Annex 4

Preparations for Barcelona Conference

EURACT Council meeting
October 19 – 21, 2000
Kusadasi, Turkey

Organisational aspects

Responsibility for Organisation

The conference would be jointly organised and hosted by EURACT and ESGP/FM. The local organisation for the meeting would be delegated to SemFYC. The more general organisation at a European level would be provided by the Secretariat of the ESGP/FM. EURACT would be responsible for the preparation of the content of the meeting.

A small organising committee will be set up with representatives from both ESGP/FM and EURACT. As far as possible this will be a virtual committee, meetings will be conducted by email correspondence and telephone conferences. Membership of the organising committee will be as follows:

Prof Jan Heyrman (chair), Prof Chris van Weel, Prof Frede Olesen, Dr Justin Allen, Dr Philip Evans,Dr.Paul Mortensen from UEMO, and Dr.Juan Mendive as local host.

EURACT will chair the organising committee, ESGP/FM will prepare minutes and reports.

Costs incurred by the organising committee will be borne by the three parent organisations - EURACT, ESGP and UEMO, in proportion to their representation.

Potential Partners

WHO // UEMO // The European Union: Healthcare development & Legislation

Sources of Funding

SemFYC have agreed to fund the EURACT delegates to both their regular meeting and the conference.

WHO is providing the meeting place in Barcelona.

WONCA World has agreed that research funding will be available for a limited number of world delegates.

It was agreed appropriate to approach the European Union to assist in the funding of the conference.

Representatives of ESGP/FM and UEMO would be funded by their respective organisations, as would any additional representatives from the three Network Organisations be funded by the individual Network Organisations.

Participants

It is intended that this will be **an expert small scale invitational conference with a maximum of 60 participants**

EURACT	30 (from 27 different countries) (or can we include some experts on this budget ??
WONCA World	6: to be negotiated further
ESGP/FM	5: as the EB of 6 includes networks, there is also room for some additional experts
UEMO	5
EGPRW	3 : to be decided by them
EQuiP	3 : to be decided by them
EUROPREV	3 : to be decided by them
WHO	3 : probably the local Barcelona representatives
European Union	3 : to be negotiated
Total	**61**

Preparation time-schedule

- **end October 2000 : after the fundamental discussion of options and planning strategy, EURACT has to prepare a conference content document, and an official invitation to ESGP/FM to co-organise the conference. Further planning of involvement of WHO, EGPRW, EQUIP, EU in a new meeting of the organising committee.**
- **end of January 2001 : the EURACT executive board has to finalise all written material for the good preparation of the conference, to be discussed on the executive board of ESGP/FM in February.**
- **Council meeting EURACT Budapest April 2001 : more intensive preparation of the « teaching agenda ».**
- **ESGP/FM meeting in Tampere June 2001 : special sessions on « preparing the core competencies, the teaching, research and CPD agenda » (to plan now already with the organizing committee, Paula Vainomaki and Gernot Lorenz)**

Barcelona Planning Group 1: What is a GP/FM?

2nd DRAFT

Discussion paper for the proposed 2001 EURACT/SEMYFC Conference

A working party of EURACT Council has been set up to consider the fundamental questions that the proposed conference should be addressing, which include:

What is a GP? What do they currently do, and what should they do?
There are many working in the discipline to a limited extent; are they to be regarded as general practitioners?
Is there a difference between a general practitioner and a specialist in family medicine?

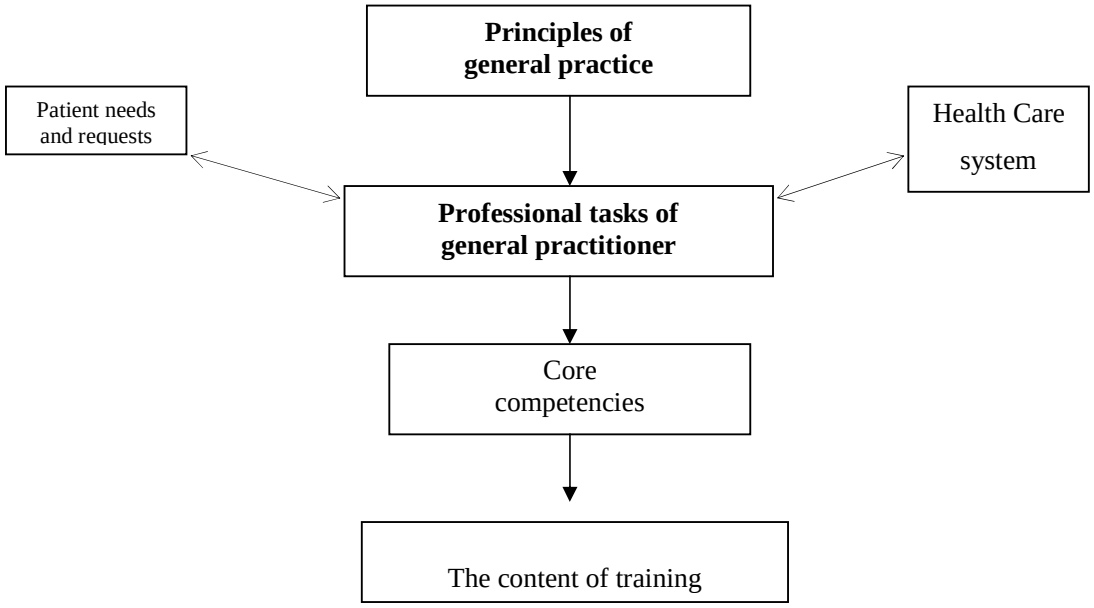
In considering any of these questions it is important to understand and agree the purpose of the conference – to produce a consensus statement on those issues which will clearly state the views of the educational and academic arm of the discipline, on the current educational needs and the requirements for future development of general practice in Europe. It is becoming clear that there are significant differences in the way that family medicine is practiced throughout Europe, and an overview of these differences, together with an authoritative statement on what family doctors should be providing in the way of services to patients, is long overdue. There is a further imperative for European Union countries, and those aspiring to join the Union. EU Directive 93/16[1] is intended to promote free movement of doctors, and, for the protection of patients, it is self-evident that family doctors should receive training that will equip them to practice in *any* member state, as their qualification entitles them to practice anywhere in the EU without further training.

There is a role definition of a general practitioner produced many years ago by the Leeuwenhorst Group[2], which has had wide acceptance. It has recently suggested that this is outdated and needs amending[3], and an alternative proposed. WONCA produced a statement on the role of the general practitioner / family physician in 1991, which included its own definition[4] and WHO Europe published its framework statement in 1998[5]. There is a great deal of common ground in all of these, and exploration of the differences will make up much of the content of the conference.

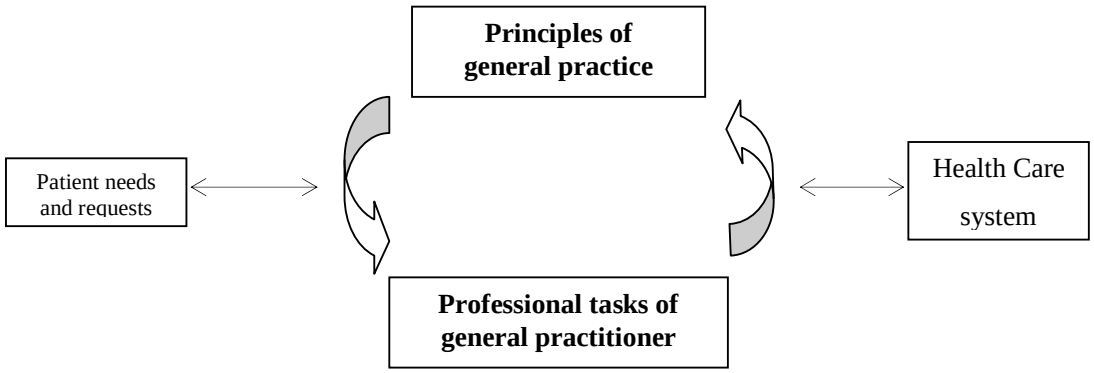
There is a lot of confusion both in language used about general practice / family medicine[6,7] and its interpretation, particularly in a European Union context. Consensus should be sought on definitions of words, in order that there can be no misinterpretations or misunderstandings. For the purposes of this paper the following terms are defined as:-

General practitioner} Family physician }	Synonyms, used to describe those doctors who have undergone postgraduate training in general practice at least to the level defined in Title 4 of the Doctors' Directive.
Primary care physician	A physician from whatever discipline working in a primary care setting.
Specialist	A physician from whatever discipline who has undergone a period of higher postgraduate training. (This term has, in the past, been applied exclusively to those working in organ/disease based disciplines)
Hospital specialist	A physician who has undergone a period of higher postgraduate training in an organ/disease based discipline, and who works predominately in that discipline.

There are different ways of approaching the task of defining the content of family medicine. The method used by the Leeuwenhorst Group, and more recently Olesen et al was to define the parameters of the discipline by describing the tasks that a family doctor carries out. Alternatively one can try to define the fundamental principles of the discipline of general practice / family medicine. These have been explored and developed by WHO Europe, and Bernard Gay took this approach in a presentation to the inaugural meeting of the European Society in Strasbourg, in 1996[8]. The two approaches are not mutually exclusive. Gay suggested that there is a linear relationship between principles and task, with some influences on the tasks from patients and the health care system:-



However when represented in this way, the plan does not represent the dynamic relationship between the underpinning principles of the discipline and the tasks that family doctors have to perform, which might be represented thus:-



The principles of the discipline as suggested by Gay were:-

- Patient centred approach
- Orientation on family and community context
- Field of activities determined by patient needs and requests
- Unselected and complex health problems
- Efficiency
- Low prevalence of serious diseases
- Diseases at early stage
- Simultaneous management of multiple complaints and pathologies
- Continuing management
- Coordinated care

and are very similar to the characteristics of family medicine described in the WHO framework statement of 1998:-

- General
- Continuous
- Comprehensive
- Co-ordinated
- Collaborative
- Family oriented
- Community oriented

The WHO statement goes on to indicate what it means by these 7 characteristics.

The heading “General” encompasses:-

- Unselected health problems of the whole population
- Does not exclude categories because of age, sex, class, race or religion, nor any category of health problem
- Easy access, unlimited by geographical, cultural, administrative or financial barriers

“Continuous” it defines as:-

- Person centred
- Longitudinal health care, over substantial periods of life, not limited to one illness episode

By “Comprehensive” it means integrated care involving:-

- Health promotion, disease prevention, curative, rehabilatitive and supportive care
- Physical, psychological and social perspectives
- Clinical, humanistic and ethical aspects of the doctor – patient relationship

“Co-ordinated” is described as, where appropriate:-

- Care managed at first contact
- Referral to specialist services
- Providing information to patients on available services
- Co-ordinate and manage care

By “Collaborative” it refers to:-

- Working in multidisciplinary teams
- Delegating care where appropriate
- Exercising leadership

“Family oriented” care it describes as addressing individual problems in the context of:-

- Family circumstances
- Social and cultural networks
- Work and home circumstances

Finally “Community oriented” suggests that family doctors should consider individual problems in the context of:-

- The health needs of the community
- Other professionals and agencies

The close interrelationship between the defining principles of the discipline and the role of the general practitioner can be seen if one examines and compares the expanded list above with the original Leeuwenhorst definition. This, of all the descriptions around, appears to have the advantage of having stood the test of time and being widely accepted.

“The general practitioner is a licensed medical graduate who gives personal, primary and continuing care to individuals, families, and a practice population, irrespective of age, sex and illness. It is the synthesis of these functions which is unique. He will attend his patients in his consulting room and in their homes and sometimes in a clinic or hospital. His aim is to make early diagnoses. He will include and integrate physical, psychological and social factors in his consideration about health and illness. This will be expressed in the care of his patients. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent or terminal illnesses. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which he can use professionally. He will practice in co-operation with other colleagues medical, and non-medical. He will know how and when to intervene through treatment, prevention and education to promote the health of his patients and their families. He will recognise that he also has a professional responsibility to the community.”

This definition covers many of the characteristics of described in the WHO framework document, but put them into the context of day to day working general practice. It is not quite so comprehensive, for example curative, rehabilatitive and supportive care are not specifically mentioned.

Olesen et al have stated that the original definition it is now very much out of date, and does not reflect the reality of family medicine in Europe today. However, it would appear that much of the dissatisfaction expressed by Olesen et al is because many of those who would regard themselves as family doctors are working in health care systems where it is not possible to comply with all of the characteristics. They argue that there is a need to up to date the definition to make it a universally applicable. Their definition reads:

"The general practitioner is a specialist trained to work in a front line of the health care system and to take the initial steps provide care for any health problem(s) that patients may have. The general practitioner takes care of individuals in a society, irrespective of the patient's type of disease or other personal and social characteristics, and organises the resources available in the health care system to the best advantage of the patients. The general practitioner engages with autonomous individuals across the fields of prevention, diagnosis, cure, care, and palliation, using and integrating the sciences of biomedicine, medical psychology, and medical sociology."

Neither of the preceding definitions encompass some of the other key features of general practice – for example that it is a people based discipline (as opposed to pathology or organ based), and that it is normality oriented (as opposed to the abnormality orientation of secondary care). These are explored by Gay, and in the statement from WONCA, which also makes the point that the prevalence of illness, and the signs at presentation are very different in primary care from those seen in hospital, where these are usually taught. There is therefore a need for a synthesis of the various statements to ensure completeness.

As well as individual statements being incomplete, there are also appear to be differences in opinion in which the statements are interpreted. Much of the concern of Olesen et al regarding the Leeuwenhorst definition appears to be in its interpretation in absolute terms. For example what do we mean by personal care? Is it care by the same doctor on every occasion? If not what are the conditions when it is acceptable for a deputy – e.g. out of working hours, or within two days? Or do we mean care for people rather than pathology – the person orientation of care described by Gay and the WHO? It would appear that the latter interpretation is correct, and in this case all commentators appear to be in agreement.

However, if we consider the interpretation of some other words within the definitions we run into significant disagreement. What is meant by continuing care? Is this care over time, and if so how long – one episode of one illness, or care over a patient lifetime? Or is it about providing healthcare 24 hours a day, 365 days a year? Here there is a range of views from the WHO description which suggests longitudinal care over substantial periods of life, not limited to one illness episode on the one hand, and the view of Olesen et al that the family doctor may have to work with one illness contact.

It is clear that there is a need for an authoritative view which define the issues in the various statements into:

1. Those essential elements of the discipline, which define it, and are generally applicable
2. Those essential elements of the discipline, which define it, but are not generally applicable, as a result of contextual differences in different countries (implicit in this statement is the fact that in places where they do not apply that this is regarded as unsatisfactory - an example might be that if dealing with all ages – ie including children, was regarded as an essential element, that this should be a policy aspiration in countries where this is not currently the case.)
3. Other elements of the discipline and its application which may legitimately differ in different contexts (an example of this might be that referral is an essential component, but that the gate-keeping function was not – there is therefore no policy decision to address any differences)

Any consensus statement must address these three issues, and be absolutely clear on them – as they will have implications on the training, quality assurance and research agendas.

There are large contextual differences at present. Jurgova in an overview of European Primary Care systems (personal communication) described three main types:

a) "Real" general practitioners providing comprehensive and continuing care to a practice population, irrespective of age, sex, or illness, with a referral system to specialists, who are not directly involved in primary care services.
b) Primary care for adults, with children and obstetrics and gynaecology being managed by community specialists.
c) Specialists working in primary care, seeing patients directly without referral, but with optional care by general practitioners.

Can all three types of system be regarded as providing a family doctor service for their citizens. The problems faced by general practitioners in each of these systems are very different. Although such systems are not easily amenable to change we should not be afraid to put forward a view of the ideal model.

What are the key questions to be answered?

The following are questions on which the conference organisers will be seeking consensus, in order to redefine family medicine for the 21st century. They are derived from the various definitions already quoted.

What is primary care? Is this healthcare limited to first contacts only?

What do we mean by personal care?

What is meant by continuing care?

What is a specialist?

Are doctors who do not deal with children, women or the elderly to be regarded as the same as those who deal with all? Do they require the same training? What about doctors who deal in only one of these areas?
(Olesen et al question the comprehensiveness of general practice in this definition – "*irrespective of age, sex and illness")*

What is it about the synthesis that is unique – is it that GPs are the only doctors to synthesise information, or is it the areas that are unique?

Does it matter where general practitioners work? Are they part of the community they serve? How important is this? What is meant by their "professional responsibility to the community"?

In these days should taking the responsibility for initial management be a negotiation with the patient? Where does the doctor's responsibility end?
Should referral to specialist medicine include the gate-keeping role, with the responsibility also of denying access?

Prolonged and repeated contacts provide opportunities for collecting information longitudinally over time. Is this a desired feature of general practice in Europe? If so, to what extent is it present in health care systems?

Who are the colleagues with whom a GP should work? What is their relationship? Is there a consensus on the make up of a primary care team?

We can probably agree easily on what is meant by treatment, but what is the precise role of the family doctor in prevention, and education?

How should we teach the epidemiology of general practice?

Where should medical education in general, and family medicine in particular, be taught?

How important is the understanding of uncertainty, and expectation of normality in our work?

Should family doctors act as care managers in relation to other health and social care providers? How well equipped are family doctors for this task?

How well are family doctors equipped to exercise leadership, and team management of other disciplines?

References

1. Council Directive 93/16/EEC to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications; Official Journal of the European Community, **165**: 7/7/93
2. The General Practitioner In Europe: A statement by the working party appointed by the European Conference on the Teaching of General Practice, Leeuwenhorst, Netherlands 1974
3. Olesen F, Dickinson J, Hjortdahl P. General Practice-time for a new definition BMJ 2000; **320**,354-357

4. The Role of the General Practitioner / Family Physician in Health Care Systems: a statement from WONCA, 1991
5. Framework for Professional and Administrative Development of General Practice / Family Medicine in Europe, WHO Europe, Copenhagen, 1998
6. Allen J, Østergaard I, What's in a name? EUJGP 1999:**5: 8-9**
7. Heath I, Evans P, The specialist of the discipline of general practice, BMJ 2000: **320; 326-327**
8. Gay Bernard, Relationship Between Concepts and Practice, Presentation to Inaugural Meeting of European Society of General Practice/Family Medicine, Strasbourg, 1995

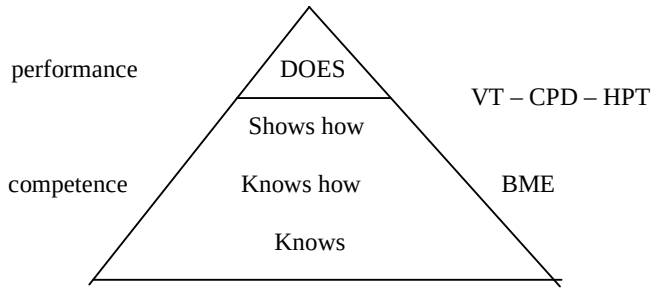
Dr J.N.B. Allen
EURACT Barcelona Working Group 1
5/11/00

Barcelona Planning Group 2: Competences of GP/FM in BME

1. *Introduction*
- general framework
- adaptation in relation to the specific conditions in each country
- GP as (extramural) clinical discipline

2. *Definition of competence versus performance*

3. *Miller*



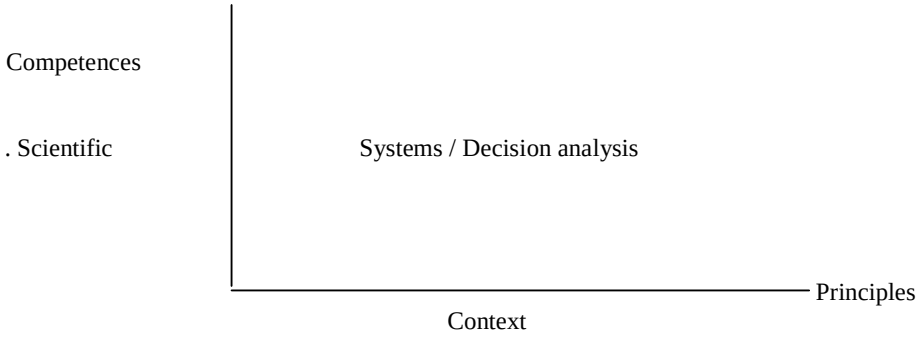
4. *Competences*

- medical aspects
- scientific aspects
- personal aspects
- aspects related to society and the health care system

5. *Principles of general practice*

- direct accessibility for all health problems in all stages
- continuous character
- central focus on person
- context

6. *Relationship of competences and principles*



7. *Consequences*

- BME* (see paper Harry)
- VT
- CME / CPD – HPT

*Example
Medical aspects
- common problems
- urgent problems
- undifferentiated problems
- chronic diseases

- disease prevention and health promotion

8. Educational methods

See: Learning pyramid
- lectures
- seminars / working groups
- activities in practice

9. Assessment Educational Research

10. Literature

Report of group discussion on Barcelona core content conference

Group members: Bernard Gay, Dolores Forres, Marten Kvist, Igor Svab, Janos Szabo.
Chairing: Egle Zebiene.

Discussion was hel mainly around the definition of general practitioner. Information presented for this discussion included analysis of main issues mentioned in the publication of Fred Olesen.

Dr. Bernard Gay proposed thta we should start with the new definition of General Practice as a discipline rather that with definition of General Practitioner.

Group apgreed that definition of Dr. Olesen concerning general practitioner has a number of ideas that are rather disputable and, as it was defined in a first draft prepared by Justin, 'does not appear to define these matters any more clearly.'

Marten Kvist made a proposal that it would be useful to accept, as a basic definition of General Practitioner, a revised Statement by the Leuvenhorst Working Group made in 1981, which includes clear description of professional in general practice and his responsibilities. Some changes according to the changing situation in Europe could be made during the conferenge if necessary.

After discussion the decision to present this opinion to the EURACT Council was made.

Egle Zebiene