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RECIPROCAL REFLECTION

KNOWLEDGE, FROM RESEARCH TO PRACTICE – AND BACK!

ANNA STAVDAL
Family Doctor
WONCA President

What does a WONCA President do?

Nov 3-4 : WONCA Executive meeting, Brussels

Nov 5 – 15: Health Summit and Regional WONCA meetings, Guatemala

Nov 18-20: NAPCRG

Nov 21- 26: WONCA Africa Conference, Abuja, Nigeria

Dec 5-10: WONCA Asia Pacific Conference, Bali, Indonesia

Dec 14-16: WHO EMRO Regional Committee Cairo, Egypt: Launch of The Family Medicine Diploma

"IN MEDICINE, WE GATHER MUCH

KNOWLEDGE,

BUT DO TOO LITTLE

THINKING"

ARILD UTAKER ,1996

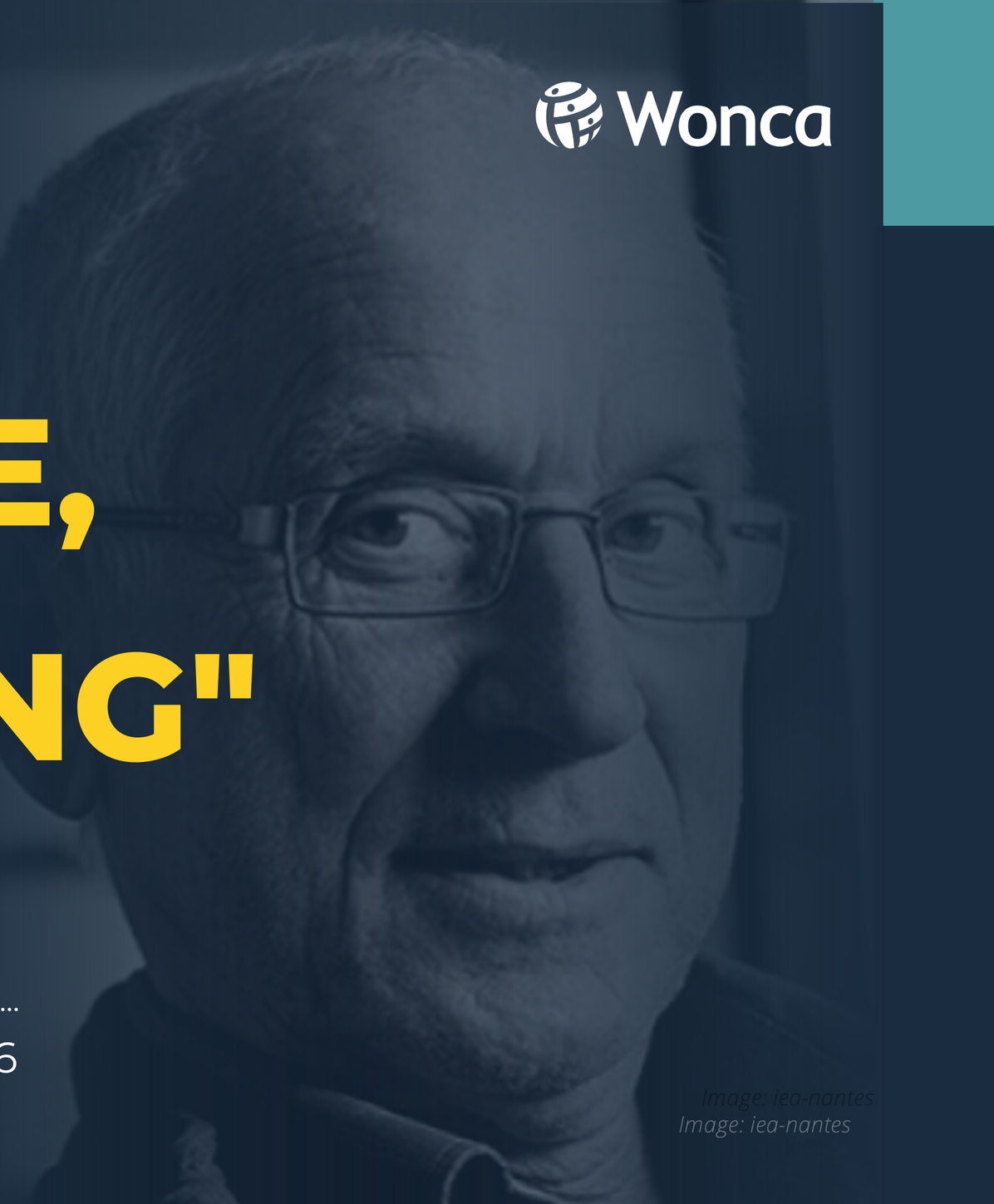

Image: iea-nantes

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How can we strengthen the reciprocal relationship between researchers and practitioners – with the humility of our shared responsibility, and the integrity of our shared accountability

"The pandemic is an issue of global health security. There is no global health security without individual security. And what is individual security- it means strong primary care. Strong PC is an absolute prerequisite to defend us against this pandemic, and future pandemics, It is the first line of defense"

RICHARD HORTON
EDITOR IN CHIEF
The LANCET

The context of Family Medicine is characterized by the core values of the discipline. Trust and the personal relationship between the patient and the doctor over time are prerequisites for comprehensive and tailor-made medical care through the life course.

AN OVERVIEW
OF OUR TIME TOGETHER

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1. Concepts and Framework

2. “The Risk Project”

3. Our Collaboration

4. Reflections in Buzz Groups

5. Way Forward

CONCEPTS AND FRAMEWORKS

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USE OF EVIDENCE

- Science asks: Is it true?
- Individual tailoring: Is it useful?
- Information asks: Is it relevant?

CONCEPTS AND FRAMEWORKS

TYPES OF KNOWLEDGE

- Medical knowledge
- Knowledge about knowledge
- Knowledge about the culture and the system;
- Knowledge about yourself

THE RISK PROJECT
1995

"The essays using blood pressure as an example of how revealing risk of possible future disease may affect individuals, and how risk, as such, is being used for all it´s worth by the insurance companies and not least by the healthcare industry"

Elisabeth Swensen

Published 2000

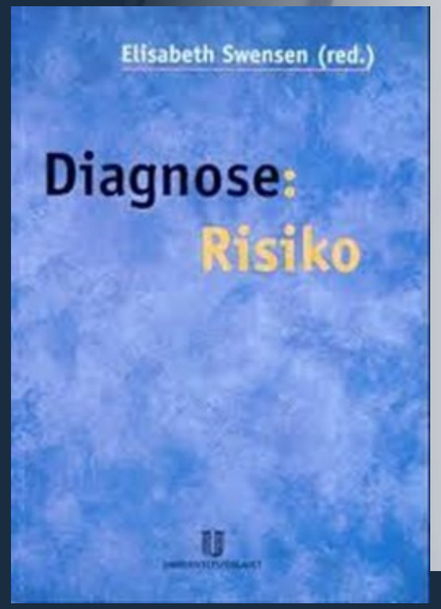

Image: LinkedIn

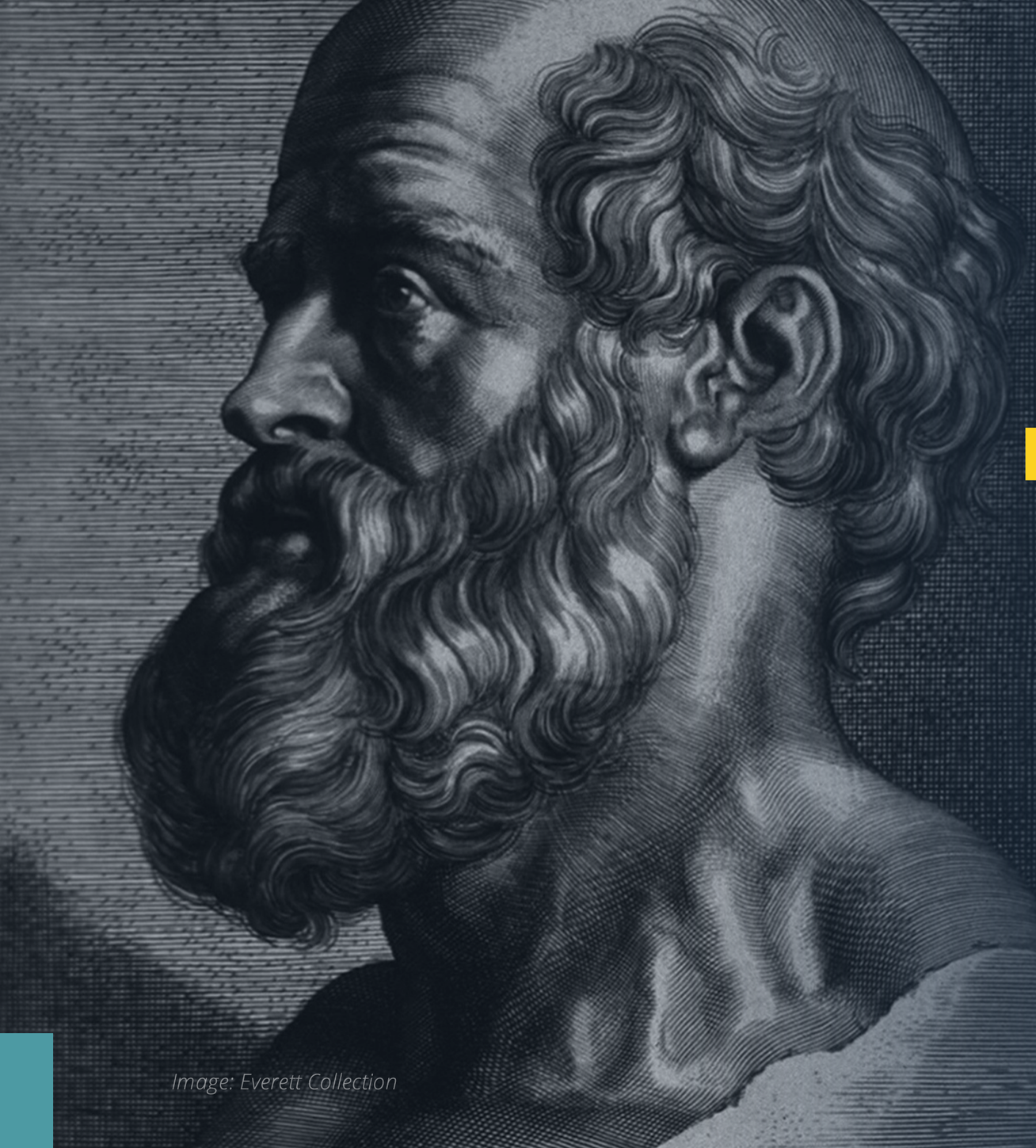

Image: Everett Collection

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PRIMUM NON NOCERE

HIPPOCRATE (470-410 B.C)

Preferably cure

Often relieve

Always comfort

But first of all: Do no harm

SELFASSESSED HEALTH

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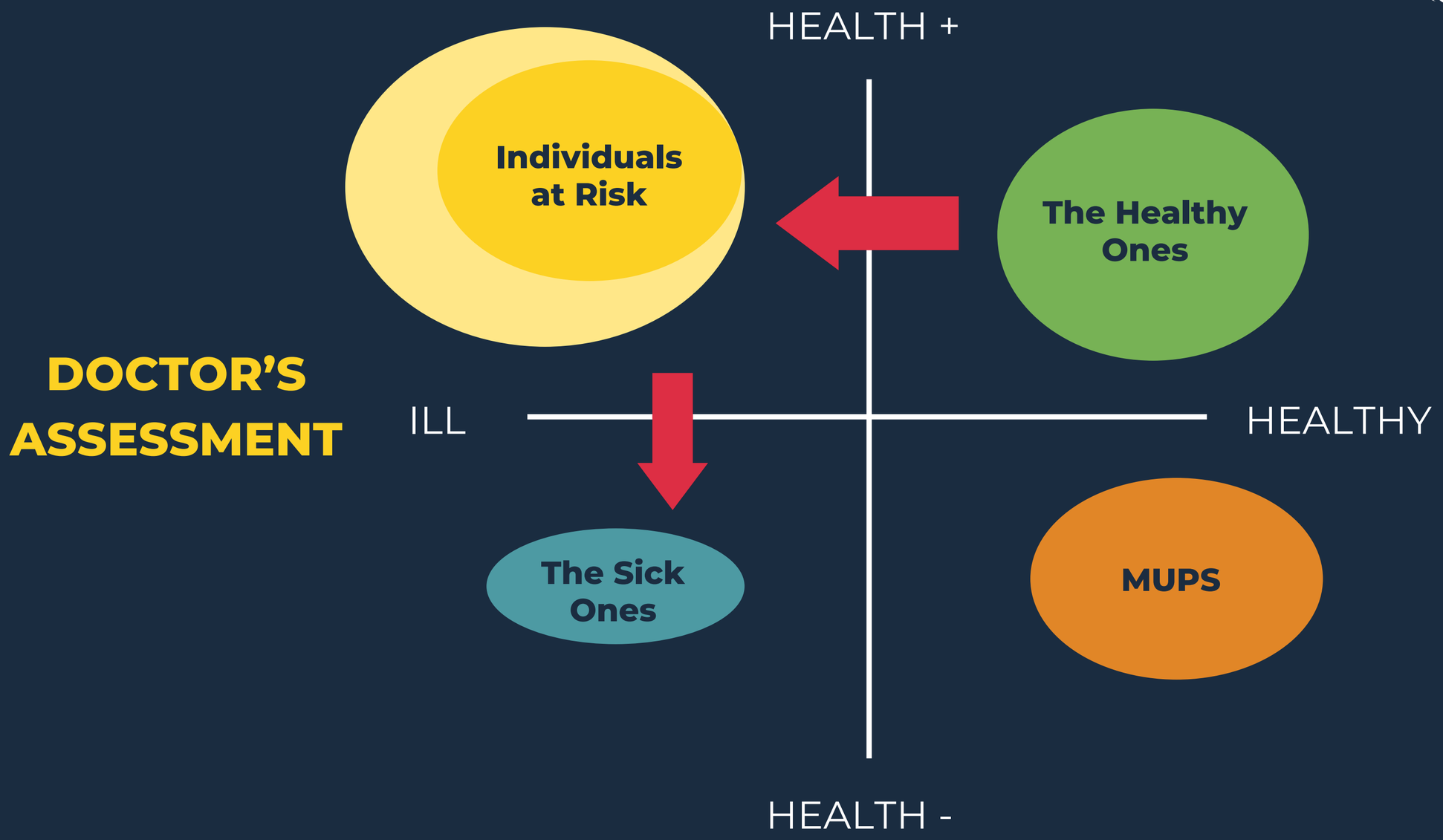

THE RISK EPIDEMIC IN MEDICAL RESEARCH

År	”Risiko-artikler”	Totalt antall artikler	Risikoartikler %
1967-1971	990	1 029 289	0,1
1972-1976	6 485	1 160 317	0,6
1977-1981	23 190	1 298 885	1,8
1982-1986	44 077	1 487 893	3,0
1987-1991	81 586	1 802 671	4,5
1992-1996	100 576	2 139 834	4,7
1997-2001	154 702	2 465 177	6,3
2002-2006	243 387	3 126 896	7,8

Skolbekken J-A.
Risikoepidemien – to tiår etter.
Michael 2010; suppl 9

QUESTIONS ARISING,

- REGARDING PRIMARY PREVENTION OF CARDIOVASCULAR DISEASE:

1. Do we need a population (mass) strategy – or is our basic strategy individual-oriented professional-based prevention?

2. What is high risk, and how to decide the intervention thresholds?

3. How to interpret absolute and relative risks?

4. Choice of treatment , - and what are the treatment goals?

5. What are the implications of guidelines for health care as a whole?

AUGUST 2005

"Ethical dilemmas arising from implementation of the European guidelines on cardiovascular disease prevention in clinical practice"

Linn Getz, Anna Luise Kirkengen, Irene Hetlevik, Solfrid Romundstad, Johann Sigurdsson

CONCLUSION: Implementation of the 2003 European guidelines on prevention of cardiovascular disease in clinical practice would classify most adult Norwegians at high risk for fatal cardiovascular disease.

CONSEQUENCES FOR PHC/GPS

99 GPs per 100 000 adults

ONLY BP follow-up

Current situation:

87 GPs / 100 000 **IN TOTAL**

BMC Family Practice 2005: Modelling study based on the Norwegian HUNT 2 population study

Halfdan Petursson*1, Linn Getz2, Johann A Sigurdsson1 and Irene Hetlevik2

The recent USA “Cochrane Sustainable Health Care” study regarding “overuse and de-implementation” calculated that each Primary Care Doctor would have to use 26.7 hours of each 24-hour day to provide the health care services recommended by the guidelines. If the care were offered in the context of a Team Practice, that could be reduced to [‘merely’] 9.3 hours per day.

https://pubmed.ncbi.nlm.nih.gov/35776372/

WHAT ARE THE RISKS RELATED TO THE RISK EPIDEMIC?

- Imposing fear and worry a risk in its own right
- Too much focus on risk and not resources, transforming healthy people wrongly into patients
- Exposing patients to treatment with potential side effects and questionable benefit
- Boosting workload , straining the budgets
- Taking resources from the sick to the well

NORDIC RISK GROUP

- FOUNDED 2004

"DOES HEALTH CARE DO HARM?"

Published 2009

http://www.ntnu.no/ism/allmennmedisin

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Position Paper on Overdiagnosis and Action to Be Taken

By WONCA Europe
The World Organization of Family Doctors in the European Region

Modern medicine has brought impressive benefits to humankind. A side-effect of its many successes is however an unfounded, cultural belief that more medicine is necessarily better, irrespective of context. Consequently, problems related to "too much medicine", overdiagnosis and overtreatment are on the rise. Ever more methods of surveillance, investigation and treatment become available, and health anxiety has become widespread. Unwarranted medical activity leads to unnecessary waste of resources, more inequalities in healthcare and, at worst, direct harm to patients and healthy citizens.

In order to avert the further escalation of overdiagnosis there is a need to reassess and disseminate new evidence on timely and appropriate diagnostic processes along with the communication skills needed to inform patients and their families about the relevant significance of their diagnoses.

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68th session of the WHO Regional Committee for Europe

Rome, Italy, 17–20 September 2018

Health ministers and high-level representatives of the 53 Member States of the WHO European Region as well as partner organizations and civil society are taking part in the 68th session of the WHO Regional Committee for Europe in Rome, Italy, on 17–20 September 2018.

http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/68thsession/multimedia/video-gallerystatements-from-non-state-actors

Image: Norce

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When the indicators on which we base treatments or tests are reduced to an insecurity that we ourselves have created, we commit an act of violence against our own integrity.

PROF. STEINAR HUNSKÅR
RESEARCHER AND DEAN

BERGEN, NORWAY, MEDICAL FACULTY

OUR COLLABORATION

Image: LinkedIn

CIRCULAR MUTUALITY

Interpretation: How can we translate from numbers to quality?

Reflection:

- Theoretical and Experimental
- Individual and collective
- Before. Under. After

POST PUBLISH DEBRIEF

- What is confirmed?
- Which ideas to be reevaluated?
- Next alternative theoretical assumptions

VALUE BASED MEDICINE

"Is provided by those who believe in the truth, but at the same time choose to prove what is 'not proven, and then combine the two."

DR GEIR SVERRE BRAUT
FORMER ASSISTANT DIRECTOR

NORWEGIAN HEALTH SUPERVISOR BOARD

Image: nynorsk

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MY AIM:

To promote reflection in order to strengthen the reciprocal relationship between researchers and practitioners – with the humility of our shared responsibility, and the integrity of our shared accountability.

BUZZING REFLECTION

- What contributions did we as Family Doctors and you as Researchers make to creating this Risk Epidemic?
- What didn't we do, or didn't do early enough?
- What are we, in fact, doing now to address this growing imbalance?
- What more or different ought we to do?
- How can we increase the degree of reflection and awareness among our colleagues about the responsibility our professions have for creating this problem, and for fixing it?

WHAT SORT OF KNOWLEDGE IS EMPHASIZED?

- Effect of action, primarily of medication
- Risk factors
- Importance of early diagnosis

LACK OF KNOWLEDGE AND COMPETENCIES

- Identify, interpret and pass on knowledge about ”non-disease”:

  - Diversity and variation
  - New phenonomens, change, adaptation
  - Normal process
  - Survival and resources
  - Living with uncertainty

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EUROPE

Core Values and Principles of General Practice/Family Medicine

WHO considers primary health care to be a cornerstone of sustainable health care systems. The General Practice/Family Doctor (GP/FD) is a key provider of primary health care.

WONCA Europe has defined General Practice/Family Medicine as both a clinical specialty and a discipline in its own right, with its own curriculum and research base.

GP/FM may be practiced in different contexts according to the characteristics of each health system, country or community. However, the foundation of GP/FM is based on the core values listed below. They are the essential elements of good quality of GP/FM, and should provide a frame of reference for our professional identity.

PERSON-CENTERED CARE

GPs/FDs practice person-centered medicine, emphasizing dialogue, context, and the best evidence available.

GPs/FPs always take the impact of biological, psychosocial and cultural determinants on individuals' health into consideration.

GPs/FDs engage professionally with their patients' current life situations, biographical stories, beliefs, worries, and hopes. This helps to recognize the links between social factors and sickness and to deepen the understanding of how life and life events leave their imprint on the human body and mind. GPs/FDs promote patients' capacity to make use of their individual and communal resources.

CONTINUITY OF CARE

GPs/FDs promote continuity of doctor-patient relationships as a central organizing principle

The doctor-patient relationship is based on personal involvement and confidentiality. Continuity of care helps build mutual trust and enable high-quality, person-centered care.

GPs/FDs seek to maintain this continuity of care when organizing their practices, regardless the size, composition and nature of the primary care team.

COOPERATION IN CARE

GPs/FDs collaborate across professions and disciplines while also taking care not to blur the lines of responsibility.

GPs/FDs integrate different programs and services and engage actively in developing and adapting effective ways to cooperate with other health and social workers.

GPs/FDs help patients navigate the health system and facilitate communication with other health professionals

COMMUNITY ORIENTED CARE

GPs/FDs remain committed to education, research, and quality development.

GPs/FDs community orientation and social accountability aim at influencing the health policies addressing health disparities by integrating clinical care, public health and social services on community level.

EQUITY OF CARE

General practitioners/Family doctors prioritize those whose needs for healthcare are greatest.

GPs/FDs provide equitable health care. Equity is an essential dimension of the quality of health care. The aim is to minimize inequalities in health service delivery. We organize our practices to allocate time and effort to those whose needs for treatment and support are greatest.

GPs/FDs perceive it their duty to speak out publicly about societal factors impacting access to health care and inequalities in health outcomes. GPs/FDs are especially aware of the health challenges facing certain groups in relation to age, gender, sexual orientation, ethnicity, socio-economic status and religious orientation.

SCIENCE ORIENTED CARE

GPs/FDs provide care based on the best available evidence, respecting patients' values and preferences.

Overexamination, overdiagnosis, and overtreatment can harm patients, consume resources and indirectly lead to harmful underdiagnosis and undertreatment. When equally effective interventions are available, GPs/FDs choose the interventions on the basis of cost-effectiveness and patient safety.

PROFESSIONALISM IN CARE

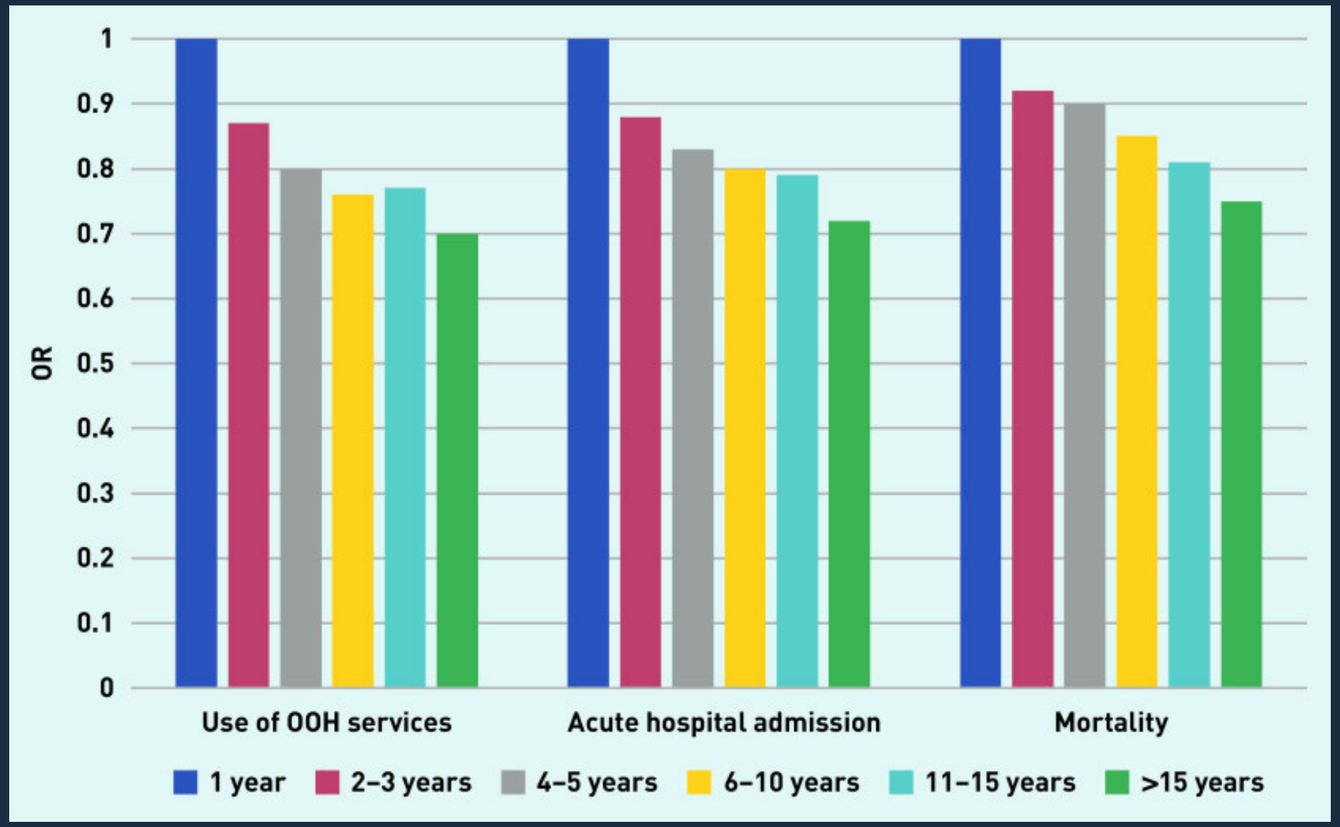
GPs/FDs provide medical care to individuals and promote health on the community level. GPs/FDs engage in political and social aspects impacting health outcomes in community-oriented advocacy.

GPs/FDs engage actively in the training of future colleagues and facilitate inclusion of young doctors in organizational and fundamental decisions regarding the under and postgraduate medical education.

GPs/FDs implement and promote research relevant to the needs of GP/FM, and assess knowledge and guidelines critically with a constructive and academic approach.

"For 200 years, medical advances have been mainly technical and impersonal which has reduced attention to the human side of medicine. This systematic review reveals that despite numerous technical advances, continuity of care is an important feature of medical practice, and potentially a matter of life and death"

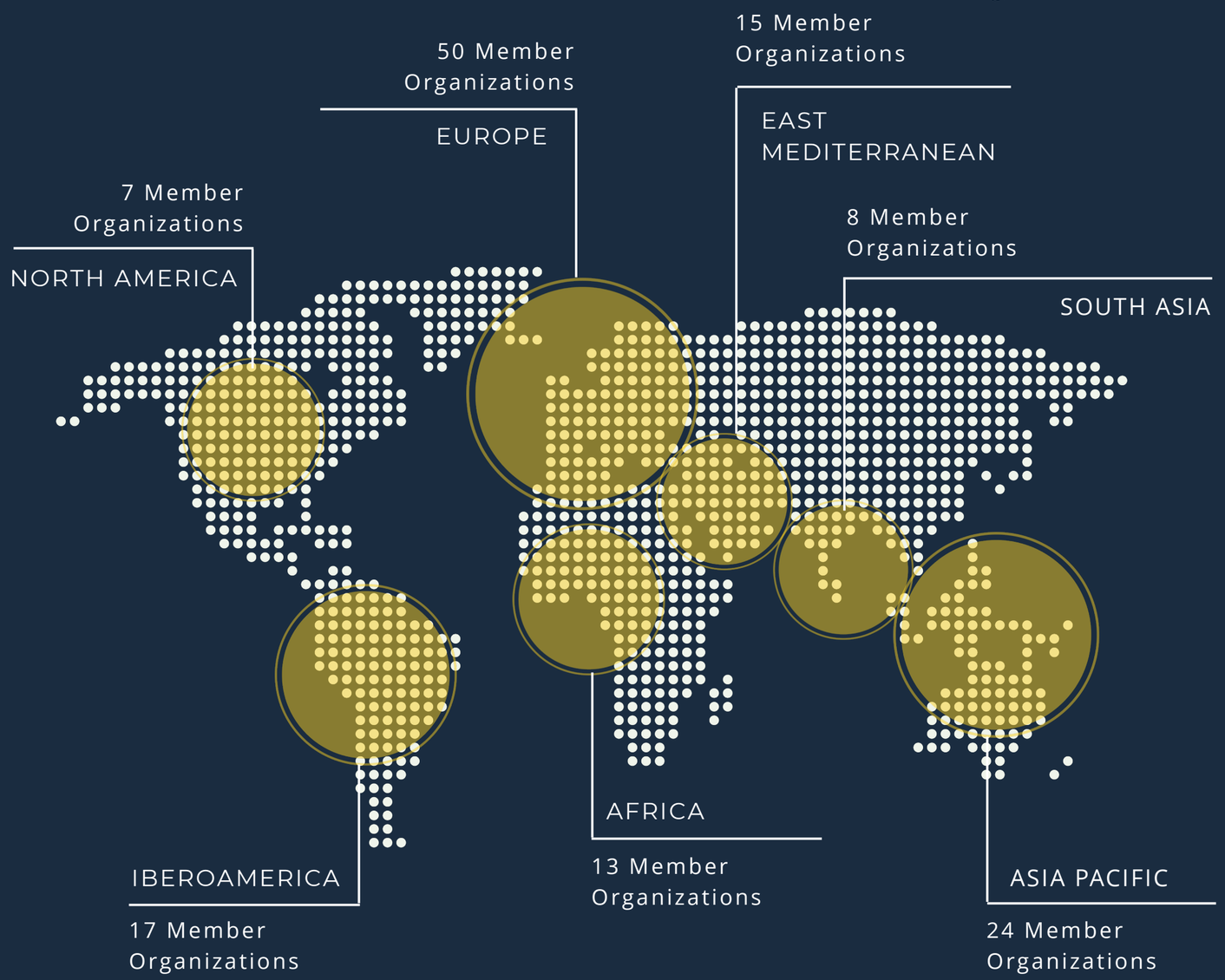
PEREIRA GRAY DJ, SIDAWAY-LEE K, WHITE E, ET AL



Length of RGP-patient relationship is significantly associated with lower use of OOH services, fewer acute hospital admissions, and lower mortality. The presence of a dose-response relationship between continuity and these outcomes indicates that the associations are causal.

Hogne Sandvik , Øystein Hetlevik , Jesper Blinkenberg , Steinar Hunskaar

MEMBER ORGANIZATIONS WORLDWIDE



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10 WONCA WORKING PARTIES

- Education
- Environment
- Ethical Issues
- eHealth
- Indigenous & Minority Groups Health Issues
- Mental Health
- Quality & Safety
- Research
- Rural Practice
- International Classification (WICC)
- Women & Family Medicine

17 SPECIAL INTEREST GROUPS

- Adolescent & Young Adult Care
- Ageing and Health
- Cancer & Palliative care
- Complexities in Health
- Emergency Medicine
- Emerging Practice Models for Family Medicine
- Family Violence
- Genetics
- Health Equity
- Indigenous & Minority Groups Health Issues
- LGBTQ Health
- Migrant Care, Int Health & Travel Medicine
- Non-Communicable Diseases
- Point of Care Testing
- Policy Advocacy
- Quaternary Prevention & Overmedicalization
- Workers' Health

HISTORICAL REFLECTION

THE MORAL RESPONSIBILITY OF SCIENTISTS

illustrated by the case of rocket scientist Wernher von Braun

Don't say that he's hypocritical.
Say rather that he's apolitical.

"Once the rockets are up, who
cares where they come down?
That's not my department,"
says Wernher von Braun.

Tom Lehrer, 1965

Image: Wikipedia

THANK YOU

PRINCIPLES AND PROBLEMS IN MOST GUIDELINES

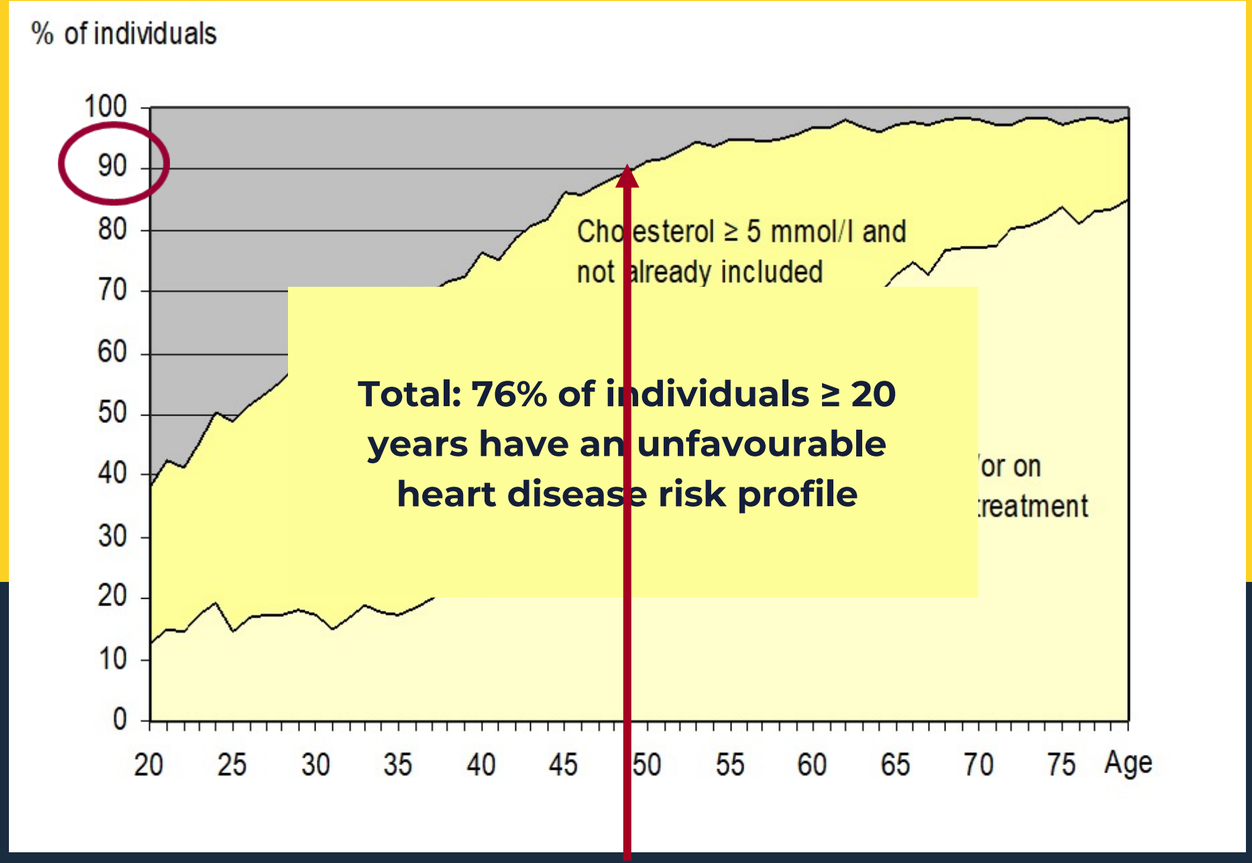
- Intervention should aim at people with highest risk, since they will gain the most.
- Risk should be assessed as total risk, and include knowledge of life habits (smoking, diet, physical activity), family history, and modifiable risk factors like blood pressure and cholesterol levels.
- Risk is best assessed with the help of risk algorithms, like Framingham, SCORE, Procam and other. They give the 10 year risk.

BUT These risk tools shows us the history. In countries with falling incidence of CVD, they will over-estimate the risk.

AND Total risk is dominated by age and gender, and will give priority to elderly men with “normal” levels of BP and cholesterol.

2003 EUROPEAN CARDIOVASCULAR DISEASE PREVENTION GUIDELINES

APPLIED ON THE POPULATION IN NORD-TRØNDELAG (HUNT 2 STUDY)



Getz et al. Scand Journal Prim Health Care, 2004

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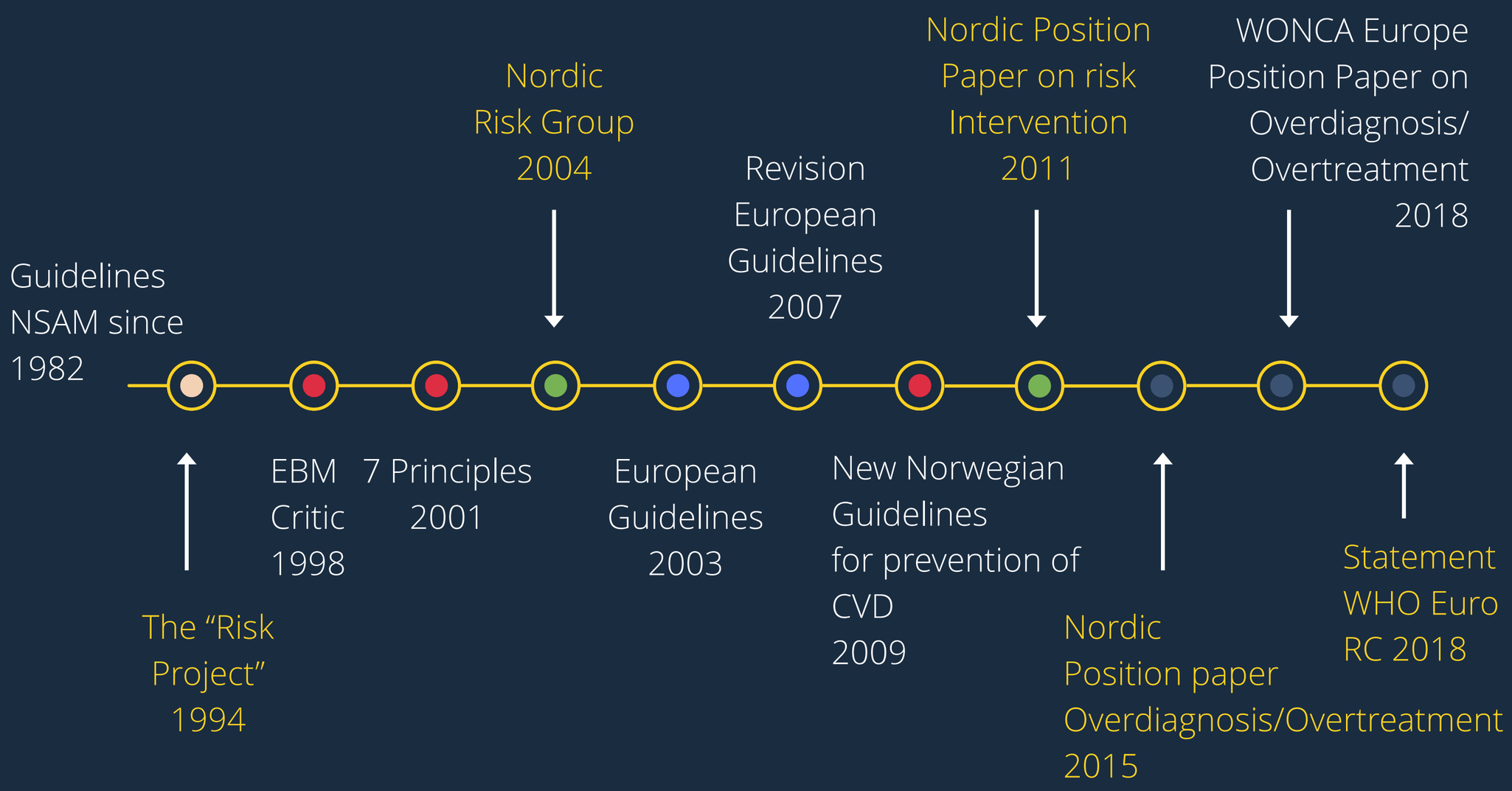
- Overdiagnosis has an immense impact; it decreases the quality of healthcare, puts patients at risk of harm, over-stretches health systems, is costly and undermines population health.

- Overdiagnosis is a public health matter: it does harm to healthy individuals and steel resources from those who are in the greatest needs of medical care.


Guidelines NSAM since 1982
The "Risk Project" 1994
EBM Critic 1998
7 Principles 2001
Nordic Risk Group 2004
European Guidelines 2003
Revision European Guidelines 2007
New Norwegian Guidelines for prevention of CVD 2009
Nordic Position Paper on risk Intervention 2011
Nordic Position paper Overdiagnosis/Overtreatment 2015
WONCA Europe Position Paper on Overdiagnosis/ Overtreatment 2018
Statement WHO Euro RC 2018

“WHERE ANGELS FEAR TO TREAD, FOOLS RUSH IN”

BATESON AND BATESON

Foto: Regin Hjertholm