurs more often in older.

Economic burden of insomnia:
• It is associated with an increased risk for numerous chronic disease outcomes, including cardiovascular disease, cancer, and metabolic dysregulation.
• Insomnia's economic consequences are attributed to indirect costs, particularly absenteeism (i.e., habitual pattern of unplanned absences from work) and presenteeism (i.e., loss of productivity when employees are not fully functioning in the workplace).

What is the treatment for insomnia?

Non-pharmacological:
1.CBT (Cognitive Behavioral Therapy): includes sleep hygiene: the importance of establishing a conducive sleep environment by keeping the bedroom dark, quiet and cool. Patients should also be reminded not to consume sleep disturbing substances, such as caffeine, nicotine, and alcohol, particularly close to bedtime. Similarly, vigorous exercise three to four hours prior to bedtime should be avoided. Additionally, a wind down routine can be helpful in readying a patient for bed. This should include discontinuation of arousing activities, including exposure to bright light (e.g., computer screen), which can negatively affect one's circadian rhythms. Similarly, at bedtime, the patients are recommended not to go to bed unless they feel sleepy. Use of the bed and bedroom is restricted to sleep and sex, which means that patients are recommended not to do other activities in bed, including read or watch television. Additionally, patients are recommended to wake up the same time each morning, seven days per week, and get out of bed within 10 to 15 minutes upon awakening.

2. Sleep restriction: one of the contributors to the development and preservation of insomnia is the tendency for patients to spend excess time in bed. this makes reasonable sense given that the patients yearn to "catch" sleep whenever they can. Unfortunately, excess time in bed results in conditioned arousal and fragmented sleep. To effectively carry out this technique, patients should provide at least one week of sleep diaries (though two weeks are preferred). The goal is to reduce a patient's time in bed to the reported total sleep time. For instance, if a patient's diary report indicated an average total sleep time of six hours but a time in bed of nine hours (bedtime 9 pm and wake time 6 am), the new sleep schedule would provide a time in bed of six hours (bedtime midnight and wake time 6 am). Importantly, patients are recommended to not go to sleep until the new prescribed bedtime and only when sleepy.

3. Relaxation and paradoxical intention: These behavioral techniques complement stimulus control and sleep restriction by providing the patient with tools for decreasing arousal prior to bedtime and in the event of nighttime awakenings. Relaxation techniques vary, but typically include diaphragmatic breathing, the tensing and relaxing of muscle groups, and possibly visual imagery. Paradoxical intention is premised on the idea that anxiety about falling asleep is inhibiting sleep onset. Using this technique, patients are asked to stay awake as long as possible, which leads to reduced anxiety and easier sleep onset.

Pharmacological:

Family of drugs used for treatment of insomnia includes:

1. Benzodiazepines
2. Melatonin Receptor Agonists
3. Selective H1 antagonists
4. Orexin receptor antagonists
5. Z drugs
6. Antipsychotics
7. Antidepressants
8. Nonselective antihistamines
9. Anticonvulsants

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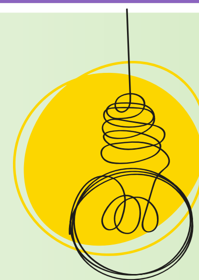

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Insomnia in Primary Health Care Setting

Together to cover the unmet needs for insomnia