

Wonca 2023

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Supplement 2: WONCA 2023 abstracts (L–Z)

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Editorial notes

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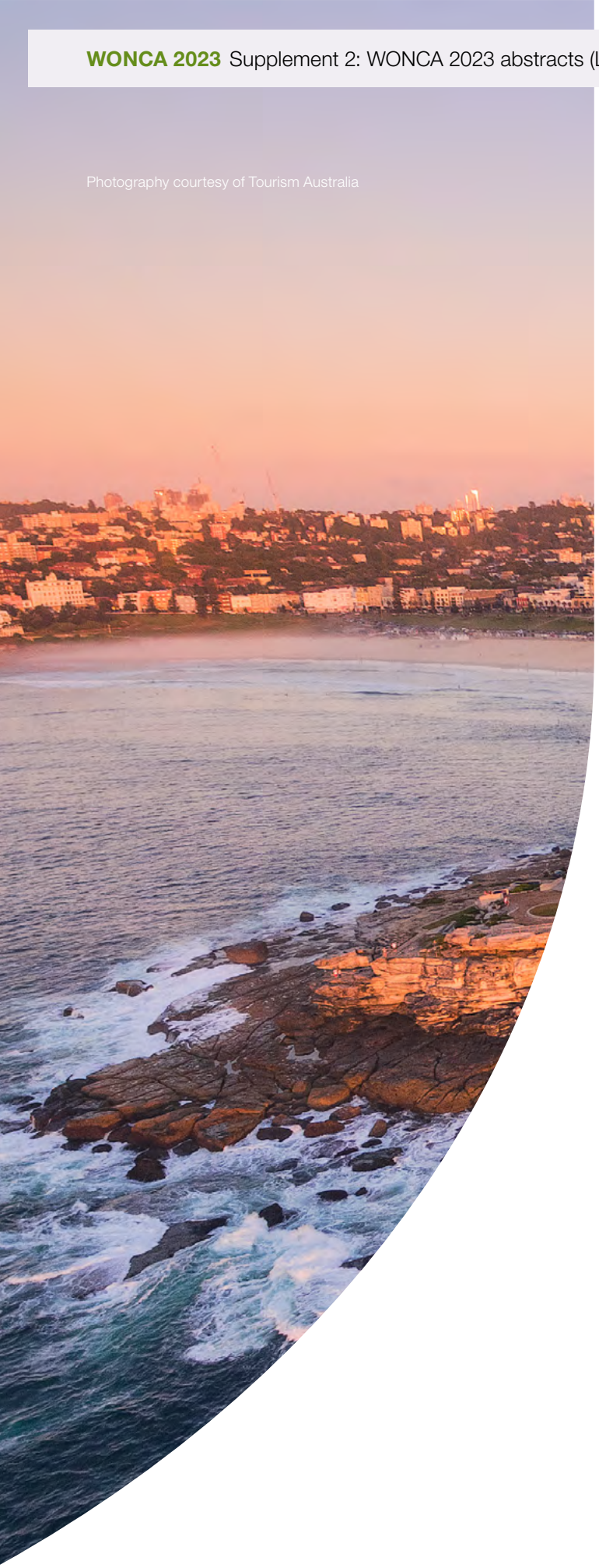
WONCA 2023 abstracts (L–Z)

Contents

Introduction	2
Welcome	4
Abstracts	7



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Introduction

The Royal Australian College of General Practitioners (RACGP) and the WONCA Conference Scientific Committee are pleased to present the abstracts from the WONCA World Conference 2023.

These abstracts are presented as two special-edition *Australian Journal of General Practice* (AJGP) supplements in alphabetical order by primary author surname. Supplement 1 covers A–K and Supplement 2 covers L–Z*.

The supplements are available in two formats – interactive flipbook and downloadable PDF – and can be accessed on the AJGP website: https://www1.racgp.org.au/ajgp/home

The RACGP sincerely thanks the WONCA Conference Scientific Committee and all other individuals who supported the review of these abstracts.

**Please note that the abstracts are the authors' original work and have not undergone the publisher's rigorous editing process; therefore, the accuracy of the content cannot be guaranteed. While the publisher has attempted to present these abstracts in alphabetical order by primary author name, this also cannot be guaranteed.*

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Welcome from Dr Nicole Higgins, RACGP President

The Royal Australian College of General Practitioners (RACGP), the voice of general practitioners (GPs) in our growing cities and throughout rural and remote Australia, is proud to be the official host of this year's GP23 and WONCA World Conference from 26 to 29 October 2023 in Sydney.

As the largest conference for GPs, family doctors and primary healthcare specialists, the conference provides a unique opportunity to reconnect with colleagues, gain international perspectives on a range of global health issues, and continue to build primary health care practice.

Themed, 'Recovery, reconnection and revival. A celebration of primary care', this year's WONCA World Conference in Sydney will reflect on what primary care has learnt during the COVID-19 pandemic, and what's needed for the future of high quality, sustainable primary care.

On behalf of the RACGP, we look forward to welcoming you to this year's exciting event!

Dr Nicole Higgins
President, RACGP



Welcome from Adjunct Professor Karen Price, Chair, WONCA 2023 Host Organising Committee

This year, we celebrate WONCA's 50th anniversary in Australia—the country where it all began 1972.

Since COVID-19 began, family doctors have experienced numerous changes. Amid these changes, some human issues remain. We need to recover, reconnect, revitalise and celebrate our profession.

The WONCA World Conference 2023 will be a life-changing experience, as you network with incredible family doctors from around the world and understand the unique local contexts of the application of primary care. By attending the presentations and workshops, participating in discussions, and listening to world leaders in primary care, you'll broaden and deepen your understanding of our profession.

Held at the International Convention Centre on the beautiful Darling Harbour, you'll also have the opportunity to explore the beautiful city of Sydney. There are many accommodation options, and incredible local cafes and restaurants. Visit our website for more information.

Finally, by remaining openly curious about ourselves and our world, we can address more easily the real and imperative global challenges ahead of us. I look forward to hosting you and your families at this year's event and listening to, and celebrating, your stories from these extraordinary times we have been through.

Adjunct Professor Karen Price
Chair, WONCA 2023 Host Organising Committee



Welcome from Professor Mark Morgan, Chair, WONCA 2023 Conference Scientific Committee

General practice is ever evolving based on the changing health needs in the community.

The coronavirus pandemic, and the impacts of climate change and natural disasters, are just some examples of emerging issues GPs and family doctors are facing around the world – themes that will be explored as part of this year's conference. There's so much we can learn from each other.

The WONCA 2023 program features innovative, thought-provoking and informative content, including world-leading research, expert keynote presentations, and a range of practice workshops.

The program is designed to provide you with new perspectives on primary care, new skills and knowledge, and importantly, a sense of connection with local and international colleagues.

Professor Mark Morgan
Chair, WONCA 2023 Conference Scientific Committee



Professor Felicity Goodyear-Smith
Deputy Chair, WONCA 2023 Conference Scientific Committee

Towards a contemporary theory of continuity in general practice: 'Following the story' in a digital age

Dr Emma Ladds[1], Richard Byng[2], Aileen Clark[1], Sarah Rybczynska-Bunt[2], Prof Trish Greenhalgh[1]

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Background

Continuity is a long-established and fiercely defended value in general practice. Traditionally referring to longevity and consistency within the individual doctor–patient relationship, its value for patients, professionals and systems has been repeatedly demonstrated. However, in recent years, UK general practice has seen the introduction of new staff roles and remote and digital approaches to patient access (online platforms and triage-first) and clinical encounters (telephone, video and electronic consultations). These changes may require an extension of how we conceptualise continuity.

Methods

As part of a longitudinal case study between 2021 and 2023, we used strategic, immersive ethnography and semistructured and narrative interviews to explore continuity in differing geographical, organisational and technological contexts among 11 UK general practices as they introduced (or chose not to introduce) digital and remote forms of access and clinical care. We analysed the data using a narrative approach and used this to develop and extend existing theory about continuity.

Results

Different practices variably defined continuity and achieved it to differing degrees. Its attainment required additional effort and work by individuals and was influenced by aspects of the locality, practice, technical infrastructure and wider healthcare system. Remote and digital modalities provided opportunities for extending continuity across time and space and for achieving (some) continuity of the record and shared team understanding of a patient and illness episode. The nature and degree of continuity influenced the coherence and witnessing of patients' illness narratives. Impaired continuity disrupted coherence and fragmented stories, impacting health outcomes, experiences of care and subsequent interactions with the healthcare system.

Conclusion

Continuity remains crucial within general practice. However, practices should consider how remote and digital approaches can be used, and individuals supported, to widen how it is conceptualised and operationalised to encourage the coherence of individual narratives.

Connecting general practice (GP) with virtual hospitals: An evaluation of existing GP advice lines in Sydney

Dr Liliana Laranjo

The University of Sydney

While there is evidence that coordination between general practice (GP) and hospitals is vital to support the care of acute patients in the community, there is a lack of evidence regarding how support and communication services should be structured and provided. The present project aimed to address this gap by analysing data on existing GP advice lines in Sydney and by exploring the perspectives of stakeholders involved in those advice lines.

The presentation will cover preliminary results from this mixed-methods translational research study covering three major regions in Sydney: Western Sydney; Northern Sydney; and Central and Eastern Sydney. All three regions had GP advice lines implemented to support general practitioners in managing acute patients. In two regions, these communication channels with the hospital were specifically set up in response to the COVID-19 pandemic, to help primary care clinicians safely manage COVID-19 patients in the community through specific advice on aspects like symptom management and antiviral therapy. There are now plans to expand the scope of these lines to support chronic disease patients in need of acute care for their conditions.

Quantitative analyses of metrics surrounding use of advice lines and other digital communication channels from the three regions will be presented, as well a qualitative evaluation through thematic analysis of interviews with members of hospital virtual care and primary care services (including clinical and managerial staff), as well as consumers.

From analyses of data gathered, key findings and recommendations will be presented as to how support services can be optimised to enhance coordination between primary and secondary care in the remote management of acute patients in the community.

Development of information system for family practice in Indonesia with a genogram model

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Prior to being required by the Indonesian Minister of Health Regulation No. 24 of 2022, electronic medical records (EMR) had been implemented in a few healthcare facilities in Indonesia, both in hospitals and primary care, as independent initiatives. The currently available information system does not yet facilitate family physicians in providing holistic and comprehensive services.

The aim of this research is to develop an information system in primary care that will assist family doctors in providing comprehensive holistic services. The first stage of this research was to develop a model by observing and interviewing health workers at several primary care facilities to inventory needs, then adding the function of assessing the risk of family stunting. The second stage is compiling an information system, and the third stage is testing at primary care facilities.

An information system for primary care facilities has been formed, consisting of five major parts in the form of integrated modules, namely the registration module, the initial examination module, the nurse module, the physician module and the management module. The uniqueness of this application is that in the registration section, if it is completely filled out, the risk of suffering from diabetes can be identified, as can the families at risk of stunting based on the criteria of woman of childbearing age, an inadequate household and no family member who earns money within six months. In the initial examination module, reasons for encounters are coded based on the International Classification of Primary Care 2. The diagnosis is documented based on clinical and psychosocial aspects, in the physician's module. The management module is equipped with items involving doctors with family from the genogram model, in addition to pharmacotherapy. The information system has been successfully tested at the primary care facilities.

Key words
family physician, information system, primary care.

A review of general practitioner research training

Dr Phyllis Lau, Elif Sakiz, Prof Wendy Hu

Western Sydney University

Background

General practitioners (GPs) should be skilled in research and lead as well as actively contribute to research to guide high-quality primary healthcare. The quality of GP research training is, however, still a contentious subject within and outside the discipline.

Aim

To provide an overview of GP research training curricula and programs in Australia and cognate countries.

Methods

Documents on GP research training (including publicly available teaching, learning, assessment, curricula, programs, accreditation and professional standards of research competencies) from English-speaking countries with similar health and educational systems to Australia (Australia, New Zealand, US, Canada, UK, Denmark, Hong Kong and Singapore) were included in the review. Documents that described GP clinical training only or research training of medical students, postgraduate degree trainees and trainees of disciplines other than general practice were excluded. Emails with GP training programs and two online interviews with GP specialists were conducted to explore information not publicly available. Data were deductively extracted and analysed.

Results

Entry point and duration of training varied in different countries from postgraduate year 1 to 4, ranging from no mandatory training to training spanning two years. Some curricula included core research competency training, and required trainees to complete research projects, publish papers and present at scientific conferences. Most training objectives included enabling trainees to conduct and present medical research, understand and critically appraise scientific literature and find appropriate information for evidence-based medical practice. In some countries, university academics provided GP research training. Assessments varied considerably from formal examinations to participation in continuing professional development. Most programs were government funded, while some were funded by GP colleges.

Implications

Our findings provide a basis for further development of GP research policies and training in Australia and other countries. Future research should explore GP trainees' views of their research training.

Exploring the views of justice health stakeholders regarding high-quality indicators and the use of QUEST PHC

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Background

There is currently no agreement on what constitutes high-quality primary healthcare (PHC) in Australia. The Quality, Equity and Systems Transformation in Primary Health Care (QUEST PHC) project has developed a suite of 79 evidence-based indicators and corresponding 128 measures of high-quality general practice to address this gap. Consultations were conducted to establish the content validity of the indicators and measures in different healthcare settings, including the prison health sector.

Aim

To canvas views of PHC clinicians and staff working in Australian prisons on the use of the QUEST PHC suite.

Methods

One focus group and one interview were conducted online with five participants from three states. Participants were asked about their views of the high-quality healthcare measures relevant to justice health, and the possible use of the QUEST PHC suite in justice health. Data were analysed thematically using a mixed inductive–deductive approach.

Key findings

Four themes emerged: (1) 'current PHC in justice health' noted the differences in PHC delivery across prisons in different states, constraints of the prison system and the high proportion of Aboriginal and Torres Strait Islander inmates; (2) 'measuring quality within justice health' described the complex prison environment impacting quality measurements, quality of existing indicators and the need to incorporate Aboriginal and Torres Strait Islander cultural perspectives into quality measurements; (3) 'QUEST indicators for justice health' talked about the relevance of the indicators in justice health and missing indicators specific to justice health; and (4) 'recommendations for measuring quality in justice health' included benchmarking across states, developing efficient coding systems, integrating into existing workflow and improving staff training.

Discussion

Although quality indicators are important and needed in Australian prisons, there are many challenges to implementing a universal tool in a diverse system. Potential application of QUEST PHC in Australian prisons should include indicators unique to that setting and strategies to overcome barriers to implementation.

Indicators and measures of high quality in Australian general practice: A Delphi study to establish consensus

Dr Phyllis Lau[1,2], Dr Samantha Ryan[1,2], Dhruvi Lathigara[1], Baneen Alrubayi[1], Lucy Bannister[1], Dylan Pakkiam[1], E/Prof Jennifer Reath[1]

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Background
Australia is among OECD countries with the highest proportion of primary healthcare (PHC) funding as fee-for-service payments. There is however no agreement on what constitutes high-quality PHC to guide alternative funding models. The Quality Equity and Systems Transformation in Primary Health Care (QUEST PHC) project developed a suite of 79 indicators and corresponding 128 measures of high-quality general practice to address this gap.

Aim
To establish consensus with general practice and primary health networks (PHNs) on the QUEST PHC tool for the Australian general practice context.

Methods
An online Delphi survey was conducted with general practitioners, practice staff and PHN staff. Threshold for consensus was set at 70% agreement in both relevance and feasibility. Participants were also asked to comment on implementation of the tool. Ratings were statistically analysed; whole group and subgroup analyses were performed. Qualitative responses were thematically analysed.

Results
All measures reached consensus. Nineteen measures, although reaching consensus, were more commonly rated as 'somewhat feasible' rather than 'feasible'. Eight of these were common to all subgroups (practice staff, PHN staff, clinician practice staff and non-clinician practice staff), six of which were related to patient-reported measures. All agreements between subgroups were statistically significant. Thematic analysis elicited four themes: (1) use of QUEST PHC indicators and measures; (2) barriers to using quality indicators and measures; (3) barriers to using quality indicators and measures; and (4) suggestions on implementation of the QUEST PHC. Although participants feel that the QUEST PHC tool is relevant and feasible, there were numerous challenges in collecting additional data, including accessibility of appropriate assessment tools, patient compliance, time constraint and requirement of technological skills.

Implications
Findings will inform the further development and implementation of the QUEST PHC tool that would enable future primary healthcare reforms in Australia.

Development of an online primary healthcare patient-reported measures (PRMs) compendium

Dr Phyllis Lau[1,2], Dr Samantha Ryan[1,2], Natalie Cochrane, Dhruvi Lathigara[1], Alice Shen[1], Baneen Alrubayi[1], Lucy Bannister[1], E/Prof Jennifer Reath[1]

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Background
Understanding patient experience and self-reported outcomes is important in providing high-quality healthcare. Patient-reported measures (PRMs) provide insight to healthcare professionals, healthcare services and primary health networks about patient needs and expectations, as well as highlight gaps for quality improvement. However, many PRMs used in primary healthcare (PHC) are not readily accessible and the quality of PRMs is largely unknown.

Aim
As part of a wider project, Quality Equity and Systems Transformation in Primary Health Care (QUEST PHC), this subproject aimed to assess the quality of current PRMs used in PHC and develop an online compendium to provide information about their purpose, quality and accessibility.

Methods
A systematic review of PRMs used in PHC in Australia and overseas within the past 10 years was conducted in 2021. Each PRM was assessed by two reviewers with clinical experience for relevance to Australian PHC. Ninety-two PRMs were included for critical appraisal. Development and validation papers were sourced and each PRM was assessed for quality of development, content validity and validation based on a modified COSMIN framework. The compendium was translated onto a webpage and piloted by the QUEST PHC research team and steering committee.

Results
Quality of the development and validation of PRMs currently used in PHC are variable. The compendium consists of a description of each PRM, critical appraisals of its quality, a repository of the PRMs freely available and the web links of PRMs that require permission for access. Feedback suggests that online compendium was accessible, easy to use and will assist clinicians to select appropriate PRMs for use.

Implications
This compendium adds to the knowledge base of PRMs used in PHC. It has the potential to inform healthcare professionals' choice of PRMs to use, increase access to PRMs and enhance patient experience and outcomes through quality improvement.

Hand-held ultrasound, the GPs' stethoscope of the future

Dr Gilles Laur

Laurel Clinical

The world is changing fast thanks to the fast pace of technological development. Hand-held ultrasound devices offer intuitive pocket-sized ultrasound capabilities that enable clinicians to easily image patients at the point of care, transforming the physical exam with more information to determine the optimised course of treatment. They fit in the palm of a hand, helping general practitioners accelerate treatment decisions at the bedside. Hand-held ultrasound devices are invaluable tools for making a difference in your practice, improving outcomes, enhancing workflows and reducing the overall cost of care. They are the new stethoscope of the future. Today, general practitioners do not only have to rely on hearing sounds, they can see pathologies and streamline patient care.

Improving physical activity interventions for cancer survivors in general practice: A mixed-methods study

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Background

Cancer survivors are at increased risk of long-term morbidity. Modifying lifestyle behaviours, in particular physical activity, can improve morbidity associated with the physical and psychological sequelae of cancer. However, many survivors do not receive comprehensive healthy lifestyle recommendations. General practitioners (GPs) are appropriately placed to provide holistic care, such as physical activity interventions, but the practicalities within the Australian setting remain unknown.

Method

We used a mixed-methods study design to explore the role of general practice in implementing physical activity interventions for cancer survivors, including the barriers and enablers. GPs were asked to complete a survey before a semistructured interview. The survey explored preferences of possible interventions arising from the findings of a realist review. The interview explored the role of general practice in physical activity interventions for cancer survivors and was underpinned by the Theoretical Domain Framework. Interview data were analysed inductively and deductively.

Results

We recruited 17 GPs who completed the study. Most GPs perceived physical activity promotion as an integral and appropriate part of their work. Greater engagement with physical activity promotion was reported to be influenced by patient mindset and interest, access to services, premorbid condition, support and early intervention within cancer care. Barriers included cost, time constraints, patient physical capacity, perception of exercise as a treatment and a lack of knowledge/evidence.

Discussion

Physical activity promotion for cancer survivors in primary care is influenced by individual and cultural contexts, cancer-related factors, health system issues and healthcare support needs. These factors should be considered when designing models of care which support sustained behavioural change and can be integrated into existing standard holistic patient care. This study forms important pre-implementation work for a physical activity intervention that will be tailored to the needs of cancer survivors in general practice.

Prevalence of otitis media, hearing impairment and language delay in First Nations children, birth to age 3 years

Prof Amanda Leach[1,2], Nicole Wilson[1,2], Beth Arrowsmith[1,2,14], Jemima Beissbarth[1,2], Kim Mulholland[3,4,5], Mathuram Santosham[6,7], Paul Torzillo[8,9], Peter McIntyre[9,10], Heidi Smith-Vaughan[1,2], Sue Skull[11,15], Mark Chatfield[1,12], Deborah Lehmann[14], Michael Binks[1,2], Ross Andrews[17], Anne Chang[1,2,13], Jonathan Carapetis[11,14], Tom Snelling[9], Vicki Krause[16], Paul Licciardi[3,4], Victor Oguoma[1,2,12], Peter Morris[1,2,18]

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Background

In remote communities of northern Australia, First Nations children with hearing impairment (HI) are disproportionately at risk of poor school readiness and performance compared with their peers without HI. Our objective was to determine a mixed pneumococcal conjugate vaccine (PCV) schedule to maximise immunogenicity and thereby reduce bacterial otitis media (OM), disabling HI and developmental delays from birth to age 3 years.

Methods

We conducted two parallel open-label randomised controlled trials. Eligible infants were first allocated 1:1:1 to standard or mixed primary PCV schedules at age 28–38 days, then at age 12 months to a booster dose (1:1) of 13-valent PCV (PCV13; Prevenar13®; +P) or 10-valent pneumococcal non-typeable *Haemophilus influenzae* protein D conjugated vaccine (PHiD-CV10; Synflorix®; +S).

Findings

From March 2013 to September 2018, 261 children were allocated to booster +P (n = 131) or +S (n = 130). Adverse events, primary and select secondary outcomes to age 18 months have been reported. Here we report six-monthly by booster dose, standardised ear, hearing and developmental assessments from age 12 to 36 months. We found high levels and non-significant group differences in the prevalence of OM at each age (eg 88% and 91%, respectively at age 18 months; difference –3% [95% CI: –11, 5]). Analyses stratified by primary schedules were non-significant. Compared with +S, the +P group had a significantly lower prevalence of moderate HI at age 18 months (23% and 42%, respectively), and a lower prevalence of expressive language delays (differences 17% to 20%) at ages 24 and 30 months.

Interpretation

Our study adds evidence of the high prevalence of chronic OM and early life trajectory of disability and disadvantage associated with OM and HI. Communities, primary healthcare services and specialists must be resourced and directed to evidence-based OM prevention and treatment for this population. Expanded-valency PCVs should be evaluated.

Early findings from the Hearing for Learning Initiative: A stepped-wedge cluster randomised trial of workforce enhancement in remote communities

Prof Amanda Leach[1,2], Kelvin Kong[3,4], Sean Taylor[1,2,6], Heather D'Antoine[1,2], Amelia McCullough[1,2], Jessica Murray[1,2], Sandra Godfrey[1,2], Tarrant Tolotta[1,2], Renee Campbell[1,2], Emily Websdale[1,2], Tess Riethmuller[1,2], Jiunn-Yih Su[1,2], Peter Morris[1,2,5], Alan Cass[1,2]

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Background

In remote communities of northern Australia, the high prevalence of early and persisting otitis media (OM) and associated hearing impairment (HI) contribute to further educational and social disadvantage of First Nations children. Inadequate resourcing and high staff turnover impede primary health service efforts to meet the needs of these children, and <10% of fly-in, fly-out specialist services reach children less than three years of age. The objective of the Hearing for Learning Initiative (HfLI) is to co-design, deliver and evaluate the broad impacts of community-based training and employment of ear health facilitators.

Methods

The HfLI is a five-year stepped-wedge (community) cluster randomised trial. The primary outcome is the difference in the proportion of children aged 0–16 years who receive six-monthly ear and hearing checks. The intervention is six weeks training On Country for community members, delivered by qualified research nurse trainers. Secondary outcomes are retrospective and prospective measures of adherence to OM guideline recommendations, and prospective interviews of stakeholders' perspectives on the workforce model.

Phases of the HfLI are: (1) lead-in – co-design consultation and trainee recruitment (six months); (2) training (approximately three months); (3) Integration into workforce (approximately two months); and (4) employment and six-monthly refreshers (three days) to end of the project.

Findings

In January 2020, following 18 months consultation, 20 communities agreed to participate and were allocated to six-monthly start dates. Adjustments to the lead-in and integration phases have been implemented in response to co-design recommendations. To end 2022, training had been successful for 35 trainees in 10 communities who reported pre to post levels of confidence, knowledge and skills increasing from 4% to 94% (skills), and performance evaluations across seven elements increasing from 45% (hear screen) to 90% (otoscopy and tympanometry).

Interpretation

The HfLI workforce model has strong potential to support effective, culturally safe and sustainable ear and hearing services across the NT.

Safety, feasibility and acceptability of telemedicine for hypertension in primary care: A proof-of-concept and pilot randomised controlled trial (SATE-HT)

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Hypertension (HT) continues to be a leading cause of cardiovascular death and an enormous burden on the healthcare system. Although telemedicine may provide improved blood pressure (BP) monitoring and control, it remains unclear whether it could replace face-to-face consultations in patients with optimal BP control. We hypothesised that an automatic drug refill coupled with a telemedicine system tailored to patients with optimal BP would lead to non-inferior BP control. In this pilot multicentre randomised control trial (RCT), participants receiving anti-HT medications were randomly assigned (1:1) to either the telemedicine or usual-care group. Patients in the telemedicine group measured and transmitted their home BP readings to the clinic. The medications were refilled without consultation when optimal control (BP <135/85 mmHg) was confirmed. The primary outcome of this trial was the feasibility of using the telemedicine app. Office and ambulatory BP readings were compared between the two groups at the study end point. Acceptability was assessed through interviews with the telemedicine study participants. Overall, 49 participants were recruited in six months and the retention rate was 98%. Participants from both groups had similar BP control (daytime systolic BP: 128.2 vs 126.9 mmHg [telemedicine vs usual care]; P = 0.41) and no adverse events. Participants in the telemedicine group had fewer general outpatient clinic attendances (0.8 vs. 2; P < 0.001). Interviewees reported that the system was convenient, timesaving, cost saving and educational. The system could be safely used. However, the results must be verified in an adequately powered RCT.

From design to delivery: InTerprofessional Education in Action – deterMining what workS (TEAMS)?

Dr Richard Meng Kam Lee, Ms Cindy Ching Siang Lee, Dr Predeebha Kannan

National Healthcare Group Polyclinic

This experiential interprofessional learning workshop provides participants with an opportunity to discuss and co-create solutions to healthcare challenges in their own context settings. This is achieved through a design thinking cognitive process using case-based learning to trigger discussions in small groups. The case scenario will depict a challenge or 'wow' moment experienced by patients in a typical primary care healthcare facility. This is used to trigger participants to reflect and co-create solutions, including the application of interprofessional competencies, to manage healthcare challenges for their own patients. The focus would be on patients who require care provided by multiple healthcare professionals at different transition points in their patient healthcare journey.

Interprofessional collaboration (IPC) is an important component of 'patient-centred and healthcare professional friendly' delivery of healthcare. Different healthcare providers often have their own professional objectives and desired outcome which may delay shared decision making in patient management. This may impact on a patient's final health outcome.

Our team has developed a novel approach to provide an opportunity for primary care providers to identify different or similar challenges/issues in delivering patient within their diverse practice context. We were able to trial this approach among family physicians, nurses and allied health providers in both wound care and child health services.

The participants then co-create solutions applying agile workplace-based learning strategies. The focus of this workshop is on deepening the application of interprofessional tenets such as cultural sensitivity, role clarity, communication, team dynamics and conflict resolution. The small group activity leads to more focused co-creative solutions, through the application of metacognitive and interprofessional competencies.

At the end of the session, the participants would be expected to apply interprofessional competencies within a theoretical design thinking model (assess, plan, implement and evaluate) to co-create contextual workplace-based solutions to complex patient journeys involving transitions of care.

Australian GP registrars and consultations in languages other than English: A love–hate relationship.

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It is recognised that ethnic or linguistic minorities shall not be denied the right to use their own language.

In Australia, one in every 10 people does not speak English well and one in every 14 GP registrars have consulted in languages other than English (LOTE); however, this is not recognised practice during GP training in Australia and not addressed during training.

This qualitative study, as part of a wider project including a quantitative study, aims to better understand the characteristics and impact of consulting in LOTE on registrars during GP training. Registrars were recruited by an email via GP Synergy, a regional training organisation, and those who self-identified as having consulted in LOTE were invited to explore their experiences. Semistructured interviews were conducted and reflexive thematic analysis applied to the data.

Interviews were undertaken with 15 registrars, of whom five were international medical graduates and 10 were Australian graduates. Their postgraduate experience ranged between four and 23 years, and the current training term ranged from term 1 to fellowship. Registrars report training at rural, remote and metropolitan areas.

Registrars did not feel that their LOTE consulting was an impediment to their training. They experienced both satisfaction and stress when consulting in LOTE, with most registrars reporting it was cognitively draining. Ambivalence as to whether it was desirable or permissible to undertake LOTE consultations during training was common. Registrars' experiences were affected by their language confidence, particularly the language of their medical education. It could increase doctor–patient affinity and understanding within the consultation, but for some registrars it was seen as an unwelcome responsibility in patient care, including creating medicolegal concerns. No registrars had discussed these experiences and concerns with educators or GP supervisors.

The implications for registrar training will be discussed, including related to professional identity formation and linguistic rights.

Giving voice to persons with disabilities (PWD): PWDs as patient educators for a more inclusive healthcare

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Background

Globally, persons with disabilities (PWD) face barriers to inclusive healthcare. As the crucible for medical professional identity formation par none, medical schools are felicitous for moulding student attitudes toward PWDs, and influencing how future doctors may impact social and physical environments for greater PWD healthcare inclusivity.

A four-hour workshop for third-year undergraduate medical students titled Communications With Persons With Disabilities was designed with PWD advisors and initiated in 2022. The workshop, developed after Kolb's experiential learning model, comprised pre-event videos and readings, a plenary, followed by in-person fishbowl discussions where participants observed peer-volunteers engaging with patient educators. These patient educators were PWDs who enacted clinical conundrums of disabilities (hearing, vision, mobility) resembling their own experiences. Tutors facilitated group reflection and sharing to deepen learning.

Methods

Students were surveyed pre- and post-workshop. Items included demographic data, the Attitude Towards Disabled Persons (ATDP)-O scale, qualitative reflections and feedback questions. Descriptive analysis was used for demographic and feedback questions, and thematic analysis for reflections. Paired t-tests were used to evaluate any change in ATDP-O scores.

Results

The response rate was 58.3% (n = 35, N = 60). Only one student found that education about PWDs in medical school had been adequate so far. Most (n = 33; 94.3%) enjoyed the workshop and agreed or strongly agreed that the workshop was relevant to their future career as doctors. Attitudes towards PWDs significantly improved after the workshop (ATDP-O +11.66, max 120; $P < 0.001$).

Discussion and conclusions

While the workshop attained a demonstrable difference in students' attitudes toward PWDs, further research should study the longitudinal effect of this difference. Importantly, by staking PWDs as patient educators, the workshop brings the PWDs' voice into the medical curriculum and sensitises tomorrow's doctors to the health and social needs of PWDs.

SmartVax – our active vaccine surveillance journey – fluvax 2010 to nine million COVID encounters

Dr Alan Leeb[1,2]

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Aim

In April 2010, the use of seasonal trivalent influenza vaccine in children was abruptly suspended following an increase in adverse events. This surprised Australia's medical profession and triggered a chain of events and innovation that would shape the active surveillance of adverse events following immunisation (AEFI). This formed the groundwork for a world-leading platform for COVID vaccine safety monitoring.

Content

A trial was run at a WA general practice during 2012–14, where all persons immunised were sent an SMS three days after vaccination asking if they experienced any reaction(s).

SmartVax further developed this prototype before partnering with AusVaxSafety in 2015, building a network of 358 sites by 2020.

In 2020, a prototype COVID vaccine safety monitoring platform was developed with a network of sites uploading data to an aggregated AusVaxSafety database to serve as an effective system for active AEFI monitoring of all COVID vaccines.

Goals

As of January 2023, the Australian SmartVax vaccine-safety monitoring network comprised 615 sites: 471 general practices, 127 pharmacies, seven Aboriginal Medical Services, three hospital vaccination clinics and seven local government or university clinics.

SmartVax has monitored more than 8.7 million vaccination encounters in Australia, including 3.7 million in 2021 and 2.4 million in 2022. This includes 5.2 million COVID-19 vaccination encounters to January 2023, thus ensuring the safety of the Australian vaccination program.

SmartVax is a proven, timely and efficient active vaccine safety monitoring platform. Reporting to the Department of Health, as well as state health departments, SmartVax has made a significant contribution to national and international vaccine safety data and post-licencing literature.

AusVaxSafety is a world leader in AEFI surveillance and, in December 2022, received the Data Innovation Award at Research Australia's 19th Annual Health and Medical Research Awards.

Reinvigorating general practice promotion and training for the future

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The future of general practice in Australia is at a crossroad.

There is noticeable shift in the interest of medical students not wanting to pursue general practice as a specialisation. This is further compounded by the reduction in trainee doctors following a career in medicine altogether due to burnout and bullying. The Medical Training Survey reported that of those who had experienced bullying, 70% did not report it, concerned of repercussions.

General practice is the cornerstone of the Australian health system. It is still viewed as a 'lesser speciality' associated with 'lower status' by many junior doctors, despite the complex and cognitively challenging skillset required, especially in rural and remote practice.

Health departments and government recognise GP training as a priority speciality training pathway. Despite this, the numbers of medical graduates choosing a general practice specialty pathway are grossly insufficient.[4] We need to consider novel and practical ways to improve the GP training experience and enhance the perception of general practice.

Attracting medical students and junior doctors to general practice is a crucial step in developing a stronger workforce. The benefits of a meaningful clinical placement are well documented, with positive outcomes from the perspectives of educators and students. Additionally, research shows when students have the responsibility in the clinical encounter (ie seeing patients independently in general practice placements), their motivation and drive is enhanced, which improves their interest in the speciality.

Medical students require immersive experiences in general practice, where they not only experience the variety and work involved, but are also actively involved in clinical encounter. This involvement reduces the student's perception as a burden in the clinical setting. A shift in our thinking and teaching is essential for the growth of general practice in Australia.

Key factors for telehealth implementation in Thai ageing population

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Background

To prepare for an ageing society, the Thai government has established a policy integrating the use of communication technology into health services (telehealth). However, local evidence about telehealth implementation in the older population was limited.

Aims and objectives

This study aimed to identify what key factors were needed for successful telehealth implementation in general and specifically in the Thai older population.

Methods

A mixed-methods approach including a critical literature review and qualitative interviews with six stakeholders in the northern part of Thailand was applied. In the critical literature review part, 11 studies from four databases (Delphis, Web of Science, PubMed and Scopus) were included. Inclusion and exclusion criteria were applied. In the qualitative part, six stakeholders were included: one policy maker, three healthcare providers, one IT worker and one older patient. Online semistructured interviews were conducted via Zoom or LINE VDO call. Qualitative content analysis was applied.

Results

Three categories of person-related factors, technology-related factors and contextual factors were extracted from the literature review and interview data. Each category had effects on one another. Seven key factors were highlighted: (1) promoting acceptance: perceived usefulness and social influence; (2) minimising barriers: health conditions, socioeconomic issues and technology skills; (3) training; (4) practical support; (5) effective tools: consideration of older people's conditions, ease of use, integration into existing infrastructure and services; (6) security; and (7) policy and funding support.

Conclusion

A holistic approach by integrating key factors into the existing healthcare system considering older people's specific needs and cultural context would lead to the successful implementation of telehealth in the Thai ageing population. However, policy and funding support was also needed to sustain the telehealth services.

Advocating for change – strengthening rural health services and systems

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Aim

To discuss and apply a framework to the development of an advocacy plan to strengthen rural health services and systems.

Contents

Health system advocacy activities relate to promoting system change, mobilising resources, addressing health inequities, influencing policy reforms and policy implementation. Advocating addresses structural determinants of health and promotes change which enables access, quality of care and sustainable service delivery. However, to be effective, advocacy activity requires specific principles and planning to achieve the deliberate pursuit of changes in policy, attitudes, behaviour and decision making, usually in the public interest. This includes multilevel strategies which blend values, evidence, timing and context. This interactive session will discuss and present an advocacy framework and implementation plan for the purpose of strengthening rural health services and systems. Participants will select from one of three identified key priority issues to implement the advocacy framework. These priorities include: (1) describe the primary care service models that are effective in different rural contexts to inform scalability; (2) advocating for high-quality integrated policies to support a strong rural health system; and (3) communicating effective local solutions through exemplars and case studies. Participants will work together to set the advocacy objectives, draft key messages considering the context and other relevant issues, define the target audience and key advocacy partners and determine the most appropriate advocacy strategy to achieve the desired outcome.

Goals

The goals of the interactive session are to build a shared understanding of advocacy for rural health systems strengthening and to discuss the different types of advocacy and approaches to advocacy that can be used to address key priority areas.

Revival of GP's medical aid and exchanges in remote foreign areas: a SWOT analysis to know its impact

Dr Jean-Claude Leners

Medicus Liber

Since the COVID-19 pandemic a lot of valuing doctor's exchanges or temporarily medical missions in remote areas have been stopped. For instance in our country, some 87 non-governmental organisations (NGO) are established and some 52 has a primary medical program. We wanted to find out how far this exchange, as it will be reactivated nowadays, is still a good medical collaboration between remote populations without access to local GPs and the temporarily expatriated GPs. A standardised methodology has to be applied in order to find out positive and negative aspects that might be targeted or questioned. SWOT analysis is one of the tools that may combat our too-narrow vision and be more objective about our processes. The acronym stands for: strengths, weaknesses, opportunities and threats. (A) Strengths in this field means: to bring the medical expertise where local GPs are missing; to get knowledge on diseases which you never saw in your own country. (B) Weaknesses: by sending regularly expatriated physicians, you will not allow local organisations to fill in the gap through local workforces; local authorities might get too much dependant on foreign GPs and local doctors might choose to leave their native areas. (C) Opportunities: by a real exchange and training in two ways, both sides may have a win–win situation; by the fact that both sides are looking on different cultures or medical approaches in similar diseases, there will be a better understanding in both surroundings. (D) Threats: it is always easy to start a kind of medical humanitarian aid, but it is much more difficult to let local GPs take over this whole task; keeping authorities dependant on GP and money transfer is not what most countries need or want. Mutual respect, understanding and trust are a minimum for a good collaboration.

Patient self-reported health and the impact of primary care funding: A national longitudinal study of English general practices, 2013–16

Dr Veline L'esperance, Mark Ashworth

King's College London

Objectives

To examine the relationship between self-reported health of patients in general practices, as measured by EQ-5D-5L, with practice funding and practice characteristics.

Methods

We combined six datasets for all English general practices (n = 7310) using data for the financial years 2013–14 to 2016–17: (1) General and Personal Medical Services database, providing workforce and patient data; (2) NHS payments to General Practice, which records payments to practices; (3) Quality and Outcomes Framework describing performance on clinical achievement of clinical quality indicators; (4) deprivation data for each practice; (5) neighbourhood ethnicity profile for each practice; and (6) practice-level patient experience scores and EQ-5D-5L index from the General Practice Patient Survey. We use data from the GP Patient Survey (GPPS) to construct a practice level EQ-5D-5L index as the health outcome in dimensions of mobility, self-care, usual activities, pain and anxiety. Key explanatories are general practice funding, practice deprivation, patient-reported measures of satisfaction, clinical achievement and practice morbidity (proportion of patients with one or more chronic condition). We estimate practice-level panel data models with random and fixed practice effects and practice and patient explanatories.

Results

Mean total funding per patient at 2016 prices was £133.66 (standard deviation £39.46). In both random and fixed-effects panel regressions, general practice funding is positively associated with one-year lags of general practice funding across each of five dimensions of health: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each of the five dimensions of health are also positively associated with one-year lags of patient satisfaction and clinical quality. However, higher levels of deprivation and practice morbidity are associated with lower health outcomes across all health dimensions.

Discussion

Practice-level EQ-5D-5L for each health dimension is positively associated with practice funding, patient-reported satisfaction and clinical achievement, but negatively associated with deprivation and practice morbidity.

Impact of general practice funding on ACSC admissions: A five-year English longitudinal study

Dr Veline L'esperance, Mark Ashworth

King's College London

Background

Hospital admissions for ambulatory care sensitive conditions (ACSC) are those that could potentially be prevented by timely and effective disease management in general practice. The aim of this study is to explore the impact of including general practice funding on ACSC admissions.

Methods

Using longitudinal data at the practice level, from 6974 English practices from 2013–14 to 2017–18, we explored the relationships between the funding and quality of primary care, and hospital admissions for ACSCs controlling for a wide range of covariates. We combined seven datasets for all English general practices: (1) workforce and patient data; (2) payments to practices; (3) clinical achievement indicators; (4) deprivation data; (5) neighbourhood ethnicity profiles; (6) patient experience; and (7) distance from nearest acute hospital. We estimate Poisson models allowing for unobserved practice effects and with robust standard errors.

Results

Mean total funding per patient at 2017 prices was £153.87 (standard deviation [SD] £41.84). ACSC admissions (per 1000 patients) increased from 15.30 (SD 5.89) in 2013–14 to 17.02 (SD 6.31) in 2017–18. Components of general practice funding significantly associated with lower ACSC admissions include performance related funding for delivering enhanced services. However, capitation funding (based on patient need) was positively associated with ACSC admissions.

Practice factors significantly associated with lower ACSC admissions include larger patient population, increased practice list growth, higher patient satisfaction, higher clinical quality, training practice status and a greater distance from the nearest acute hospital.

However, higher ACSC admissions were significantly associated with deprived patient populations, higher proportion of nursing home patients, higher patient access scores and higher GP staffing.

Discussion

Components of general practice funding related to performance and operational aspects demonstrate a direct relationship with lower ACSC admissions. This implies that additional funding directed towards incentivising the additional work may be required to keep the patients out of hospital.

Addressing quality and interoperability of data in general practice

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UNSW Sydney

Coupled with evidence-based guidelines and well-designed algorithms, digital real-world data (RWD) from health information systems (HIS) will support personalised medicine and continuity of care through the linkage of good quality information from multiple health facilities in primary and secondary care. The key challenges to data-driven innovation are interoperability and the quality of digital data and tools. Interoperability standards and data quality benchmarks exist, but the quality and fidelity of compliance to them remain significant unknowns. Many studies, however, suggest compliance is low and that RWD from general practice HIS are not fit for purpose.

Aim

To assess the compliance of MedicineInsight, a national repository of RWD from 600+ Australian general practices, to interoperability standards and quality benchmarks.

Methods

We mapped MedicineInsight data to a widely used common data model (CDM) and assessed its ability to aggregate 600+ disparate GP datasets to conduct 'big data' research using four scenarios: opioid use for cancer and non-cancer pain; cardiovascular risk assessment and heart failure; surveillance of infectious disease and vaccine use; and youth mental health. Shared open-source data analytics and quality assessment tools were used in a secure digital health research environment at UNSW Sydney.

Outcomes

Significant preparatory technical work was required to address architecture design, operating procedures, security and governance challenges in preparing the datasets. This was compounded by a change of MedicineInsight data custodian. The syntax (CDM) and semantic (SNOMED-CT) mapping was relatively uneventful. The final results from the four scenarios will be discussed for methods robustness and fitness-for-purpose of RWD. The implications for good clinical practice and documentation for continuity-of-care in integrated primary care settings will be discussed. Working through the Australian Health Research Alliance, a CDM approach will enable data linkage of RWD from registries, biobanks, social media and wearables to advance the potential of personalised medicine at individual and population levels.

Exploring how patients assess online health information: A qualitative study using vignettes and think-aloud methods

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Aim
People are exposed to variable health information from the internet, potentially influencing their health behaviour and decision making. It remains a challenge for people to discern between good- and poor-quality online health information (OHI). This study explored how patients assess and trust OHI related to their health conditions.

Methods
This qualitative study used vignettes and think-aloud methods. We recruited patients with high cardiovascular risk in a primary care clinic. Participants were given two vignettes about statins: high-quality, evidence-based information and low-quality information. Participants voiced their thoughts when reading the vignettes, determined a trust level for each vignette using a five-point Likert scale, and then participated in an interview. We used an interpretive description approach with thematic analysis.

Results
In all, 20 participants were recruited, with ages ranging from 38 to 74 years. Among all the high cardiovascular-risk participants, eight had pre-existing cardiovascular diseases. Five themes emerged from the analysis of how patients assess OHI: (1) logical sense of content; (2) neutrality of content and tone; (3) concordance with personal experience; (4) sources of information; and (5) consistency of information.

Conclusions
Patients with direct involvement in the topic of OHI focused on the content in their evaluation process. Although patients used source credibility criteria in assessing OHI, they trusted low-quality information that used signals associated with higher-quality OHI. Seeking external validation of OHI was a key process for patients to decide their trust in OHI. This study informed the designing of tailored strategies to educate patients on appraising OHI.

Practical challenges in medical education reform for capacity building of primary care doctors in Cambodia

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University Of Health Sciences

Introduction

Primary care doctors are essential for the healthcare system, with better health outcomes at lower costs and greater equity. Medical education reform as an upstream strategic intervention is needed to improve primary healthcare capacity, especially in resource-limited contexts. Competency-based medical education (CBME) has gained momentum as the premier curricular model to produce competent doctors. However, moving toward a competency-based curriculum comes with challenges. Resource constraints may exacerbate inherent challenges. Contextualisation plays a crucial role in curricular change. Adopting the CBME model, originating from the Western world, requires the acceptance of instructional design and social organisation. In Cambodia, CBME implementation efforts have been ongoing for a decade now. However, significant barriers persist, and progress is limited. This study aims to explore practical challenges of CBME implementation in a resource-limited, non-Western context.

Methods

Information was collected through document reviews and semistructured interviews. First, grey literature, public documents, strategic plans, project outputs and pertinent reports were examined. Second, three international consultants and 10 faculty members from all five medical schools in Cambodia were interviewed. Data were analysed using inductive thematic analysis.

Results

The study identified 12 themes and numerous subthemes. Several issues were directly related to the curriculum, including conceptual understanding, the national curriculum standard, clinical training and assessment. Challenges in stakeholder engagement, resources, teachers and students affected the process of implementing curricular change. Contextual factors also hampered CBME, such as policy, culture and organisation, accreditation and leadership.

Conclusion

Study results reveal interrelated factors that may facilitate or hinder CBME implementation. Some challenges are similar across contexts, while others are specific to Cambodia, including pragmatic approaches to CBME adoption, conceptual misconception, the prescriptive curriculum, resource constraints and contextual barriers. Relevant stakeholders must find collaborative strategies to overcome these challenges, turn them into opportunities and learn from successful examples.

Empathy in action: A catalyst for change across the global primary healthcare landscape

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Aim

Provide education and skills to primary care professionals to navigate evolving clinical practice. Evidence-based research has shown that the adoption and implementation of trauma-informed and inclusive care models improve global health inequity.

Content

This skills-building session aligns with the World Health Organization's *A conceptual framework for action on the social determinants of health*. By systematically eliminating barriers to health inequities through the application of trauma-informed and inclusive care models, this session aims to equip primary healthcare professionals with the tools needed to enact transformational change.

Evidence shows minority stress is one of the main indicators for poor health outcomes in priority populations globally. Empathy-building exercises allow participants self-reflection and development around their own experiences. In turn, this builds a connection between participants' stories and the lived experiences of priority population groups who are subjected to unconscious bias when accessing healthcare.

Comparisons can be drawn between best-practice trauma-informed and inclusive care models and participants' existing primary health frameworks. When health inequities are identified, use of continuous quality improvement strategies can be applied to create better health outcomes for global priority population groups.

Each person has a direct role and responsibility in the betterment of health outcomes for all individuals. By coming together to investigate and understand the benefits of trauma-informed care and inclusive practices, we can support the healthcare needs of all our clients, thereby ensuring their human rights to healthcare globally.

Goals

1. Learn the foundations of best-practice trauma-informed and inclusive care models in primary healthcare
2. Identify and reflect on your domestic priority population groups and the negative impacts they experience in accessing primary healthcare
3. Apply learned strategies to improve priority population health outcomes and global health equity

Progressive neurological deterioration during a primary care consultation: Is it the great pretender?

Dr Yen Li Lim

Sexual Health Service, Royal Prince Alfred Hospital

This session uses an interesting neurosyphilis case, with significant progressive neurological deterioration, to educate the audience on the general principles of syphilis testing, diagnosis and treatment, and specific investigations for neurosyphilis diagnosis and treatment.

Syphilis is a sexually transmissible infection caused by the bacterium Treponema palladium. In 2020, there were an estimated seven million new syphilis infections globally. While men who have sex with men still carry a higher burden of disease, rates of syphilis in heterosexual populations have been increasing. Neurosyphilis, infection of T. palladium in the cerebrospinal fluid (CSF), can occur at any stage of syphilis infection. Increased syphilis infection numbers may result in higher neurosyphilis cases. Neurosyphilis can present with variable neurological symptoms. While CSF examination remains the mainstay of diagnosis, clinical suspicion with assessment of pretest probability is equally important.

Internationally, primary healthcare practitioners are the first point of contact with healthcare services. They are the first clinicians to assess sometimes complex symptoms, and are well-placed to assess for, diagnose, treat and follow up syphilis infections early, including neurosyphilis.

The case study is a 63-year-old man who has sex with men, living with human immunodeficiency virus on anti-retroviral therapy. He reported two weeks of bilateral visual changes with photophobia, polyarthritis and weakness. At presentation, he also had ataxia and reported cognitive changes. His motor symptoms worsened during the consultation and he was unable to mobilise independently on transfer to emergency. CSF results were diagnostic for neurosyphilis. He was treated with benzylpenicillin 1.8 g intravenously every four hours for 12 days. Due to reported side effects, he had ceftriaxone intravenously 2 g daily to complete a 15-day treatment course.

The goals are to provide education and resources, and to increase the confidence of primary healthcare practitioners to test, diagnose, treat and follow up syphilis cases.

Poor grip strength and walking speed increase all-cause mortality in the elderly

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Introduction
Grip strength and walking speed influence physical performance in the elderly. The risk of obesity for mortality is controversial. The study aims to determine the association between grip strength, walking speed and all-cause mortality in the elderly.

Objectives
The objective of this study was to determine the risk of all-cause mortality in different physical performance of the elderly.

Methods
We included elderly (above 65 years old) in 2009 and followed up until 2021 from a community cohort group. Demographic data, clinical parameters, physical performance and outcomes were recorded, including age, gender, body height and weight, baseline disease, grip strength, 5-m walking speed, the date of inclusion and mortality. We defined normal grip strength (NG) as ≥28 kg in men and 18 kg in women and normal walking speed (NW) as ≤1 m/s. Conversely, participants not meeting these levels were defined as having poor grip strength (PG) and poor walking speed (PW). Participants with a body mass index ≥25 and <25 kg/m^2 were defined as obese and non-obese, respectively. Continuous and categorical variables were analysed with Student's t-test, logistic regression and Chi-squared tests, respectively. Cox regression was used for survival analysis, adjusting for age, sex, physical activity and baseline disease.

Results
Among 1029 participants, the mean age was 73.4 years and males predominated (52.1%). The percentage of non-obese and obese participants was 60.3% and 39.7%. All-cause mortality in the PG and NG groups was 60.3% and 29.8% ($P < 0.005$); all-cause mortality in the PW and NW groups was 40.0% and 19.6% ($P < 0.005$), respectively; and all-cause mortality in the non-obese and obese groups was 38.3% and 34.6% ($P = 0.220$). The hazard ratios for all-cause mortality in PG and PW groups were 1.71 (95% CI: 1.344, 2.176; $P < 0.005$) and 1.402 (95% CI: 0.956, 2.055; $P = 0.084$), respectively.

Conclusion
Poor grip strength and poor walking speed increased the risk of all-cause mortality in the elderly.

Applying an ecological model to reduce the climate impact in health-promoting hospitals

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The Ottawa Charter for Health Promotion in 1986 aimed at promoting human health not treating diseases only. Five health actions were announced which pointed out that health policies, supportive environment, collective community action along with personal skills are key factors to reorient the health services to promote biopsychosocial wellbeing.

The World Health Organization pointed out climate change is an imminent threat to human health. Climate change will intensify existing health risks with frequent and severe extreme weather events, poor air and water quality, emerging and re-emerging infectious diseases. It places enormous pressure and demand on the healthcare sector. Furthermore, the healthcare sector is a major contributor to greenhouse gases, accelerating the vicious cycle. Reducing the environmental impact is an important issue for the healthcare sector.

The International Network of Health Promoting Hospitals and Health Services (HPH) was established in 1990 for promoting health from a setting approach. In 2010, the taskforce of HPH and Environment was established to address the mitigation and adaptation issues of healthcare sectors to tackle climate change.

Using the ecological model, HPH revised its standards in 2020 at the macro level, putting environmental health in Standard 5.3 for HPH member hospitals to follow, which listed important principles to guide the hospitals' green programs.

At the meso level, the HPH committee in hospitals organises programs for environmental health, which will develop, enforce and review annual programs to reduce climate impact and build the climate resilience of the organisation, such as a recycling policy in medical waste segregation, promoting environmentally friendly diet and so forth.

At the micro level, awareness and practice of personal behaviour and lifestyle change improve personal skills such as using energy-efficient appliances, taking public transportation, prescribing fewer MDI inhalers and so forth to reduce the greenhouse gas emissions.

Awareness of the climate change impact on health is important for family physicians working as frontline healthcare workers.

A world in crisis: Time for action to support healthcare workforce – the WONCA Working Party on Mental Health approach

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WONCA Working Party on Mental Health

The COVID-19 pandemic has disrupted the delivery of mental health services worldwide, disproportionally affecting low- and middle-income countries (LMCIs), where the new demands overburdened the already fragile and fragmented healthcare systems. Healthcare professionals everywhere are struggling in their attempt to meet expanding mental healthcare needs of people of all ages, and it is now the time for primary healthcare (PHC) to take plausible strategies to respond to unmet needs, and this requires greater leadership and advocacy. Responding to the need of enhancing professional capacity during these hectic times, the WONCA Working Party on Mental Health (WWPMH) has been proactively involved in numerous training activities to support the practice of the frontline PHC workforce worldwide. This workshop will provide an overview of WWPMH's approaches, focusing on efforts to build leadership among early career family doctors, to enhance the capacity of family physicians to manage severe mental illnesses and promote the PHC workforce's resilience during the multiple crises of our time.

Increasing the GP competences: Closer to the patient, more efficient to the healthcare system

Dr Peter Lipovský[2]

[1]MEDILIP – Private GP Practice, [2]Slovak Society of Primary Health Care – Vice President

Over the past 10 years, the competencies of Slovak general practitioners have increased significantly. Their activity was limited to curative treatment, basic prevention with basal blood tests, vaccination. Most chronic conditions were managed by the specialist to whom the patient was referred. Currently, a Slovak general practitioner manages arterial hypertension, dyslipidaemia, prediabetes and obesity, and performs preoperative examinations. The general practitioner is competent to perform and evaluate ECG, ABI, FOB, INR, CRP, 24-h blood pressure monitoring and solve acute hypertensive cases. A few GPs do abdominal ultrasonography. GPs perform cardiovascular risk stratification according to the latest guidelines and set up adequate treatment. They apply and evaluate the Montreal Cognitive Test in indicated patients, who are then referred to specialists. During the COVID-19 pandemic, telemedicine procedures were added. From the patient's point of view, such comprehensive healthcare is welcome, because the GP can solve many of a patient's problems in one place. All the mentioned activities, including preventive examinations, are covered by public health insurance beyond the capitation. This results in a higher medical and economic motivation of the general practitioner. Conversely, it brings a much higher efficiency in the use of public funds, since specialised care is much more expensive and difficult to access. Last but not least, a timely and efficient GP service for the patient significantly reduces the number of preventable deaths.

Burden and complications of herpes zoster ophthalmicus: Preventable by vaccination

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Herpes zoster ophthalmicus (HZO) involves latent varicella-zoster virus reactivation within the ophthalmic branch of the trigeminal nerve. Due to the risk of complications, HZO is considered an emergency requiring ophthalmic consultation. Recognising the clinical signs is key to early treatment. A non-systematic literature review evaluated HZO burden, complications and patient management. The PubMed search for '(zoster[Title/Abstract]) AND (ophthalm*[Title/Abstract])' (2015–2023) revealed 429 articles, including 132 of relevance.

Approximately 8–20% of patients with herpes zoster (HZ) develop HZO. Consistent with HZ epidemiology, adults aged ≥60 years and immunocompromised individuals experience higher HZO incidence and more severe disease. Up to 25% of patients may develop chronic or recurrent HZO. Clinical signs include facial herpetic rash, sometimes preceded by neuropathic pain, fever and headaches. Ocular involvement increases if the rash extends to the tip of the nose (Hutchinson's sign), flagging nasociliary branch involvement. Without antiviral therapy, approximately 50% of patients with HZO develop ocular manifestations, including conjunctivitis, uveitis, episcleritis, keratitis and retinitis. Ocular symptoms include discomfort, discharge, redness, pain and photophobia. One in 10 patients develop moderate or severe vision loss, which can be permanent. Other complications include risk of cardiovascular events and stroke.

Antivirals, topical steroids and pain medication are the mainstay of treatment. Antiviral initiation within 72 h of rash/new ocular involvement reduces chronic ocular complications by 20–30%.

Two HZ vaccines are available: a live-attenuated vaccine and a non-live recombinant, adjuvanted vaccine. The latter has fewer contraindications but higher reactogenicity. In independent real-world US studies, vaccine effectiveness in preventing HZO has been reported as 27–63% for live-attenuated vaccines and 67–89% for non-live recombinant, adjuvanted vaccines. Primary care physicians should consider vaccination in preventing HZO and its complications.

Identification of potential vaccine features important in the public decision making of herpes zoster vaccination in Australia

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Background

Vaccination is important for preventing herpes zoster (HZ), which typically affects older adults due to immunosenescence, placing a significant burden on patients and their families/caregivers. The Australian public may not be fully aware of the profiles of available HZ vaccines and an understanding the vaccine-related preferences of adults ≥50 years of age (YOA) is needed.

Aim and goals

Using concept elicitation to understand how vaccine attributes may inform vaccine choice generally and identify vaccine features that may influence HZ vaccination decision making among HZ-naïve/HZ-experienced/HZ-vaccinated individuals.

Methods

One-to-one exploratory qualitative interviews were conducted in Australia in April–May 2022 among 20 adults ≥50 YOA (general population [HZ-naïve], n = 10; HZ-experienced patients, n = 10). The general population was stratified by HZ vaccination status (not HZ-vaccinated, n = 6; HZ-vaccinated, n = 4).

Results

The most important vaccines among respondents were flu vaccines (17/20) and COVID-19 vaccines (14/20). HZ vaccines were most important to the HZ-vaccinated general population (4/4) and moderate/severe HZ patients (3/10). Generally, key reasons for vaccination included preventing disease or serious infection/complications and maintaining good health. Multiple respondents (13/20) considered doctors important in providing information proactively on recommended vaccines and alleviating vaccine-related concerns. Some respondents (n = 4) relied on media/their own research when considering vaccination.

HZ vaccine features considered important among respondents included reducing lifetime HZ risk (19/20), preventing HZ-related complications (18/20), duration of protection (17/20), government/medical societies' recommendations (14/20), number of HZ cases prevented in the next five years (13/20), short-term side effects (12/20), number of doses for full protection (10/20) and vaccine type (6/20).

Conclusion

In general, physicians' understanding of individuals' vaccination-related needs is crucial, particularly for HZ vaccination due to a lower Australian public view on its importance compared with other vaccines. These findings elucidate individuals' preferences regarding HZ vaccination, top vaccine attributes considered and the roles of different information sources/stakeholders that drive HZ vaccination decision making.

Cost-effectiveness analysis of digital therapeutics for home-based cardiac rehabilitation for patients with chronic heart failure: Model development and data analysis

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Background
In recent years, numerous guidelines and expert consensus have recommended the inclusion of digital technologies and products in cardiac rehabilitation.

Objective
This study aimed to conduct an early technology assessment of digital therapeutics. Based on the evaluation methods and models of health economics, we analyse the potential cost effectiveness of digital therapeutics for home-based cardiac rehabilitation for patients with chronic heart failure from the perspective of healthcare decision makers so as to provide a basis and reference for application and the promotion of digital therapeutics.

Methods
Markov models were constructed to simulate the outcomes of digital therapeutics for home-based cardiac rehabilitation (DT group) compared to conventional home-based cardiac rehabilitation (UC group) in patients with chronic heart failure. Model input parameters were clinical indicators and cost data. The outcome indicators were quality-adjusted life years (QALYs) and incremental cost-effectiveness ratios (ICERs). The robustness of the evaluation methods and results was tested by sensitivity analyses. Clinical indicators, cost data and health utility values were obtained from real-world data, including clinical study data, published literature and public website information.

Results
The Markov model simulated a time span of 10 years with the cycle set at one month, for a total of 120 cycles. The results showed that the per-capita cost of the UC group was 38,442.11 RMB/year, with a QALY of 0.7196 per person per year. The per-capita cost of the DT group was 42,300.26 RMB/year, with a QALY of 0.81687 per person per year. The ICER per person was 39,663.5 RMB/QALY each year, which was below the willingness-to-pay threshold of 80,976 RMB.

Conclusions
Digital therapeutics for home-based cardiac rehabilitation is an extremely cost-effective rehabilitation option compared to conventional home-based cardiac rehabilitation. From the perspective of healthcare decision makers, digital therapeutics for home-based cardiac rehabilitation is potentially valuable.

Revival of the clinical exam: From OSCE to Clinical Competency Exam

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The Clinical Competency Exam (CCE) is a multistation examination that samples candidate competency across the RACGP curriculum focusing on the application of clinical management skills in the context of Australian general practice. It is the final hurdle assessment prior to candidates obtaining Fellowship.

The CCE represents an agile, contemporary, evidence-based examination. Extensive consultation with leading international medical assessment experts informed the development of this examination, ensuring that the assessment is valid and reliable, and enabling the RACGP to assess candidates' clinical competence in multiple contexts, upholding the standard of Fellowship.

The CCE was developed in 2019 following a decision to review and update the longstanding Objective Structured Clinical Examination (OSCE). The COVID-19 pandemic accelerated the development of this exam with a transitional remote clinical exam (RCE). The successful delivery of the RCE demonstrated that the 'show's how' of Miller's pyramid could be assessed virtually without compromising the attributes and quality of a face-to-face exam.

This presentation will showcase the theory, development and implementation of one of the largest successful online competency assessments worldwide. Developed and delivered in pandemic conditions and now to become the benchmark final clinical assessment of the RACGP Fellowship.

The CCE has been observed internationally and our team continues to work with international partnerships to help our peers create contemporary assessments in primary care worldwide.

All hands on deck: A workshop on how to engage patients and their families in patient safety

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People using healthcare services, both patients and their families, have an essential role as co-producers of their health and their healthcare. They uniquely represent the consistent factor throughout the care pathway and benefit from a privileged perspective that can elicit vital information for improving healthcare. Patient and family engagement is the process of building the capacity of patients, families, carers, as well as healthcare providers, to facilitate and support the active involvement of patients in their own care in order to enhance safety, quality and people-centredness of healthcare service delivery.

Tapping into such a rich resource can significantly improve safety in primary care. In 2017, the US Agency for Healthcare Research and Quality (AHRQ) developed the *Guide to improving patient safety in primary care settings by engaging patients and families*. This landmark document provides a compilation of evidence-based best practices for improving patient safety through patient, family and caregiver engagement. The World Health Organization, in particular, has made patient and family engagement a key priority in patient safety through the development of the WHO technical report on safer care Patient engagement (led by one of the workshop presenters) and by selecting patient and family engagement as the theme for the 2023 WHO Patient Safety Day. The WONCA Working Party in Quality and Safety is contributing to this agenda with a scoping review that will elicit additional updated evidence of relevance for family practice.

In this skills-building session we will revisit how patient and family engagement may contribute to patient safety. We complement the reference guidance for family doctors with the perspective of more recent work conducted by the WONCA Working Party to consider the role of patients and families and how they may be partners in ensuring the safety of patients.

The impact of COVID-19 lockdown on the prevalence of paediatric depression

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Introduction

As one of the most vaccinated countries in America, Puerto Rico's success in containing the pandemic has come after many months of strict public policy implementation. Government officials declared a state of emergency on the island on 15 March 2020. These measures included closing all schools across the island, forcing educational administrators to improvise online school efforts to complete the academic year.

This significant increase in lockdown-related anxiety and depressive symptoms is an unfortunate observation across several countries in the world. A 50% increase in suicide attempts has been reported among adolescent girls in the US alone compared to statistics from 2019.

Our purpose is to compare the prevalence of depression in Puerto Rican paediatric patients, from a paediatric practice located in Mayaguez, Puerto Rico, between 9 and 21 years old prior to the pandemic lockdown (2018–19) and compare results to those during the lockdown(2020–21). In addition, we will compare body mass indices with Patient Health Questionnaire-9 (PHQ-9) scores to determine if there is an association with higher BMIs and a higher prevalence in depression.

Methods

Patients were systematically selected filtering for age. The PHQ-9 was used for children between the ages of 9 and 21 years within the period of January 2018 – December 2021.

Results

In all, 196 patients were reviewed via electronic medical record during 2018–19 until 2021. There is an increased tendency in PHQ-9 scores was found in the 2020 group after lockdown although these results were not statistically significant.

This tendency between the groups was not associated with BMI as both groups had similar BMIs. We did find a statistically significant association between higher PHQ-9 levels and increased BMI with a P value 0.005 and 96% confidence interval of 0.06–0.33. Psychology referral was increased in 2020 with 40% referral compared to 28.3% in 2018–19.

A survey on the knowledge of family medicine specialty among the Puerto Rican population

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In 1971, the Puerto Rican Chapter of General Practitioners changed its name to the American Academy of Family Physicians, which was done to distinguish between non-specialised 'generalist' physicians and specialised family physicians. Puerto Rico is unique when compared to the mainland United States in that 50.3% of the island's practising physicians are non-specialised physicians. Less than 3% of physicians in Puerto Rico are family medicine physicians. Our premise is that the vast majority of the Puerto Rican population do not know the scope of practice of a family medicine physician, in part because of the perception that family physicians are non-specialised. On an island that is in critical shortage of specialised primary care physicians, like paediatricians and OBGYN, it is paramount to know that, if indeed, our premise is correct – that the vast majority of the Puerto Rican population does not know the full scope of practice of a family medicine physicians. Then, the Family Medicine Academy of Puerto Rico along with local and state officials can perhaps implement an educational campaign on the scope of our practice so as to cover other specialities that are in critical shortage on the island, like paediatricians. The purpose of this survey is to determine the current general knowledge of our speciality in family medicine in Puerto Rico.

We conducted an observational cross-sectional study which consisted of a total of 592 participants. There is no association between knowing a family medicine physician and the knowledge that they are specialists. There is a direct relationship of having a higher education level and having a better understanding of family medicine with a statistically significant value of $P < 0.0001$.

Usability study of a technological tool aimed at self-care in patients with multimorbidity

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Aim

To analyse the effectiveness, efficiency and satisfaction in usability of a technological tool dedicated to health and self-care in patients with multimorbidity in primary care.

Material and methods

Cross-sectional observational descriptive study of usability within the framework of the clinical trial in Primary Care in Madrid of the TeNDER project (NCT05681065). Patients over 60 years of age with one or more chronic diseases were included. The main study variable was usability effectiveness, which was determined as the degree of completion and the total number of errors per task. Five tasks based on real case scenarios were evaluated. Sociodemographic variables and technology affinity and satisfaction were collected. Descriptive analysis was performed and factors associated with task completion were estimated using a logistic regression model.

Results

In all, 12% (30/250) of the included patients agreed to participate in the usability study. The usability effectiveness was 89.3% (134/150 tasks completed). In all, 66.7% of patients (20/30) completed all tasks and 56.7% (17/30) required personalised help on at least one of the tasks. In multivariate analysis, education level acted as a facilitating factor (OR 1.79 [0.47–6.83]) for independent task completion. The median time to complete all tasks was 296 seconds (IQR 210–397) and the median satisfaction was 55 (IQR 45–62.5) out of 100.

Conclusion

Task-based usability effectiveness was high. The moderate usability satisfaction scores and the dispersion of usability efficiency scores suggest that other factors may be interfering. No association has been described between multimorbidity and the usability results of this technological tool.

Perceived extrinsic barriers hinder community detection and management of mild cognitive impairment in China

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Background

General practitioners (GPs) play a critical role in community detection and management of mild cognitive impairment (MCI). Although adequate knowledge is essential, healthcare practice is shaped by intrinsic and extrinsic factors. This study aimed to test the mediating effect of perceived extrinsic barriers on the associations between knowledge, attitudes and intended practice of GPs in community detection and management of MCI.

Methods

A cross-sectional study was conducted through an online survey of 1253 GPs sampled from 56 community health centres (CHCs) in Shanghai in 2021. Perceived extrinsic barriers were rated on a five-point Likert scale for patient engagement, working environment and system context. A summed score was generated subsequently for each domain ranging from 0 to 100, with a higher score indicating higher barriers. The mediating effect of perceived extrinsic barriers (second-order) and the moderation effect of training on the association between MCI knowledge and practice scores, as well as the moderation effect of past experience on the association between MCI knowledge and extrinsic barriers, were tested through structural equation modelling (SEM) with a partial least squares (PLS) approach.

Results

The study participants reported an average barrier score of 65.23 (SD = 13.98), 58.34 (SD = 16.95), and 60.37 (SD = 16.99) for patient engagement, working environment and system context, respectively. Although knowledge had both direct and indirect (through attitudes) effects on intended practice, perceived extrinsic barriers negatively mediated (ß = –0.012, P = 0.025) the association between knowledge and practice. Training moderated the effect of knowledge on practice (ß = –0.066, P = 0.014).

Conclusions

Perceived extrinsic barriers have a detrimental effect on the translation of knowledge into practice for community detection and management of MCI. The effect of training on practice declines when knowledge scores become higher.

Cardiometabolic health and determinants during pregnancy: Results from the first year of the PROMOTE pilot study

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Background

A demographic shift among pregnant patients, including older age and increasing obesity, has resulted in an increase in cardiometabolic complications during pregnancy and over the lifetime. Lifestyle interventions during pregnancy have not yet produced clinically meaningful perinatal or long-term outcomes. There is an urgent need for high-quality observational data about cardiometabolic health during pregnancy to identify subgroups at highest risk and to understand the interplay of clinical and social determinants.

Methods

The PROMOTE pilot study is a prospective cohort study recruiting pregnant participants from a highly diverse population in Western Sydney, Australia. Participants are surveyed about physical activity levels, diet, emotional wellbeing and sociodemographic status. Participants are consented for biobanking and the use of routinely collected data, including medical conditions, body mass index (BMI), blood pressure (BP), glycaemia and perinatal outcomes. Outcomes include: the incidence of non-communicable diseases during pregnancy, including gestational diabetes mellitus (GDM) and hypertensive disorders of pregnancy (HDP). Postnatal and longitudinal outcomes are planned.

Results

During the first year, 235 participants were recruited in a socially/ethnically diverse population; 110 had birthed. The recruitment rate was 90%. The mean maternal age was 31.88 years (range 21–43). Mean gestational age was 12 weeks, 3 days (range 8–15). In all, 232 of 235 participants provided data on physical activity; 33.62% demonstrated sufficient levels, 54.74% demonstrated insufficient levels and 11.64% were sedentary. This is similar to Australian national data, but well below recommendations. The mean servings of fruit/week was 11.86 (range 0–42), vegetables 10.81 (range 0–35), fried food 1.64 (range 0–14), crisps 1.95 (range 0–14), soft drink 4.10 (range 0–35) and take-out food 1.65 (range 0–14). In all, 231 of 235 provided demographic data.

Conclusions

The first year of recruitment demonstrates high levels of acceptability, recruitment and reach. The PROMOTE pilot study is well positioned to provide high-quality granular data about clinical/social determinants of cardiometabolic risk in pregnancy and beyond.

Guideline adaptation in primary care: An opportunity to foster equity

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Background

HealthPathways is a quality improvement initiative where guidelines are adapted into locally relevant clinical protocols for point-of-care use by GPs. While guidelines are often derived from evidence formulated in specialist urban settings with high resourcing, clinical protocols need to reflect local resourcing and variation in patient needs. The gap between guidelines and local realities can be a challenge to address.

Aims

This session will provide an overview of the challenges with guideline adaptation in Western Sydney – an area of high social, cultural, ethnic and economic diversity. The session will outline opportunities and strategies to ensure that guideline adaptation benefits the most underserved people in our community.

This presentation will provide:

- A case study of a challenging guideline localisation: hypertension. The evidence cited in Australian national guidelines will be compared with the challenges presented by the local context. Demographic data from our Primary Health Network (PHN) will be presented to highlight population differences between those recruited into trials and the local population, and demonstrate contextual challenges specific to Western Sydney.
- Examples of strategies which bridge the gap between guidance and local realities. The value of commissioned services will be discussed, including an example of a lifestyle intervention commissioned by the PHN. This presentation will demonstrate how guideline adaptation initiatives can work with service commissioners to bridge the gap between guidance and local realities, including information-sharing platforms in language. Team-based care will be discussed.
- An overview of guideline quality assessment tools (including AGREE II), their role in adaptation and future directions for the development of tools to improve the quality adaptation for the primary care setting.

Conclusion

Guideline adaptation should consider the needs of those at risk of poorer health outcomes. Strategies should be implemented to ensure that the vulnerable benefit from clinical guidance.

Association between visit-to-visit blood pressure variability and cardiovascular disease: comparation among studies from clinical trial, observational and electronic health records

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University of New South Wales

Background

Studies investigating the association between visit-to-visit blood pressure variability (BPV) and cardiovascular disease have been conducted in different settings, such as post hoc analysis of clinical trial, observational studies and electronic health record data. The primary aim for systematic review and meta-analysis is to comprehensively compare the effect of visit-to-visit BPV on cardiovascular events among studies using observational, clinical trial and electronic health record data. While the secondary aims are to investigate the association of baseline characteristics and comorbidities (age, gender, BMI, comorbidities: diabetes mellitus, hypertension, dyslipidaemia, smoking) BPV and evaluating the approaches (number of visits, time interval between visits) used to estimate BPV.

Methods

A systematic literature search will be performed in the following databases: MEDLINE (PubMed); SCOPUS; EMBASE; CINAHL; and Web of Science. All collected studies will be screened based on title, abstract and full text by two independent reviewers. Studies with the following criteria: (1) adult participants aged ≥18 years; (2) measurement of BP at three or more visits on different days; (3) follow up for outcomes of incident CVD (myocardial infarction, fatal and non-fatal coronary heart disease, fatal and non-fatal stroke, heart failure, peripheral artery disease, atrial fibrillation; (4) events confirmed via database or event ascertainment committee; (5) adjustment for confounders undertaken in the design or analysis stages of the study; (6) duration of follow up three or more years; and (7) studies in English Language. Risk of bias will be assessed using standard form. Random effects meta-analysis and meta-regression will be applied using R.

Discussion

The comparation of three major sources of BPV data will be the major novelty of this systematic review and meta-analysis with respective of baseline characteristics and the comorbidities into account.

A new care model for patients with complicated multimorbidity: A cluster randomised pilot study in general practice, municipalities and hospitals

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Background

General practice is the key organisational setting in terms of offering people with complicated multimorbidity high-quality, patient-centred, integrated care. However, there is limited knowledge of the most appropriate organisation of healthcare services for this patient group. Based on the evidence we developed the care model 'Complex intervention for patients with complicated multimorbidity model' (CIM). The CIM was tested in a feasibility study and, based on the results, an improved version 2 of the model was developed (CIM2). The CIM has contributed to part of the Agreement between Danish Regions and The Danish Organization of General Practitioners (PLO) approved for 2022–24 (OK22).

Aim

The overall aim of this study is to test the CIM2. The aim of this abstract is to present our experience in recruiting general practices and patients, and the findings from the intervention practices on how they implemented and carried out the extended overview consultation.

Methods

Fourteen general practices will be included in the pilot study taking place in the two Regions of Denmark; five municipalities and one hospital in each region. The intervention elements in CIM2 include training of healthcare professionals, an extended overview consultation in general practice, an individual care plan and improved integration of care between primary and secondary care. The intervention period is 12 months. Data are collected at baseline and at the 12-month follow-up.

Results

The following data are reported: CIM2 and usual care population characteristics (age, sex, multimorbidity patterns, medications, socioeconomic factors), results from patient questionnaires and experience in recruiting general practices and patients.

Conclusions: The intervention is designed to improve the quality of care for patients with complicated multimorbidity (primary outcome) by supporting integrated care. Furthermore, the results from the CIM2 project are important evidence for the planning of The National Multimorbidity Project in the OK22.

The generalist gaze: Making visible the generalist skills at the heart of quality healthcare

Dr Johanna Lynch[1,2,3], Kurt Stange[3,4], Joanne Reeve[5], Larry Green, Adj Prof Karen Price[6]

[1]The University Of Queensland, [2]Australian Society for Psychological Medicine, [3]Sense of Safety Project, [4]Case Western University, [5]Hull and York Medical School, [6]Monash University

General practice has faced challenges to its legitimacy and integrity in recent years, often from those who do not understand the invisible work that general practitioners (GPs) do. Across medicine there is a drive towards measuring outcomes through the lens of increasingly smaller 'manageable parts' while losing sight of the deep clinical wisdom of the generalist. As GPs wrestle to define ourselves and our valued place in the health ecosystem, there is an urgent need for us to honour and understand the importance of generalism. This professional forum invites discussion from GPs who have worked to name and champion this often unseen and yet essential core competency of good-quality general practice. They will bring insights from their research, clinical practice and public advocacy to this conversation. Discussion will consider the way that generalism is at the heart of quality whole-person healthcare. It will notice the generalist skills of broad gaze, pragmatic healing focus, relational and integrative processes of knowing and the interpretive wisdom and discernment required to attend to a whole person. Key takeaways for attendees will be inspiration to continue to hone and refine their generalist skills, no matter where they work. They will also gain understanding of and respect for the sophistication of their work – the complex work of bringing together both biological and biographical understandings of health, the relational and community connections and the clinical skills required to look wide to the whole person as well as attend to the details in iterative, interpretive and integrative ways. Come ready to be inspired by some of the great scholars and advocates of our generation.

Sensing and building patient safety: Practical trauma-informed and strength-based skills and attitudes for general practice

Dr Johanna Lynch[1], Prof Linn Okkenhaug Getz[2], Kurt Stange[3], E/Prof Christopher Dowrick[4]

[1]The University Of Queensland, [2]NTNU Norwegian University of Science and Technology, [3]Case Western University, [4]University of Liverpool

Supporting patients experiencing distress is an everyday part of primary care clinical encounters. GPs often encounter psychosocial, environmental, cultural, existential and physical distress. Distress is also part of the complex experiences of 'comorbid' illness that result from ways humans cope – such as addiction, obsessions, phobias, suicidality, self-harm, violence and hopelessness. Many of these causes of distress are complex, chronic, preventable and rooted in intergenerational patterns of violation or neglect. This skill-building session will introduce practitioners to a generalist approach to distress that is strengths based, trauma informed, person centred and embodied – attending to a 'sense of safety'.

This session will be conducted in three interactive and practical sections:

1. Theory – This section will introduce the theoretical background of this approach (including the robust links to stress and trauma research) and metacognition, pattern recognition and generalist whole-person systems review tools to aid clinical reasoning and understanding. These can guide subtleties of the clinical conversation as well as overarching goals of care to build a sense of safety in each encounter.
2. Practice – Attendees will be given the opportunity to practice new skills in dyads, particularly focusing on the breadth of awareness (sense of safety domains), microskills and dynamics (sense of safety dynamics) involved in connecting to, assessing and building safety in the whole person in distress.
3. Reflect – Attendees will have the opportunity to reflect in small groups with experienced GPs. They will reflect on the important and subtle expertise of generalist attitudes to the person and strength-based approaches that acknowledge lived experience – biography as well as biology. At the end of this section, attendees will reflect personally on their own practice and personal sense of safety in the work they do.

Sense of safety audit: Codesign and validation of a new whole-person assessment tool for primary care

Dr Johanna Lynch[1], Prof Linn Okkenhaug Getz[2], Kurt Stange[3], Pamela Meredith[4], Mieke van Driel[1], E/Prof Christopher Dowrick[5]

[1]The University Of Queensland, [2]NTNU Norwegian University of Science and Technology, [3]Case Western University, [4]University of Sunshine Coast, [5]University of Liverpool

Supporting patients experiencing distress is an everyday part of primary care clinical encounters. Whole-person care offers the potential to improve clinician responses to distress; however, clinicians need guidance in practising and applying the tenets of whole-person care, particularly to integrate both objective biomedical and subjective psychosocial forms of knowledge. Previous research has found that attending to a person's sense of safety (the domains or areas in their life in which they feel safe and the dynamics or processes they use to build safety) offers clinicians an organising framework to provide whole-person care. This research builds on this by exploring, through focus groups, what language can help people to describe how safe they feel in themselves and in their world, and how practitioners can observe patterns of behaviour that are suggestive of how safe a patient is feeling, to inform the development of practical clinical tools. A total of 76 practitioners from Norway, the US, Netherlands and Australia participated, from a range of disciplines, including general practice, social work, education and allied health. Through qualitative analysis, practical observations clinicians used to sense safety were identified as well as reflective questioning that clinicians engaged with to assess safety. Additional themes included the dynamics of the practitioner and patient relationship, such as the clinician noticing self, other (patient) and the interactions within. The findings presented in this research presentation will contribute to practitioner knowledge of how to assess patient safety and provide whole-person care in the context of distress.

Early pregnancy education: How do GPs manage it all in the primary care setting?

Dr Jenna Lyttle, Gary Rogers

Deakin University

New pregnancy is a period of intense development; physically for the growing fetus, and both physically and mentally for the parent to be. Early optimisation of health in pregnancy can promote better health outcomes in new babies, so much so that interventions like the supplementation of folate and iodine are considered routine in antenatal care. Many other areas of preventative health are also important in the early care of pregnant people, for example abstaining from alcohol, an awareness of potentially toxic foods to the fetus and the options for vaccines and chromosomal screening. This equates to an enormous amount of information that needs to be conveyed to the pregnant person, as early as possible in the pregnancy. So how do general practitioners (GPs) manage this information provision in the time-pressured, multipriority primary care setting?

The study being presented is a qualitative look into the way GPs are currently approaching this clinical problem in Victoria, Australia. Via focus groups with GPs and thematic analysis techniques, the barriers and facilitators to this education process will be explained. Some take-home tips learnt from this study will aim to help primary care doctors ensure they are optimising their education provision to early pregnancy patients.

Negative factors of RTW after mTBI

Mr Qin Xue, Li Ma

Beijing Tiantan Hospital, Capital Medical University

Study objectives

To analyse the negative factors of return to work of patients with mild traumatic brain injury, and provide suggestions for clinical diagnosis and treatment.

Methods

Patients presenting to the Neurotrauma Clinic of Beijing Tiantan Hospital of head injury and evaluated for mTBI were eligible for our study. Demographic and injury-related information were collected in the outpatient department. Patients completed phone interviews and questionnaire to provide follow-up data on neurological systems symptoms, sleep, anxiety and depressive at three and six months after injury. A total of 99 patients provided sufficient data for analysis from August 2021 to July 2022.

Results

Patients with poor sleep quality or low levels of education were at increased risk for return to work at three months after the injury, and patients with multiple injuries were at six months.

Conclusion

mTBI have a variety of negative impacts on physiology and psychology, which influence prognosis. Poor sleep quality, low levels of education and multiple injuries will delay the return to work of mTBI patients.

Factors associated with prolonged length of stay in the ambulatory care unit of a tertiary government hospital in the Philippines

Dr Erika Macalalad, Jonathan Babsa-ay, Marishiel Mejia-Samonte

Philippine General Hospital

Background

Length of stay is one of the metrics of crowding in the emergency department. Identification of the factors associated with prolonged length of stay is vital for staffing and policy making to prevent overcrowding at the ambulatory care unit.

Objective

This study aimed to determine the association of sociodemographic, clinical and temporal factors with length of stay among patients seen at the ambulatory care unit of a tertiary government training hospital in the Philippines.

Methods

A retrospective case-control study was conducted between 1 January 2019 and 31 December 2019 at the ambulatory care unit of a tertiary government hospital in the Philippines. Charts of patients who stayed for more than six hours were classified as cases, while those who stayed for more than two hours up to six hours were classified as controls.

Results

The case group consisted of 86 patients, while the control group consisted of 172 patients. Eight factors influenced the probability of prolonged length of stay at the ambulatory care unit: age 40–59 years (OR 2.29, 95% CI: 1.16, 4.49), ESI 3 at triage level (OR 3.35, 95% CI: 1.50, 8.38), psychiatric complaint (OR 6.97, 95% CI: 2.53, 19.21), medications given and diagnostics done (OR 2.16, 95% CI: 1.16, 3.99), medications given and diagnostics and referral to other services done (OR 7.67, 95% CI: 2.70, 21.80), psychiatric/substance-related case (OR 6.97, 95% CI: 2.63, 18.49), transferred to other services (OR 3.25, 95% CI: 1.33, 7.94) and endorsed to next shift (OR 6.94, 95% CI = 3.90, 12.35).

Conclusion

The predictors of prolonged length of stay were middle-aged adults, conditions with severe presentation, psychiatric/substance-use related cases, need for more diagnostic test and treatment intervention and decision to transfer care to other services.

‘Questionable’ clinical activities and RACGP examination performance: Is a measure of registrars’ quality of clinical practice predictive of examination outcomes?

Prof Parker Magin[1,2], Anna Ralston[2], Elizabeth Holliday[1], Andrew Davey[1,2], Jason Dizon[3], Dr Katie Fisher[1,2], Alison Fielding[1,2], Dominica Moad[1,2], Mieke van Driel[4]

[1]University of Newcastle, [2]GP Synergy Regional Training Organisation, [3]Hunter Medical Research Institute, [4]University of Queensland

Introduction

Non-evidence-based and ‘low-value’ clinical care and medical services are ‘questionable’ activities, being more likely to cause harm than good or whose benefit is disproportionately low compared with its cost. We sought to establish if a measure of questionable clinical practice (the QUestionable In Training Clinical Activities Index [QUIT-CAI]) is predictive of GP registrars’ (trainees’) performance in RACGP Fellowship examinations (licensure examinations for independent general practice).

Methods

The study was nested in the ReCEnT study, an ongoing cohort study in which GP registrars record details of their clinical practice. Outcome factors in analyses were individual NSW- and ACT-based registrars’ scores on the three Fellowship examinations (AKT, KFP and OSCE) and overall pass/fail, during 2012–21. Analyses used univariable and multivariable regression (linear or logistic, as appropriate). The study factor in each analysis was ‘QUIT-CAI score percentage’, the percentage of times a registrar performed a QUIT-CAI clinical activity when ‘at risk’ (ie when managing a problem where performing a QUIT-CA activity was a plausible option).

Results

In all, 1265, 1145 and 553 registrars sat the AKT, KFP, and OSCE examinations, respectively. On multivariable analysis, higher QUIT-CAI score percentages (more questionable activities) were significantly associated with poorer AKT scores (P = 0.001), poorer KFP scores (P = 0.003) and poorer OSCE scores (P = 0.005). QUIT-CA score percentages predicted RACGP exam failure (OR 1.06; 95% CI: 1.00, 1.12; P = 0.043).

Discussion

Performing questionable clinical activities in training was predictive of summative RACGP Fellowship examination performance. A 1% increase in the absolute percentage of ‘at-risk’ problems for which a registrar performed a questionable clinical action was associated with 6% increase in the odds of failing at least one examination, a modest but clinically significant difference.

Thus, RACGP examination performance reflects actual clinical performance (by the measure of clinical performance we have examined, which is relevant for a licensing examination).

Menopause: How to confidently deliver evidenced-based care

Dr Karen Magraith[1], Dr Marita Long[1]

[1]Australasian Menopause Society, [2]University of Tasmania, [3]General Practice Plus, Hobart

Menopause marks the end of a woman's reproductive years, with perimenopause the time leading up to and for 12 months after the final menstrual period. Most women experience menopause between the ages of 45 and 55 years as part of biological ageing, but it can also occur as a consequence of surgical or medical procedures. Women make up over half the world's population and are now living for longer in this post-menopausal state. The hormonal changes associated with perimenopause and menopause can affect physical, mental and social wellbeing and women's experiences of symptoms vary widely. It is crucial that women have access to evidenced-based care to not only treat the symptoms, but also to address the potential long-term health consequences of menopause. Barriers to access to appropriate care at menopause lead to poorer health outcomes for women.

This workshop will provide a practical approach to improving participants' knowledge and improve their confidence to deliver evidence-based care to women using a more structured approach in the menopause consult.

The session will encourage interaction and engagement through:

- acknowledging (and building on) the skills, knowledge and experience in the room
- linking to current practice through a strengths-based approach
- ensuring relevance to a general practice context
- inviting participation and contribution in both whole-group and small-group activities
- the use of case studies to demonstrate key concepts.

Participants will be encouraged to reflect on:

- their own experiences with managing women's health in the menopause transition and beyond
- how they might integrate evidence-based care into their practice
- how to utilise a menopause consult to incorporate essential preventative health strategies for women.

Antibiotic therapy for Group A streptococcus pharyngitis in patients at Lami Health Centre, Fiji: A cross-sectional study

Dr Ana Kafo'atu Maile

Fiji National University

Sore throat caused by the bacterium Group A streptococcus (GAS) can lead to acute rheumatic fever and subsequently chronic rheumatic heart disease. In Fiji, due to the limited laboratory setting, it is recommended to use the clinical decision rule (CDR) to diagnose GAS and determine whether to treat. The Fiji-specific CDR criteria are: the presence of a sore throat, plus no runny nose or no hoarseness of voice. This differs significantly from the guidelines in Australia and New Zealand, where throat swabs are more feasible. Antibiotics are the cornerstone of therapy, with benzathine penicillin G (BPG) as first-line treatment. Clinical practice guidelines are therefore produced to improve the appropriate use of antibiotics.

This study is an audit of the management of probable GAS pharyngitis in Fiji and whether management complies with Fiji clinical guidelines. This was a cross-sectional, single-centre study from 3 August 2022 to 31 August 2022 at Lami Health Centre, Fiji, on all children aged 5–14 years and adults who presented with a sore throat. In all, 294 participants were included, with 284 (96.6%) found to have probable GAS using the Fiji-specific criteria. The study showed a large discrepancy in the prescribing practices used by doctors, with 93.9% (276) not adhering to the guidelines. Of the patients prescribed an oral antibiotic, 56.3% (165) received the incorrect dosage and duration, with 37.5% (110) given both an oral and intramuscular antibiotic. Only 6.1% (18) of patients received the correct antibiotic treatment.

These are alarming numbers, particularly given the situation in Fiji, a high-risk setting for rheumatic fever. The high rates of partially treated infections are concerning, with the added possibility of antibiotic resistance if not addressed urgently. However, further studies are needed to identify the reasons why doctors do not abide by these guidelines.

Challenges facing postgraduate female medical learners: An interactive workshop

Dr Martha Makwero, Mulinda Nyirenda

Kamuzu University of Health Sciences

Background

Despite efforts to improve female learners' medical education by promoting recruitment equality and fairness, they continue to face challenges in their academic and training journey, and few women are able to successfully complete their education in time. Most especially, in postgraduate family medicine education; training is stressful and tends to take away learners from their normal, centralised environments. Studies highlighting insight into female learners' experiences of their training and challenges, and how they navigate them are still sparse. Still more, sources of support to navigate challenges are hardly known.

Strategies to support the female learner along the academic journey ought to be targeted and sensitive. Anecdotal evidence from Malawi highlights barriers (eg societal and cultural norms in handling interpersonal interactions, conflicting roles at this stage in life and a lack of acknowledgment of such subtleties in the learning climate). For instance, female students were seemingly less decisive in handling their daily clinical practice decision making. This was not due to their inability to decide or apparent knowledge gaps, but rather to unwritten norms of how females should interact in male-dominated group dynamics. Their need to juggle their female roles (motherly, spousal, student) on a daily basis makes this particularly challenging. Yet, they are expected to navigate through their academic journey as their male counterparts with minimal or no support. This requires innovation to address.

This workshop, therefore, serves to stir up discussions to come up with recommendations on how to effectively support female medical learners during their postgraduate academic journey.

Aim

- To explore social–cultural barriers affecting the female learner's academic journey
- To explore opportunities for support to improve the learners' experiences of learning

Key insights/takeaways

Africa is seeing a lot of female doctors enrolling in the FM training program. To ensure their successful completion, WWPWFM needs to acknowledge these challenges and innovate.

Patients' perception of patient-centred care: Does it matter in low-resourced contexts?

Dr Martha Makwero[1], Jude Igumbor[2], Adamson Muula[1], Felix Anyanwu[2]

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Background

Patient-centred care (PCC) is known to improve experiences of chronic care medical encounters and outcomes. As Malawi strives to institutionalise PCC in its quality-of-care initiatives, documenting the extent of its practice and its correlates is an important starting point in implementation and advocacy efforts.

Aim

We sought to assess diabetes mellitus (DM) patients' level of perception of PCC and its relationship to self-efficacy, adherence and glycaemic control.

Methods

Using a locally generated tool we assessed the adequacy of PCC experienced by patients with DM during medical encounters in Malawi. We used regression models to assess PCC correlation with self-efficacy, adherence and long-term glycaemic control.

Results

We report low levels of PCC perception, with about half the DM patients receiving inadequate PCC, 241 (56.3%), especially in patient participation. Female patients and those who reported having DM complications particularly reported low PCC levels. PCC was shown to mediate process outcomes in the DM management pathway and a minimum mean score of 65.9 (SD 9.6), a range of 81–112 seems to be required. The perception of PCC was negatively associated with self-efficacy (aß = –3.11; 95% CI: –5.98, –0.43), positively associated with adherence (aß = 0.98; 95% CI: 0.60, 1.36) and was not statistically significantly related with glycaemic control. Independently, self-efficacy itself was a predictor of better adherence (aß = 0.04; 95% CI: 0.02, 0.05) and glycaemic control (aOR = 0.03; 95% CI: 0. 01, 0.04).

Conclusion

Although PCC is not an end in itself, it matters in facilitating better process outcomes in the DM management pathway; especially in those with complications and, minimum required dose required. To effect better self-efficacy for long-term outcomes, PCC delivery should go beyond providing a good interactional ambiance to acknowledging and leveraging patients' capabilities for self-care. The findings stimulate discussions on the value of PCC and how it can be optimised for better chronic care.

Community building: Breaking barriers and fostering collaboration between Young Doctors' Movements and other networks

Dr Nick Mamo[1], Dr Rohini Pasricha[2], Stuart Holmes[1], Dr Sankha Randenikumara[3], Dr Ping Foo Wong[4]

[1]EYFDM, [2]Polaris Movement, [3]WONCA, [4]Rajakumar Movement

The Young Doctors' Movements (YDMs) are based on grassroots action and fostering collegiality. We welcome anyone who wants to contribute to family medicine, through research, sharing ideas or learning from colleagues. The YDMs recognise that together we have the power to move family medicine forward. The challenges inherent in this are also recognised.

The purpose of this session is to identify the barriers, seeking solutions, as well as using the potential of a networking space to create new connections, not only among the YDMs but with others in WONCA: individuals, networks, working parties (WPs), special interest groups (SIGs) and others. By using the energy and collective experience and ideas concentrated in one space, we can foster deeper connection and collaboration, as well as supporting each other in moving family medicine forward.

This session will be split broadly into three sections. Section one will look at what the WONCA YDMs have achieved as well as the challenges they have faced.

Section two will focus on identifying barriers and challenges in collaboration between different groups (YDMs, WPs, SIGs and others), and identifying solutions to this. This will be through facilitated small working groups with two rounds focused initially on barriers and then on potential solutions.

Section three will use open space technology, a facilitation system that encourages idea generation, sharing and networking.

The result of this will be a better understanding of what we as networks of family doctors face in our attempts to collaborate, some realistic solutions, as well as fresh ideas to move forward with.

Through the sharing and growth possible in such sessions, the younger generation of family physicians and general practitioners, through the YDMs, can become a vibrant and strong part of the WONCA world, and we can be a stronger force for family medicine worldwide.

The right to make bad decisions: Capacity and consent across Europe

Dr Nick Mamo[1,6], Dina Salkovic[1,2], Alina Zidaru[1,3,4], Genco Gorgu[1,5]

[1]EYFDM, [2]Sanitas Huisartsen, [3]Kilmacud Medical Centre, [4]ICGP, [5]Bandirma 1st Family Medical Center, [6]ICPE, UMCG

Background

Respect for autonomy is a central pillar of medical ethics. Yet, while we often talk about its importance, it often gets forgotten during busy schedules, especially when complicated by questions regarding capacity. Respect for autonomy must be balanced alongside beneficence and non-maleficence in individual patient care decisions, as well as being balanced against justice in care for the whole community. However, we risk dehumanising our patients by not considering their wills and preferences simply because their capacity may be in question.

Session aim

Refocus the debate to maximise the person's potential for capacity, in day-to-day primary care practice. We will do this through a review of the ethical framework, case discussion and creating realistic action lists.

Target group

GPs, other healthcare professionals involved in primary care, patients.

Didactic method

Review of theoretical framework and different policies governing decision making in countries across Europe.

Practical workshop

Case-based discussions involving persons with reduced capacity with creation of an action list for supporting such persons in practice.

Incorporating cognitive load theory in teaching: The development of schemas in family medicine teaching curriculum

Dr Rohini Pasricha[1], Dr Nick Mamo[2], Dr Sankha Randenikumara[3], Dr Ping Foo Wong[4]

[1]Polaris, [2]EYFDM, [3]WONCA, [4]The Rajakumar Movement

Family Medicine has a comprehensive, broad scope of practice that is ever changing and requires ongoing diligence by practitioners to stay up to date with most recent guidelines. The insurmountable amount of information needed to practice best patient care can be overwhelming for many.

To overcome this, the use of cognitive load theory in practice and in teaching can be an effective tool in increasing understanding and application of family medicine concepts. Cognitive load theory is an education strategy that simplifies complex knowledge into succinct models to allow new information to be transferred from working memory to long-term memory.

At the Queen's University School of Medicine in Kingston, Ontario, Canada, cognitive load theory in teaching is used to teach first year medical students the family medicine curriculum through schemas and visual aids. Each lecture was based on a key presentation and a visual schema was created for clinical decision making. In 2020, 92/107 first year Queen's medical students completed an anonymous course evaluation for the family medicine course. Eighty-nine (96.7%) students strongly agreed that this was an excellent course and 87 (94.6%) students strongly agreed that the course content was delivered effectively.

This workshop will explore the use of various cognitive load practices in teaching to assist educators. Such schemas can be used not only in teaching settings suitable for students and residents, but also for continuing professional development in later career stages, allowing for more effective updating of practice management.

In this workshop, we will explore various schemas of common presentations in family medicine practice. Using facilitated small groups, we will give participants the opportunity to collaborate and develop their own schemas/visual aids, learning how to construct these and then apply them to a wide range of family medicine areas (knowledge based as well as competency based).

Switching bad – opioids edition

Dr Matteo Mannucci, Enrique Ferrer Mygind

Semfyc

Background

WHO considers that the consumption of opioid analgesics in a country is an adequate indicator of pain management. At present, the consumption of these drugs is increasing in a controlled way thanks to the adequate training of health professionals and the increasing use in non-cancer pain. Although we have to deal with the risk of misuse and abuse. Switching opioids can improve pain control and reduce secondary effects

Aim and learning objectives

Improve the management of opioids by primary care physicians, in order to increase confidence as well as optimise their use.

Methods and timetables

Following an illustrated presentation looking like 'Breaking Bad'© TV series, easy-to-remember rules for opioids switching will be shown ending up with a Kahoot test with a final winner.

- Introduction (five minutes)
- Realistic clinical cases where each team will have its role and where they will have to choose the rotation, dose and route. We will take advantage of each one of the cases to give the keys in the management and calculation of opioid doses (45 minutes)
- Conclusions and take-home messages (10 minutes)

Conclusions

Using the techniques of learning by playing, we aim to achieve that the participants return to their consultations and to their routine, having gained skill and confidence in the handling and rotation of morphs.

The global state of PHC: Measurement for improvement and how to include family medicine as a solution

Dr Jeffrey Markuns[1], Christoph Gelsdorf[2]

[1]Boston University, [2]University of California, San Francisco, Santa Rosa Family Medicine Residency

Global interest in primary health care (PHC) continues to grow, as evidenced by the Astana Declaration, the globally endorsed PHC measurement framework and indicators from WHO and UNICEF, as well as the flagship report from the World Bank. Countries, bilateral and multilateral organisations have developed further increased interest in the wake of the challenges and collateral damage experienced during the COVID pandemic.

This session will review the current global state of PHC, the proposed mechanisms for measurement, and how family medicine does – or does not – fit into the current global perspective on PHC. We will begin with a review of recent developments in global PHC, frameworks and dashboards for measurement developed in recent years, discuss how well these capture the service delivery of primary care and explore together where there remains significant room for improvement.

Participants will then review a potential blueprint for PHC system strengthening, identify where their own health system lies on the blueprint and identify potential next priority steps for promoting PHC improvement.

Promoting greater organisational equity within WONCA

Dr Jeffrey Markuns[1,2], Viviana Martinez-Bianchi[3,2], Dr Elizabeth Reji[4,2,5], Dr Innocent Besigye[2,6], Julien Artigny[2], Dr Suha Hamshari[7,2], Dr Dora Bernal[2], Hina Juwaid[8,2], Dr Marjorie Cross[2,9,10]

[1]Boston University, [2]WONCA Organisational Equity Committee, [3]Duke University Department of Family Medicine and Community Health, [4]WONCA Working Party on Women and Family Medicine, [5]Department of Family Medicine, Universities Academic Hospital, Free State, [6]Department of Family Medicine, Makerere University Kampala, [7]An Najah National University, Nablus, [8]University of Health Sciences, Lahore, [9]Australian National University, [10]Royal Australian College of General Practitioners

The aim of this session is to increase representation and promote greater equity across WONCA by developing regional organisational equity committees within WONCA.

Globally, there has been an increasing interest in addressing a variety of inequities and promoting diversity, equity and inclusion. WONCA established an Organisational Equity Committee at the global level whose goals include advising the World Council on all issues concerning equity within WONCA, measuring and monitoring the effectiveness of equity policies of WONCA Council and Executive, monitoring and reporting upon progress in equity in WONCA and reporting and making recommendations regarding additional efforts in regard to nominations of women members for office and awards within WONCA.

The Committee recently recommended the development of organisational equity committees in each region to help advance these goals, and this workshop is intended to introduce the topic of organisational equity, review priorities within WONCA and build the skills to develop regional committees.

The session will begin with an introduction and identity exercise, followed by a review of the topic of organisational equity. Members of the WONCA Organisational Equity Committee will then act as a panel to describe some of the key equity priorities identified within WONCA, including those of language, gender, economics, ethnicity and race, broadband access, geographical, and those related to the pandemic and cross-regional inequities. We will then move into guided and small-group discussions on regional priorities, followed by a review of the expectations and process for developing regional organisational equity committees, including a brief question-and-answer period.

Dispensing of high-risk medicines: How does your area compare?

A/Prof Liz Marles

Australian Commission on Safety and Quality in Health Care

Dispensing rates for antipsychotic and opioid medicines in Australia have dropped over five years, according to Atlas time series reports from the Australian Commission on Safety and Quality in Health Care (the Commission).

Nationally, there was an 11% reduction in the rate of antipsychotic medicines dispensed in people aged 65 years and over between 2016–17 and 2020–21, and an 18% fall in opioid medicines dispensing (all ages).

The drop in dispensing of these high-risk medicines is good news, but there is continuing geographic variation across Australia.

Data from the Atlas time series reports will be presented to show how mapping healthcare use can help GPs identify potentially unwarranted variation and inappropriate care.

The reports build on data in the *Australian atlas of healthcare variation*, which maps the use of healthcare according to where people live.

The interactive reports cover trends at national, state and territory, Primary Health Network (PHN) and local area levels.

The presentation will demonstrate how GPs and PHNs can use the interactive graphs to see how dispensing rates in their local area compare to other areas.

The Commission is working with PHNs that have consistently high rates of dispensing of antipsychotic and opioid medicines to understand reasons for the higher rates and to discuss strategies to reduce dispensing rates.

Australia's dirty little secret: 20% of Australian children cannot read

Dr Sandra Marshall, Dr Deborah Martin

Code REaD Dyslexia Network

A significant number of Australian children are struggling readers, despite strong evidence showing reading difficulties can be prevented and overcome if identified early and provided with evidence-based instruction.

These struggling children are visible, in NAPLAN and other assessments, but the system is failing to intervene early and effectively. Consequently, the number of students with low literacy is growing rather than shrinking as students progress from primary school to high school.

There are a total of 800,000 students currently in schools in Australia who are not reading at the minimum standard. These children have the potential to achieve and thrive at school. The education system is stuck in a reactive and obsolete 'wait to fail' model, despite the availability of low-cost, highly effective screening and intervention tools.

Dyslexia is the most common form of learning disability, which can be identified by specific diagnostic criteria (although diagnosis requires educationally and financially affluent parents to obtain). There is a significant underidentification of children with dyslexia in Australia.

Children with learning difficulties struggle to achieve academically for a wide range of reasons, including sensory impairment, psychological/emotional issues, English as a second language, absenteeism and, commonly, ineffective and/or inadequate instruction.

Regardless of diagnosis or contributing factors, effective intervention should be the same.

These children present to general practice with school avoidance, anxiety, depression and psychogenic symptoms.

Educated GPs can help identify and direct families to reliable resources to prevent reading failure, as often schools lack this knowledge.

Children who can't read grow into functionality-illiterate adults with limited opportunities and poor health outcomes.

A rural case study of telehealth in a Victorian Healthy@ Home program to address repeat hospitalisation

A/Prof Carmel Martin[1], Kevin Smith[2], Mike Allen[2]

[1]Monash University, [2]PHC Research Ltd

Background

Rural regions are particularly challenged by distance and access to care, given the scattered distribution of services. Yet, older and sicker patients experience repeat hospitalisations, which may be prevented by early detection and care. Ararat Healthy@Home incorporated a telehealth outreach service staffed by local residents into its community program to expand skilled clinicians' outreach. A successful trial of the telehealth program had been conducted in Monash Health previously.

Aims

To describe the telehealth telephone calls to high-risk rural patients identified through the Victorian Hospital Readmission Prevention Program screening tool from March 2016 to July 2022 in a Healthy@ Home deployment in Ararat, East Grampians Health Service, Victoria.

Methods

Case study of weekly or more frequent outreach telephone calls by three part-time local telehealth assistants to 160 patients. Nurse managers supervised the non-clinician telehealth assistants. The telehealth – Patient Journey Record System (PaJR) guided outreach telephone calls with a clinical algorithm predicting deterioration.

Findings

Of 10,579 calls, 8,135 calls recorded no problems; while the remaining 23% of calls flagged that 2% were very high risk of admission and 20% were a moderate–high risk, indicating an 80:20 power-law distribution. COVID exposure was associated with the expansion of total calls and calls reporting health problems from March 2020 to July 2021.

Discussion and conclusion

The telehealth assistants monitored high-risk patients with low-cost telehealth calls, reducing the need for expensive community nursing welfare checks. Patients reporting health deterioration were rapidly transferred to professional care, while the stable case load was continually monitored. COVID stimulated a rapid increase in patient load and calls, which was easily accommodated.

Evaluating the impact of the PaJR calls used ongoing learning, feedback and adaption. This is shaping its further rollout in Beaufort Skipton Health Service, Maryborough District Health Service, East Wimmera Health Service and Grampians Health.

Frequent users of acute care. Why do interventions fail? A draft position of the NAPCRG CASFM Working Group on Complexity

A/Prof Carmel Martin[1], A/Prof Joachim Sturmberg[2], Richard Young[3], Ginetta Salvalaggio[4]

[1]Monash University, [2]Newcastle University, [3]University of North Texas Health Science Center at Fort Worth, [4]University of Alberta

The North American Primary Care (NAPCRG) Working Group proposes a complex adaptive learning systems approach to superutilisation. We ask for your feedback.

Frequent use (superutilisation) represents patterns of increased acute care use by people with subacute or chronic conditions with unmet non-emergency care needs. While frequent users cost less than those with emergency conditions, including trauma, sepsis and cancer, they represent vulnerable individuals whose needs are not being met in general practice, hospitals and other services. Superutilisation is a complex systems problem. Biopsychosocial, economic and environmental pressures with other social determinants of health are key drivers.

Statistics of complex systems are challenging, including Pareto distributions, regression to the mean and difficulties in control selection. Terminology is variable. Intervention trials provide results of centralised diversionary activities – case management – on cohort trajectories. They do not address sustainability in the wider health, service and social context of superutilisation.

A complex adaptive systems learning framework, in contrast, builds from practice-based evidence – what is happening on the ground – incorporating feedback from patients, communities and providers, as well as research learnings. Adapting care to patterns of longitudinal local acute care use and provider responses is central. Service access and funding models must address population health dynamics. Trials are useful entry points if not strictly pass–fail and the implications for sustainability are recognised.

We recommend superutilisation approaches that recognise complex system dynamics and address core values including an emphasis on participatory leadership, inclusiveness, scientific rigour and person-centredness and equity. Approaches must reach beyond acute service diversion to address the complex adaptive system structures and dynamics that generate superutilisation. This is a slower and more challenging task. Addressing superutilisation pressures involves shifting broad systems of care to the underserved with subacute or chronic conditions so that their needs are addressed more optimally in place and time.

Unintended consequences – case studies of (de)prescribing opioids for chronic pain: Implications for practice and policy

A/Prof Carmel Martin

Monash University

Background

Increasingly, opioid (de)prescribing for chronic pain is the subject of actions by governments, academic teachers and institutions.

Methods

Autoethnography which I, as a GP, connect my personal experiences of (de)prescribing opioids for chronic pain to wider practice and policy.

Findings

Case 1: Mary, aged 37 years, on long-term opioids for chronic pain and PTSD, contemplated their reduction as she re-entered the job market. Her long-term partner suddenly became violent. Extremely traumatised, Mary accessed an out-of-town domestic violence (DV) shelter. A local practice immediately (de)prescribed smaller, lower doses of the opioids by different GPs 'they were not opioid prescribers'. She called me in a suicidal crisis with panic about her pain and dependence. Via telephone consults, I reinstated her regular medications and DV services helped her slowly stabilise.

Case 2: Belinda, 55 years, is on long-term opioids for complex regional pain syndrome. She fell and fractured her nose and toe with extensive tissue damage. She was denied additional pain medication because she was an opioid 'user' in the emergency department: 'they were not opioid prescribers'.

Case 3: Suzie, aged 58 years, sought my help to reduce her long-term prescribed opioids and benzodiazepines for chronic pain, as she had been told by the GP nearest her home that she was an addict and drug-seeking. He/she was not an opioid prescriber, and would not 'prescribe' for her. Over 12 months we have halved her medications, but it is an ongoing struggle.

Discussion

Deprescribing is failing to reduce opioid deaths in the US. Dose tapering has been significantly associated with overdose or mental health crises. Current strategies of harm reduction may overlook stages of change including precontemplation, contemplation, preparation, action, maintenance and relapse. People, prescribed opioids for chronic pain, may be rejected and stigmatised in general practice and emergency departments and denied appropriate care.

Using primary care data to identify patients at risk of cancer in primary care

Dr Javiera Martinez[1,2], Damien McCarthy[1], Sophie Chima[1], Dr Barbara Hunter[1], Dr Natalie Lumsden[1], A/Prof Jo-Anne Manski-Nankervis[1], Craig Nelson[3], Warwick Strangward[1], Christine Chidgey[1], Jon Emery[1]

[1]The University of Melbourne, [2]Pontificia Universidad Catolica de Chile, [3]Western Health

Background

Up to 50% of patients with anaemia and thrombocytosis are not followed up in primary care. Inadequate follow-up of abnormal test results can lead to missed opportunities for early cancer diagnosis. Primary care data, stored in general practice electronic medical records, can be used to identify patients at risk of undiagnosed cancer. We aimed to evaluate the follow-up of patients with abnormal test results, such as anaemia or thrombocytosis, in an Australian primary care dataset. Our goal was to use this information to develop a clinical decision-support tool to identify patients at risk of cancer and improve early cancer diagnosis in general practice.

Methods

We retrospectively analysed 10 years of data (2010–19) from 79 general practice sites and a cohort of 598,075 unique patients captured in the Patron primary care database. We calculated prevalence and inadequate follow-up for patients with anaemia and thrombocytosis.

Results

The prevalence of anaemia and thrombocytosis was 17.6% and 4.6%, respectively. Patients with one abnormal test result had no evidence of follow-up in 60.5% and 75.6% of cases of anaemia and thrombocytosis, respectively. This increased to more than 85% for patients with two abnormal test results. Using this data, we have developed an algorithm for early cancer detection.

Conclusion

Most patients with anaemia and thrombocytosis are not followed up in Australian general practices increasing the risk of delayed diagnosis of cancer. Primary care data can be used to develop tools to facilitate timely cancer detection in primary care.

Developing and sustaining rural family medicine/general practice training programs: Experiences from around the world

Prof Viviana Martinez-Bianchi[1,2,3], A/Prof Victor Ng[2,9]

[1]WONCA Working Party on Rural Practice, [2]WONCA Working Party on Education, [3]Department of Family Medicine and Community Health, Duke University, NC, [4]Primary Care and Rural Health, [5]Department of Family and Community Medicine, Southern Isabela Medical Center, [6]Department of Family Medicine, School of Medicine, University of Split, [7]Western NSW LHD, [8]Australian College of Rural and Remote Medicine, [9]College of Family Physicians

The purpose of this skills-building workshop is to improve and expand access to healthcare in rural areas by sharing experiences and steps taken to develop new, sustainable rural residency programs or rural track programs.

The presentation will focus on addressing the physician workforce shortages and challenges faced by rural communities, through the sharing of the experiences of faculty who have been involved in the development of programs established through different models: academic universities and rural hospital partnerships, rural hospitals, public, non-profit or private organisations, including faith-based and community-based organisations, tribes and tribal organisations, rural community-based ambulatory patient care centres and rural health clinics; distributed education models with a regional perspective and graduate medical education consortia.

Presenters will share steps taken in the design of the programs, getting the program off the ground, application, hiring and recruiting program staff (administration, trainers, members of the healthcare team and trainees); sources of funding and budget development; where training takes place; partnerships and models established and how the program integrates into the community; protected time for faculty to teach; providing faculty development; and measuring success.

An interactive workshop format will then follow with the listing of the most important aspects of starting and sustaining rural training programs, efforts each attendee can do in their own settings, curriculum development, advocacy plans, budget development and sustainability propositions.

Finally, presenters and attendees will share successes, difficulties and lessons learned during the workshop.

Community orientated primary care: An African model of primary healthcare with a global reach

Prof Bob Mash[1], Edith Madela-Mntla[2], Prof Stephen Reid[3], Jacob Shabani[4]

[1]Division of Family Medicine and Primary Care, Stellenbosch University, [2]Department of Family Medicine, University of Pretoria, [3]Primary Health Care Directorate, University of Cape Town, [4]Department of Family Medicine, Aga Khan University

Community-orientated primary care (COPC) is a model of service delivery for primary healthcare that has emerged from the African continent. Fundamentally it changes the focus of the primary healthcare team from the practice population (those that come to the practice) to the population at risk (those that live in the catchment area). Originally described in South Africa in the 1940s, it embraces all the essential components of primary healthcare – an integration of primary care and public health, community engagement and empowerment, as well as multisectoral engagement and action. Family medicine on the African continent teaches the principles of COPC and equips family physicians to take the lead in implementing COPC and care coordination. In some countries national and subnational policy has embraced the principles of COPC with a primary healthcare team that is both facility and community based. The model of COPC has also been exported to many other countries, both high-income and low/middle-income countries.

In this professional forum the four speakers will outline:

- the principles of COPC as a model of service delivery
- the experience of implementing COPC on the African continent in both Kenya and South Africa
- the contribution of family doctors to the implementation of COPC
- the role of community health workers in the implementation of COPC.

This will be followed by a discussion on the applicability of COPC to family doctors from different contexts.

The work of the Primary Health Care Research Consortium: Addressing global research priorities

Prof Bob Mash[1], Prof Felicity Goodyear-Smith[2], Dr Innocent Besigye[3], Dr Martha Makwero[4]

[1]Division of Family Medicine and Primary Care, Stellenbosch University, [2]Department of General Practice, Auckland University, [3]Department of Family Medicine, Makerere University, [4]Department of Family Medicine, Kamuzu University of Health Sciences

WONCA World is a founding member of the Primary Health Care Research Consortium (PHCRC). Between 2017 and 2023, the PHCRC conducted an analysis of evidence gaps in primary healthcare research and then proceeded to conduct initial research to address some of the key global questions. The PHCRC is committed to research led by low- and middle-income countries (LMICs) and is focused on research that helps strengthen primary healthcare in this context. Other members of the consortium include the Primafamed Network (Sub-Saharan Africa), idccr'b (Bangladesh), George Institute for Global Health (India and Australia), American University of Beirut (Lebanon), George Washington University (USA), and Northwestern University (USA).

In this professional forum, the PHCRC will report on the body of work conducted to date:

- Overview of the PHCRC, evidence gaps and research priorities
- How are different LMICs implementing PHC team integration to support comprehensive primary healthcare? A multicountry mixed-methods study – Mexico, Uganda, India
- Characterising the use of primary healthcare (PHC) performance information: A multiple case study in El Salvador, Lebanon and Malawi
- An international survey on the integration of public health and primary care in COVID-19 vaccination campaigns (with Besrour Centre)
- Identifying effective primary healthcare service delivery models for integrated management of non-communicable chronic diseases in resource-constrained settings (with GACD)

This will be followed by a discussion on future primary healthcare research priorities and how WONCA can engage further in this work.

The session will be attended by several other members of the PHCRC who have been engaged with the work: Rohina Joshi (University of New South Wales, Australia), David Peiris (George Institute, Australia) Innocent Besigye (Makerere University, Uganda), Martha Makwero (Kamuzu University of Health Sciences, Malawi), David Ponka (Besrour Centre, Canada), Praveen Devarsetty (George Institute, India).

Association between multimorbidity patterns and functional decline during acute infectious diseases hospitalisation among older adults: Nationwide observational study in Japan

Shingo Masuda[1,2], Dr Hirotomo Yamanashi[1,2,3], Mr Wenbo Song[3,4], Masato Tashiro[5,6], Shuntaro Sato[7], Hideaki Takahata[8], Shogo Akabame[1,2], Yukiko Honda[9], Yuji Shimizu[1], Poppy Mallinson[4], Judith Lieber[4], Sanjay Kinra[4], Kiyohide Fushimi[10], Takahiro Maeda[1,11]

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Background

Multimorbidity is a risk factor of physical functional decline among community-dwelling older adults. We aimed to: (1) investigate multimorbidity patterns; and (2) explore the association between multimorbidity patterns and functional decline of older adults during acute admission due to infectious diseases.

Methods

The retrospective cross-sectional study was conducted, using the data of the nation-wide diagnosis procedure combination database in Japan. Participants hospitalised due to acute infectious diseases aged ≥65 years and Barthel Index score ≥40 on admission from 2015 to 2020 were analysed (n = 953,110). (1) Multiple correspondence analysis was performed to explore multimorbidity patterns. (2) The association between multimorbidity patterns and functional decline or death was investigated by age- and sex-adjusted multivariate logistic regression analysis, treating the functionally stable group as a reference subject. Functional decline was defined by a more than 5-point decrease in the Barthel Index during the hospital stay.

Results

Among all, three major multimorbidity patterns were identified: (1) bronchial asthma, chronic obstructive pulmonary disease; (2) chronic pain, osteoporosis; and (3) dementia, depression, Parkinson's disease. Functional decline and death were 12.6% (119,837) and 4.8% (45,318), respectively. Multimorbidity Patterns 2 and 3 were associated with mortality (OR 1.66 [95% CI: 1.59 to 1.74] and OR 1.78 [95% CI: 1.32 to 2.42], respectively). Conversely, Pattern 2 was associated with functional decline, and Pattern 3 showed a more marked association (OR 1.06 [95% CI: 1.03, 1.10] and OR 3.67 [95% CI: 3.13, 4.31], respectively).

Conclusions

Multimorbidity pattern with dementia, depression and Parkinson's disease was associated with a worse outcome of both physical functioning decline and mortality. In contrast, the pattern with chronic pain and osteoporosis was also associated with mortality, but weakly associated with functioning decline. Early recognition of predisposing multimorbidity patterns may be beneficial to predict adverse outcome when providing care for hospitalised older patients due to infectious diseases.

Long-acting reversible contraception: A national survey of Australian general practitioner knowledge, attitudes and practice

Dr Sharon James[1], Professor Danielle Mazza[1], Kirsten Black[2], Prof Angela Taft[3], Prof Deborah Bateson[2], Prof Wendy Norman[4]

[1]Monash University, [2]University of Sydney, [3]La Trobe University, [4]University of British Columbia

Aim

To investigate the knowledge, attitudes and practices of Australian general practitioners (GPs) in long-acting reversible contraception (LARC) provision.

Content

GPs are well placed to support women's access to and the provision of LARC. However, uptake in Australia is low (11%), compared with other contraceptive methods.

A national survey was undertaken from July to October 2021 exploring GP LARC knowledge, attitudes and practices. This survey forms part of the Australian Contraception and Abortion Primary Care Practitioner Support (AusCAPPS) Network, a mixed-methods study aimed at improving access to LARC and early medical abortion in primary care.

Data were analysed using counts and proportions.

Of the 500 GP participants, 78% (n = 388) identified as female, 54% (n = 270) were from metropolitan areas and most lived in Victoria (31%; n = 156) or New South Wales (30%; n = 148). To prevent pregnancy, most (97.6%; n = 488) knew that LARCs were more effective than the contraceptive pill and that intrauterine devices (IUDs) are suitable for nulliparous women (91.8%; n = 459). Contraceptive consultations about LARC were generally GP initiated either very often (45.3%; n = 226) or always (40.3%; n = 201). GPs were influenced by patient preference (94.4%; n = 472), age (78.0%; n = 390) and cost (72.8%; n = 364) when recommending LARC. Regarding LARC insertion and removal, 76.2% (n = 380) provided this for implants, but only 26.9% (n = 134) for IUDs. Most GPs answered 'neither' when asked whether the possible side effects of implants (76.4%; n = 382) and IUDs (78.6%; n = 393) outweighed the benefits of their use.

To reduce barriers to LARC practice, AusCAPPS will be presented. This online platform was developed with support from key stakeholders in women's health services with features including peer networking opportunities, a provider database, resources and training links.

Goals

1. To present Australian GP knowledge, attitudes and practices in LARC provision.
2. To discuss the gaps for Australian GPs in LARC service provision.
3. To discuss ways GPs can be supported to provide LARC services.

Medical abortion: A national survey of Australian general practitioner knowledge, attitudes and practice

Professor Danielle Mazza[1], Dr Sharon James[1], Kirsten Black[2], Prof Deborah Bateson[2], Prof Angela Taft[3], Prof Wendy Norman[4]

[1]Monash University, [2]University of Sydney, [3]La Trobe University, [4]University of British Columbia

Aim

To investigate the knowledge, attitudes and practices of Australian general practitioners (GPs) regarding early medical abortion (EMA) provision.

Content

Although GPs are the first point of contact for women seeking EMA in Australia, only about 10% are certified to prescribe EMA medication. As part of the Australian Contraception and Abortion Primary Care Practitioner Support (AusCAPPS) Network, a mixed-methods study aimed at improving access to long-acting reversible contraception and EMA in primary care, we undertook a national survey from July to October 2021 to explore GP EMA knowledge, attitudes and practices. Data were analysed using counts and proportions.

Of the 500 GPs who completed the survey, 78% (n = 388) identified as female, 54% (n = 270) were from metropolitan areas and most resided in Victoria (31%; n = 156) or New South Wales (30%; n = 148). Most GPs (84%; n = 418) felt that it was acceptable for them to provide EMA, but only about half (54%; n = 272) felt they had the knowledge to provide counselling in relation to EMA. While 23% (n = 116) of those surveyed were registered prescribers of EMA medication, 22% (n = 111) provided an EMA service delivering on average of 5 (SD = 10.6) EMAs per month. EMA service delivery via telehealth was only 8% (n = 41) of all GPs.

To support evidence-based practice for women seeking the management of unintended pregnancy and address knowledge gaps, a unique national online community of practice, the AusCAPPS Network, will be presented. This platform enables peer and expert networking, the ability to locate a provider near you and access to resources and training in the provision of EMA care.

Goals

1. To present Australian GP knowledge, attitudes and practices in LARC provision.
2. To discuss the gaps for Australian GPs in LARC service provision.
3. To discuss ways GPs can be supported to provide LARC services.

Family medicine rotation assessment with the Student Evaluation of Course and Teaching (SECAT) form at the University of Botswana

Dr Deogratias Ongona Mbuka, Dr Stephane Tshitenge, A/Prof Billy Tsima, A/Prof Vincent Setlhare, Mubuuke Gonzaga

Introduction

The University of Botswana (UB), like other universities, adopted the use of students' feedback forms to improve teaching, promote better learning experiences and appraise teachers. This form is used across disciplines at UB and is known as the Student Evaluation of Course and Teaching (SECAT). SECAT sections are students' self-rating, teaching evaluation with teachers' attributes of performance, course evaluation and overall general appraisal of the lecturer and the course. This study aimed to assess the usefulness of completed final year SECAT forms in assessing teaching and learning during the family medicine rotation (FMR) and explored students' views on SECAT use in the evaluation of the FMR.

Methods

A cross-sectional descriptive study using a mixed-methods approach analysed the 2016 final year medical students' completed SECAT forms and findings from a focus group discussion (FGD) with these students the same year.

Results

In 56 (71.7%) of the 78 SECAT forms expected, 23 (41.1%) assessed the overall teaching and learning (T&L) during FMR as very good. More than one-quarter (26.8%; n = 15) assessed the T&L as excellent, while the assessment was rated as good in one-third (33.1 %; n = 18) of forms. No SECAT had a poor assessment. The FMR organisation was assessed as unsatisfactory in about one-third of forms (30%). Students' overall satisfaction with FMR was associated with their satisfaction with the lecturer's attributes like the teacher's ability to explain concepts ($P < 0.001$) and provide useful feedback ($P = 0.01$).

Emerging FGD themes were different relevance of SECAT sections for FMR and the need for alteration of SECAT sections to align with FMR.

Conclusion

SECAT may be providing useful information for teachers' performance across disciplines. However, customisation of the tool with relevant clinical domain activities is needed. This will improve the FMR's constructive alignment of assessment and the validity of the overall FMR assessment.

International medical graduates in rural and remote Australia: The overlooked trainers?

Dr Gregory Mcanulty[1,2,3], Eliza Gill[1,2], Dina Indrasafitri[1,2], A/Prof Emma Kennedy[1,2]

[1]Flinders NT Regional Training Hub, [2]Flinders University, [3]Alice Springs Hospital

Australia is promoted as being rugged and sparsely populated. Remoteness is central. Reality differs. Australia is highly urbanised. However, almost 15% of Australians living outside cities have poorer access to healthcare even though there is greater demand. The distribution of specialists is highly skewed to major urban centres. Complex specialist services are appropriately co-located in cities but urban-trained graduates are reluctant to live rurally. Effective, equitable health services require both primary and secondary healthcare within a reasonable distance.

Twenty-six regional training hubs (RTHs) were established in 2017 as an Australian Government initiative to increase the number of medical graduates committed to living in rural and remote areas. Evidence suggests that medical students who spend time in rural placements are more likely to continue to practise outside major urban centres after graduation. It is likely a similar effect could be present for non-primary care specialists and that increasing the number and length of rural placements will increase the availability of key specialties in rural areas as well.

Although evidence to support this extrapolation is limited, it is clear that there is a need for investment in regional training faculty in order to facilitate training in both primary and secondary healthcare in regional Australia. At present, the majority of both primary and secondary medical specialist positions are filled by international medical graduates (IMGs). These doctors are providing supervision and training in our context.

This presentation will explore the challenges of provision of supervision in medical training, the importance of inclusion of IMGs in training to enhance their roles as clinical service providers and supervisors. RTHs must prioritise the inclusion of specialist IMGs training in programs for training in education, supervision and assessment in regional Australia.

Primary care experiences in the introduction of HPV-based cervical screening

A/Prof Lynn McBain[1], Kayden Borchowsky[1], Morgan Rush[1], Thomas Mullally[1], Ben Hudson[1], John McMenamin[3], Sue Garrett[1]

[1]University of Otago Wellington, [2]University of Otago Christchurch, [3]Health Solutions Plus Whanganui

Aims

This study explores primary care staff's experience of using the HPV testing pathway in the Let's Test for HPV study so that recommendations can be made to improve the testing process before nationwide rollout in New Zealand during 2023.

Methods

This is a substudy of a primary care intervention study – Let's Test for HPV (and prevent cervical cancer) designed to provide an evidence base on which practical recommendations can be developed to guide the introduction of primary hrHPV testing for cervical screening in New Zealand.

In all, 39 individuals were interviewed across all 17 practices in the Capital and Coast, Canterbury and Whanganui region participating in the Let's Test for HPV study. In total, 19 semistructured interviews took place. These interviews were recorded and transcribed. Template analysis was carried out on transcripts to aid in identifying themes.

Results

Three key themes, with additional subthemes, were identified:

1. Clinicians (and their patients) were strongly positive towards the pathway. More patients are screened (including those previously under screened), and the pathway in this study is less onerous for patients and clinicians.
2. There were some issues with the pathway; most difficulty encountered is because the pathway is new to clinicians.
3. There are educational requirements for clinicians (particularly regarding management of positive tests), and for patients to understand HPV and the new pathway.

Conclusion

Clinicians described the experience of using the HPV testing pathway positively. Clinicians desired continued support, practitioner education taking place online and a national advertising campaign to improve patient knowledge on HPV testing and follow up.

The rural medical workforce revolution across the 'Blue Continent': Supporting primary care specialty training in Pacific island countries

A/Prof Lachlan McIver, Dr Lisiate 'Ulufonua

Rocketship Pacific Ltd

The island countries and territories that make up the spectacularly beautiful Pacific region – the aptly named 'Blue Continent' – are home to millions of people, most of whom live rurally and have great difficulty accessing medical care. Pacific island communities have among the highest burdens of communicable and non-communicable diseases in the world and simultaneously face the existential threat of climate change. The few clinicians who do live in rural communities and work in the outer-island hospitals and clinics have hitherto lacked the ability to train as generalists, as – up until recently – no such programs existed in the Pacific region.

At last, and in line with the 'Healthy Islands' strategic vision for the region, new programs are being established to train postgraduate doctors from Pacific island countries in the specialities of family, community and rural hospital medicine. Rocketship Pacific Ltd, an international health non-profit organisation based in Australia, has been involved in the design and delivery of postgraduate medical training programs in these fundamental specialities in five countries across the Pacific region since 2014.

In this presentation, we will share the experiences and lessons learned from almost a decade of Rocketship's work, all of which has been undertaken in collaboration with the Ministry of Health, regional academic institutions such as Fiji National University and other key partners. Together, these programs are producing the Pacific region's first-ever family medicine specialists, equipped with the knowledge and skills to provide quality, sustainable primary care to their island communities.

The write mindset: How to improve your writing, get published and (mostly importantly!) stimulate the right side of your brain

A/Prof Lachlan McIver

Médecins Sans Frontières

Has medicine suppressed your creativity? Do you have a love of literature? Do you dream of writing a short story, poem, novel or memoir? Have you ever wondered what literary agents and editors really do? Are you curious about the difference between traditional publishing and self-publishing? Or are you interested in academic writing? Would you like to get more articles published in scientific journals? Are you (crazy enough to be) thinking about a PhD?

If the answer to any of the above is 'Yes', then this skill-building session is for you!

The facilitator of this workshop, A/Prof Lachlan McIver, is a rural generalist and public health physician with a PhD in global health. He has published over 50 scientific articles in journals and textbooks and co-authored two major publications for the World Health Organization. He is also the author of the bestselling memoir *Life and death decisions*, which was published in Australia, New Zealand, Europe and the UK in 2022.

During the workshop, participants will share their experiences with writing across various genres, from poetry and creative prose to non-fiction and formal academic writing. Strategies for improving techniques, completing manuscripts, submitting to journals, approaching agents, finding editors and publishing works will be provided, along with specific tips to remember and pitfalls to avoid.

The overall aims of this session are to make participants to feel inspired and empowered with their writing and to create a community of practice for doctors who love the written word.

Data-driven patient-centred general practice: A collaborative integrated approach

Mr Adam Mcleod

Outcome Health

Aim

To develop and implement a partnership-based data strategy for general practice capable of delivering priority outcomes for the Australian public.

Content

GPs are the gateway to most realms of Australian healthcare. Analysis of the data recorded during GP consultations is a powerful source of knowledge and evidence. Capture, curation and distillation of these data at an aggregated regional level provide much earlier and deeper insight into those at highest risk of hospitalisation and deterioration compared to any other data source.

Advances in digital health promise dramatic changes in healthcare, not just in how care providers operate, but also in how individual patients are managed to achieve optimal care. Digital innovation in systems to link, deploy data and compute predictive analytics can be applied to deliver benefits to patients and health services, for example, reducing hospital admissions, health system costs and provision of the right care at the right time and place.

The program presented here is an action research-based integrated health intelligence platform which is capable of supporting GPs at the point of care through real-time data analytics, prompts and insights while simultaneously contributing to the national health picture by curating deidentified data snapshots for research, policy debate and health system evaluation.

This partnership program is ongoing; notable achievements to date include:

- avoidable hospitalisation risk calculator
- point-of-care support to make evidence-based care easier for GPs
- supporting early diagnosis of chronic conditions
- increasing adherence to interventions among patients with complex health needs
- improving primary healthcare data linkage with a range of linkage partners, including hospitals, clinical registries and the National Disability Insurance Agency.

For the past seven years, our program has demonstrated that pursuing a partnership-based integrated patient-centred data strategy for general practice enhances care and improves patient outcomes.

Assessing and addressing diabetes distress: Design and implementation of a digital health solution in general practice

Dr Rita McMorrow[1,2], Dr Barbara Hunter[1], A/Prof Jo-Anne Manski-Nankervis[1]

[1]Department of General Practice, The University of Melbourne, [2]Parkville Precinct Medical

Background
Up to 36% of people with type 2 diabetes experience diabetes distress, the negative emotional experience from the challenges of living with diabetes. Routine assessment using the guideline-recommended Problem Areas in Diabetes (PAID) scale is infrequent. Given that most people with type 2 diabetes receive medical care in general practice, it is important to optimise approaches.

Aim
To design and implement a digital health solution to support general practice to assess and address diabetes distress.

Methods
In the first phase, iterative design thinking was used in three qualitative sessions with nine general practice staff to design a solution to collect the PAID scale. The second phase was a 12-week case study in three general practices to explore implementation barriers and facilitators. Qualitative data were collected from general practice staff and people with type 2 diabetes. Analysis was in NVivo 12 using framework analysis, guided by the Theoretical Domains Framework and the Consolidated Framework for Implementation Research.

Results
The developed solution digitally collected and stored the PAID scale with links to resources. Key themes identified in Phase 1 included focusing on language to minimise patients' negative emotions, flexibility within the solution to fit the environment, and clarity regarding the intention. In Phase 2, the solution worked technically as designed, with 25 people with type 2 diabetes participating. People with type 2 diabetes found the solution simple to use. Practice nurses sent the PAID scale, with general practitioners (GPs) reviewing responses. Implementation was separate from routine diabetes care, offered to people with an ongoing GP–patient relationship, rather than a recommendation from diabetes guidelines. COVID-19 diverted practice priorities and limited staff engagement.

Conclusions
Completing the PAID scale using the developed digital solution was acceptable to people with type 2 diabetes. The PAID scale, if used, was within an ongoing GP–patient relationship.

Cardiovascular disease in people with chronic HIV infection: A pilot study

A/Prof Marilyn McMurchie

East Sydney Doctors

Aim

To explore the association of chronic HIV infection with comorbid cardiovascular disease (CVD) in one high case load inner Sydney general practice, in part to reconnect with normal clinical practice after COVID pandemic restrictions.

Rationale

The proportion of people infected with HIV older than 50 years is increasing across first world countries; non-AIDS defining disease is now a more common cause of morbidity and mortality than AIDS. Some older antiretroviral treatments increased the risk of ischaemic heart disease, largely mediated by dysregulated lipids, but people now live longer with the associated increased risks of CVD, type 2 diabetes (T2D), central adiposity, chronic kidney disease and polypharmacy with the potential for drug–drug interactions.

The increased risk of CVD is thought to approximate that of co-incident T2D.

Methods

Electronic medical records of patients with chronic HIV infection seen at East Sydney Doctors since updated computer software was introduced in 2000 were reviewed. Comorbid diagnoses of acute myocardial infarction (both ST elevation, or STEMI, and non-ST elevation, or NSTEMI), peripheral vascular disease and heart failure.

Summary

In all, 1055 HIV infected people were seen: 13 female (age range 18–72 years) and three male-to-female transgender.

Tools used

The Cardiac Society of Australia and New Zealand refers to management guidelines produced by the European Society of Cardiology. There are guidelines for heart failure (HF 2021), STEMI (AMI.STEMI 2017), NSTEMI (NSTE 2020) and peripheral vascular disease (PAD 2017).

Management of these conditions in this population will be assessed against these guidelines.

Study limitations

As in all real-life settings, data depend on the quality of information recorded by the consulting doctor.

Learning objective

Identify the increased risk of CVD in HIV positive patients.

How much do the Australian public value general practice?

Dr Hamish Meldrum

Ochre Health

Aim

To quantify the cost and value of general practice to the Australian public.

Content

General practice is allocated about 1% of government expenditure (noting that health is 16%).

What is the evidence that this is value for money?

Part of the evidence is a nationally representative survey of 1000 Australians in late 2021 by Roy Morgan.

From this survey we learnt that when rating the importance of general practice to the Australian health system, more than 60% of Australians gave general practice a rating of 10 out of 10 (on a 10-point Likert scale).

More than 60% of survey respondents said general practice provides more than 50% of their healthcare.

General practice has significant downstream savings of approximately $15 for every dollar spent (this is referenced to other study data and not the Roy Morgan survey).

General practice, at 6.8% of the total health spend, is the lowest cost and highest value component of the Australian health system.

Another way to assess the value of general practice to the public is to ask the public how much of the total health expenditure goes on general practice. The median response of survey respondents was 30%. This estimate is four to five times above the actual spend. This suggests that there is a public appetite for government to increase the spend on general practice.

Goals

To raise self-esteem for the value of general practice as a career choice

To increase macro-economic financial literacy among primary care physicians

To assist GPs in advocating with policy makers, the public and other key stakeholders for more sustainable resourcing and funding models for GP-led primary care

ORVAC: Optimising Rotavirus Vaccine for Aboriginal Children

Dr Bianca Middleton[1], Ms Ada Parry[2], Ms Gregoriana Parker[1], Tom Snelling[3]

[1]Menzies School of Health Research, [2]Royal Australian College of General Practitioners, [3]University of Sydney

Rotavirus is the leading cause of diarrhoea morbidity and mortality for young children worldwide. In 2006, oral Rotarix rotavirus vaccine was licensed for use in Australia. However, despite high vaccine uptake, Aboriginal and Torres Strait Islander children living in rural and remote Australia remain more than 20 times more likely to be hospitalised with rotavirus gastroenteritis than children living in other Australian states and territories.

The ORVAC (Optimising Rotavirus Vaccine for Aboriginal Children) study, is the first study to evaluate both the immunological and clinical impact of a 'booster dose' rotavirus vaccine schedule. This adaptive clinical trial randomises Aboriginal and Torres Strait Islander children aged 6–11 months in the Northern Territory to receive an additional 'booster' dose of oral rotavirus vaccine or placebo. The primary outcome is decreased medical presentations with gastroenteritis in the first three years of life.

This real-world pragmatic clinical trial is conducted under the guidance of Aboriginal Elder and Cultural Advisor, Ms Ada Parry, and Aboriginal members of staff including Gregoriana Parker, Lorraine Gilbert and Gloria Baliva. It is run in partnership with both NT Government Primary Care Clinics and Aboriginal Community Controlled Health Services in the Northern Territory.

We anticipate that a successful trial outcome – evidence that a booster dose of oral rotavirus vaccine leads to decreased medical attendances with gastroenteritis – would lead to a direct change in rotavirus vaccine policy for Australian Aboriginal and Torres Strait Islander children and have implications for rotavirus vaccine policy in other high-burden, low-resource settings in Africa and Asia.

Report on practice and tips for adolescent care at our university hospital

Mrs Miwa Misawa[1,2], Yuki Kanetsuki[1], Enri To[1], Hajime Mizutani[1], Momoko Iwamoto, Sho Isoda, Youhei Kawaguchi[1], Kazuki Shigetome[1], Saneyuki Sumitomo[1], Kazuomi Sekine[1], Tadayuki Hashimoto[1], Fumio Shimada[1], Seiji Miyahara[2], Prof Tomio Suzuk[i1]

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According to statistics from Japan's Ministry of Education, Culture, Sports, Science and Technology, the number of Japanese high school students who miss 30 or more days of school per year will be 43,051 in 2020, or 13.9 per 1000 students. Of these students, those who are absent for 90 days or more are estimated to account for 19.6%. This problem is currently on the rise, and has become one of the major social problems among young people in Japan.

Our department was visited by about 100 high school and college students who were unable to go to school in 2022 for a variety of reasons. Health problems include orthostatic disorder, irritable bowel syndrome, functional dyspepsia, chronic headaches as typified by migraine, dizziness and other physical problems. In addition, mental health, social and family background play a significant role, including juvenile depression, low motivation, delayed sleep–wake phase disorder, addiction to games and smartphones, developmental and learning skills issues, parent–child attachment disorder, bullying, gender identity, trauma and social anxiety disorders. We deal with adolescent patients not only by approaching the patients themselves, but also sometimes by approaching the adults around them, such as parents and teachers, counselling such as cognitive behavioural therapy by specialised professionals and collaboration with psychiatrists. The problem of 'not being able to go to school' is a problem that has no corresponding specialty and should be addressed by family physicians and general practitioners.

In this presentation, we will analyse the reasons for visits and symptoms of patients between the ages of 15 and 22 years who visited our hospital, and share the ideas of adolescent care at an urban university hospital in Japan. We will also consider the influence of Japan's unique school culture.

Key messages for generalists on managing patients with severe eating disorders

Dr Hajime Mizutani, Prof Tomio Suzuki

Osaka Medical and Pharmaceutical University Hospital

Eating disorders are relatively common psychiatric disorders encountered by primary care physicians. In severely malnourished cases, patients need to be hospitalised due to hypoglycaemia, refeeding syndrome and infection. Care must be provided by a multidisciplinary team that understands that the care continuum is complex, as their condition changes rapidly and repeatedly during a single hospitalisation. The need for a good handover of the patient into the community is also essential at the time of discharge to prevent rehospitalisation. Thorough planning and discussion with family members and their primary care physicians are also essential as eating disorders require family-oriented care.

A 37-year-old female with severe eating disorder with a BMI of 8 kg/m^2 was hospitalised in the Department of Psychiatry. The following key learning lessons were identified:

1. BMI <10 kg/m^2 is a life-threatening condition with persistent risk of hypoglycaemia and sudden cardiac arrest.
2. Support for the medical staff will be needed to prevent burnout as care for these patients is often emotionally exhausting. One unusual strategy may be to transfer patients back-and-forth with a collaborating hospital to give both the medical team and the patient a 'time out' from each other.
3. Multidisciplinary nutritional support team meetings should be held regularly. Patients should be educated and counselled on healthy eating habits while receiving psychiatric care.
4. Young patients with eating disorders should also receive rehabilitation for their sarcopenia, but caution is required as patients are easily overworked.
5. Successful handover to the community care team must include psychological care for the family members and a discharge planning meeting involving family members, the primary care physician and the outpatient care team.

Working with patients' painful life stories in general practice: Why, when and how

A/Prof Bente Prytz Mjolstad[1,2], Prof Linn Okkenhaug Getz[1], Mrs Marianne Rønneberg[1,3]

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Aims

To strengthen participants' knowledge of why it is medically important to engage actively with patients' painful life stories in a life course perspective and to provide suggestions on how to work constructively with patients' life stories.

Background: Why is adversity clinically relevant?

Research has documented strong connections between adverse experiences and disease development in a life course perspective. Trauma, integrity violations and neglect literally become inscribed in the human body, potentially even crossing generations. Furthermore, unresolved adversity can lead to poor parenting skills, increasing the risk of passing on adversity to the next generation. For these reasons and in accordance with the core values and principles of general practice, GPs need to engage professionally with their patients' biographical stories. However, many GPs find it difficult to address painful life stories in the consultation and may feel uncertain and even sceptical about the relevance of doing so.

Content of session

We will present research data to address different aspects of the topic: (1) life experiences and health – the evidence; (2) pregnant women's thoughts on parenthood, seen in the light of their own upbringing; and (3) how GPs work with patients' life stories in clinical practice. The participants will then be invited to exchange experiences about the challenges and successes of working with patients' painful stories and discuss both the therapeutic and preventive roles of primary care professionals.

Goals

To heighten GPs' awareness of the interconnectedness between adverse life experiences and disease development and to encourage GPs to engage actively with patients' painful stories both to improve clinical practice and prevent parents' unsolved adversity from becoming the prologue of a child's difficult life.

Active patient participation in the electronic health record: Ethical and professional considerations

Dr Tania Moerenhout[1], Miss Carmen Nadal[2], Amal Al Ali[3], Prof Tariq Aziz[4]

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Background

Shared decision making with active patient involvement in healthcare decisions has been promoted over the past decades as a means forward to a more equal, inclusive and less paternalistic version of medicine. This evolution has also driven design changes in the electronic health record (EHR): patient access to results and notes has been widely included via patient portal systems, although there is great variability in EHR implementation and sharing of information globally. Patient access to the EHR has created many challenges to ethics and professionalism. Could access to results be harmful to patients? Should patients also be able to add information to the record? And how to manage record access for teenagers? The aim of this interactive presentation is to discuss these challenges with the audience and to contribute to the establishment of practical recommendations for sharing information online with patients.

Methods

First, an introductory presentation will present the most common challenges of sharing information via patient portals and an ethical background to these challenges. Second, scenarios based on literature review and experiences of our working party members will be discussed in small groups, including cases and experiences brought forward by the audience. Participants will discuss strategies in collaborative, cross-disciplinary group work for a practical approach to bioethics. Lastly, the solutions to the scenarios will be translated to practical ethical recommendations, while critically evaluating the feasibility of designing global guidelines for patient portal use.

Results/outcome

This workshop will allow participants to consider the impact of using a patient portal system and sharing information online with patients more in-depth. Through a focus on ethical and professional challenges in scenario-based analysis, participants will share their own experiences and codesign guidelines for best practice online information sharing. We will specifically focus on their usefulness in different stages of EHR implementation.

Evaluation of the quality of service delivery in primary care facilities in the private sector in Nairobi, Kenya

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[1]Aga Khan University, Nairobi, [2]Stellenbosch University

Introduction

The core functions of primary care (PC) are first-contact access, continuity, comprehensiveness, coordination and person centredness. These should be measured to evaluate PC performance. No previous study has evaluated the core functions of primary care in Kenya. This study aimed to measure these key elements in the primary care clinics in the private sector in Nairobi.

Aim

Evaluation of the quality of service delivery in primary care facilities in the private sector in Nairobi.

Methods

Five descriptive cross-sectional studies measured PC performance. First, a survey of patient perceptions on the comprehensiveness of care (n = 162). Second, a survey of patient satisfaction using the General Practice Assessment Questionnaire (n = 378). Third, an evaluation of recorded consultations using the Stellenbosch University Observation Tool (n = 23). Fourth, an evaluation from the patient's perspective, using the Primary Care Assessment Tool (KE-PCAT) that was validated for the Kenyan context (n = 412). Fifth, a survey measured clinical skills of the general practitioners (n = 25).

Results

Primary care doctors were mostly young, without postgraduate training in family medicine, and lacked basic skills. First contact access was good for acute minor problems, although older patients and those with chronic conditions appeared to primarily use the specialists at the tertiary hospital. Informational continuity was well supported by an electronic patient record linked with the associated tertiary hospital, which enabled care coordination. Care comprehensiveness showed gaps in the management of chronic conditions, women's health and preventative care. There was little need for sequential care coordination. Consultations were brief, of low-to-moderate complexity and doctor centred. The mean PC score was 2.64 (SD=0.23), implying poor overall performance.

Conclusion

The studies confirmed that this private healthcare system was not offering comprehensive and high-quality primary care. Care and performance could be improved by redesigning the model of care, deploying family physicians and training the PC doctors. Quality improvement cycles using KE-PCAT are recommended.

HealthPathways as a tool for health system collaboration: Benefits, barriers and enablers

Dr Sarah Mollard

Healthy North Coast (North Coast Primary Health Network)

Aim

To demonstrate the contribution of HealthPathways, a localised clinical management support tool, to health system collaboration and describe the barriers and enablers for successful implementation.

Content

HealthPathways is an online platform designed to deliver localised clinical and referral content to clinicians at the point of care. The program has been implemented in all 31 Primary Health Networks across Australia, as well as in New Zealand and the UK. Findings from a combined process and outcome evaluation of a HealthPathways program will be presented. The evaluation used a mixed-methods approach to assess program uptake, barriers and enablers, outcomes relating to general practitioner experience of care and collaboration across different levels of the local health system. HealthPathways was found to be a credible tool used to support clinical decision making. Spikes in usage correlated with key regional events, including COVID-19 outbreaks and disasters, highlighting the value of the tool to meet the information needs of clinicians in novel scenarios that are rapidly changing. The program was found to have contributed to local models of care and health system changes; however, limited high-level integration into local health organisation planning and processes was identified as a key barrier to growth and effectiveness. The contribution of HealthPathways to collaboration in the health system was explored. At a micro level, HealthPathways was suggested to add value through quality content provided about local models of care and best practice. At a meso level, the program was identified as an enabler of interorganisational and interprofessional collaboration to facilitate strategic conversations addressing specific pain points in the health system. At a macro level, opportunities to leverage HealthPathways for wider system improvements were identified.

Goals

Attendees will be able to describe potential benefits of implementing a HealthPathways program and understand important barriers and enablers for successful implementation.

GP data for GPs: The effectiveness of real-time computer decision support in Australia

Prof Mark Morgan

Bond University

Aim

To evaluate a software program that analyses routinely collected electronic clinical information before returning real-time alerts and prompts.

Methods

After development, testing and implementation across a region of Australia, an evaluation of impact was made. Response rates in which patient care altered were recorded for the various medication safety alerts and care prompts.

Results

Primary Sense software was installed in 87 GP practices in the Gold Coast region of Australia. Medication safety alerts resulted in changed patient care for 45% of alerts (30–69% between different safety alerts). Risk-stratified care prompts were followed 26% of the time (12–57% between different prompt categories). Response rates were maintained over two years of data collection.

Discussion

This research has demonstrated a remarkable impact that far exceeds other interventions, including educational, audit with feedback and nudge letters.

Conclusion

Real-time computer decision support is a valuable tool that can be delivered at scale. As the software is rolled out nationally, there is further scope to combine risk information held in multiple practices to further improve patient safety.

Specialist palliative care in aged care: A retrospective cohort study of needs rounds in RACFs

Dr Nicola Morgan

Clinical Excellence Queensland, Queensland Health

Introduction

The integration of specialist palliative care into residential aged care facilities (RACFs) through 'needs rounds', an evidence-based approach of monthly triage and risk stratification meetings, has shown to improve the quality of care for elderly residents at the end of life.

Objective

This study aimed to examine the impact of introducing specialist palliative care via an appropriate scalable model of needs rounds into RACFs across the Gold Coast Health Service.

Design and methods

A retrospective cohort study of introducing palliative care needs rounds was conducted in 57 RACFs (5615 beds) across the Gold Coast Hospital and Health Service. A mixed-methods qualitative and quantitative evaluation was conducted one-year after implementation to assess the project's effectiveness, staff confidence, resident end-of-life experiences and impact on the health service's ED presentations, hospital admissions and length of stay.

Results

The Needs Rounds project impacted 96% of the RACFs, and there was a significant increase in staff confidence in identifying deteriorating residents. Earlier identification of end-of-life care needs enabled GPs to provide timely and appropriate care to their patients. There was a 20% reduction in ED presentations from RACFs in the first year of operation, and hospital length of stay was also reduced, creating a released bed space to treat approximately nine additional non-RACF patients each day.

Conclusion

Gold Coast Needs Rounds improved staff confidence, access to specialist palliative care expertise and the quality of care for residents in RACFs, while reducing the burden on GPs and avoiding unnecessary hospitalisations and ED presentations. This project provides a model for improving access to specialist palliative care in residential aged care that could be adapted to other healthcare systems worldwide. Future studies are needed to explore the facilitators and barriers to the implementation of needs rounds to inform wider adoption and standardisation as part of specialist palliative care in RACFs.

SPACE: Improving access to Specialist Palliative Care in Aged Care

Dr Nicola Morgan

Clinical Excellence Queensland, Queensland Health

Introduction

Specialist Palliative Care in Aged Care (SPACE) was implemented across Queensland in 2020 to improve end-of-life care coordination for older people living in residential aged care facilities (RACFs). The project aimed to increase the capacity of RACFs and GPs to provide end-of-life care in place of choice with education, pre-emptive planning and access to specialist palliative care support. Fifteen Queensland Hospital and Health Services (HHS) were supported to develop and implement contextually appropriate models of care aligning with core service principles.

Methods

A mixed-methods qualitative and quantitative evaluation was conducted one-year after implementation to assess the effectiveness of implementation, proportion of RACFs impacted by SPACE, staff confidence and resident end-of-life experiences.

Results

All 15 HHS developed and implemented a model appropriate for local context. Extensive stakeholder consultation and codesign enabled effective implementation of the project, improving cohesion and networking across the state. Eighty per cent of the 517 RACFs across Queensland were impacted by SPACE. There was a significant increase in staff confidence identifying deteriorating residents. Earlier identification of end-of-life care needs enabled GPs to provide timely and appropriate care to their patients.

Conclusions

There was a high level of engagement with SPACE services across Queensland despite aged care lockdowns, limited staffing and COVID-related redeployment of SPACE teams. The SPACE project had a positive impact on staff confidence, improved access to specialist palliative care expertise, reduced burden on GPs to provide complex end-of-life care and improved quality of care for residents. The results of this evaluation have international implications for GPS who provide primary care for ageing populations. The SPACE project provides a model for improving access to specialist palliative care in residential aged care that could be adapted to other healthcare systems.

Youth mental health – exploring what works: Engagement, shared formulation and effective risk assessment and management

Dr Sonya Morrissey[1,2], Christine Sasse[3]

[1]headspace Craigieburn, [2]Orygen, [3]headspace Bendigo

Many primary care clinicians find working with adolescents interesting and rewarding. However, some report that working with young people is challenging, and the difficulties are often ascribed to characteristics of the young people themselves, rather than considering the whole picture, including practitioner barriers that may be brought to the consultation.

The headspace model has been successful in engaging young people, family and communities, and enhances the care provided by community GPs. General practitioners are uniquely placed to improve the mental health of young people and bring knowledge of family, community and culture, and provide holistic and long-term continuity of care. Effective engagement and establishing rapport are key in working with adolescents and reap benefits for the long-term health of the individual and families, as well as improving work satisfaction for the clinician. Working effectively with this age group is vital, as 75% of adult mental health conditions first present before the age of 25 years. Being able to respond effectively to a young person presenting with suicidal thinking and self-harm may reduce attendances at emergency departments and build stronger therapeutic relationships between the GP and the young person.

This presentation will consider some of these perceived challenges through a developmental framework, look at factors specific to adolescence which commonly inhibit engagement and identify some practitioner factors that may inhibit the process. The presenters will share practical tips and strategies when working as a GP with young people in the mental health context, and some specific clinical scenarios will be discussed (including young people with ASD, gender diversity and complex trauma). The value of a shared formulation approach will be explored. A framework for assessing and responding to risk in young people presenting with suicidal ideation or self-harm will be presented, including the role of safety planning.

The changing face of primary care teams in Aotearoa

Ms Katie Mottram, Ms Mabli Jones

Tu Ora Compass Health

Aotearoa New Zealand's primary care health system is currently under considerable pressure due to significant workforce shortages, increasing populations and unsustainable demands on services. These challenges present the opportunity for new ways of working and the development of improved pathways of care within the primary care setting. A sustainable primary care workforce will require team-based care and utilisation of a comprehensive care team. This approach aligns with New Zealand's national health system reform where allied health professionals have been identified as a key priority workforce to support the sustainability of healthcare delivery. Through collaborative pathways we can shift towards more patient-centred, proactive, interdisciplinary models of care.

As part of the commitment to He Waka Eke Noa, Te Pae Tata and Ola Manuia, a strong emphasis has been placed on the development and implementation of a number of allied health projects. All projects have a strong equity focus and work in collaboration with local healthcare services and communities to deliver more equitable, accessible and efficient health solutions with the aim of achieving Pae Ora, and better health and wellbeing outcomes for our communities. Programs of work include greatly subsidised physiotherapy services to finically challenged populations within the community; the integration of paramedics into the primary care setting to assist with the management of acute and non-planned care; and utilisation of the physiotherapy workforce to reduce orthopaedic waiting times and improved access to musculoskeletal care. Centralised coordination of these initiatives allows a deeper understanding of future commissioning needs, improved patient access to care and relieves demand on primary care during a period of acute clinical workforce shortages.

Does it rain after the storm? Family medicine resident's reflection during pandemic at Qatar: Results from a cross-sectional study

Dr Rasha Moussa

Family Medicine Training

The literature is enriched with evidence that the COVID-19 crisis led to negative impacts, such as disruption of economy, health/social impact and financial difficulties. Our purpose is to investigate how family medicine department move beyond crisis recovery, develop resilience and what the family medicine residents learnt from the crisis and if they have had any negative or positive consequences that we can shed light on them. Therefore, we develop a survey-based questionnaire to understand how our residents got actively or passively impacted, thus the family medicine program could provide an insightful bidirectional support for the trainees. Gain from a crisis was not expected. However, results from this survey showed that family medicine residents benefited from their experience as front-line staff managing patients during the COVID-19 pandemic mostly in social, behavioural and skills aspects and to a minor degree in professional aspect. Conversely, the family medicine educational aspect was negatively impacted.

Antenatal couples' counselling to improve uptake of birth planning and postpartum family planning: A process evaluation

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[1]Mbarara University of Science and Technology, [2]School of Primary Care, Population Sciences and Medical Education, University of Southampton

Introduction

Lack of birth planning and family planning are important avoidable factors in maternal and perinatal deaths in Uganda. An intervention to train VHTs and health workers to deliver couples' counselling to women and their partners during the antenatal period, aiming to encourage delivery in an appropriate facility and uptake of postpartum family planning (PPFP) was developed.

Objective

To understand the mechanisms and contexts for successful and unsuccessful outcomes of the intervention.

Methods

A nested qualitative study alongside a feasibility cluster randomised trial was conducted. Some participants who had followed the advice about birth planning and/or PPFP, and some who had not, as well as VHTs and health workers were purposively selected and interviewed. Interviews were transcribed verbatim in the local language and then translated into English and analysed thematically, using a realist evaluation framework.

Results

Twenty-seven interviews were done; 16 participants (10 women, six men), seven VHTs, three health workers, and one clinic manager. The five men were linked to five of the women. The trained VHTs and health workers gave couples an opportunity to discuss birth planning and PPFP and to come to a joint decision. Men listened more to VHTs and health workers than to their wives, which changed their attitudes. Home visits by the VHTs and weekend clinics enabled more couples to access the counselling. Men felt valued when they were welcomed at health centres, and women felt empowered to decide to use PPFP when supported by their husbands.

Key reasons underlying unsuccessful outcomes were women's beliefs (religion, social norms), attitudes (fears of side effects, myths), lack of time, unsupportive husbands and services not being available (due to stock-outs, not all health workers being trained and COVID-related closures).

Conclusion

The intervention functioned well in the presence of supportive husbands and good collaboration between VHTs and health workers.

Understanding the common ailments of the internally displaced persons in north-central Nigeria: The role of the family physician

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Background

The worsening humanitarian crisis in Benue State, north-central Nigeria occasioned by the frequent Fulani herdsmen attacks and displacement in several communities of the State, has led to the establishment of 27 internally displaced persons (IDPs) camps (seven official and 20 unofficial). These camps are home to about two million IDPs. Family physicians often encounter IDPs; hence, learning to provide primary care for these patients serves as an important part of the family medicine practice. The aim of the study was to strengthen the understanding of IDP health issues with a view to make recommendations aimed at improving IDPs' health.

Materials and methods

This study was a cross-sectional study carried out in October 2022 during a medical outreach in an IDP camp located in Benue, Nigeria. Self-reported data were obtained using self-administered questionnaires from 115 consecutive patients who gave consent to be included in the study. Only consenting patients were included in the study. Data analysis was done using SPSS version 20.

Results

The mean age of the participants was 45.12 ± 34. The majority were females (88.7%; n = 102). Borehole water was the major source of water supply (98.3%) and up to 90.4% defecated in a pit latrine. A total of 80% of respondents had reported being ill in the preceding six months. The commonest ailment was febrile illnesses (30.6%), then dyspepsia (24%). The least were diarrhoea (7.7%) and bites from scorpions, snakes and dogs (7.7%). There was a statistically significant association between the use of insecticide-treated nets (ITNs) and occurrence of disease.

Conclusion

The family physician can be an important contact person and source of help to the IDPs if they know something about the IDPs' special health problems and needs. The consistent use of ITNs will help forestall majority of the illnesses occurring in IDPs.

A global perspective on primary healthcare indicators: What are we measuring and why?

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[1]Kenya Association of Family Physicians, [2]Nakuru County Government, [3]PHC Performance Initiative, [4]College of Family Physicians of Canada

Primary healthcare (PHC) is the first point of contact for individuals seeking medical attention and serves as a critical component in improving the health outcomes of the community. It has been recognised as an essential element for strengthening health systems and achieving universal health coverage (UHC). However, the effectiveness of PHC in different countries and regions is difficult to assess due to the lack of standardisation in measurement frameworks and key performance indicators (KPIs).

In 2018, the World Health Assembly (WHA) passed resolution WHA72.2, which called for guidance on assessing, tracking and monitoring PHC performance to accelerate progress towards UHC and the health-related Sustainable Development Goals (SDGs). Consequently, various measurement frameworks and KPIs were developed to serve as a mechanism for tracking quality improvement in PHC. These KPIs provide feedback to inform better public service delivery, promote accountability and guide policy direction. However, various countries are using different measurement systems, making it difficult to compare the effectiveness of PHC services.

Most existing validated measurement frameworks and KPIs for measuring primary care functions were initially developed in higher-income countries, such as the Quality and Outcomes Framework (QOF) used in the UK to measure the quality of care provided by general practitioners. The Primary Care Assessment Tool (PCAT) was also developed in the US to measure the quality and effectiveness of PHC services, although it has since been adapted for use in many countries around the world.

Low- and middle-income countries have limited resources and lack standardised measurement frameworks and KPIs developed specifically for their context. Therefore, this roundtable aims to provide a global perspective on the various PHC measurement systems used around the world, highlight the lessons learned, identify challenges and propose steps towards improvements.

Twenty years of Tele-Derm: The impact of an online dermatology education and advice service for rural doctors in Australia

Dr Jim Muir

Australian College of Rural and Remote Medicine

Skin conditions are one of the most common reasons for primary care visits in Australia, affecting 3.4 million people annually.

There is a substantial shortage of dermatologists. The average waiting time to see a dermatologist is anywhere from six months to one year.

To address this ongoing challenge, the Australian College of Rural and Remote Medicine developed Tele-Derm, an online education and advice platform for rural doctors providing high-quality and timely guidance and support, thereby enhancing the ability of rural doctors to diagnose, treat and manage skin conditions in their local communities.

Aim

This presentation aims to present the results of a 20-year analysis of Tele-Derm, including an interactive review of the cases of significance submitted to Tele-Derm.

Results

Tele-Derm has received more than 15,000 case submissions from rural doctors. Our surveys indicated that the service significantly reduced waiting times for patients and improved doctors' ability to diagnose and manage skin conditions. Only 10% of complex dermatology cases required referral to a dermatologist, suggesting the service effectively supports doctors in providing high-quality dermatological care.

Conclusion

For the past 20 years, Tele-Derm has played a crucial role in improving access to dermatology advice for patients in rural and remote areas. The service provides doctors with the necessary knowledge and resources to manage skin conditions locally, reducing waiting times and ensuring timely care. As we celebrate the 20th anniversary of Tele-Derm, the importance of telemedicine in improving access to healthcare for all Australians is recognised.

Validation of cold spots using the two-step floating catchment area method: Geographic information system-based ecological study in a Japanese prefecture

Dr Akihisa Nakamura, Kazuhiko Kotani

Division of Community and Family Medicine, Center for Community Medicine, Jichi Medical University

Background

Access to medical facilities is important in primary care. To ensure geographic access to medical facilities, the characteristics of districts with poor medical access were examined using spatial statistical analysis.

Methods

All 2554 administrative census mesh blocks and all 89 hospitals in a Japanese prefecture were included in the study. The population was approximately two million. The enhanced two-step floating catchment area (E2SFCA) method was used to evaluate geographic access to medical facilities. The E2SFCA scores were calculated for all meshes using ArcGIS Pro 3.0 (ESRI, Redlands, CA, USA). The Kruskal–Wallis test, multiple comparisons (ie the Bonferroni method), spatial autocorrelation analysis and spot analysis (Getis-Ord Gi*) were used for the analysis.

Results

The median E2SFCA score was 4.0 hospitals/100,000 (interquartile range [IQR] 2.4–5.8/100,000), which was almost equivalent to 4.5 per 100,000 population. Spatial autocorrelation analysis showed spatial agglomeration in the E2SFCA scores ($P < 0.001$). Spot analysis detected 81 cold spots and 115 hot spots. Median population sizes were 134 (IQR 76–207), 178 (IQR 60–389), and 478 (IQR 227–908) in cold spots, hot spots and the remaining meshes, respectively ($P < 0.001$). Median ageing rates in the >65-year-old population were 37% (33–43%), 38% (30–48%) and 29% (22–34%) in cold spots, hot spots and the remaining meshes, respectively ($P < 0.001$). In multiple comparisons, the population in cold spots was significantly smaller and the ageing rate in cold spots was significantly higher than in the remaining meshes ($P < 0.001$).

Conclusion

Spatial statistical analysis in the E2SFCA method detected 81 cold spots in 2554 meshes. These cold spots had smaller populations and higher rates of ageing than the other meshes. Continued discussion is needed on how to ensure access to primary care in depopulated areas with high ageing rates.

Safe prescribing of PPIs in Western Cape Province, South Africa: A health system improvement journey

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[1]UCT and Metro Health Services, Western Cape, [2]Western Cape Health and Wellness Department, [3]Public Health Department, University of Western Cape

Background and aim

The misuse of proton pump inhibitors (PPIs) was a concern to both clinicians and pharmacists in the Western Cape for many years. This medicine was reported as 'problem prone' by clinicians and an unnecessary 'high use' item by the pharmacists. However, this misuse was based on perception. In 2019 the Provincial Pharmacy and Therapeutics Committee (PPTC) prioritised the investigation of the use of PPIs in the public sector of the Western Cape.

Methods

A narration of a HSI journey steered by the three authors (members of the PPTC) to investigate the concerns about the misuse of PPIs using the medicine-use evaluation (MUE) methodology. Once confirmed, MN and YJ proceeded to coordinate a solution-seeking process by interviewing and working with identified relevant stakeholders to produce a tool that would guide the deprescribing of PPIs. These stakeholders included primary care clinicians, pharmacology and pharmacy students from local universities, members of the PPTC and MUE committee and the gastroenterologists from the two tertiary hospitals of the province.

Results

The outcome: An official Western Cape circular was released in 2021 to provide guidance for the safe use of PPI. Subsequently, various PTCs embarked on a training drive for prescribers, dispensers and using a tool in circular H29/2021.

Conclusion

This is an example of a collaborative project to improve medicine safety for communities in the Western Cape that was co-led by a family physician.

Developing research capacity through short-term community-engaged scholarly projects for rural and remote medical students

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Introduction

Conducting meaningful research as part of a medical student's training provides essential skills and professional development. Despite its importance, there is limited evidence of medical curricula which integrate compulsory research projects. The Rural and Remote Medicine (RRM) clinical unit within the University of Queensland's Doctor of Medicine (MD) program conducts compulsory rural health projects (RHP) as part of their assessed curriculum. The RHPs are community based and engage students in formal short-term research activities. This study aimed to review RHP topics based on standardised disease categories, as well as their geographical distribution.

Methods

This study conducted a retrospective analysis of RHPs conducted between 2011 and 2021. Descriptive analyses were used to present RHP locations by Modified Monash Model (MMM) geographical classification categories and disease/research categorisation using the International Classification of Diseases and Related Health Problems – 10th Revision (ICD-10) codes and the Human Research Classification System (HRCS) categories.

Results

There were a total of 2806 eligible RHPs conducted between 2011 and 2021, with most conducted in Queensland (n = 2728; 97.2%). The RHPs were mostly conducted in small rural towns (MMM-5; n = 1044; 37.2%) or other rural towns up to 15,000 population (MMM-4; n = 842; 30.0%). Projects most addressed individual care needs (n = 1233; 43.9%) according to HRCS categories or were related to factors influencing health status and contact with health services (n = 1012; 36.1%) according to ICD-10 code classifications.

Conclusions

The integration of RHPs as part of this program's MD curriculum demonstrates a valuable approach to engaging medical students in research projects and enhancing their research skills. Students address topics of interest through their RHPs, increase their involvement with the rural communities and other health professionals, develop important resources and acquire an increased understanding of local health issues in rural and remote communities.

Do women want information about menopause? A cross-sectional survey among women in Norway

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University of Oslo

Background

Information about menopause is not systematically given to women. Studies have shown that this might be helpful when entering this period in life, both in relation to her attitude to menopause and to cope with symptoms.

Aims

To increase our knowledge about drivers and inhibitors of women's information needs about menopause: if, when and from whom they request information.

Methods

A cross-sectional survey was conducted in the autumn of 2022 in 53 Norwegian general practice clinics. Medical students recruited women that answered the survey in the clinic's waiting room. Data were analysed using IBM SPSS Statistics 29.

Results

Of the 804 responses, 789 were included. Mean age was 46.5 years. The women had 50 different nationalities, the majority being born in Norway (85%). Among the participants 52% defined themselves as premenopausal, 20% as menopausal, 29% as postmenopausal and 8% did not know. In all, 52% answered that they wanted information about menopause and 74% (n = 305) of these wanted their general practitioner to inform them from a mean age of 43. Among premenopausal women, 60% wanted information and 61% among menopausal women. A main driver of information need was to obtain self-management in the present (65%; n = 241) and the future (61%; n = 225). In all, 39% (n = 305) did not want information. In this group 39% were premenopausal, 17% menopausal and 40% postmenopausal. Main reasons were they already possessed sufficient information (33%), would take menopause as it comes (27%) or were already postmenopausal (32%). The gender of the woman's general practitioner did not influence the results.

Conclusion

The majority of women wanted information about menopause and the general practitioner plays an important role in this. The general practitioner needs to make room for this conversation and to be up to date on recommendations and treatment options.

The BETTER MAN website: An early intervention tool for men who use domestic violence

Dr Carolina Navarro Medel, Prof Kelsey Hegarty, Laura Tarzia, Minerva Kyei-Onanjiri, Brad Anderson

The University of Melbourne

Domestic violence (DV) is prevalent among primary care populations and damaging for patients and families, but well-evaluated interventions in this complex context are rare. There is evidence that intervening at an earlier stage in men's use of IPV might contribute to reducing domestic violence.

Aim

BETTER MAN is a healthy relationship website for men who use controlling behaviour or violence in their intimate relationships. It aims to encourage men to seek help for their abusive behaviours by increasing their awareness and readiness to change such behaviours.

Content

BETTER MAN offers a private, accessible and non-judgemental resource for men who use IPV. Motivational interviewing techniques across three modules (Better Communication, Better Values, Better Relationships) encourage awareness and self-reflection, reduce stigma and improve communication skills. The final module (Take Action) provides men with an action plan with specific strategies to seek help for their behaviour. Once tested, BETTER MAN will be a free-access resource of particular value for GPs to use as an early intervention tool in primary care.

Goals

The BETTER MAN website is being rigorously evaluated using a randomised controlled trial. Participants (n = 360) recruited online are randomly assigned to either BETTER MAN or a website that gives information on healthy relationships. The trial will test whether BETTER MAN increases men's help-seeking activities for use of DV, men's identification of their behaviour as IPV and men's readiness to change regarding their abusive behaviours, as well as whether it is cost-effective.

Despite using tested recruiting strategies and emphasising privacy and confidentiality, recruitment has been slow. Request to provide personal information for verification purposes and the post-pandemic 'screen fatigue' might explain the low registration level, leading the team to use alternative recruitment strategies. This reveals challenges for engaging this group of men in research.

Effectiveness of 'Every Thai family, a family physician and team' policy and its role in strengthening PHC in Thailand

Dr Siranut Nawong

Phang-nga Hospital

Background

The Thai Ministry of Public Health has initiated 'Every Thai family, a family physician and team' policy since 2020, making further advancements from the universal health coverage scheme. Each family was assigned three doctors. The policy emphasised a village health volunteer as the first doctor for providing basic healthcare services in the community, officials of a subdistrict health-promoting hospital as the second doctor and a family physician as the third doctor, working together. This study aimed to examine the effectiveness of this policy from patients' perspectives.

Methods

This cross-sectional study was conducted in Phang-nga Province, and questionnaires were distributed to 324 samples by systematic random sampling. Stata 16 SE was employed for data analysis. Statistics used to analyse the data were frequency, percentage, mean, standard deviation and logistic regression.

Results

In all, 78.4% of respondents reported receiving care from the team, primarily for health promotion, preventive primary care outreach and chronic disease management. They recognised the family physician and team's role as a resourceful person and healthcare consultant for the community ($\bar{x}$ = 3.71, SD = 0.455). Patients addressed that the policy improved elderly and disabled patients' access to healthcare (63.9%), and reduced their visits to secondary-level care (84.6%). Receiving care from a team has improved their knowledge and understanding of their medical condition (93.2%). Patients' perception of this policy was associated with utilisation of a primary healthcare centre as a first choice (OR 2.45; 95% CI: 1.22, 4.94; P = 0.017).

Outcome and implication

The policy strengthened Thailand's primary healthcare system by organising in multidisciplinary teams and collaborating with community health services to respond to community needs. The policy enabled broader access to healthcare, particularly for vulnerable populations. The Ministry of Public Health should continue this policy, develop the potential of teams and integrate with other stakeholders to provide better-quality primary healthcare.

What does it take to run randomised controlled trials in primary care? Barriers and facilitators from four countries

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[1]University of Tasmania, [2]University of Oxford, [3]University of Auckland, [4]Fukushima Medical University

Research is best applied to where it has been conducted. However, general practice has been traditionally shunned as a site for research by clinical trialists. The reasons for this lie in both the trialists and the primary care sector. Recognisable barriers to the conduct of research in general practice include the competing clinical care burden, geographical dispersion, lack of research experience and funding. These barriers can be addressed by investigators working with clinicians familiar with the breadth and variety of the sector. There are also enablers, such as the rich clinical datasets that act like clinical clearing houses for trial outcome ascertainment.

At this session four international experienced primary care researchers will briefly present their approaches to addressing barriers and utilising enablers to allow successful completion of trials in general practice. Such discussions will include, but are not limited to, research practice networks, in practice support for GPs as site principal investigators, utilising primary care routine data for follow-up/outcomes, different approaches for different problems (eg cholesterol lowering vs COVID-19 treatments), how this may differ between countries and how we can collaborate internationally.

A general discussion will follow, allowing attendees to voice their own experiences and perhaps lead to a common learning outcome.

Validating a toolkit to guide the implementation of high-quality virtual primary care: An international eDelphi study

Dr Ana Luisa Neves

Imperial College London

Background

Research is needed to consider how to support primary care organisations to smoothly incorporate virtual consultations as part of their clinical practice, while ensuring the quality and safety of the care provided. Based on qualitative research capturing the views of more than 1600 general practitioners across 20 countries, we developed a toolkit to guide the implementation of high-quality virtual primary care. The toolkit includes several domains: contextual considerations, technology infrastructure, awareness and experience, safety and risk management, strategic planning and supporting policies (LiE-PLOSDigHealth-2022).

Research questions

The aim of this study is to explore general practitioners' perspectives on the appropriateness and relevance of this tool.

Method

An eDelphi approach to engage GPs (n = 100–150) with experience using virtual consultations (ie telephone or video) will be used. GPs will be recruited through purposive and snowball sampling techniques. Social medial platforms, including WhatsApp, Facebook and LinkedIn, will also be used. Data will be collected using semistructured online questionnaires (three eDelphi rounds). Participants will be asked to rank the relevance of each item using a five-item Likert scale. An item of the framework will be considered relevant and retained in the final framework when at least 70% of the participants, in any round of the survey, chose the options 'strongly relevant' or 'somewhat relevant'. Descriptive statistics (average/SD; median/IQR) will be calculated in each round.

Results

Preliminary results on key items of the framework that achieve consensus will be presented. It is expected that this study will provide an evidence base on whether our new instrument can be used in practice to guide, evaluate and monitor the implementation of high-quality virtual care in general practice.

Emergency airway – a doctors' nightmare … or is it? Improving the odds stacked against you

Dr Sheri Newman

Royal Melbourne Hospital

Introduction

A case of emergency airway will be illustrated as an example of using surgical skills when you need to act fast. You may be in an unfamiliar environment, unprepared and most likely stressed. The patient will be desaturating and peri-arrest with no definitive airway. This is often a skill left to anaesthetics, trauma, emergency or ENT, but it may just be you, at your skill level with one key instrument.

Aim

This extremely challenging situation can effectively be managed with clear-headed judgment and the confidence of having practised the technique to improve the odds stacked against your patient, even if you have never performed it in an emergency scenario. The basics of managing this will be revisited, with the emphasis on individual repeated practise in simulated sessions.

Content

In this case, the patient was substance affected, had a huge physique with a bull neck and difficult landmarks. As he became more agitated, he was rapidly sedated, unfortunately aspirated and began turning blue. An emergency airway was declared.

The case will discuss how this was managed with a disposable 15-blade scalpel, lots of packs and an endotracheal tube in less than 10 seconds. The patient was then connected to a portable ventilator and taken to theatre for a definitive tracheostomy. He remained in ICU for treatment of aspiration pneumonia and was discharged thereafter.

Discussion

The confidence that can be achieved by consistent practise where routine drills become normal and emergency becomes routine is much left to the individual. This case reflects more widely 'lessons from the flight deck' in anaesthesia where drills and checklists themselves are routine, and leadership in functioning teams ensures everyone holds the same mental model. When an emergency is declared, it is managed more safely by the whole team, no matter the situation.

Building capacity in public and patient involvement in research: Lessons learned from Malaysia, Singapore and Thailand

Prof Chirk Jenn Ng[1,2], Prawira Oka[1], Prof Ping Yein Lee[3], Dr Hani Syahida Salim[4], Apichai Wattanapisit[5]

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Background

Public and patient involvement in research is recognised as part of good research practice that enhances the research relevance and implementability. While there are many PPI activities across the world, especially in the West, engaging public and patients in the research process remains uncommon in the South-East Asian (SEA) region. In Malaysia, Singapore and Thailand, while the understanding and participation in research in primary care vary within and across the countries, the need for PPI is increasingly recognised by policy makers, research leaders and patient advocacy groups as important for charting research direction and part of good research governance.

Aim

The aim of this forum is to present the PPI initiatives and activities in each of the three SEA countries, share the challenges and lesson learned and highlight the opportunities for research and education for both public and patients, as well as the research community.

Methods

The forum will showcase:

- the Malaysian PPI initiative with asthma patients, drawing on the RESPIRE collaboration between Malaysia and UK in establishing partnership with patients living with asthma, schools, health clinics, universities, NGOs and the Ministry of Health
- the Singapore PRAGMATIC PPI group, which meets regularly to provide constructive feedback to researchers conducting research on wide-ranging topics relevant to primary care; the group uses self-developed tools to facilitate communication between PPI members and researchers
- the current perspectives and practices of PPI in research in Thailand.

Format

The moderated forum comprises:

1. Introduction – five minutes
2. Presentations – 40 minutes
3. Q&A – 10 minutes
4. Key messages – five minutes

The forum will provide opportunities for the audience to raise questions, share experiences and facilitate collaborations.

An unusual case study of Stevens–Johnson syndrome/toxic epidermal necrolysis

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National Healthcare Group Polyclinics

Background

Stevens–Johnson syndrome/toxic epidermal necrolysis (SJS/TEN) overlap is a rare and unpredictable reaction to a medication in which there is sheet-like skin and mucosal loss. Taking a drug history and proper physical examination are crucial towards the clinical diagnosis as it is a serious medical emergency requiring immediate treatment.

Methods

This was a case of a patient who consulted at a primary care clinic in Singapore. Complementary information was collected by researching databases on this matter.

Results

A 79-year-old Chinese gentleman presented with a one-week history of worsening rash which spread from his bilateral upper limbs to the rest of his body. He had a past medical history of gout, diabetes mellitus, hypertension, hyperlipidaemia, chronic kidney disease, benign prostate hyperplasia, osteoarthritis and anaemia. Besides the multiple target lesions, the patient also presented with oral ulcers. There was an increased dose of allopurinol over the past few months, otherwise no other risk factors were found. The teledermatology service was activated for urgent consultation with a dermatologist. Although the initial differentials were atypical erythema multiforme and psoriasiform drug eruption, the patient was admitted and eventually diagnosed with Stevens–Johnson syndrome/toxic epidermal necrolysis (SJS/TEN) overlap secondary to allopurinol use.

Conclusion

Stevens–Johnson syndrome/toxic epidermal necrolysis overlap is a potentially fatal multiorgan disease with a strong aetiological link to certain medications. Family doctors are often the first medical contact in the health ecosystem whom patients consult in an early stage. They must be vigilant and consider Stevens–Johnson syndrome as a potential complication of treatment when patients are on potential medications. Surviving patients must also be educated to avoid taking the causative drug in the future.

Presenting 2023 WONCA global postgraduate education standards

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Background

The WONCA global postgraduate education (PGME) standards adopted in 2013 have served as the education standard used for WONCA accreditation and a guide for best practices in teaching, curriculum development, assessment and quality improvement. As the field of education is ever evolving, the WONCA Working Party on Education (WWPE) has convened a task force to revise and update the standards to ensure that new trends in the field of education are incorporated. This workshop aims to present the updated draft 2023 WONCA global postgraduate education standards and provide an opportunity for WONCA members, family medicine teachers and trainees to offer feedback through facilitated discussions.

Target group

Education leaders, family medicine teachers, family medicine trainees and students

Didactic method

Interactive workshop (small round tables preferred)

Objectives

1. Discuss and review the latest trends in global postgraduate medical education.
2. Present the draft 2023 WWPE postgraduate education standards for review and feedback.
3. Facilitate structured discussion based on topics in best practices in medical education and consider possible additions to the 2023 draft WWPE PGME standards.

*HLA-B*58:01* testing in primary care before allopurinol initiation in gout: A qualitative study from patients' and doctors' perspectives

Dr Wei Leik Ng[1], Norita Hussein[1], Chirk Jenn Ng[1,2], Boon Pin Kee[1], Dr Yew Kong Lee[1], Sue-Mian Then[3], Zhenli Kwan[1], Dr Tun Firzara Abdul Malik[1], Nadeem Qureshi[4]

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Introduction

Allopurinol, the first-line treatment for chronic gout, is a common causative drug for severe cutaneous adverse reactions (SCAR). The *HLA-B*58:01* allele was strongly associated with allopurinol-induced SCAR in Asian countries such as Taiwan, Japan, Thailand and Malaysia. *HLA-B*58:01* screening before allopurinol initiation is conditionally recommended in the South-East Asian population, but the uptake of this screening is slow in primary care settings, including Malaysia. This study aimed to explore the views and experiences of primary care doctors and patients with gout on implementing *HLA-B*58:01* testing in Malaysia as part of a more extensive study exploring the feasibility of implementing it routinely.

Methods

This qualitative study used in-depth interviews and focus group discussions to obtain information from patients with gout under follow up in primary care and doctors who cared for them. Patients and doctors shared their gout management experiences and views on the implementation of *HLA-B*58:01* screening in primary care. Data were coded and analysed using thematic analysis.

Results

Eighteen patients and 18 doctors from three different healthcare settings (university hospital, public clinics, private general practitioner clinics) participated. The acceptability of *HLA-B*58:01* screening was good among the doctors and patients, motivated by improved prescription safety. We discovered inadequate disclosure of severe side effects of allopurinol by doctors due to concerns about medication refusal by patients. Barriers to implementation included out-of-pocket costs for patients, the cost-effectiveness of this implementation, lack of established alternative treatment pathway besides allopurinol, counselling burden and concern about genetic data security. Our participants preferred targeted screening for high-risk populations instead of universal screening.

Conclusion

Implementing *HLA-B*58:01* testing in primary care is potentially feasible if a cost-effective, targeted screening policy on high-risk groups can be developed. A clear treatment pathway for patients who test positive should be available with adequate training for the healthcare providers.

Delivering culturally safe and integrated team care: The role of GPs in Aboriginal Community Controlled Health Services in Victoria

Miss Hung The Nguyen[1,2]

[1]Victorian Aboriginal Community Controlled Health Organisation, [2]Dandenong and District Aborigines Co-operative Ltd

The aim of the presentation is to highlight the important role of general practitioners in addressing the health needs of Aboriginal and Torres Strait communities in Victoria, Australia. The content of the presentation focuses on how GPs can work effectively in Aboriginal Community Controlled Health Services to deliver high-quality, culturally safe and integrated team care while maintaining their own wellbeing.

The presentation's goals include providing an overview of the governance and service delivery of these services, highlighting the importance of both cultural and clinical competence of GPs working in this sector, and offering practical tips and developed resources to help GPs develop a culturally safe and responsive approach.

The presentation also aims to discuss the complexity of care and the role of GPs in delivering integrated team care and wrap-around support, as well as wellbeing initiatives for GPs working in the sector. By the end of the presentation, participants should have an understanding of how to work effectively in Aboriginal Community Controlled Health Organisations, deliver integrated team care and maintain their own wellbeing while providing care to others.

Lastly, the presentation aims to promote cultural safety and highlight the essential role of Aboriginal Community Controlled Health Organisations in Victoria in providing quality care and support to Aboriginal and Torres Strait Islander communities.

Family medicine innovative training in the digital technology era: A lesson learned from Vietnam

A/Prof Minh-Tam Nguyen[1], Laura Goldman[2], Dr Jeffrey Markuns[2], Quynh-Anh Le Ho Thi[1], Quoc-Huy Nguyen Vu[1], Anselme Derese[3], Alain Montegut[4]

[1]Hue University of Medicine And Pharmacy, Hue University, Vietnam, [2]Boston University, [3]Ghent University, [4]Global Primary Care Consultants

The recent development of family medicine training has provided a strong and resilient foundation for the future of primary care in Vietnam. This article describes how an innovative approach was implemented to improve the capacity of a robust primary care workforce in central Vietnam. Most health staff working at commune health centres (CHCs) in Vietnam are already taxed with a large number of responsibilities, thus limiting the capacity to leave work to study away from their home town. A project with e-mentoring and a case-based learning approach has been implemented at Hue University of Medicine and Pharmacy to transfer knowledge and capacity of primary care and to build an academic community of physicians and interdisciplinary specialists in central Vietnam.
A high internal synergy has been created through this project with complementary activities, such as curriculum revision, production of platform, e-learning modules and development of trainings and guidelines. All these activities have been strongly linked to building up capacity and outreach on FM. The innovative modular training program fits well with the local context to improve the performance of health professionals while also allowing them to continue working at their CHCs during their studying. Virtual reality, 360° immersive technology were applied to enhance clinical reasoning skills and patient-centred care competency of trainees. Due to the shortage of faculty in clinical settings, a train-the-trainers approach to develop community-based preceptors in primary care education was focused to provide a rich environment for learning and teaching within a sustainable FM training program; however, training local field trainers in teaching methods proved to be more challenging than anticipated and need to improve. These innovative approaches can serve as flagship state-of-the-art primary care training to support the capacity improvement of a robust primary care workforce for the 21st century.

Family medicine development through capacity building and policy advocacy in Vietnam: Best practices and lessons learnt

A/Prof Minh-Tam Nguyen[1], Dr Jeffrey Markuns[2], Quynh-Anh Le Ho Thi[1], Quoc-Huy Nguyen Vu[1], Anselme Derese[3], Alain Montegut[4]

[1]Hue University Of Medicine And Pharmacy, Hue University, Vietnam, [2]Boston University Global Health Collaborative, [3]Ghent University, [4]Global Primary Care Consultants

Vietnam utilises a substantial network of primary care; however, it has been undergoing a tremendous burden driven by economic growth, an ageing population and a shift in healthcare needs. This paper describes the movement of family medicine (FM) discipline in Vietnam healthcare system in the past 10 years with best practices and lessons learnt in capacity building and policy advocacy.

Methods

An objective observational approach was taken based on available evidence.

Results

Vietnam has made impressive progress in primary care reform over the past 10 years.

1. From the initial project to train family physicians to work in the existing primary care network, a hierarchical structure of training programs for the specialty of FM was established, approved and implemented including undergraduate, specialist, Master's and residency training.
2. The evolution and expansion of the professional association of family physicians significantly contributed to policy advocacy activities and achievements.
3. Over 2000 general doctors trained with Master's, specialist degree or some core modules in FM and about 200 nurses/assistant physicians trained with a CME-based module.
4. Family physicians officially recognised and well performed in chronic NCD management, especially during COVID-19 period.
5. Policy advocacy has moved at a much faster and more robust pace than initially anticipated. A series of policies and guidelines to develop FM clinics and the integration between primary care and universal health coverage was issued. The most remarkable achievement is the regulation on FM practice now stated as the Degree 81 of the Vietnam National Law on medical examination and treatment issued on 15 January 2023.

Conclusion

The development of FM has provided a strong and resilient foundation for the future of primary care in Vietnam. Maintaining progress on further policy developments, aggressively recruiting faculty and faculty development, and developing interprofessional education are recommended.

The increasing problem of financial toxicity of medical treatments and primary care's essential role in supporting patients on their journey

Ms Maria Niedzielska

HowMuchExactly

Aim

To offer an interactive and engaging way of presenting a topic that is gaining more and more significance in today's world: rising healthcare costs. Out-of-pocket costs, the patient's direct contribution to treatment costs, are a massive problem in Australia and in the world and affect the affordability of healthcare for patients. This is especially significant when it comes to, for example, chronic disease or cancer treatments where an exact estimation of the expected out-of-pocket costs is difficult as it involves many different healthcare providers.

Content

In today's post-pandemic world, this is even more important, as financial distress and financial toxicity are now often listed as side effects of medical treatment. In this, most-likely prerecession, world, we cannot look at medical treatment without the consideration of the financial burden on the patient.

Primary healthcare providers, general practitioners and family doctors play a significant role in shaping the patient's journey – and even though in an ideal world the patient would receive the best, state-of-the-art treatment plan, often a plan might end up incomplete or rejected (often without consultation with the primary care physician) due to financial constraints not disclosed at the time of planning.

The presentation will outline the problem in Australia and around the world, showing real numbers and specific examples of the problem and its impact on patients. The facilitated discussion will encourage participants to share their experiences and view on this issue. The participants will be encouraged to engage with and validate the practicality of potential solutions for this problem.

Goals

- Raising awareness about the increasing issue of rising healthcare costs from a patient's perspective
- Sharing primary care practice experience in this area
- Outlining existing and potential solutions (policy, technology, primary care practice)
- Engaging participants in the evaluation of solutions
- Achieving the three major learning outcomes

First aid and management of bites and stings from Australian venomous creatures

A/Prof Vasilios Nimorakiotakis

Royal Flying Doctor Service of Australia

Objectives

As Australia moves into the summer bites and stings season, this session will provide refresher training tailored for primary care clinicians to improve their knowledge of appropriate first aid and management of bites and stings by venomous creatures native to Australia.

We anticipate that this session will educate primary care clinicians on the following topics:

- Venomous species native to Australia and the effects of their venom
- Appropriate first aid, including when to apply a pressure bandage and immobilisation, heat, ice, etc
- Signs and symptoms of envenoming, and how to recognise it
- Management of envenoming
- The development of antivenoms and their appropriate use

There are five components to this session:

1. Venomous creatures of Australia
    - Purpose and goals of the training session
    - Venomous species in Australia
    - Overview of different venoms and their effects on the human body
    - Importance of bites management and treatment
2. Patient management
    - Appropriate first aid measures for bites and stings by venomous creatures
    - Examination and investigation to diagnose envenoming
    - When to consider transfer to a tertiary care centre
    - The role of clinical toxicologist and poisons information centre
3. Antivenom
    - The development of antivenom
    - Do all bites require antivenom?
    - Antivenom administration
    - Possible antivenom complications explained
4. Case studies and practical application
    - Real-life scenarios and case studies
    - Demonstration of clinical management techniques
    - Hands-on training for administering antivenom and other treatments
    - Practice sessions for emergency response and first aid
5. Prevention and control
    - Awareness and education for at-risk populations
    - Protective measures and safety precautions
    - Resources and support: Free Australian Bites and Stings app and website

Physical inactivity increases lifetime cardiovascular risk

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Background
Cardiovascular diseases (CVDs) are the number one cause of death globally. The risk of developing a cardiovascular event depends on multiple risk factors. Current trends in CVD prevention emphasise the need to manage patients based on the individual's risk assessment. The study aimed to assess CVD risk among the staff of selected banks and examine the association between physical inactivity and CVD risk.

Methods
This was a cross-sectional study involving five randomly selected commercial banks. The World Health Organization STEP-wise Approach to Non-communicable Disease Risk Factor Surveillance Questionnaire was used to assess CVD risk factors and the CVD risk scores were calculated using the 2013 ACC/AHA/ASCVD risk calculator. Study outcomes were determined using univariate and bivariate analysis, and multivariate logistic regression models.

Results
The mean age (± standard deviation [SD]) of the 219 participants studied was 40.0 ± 7.9 years. The prevalence of high lifetime and high 10-year CVD risk among the study group was 72.8% and 32.0%, respectively. Overall, both lifetime and 10-year CVD risk scores were significantly higher among physically inactive bankers compared to those who were active. Physical inactivity was independently associated with a fivefold increase in lifetime CVD risk (AOR 5.366; 95% CI: 1.334, 21.580; P = 0.018) but not the 10-year CVD risk.

Conclusion
Physical inactivity is a predictor of lifetime cardiovascular risk. An implication for health promotion to reduce inactivity levels among workers.

Quality improvement using process map in health services during COVID-19 pandemics

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Introduction

During the COVID-19 pandemic, an overwhelming number of patients led to limited access to care. This issue may increase morbidity and mortality rates which are preventable. Quality improvement (QI) was used to address and identify opportunities to manage the issues. There are various QI tools. 'Process map' was chosen to recognise the problems. It is a visualised process flow that helps to guide the solutions for multidisciplinary teams (MDT) and stakeholders. Stakeholders must be involved for greater care. This participatory action research is aimed to analyse safety and efficiency of the QI process in healthcare services and develop a culture of sustainable QI.

Methods

This study was conducted between February and March 2022 at Ra-ngae Contracted Unit of Primary Care (CUP), Narathiwat, Thailand. The pre-sandbox group received usual services. The post-sandbox group received reorganised services by the 'process map' in which the number of steps was reduced from 18 to 12. The intervention was conducted with MDT and stakeholders. A re-evaluation was done before launching the reorganised services. Mann–Whitney U tests were used to analyse the outcomes.

Results

There were a total of 3645 patients, of whom 2544 patients were in the post-sandbox group. Gender and mean age were similar between the groups. The study found that the mean total waiting time in the post-sandbox group was lower than in the pre-sandbox group (81 and 157 minutes, respectively), which was significantly different ($P < 0.01$). The number of ARI clinics increased 14 times after sandbox. There was no cardiac arrest or death in both groups. In addition, referral rates were not different.

Conclusion

Total waiting time was dramatically reduced and the number of ARI clinics was increased in the post-sandbox group. Furthermore, adverse events and referral rates were not different. The data were reported to stakeholders. This lesson also applies to other departments within CUPs for sustainable QI.

The core functions of primary care, the values of family medicine, practices transformation post-COVID-19 and directions for the new era

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Primary healthcare (PHC) has been through a long road of development since the Declaration of Alma-Ata; although many countries achieved to have significant progress, most countries face challenges in PHC development. The Royal College of Family Physicians of Thailand together with the WONCA Working Party on Research organised a webinar series from December 2022 to September 2023, engaging representatives from more than 20 countries in the presentation, to gain a better understanding of the challenges that each country faces and the progress that has been made.

The webinar series was organised to explore PHC and family medicine development under three key themes. The first theme was the core functions of primary care (comprehensiveness, coordination, continuity, access). The second theme explored the core values of person-centredness, clinician–patient relationship, equity, teamwork collaboration and community perception of family medicine. The third theme studied how the practices transformed in the post-COVID-19 era; if the core functions, values and practice changed and, if so, how?

This forum presents the summary and key findings coming out of each theme. The objective of this forum is first to engage the audiences to learn from the data collected from the countries that participated in the webinar series. The second objective is to generate a discussion, allowing the audience to debate and compare the findings with the experiences of their countries, whether there are similarities or differences. This forum also has objectives to convey directions for primary care and family medicine development in this new era and identify joint research questions that arise from the findings and the roundtable discussion.

In summary, this forum is designed to develop a learning and sharing platform, enabling the development of a network of general practitioners/family practitioners with a common interest in research and the primary healthcare system, to enable constructive development.

Motivational interviewing: Assisting behavioural change for people with non-communicable diseases

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Motivational interviewing (MI) is a client-centred, empathic and directive counselling style that helps elicit behavioural change by helping the patient to explore and resolve ambivalence. MI possesses essential skills and techniques beneficial for family practitioners in providing care for patients with non-communicable diseases. Systematic reviews and meta-analyses showed significant effects of MI for the control of body mass index, total cholesterol, systolic blood pressure and alcohol concentration, and increased participation in physical activities.

The spirit of MI is based on Carl Rogers's client-centred counselling principle, in which a practitioner works collaboratively with a patient, with compassion and respect for the patient's autonomy. MI is also linked to self-determination theory and the transtheoretical model of behavioural change. In the process of MI, a practitioner, therefore, applies four core skills, namely Open-ended questions, Affirmation, Reflection and Summarisation (abbreviated as OARS), to evoke the patient's ambivalence and enhance their motivation.

During the conversation, a practitioner applied OARS skills to help the patient recognise their motivation, the discrepancy between their present thoughts and the goal where they would like to be. Meanwhile, recognising that resistance to change is normal, a practitioner avoids argumentation by using reflective listening to roll with resistance, to express empathy in the patient's experience, to support the patient's self-efficacy and to guide the conversation to enhance the motivation for behavioural change. MI helps the practitioner understand the patient's thoughts where they are in the process of change and the level of the patient's motivation from the patient's talk.

In this workshop, attendees will learn about the skills and techniques that are the foundation of MI through a demonstration of case scenarios that are commonly found in clinical practice. This interactive workshop will provide a chance for attendees to discuss and practice through small group activities and role-play.

Future use of e-consultations within a regular GP scheme

Dr Børge Lønnebakke Norberg, Prof Linn Okkenhaug Getz, Dr Bjarne Austad

NTNU

Background

There is an ongoing digital shift in family medicine regarding the way consultations are provided to patients, with introduction of video and text-based consultations. Knowledge of gains and losses associated with this transformation is deficient.

Objective

To explore future potentials and pitfalls for GPs and patients using digital consultations within the context of a regular GP scheme.

Methods

Qualitative study based on five focus groups with GPs from all over Norway.

Results

In a context characterised by continuity of care, digital consultations can increase the overall quality and efficiency of the health service. GPs' preferences vary as for how and when to implement digital consultations in the trajectory of care. Some prefer them for triage, others for follow-up. Video consultations can facilitate relationship building with certain vulnerable patients. Text consultations offer advantages as the patient and GP can attach text, images and videos that explain the disease. GPs report that variations between different types of consultations help them regulate emotional intensity and stress during the workday.

A downside of digital consultations is that they tend to follow a 'one problem approach', limiting the chances of addressing more implicit and complex issues. Easy access to digital consultations might reduce patients' capacity for self-care, displacing more important requests. GPs expressed willingness to offer more digital consultations than they find professionally optimal, hoping to protect their patients from commercial one-time consultations and retaining a well-functioning GP scheme.

Ethical dilemmas arise about responsibility, if, for example, serious patient events occurring while their requests for medical care remain unread in the busy GP's inbox.

Implications

Digital consultations provide opportunities for increased variety for GP and patient, increased quality in patient treatment and increased responsibility for both parties. A lower threshold for contacting the GP might increase the total workload and lead to unfavourable resource allocation.

The Caring Tree: An example of decolonising methodology in Aboriginal research

Dr Annapurna Nori[1], Lenore Bagnara, Jennadene Smith[1]

[1]The University of Adelaide

The Care Project is a community-requested participatory research project to develop a model of care (MoC) to improve the wellbeing of older Kaurna and Ngarrindjeri women. 'Older' was self-defined by the women as age ≥45 years.

The research ethic has sought to honour the lived experience of these older women and to give voice to their care needs. Guided by Indigenous women's standpoint, the project has adopted decolonising approaches throughout its course. An Aboriginal Advisory Group has provided oversight of and cultural governance over the project.

A crucial prerequisite to the MoC is a codesigned care framework, developed by Kaurna and Ngarrindjeri women working closely with the principal researcher. Yarning sessions were used to incorporate appreciative inquiry (AI) and Aboriginal ways of knowing, being and doing into the care framework method and codesign. AI involved a strengths-based exploration in the phases of Discovery (what's already working), Dream (vision or what could be), Design (what are the options), and Deliver (how to make it happen).

This roundtable session will be jointly facilitated by an Aboriginal and a non-Aboriginal researcher. They will present 'The Caring Tree' (the care framework) and its development and use it as a springboard for a respectful yarning on decolonising approaches including the principles of equity, self-determination, autonomy, cultural responsiveness, radical reflexivity, responsibility, reciprocity, cultural safety, inclusivity and negotiating power differentials.

The Functional Health Status of older Kaurna and Ngarrindjeri women

Dr Annapurna Nori[1], Vivienne Moore[1], Megan Warin[1], Odette Pearson[2]

[1]The University of Adelaide, [2]South Australian Health and Medical Research Institute

The Care Project is a community-requested participatory research project developing a model of care to improve the wellbeing of older Kaurna and Ngarrindjeri women (self-defined by the women as age ≥45 years). A core aim is to understand the health status of these older Aboriginal women. Triangulated data sources included in-depth interviews with older Kaurna and Ngarrindjeri women (community participants), staff interviews at two Aboriginal health services, a clinical file audit of medical records and a functional health assessment (FH) of the community participants. FH was included since as WONCA states 'Functional status relates to the patient, not to the health problem, disease or episode of care'.

The WONCA-COOP charts are a valid and reliable means of assessing FH. They have also been tested for ease of use and acceptability in several countries and population groups, including Indigenous peoples. Use of the WONCA-COOP charts has been limited to clinical care and its utility in research is largely untested.

We used these charts for their ease of administration, validity of use in Indigenous people and the first author's extensive experience with them in clinical practice.

Sixteen community participants ranging in age from 47 to 79 years assessed their functional health in eight domains: physical fitness, feelings, daily activities, social activities, pain, overall health, social supports and quality of life (QoL). A descriptive analysis was conducted enriched by insights from interview data.

From the traditional disease-oriented (pathogenic) view, the results support the common narrative that Australian Aboriginal and Torres Strait Islander people have significant physical and mental problems. From a health-promoting (salutogenic) view, the women have preserved their QoL despite reduced physical and emotional wellbeing. This contradicts the stereotype of Aboriginality being synonymous with disadvantage.

The FH results, strengths and limitations of FH assessment and the role of cultural determinants in preserving wellbeing will be presented.

So you want to be a researcher? Key skills for clinicians who want to ask and answer practice-based research questions

Prof Wendy Norman[1], Prof Grant Russell[2]

[1]University of British Columbia, [2]Monash University

Family doctors and members of the healthcare professional team are well placed to identify key gaps in current knowledge, guidelines and practice. Being on the ground means that the gaps are most likely to be relevant to the issues that really matter to patients and to the communities in which they work. While early career clinicians are enthusiastic users of guidelines and clinical pathways, many begin to find themselves in situations when existing evidence does not apply. Some begin to wonder whether new research may be needed to address some of these unknowns.

But how does an early career clinician get started on a research journey? There is minimal research training in most medical and health sciences courses. While early career clinicians are well positioned to confront puzzling clinical questions, most do not have experience in research.

This session will point out some key first steps for clinicians hoping to make research a part of their professional life. Our approach will be relevant to those who are simply keen to put their toe in the water, right up to those seeking to become primary care academics.

We will begin by presenting some case examples of pathways for clinicians beginning research. Through audience discussion we will explore participants' own experiences and discuss some of the pitfalls and opportunities associated with the varied approaches. Then, we will explore in small groups key facilitating strategies before reporting back and identifying group priorities. As we conclude, participants will be provided with key resources designed to assist those considering their next steps towards a clinician-researcher career.

This interactive audience-engaged session will bring an overview of the challenges facing clinicians and explore potential resources. Discussions will focus on key tips, strategies and supports that every clinician needs when taking the first steps into the research world.

How far is too far: Considerations for safe medical abortion care for residents living four hours or more from emergency services

Prof Wendy Norman[1], Professor Danielle Mazza[2], Prof Felicity Goodyear-Smith[3]

[1]University of British Columbia, [2]Monash University, [3]University of Auckland

Audience members will join international experts for a lively discussion exploring considerations for the provision of medical abortion care for residents living in very remote locations.

The problem

The rare outcome of massive haemorrhage following medication abortion (one in 1000 cases, often occurring weeks later) drives current cautions to restrict medical abortion to those living close to emergency services. However, people in rural and remote areas could benefit greatly from closer-to-home access to abortion care through provision of medical abortion. Evidence is needed so patients and their healthcare providers do not need to guess on safe parameters for care, or undertake unnecessary risks or travel.

The evidence

Panel experts will summarise current clinical practice guidelines from a range of countries on the provision of medical abortion for residents living four hours or more from emergency services (eg a transfusion service and surgical facilities capable of uterine evacuation). Evidence from the world literature will then be presented.

Steps to solutions

Audience members will join the panel to explore considerations for clinical practice, and personal and professional contexts that should be factored in to the counselling and provision of abortion care for residents living in very remote locations. Finally we will summarise the discussions and identify areas that need future research to address evidence gaps.

Revive your work fulfilment and sustainability post-pandemic (caring for the carer)

Rebecca Nothrop

[1]Doctor Becc

We cannot go on like this. We are not okay. It's time to care for the carers. General practitioners are showing up to work every day in an environment that is both chronically stressful and morally injurious. The system needs to change. But the question remains: how do we address this urgent problem?

During this interactive session, you will upskill in powerful coaching tools that can be immediately utilised to respond to, recover from and prevent burnout and moral injury. The personalised and intuitive coaching approach is based on behavioural psychology, which means that the tools you will learn are effective and sustainable. No long wellness to-do lists, no bubble baths or 'self-care' talk.

With our causal coaching style, you will learn how to identify the specific sources of stress and moral injury that affect you as an individual, and then use the coaching tools to manage and prevent these issues. Say goodbye to old-fashioned concepts like 'willpower' and hello to a smarter, more efficient approach that will help you achieve bigger and better results with less struggle and suffering.

During the session, you will not only be educated on the tools, but you will also get hands-on experience practising them. This maximises your understanding and retention, so you can start benefiting from them immediately in your personal and professional life. Our relatable demonstrations will ensure that you are motivated by the benefits of the tools and the real-life scenarios in which to apply them.

By the end of the session, you will leave feeling self-sufficient and empowered with the knowledge and tools to improve your quality of life, both personally and professionally. And with our Q&A opportunities, you can get the answers you need to ensure you are applying the tools in the right context for maximum benefit. Do not miss out on this practice- and life-changing opportunity!

The virtual rural generalist service: An innovation medical model to combat medical workforce challenges in rural and remote Australia

Shannon Nott, Dr Georgia Wingfield, Ms Amelia Haigh

Western NSW Local Health District

Western NSW Local Health District (WNSWLHD) is a large rural health district in the state of New South Wales, Australia, covering some 247,000 km^2 with approximately 279,000 residents. The district delivers healthcare services via 40 inpatient facilities and over 50 community health centres. Alike many rural health districts, WNSWLHD experiences significant challenges with recruitment and retention of general practitioner visiting medical officers (GP VMOs). The gradual decline in general practitioners per capita and vacancies in the local medical workforce led to rostering gaps and an increased dependency on locum contracts, which was further exacerbated during the COVID-19 pandemic and associated border closures. To counter medical workforce challenges and provide medical coverage for hospitals when VMOs were not available, or locums were prevented from entering the district, WNSWLHD introduced the virtual rural generalist service (VRGS). The VRGS is an adaptable and scalable medical model that permits routine and ad hoc after-hours and/or weekend cover during periods of planned or unplanned leave. The innovate model leverages advances in telehealth technologies to deliver virtual and face-to-face medical consultations to emergency departments and inpatients 24 hours per day, seven days per week. The service employs 28 skilled rural generalists and has provided over 52,000 medical consultations and delivered 1000 days of face-to-face cover in facilities with ongoing medical cover challenges. During 2021, the service was awarded the NSW Health COVID-19 Grant to conduct a formal evaluation to determine the impact and influence of the VRGS on the rural workforce and assess if the service provides a COVID-19-resilient model of care. This presentation will discuss the VRGS model and evaluation outcomes as they pertain to the values-based healthcare domains; health outcomes that matter to patients, experiences of receiving care, experiences of providing care and effectiveness and efficiency of care.

4Ts whole-of-health model for small rural communities: A solution for primary healthcare service access and sustainability in rural Australia

Shannon Nott, Ms Amelia Haigh

Western NSW Local Health District

The maldistribution of medical workforce between metropolitan, rural and remote areas of Australia is well known. Existing remuneration mechanisms and business models have made it difficult for general practitioner (GP) private practices to operate, especially in rural areas. In western NSW, 41 towns are projected to face complete GP market failure by 2029.

To address this, an innovative model of primary care has been trialled over four years in a subregion of western NSW that covers four small rural towns with populations less than 1500 experiencing market failure: Tottenham, Tullamore, Trundle and Trangie (4Ts).

The 4Ts model is a whole-of-healthcare model, utilising a single-employer mechanism to allow the local health district (LHD) to employ rural generalists, clinical and administrative staff to work collaboratively to deliver acute, emergency and comprehensive primary care services across the subregion. This model is novel in NSW as traditionally LHDs have not stepped in to run primary care, including when this impacts hospital services. The hypothesis behind the model is that communities are stronger by working together to better meet local health needs. The model pools both federal and state health resources through a 19(2) Exemption to maintain service access where traditional market forces have failed.

The project is supported by local communities and regional health stakeholders and has received project support from the Australian Government through the Collaborative Care Program.

This presentation will provide an overview of the enablers and barriers for providers interested in implementing a whole-of-health, single-employer model in small rural communities. It will also share the evaluation findings of the 4Ts model to date, covering the four domains of value-based healthcare.

This case study demonstrates the potential of the 4Ts model as one way of overcoming the intractable challenges of maintaining access, quality and sustainability of primary healthcare in a rural context.

Evaluating maternity codesigned services for growth in services, outcomes in Australian First Nations women and their babies

A/Prof Shelley Nowlan

Department of Health – Queensland, Australia

Australian Aboriginal and Torres Strait Islander women and babies have poorer mortality and morbidity rates compared to non-Indigenous women and babies. First Nations babies are twice as likely to be born preterm and have low birth weights impacting optimal development and higher likelihood to developing lifetime chronic health conditions.

The Growing Deadly Families (GDF) strategy aims to improve outcomes for women birthing First Nations babies within Queensland through codesigning maternity services between public maternity health services and Aboriginal and Torres Strait Islander Community Controlled Organisations (ATSICCHO). Evaluating implementation of the GDF is critical to determining effectiveness of adopting a codesigned approach to scale up midwifery continuity of carer models of care and ensure delivery of high-quality and culturally capable maternity services.

When mothers are healthy, before and during pregnancy, the likelihood of full-term pregnancies and babies being born at a healthy birthweight increases. To achieve this there are three overarching objectives of the GDF. These are partnership for governance and leadership, continuity of carer and embedding Australian First Nations workforce and support into health services. Each overarching objective will be monitored and evaluated in accordance with the RISE framework.

This presentation will share the work occurring under this GDF strategy. The tool developed inclusive of the RISE framework to evaluate and monitor the impact of the codesigned approach between public maternity health services and ATSICCHO will also be discussed.

Building capacity of nurses in rural and remote communities

A/Prof Shelley Nowlan

Department of Health – Queensland, Australia

Rural and remote health services are unique given the immense distances between communities, small local populations and the wide variation in health needs and social determinants within these communities. Compounding these challenges are limitations to health infrastructure and access to specialised services. Approximately 53% of the clinical workforce in rural and remote health services within Queensland are registered nurses. In these settings, a nurse is often the first and only healthcare provider and is required to undertake a wide range of clinical care across the lifespan.

Building capacity of the nursing workforce is integral to improving health outcomes in rural and remote communities. Nurses working in this context need to be resilient and resourceful with both generalist and specialised skills, responsive to the needs of communities while understanding the strengths and limitations within the context of practice.

The Rural and Remote Generalist Nurse (RRGN) project is an investment by Queensland Health which involves the development of a program to provide supports and training for registered nurses specific to the context and needs of communities.

During development of the RRGN program, considerations were given to existing clinical education, workplace supports, challenges and lessons from the established medical and allied health rural pathways. In developing the program, stakeholder engagement identified opportunities for immersion in rural and remote practice and importance of understanding the individual needs of communities.

The RRGNP is currently being piloted across five Hospital and Health Services within Queensland.

Queensland normal birth strategy, Queensland Health, Australia

A/Prof Shelley Nowlan

Department of Health – Queensland, Australia

Addressing unmet need for caesarean section (CS) in low-income countries and overuse in high-income countries is a global priority. In the past three decades CS rates have doubled in Australia from 17.5% in 1990 to 35% in 2018. With rates beyond 10% not showing improvements to maternal or neonatal health outcomes. High rates of induction of labour and epidural analgesia, along with low rates of vaginal birth after caesarean (VBAC) directly, or indirectly, are driving CS rates.

In 2021 and in response to 2018 and 2020 Australian Commission on Safety and Quality in Health Care call to reduce non-medically indicated CS rates, Queensland Health, Australia, sought to identify factors to address high CS rates, resulting in the development of the Queensland Normal Birth Strategy (QNBS).

The QNBS report outlined five key recommendations to achieve reduction in non-medically indicated CS rates and increase normal birth. These were universal access to continuity of carer including homebirth, provision of multidisciplinary normal birth education, development of codesigned resources to facilitate informed decision making, embed respectful maternity care and positive workplace culture and establish a sustainable Normal Birth Collaborative committee.

In October 2021, the QNBS project commenced scoping these recommendations and developing an implementation plan. The QNBS aims to improve outcomes for mothers and babies, enable midwives to work to full scope practice, improve cohesion and collaboration in maternity services, promote informed decision making for consumers and encourage a reduction in maternal and neonatal morbidity.

Cardiovascular risk and its relationship to caregiver burden among informal caregivers of elderly patients in a low-resource setting

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Background

There is growing evidence that caregiver burden (CGB) is emerging as an important predisposing factor to cardiovascular disease (CVD). Improved life expectancy has resulted in a growing number of the elderly, even in developing countries like Nigeria – and there is an attendant burgeoning of caregivers (CG) who by cultural dictates are family members. These family caregivers are vulnerable to experiencing CGB. Early identification of their CVD risk profile that may be related to CGB is imperative in ameliorating the effect of cardiovascular disease.

Objective

To assess CVD risk and CGB using validated tools and to determine the association between both variables.

Methodology

A cross-sectional descriptive study was conducted. Informal caregivers of elderly patients (ICEPs) who met the inclusion criteria for the study were recruited via a systematic sampling method. Data were collected using a structured pretested interviewer-administered questionnaire adapted from the World Health Organization STEPs questionnaire, Zarit Burden Interview and 30-year Framingham CVD risk calculator. The Chi-squared test was used to explore the relationship between the variables.

Results

In the study, 409 respondents with a 0.73:1 male-to-female ratio, exhibited a high prevalence of CVD risk and CGB. Although this study showed no statistically significant association between CGB and CVD risk, two aspects of CGB (long duration of caregiving more than one year and not residing with the care recipient) were shown to have a statistically significant relationship with an increased CVD risk.

Conclusion

The demonstrated high prevalence of CGB and CVD risk underscores the need for CGB and CVD risk screening among family caregivers in primary care.

A pain and coordination plan for reduced opioid use and improved quality of life after accidental injuries: An RCT protocol

Mrs Gunhild Nytrøen[1], Lene Bergendal Solberg[2], Holgeir Skjeie[1], Bård Natvig[1], Leiv Arne Rosseland[3], Trygve Skonnord[1]

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Introduction

Patients experiencing serious injuries are at risk of developing long-term opioid use, yet many do not receive plans for opioid reduction when discharged from the hospital. General practitioners (GPs) also experience lack of communication from the hospital regarding pain management plans. The opioid epidemic in the US, characterised by opioid use disorders and addiction, has led to high mortality rates and social need. This study aims to reduce the proportion of opioid users and improve patient outcomes after accidental trauma by implementing a pain and coordination plan (PAC-plan).

Methods

This register-supported randomised controlled trial (RCT) will evaluate the effect of a PAC-plan compared to usual care. Patients will be recruited from Oslo University Hospital, Norway. We include adult patients in need of acute orthopaedic surgery after accidental injury and discharged to home with opioid analgesics. The participants will be randomised in patient–GP pairs and allocated into PAC-plan or control (100 patients in each group). The PAC-plan includes: (1) an opioid management plan to facilitate patient education and provide instructions after discharge; (2) a GP appointment within two to four weeks after discharge; and (3) enhanced collaboration between hospital specialists and GPs. The primary outcome is oral morphine equivalent consumption at six and 52 weeks after randomisation. This patient-reported outcome measure (PROM) will be validated by data from the Norwegian Prescription Database. Secondary outcomes are pain, health-related quality of life (HRQoL) and other PROMs at six and 52 weeks.

Discussion

The intervention is expected to demonstrate efficacy in reducing harmful use of opioids, reducing pain and increasing HRQoL. If effective, the PAC-plan can be implemented into clinical practice and thereby improve patient outcomes and reduce problematic use of opioids in society.

Ethics

The project is approved by the Regional Committee for Medical Research Ethics and will be registered in ClinicalTrials.gov.

Care of transgender and gender diverse adults: How to diagnose, support, affirm, prescribe, monitor and screen

Dr Robert Obara[1,2], Dr Leon Waye[2]

[1]Transgender Health Program, Klinic Community Health Centre, [2]Department of Family Medicine, University of Manitoba

This presentation is intended to help your transgender and gender-diverse patients by increasing your competence, comfort and confidence in trans health! This session will be led by two Canadian family physicians who work in a leading provincial transgender health program. We will share our experiences and lessons learned, and best evidence-based guidance on gender-affirming care in line with the World Professional Association for Transgender Health (WPATH) Standards of Care version 8.

Clinical decision support: Can we tame this beast?

Dr Patrick O'Connor

HealthPartners Institute

Aim

The goal of this interactive session is to share the presenter's and participants' experiences, positive and negative, with outpatient clinical decision support (CDS), and to collectively envision a path toward outpatient CDS that may maximise benefits to both patients and clinicians.

Content

In the first 15–20 minutes of this roundtable, the presenter will compare and contrast features of successful versus less successful outpatient CDS systems, such as: (1) advantages and disadvantages of patient-specific versus disease-specific CDS in primary care settings; (2) the advantages and limitations of implicit versus explicit methods of prioritising care options; and (3) challenges of efficiently communicating the benefits and risks of care options in an accurate and unbiased way to patients in order to support evidence-informed shared decision making. The remainder of the session will be a presenter-facilitated discussion among all present of: (1) their experiences, desires, insights, misgivings, aversions and preferences for chronic disease and preventive care clinical decision support; and (2) participant sharing memorable experiences and current strategies for eliciting 'evidence-informed' patient treatment preferences.

Goals

At the conclusion of this presentation participants will be able to: (1) compare and contrast 'disease-specific' versus 'patient-centred' approaches to clinical decision support; (2) articulate the advantages and limitations of 'explicit' versus 'implicit' methods of prioritising care options; (3) experiment with new ways to elicit 'evidence-informed' patient treatment preferences; and (4) honestly say they enjoyed the session.

Establishing the RACGP Aboriginal and Torres Strait Islander cultural and health training framework

Dr Kali Hayward, Dr Danielle Arabena, Ms Paula Myott, Dr Olivia O'Donoghue, Simone Raye

RACGP

The Royal Australian College of General Practitioners (RACGP) is committed to developing and supporting a culturally safe and reflective general practitioner (GP) workforce that works effectively with Aboriginal and Torres Strait Islander patients and communities. A key strategy addressing Aboriginal and Torres Strait Islander health inequity is training that is evidenced to result in changing practice and in health outcomes. This commitment includes increasing the numbers of Aboriginal and Torres Strait Islander GP registrars.

In February 2023, the RACGP transitioned to a profession-led training (PLT) model, and is directly responsible for the governance, management and delivery of all aspects of the general practice vocational training program. RACGP PLT brings an approach to educational structure and delivery that recognises Aboriginal and Torres Strait Islander health training needs from national, regional and local perspectives. To this effect the RACGP recognises the need to develop an Aboriginal and Torres Strait Islander cultural and health training framework (the Framework) which also builds on successful general practice education and training (GPET) approaches to general practice training.

Aboriginal and Torres Strait Islander sovereignty and self-determination are integral to this Framework. We know that the impacts of colonisation, which is ongoing – dispossession, institutional and systemic racism, disempowerment – are main causes of ill health in First Nations individuals and lack of wellbeing in communities. By acknowledging these realities and embedding Aboriginal and Torres Strait Islander governance as part of this Framework, we seek to ensure that Aboriginal and Torres Strait Islander knowledge systems and ways of knowing, being and doing are grounding medical education and care within the RACGP.

By moving beyond a medical educational system that is rooted in a Western-focused biomedical model, we can create a paradigm shift and achieve health equity through the unfurling of a sovereign vision for the future.

Protein energy malnutrition in Liberia: A call for action

Dr Michael Odewale[1], Dr Tijani Idris Ahmad Oseni[2]

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Background

Liberia is among the 37 countries that account for the estimated 85% of the global burden of stunting according to the World Bank. The 2019–2020 Liberia Demographic and Health Survey reported that 30% of children under five years of age are stunted, with 10% of them severely stunted. Although 55% of infants aged 0–5 months were exclusively breastfed, only 3% of children aged 6–23 months were fed with a minimum acceptable diet.

Methods

An appraisal of the burden of malnutrition in Liberia through observations at the ELWA Hospital, Monrovia, and a detailed literature review of current works was done.

Results: Protein energy malnutrition was worsened by the Liberian civil war followed by the 2014–16 Ebola outbreak in the country. This has led to the impoverishment of most citizens with the children worst hit. There is a resultant rise in teenage pregnancy rates, high school dropout and high illiteracy levels. The attendant poverty has affected food security and social protection. Although some NGOs provide a fortified diet for malnourished children in ELWA Hospital, it is not adequate and cannot be sustained. There is need for advocacy and training of local women on how to prepare a fortified diet using local resources.

Conclusion

There is an urgent need for increased advocacy and mass education to reduce teenage pregnancy through increased contraceptive use and good sexual and reproductive health practices. Increase maternal literacy on exclusive breastfeeding, adequate nutrition including use of local alternatives, child spacing and women empowerment. Policy makers must make effort to put in place measures that will improve access to quality education, reduce gender inequality and provide social support. The international community can also help by providing support to the government and people of Liberia to help improve child nutrition and reduce stunting and its sequelae.

Key words

malnutrition, stunting, gender inequality, maternal literacy, Liberia.

Blood pressure parameter among young adults with hypertensive and normotensive parents attending the outpatient clinic of a public tertiary hospital

Dr Oziegbe Oghide, Iorhen Akase

Lagos University Teaching Hospital

Background

Hypertension was traditionally believed to be a disease of advancing age but recent studies have shown increased incidence in young adults. Family history, especially parental history of hypertension, has been associated with increased incidence of hypertension in their progeny. However, some studies have suggested that this association is secondary to life style and other environmental factors

Objectives

This study was aimed at determining the blood pressure patterns of young adults with hypertensive and normotensive parents attending the General Out-Patient Clinic of the Lagos University Teaching Hospital. The findings from this study may provide a template for recommending protocols for screening of young adult at risk of hypertension.

Methods

The study was a hospital-based cross-sectional study of 524 young adults aged 18–35 years, comprising of 260 offspring of hypertensive parents and 264 offspring of normotensive parents who were closely matched for age and sex. Data were collected using a validated, structured, interviewer-based questionnaire to get information on the sociodemographic characteristics, lifestyle, anthropometric indices and other clinical parameters such as blood pressure. Data were analysed using SPSS 22 and were summed as proportions and means. Chi-squared, Fisher's exact, Student's t-test and logistic regression were used where applicable. The test of significance was set at a P value of 0.05.

Results

The overall prevalence of prehypertension and hypertension among young adults in this study was 29.8% and 9%, respectively. Parental hypertension status was not significantly associated with the hypertension status of respondents (P = 0.802). The prevalence of diagnosed hypertension and incidental findings among respondents were 7.25% and 1.72%, respectively.

Conclusion

The prevalence of hypertension was low but prehypertension was very high and both conditions were without significant relationship with parental hypertension status, hence the need for routine blood pressure screening among young adults irrespective of their parental hypertensive status.

A review of presenting vital signs and outcome among COVID-19 patients in a tertiary hospital: A descriptive study

Dr Oziegbe Oghide, Iorhen Akase

Lagos University Teaching Hospital

Introduction

The association between presenting vital signs and outcome of patients admitted with COVID-19 in our setting is lacking. The aim of this study is to review the vital signs of patients with COVID-19 at presentation and their relationship to patient outcome at a tertiary hospital in Lagos, Nigeria.

Methodology

This is a descriptive cross-sectional study. Records of patients admitted with COVID-19 in our facility were reviewed from April 2020 to December 2021 and information on the age, sex, vital signs at presentation (temperature, respiratory rate, pulse rate, systolic and diastolic blood pressure, oxygen saturation) as well as patient outcome (died, DAMA, discharged with oxygen, discharged without oxygen, transferred to the ward) were documented. Quantitative variables were presented as the mean (standard deviation), and categorical variables were presented as proportions. Difference in means among the groups was determined using the ANOVA test.

Results

A total number of 773 medical records was retrieved; 487 (63%) patients were male and the mean age (SD) of the participants was 46.67 (16.8) years. The mean temperature was 36.39 ± 0.6, with 495 of 509 patients (97.2%) presenting without fever. Tachypnoea was recorded in 213/294 (72.5%) and hypoxemia in 79/422 (18.7%), while tachycardia was also noted in 70/394 (17.8%). Of the patients admitted, 70 (9.1%) died while 636 (82.3%) were discharged home without need for oxygen supplementation. There was a statistically significant correlation between mortality and the temperature, respiratory rate, pulse rates and the oxygen saturation at admission.

Conclusion

The outcome of patients presenting with COVID-19 was significantly associated with tachypnoea, tachycardia and hypoxemia. The majority of patients presented without fever. There is a need to prioritise the clinical care of COVID-19 patients presenting with these features.

The association between cotinine-measured smoking intensity and sleep quality

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Aim

Cigarette smoking is suggested to be associated with sleep problems. This study evaluated the quantitative association between urinary cotinine-verified smoking intensity and sleep quality assessed by the Pittsburgh Sleep Quality Index (PSQI).

Methods

This was a cross-sectional study of 189,970 participants from the Kangbuk Samsung Health Study recruited between 2016 and 2018. Logistic regression analysis adjusted for covariates was performed to estimate the association between urinary cotinine levels assessed by quartiles and poor sleep quality, defined as global PSQI score >5.

Results

The odds ratios (OR) and 95% confidence intervals (CI) for poor sleep quality comparing the highest urinary cotinine quartile to non-smokers were 1.23 (95% CI: 1.16, 1.30) for overall, 1.19 (95% CI: 1.12, 1.26) for males and 1.55 (95% CI: 1.29, 1.87) for females. Among self-reported never smokers, cotinine-verified smokers had higher odds for decreased sleep quality compared to cotinine-verified never smokers with an OR of 1.26 (95% CI: 1.08, 1.46).

Conclusions

Elevated urinary cotinine levels were associated with poor sleep quality in relatively young and middle-aged South Korean adults. Higher odds for poor sleep quality among cotinine-verified smokers who self-reported as never smokers also demonstrate the value of quantitative measurement of urinary cotinine.

Prospective studies are warranted to clarify the cause–effect relationship between smoking and sleep quality.

Can practising angklung improve the quality of life for elderly people with degenerative diseases?

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Background

The angklung is a traditional musical instrument originating from West Java, Indonesia, made from bamboo tubes that produce sound when shaken simultaneously and harmoniously. One person can hold and shake one or more angklungs. Creating beautiful melodies requires good cooperation among the players. Each player needs to know when to shake and when to stop shaking their angklung. Family clinics that form communities of elderly angklung players with degenerative diseases are very rare.

Objective

To explore the experiences of elderly patients with degenerative diseases who have regularly practised angklung and their relationship with quality of life.

Methods

A qualitative phenomenological approach was used, conducting interviews with 26 elderly individuals with degenerative diseases such as hypertension and diabetes.

Results

Psychologically, almost all participants expressed feelings of happiness, enjoyment and entertainment. In terms of the physical aspect, some experienced improved motor skills, coordination, movement, concentration, memory and even stabilised blood sugar levels. From a social perspective, nearly everyone expressed pleasure in meeting and gathering with others. Moreover, in terms of the environmental aspect, angklung created harmonisation that could be enjoyed together.

Discussion

Despite the degenerative conditions, engaging in angklung practice can enhance cognitive function.

Co3nclusion

Regular angklung practise can improve the quality of life for elderly individuals with degenerative diseases.

Addressing child development disorders in a favela in Rio de Janeiro

Ms Izabela Oliveira, A/Prof Brenda Costa, Thaís Yamamoto

UERJ

Child development begins at birth and progresses until the age of nine. Enabling children to reach their full developmental potential is a human right and an essential requirement for the development of autonomy. For this reason, monitoring growth and development as an action provided throughout the basic health services network is one of the priority axes of the National Policy for Comprehensive Assistance to Children (PNAISC). Thus, the primary care professional has the first contact with child development disorders, either by observation during monitoring or by family demand. Within the favela context, some risk factors for this condition are very common, such as discrimination, marginalisation and exposure to violence. Moreover, with the COVID-19 pandemic, the demand from families and schools for case evaluation has increased. The suspicion and diagnosis of a disturbance in a child's development have repercussions on families, often leading to changes in the routine and dynamics of family relationships. They may trigger a paranormative family crisis, causing intense anxiety and stress. Because of this, throughout 2022, a family health strategy team in Rio de Janeiro, whose target area includes a favela, mapped children with reports and signs of developmental disorders. Before doing so, they had to resort to scientific literature in search of references on methods of multidisciplinary approach and follow up, considering the particularities of the population and the territory. Children and their families were welcomed, underwent medical and nursing care and individual therapeutic plans (STP) were drawn up. This paper reports this experience, seeking to discuss and reflect on the challenges and potentialities encountered and the care strategies adopted.

The pattern and characteristics of sexual assault perpetrators and survivors managed at a sexual assault referral centre in Lagos, Nigeria

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LASUTH, Ikeja

Background

The establishment of the first sexual referral centre in Nigeria (Mirabel Centre) changed the management of cases of sexual assault in organising care while providing data on the characteristics of the survivors and perpetrators which was not previously available.

Aim

To report the pattern and characteristics of sexual assault managed at the Mirabel Centre, Lagos State University Teaching Hospital (LASUTH), Ikeja – an eight-year review.

Methods

A retrospective audit was carried out at the Sexual Assault Referral Centre (SARC) – Mirabel Centre, LASUTH, Lagos State, Nigeria. A total of 7113 case files from July 2013 to March 2022 were assessed for their clinical characteristics.

Results

The mean age of survivors was 13.9 (± 4.4) years with the 11–17-years age group having the highest number of survivors (3188; 43.8%) and the 0–10-years age group having 2594 (36.4%) survivors. A majority of the survivors (6910; 97.1%) were female. The majority of the perpetrators (5292; 74.1%) were known to the survivors, with 817 (11.5%) being family members. Defilement 5480 (77%) was the most reported type of assault, with rape 1250 (17.6%) being the second most common. The police referred a majority (5280; 74.2%) of the survivors to the Centre.

Conclusion

Minors and adolescents formed the majority of the survivors. Defilement was the most reported form of sexual violence. The efforts of the Mirabel Centre have led to the Duchess of Cornwall taking up a patroness role. The establishment of more SARCs in Nigeria will increase the reportage and treatment of survivors.

Impact of FHE on stigma and QoL of adult patients with HIV infection in south-west Nigeria

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Background

The advent of highly active anti-retroviral therapy brought hope of significant reduction in human immunodeficiency virus (HIV)-related disease burden, especially in Sub-Saharan Africa. But HIV-related stigma persists and prevents voluntary testing, status self-disclosure and pills uptake among infected persons. There is a dearth of relevant interventional studies from Nigeria directed at reducing HIV stigma.

Aim

To assess the effect of focused health education (FHE) on the levels of stigma and quality of life (QoL) of newly diagnosed treatment-naïve adults who came for voluntary counselling and testing (VCT) at Olabisi Onabanjo University Teaching Hospital, Nigeria.

Methodology

A hospital-based randomised controlled study was carried out on 148 HIV-positive adults (randomised into two arms of 72 each). The WHOQOL-HIV BREF and the Berger HIV-stigma scale short form were used to assess QoL and stigma, respectively. Data were analysed using SPSS package version 24. Chi-squared and t-test were used to explore the relationship between variables. A P value of <0.05 (95% confidence interval) was used to determine the level of significance.

Results

A total of 145 persons completed the study; 72.3% were female and 27.7% were male. Their mean age was 39.78 years (SD = 10.38); 64.5% were married and 92% were formally educated and employed. Baseline HIV stigma levels for both groups were high but similar (30.45 and 31.19, respectively). Their QoL domain scores were equally high at baseline. At the end of the study (four weeks), there was a significant reduction in the mean stigma score of the intervention group compared with the control group ($P < 0.01$). Also, the QoL domain scores of the intervention group were significantly higher than those of the control group ($P < 0.05$).

Conclusion

Patients who received FHE in addition to routine care had a significant reduction in HIV-related stigma and significant improvement in their QoL scores, after the intervention.

A five-year descriptive analysis of potentially preventable hospitalisations for ear, nose, and throat conditions in regional Victoria, Australia

Ms Susan O'Neill[1,2], Stephen Begg[1], Evelien Spelten[1]

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Potentially preventable hospitalisations (PPH) of ear, nose, and throat (ENT) conditions in the Murray Primary Health Network (PHN) region have been found to be higher than the state average of Victoria, Australia (also termed hotspots). The Perils of place report by the Grattan Institute recommends place-based interventions to target hotspots, warranting further investigation within the Murray PHN. This study aimed to examine the association between patient characteristics and PPH for ENT conditions from 2015 to 2020 in the Murray PHN. More specifically, this research intended to identify the clinically meaningful ENT subgroups of PPH, map the identified postcodes of significance for potentially preventable ENT hospitalisations and identify the compounding selected patient characteristics of the PPH for ENT conditions. Unit record hospital separation data were obtained from the Victorian Admitted Episodes Dataset. Differences between patients from 'higher than expected' postcodes and 'other' postcodes (with respect to the distribution of demographic and other patient characteristics) were determined using Chi-squared tests for each ENT subgroup. The results were confirmed by logistic regression analyses using resident of a postcode with higher-than-expected hospitalisations as the outcome variable. There were 4816 hospital separations in the Murray PHN with a primary diagnosis of ENT as defined by the PPH framework in the National Health Agreement. Of the 169 postcodes located in the catchment area, 15 were identified as having higher than expected numbers of upper respiratory tract infection hospitalisations, 14 were identified for acute tonsillitis and 12 were identified for otitis media. Of the postcodes identified, differential patient factors included 0–9 year olds, the Aboriginal and Torres Strait Islander population and those from culturally and linguistically diverse backgrounds (patients requiring an interpreter and language other than English patients). Further investigation of the postcodes identified is warranted to determine access to and utilisation of primary healthcare services in these regions.

Reducing loneliness through nature-based social prescribing approaches in community-based interventions

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RMIT University

Loneliness is a widespread phenomenon mostly occurring when a person's social needs are not met. While loneliness remains under-recognised as a strong determinant of health status, there is growing evidence and recognition of this link. Recent COVID-19-associated confinement has brought loneliness to our attention all around the world. An emerging subset of social prescribing called 'nature-based social prescribing' (NBSP) attempts to give people access to chances to interact with others while spending time in natural environments. Visits to parks, forest bathing, bird viewing, community gardening and many more activities are examples of NBSP activities. Although NBSP research is still in its early stages, there is evidence that spending time in natural settings benefits one's health and wellbeing. To address the danger that loneliness poses to a person's mental health and wellbeing, community-based initiatives are required. This project is an EU and NHMRC-funded study with the aim through ethnographic and participatory action research jointly create, test and evaluate such initiatives that aim to reduce the feelings of loneliness in individuals belonging to the LGBTQIA+ refugee and asylum seeker communities living in Melbourne, Australia. To enable nature-based social prescribing, social network studies will be used to evaluate the policy and social structures. Furthermore, a loneliness scale, quality of life and nature dosing surveys will be used to evaluate NBSP's social impacts.

A quantitative–qualitative comparison of the biopsychosocial health of physically active elderly with and without intervention in Marikina

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Philippine Academy of Family Physicians

The study aimed to determine if there is a difference between the biopsychosocial health of physically active elderly participants and non-participants of the Above 60 Academy, an intervention program in Marikina City that is directed towards senior citizens. The participants for the study are registered senior citizens, those aged 60 and above, who are still able to perform basic physical and functional activities such as walking, without the need of assistance or with little need of assistance.

The biopsychosocial health of the participants was measured using an interviewer-administered Comprehensive Geriatric Assessment survey that comprised of five tests, namely Nutritional Health Checklist, Geriatric Depression Scale, Activities of Daily Living, Mini-Mental State Examination and Timed Up and Go. The biological component is measured by the NHC, ADL and TUG, while the psychological component is measured by the GDS and MMSE.

Results show that there were no statistically significant differences between the biological aspect of the two study groups. In terms of the psychological aspect, however, both GDS and MMSE were significant at $P < 0.05$ (GDS, $P = 0.013$; MMSE, $P = 0.029$). This shows that there is a significant difference between the two study groups. Further tests using Pearson's correlation show that both GDS and MMSE (at 0.275 and at –0.245 respectively) have a weak correlation to the intervention.

In conclusion, there is evidence to show that the Above 60 Academy has an impact when it comes to the psychological health of the elderly. This impact can be attributed to the monthly lectures and consistent activities held by the program. In the end, the Above 60 Academy is considered by the researchers as an intervention that initiates and advocates active ageing.

Medication adherence and blood pressure control: A preliminary assessment of the role of health insurance in Nigeria and Ghana

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Background

Health financing through health insurance has been adopted by most countries of the world, including Ghana and Nigeria, as a preferred payment option for healthcare services. It helps to achieve universal health coverage (UHC) by reducing catastrophic health expenditure. Hypertension is a major public health issue affecting about one-quarter to half of the African population, with over half of patients with hypertension not having their blood pressure controlled. A major setback in the management of hypertension is poor medication adherence as most patients are unable to pay for medications.

Aim

This study, sought to assess the current impact of health insurance coverage on medication adherence and blood pressure control of patients being managed for hypertension in Ghana and Nigeria.

Methods

The study was a prospective study among 109 patients with hypertension in two health facilities with similar population dynamics in Ghana and Nigeria. Patients were systematically selected, categorised as having health insurance coverage or not and followed up monthly for six months. The outcome variables (medication adherence and blood pressure control) were then measured and compared at six months. Analysis was done using Stata with level of significance set at $P \leq 0.05$.

Results

There was a 90% insurance coverage among participants from Ghana compared with 15% from Nigeria. National Health Insurance Authority (NHIA) enrollees in both countries had better blood pressure control and medication adherence compared with non-enrollees (AOR = 2.6 and 4.5, respectively).

Conclusion

NHIA enrolment was found to be poor among respondents in Nigeria compared to Ghana. Enrolment into the national health financing schemes in both countries led to better blood pressure control and medication adherence among patients with hypertension at primary health facilities. There is therefore the need for system strengthening to improve their sustainability.

Key words

hypertension, medication adherence, NHIA, Ghana, Nigeria.

Mapping of family medicine training and practice in the Eastern Mediterranean Region

Dr Mona Osman[1], Hassan Salah[2], Saaed Salah Soleiman[2]

[1]American University of Beirut, [2]World Health Organization

Family medicine is delivering comprehensive, first-contact, person-centred and community-based medical care. Evidence showed the impact of family medicine (FM) on better outcomes, lower costs and improved health equity. The World Health Organization (WHO) adopted the concept of family practice for effective and efficient delivery of primary healthcare services, and for achieving universal health coverage in the Eastern Mediterranean Region (EMR). A research study was conducted to map and describe the postgraduate FM training programs in the EMR and to identify challenges facing the FM training and practice. A mixed-methods approach was used including qualitative and quantitative data collection along with literature review. Results showed that the training in family medicine started in 1979 in the EMR region, with the first programs being established in Lebanon and Bahrain, followed by Egypt. There is a great variability in the family medicine training as well as practice among the different countries. Most countries in the region require a residency in family medicine as the formal postgraduate training such as Kuwait, Egypt, Lebanon, Bahrain, Kingdom of Saudi Arabia, United Arab Emirates, Qatar and Oman. In other countries like Sudan, Islamic Republic of Iran and Egypt, a Master's degree in family medicine is also recognised as a formal postgraduate training. Fellowships in family medicine are also recognised as formal postgraduate training in other countries. The residency training programs are of four years in duration in most of the countries; however, a three-year residency program is acceptable in few countries. A formal postgraduate training in FM is still absent in a few countries in the region like Yemen and Morocco. Many challenges are facing the development of FM in the region, including characteristics of the health system, the image of family medicine, the availability of gatekeeping and referral mechanisms, financing issues and contextual factors such as war and others.

Prevention of sudden cardiac arrest in young athletes

Dr Mona Osman

American University of Beirut

Sudden cardiac death is the leading cause of death among young athletes aged 12–35 years. Non-diagnosed cardiovascular diseases are reported to be the most common cause of sudden cardiac death in young athletes. Exercise can increase the risk of sudden cardiac death in susceptible athletes with specific cardiac conditions. Sudden cardiac death in young athletes can happen during sports activities, within an hour of exercise or even outside of sports. Sudden cardiac death in young athletes might be rare, but it is devastating not only to the family of the athlete, but also to their peers, institutions (schools, universities and sports clubs) and communities. Prevention of sudden cardiac death in young athletes is possible through primary and secondary measures.

Primary prevention includes cardiac screening that aims at early detection of life-threatening conditions in young athletes. There is a general agreement among major scientific authorities on the importance of preparticipation cardiac screening of young athletes before enrolment in competitive sports and periodically thereafter; however, the main debate is on the screening protocol and whether to include an electrocardiogram or not.

Secondary prevention of sudden cardiac death is namely improving the chances of survival for victims of sudden cardiac arrest. This entails prompt recognition of sudden cardiac arrest, the presence of trained personnel to initiate cardiopulmonary resuscitation and early access to an automated external defibrillator. The availability of an emergency plan and the prompt use of defibrillation have been shown to improve the survival rates for victims of sudden cardiac arrest.

This presentation will discuss the relevance of cardiac screening in young athletes, highlighting the required history, physical examination and screening tests needed. It will also discuss the recommendations of the different scientific societies in this respect.

An overview of the regional professional diploma in family medicine

Dr Mona Osman[1], Hassan Salah[2], Saaed Salah Soleiman[2], Nagwa Nashat[3]

[1]American University of Beirut, [2]World Health Organisation, [3]World Organization of Family Doctors

The World Health Organization in the Eastern Mediterranean Region (WHO-EMRO) adopted the concept of family practice for the effective and efficient delivery of primary healthcare services and for achieving universal health coverage in the countries of the Eastern Mediterranean Region. The main challenges reside in the limited number of available family medicine programs and the limited number of family physicians. In fact, the total number of certified family physicians in these areas is much lower than the number of 185,497 family physicians needed to cover the population in these countries based on international standard requirement of at least three family physicians per 10,000 population.

Parallel to this, there are around 250,000 general practitioners without any vocational training working in the primary healthcare facilities in the countries of the region. Building the capacity of these doctors is arguably the best short-term solution to increasing the number of doctors proficient in family practice. In fact, bridging programs leading to diplomas or certificates have been adopted by different countries for more than 20 years with the aim of improving the standard of care of general practice.

WHO-EMRO and the Arab Board of Health Specializations launched a two-year regional Professional Diploma in Family Medicine (RPDFM) in collaboration with the World Organization of Family Doctors (WONCA) and other United Nations agencies. The Professional Diploma in Family Medicine aims at equipping general practitioners with the knowledge, skills and attitudes that are needed to provide comprehensive, continuous and appropriate healthcare to individuals and families. The training is delivered in a blended format using a mix of online and face-to-face clinical training with both academic and clinical supervisory support. This presentation will discuss the process followed in the development of the diploma, describing its curriculum and highlighting the different challenges faced.

Mindfulness training for primary care specialist trainees: The impact on burnout and mental health

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Background
Being a postgraduate medical trainee is challenging, given the added responsibility of completing their studies on top of the existing clinical work demand. Studies reported that stress and burnout are common among medical doctors. The negative implications of stress and burnout are detrimental to doctors' physical and mental health. Importantly, this can affect the way they perform at work and home. Mindfulness-based stress reduction (MBSR) is a well-known example of mindfulness training that can reduce stress, depression and anxiety in clinical and non-clinical populations.

Aim
This study evaluated the feasibility of conducting modified mindfulness-based stress reduction (m-MBSR) training and the impact of the training on burnout, stress, anxiety and depression among postgraduate clinical trainees in primary care.

Methods
Postgraduate trainees (n = 38) were randomly allocated to an intervention group (m-MBSR training for four weeks, each session for 1.5 hours) and a control group. Participants administered the Copenhagen Burnout Inventory and DASS-21 at Months 0, 1 and 3 of intervention completion. The control group received m-MBSR training after the study concluded.

Results
There was no difference between the intervention and control groups at baseline. The intervention group had a significant reduction in work burnout score at one month (P = 0.042) and client-related burnout score at three months (P = 0.04) compared to the control group. In addition, the depression score was significantly reduced at three months (P = 0.003), while the stress reduction score was significantly reduced at one month (P = 0.017) and three months (P = 0.029).

Conclusion
The result of this study supports the effectiveness of m-MBSR in reducing burnout, stress and depression score at different times within three months of completing mindfulness training. However, no differences were found in anxiety scores. The shorter duration of training and contact time of m-MBSR can be easily offered for mindfulness training among busy postgraduate trainees.

Implementing CRP POCT test for respiratory tract infections in children in Kyrgyzstan: Studying enablers and barriers to implementation

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Introduction

Inappropriate prescriptions of antibiotics to children are common in primary care in Central Asia. 'Currently, a cluster randomised trial is investigating this possible reduction through the implementation of point-of-care CRP-testing in primary care clinics in rural areas of the Kyrgyz Republic.'

Introducing point-of-care CRP testing is a process consisting of several interacting educational and behavioural components, and the success depends on the acceptance and coordinated efforts of the involved health professionals.

Aim

We aim to evaluate how primary care professionals accept the new test technology.

Methods

Qualitative interviews with 20 general practitioners, feldshers and practice nurses before and during the implementation period.

Results

Data collection, parallel to the rollout of the randomised trial, is still ongoing but will finish in spring 2023. Initial results point towards barriers to change prescription style so that this is based on CPR test results relate to practical conditions, such as having a sufficient amount of test kits, professionals' differences in education level and their view of themselves as evidence-based practitioners.

Social empathy and related factors in sixth-year medical school students in Japan

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Background and objectives

Empathy is an essential component of physician competence. In recent years, the influence of social determinants of health (SDH) on health outcomes and the advocacy role of physicians have gained attention. Therefore, it is becoming increasingly important to nourish both interpersonal and social empathy during medical education. However, little is known about social empathy in graduating medical students. The objective of this study was to clarify the factors related to social empathy in graduating medical students in Japan.

Methods

The study was a cross-sectional survey using an anonymous, self-administered questionnaire. Participants were 133 sixth-year medical school students at the University of Tsukuba who completed the clinical clerkship in July 2022. The Japanese version of the Social Empathy Index (SEI), which consists of four interpersonal empathy components and two social empathy components, was used. Participant age, sex, volunteer activities, donations, living abroad, studying abroad and self-rated understanding of SDH were ascertained. Overall and component SEI scores were compared with other factors using t-tests. The study was approved by the University of Tsukuba Medical Ethics Board.

Results

There were 81 participants with a mean age of 24.2 ± 2.2 years; 30 (37.0%) participants were female. Those with a better understanding of SDH had significantly higher overall SEI scores and higher scores on two interpersonal components (affective mentalising and perspective taking) and one social empathy component (contextual understanding of systemic barriers). Participants with experience studying abroad had significantly higher scores on an interpersonal component (affective response) and a social empathy component (contextual understanding of systemic barriers), but this trend was not seen in participants with experience living abroad.

Conclusion

Graduating medical students with better understanding of SDH had higher SEI scores. Those with experience studying abroad had higher scores on some SEI components.

Severity and clinical outcome of COVID-19 patients admitted in Gulmi Hospital, Lumbini Province

Dr Uttam Pachya

Gulmi Hospital, Lumbini Province

Introduction

Since the pandemic we have lost more than 66 million lives. The severity of the disease and age of the patients were seen as the important factors for the fatality besides existing comorbidities. This study was done to see the severity and clinical outcome of the cases admitted in a rural hospital in Nepal, after the period of active immunisation against COVID-19 vaccine in Nepal.

Method

This was a retrospective analysis of all the cases admitted to Gulmi Hospital from 28 April 2021 to 9 February 2022 who were diagnosed positive by antigen test or real-time RT-PCR for SARS-CoV2. The data were extracted from Information Management Unit (IMU) database designated for Gulmi Hospital during the COVID-19 outbreak. Based on the clinical presentation, the severity of COVID-19 was assessed and patients were categorised as mild, moderate and severe. Descriptive statistics and tests of significance were done as applicable.

Result

A total 253 patients were admitted with a diagnosis of COVID-19 in the study period. There were 145 (57.3%) male patients. Based on clinical presentation of the cases, there were 156 (61.6%) mild and 97(38.4%) moderate cases. The median (Q1, Q3) length of hospital stay of the patients was 4 (2, 6.5) with a maximum 20 days of hospital stay. There were 14 (5.5%) deaths. The age of the patients who died due to COVID-19 had a higher mean (67.5 ± 14.75 years) than those who were discharged (51.4 ± 16.8) which was statistically significant (P = 0.002). The severity of disease showed significant association with outcome (P = 0.040) with an odds ratio of 3.08 (1.003–9.508).

Conclusion

Death toll in the hospital admitted cases is still 5.5% with increased mortality among the older and cases with increased severity at presentation. Only 9.9% were vaccinated among these admitted cases.

Enablers of and barriers to nurses providing preventive care in general practice

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Background
General practice nurses play an essential role in Australia's primary healthcare sector by delivering effective preventive care and chronic disease management. This is not surprising given approximately 80% of Australia's burden of disease is attributed to chronic illness, 38% of which may be prevented by addressing lifestyle risk factors.

Aims
Identify enablers of and barriers to effective preventive care by general practice nurses and improve understanding of the factors contributing to advancements in the field.

Methods
An exploratory sequential, mixed-methods design. Quantitative data were collected via the Lifestyle Risk Factor Survey and analysed using SPSS. Qualitative data were collected via semistructured interviews and analysed thematically using NVivo 12.

Results
From 245 survey responses, most general practice nurses indicated: patients found it acceptable to discuss lifestyle risk factors during consultations; addressing lifestyle risk factors with patients was important; and the level of priority given to addressing lifestyle risk factors at their practice was high. Most general practice nurses found it 'easy' to find support services for patient referrals for all risk factors excepting alcohol counselling and were confident to perform preventive care including patient assessments (excepting nicotine dependency assessments), provide lifestyle change recommendations, conduct motivational interviewing and apply adult education principles. However, most general practice nurses perceived their behaviour change advice was only 'somewhat effective'. Interviews with 34 general practice nurses revealed the primary enablers of effective preventive care were related to individual factors (experience, motivation, knowledge, confidence, attitude) and interpersonal factors (motivated patients, supportive work colleagues, working dynamics). The main barriers were related to organisational factors (time, organisational structure, workplace culture, consultation space) and public policy and funding factors.

Conclusion/summary
General practices nurses, general practices and patients acknowledge the importance of effective preventive care. Training, resources and support initiatives including funding opportunities and allocations may promote practice improvement.

Risk identification for stunting among female teenagers at remote high school of Timor Island, Indonesia

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Background

East Nusa Tenggara Province where Timor Island becomes the mainland is in high prevalence of stunting among children under five. One of the risk factors is the mothers and perhaps their condition before marriage. This study aims to describe healthy status of female teenagers as future mothers about their capability to bear healthy baby.

Methods

This is a cross-sectional study in a remote Timor Island among female high school students. They were measured for weight and height, followed by dental and blood haemoglobin examinations. The haemoglobin was tested using Sahli's method for estimation.

Results

Thirty-three students participated in this study, aged 16–18 years. The height measurements found 81% stunting. Weight measurements were 51% underweight, and 12% had body mass index less than percentile 5 (very low). Anaemia was found among 72% of the students. East Nusa Tenggara Province was high prevalence of stunting among children under five for quite a long time. As a long-term public health problem, stunting might continuously happen from children under five until teenagehood, and perhaps less detected. Therefore, the female teenagers as the future mothers had still the risks to deliver and raised children in a chronic situation that allows stunting to happen.

Conclusion

Chronic situation that affect nutrition status among female teenagers in remote village of Timor Island may impact to the continuity of stunting over generation. Such early detection of risk factors among female teenagers is important to be applied.

Leadership: Identifying gender gap and stressors with a focus on self-competency assessment and resilience

Dr Elissa Palmer

Kirk Kerkorian School Of Medicine at UNLV

Aims

(1) Determine physician stressors; (2) define issues related to gender discrepancies; (3) delineate gaps in personal leadership and resilience competencies; and (4) compare evidence-based techniques, tools and resources to create a personal action plan for personal professional development to enhance leadership skills and counter burnout.

Methods

Interactive discussion provides a framework of the current literature with individual and group exercises to identify gaps in personal leadership and resilience competencies followed by action plan development.

Background

Stress, emotional distress or burnout can affect a physician's ability to provide high-quality care. The 2022 Commonwealth Fund International Health Policy Survey of Primary Care Physicians showed that the majority of physicians in the 10 high-income countries surveyed revealed increasing physician burnout since the COVID-19 pandemic. Demographics of young age, female gender, long hours and poor job satisfaction increase the risk for burnout. Compounding this, the literature suggests that women may experience a number of gender-related individual challenges that impact their path to leadership, including gender differences in approaches to career and life goals. The under-representation of women in leadership positions worldwide in industry and medicine continues even though the proportion of women in the workplace has increased.

Review of GP involvement in the care of paediatric patients who attend the emergency department frequently

Dr Helen Parry, Dr Emily Roxburgh

Women's and Children's Hospital

Australian emergency departments are under increased pressure with increased demand and overcrowding. The type of urgent care services provided in general practice (GP) often overlap with the low-acuity presentations in emergency departments (ED). Paediatric patients that present frequently to the ED often have complex health problems independent of the triage category they are assigned at each presentation. Socioeconomic factors can also impact on the use of emergency services.

General practice provides the majority of healthcare for patients with complex health conditions and is linked with reduced hospitalisation and improved health outcomes.

This retrospective study aims to increase understanding of patients who attend a tertiary paediatric emergency department frequently with a focus on GP involvement. The medical records of children aged under 18 years who have attended the WCH PED more than five times in 12 months over a retrospective two-year time frame were reviewed. An analysis of GP, patient and hospital factors was reviewed. GP factors: recorded GP in the hospital medical record, clinical handover and coordination with patient's GP. Patient factors: health conditions, ethnicity, age, postcode, frequency of visits, presenting complaint. Hospital factors: admissions, cost analysis.

An increased understanding of the needs of paediatric patients who attend the ED can inform appropriate strategies to improve supports such as regular longitudinal GP care and improved coordination of care between emergency and GP health services.

GP first choice for medical graduates: Innovative medical education

A/Prof Riitta Partanen

The University Of Queensland Rural Clinical School

Aim

To share the innovative end-to-end Medical Pathways models in Queensland aiming to provide the medical workforce rural communities need, by increasing the percentage of graduates choosing rural general practice (GP) careers as a first choice.

Content

Rural general practitioners continue to be a scarce resource in Australia and globally. In Australia only 18% of medical school graduates are choosing general practice (GP) as their first preference for their future medical career. Yet rural communities need more GPs to ensure they receive the care they need, at the time they need close to home. More needs to be done in the medical education and training sector to foster a higher percentage of graduates choosing GP as their preferred career choice.

To facilitate this, The University of Queensland, with its reimagined MD program, has partnered with regional universities and local hospital and health services to develop rural Medical Pathways, which provide end-to-end (end of high school to end of Fellowship) medical education training within rural communities.

The UQ-affiliated end-to-end rural Medical Pathways (MP) are an innovative model that will showcase rural general practice from Year 1 of the three-year undergraduate degree and throughout the four-year postgraduate medical degree. Early, longer and longitudinal general practice experiences inrural communities is aimed to foster more MP graduates to want to become GPs and in particular rural GPs.

Goals

The innovative and unique end-to-end Medical Pathways aims to address the workforce needs of its communities and in particular improve access to primary healthcare, by having more graduates choosing GP as their first career choice, and who choose to work in rural communities.

Geographical narcissism during medical education and training and its role in 'ruling in' or 'ruling out' rural future rural practice

A/Prof Riitta Partanen

The University Of Queensland Rural Clinical School

Aim

Better understanding geographical narcissism (GN) and its influence on ruling out rural medical practice could improve workforce distribution and thus improved rural health outcomes.

This systematic exploration of GN is necessary to gain a greater understanding both how it is experienced, and its role and influence on Australian medical students and prevocational junior doctors in their deliberations on whether to work in metropolitan, regional or rural areas during their prevocational years and in the longer term.

Content

There are well-understood factors (rural background, rural undergraduate clinical training, rural working experiences and high rural self-efficacy) that increase the likelihood of medical learners choosing rural medical careers, but there are potentially other factors that are less understood on why those with an increased likelihood of working in rural areas do not.

Geographical narcissism (GN) is the subtle, often unconscious, devaluation of non-urban knowledge and expertise due to the belief that urban knowledge and expertise is the norm or even superior.

A qualitative study informed by realistic evaluation was selected to ensure strength and rigour in the research findings. Twenty-nine semistructured interviews were conducted with rural and metropolitan-based university medical students and prevocational junior doctors employed by regional or metropolitan hospitals.

Data analysis suggests GN is a genuine phenomenon influencing medical learners and variably influences the 'ruling in' or 'ruling out' of rural medical practice. The findings also suggest those with a rural background and rural medical education appear to be less influenced by GN.

Goals

A GN framework will be developed from this new evidence to help illustrate its role in rural versus metropolitan medical career development and workforce and is likely to provide valuable insights into an under-recognised barrier to rural medical careers, potentially informing medical workforce policy and medical education and training frameworks.

Bringing the arts to medical practitioners

Dr Ameeta Patel, Dr Kathryn Hutt

Doctors' Health NSW

Aim

The arts – music, painting, drawing – have been used for healing for millennia. This interactive workshop will explore the evidence for the effectiveness of art as a therapeutic tool for medical practitioners and provide an engaging and enjoyable opportunity for attendees to experience a guided creative art activity, focused on their clinical practice.

Content

Medical practitioners are increasingly at risk with high rates of burnout, depression, anxiety, substance use and suicide. The risk to individuals and their families, workforce and communities, as well as to poorer patient outcomes, is significant. There is a need to explore what can be done to assist medical practitioners and others in self-care and avoiding burnout. Art is validated as a therapeutic tool for treating illness in patients and there is an increasing use of the arts as an educational tool in undergraduate studies, teaching professionalism, ethics and empathy. It needs to be expanded to working professionals who experience the stresses of clinical practice. There is regional expertise in the area of art therapy, but it is disconnected and currently has no focus in primary care.

Goals

Attendees will:

- gain an understanding of the history and application of art in healthcare, look at the evidence base to support its use and see interesting examples from around the world
- experience a guided visual arts activity to encourage reflective practice and an opportunity to share their reflections
- share experiences and expertise and build a network for the region.

A qualitative exploration of the impact of telehealth in vocational general practice training

Miss Irena Patsan[1,2], Dr Linda Klein[1,2], Dr Katie Fisher[1,2], Jordan Tait[1,2], Alison Fielding[1,2], Andrew Davey[1,2], A/Prof Penny Abbott[3], Prof Parker Magin[1,2]

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During the COVID-19 pandemic, telehealth became a permanent feature of Australian primary healthcare. Increased use of telehealth likely introduces complexity and/or disruption to usual supervisory and assessment processes in the general practice vocational training model. Currently, there is limited qualitative evidence exploring the impacts of telehealth on the educational experiences of general practice registrars.

This study aimed to explore how telehealth uptake impacted the clinical and educational experiences of registrars, and how this has affected the general practice vocational training model.

A qualitative research design used in-depth semistructured interviews and reflexive thematic analysis. GP Synergy registrars who trained during 2020 and/or 2021 in NSW and ACT, and supervisors and medical educators who were actively involved in training registrars over the same period, were invited to an individual interview. Fifteen registrars, five supervisors and five medical educators were purposively recruited and interviewed.

Analysis identified six themes:

1. Lack of formal telehealth training; everyone was learning telehealth in-practice in real-time
2. Primary focus on getting the patient-care job done, not clinical learning
3. Inseparable impact of telehealth versus COVID
4. Overarching need for in-person interactions
5. Skewed case exposure
6. Disruption of immediate feedback for learning.

The presentation will briefly describe each theme from registrar, supervisor and medical educator perspectives. Discussion will explore how the findings translate to educational actions to support registrars and their educators when using telehealth in the future, whether during a new pandemic or during business as usual.

Updating *Therapeutic guidelines: Antibiotic*

Ms Alli Patterson

Therapeutic Guidelines Ltd

For over 40 years, Therapeutic Guidelines has supported Australian doctors to prescribe antimicrobials appropriately. *Therapeutic guidelines: Antibiotic* provides advice on managing almost 200 unique infections, almost half of which are treated in primary care. Work on an update – the most complex yet – is underway, with the first topics scheduled for publication later this year.

Content

The *Fourth Australian report on antimicrobial use and resistance in human health: AURA 2021* identified ongoing high rates of inappropriate antimicrobial prescribing for common infections (eg bronchitis, tonsillitis, otitis media). Multiple factors are suggested to contribute to this problem, including patient expectations, limited time, diagnostic uncertainty and general practitioner (GP) attitudes and beliefs about antimicrobial resistance (AMR).

To support appropriate prescribing in primary care, the update to *Therapeutic guidelines: Antibiotic* includes a dedicated stream of work to address infections treated in primary care. GP representation on the group has increased fourfold. In recognition of the broad spectrum of care delivered in general practice, GP representatives will also be involved in other streams of work (eg the stream addressing infections usually treated in hospital). Approximately 100 experts will be involved across the six streams of work, which will be staggered over two years. Streams with related content will have periods of overlap to support consistency.

These changes are part of broader efforts to move to a living guidelines model, whereby seminal changes in evidence or clinical practice prompt review to update the guidelines between full guideline reviews.

In preparation for the update, almost 500 items of unsolicited feedback were reviewed. Additional feedback (eg usage patterns, potential gaps in guideline content) was solicited from the Therapeutic Guidelines evaluation network, which includes many GP users.

Goals

For GPs to understand the steps being taken to support appropriate antimicrobial prescribing in the update to *Therapeutic guidelines: Antibiotic*.

Providing clear referral pathways to support for pregnancy loss parents

Mrs Samantha Payne

The Pink Elephants Support Network

Aim

To raise awareness of the need to ensure clear referral pathways for bereaved parents who have lost their baby during pregnancy.

Content

Pink Elephants can speak briefly and succinctly to the evidence around miscarriage being a traumatic event which, if left unsupported, can lead to poor mental health outcomes. We can speak to internal qualitative research where women shared what they want from their GP when experiencing the loss of their baby and subsequent pregnancy after loss.

Sam Payne, our CEO, can highlight our top-level support options, the evaluation of them and the moderation of our circle of support.

Goal

To increase knowledge of Pink Elephants as a clear referral pathway for patients experiencing a pregnancy loss.

Relationships still matter, but health information technology is changing them!

A/Prof Christopher Pearce[1], Elizabeth Toll[2], Shmuel Reis[3]

[1]Aurora Primary Care Research Institute, [2]Brown University, Rhode Island, [3]The Hebrew University of Jerusalem

The advance of digital medicine over two decades has been as transformative as the introduction of the scientific method in the 1800s or the rise of science in the 1950s. Digital healthcare now pervades every aspect of medicine – starting with the patient–physician relationship – and encompassing all diagnostics, procedures and patient data. Computers and electronic health records (EHRs) offer instant access to patient records, decision support and informatics, and increasingly facilitate remote communication and care, all advanced by the pandemic.

This technological explosion has shifted many relationship paradigms. The former patient–physician dyad is now the patient–physician–EHR triad, and Artificial Intelligence may well be similarly transformative. Data itself has a life beyond the patient. Team-based care, shared decision making, patients accessing clinical data and other information and privacy concerns are all changing patient–practitioner power dynamics. Modalities like telehealth, remote monitoring, smartphone applications, SMS texting and robots are redefining trust to include not only humans, but also health information technology (HIT).

These changes are redefining relationship aspects of care. What have we gained and lost in this rapid transformation? How can we prepare current and future physicians for this evolving landscape? Training methods based on old models are no longer adequate.

The presenters have spent many years conceptualising, researching and teaching about these changes, including participation in three international conferences on the subject. In this session they will share their experience and ideas about educating current and future generations to balance human relationships and HIT, maximising the benefits of both while minimising adverse effects of rapid change. They will summarise the current state of research and present practical methods to prioritise human relationships while integrating the best of HIT.

APHT: The WHO Air Pollution and Health Training toolkit for health workers

Dr Samantha Pegoraro

Technical Officer, Air Quality and Health Unit, Department of Environment, Climate Change and Health, World Health Organization

Air pollution is a major environmental health threat and one of the main risk factors for non-communicable diseases. Globally, air pollution is responsible for about seven million premature deaths per year due to ischaemic heart disease, stroke, chronic obstructive pulmonary disease and lung cancer, but also from acute lower respiratory tract infections.

While health workers are often not aware of the health impacts of air pollution, the international community recently recognised that they should play a more prominent role in the battle for clean air. Mandated by its member states, WHO is developing the Air Pollution and Health Training (APHT) toolkit for health workers.

The APHT toolkit is a set of materials designed to enable health workers, in both the clinical and public health fields, to understand health risks of air pollution, identify risk reduction measures and use the health argument to advocate for clean air interventions and promote the collaboration between civil society relevant actors, political parties and institutions for policy implementation. Using a 'train the trainers' approach, the APHT toolkit also helps facilitate the organisation of in-person workshops, online courses and other learning opportunities.

Main elements:

- 12+ training modules
- training-the-trainer manual
- clinical case scenarios
- job aids and flipcharts for community engagement.
- For more information: https://www.who.int/activities/capacity-building-and-training-materials

Air Pollution and health: From evidence to clinical practice and community interventions

Dr Samantha Pegoraro[1], A/Prof Alan Abelsohn[2], A/Prof Ozden Gokdemir[4], Prof Enrique Falceto de Barros[3]

[1]Technical Officer, Air Quality and Health Unit Department of Environment, Climate Change and Health, World Health Organization, [2]University of Toronto, Canada Department of Family and Community Medicine, University of Toronto, 2 Dalla lana School of Public Health, University of Toronto, [3]Instituto de Ciências Básicas da Saúde-Programa de Pós Graduação de Educação em Ciências, Universidade Federal do Rio Grande do Sul, Porto Alegre, [4]Associate Professor Izmir University of Economics, Faculty of Medicine

You are a family doctor and a young girl has been seeing you with frequently recurring asthma attacks. Would you consider air pollution as a potential risk factor in your patient assessment? What questions would you ask to further explore this? Which tools might you use to better understand whether air pollution contributes to her symptoms? How would you advise her to reduce her risk?

Air pollution is the greatest environmental risk to public health through the life course and one of the five top risk factors for non-communicable diseases. The World Health Organization estimates that about seven million deaths annually are attributable to both ambient and household air pollution and that 99% of people worldwide are exposed to harmful levels of air pollution.

Air pollution contributes significantly to the onset, exacerbation and progression of common diseases seen in primary healthcare, including heart disease, stroke, chronic obstructive pulmonary disease (COPD), lung cancer, pneumonia, asthma and cataract. Increasing evidence is also showing associations between air pollution and other health outcomes, like low birth weight, diabetes, cognitive impairment and even mental health.

This session will present the evidence linking air pollution with health outcomes and its underlying biological mechanisms, and guide family doctors in identifying where exposures happen, who are the at-risk patients and developing clinical skills, advocacy actions and community interventions to reduce air pollution exposures for disease prevention and health promotion.

The session will be based on the WHO Air Pollution and Health Training toolkit (APHT) for health workers and the WONCA Working Party on the Environment's Train-the-trainer program on air pollution, climate change and health.

More information at:

- https://www.who.int/news/item/14-09-2022-who-trains-health-workers-in-ghana-on-air-pollution-and-health
- https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(22)00218-2/fulltext?dgcid=raven_jbs_etoc_email

Pellegrini optimum place for care (POPC) framework: A discussion of therapeutic reasoning of rural generalists and GPs providing emergency care

Dr Daniel Pellegrini, Dr James Padley

Adelaide Rural Clinical School

Background/aims

Clinical reasoning can be considered to be made up of two separate but parallel processes: diagnostic and therapeutic. Diagnostic reasoning is primarily concerned with information gathering, which enables the clinician to form a differential diagnosis. Secondly, and perhaps more importantly in rural and remote settings, therapeutic reasoning takes into account the management options, the context in which treatment occurs and the likely therapeutic trajectory, as well as social and ethical considerations. In order to uncover the cognitive processes occurring when rural clinicians are treating patients in remote settings with limited resources and deciding on optimal place for care, we developed a framework using a rural emergency simulation exercise. The goal of this interactive workshop is to discuss and further define the framework and its utility for teaching clinical learners.

Methods

The Pellegrini optimal place for care (POPC) framework will be presented, with a brief discussion of the methodology. Attendees will break into small groups where they will consider a rural clinical scenario and discuss therapeutic reasoning using the POPC framework as scaffolding. The exercise will conclude with mini presentations from the groups and summaries from the clinical presenters

Outcome

Attendees will gain insight into the cognitive processes underlying therapeutic reasoning of rural generalists and GPs providing emergency care and provide pedagogical approaches to teaching clinical reasoning skills for medical students and junior doctors.

Climate change is impacting our patient's health more and more: How can we teach about it in family practice?

Dr Catherine Pendrey[1,2,3,4,5], Prof Enrique Falceto de Barros[6,7,8,9,15], Dr Laura Beaton[5,10,11], Wendy Connor[5,12,13], A/Prof Ozden Gokdemir[14,15,16], Christian L Lokotola[17], Julian Cassar[4,5], Dr Christie Rodda[4,5,17]

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Background

The World Health Organization has declared that 'Climate change is the greatest threat of the 21st century.' Indeed, the impacts of climate change and environmental unsustainability are more and more evident every day in the practice of family medicine. Extreme heat, air pollution, extreme weather events and vector-borne diseases have a range of physical and mental health consequences across the full life spectrum. For many conditions, especially non-communicable diseases, increasing focus on preventative strategies (including diet and exercise) has benefits for human and environmental health. To adapt to these changes, family doctors and medical educators need to become familiar with how to treat and teach about new and evolving clinical presentations and modifiable risk factors. In response to these changes, medical education is adapting to incorporate climate change and health and more broadly, planetary health, into medical education.

Objectives

- To enable participants to become familiar with resources relevant to support the delivery of medical education addressing climate change and planetary health.
- To provide participants an opportunity to practice developing educational activities on common presentations relevant to climate change and planetary health.

Content

This session will begin with a presentation-style overview of common clinical presentations affected by climate change and recently developed medical education resources addressing climate change and planetary health.

- Participants will then move into small groups where, supported by a facilitator, they will have the opportunity to use these resources to develop a mini teaching session on one of these presentations, such as heat-related illness, air pollution and respiratory disease, effects of extreme heat and air pollution on pregnancy, Japanese encephalitis, eco-anxiety and planetary health co-benefits.
- Participants will have the opportunity to reflect on their experience, share learnings and provide feedback on their experience.

The role of higher education institutions to support primary palliative care education in LMICs: Online workshop report

Mr Teguh Kristian Perdamaian, David Fearon, Liz Grant

The University of Edinburgh

Background

Integration of palliative care into a national primary healthcare system would need an adequate skilled workforce, especially in low- and middle-income countries. Higher education institutions (HEI) have a strategic position to support the demand of primary palliative care practitioners directly, through development of palliative care education in various levels, and indirectly, through collaboration and coordination with other established institutions which are involved in palliative care education.

Methods

An international workshop was conducted to explore the role of HEIs in supporting each country to achieve the sufficient and high-quality palliative workforce, especially in primary care setting. This workshop was led by international experts from the WHO, universities and organisation representing several low- and middle- income countries, and attended by international participants with various backgrounds who work or are interested in primary palliative care.

Results and discussion

General key themes arising from the workshop discussion were accessibility of palliative care education, multi-institutional collaboration and interprofessional approach to palliative care education. Accessibility and collaboration mostly needed to support primary care practitioners who work in government sectors and in remote areas. Regarding the interprofessional nature of primary healthcare system in most LMICs, the palliative care education should consider to involve interprofessional approach as well. In the future, this workshop hopefully can explore the possibility of developing an international network to collaborate to advance the role of HEIs in supporting palliative care education in LMICs.

Opportunities for remote patient monitoring in aged care

Dr Silvia Pfeiffer

Coviu

Chronic illness is returning to the spotlight as the main challenge for our healthcare system. Data shows almost one in two Australians suffers from a chronic disease (Australian Bureau of Statistics).

Technology was the answer to the pandemic and will be the answer to chronic illness. Through remote patient monitoring (RPM), we are able to support chronically ill elderly patients in their daily lives.

Studies have demonstrated that the use of a mobile app-based RPM solution can save about 40% time in reviewing patient status. That represents a chance for an increase in productivity in aged care and outpatient clinics. In addition, RPM is a scalable solution, allowing practitioners to be proactive about treating symptoms before they escalate and patients to self-report data over time.

The reimbursement model for RPM/RTM (remote therapeutic monitoring) in the United States is instructive and has recently expanded to include provision under general supervision. It covers the initial enrolment of the patient and provides a base monthly payment for monitoring patient data. Furthermore, Medicare provides payments for communicating with the patient about the transmitted data and their care management plan.

In Australia, we only provide reimbursements for two specific procedures: implanted echocardiogram loop recording for heart rhythm monitoring and pacemakers. There is no reimbursement for physiological monitoring, such as weight and blood pressure, or mental health monitoring.

This presentation will discuss the need for RPM in aged care to manage chronic conditions with ongoing physiological and mental health monitoring as part of digital care pathways that also provide information material and PREMs and PROMs measures. It will contrast international examples of reimbursements for RPM in aged care and the lack thereof in Australia, discussing the need for incentives encouraging adoption of RPM in aged care.

Telehealth and safety-making by clinicians and patients in primary care

Prof Christine Phillips, Prof Sally Hall-Dygraaf, Anne Parkinson, Prof Kirsty Douglas, Jane Desborough, Dr Danielle Butler, Jasmine Lykissas, Korda Rosemary

Australian National University

Australia introduced widespread telehealth reimbursement into general practice in a series of policy innovations in 2020, in response to the COVID-19 pandemic. This innovation presented an opportunity to study in real time the challenges and strategies used by clinicians and patients to achieve good consultation outcomes as they develop skills and familiarity with telehealth. A particular concern, frequently raised around telehealth, is how safe clinical decision making and care provision can be ensured in the remote consultation setting.

This interactive roundtable focuses on challenges negotiating availability, accessibility and safety to deliver quality primary care within episodes of patient care. The roundtable aims to sense-check findings from the Australian National University Telehealth in Primary Care study, which includes quantitative analysis of linked administrative data, think-aloud interviews with clinicians and deliberative workshops with consumers.

After presentation of findings, participants will engage in a set of facilitated, interactive, gamified consultations using simulated patient scenarios that pose quality and safety challenges in the context of remote consultations. Participants will variously take the role of the clinician and the patient, to explore negotiating strategies to support safety, such as safety-netting, distant monitoring and mode switching, in a range of clinical situations and for clinical conditions. The discussions around these strategies will be used to further clarify and seek consensus on ways to optimise safety-making in telehealth consultations.

Rare diseases and the dilemma of diagnosis in primary care

Prof Christine Phillips, Anne Parkinson, Jane Desborough, Tergel Namsrai

Australian National University

Rare diseases present a notorious diagnostic dilemma in primary care. They often present with symptoms attributable to common conditions or with polysemic symptoms such as fatigue or pain. Clinicians must weigh up the risks of untoward or unnecessary use of resources against the risk of delayed diagnosis of a rare disease. This study aimed to identify whether earlier diagnosis of rare diseases might be possible without overinvestigation and waste of resources. Journey mapping was conducted with 26 people (10 with sarcoidosis, eight with myositis and eight with primary immune deficiency). These were used to develop think-aloud interviews with primary care clinicians, specialists in a discipline relevant to the condition and nurses to identify. While each disease has a prediagnosis period, prolonged delay is often associated with a state of normalisation, in which the symptoms become part of everyday life for the patient, and unremarkable to the clinician. Coming to a diagnosis often involves the patient relabelling their symptoms as pathological and the clinician reviewing, or seeking review, of a historical diagnosis which may not fit the present reality of the patient's symptoms. A persistent change in the pattern or degree of symptoms, particularly when they impact on normal life activities, often triggers clinicians to reassess. This study suggests that attitudes of mind – such as persistence, preparedness to reflect upon and/or seek review of a patient and patient-centredness – are more important than knowledge of the particular rare diseases in reaching a diagnosis.

Primary healthcare is essential for health security and securing health

Prof Robert Phillips[1], Prof Chris van Weel[2], Dr Anna Stavdal[3], Prof Claire Jackson[4], Akin Moses[5]

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Primary healthcare aims to support whole-person and community health by integrating primary care with behavioural health, public health, population health and other functions fundamental to health. Achieving primary healthcare requires a solid foundation of primary care, and this foundation is actively eroding in most countries. This professional forum will be a panel presentation about the unique and common problems facing primary care, examples of efforts to repair and enhance primary care and opportunities for the international community to share solutions and innovations. Particular attention will be given to how WONCA can help lead.

- The United States is, for the first time, creating a federal infrastructure to support primary care strategies for its most pressing health problems. It starts this effort well behind most other developed countries. The success of this effort will depend on its ability to translate intention into policy and infrastructure.
- Australia's Primary Healthcare 10 Year Plan released in March 2022 still awaits an implementation strategy and budget, despite the current crisis in GP workforce numbers and funding. This forum will explore with participants important priorities for general practice in the adoption of key elements.
- In addition to securing health around the world, primary healthcare is essential to health security. How we identify and respond to pandemics, how we resolve widespread health disparities, how we prevent weaponized biologics from spreading rapidly.

Challenges for COVID-19 vaccination delivery and data interoperability in smaller independent primary care practices

Prof Robert Phillips[1], Shiying Hao[2], David Rehkopf[2], Esther Velasquez[2]

[1]The Center for Professionalism and Value in Health Care, American Board of Family Medicine Foundation, [2]Stanford University

Context
Initial US COVID-19 strategy relied on mass vaccination campaigns and many primary care practices were also unable to reliably receive vaccination data.

Objective
Test the hypothesis that between the lack of inclusion of primary care in a national vaccination strategy and the lack of vaccine data interoperability, the primary care practices were unable to vaccinate or know patient vaccination status.

Study design
Cross-sectional analyses of COVID-19 vaccination status captured in practices from 1 December 2020 to 31 December 2021. Patients were aggregated by month by dates of first doses and patient counts in each month to compare cumulative counts between administration sites. We compared practice vaccination rates to vaccination rates reported by Centers for Disease Control and Prevention (CDC) for the county of practice location.

Setting
We used data from the CDC and the American Family Cohort dataset (EHR data from 947 practices).

Population Studied
Patients aged five or older who visited or had immunisation reported to practices. Vaccination status and administration were assessed using COVID-19 vaccine CPT, RXNorm, ICD, SNOMED CT, CVX, HCPCS and free text.

Outcome measures
Practice vaccination rate calculated as the number of patients who received at least one dose divided by the total number of patients who had visits or had immunisation recorded during the study period.

Results
In all, 539 (57%) practices gave a COVID-19 vaccine or captured patient vaccination status. Of the 1,838,936 patients who visited practices, 435,112 (23.7%) had at least one dose of vaccine, but only 89,423 (4.9%) were vaccinated in practices; 60% of patients were vaccinated in the first quarter of 2021 or prior. The CDC reported higher vaccination rates for the same counties.

Conclusions
PRIME Registry practices were generally unable to provide COVID-19 vaccine or capture vaccination status through the end of 2021 due to an absence of a primary care vaccination strategy combined with poor immunisation data exchange.

HEAD-MIP – HEAlth Dialogues for patients with Mental Illness in Primary care: A feasibility study

Dr Miriam Pikkemaat[1], Veronica Milos Nymberg[1], Susanna Calling[1], Peter Nymberg[2]

[1]Center for Primary Health Care Research, Department for Clinical Sciences, Lund University, Malmö, [2]School of Health and Welfare, Halmstad University, Halmstad, Sweden

Background

Patients with mental illness have an increased risk of cardiovascular morbidity and mortality, which is partly related to unhealthy lifestyle habits. To individualise lifestyle counselling in primary care, the Swedish-developed Health Dialogue (HD) can be used as an educative tool at recurrent measurement points with the goal to improve non-healthy lifestyle habits. HD has not been aimed specifically at patients with mental illness, and the effect of a systematic approach with repeated HDs in patients with mental illness in primary care has not been previously studied.

Aim

The aim of this pilot study was to assess the feasibility of the study design for a larger-scale study using repeated HDs focused on the improvement of lifestyle habits in patients seeking primary care due to anxiety, depression, sleeping problems or stress-related symptoms.

Methods

Patients were recruited after a visit to a primary health care centre due to mental illness between 2019 and 2021 and underwent an HD, including an assessment of cardiovascular risk factors through a Health Curve. Specific feasibility objectives measured were dropout rate, time to follow-up and risk improvement rate for different lifestyle habits.

Results

Sixty-four patients were recruited at baseline, and all participants had at least one elevated cardiovascular risk level on the Health Curve for the assessed lifestyles. Twenty-nine (45%) attended a second HD, with a mean follow-up time of 15 months.

More than 10% of the participants improved their risk levels for any of the lifestyle areas, except for tobacco use.

Conclusion

Despite a higher dropout rate than expected, we suggest that the proposed methodology for a full cohort study within general practice of patients with mental illness in primary care is both acceptable to practices and feasible.

Collaborative goal setting for diabetes self-management in general practice

A/Prof Janani Pinidiyapathirage[1,2], Dr Kay Brumpton[1,2], Dr Robert Heffernan[1,2], Eesha Bajra[1,2], Lisa Maree Mathison[1,2], Thedini Pinidiyapathirage[1,3], Sherrilyn Walters[1], Kylie Vuong[2], Dr Hannah Woodall[1,2]

[1]Rural Medical Education Australia, [2]School of Medicine and Dentistry, Griffith University, [3]School of Medicine, Monash University

Introduction

Many people living with type 2 diabetes (T2D) do not achieve optimal diabetes management goals. This discrepancy has led to the need to identify innovative and effective self-management support for patients with T2D presenting to general practice (GP) where the majority of T2D diagnosis and management occurs. The aim of this study was to understand the complexity of self-management goal setting in patients with T2D presenting to GP by evaluating current goal-setting practices.

Methods

Using a previously validated diabetes goal-setting evaluation tool (GET-D), quality of goal setting was assessed among T2D patients presenting to selected mainstream and Aboriginal GP services in a regional Australian setting. Data on goals and action plans over two time points during an 18-month period were extracted from patient records for analysis. Changes in goal attainment scale (GAS) over time were prospectively assessed in a subset of the sample by the treating general practitioners.

Results

Of the 218 patient records examined during the preliminary analysis, on average six other comorbid chronic conditions were reported per patient. Most patients had complex care plans with evidence-based goals routinely documented (mean number of goals = 11); however, appropriate application of these goals to ensure patient-centredness was not always evident in management plans (mean GET-D score = 13; 26 points possible). The change in GAS score ranged from 0 to 54, with a mean of 37 (SD = 14; a score of 50 indicating the goal was achieved as expected).

Conclusion

The documentation of individual patient attributes and abilities into evidence-based goals and action plans is not routine in general practice. Complex templates used for GP management plans, time constraints and limited practitioner skills are likely barriers encountered in this process. Simple, user-friendly, less time intensive resources could provide both the patients and the clinicians with effective, person-centred diabetes self-management support.

Demystifying gender-affirming care: The critical role of GPs in providing care for transgender patients

Dr Portia Predny[1,2,3,4], Emerson Osterberg[1,2,3,5]

[1]Loveberg Consulting, [2]AusPATH (Australian Professional Association for Trans Health), [3]PATHA (Professional Association of Trans Health Aotearoa), [4]Dr Portia Predny Pty. Ltd., [5]HMHK Psychology

Gender-affirming care lies firmly within the scope of general practice and family medicine.

General practitioners (GPs) and family physicians have the necessary skills and knowledge required to provide high-quality gender-affirming care to transgender patients; however, many practitioners feel they do not have the confidence or experience to do this. This creates barriers for patients, and limits their access to care.

This session strengthens knowledge and confidence in the provision of quality medical care and gender-affirming treatments for the transgender community. Underpinned by principles of the informed consent model of care, an understanding will be developed of issues and barriers faced by the transgender community and how GPs and family physicians can be a professional, safe and vital part of their medical team.

This session builds empathy and understanding of the diverse experiences of the transgender community, building the capability of GPs to be vital advocates and allies, and positioning transgender healthcare as a human rights issue.

Best practice palliative care: National palliative care standards for all health professionals and aged care services

Dimity Pond[1], Miss Isabel Schibig[2]

[1]The Royal Australian College of General Practitioners (RACGP), [2]Palliative Care Australia

Aim

Australia's national peak body for palliative care developed the *National palliative care standards for all health professionals and aged care services* (the Standards). The organisation is recognised internationally as a producer of high-quality standards for palliative care. The Standards are aimed at general practitioners (GPs) and those working in primary care, to guide best practice delivery of palliative care. The presentation will outline the importance of the Standards to GPs.

Content

The presenters will begin by outlining the context. Access to quality palliative care is a global problem. The estimated demand for palliative care in Australia is expected to increase by 50% between now and 2035, and double by 2050. General practitioner clinical input will be vital into the future.

The presenters will outline key elements of the Standards. A focus of the presentation will be under-served and vulnerable population groups who experience barriers to accessing quality palliative care, including, but not limited to, Aboriginal and Torres Strait Islander peoples, chronically ill, aged, people experiencing socioeconomic disadvantage and those in rural and remote areas.

The Standards were developed by experts from a range of backgrounds, and as such have broad, practical application and can improve delivery of quality palliative care in non-specialist settings. The nine standards and 67 elements outline best-practice palliative care in simple and descriptive terms. The Standards seek to encourage innovative and adaptive approaches to increase access and promote high-quality palliative care for all Australians.

Goals

The presentation will acquaint the audience with the Standards. The Standards will improve access to palliative care for all Australians through better understanding of palliative care and its delivery by all health professionals across non-specialist palliative care settings. This will improve the quality of palliative care delivered by GPs into the future.

Identification and management of abuse in older people with cognitive impairment

Prof Constance Dimity Pond[1], Prof Jinan Usta[2], A/Prof Nena Kopčavar Guček[3], Prof Sajaratulnisah Othman[4], Dr Wei-May Su[5], Dr Raquel Gómez Bravo[6], Elizabeth Hindmarsh[7], Prof Amanda Barnard[8], Dr Hagit Dascal-Weichhendler[9], Fadzilah Hanum[4]

[1]Western Sydney University, [2]American University of Beirut, [3]University of Ljubljana, [4]University of Malaya, [5]Health Education Training Unit, [6]Andalusian School of Public Health, [7]Safer Families Centre, [8]Australian National University, [9]Ruth and Bruce Rappaport Faculty of Medicine, Technion

This submission is a joint submission between SIG Ageing and Health and SIG Social Prescribing. It is not the main SIG Ageing and Health submission.

Aim

To identify best practice in identification and management of the abuse of older people who are living with cognitive impairment or dementia.

Background

The demographic transition means that in most countries there are now increasing numbers of older people. As cognitive impairment and dementia are more prevalent in the older population, this means that there are increasing numbers of the population with these conditions. Guidelines around family abuse and violence need to identify ways in which abuse can be identified and managed in the presence of cognitive impairment.

Content

Jinan Usta (SIG Ageing and Health) will present a case study involving abuse of an older person with cognitive impairment and raise a number of issues that arise from this for discussion.

Speakers from the SIG Family Violence will present a case of family violence in the presence of dementia which involves cultural issues for discussion.

Following the presentations, attendees will be invited to join tables for discussion of these two cases.

A plenary will follow in which table discussion points will be presented and further discussed.

Goals

To develop some recommendations which may inform clinical guidance around the topic of abuse of older people who have cognitive impairment.

Social prescribing: New paradigms for meeting the needs of older patients

Prof Constance Dimity Pond[1], Louise Robinson[2], A/Prof Kheng Hock Lee[3], Prof Joyce Kenkre[4], Mohd Fairuz Ali[5], Ferdinando Petrazzuoli[6], Juan Mendive[7]

[1]Western Sydney University, [2]University of Newcastle, [3]SingHealth, [4]University of South Wales, [5]Universiti Kebangsaan Malaysia, [6]University of Naples, [7]La Mina Primary Care Centre Barcelona

Note: This is the official presentation for WONCA SIG Ageing and Health.

Aim

To explore the ways in which social prescribing programs work in a range of countries, in particular for the needs of older patients

Background

Older patients would benefit from better integration between their medical and social care. Social prescribing is a term used to describe the provision of social care, which is seen as addressing the social determinants of health, and may be prescribed by a medical practice. However, such schemes can be challenging because of the complex and wide-ranging issues they seek to address. There is as yet no generally accepted evaluation for such projects. The SIG Ageing and Health has collaborated with the new SIG Social Prescribing to present this workshop.

Content

A series of short presentations will explore models of social prescribing in a range of countries. Louise Robinson will present a review of the outcome measures used to evaluate social care, Lee Kheng Hock will present on development of a competency framework for family physicians in social prescribing and Joyce Kenkre will present on collaboration in social prescribing, across communities, health systems and cultures.

Following the presentations, attendees will be invited to join tables for discussion about how these presentations and models might be adapted to their own practices.

A plenary will follow in which table findings will be presented and further discussed.

Goals

To explore a range of models for social prescribing that attendees could take back to their home countries for further development and adaptation to their local environment.

New Australian guidelines for the appropriate use of psychotropic medications in people living with dementia and in residential aged care

Ms Brooke Blakeley[1], Michelle Steeper[1], Darshna Goordeen[1], Mouna Sawan[2], Dimity Pond[3], Malcolm Clark[4], Susan Kurrle[2], Velandai Srikanth[1], Christopher Etherton-Beer[5], Dina LoGiudice[4], Ravi Bhat[4], Andrew Stafford[6], Tuan Nguyen[4], Julia Gilmartin-Thomas[7], Davina Porock[8], Alison Kitson[9], Leanne Jack[10], Jane Thompson, Susan Field[11], Terry Haines[1], Sue Brennan[1,12], Sarah Hilmer[2], Simon Bell[1]

[1]Monash University, [2]The University of Sydney, [3]The University of Newcastle, [4]The University of Melbourne, [5]The University of Western Australia, [6]Curtin University, [7]Victoria University, [8]Edith Cowan University, [9]Flinders University, [10]Central Queensland University, [11]The University of New England, [12]Cochrane Australia

Aim

To describe Australia's new clinical practice guidelines for the appropriate use of psychotropic medications in people living with dementia and in residential aged care (the Guidelines).

Content

Australia's Royal Commission into Aged Care Quality and Safety highlighted an over-reliance on psychotropic medications for chemical restraint. An 18-member multidisciplinary guideline development group (GDG) was convened to develop new guidelines. The Guidelines outline best practice for initiating, monitoring and discontinuing antipsychotics, benzodiazepines and antidepressants. Guideline development followed the National Health and Medical Research Council process. When formulating recommendations, the GDG considered the balance of benefits and harms, certainty of evidence, preferences and values of people living with dementia, carers and families, resources, equity, acceptability and feasibility. The Guidelines contain 15 conditional recommendations and 49 good practice statements. The Guidelines highlight the importance of facilitating the active involvement of people living with dementia in decision making. General practitioners (GPs) should identify and document target symptoms and anticipated treatment outcomes, complete an individual harm–benefit analysis and ensure informed consent is obtained from the person living with dementia and/or their substitute decision maker. The Guidelines support GPs by providing guidance in relation to monitoring treatment effectiveness and adverse events and implementing discontinuation strategies. Following antipsychotic discontinuation, GPs should seek advice from a psychiatrist, geriatrician, outreach team or behavioural advisory service if recurrent symptoms are not adequately treated with other measures. The Guidelines recommend against the routine use of pro re nata (PRN) antipsychotics and benzodiazepines.

Goals

The Guidelines outline steps for GPs when initiating, monitoring and discontinuing psychotropic medications. The Guidelines support GPs to regularly assess the balance of harms and benefits of psychotropic medications, monitor for effectiveness and adverse events and implement discontinuation strategies.

Finding joy in practice after despair: The importance of regaining morale for our patients and for ourselves

Prof David Ponka[1], Dr Francine Lemire[1], Prof Felicity Goodyear-Smith[2], Ichsan Ichsan[3]

[1]The Besrour Centre for Global Family Medicine at The College of Family Physicians of Canada, [2]University of Auckland, [3]Syiah Kuala University

The COVID-19 pandemic has led to unprecedented stress in primary care healthcare providers across the world, with workforce shortages and alarmingly low levels of morale. Many practices are still struggling to deal with the increased workload from delayed consultations, and to address the rising mental health issues in patients responding to the crisis precipitated by the pandemic, consequent changes to their lives, sometimes from devastating loss, and the anxiety of living in uncertain times. In this professional forum we will apply a framework and typology to understand predictors of workplace wellness and joy and explore the meaning of agency. We will give examples of how working in interprofessional teams can share the care of our patients' physical, emotional, social and spiritual health, and how this can help us regain meaning, perspective and joy in our clinical practice. The import of a community if not global perspective will be emphasised – at the very least, family physicians should respond to family dilemmas during the pandemic. We will have a whole-group debrief at the end.

- 10 minutes – Moderator
- 10 minutes – Perspective from Canada and IHI framework
- 10 minutes – Examples of models in NZ that model wellness
- 10 minutes – Regeneration, meaning and joy after devastating loss; social support, happy family and spirituality
- 20 minutes – Discussion

MD in general practice specialty, first postgraduate program at Institute of Medicine and in the country at glance

A/Prof Pratap Narayan Prasad

Tribhuwan University Teaching Hospital

The Institute of Medicine (IOM) was established in mid-July 1972 under the New Education System (NESP).

The IOM started campuses for different grades of health workers, in different parts of the country. The medical course at the IOM was started in 1978. The first batch of IOM's basic community-oriented doctor in 1984. In 1981 the Secretary of Health and Dean of the Institute of Medicine requested the University of Calgary to assist them in resolving the lack of relevant postgraduate medical education in Nepal. Hence, the first postgraduate program in general practice started in 1982 in collaboration with the University of Calgary, Canada.

The goal of the program is to provide the Ministry of Health with well-trained generalist physicians for the hospitals to cope with emergency problems by undertaking lifesaving procedures, diagnosis and in-hospital care, and to provide a wide range of outpatient services with an emphasis on health promotion and disease prevention. This directly contributed to the goals of the Ministry of Health's health policy, as an essential link in primary healthcare.

The program extends over a three-year period and is intensive in nature. The weekly timetable includes daily educational activities, teaching ward rounds and seminars, hands-on patient management and two afternoons reserved for general practice rounds. The curriculum was divided into three years: first year, medical speciality; second year, surgical specialty; and third year, general practice and other subspeciality. In its structure and intent, this program is unique in that it has been specifically designed to train physicians to work in a rural and emergency setting.

Spaced repetition for knowledge retention in a cohort of practicing physicians

Prof David Price[1,2], Ting Wang[1], Thomas O'Neill[1], Warren Newton[1,3]

[1]American Board of Family Medicine, [2]Department of Family Medicine, University of Colorado Anschutz School of Medicine, [3]Department of Family Medicine, University of North Carolina at Chapel Hill

Spaced repeated testing over time results in better long-term knowledge retention than repeated study of the same material. Physicians participating in the low-stakes Continuing Knowledge Self-Assessment (CKSA) receive 25 online questions per quarter. After answering each question, they rate their confidence in their answer before receiving feedback, an educational critique and a list of appropriate references. This study compared the effect of five different spaced repetition strategies on physician knowledge retention and transfer of knowledge from one clinical scenario to another.

In all, 26,255 family physicians (mostly practising, some residents) who completed the CKSA in the fourth quarter of 2020 (baseline period) were eligible for study inclusion. Participants were randomised to a control group or one of five spaced repetition conditions over the subsequent five calendar quarters (1 January 2021 – 31 March 2022). Control group participants received no repeated questions during this time. Participants in the other five groups received up to six questions repeated either once or twice; the interval between repetitions differed between each group.

Incorrectly answered baseline questions were prioritised for spaced repetition – those answered extremely confidently received highest priority, with decreasing priority for those questions answered with lesser degrees of confidence. If necessary, correctly answered questions could then be selected for spaced repetition, with higher priority for questions not answered confidently (eg 'guesses') than those answered more confidently.

In Quarter 6 of the study, all remaining participants received their repeated questions. Participants in spaced repetition groups performed better than those receiving no previous repetition; those who received two prior repetitions performed better than those who received one. There were no substantive differences in performance based on repetition interval in the one-repetition groups or in the two-repetition groups. Results on transfer (assessed in Quarter 8 of the study) are currently being analysed and will be presented.

‘No one prepared me for this’: Introducing a new postpartum support planning template

Dr Rikki Priest[1,2,3], Lucy Gilkes[1], Diane Arnold-Reed[1], Caroline Bulsara[1]

[1]University of Notre Dame, Fremantle, Western Australia, [2]Cockburn Medical Centre, Spearwood, Western Australia, [3]King Edward Memorial Hospital, Subiaco, Western Australia

A group of experts (from a wide range of professions and lived experience experts) have developed a postpartum support planning template and resource through a Delphi method research project. The template represents consensus by the expert group and answers an important question: how can we plan for better support for mothers beyond birth?

This presentation will include narrative story telling of one GP’s experience with using the template in general practice.

Becoming a mother, a transition known as matrescence, is a monumental time in a woman’s life. It is a time that is crowded with new learning, identity shifts, uncertainty, brain and body changes, cognitive changes and relationship changes. Access to support is the cornerstone to the health and wellbeing of mothers during the first three months after birth, a time known as the fourth trimester. Mothers commonly reflect that they felt inadequately prepared for the postpartum period, and many wish that they had spent more time planning for support beyond birth.

The wellbeing of new mothers is intimately entwined with their access to support from others. Lack of social support is an important predictor of postpartum women’s health status. When there is scaffolding around mothers to support them in the fourth trimester, families are equipped with the stepping stones they need to navigate the many challenges of this significant time. Physical health, mental health and identity changes are, at the same time, a common challenge, as well as an opportunity for expansion and growth.

The long-term relationships between general practitioners and families are an opportunity for supporting mothers to prepare and plan for support in the fourth trimester.

Australian haemochromatosis patient register: A collaborative initiative aimed at reshaping health outcomes for people at risk of iron overload

Dr Dianne Prince

Haemochromatosis Australia

This Rapid Impact presentation aims to introduce primary care practitioners to the new Australian national haemochromatosis patient register.

The cloud-based national patient register is designed to reshape patient outcomes by enabling research into the role of iron in a number of related chronic health conditions, including liver disease, arthritis, diabetes and heart conditions, with the ultimate goal of preventing harm from iron overload.

Development of the register is a collaborative initiative of Haemochromatosis Australia (HA), The Council of the Queensland Institute of Medical Research (QIMR Berghofer), Edith Cowan University (ECU), the School of Biomedical Sciences at the Queensland University of Technology (QUT), Australian Red Cross Lifeblood (Lifeblood) and the Hunter Medical Research Institute (HMRI). It is funded by the Australian Department of Health and Aged Care.

The presentation will:

- outline the background to the development of the register
- illustrate the structure of the register
- provide links to support resources for general practitioners and their patients interested in registering.

Association of screen media exposure and burnout among adolescents enrolled in different online curricula in Metro Manila: Analytical cross-sectional study

Mr Jomar Jay Pucan, Yna Paulina Palma, Vittorio Jr Panaguiton, Leo Alfonso Pascua, Jem Kathleen Pel, Peter Jan Pineda, Paul Gregory Polintan, Irene Punzalan

University of the East Ramon Magsaysay Memorial Medical Center – College Of Medicine

Introduction

Due to the COVID-19 pandemic, it became imperative for the education sector to shift to full online curriculum and eventually hybrid education, which utilised both synchronous and asynchronous teaching–learning activities with the use of internet-enabled devices. However, this new educational policy posed several challenges to educators and students, such as increased workload, prolonged screen time and burnout. This study determined the association of online screen media exposure and burnout among adolescent senior high school students enrolled in different online curricula in Metro Manila.

Methods

This analytical cross-sectional study identified adolescent senior high school students from different high schools in Metro Manila who were recruited via non-probability convenience sampling. The level of online screen media exposure was assessed based on the cut off value of four or more hours of internet usage related to online academic work, and participants answered the Copenhagen Burnout Inventory to ascertain the presence or absence of said mental health condition. Data analysis included cross-tabulation for prevalence rate ratio, and Chi-squared tests were used to determine statistical significance.

Results

Of the 117 respondents, most had significant online screen media exposure (88; 75.21%). In relation to the Copenhagen Burnout Inventory, the majority scored less than 50 (66; 56.41%) which comprised those without burnout. The prevalence rate ratio (PRR) was calculated 3.9 (P value 0.002).

Conclusion

Among adolescent senior high school students with significant online screen media exposure of four hours or more, there was 3.9 higher risk of exhibiting burnout symptoms, and this was statistically significant.

Prediabetes progression and regression on objectively measured physical function: A prospective cohort study

Dr Shanhu Qiu[1], Bo Xie[1], Zilin Sun[2], Wenji Chen[1], Tongzhi Wu[3], Xue Cai[4]

[1]Department of General Practice, Zhongda Hospital; Southeast University, [2]Department of Endocrinology, Zhongda Hospital; Institute of Diabetes, School of Medicine, Southeast University, [3]Adelaide Medical School and Centre of Research Excellence (CRE) in Translating Nutritional Science to Good Health, The University of Adelaide, [4]Department of Nursing Management, Zhongda Hospital, Southeast University

Background
Prediabetes leads to declines in physical function in older adults, but the impact of prediabetes progression or regression on physical function is unknown. This study assessed this longitudinal association, with physical function objectively measured by grip strength, walking speed and standing balance, based on the Health and Retirement Study enrolling US adults aged >50 years.

Methods
Participants with prediabetes were followed up for four years to ascertain prediabetes status alteration (maintained, regressed or progressed) and another four years to assess their impacts on physical function. Weak grip strength was defined as <26 kg for men and <16 kg for women; slow walking speed was defined as <0.8 m/s; and poor standing balance was defined as an uncompleted full-tandem standing testing. Logistic and linear regression analyses were performed.

Results
Of the included 1511 participants with prediabetes, 700 maintained as prediabetes, 306 progressed to diabetes and 505 regressed to normoglycaemia over four years. Grip strength and walking speed declined from baseline during the four-year follow-up, regardless of prediabetes status alteration. Compared with prediabetes maintenance, prediabetes progression increased the odds of developing weak grip strength by 89% (95% confidence interval [CI]: 0.04, 2.44) and exhibited larger declines in grip strength by 0.85 kg (95% CI: –1.65, –0.04 kg). However, prediabetes progression was not related to impairments in walking speed or standing balance. Prediabetes regression also did not affect any measures of physical function.

Conclusions
Prediabetes progression accelerates grip strength decline in ageing population, while prediabetes regression may not prevent physical function decline due to ageing.

Primary care and professional integrity

A/Prof Randolph Quaye

Ohio Wesleyan University

Aim

A confluence of forces – an ageing population, increased healthcare costs, improved access to healthcare through innovation in medical technologies, high rates of cancer deaths and demands by patients for more choices and better quality care – have forced some European countries to rethink their healthcare delivery systems.

This paper explores ways to strengthen the role of GPs in the overall healthcare delivery systems in Europe. Much of the debate in healthcare centres on burnout, fragmentation of care and greater financial responsibility undertaken by GPs.

Content

Research data come from a survey randomly distributed to 100 GPs attending the WONCA 2022 conference in London with a return rate of 55%; 61.8% of respondents were male, 30.9% were female. All respondents (100) identified themselves as GPs with more than 70% in the age group of 25–45 years.

Goals

With few exceptions (15%), the majority of respondents reported general satisfaction with their work. Twenty per cent of GPs reported that their practice involved payments in the form of bonus; 71% were opposed to patients paying more as a result of cost containment policy. GPs reported their role as gatekeepers to the healthcare system and they were opposed to market reforms in healthcare. The study is limited by the small sample size and sole reliance on GPs. Nevertheless, understanding how they feel about these issues of cost, medical practice and professional autonomy is critically important.

Feasibility of a text-mediated recall system to increase CVD risk assessment in general practice: Pilot evaluation results

Miss Natalie Raffoul[1], Ms Kerryn Brims[1], Josh Knight[2], Atef Asham[3,4], Julie Anne Mitchell[5], Garry Jennings[1], Dr Carissa Bonner[5]

[1]National Heart Foundation of Australia, [2]Statistically Speaking Consultancy, [3]RACGP Specific Interest Group Cardiology, [4]Baker Heart and Diabetes Institute, [5]University of Sydney, Faculty of Medicine and Health, School of Public Health

Background

Coronary heart disease is the leading cause of death in Australia. National guidelines have recommended regular cardiovascular disease (CVD) risk screening for adults aged 45–74 years without a history of CVD since 2009. Yet one in three Australians eligible for CVD risk assessment does not have up-to-date blood pressure and cholesterol measurements recorded in general practice software. No formal structured population screening programs are currently in place for CVD in Australia. The aim of this study was to test the feasibility of a general practice focused SMS recall system to invite eligible patients for a Heart Health Check.

Methods

Designed as a randomised control trial, approval by the RACGP National Research and Evaluation Ethics Committee, the pilot study recruited 231 eligible general practices, making it one of the largest targeted CVD screening trials of its kind in Australian general practice. Patients eligible for CVD risk assessment were identified using widely used clinical audit tools and a novel SMS recall feature embedded into the software. Eligible patients received a personalised SMS inviting them to see their general practitioner for a Heart Health Check and a link to supporting information and tools. Deidentified baseline and two-month data were extracted via clinical audit software. A survey was administered to 35 intervention general practices.

Results

Intervention practices showed a 14-fold increase in Heart Health Check delivery compared to control. More Heart Health Checks were associated with outer regional/remote regions, larger general practices and less disadvantaged areas. Process evaluation indicated good acceptance of the program by general practice staff.

Conclusion

This study showed that an SMS recall program for Heart Health Checks can be effective and acceptable in Australian general practices in both metropolitan and rural locations.

New Australian guideline and risk calculator for assessing and managing cardiovascular disease risk

Miss Natalie Raffoul[1], Garry Jennings[1], Prof Mark Nelson[2], Ms Lisa Kalman[1], Ms Emily Bradburn[1]

[1]National Heart Foundation of Australia, [2]University of Tasmania

Cardiovascular disease (CVD) is responsible for significant morbidity and premature mortality in Australia. Risk assessment remains fundamental to the primary prevention of CVD and is utilised by general practitioners (GPs) to target pharmacotherapy to individuals who will benefit most.

For the first time in over a decade, Australia's guideline for assessing and managing CVD risk has been updated, incorporating a new CVD risk calculator and updated evidence-based recommendations. The guideline has been developed by the Heart Foundation on behalf of the Australian Chronic Disease Prevention Alliance and with endorsement from The Royal Australian College of General Practitioners (pending at the time of abstract submission). The project has invited extensive consultation and input across nine expert advisory groups consisting of GPs, specialists, epidemiologists and consumers.

This interactive session will facilitate an extended discussion around the key clinical recommendations arising from the guideline, focusing on key changes that should be understood by primary care clinicians. The guideline offers new advice on the target age group for CVD risk assessment and redefined risk categories and treatment thresholds. It also introduces the concept of reclassification factors (including mental health, ethnicity and family history), as well as providing specific advice on pregnancy complications and the communication of risk. Specific recommendations, resources and practice points for First Nations peoples have been embedded throughout the guideline.

The guideline is accompanied by a new Australian CVD risk calculator developed through modification and recalibration of the New Zealand PREDICT equation. Best-practice patient decision aid strategies have been embedded throughout the calculator to facilitate improved communication of risk, and shared decision making between GPs and their patients.

This session will be presented by members of the guideline expert steering group, followed by a live demonstration of the new CVD risk calculator and opportunity for questions and discussions.

Community clinic for sustainable development: Experience from rural Bangladesh

Prof Md Zakiur Rahman

Bangladesh College of General Practitioners

Background

Bangladesh has established more than 13,000 community clinics (CCs) to provide primary healthcare covering a population of around 6000. The inception of CCs in the country has revolutionised the healthcare delivery to reach the doorstep of people. The provision of healthcare through CCs is truly participatory since the community people donate land for building infrastructure and are also involved in the management process. The study was conducted to assess the pattern of public–private partnership in healthcare delivery through participation of community people.

Methods

This quantitative study involving descriptive cross-sectional design included 63 healthcare providers, 2238 service users and 3285 community people as household members. Data were collected by face-to-face interview and reviewing records of CCs with the help of a semistructured questionnaire and checklist respectively. The public–private partnership was assessed in this particular study by finding community participation in different activities of CCs. Data were analysed using descriptive statistics.

Results

Almost all (96.9%) CCs are located in easy-to-reach areas having good infrastructure. The security of most of the CCs (93.7%) is maintained by community people. Community groups (CGs) of 88.9% and community support groups (CSGs) of 96.8% CCs are found to be active. In most of the CCs (98.4%), monitoring is done by analysis of monthly reports. All CCs provide referral services for pregnant women. Healthcare delivery is found to be 'good' in more than three-quarters, while health education service is 'good' in 96.7%. Benefits of CCs as perceived by service users included free drugs (82.1%) and free treatment (81.2%).

Conclusion

Public–private partnership in primary healthcare delivery through community clinics ultimately plays a crucial role in the sustainable development of community health by providing quality healthcare. The study recommends public–private partnership for strengthening CCs.

Effectiveness of strategies to improve statin adherence among patients at risk of cardiovascular diseases

Miss Shagoofa Rakhshanda, E/Prof Siaw-Teng Liaw, Jitendra Jonnagaddala, A/Prof Joel Rhee, Kerry-Anne Rye

University Of New South Wales

Statins are a group of lipid/cholesterol-lowering medications that are commonly used for primary and secondary prevention of cardiovascular diseases (CVD). In Australia, this is the first line of pharmacological therapy for CVD risk management. High-risk patients who do not adhere to lipid-modifying medicines have an increased risk of CVD mortality, hospitalisation and revascularisation. However, studies show that 67% of patients are non-adherent to statins. As such, improving statin adherence through various strategies is very important. This systematic review delves into the studies from the past 10 years to identify the effectiveness of various strategies to improve statin adherence, and how the effectiveness changes in people with a higher risk of CVD (in primary prevention) or in those who are taking statins as secondary prevention.

The review will include intervention studies with the adult (≥18 years) population, who were prescribed statin drugs as primary prevention for CVDs. Qualitative studies, reviews, narrative reviews, systematic reviews, meta-analyses, pharmacological and biochemical studies, animal model studies, conference abstracts, conference proceedings and theses/dissertations will not be included in this systematic review. The electronic databases MEDLINE (PubMed), SCOPUS, EMBASE and CINAHL will be searched between 1 January 2013 (World Wide Web live/onset) and December 2023. Two keyword groups (medication adherence and intervention studies) have been identified, followed by the development of search syntax based on the keyword groups. During the initial search, 1081 articles were found through the PubMed database and 1738 articles were found through the EMBASE database. The quality of the included studies will be assessed using the ROBINS-I, ROB 2.0 and the Newcastle–Ottawa Scale (NOS) tools. A random effects model will be used to pool data where appropriate. Heterogeneity will be assessed using Chi-squared and I-squared statistics. The results will be reported using PRISMA standards and flow diagrams.

CPD for rural and remote family doctors: Today's challenge, tomorrow's reality

Dr Sankha Randenikumara[1], Prof Valerie Wass[2]

[1]WONCA Young Doctors' Movements, [2]WONCA Working Party on Education

Background and purpose

Family doctors (FDs) are responsible for recognising and managing a wide range of health conditions, including the provision of emergency services, in the community. They must keep up to date with knowledge, skills and healthcare developments throughout their careers. Lifelong learning can be achieved by participating in continuing professional development (CPD) activities. Rural and remote FDs face many challenges, especially in low- and middle-income countries (LMICs). Yet CPD activities mainly take place in urban settings.

This workshop aims to identify the challenges experienced by rural and remote FDs in CPD and explore strategies to overcome these.

Methods

Workshop will be interactive with presentations and group exercises. The challenges faced by rural and remote FDs when participating in CPD programs in different countries will be identified by group discussion facilitated by the authors. Identified challenges will be recorded. The same groups will brainstorm possible solutions and share best practice. Facilitators will summarise the conclusions and discuss the way forward.

Outcome

This workshop will reveal the challenges faced in relation to CPD for FDs in rural and remote areas. Identifying the issues and new strategies to overcome them and sharing LMICs' experiences will bring the rural perspective to the WONCA CPD standards.

Conclusion

CPD activities should be made available for all FDs regardless of their location. Identifying challenges encountered by the FDs in CPD in rural and remote areas, especially in LMICs, and suggesting practical solutions will be important in maintaining health equity.

How will a potential lung cancer screening program impact on primary care providers and patients?

A/Prof Nicole Rankin[1], Jon Emery[1], A/Prof Joel Rhee[2], Emily Stone[2,3]

[1]The University of Melbourne, [2]University of New South Wales, [3]St Vincent's Hospital

Lung cancer significantly impacts the Australian population with nearly 14,000 cases diagnosed annually. Lung cancer screening (LCS) has demonstrated clinical effectiveness, both reducing mortality and detecting early-stage disease, based on the results of two landmark trials using low-dose computed tomography. The implementation of LCS programs is complex and presents a significant challenge for healthcare systems globally. In Australia, implementation of a potential national LCS program has been supported by scoping work undertaken by government policy makers and researchers. In October 2022, the Australian Medical Services Advisory Committee (MSAC) recommended funding a national program and government endorsement is eagerly awaited. Internationally, there is widespread interest in LCS programs but the challenges for primary care providers are yet to be fully understood.

The aim of this presentation is to consider how LCS will impact the primary care workforce. The issue of health equity and equipping general practitioners and other primary care practitioners to meet the needs of high-risk populations will be central. This professional forum will present a clinical case study to follow throughout the discussion. We will present the proposed screening and assessment pathway, how the eligible high-risk population might be identified in general practices and what clinical practice guideline updates are available. We will address what actionable incidental findings are likely and how these could be managed clinically. The topic of smoking cessation and how general practice staff can best offer suitable cessation interventions during patient consultations will be covered, focusing on practical strategies. The session will conclude with an update about strategies to engage communities and how education across healthcare professions can help prepare general practices for the potential rollout of LCS. This content will be relevant and engaging for both Australian and international conference participants.

Prescribing parkrun: A global social prescription

Dr Michelle Redford

HNECC PHN, parkrun Australia, Blackbutt Doctors Surgery

Every Saturday morning in thousands of parks in 22 countries around the world, hundreds of thousands of people gather for parkrun. Parents hold their children's hands or push them in a pram, people bring a dog, older folk come with grandchildren, introverts wear headphones while extroverts move excitedly through the crowd. It's free, fun, friendly, informal and in the fresh air.

parkruns are volunteer led, and the model is the same everywhere in the world: every week, forever, for everyone. If you are feeling energetic you can run the traffic-free 5-km course, or you can opt for a leisurely stroll, help as a volunteer yourself or spectate and support on the sidelines.

At parkrun there is no commitment. The aim is to create an opportunity for everyone in society to be involved whenever they want to be.

This presentation will explore peer-reviewed research and patient and practitioner case studies to demonstrate how parkrun can be used as a social prescription to tackle social determinants of health, such as social isolation, loneliness and physical inactivity. The support of The Royal Australian College of General Practitioners, Royal College of General Practitioners and Irish College of General Practitioners has enabled to the development of the 'parkrun practice initiative' in Australia, the United Kingdom and Ireland.

'parkrun practices' supports general practitioners to build a relationship with their local parkrun(s), start a conversation with patients about parkrun and signpost them to their nearest event. More than 2000 'parkrun practices' are registered with this strategic initiative globally, and this presentation will demonstrate the benefits of parkrun as a national social prescribing opportunity that has a significant impact on patients and practice staff.

What was a social running event when it started almost 20 years ago is now one of the most important health and social interventions of our time.

A randomised controlled trial of GP voluntary enrolment, longer appointments and timely follow-up after hospitalisation for high-risk patients

Prof Richard Reed[1], Leigh Roeger[1], BIllingsley Kaambwa[2]

[1]Discipline of General Practice, Flinders University, [2]Health Economics, Flinders University

Background

Observational evidence suggests that continuity of care with a preferred general practitioner (GP), longer appointment times and rapid follow-up after hospital care episodes can produce better health outcomes and improve health service use. We aimed to test whether a multicomponent intervention comprising these components cost-effectively improved health and reduced health service use.

Methods

We conducted a clustered randomised controlled trial of a multicomponent intervention with patients who had been identified by their regular GP as being at high risk for poor health outcomes. The primary outcome was self-rated health at the 12-month follow-up. Secondary outcomes were health service utilisation (hospital service use, MBS claims, PBS items) and cost-effectiveness (assessed at the 12- and 24-month follow-up) based on the number of quality-adjusted life years (QALYs) gained derived from EQ-5D-5L utility scores.

Results

Twenty general practices in Adelaide, South Australia, with 92 GPs took part in the trial. The trial recruited 1044 patients comprising 58 children, 315 adults under 65 years of and 671 older (age ≥65 years) adults. At the 12-month outcome assessment the intervention was not found to improve self-rated health or health service utilisation. The economic evaluation found that the intervention was more effective in terms of QALYs but not cost-effectively. A prespecified subgroup analysis found the intervention to be cost-effective in the older adults group. At 24 months the intervention was not found to improve health service utilisation, but cost-effectiveness was demonstrated for the total sample, and in the older adults group the intervention was both cheaper (due to lower hospital costs) and more effective than usual care.

Conclusions

This study demonstrates that a complex primary care intervention for older adults was cost-effective at 12 and 24 months, but further studies with greater power are required to confirm the findings.

Help! Is there a doctor on board?

Dr Ana Rego[1], Dr Sofia Ferrão[2], Ana César[2], Adriana Caetano[2], Anabela Martins[2]

[1]USISM, [2]USF Global

While on a commercial flight, hearing 'Is there a doctor on board?' can make any doctor anxious. When in-flight medical emergencies occur, by the Code of Medical Ethics, physicians must provide assistance, despite limited training or experience with this unfamiliar clinical scenario. Airlines have partnerships with healthcare institutions to deliver real-time medical advice from an emergency call centre to airline personnel, as a way to improve the healthcare provided.

In this workshop the presenters intend to teach in a simple and practical way how to manage an in-flight medical emergency, using clinical cases. The medical equipment on board and the environmental challenges of treating patients on an aircraft will be explained. Furthermore, the group will clarify briefly airlines' policies and procedures and their legal and ethical duties to respond.

Community efforts to improve care of non-communicable disease using community-oriented primary care (COPC): A Cape Town story

Prof Stephen Reid[1], Peter Delobelle[1], Tumelo Assegaai[1], Dr Darcelle Shouw[2]

[1]University Of Cape Town, [2]Stellenbosch University

Non-communicable disease (NCD) is a significant burden on the public primary care services in many low- and middle-income countries (LMICs), and community-oriented primary care (COPC) seems to offer an innovative way of tackling the challenges. The aim of this project was to identify and develop a feasible, acceptable and effective package of community-based NCD prevention activities that could be embedded in COPC rollout in two learning sites based around community health centres in socioeconomically disadvantaged areas the Cape Town Metro, with a view to inform scale-up nationally and extending the program to other LMICs.

A process of community-based participatory research involved cooperative inquiry groups over three years to guide selected interventions in the two sites. Non-governmental organisations employed community health workers to visit homes, run wellness hubs and monitor diabetes and hypertension outside of the health facilities.

In this presentation we report on a mixed-methods evaluation of the project, using key informant interviews, focus group discussions, document reviews, routine data analysis and participant observations, in order to describe the process that evolved following the original intention. The project was significantly disrupted by COVID-19, which forced community-based services to pivot around home delivery of chronic medications, and later to COVID vaccinations. The two sites showed some interesting differences in their responses. A separate project arose to investigate vaccine hesitancy among staff and patients with NCDs, since they were more vulnerable. The interventions and outcomes in the two sites were different, and the processes were analysed in terms of reach, effectiveness, adoption, implementation and maintenance (RE-AIM).

We concluded that community-based approaches to NCD prevention and control are feasible, but the processes are not linear. Although the outcomes are not guaranteed, COPC has the potential of stimulating major improvements in the control of non-communicable diseases at a population level.

The SOFIA pilot trial: A cluster-randomised trial of coordinated, co-produced care for patients with severe mental illness in general practice

Ms Elisabeth Søndergaard[1], E/Prof Susanne Reventlow[1], Maria Nielsen[1], Annette Davidsen[1], Marius Brostrøm Kousgaard[1], Cathrine Bakkedal[1], Volkert Siersma[1], John Brodersen[1,4], Katrine Jensen[1], Cæcilie Hansen[1], Mette Risør[1], Kristine Bissenbakker[1,4], Ann Dorrit Guassore[1], Maarten Rozing[1,2], Stewart Mercer[3], Pia Kjellberg[5], Iben Christensen[5], Jakob Bardram[6], Kevin Doherty[6], Ann-Katrin Christiansen[1], Alexandra Jønsson[1], Anne Møller[1,4]

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Introduction

People with severe mental illness (SMI) have an increased risk of premature death, predominantly due to somatic health conditions. Research suggests that general practice may play a key role in reducing this mortality gap.

The SOFIA study examines a coordinated co-produced care program in the general practice setting aiming to reduce mortality and improve quality of life in patients with SMI. To assess feasibility, acceptability and implementation barriers, SOFIA was tested in a pilot study.

Methods

The SOFIA pilot study was designed as a cluster randomised controlled trial targeting general practices in two regions in Denmark. Twelve clinics were included in the study, and each clinic recruited 6–15 adult patients with SMI (severe depression, bipolar disorder, schizophrenia). Clinics were randomised in a ratio of 2:1 to deliver either a coordinated care program or usual care during a six-month period. The coordinated care program included educational training of general practitioners and their clinical staff, a prolonged consultation focusing on individual needs and preferences of the patient with SMI and a follow-up plan if indicated. Both qualitative and quantitative methods were used to evaluate the intervention.

Results

Our preliminary findings from the pilot study point at: difficulties with the recruitment of both patients and doctors; a prolonged consultation targeting somatic health problems in patients with SMI might be beneficial for these patients; general practitioners reported discovering undetected somatic symptoms among the patients and changes in medication prescriptions; and building a trustful relationship with the patients was essential as well as time-consuming.

Conclusion

The SOFIA intervention was developed by combining state-of-the-art clinical and social knowledge, with the perspectives of all involved parties (eg patients, general practice, municipalities, psychiatrists) in a participatory codesign process.

Preliminary findings suggest that changes in diagnosis or medication prescription might be initiated through this intervention.

Improving an out-of-hours service for complex and palliative patients at home: A tale of 10 years

Dr Miriam Rey Seoane[1], Mireia HumàPerez[3], Elena Pintado Outumuro[2], Eugenia Cardeñosa Valera[3]

[1]ICS Barcelona/CUAP Manso, [2]ICS Delta/Cronicidad, [3]ICS DELTA/ ACUT/SEVIAC

Background

The SEVIAC out-of-hours service for complex and palliative patients has been providing comprehensive care to patients for the past 10 years since February 2013. This is achieved through an interdisciplinary approach that involves healthcare providers, support staff, patients and their families. The service has been able to keep patients at home, as they desire, by offering telephone consultations and home visits and avoiding unnecessary referrals to the hospital.

Regular assessments of patients' physical, emotional and social needs, as well as their overall health status, are the key. The active involvement of patients and families in their care, with clear lines of communication and access to information and support, is also critical to ensuring that patients receive the care they need.

Aim

To revise the activity of the service, including both home visits and telephone consultations, and track the evolution of the number of interactions and the percentage of secondary care referrals over those 10 years of work.

Results

From 2013 to 2014, the service had an average attendance of 3500 consultations per year, with a referral rate of 3–3.5%. Telephone consultations accounted for 55–68% of all consultations. Other consultations started with telephone triage and home visits.

From 2018 to 2022, attendance increased to approximately 5500 consultations per year and the referral rate stabilised at around 5% and telephone consultations around 65%.

In 2020, the referral rate was 3.2%, exceptional due to the pandemic situation.

Conclusions

The exceptional reduction in the referral rate in 2020, due to the pandemic situation, highlights the importance of being able to adapt to changing circumstances to continue providing high-quality care to patients and ensuring that their needs are met.

Regularly monitoring and evaluating the activity of SEVIAC and adjusting as needed is mandatory to ensure the care of our patients.

Urgent care hunger games: What to do when demand goes through the roof

Dr Miriam Rey Seoane[1], Dr Elena Klusova Noguiná[2], Dr Rabee Kazan[3], Ms Raisa Álvarez Paniagua[4], Stuart Holmes[5], Dr Sonia Tsukagoshi[6], Paloma Sanchez Castro[7], Christian Rechtenwald[8]

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Out-of-hours or urgent care is an essential component of healthcare systems, providing prompt medical attention to patients with all types of medical and non-medical problems. This workshop aims to enhance the skills of family doctors in managing urgent care situations effectively, particularly during periods of high influx of patients and limited resources.

The workshop utilises a gamified approach to learning, involving the use of games and techniques to enhance engagement and motivation among participants. This approach promotes an immersive and interactive learning experience, using a unique board and card game format, as well as competition between participants.

Participants will work in groups to promote teamwork and collaboration. This approach aims to provide a realistic simulation of the teamwork required in managing acute care situations, especially during periods of high patient volume. The groups will be composed of participants with diverse backgrounds and experiences to encourage cross-disciplinary collaboration and learning.

The workshop will cover several topics, including the identification and triaging of urgent care patients, effective communication and coordination among team members, and the implementation of evidence-based practice in resource and personnel-limited settings. The workshop also emphasises the importance of leadership and decision making in managing these situations.

This innovative workshop will provide a unique and engaging approach to learning about primary care emergencies, urgent care systems and teamwork. Our approach offers practical simulation of real-world scenarios and encourages collaboration and knowledge sharing among participants, as well as clear feedback to facilitate learning. Participants will be equipped with the necessary skills and knowledge to manage these situations effectively, and they will have a feedback opportunity to understand their own limits and those of the system in times of peak demand.

Do general practitioners (GPs) conduct research? Australian GPs and higher degree by research: Comparison with other specialities

A/Prof Joel Rhee[1], Michael Tran[1], Dr Michael Wright[2,3]

[1]UNSW, [2]UTS, [3]Avant

Aim

Academic research in primary care is essential to improving and maintaining high-quality primary care. Unfortunately, the rate of general practitioners (GPs) entering the academic workforce remains low in Australia and internationally. We analysed a large dataset of Australian medical practitioners (MABEL – The Medicine in Australia: Balancing Employment and Life survey – 2018 wave) to determine the proportion of specialist GPs that have completed a higher degree by research.

Content

A total of 4643 medical practitioners (female = 2261) were included in the analysis. Of these, 2770 were GPs and 1873 were non-GP specialists. Five non-GP specialities were examined: obstetrics and gynaecology (n = 180), paediatrics (n = 210), internal medicine (n = 873), psychiatry (n = 307) and surgery (n = 303). In a multivariable logistic regression analysis, medical practitioners from all five disciplines had higher odds of completing a higher degree by research than GPs. The odds ratio ranged from 1.5 (95% confidence interval [CI]: 1.0, 2.1; P = 0.05) for obstetrics and gynaecology to 2.8 for internal medicine (95% CI: 2.3, 3.4; P < 0.001). Increasing age, teaching medical students and obtaining the primary medical degree from Australia, but not gender or rurality, were associated with increased odds of a higher degree by research completion.

Goals

Our analysis of a large dataset of medical practitioners in Australia shows that GPs have a lower rate of completion of a higher degree by research than medical practitioners working in other specialities. Our findings contribute to the evidence base showing inadequate engagement with, promotion of and investment in primary care research in Australia and internationally.

A robust strategy from policy makers, universities, research institutes and professional organisations is required to address the imbalance and encourage more GPs to undertake formal research training to ensure that primary care practice is informed by high-quality research.

MAN UP – Men's mental health: Intersecting a youth community program with primary healthcare

Mr Haseeb Riaz, Mr Matthew Hardie

University of Western Australia

MAN UP is a not-for-profit, peer-to-peer education service in WA, with the goal of empowering young men and redefining masculinity. Currently led by two third-year medical students at UWA, Haseeb Riaz (Co-Founder and Chairperson) and Matthew Hardie (President), we run workshops on various topics centred around men's mental health and wellbeing, with an emphasis on transforming boys into confident, purpose-driven and emotionally capable men.

Their aim is to change the phrase 'MAN UP' to mean something positive; to live authentically from one's heart, embrace vulnerability, and hold one another accountable to stand up for what is right. Since their inception, MAN UP programs have had a proven impact on male student beliefs, attitudes and behaviours towards men's health. By having conversations with over 2000 young men across WA, they have shown that our workshops are important, necessary and impactful.

At WONCA 2023, MAN UP will discuss how some of their work has helped engage GPs and primary healthcare to one of the most disempowered populations when it comes to mental health: young men. They will discuss how the efficacy of combining community education programs, peer-to-peer health education and workshop-style delivery with young men directly leads to higher levels of recognition, engagement and access to GPs to establish mental health care plans. As Matthew and Haseeb are both medical students, they also hope to provide their personal insight into the program from young people on placement in the mental health system and provide some unique tips and strategies for GPs to employ to engage with young men in the clinical setting through their workshops.

Please note this presentation may be as a roundtable or a professional forum (either would be suitable).

The Huon Valley Social Prescribing Pilot Project

Mr Andrew Ridge[1,2], Bastian Seidel[1,3], Gregory Peterson[2], Rosie Nash[3]

[1]Ochre Huonville, [2]School of Pharmacy and Pharmacology, College of Health and Medicine, Hobart, Tasmania, [3]School of Medicine, College of Health and Medicine, Hobart, Tasmania

Background

Potentially preventable hospitalisations (PPHs) often result from decreased access to primary healthcare services. Person-level socioeconomic factors are responsible for a significant number of GP visits. The culminative influence of disease burden, social factors and rurality is not well understood. Social prescribing (SP) is a way of linking primary care patients with support within their community. Overseas experience suggests SP is an emerging strategy for tackling health inequities and provides health practitioners with an additional pathway to address patients' physical, psychological, psychosocial or socioeconomic needs. Isolated patients, or those with predominantly psychosocial or health literacy needs, are suitable candidates for SP activities.

Methods

The Huon Valley Social Prescribing Pilot Project (SPPP) introduced an SP pathway into a general practice setting and measured the feasibility and acceptability of the SP model among GPs. Existing local community 'hubs' were used to link general practice patients with community activities. Patients voluntarily participated in the SP referral pathway. Before-and-after surveys of GPs were used to determine the feasibility and appropriateness of the SPPP.

Findings

The SPPP was delivered to 13 GPs in rural Tasmania. Follow-up surveys indicated that GPs found the SPPP an appropriate and feasible approach to increasing the use of SP in primary care. Impediments to full uptake of SP included time constraints during consultations, general uncertainty about SP and the quality of activities offered in the community. Potential benefits of the SPPP included an additional option for vulnerable patients, an easily reproducible model and high GP acceptance.

Conclusions

Implementing SP is seen as a feasible and appropriate way to assist vulnerable patients. The SPPP offers a model for SP implementation that could be reproduced in other primary care settings. Long-term data are required to better understand the costs and benefits of SP in the rural Australian context.

Early detection of non-alcoholic fatty hepatic steatosis associated with childhood obesity and its comorbidities in the family environment

Señor Rafael Ríos de Moya-Angeler[1], Teresa Sánchez Moya[2], Señor Rafael Ríos Bernabé[3], Juana Dolores Valero Morenilla[1], Martín López Marín[1], Carmen Frontela Saseta[2]

[1]Medical Specialist in Family and Community Medicine, San Diego Health Center, Lorca, Murcia, [2]Professor and Researcher, Department of Food Science and Nutrition, Faculty of Veterinary Science, Regional Campus of International Excellence Campus Mare Nostrum, University of Murcia, Murcia, [3]Resident of Family and Community Medicine, Lorca Sur Health Center, Lorca, Murcia

Introduction

Non-alcoholic fatty liver disease (NAFLD) is the main cause of chronic liver disease in adults/children in Western countries. Prevalence corresponded to 10% in children and in obese 38–80%. The Viva Project study found that a greater waist circumference at three years increases the probability that at eight years they will have NAFLD markers. According to a study carried out by the OECD, Spain ranks seventh in obese children aged 5–19 years in the European Union. Once a diagnosis of obesity has been established, it is useful to identify early those patients with a higher risk of hydrocarbon metabolism disorders, dyslipidaemia, high blood pressure and NAFLD.

Objectives

1. Early detection of NAFLD associated with childhood obesity and its comorbidities (children aged 3–10 years).
2. Evaluation of cardiovascular risk factors in parents.
3. Nutritional and physical activity interventions (children/parents) and assessment of their effectiveness.

Study design

Sequential, longitudinal and cross-sectional analysis. An initial assessment at three years and annual reassessment up to 10 years at a health centre located in Lorca (Murcia, Spain) will be carried out.

Materials and methods

Two branches: first, three-year-old subjects will be selected in two groups (both n = 50), namely G1 (overweight or obesity)and G2 (normal weight). Second, 50 obese children aged eight years will be selected. In each evaluation and in both branches (children/parents) a liver ultrasound will be performed, analysing demographic, anthropometric variables (body mass index/abdominal waist), blood pressure and biochemical data (ALT, AST, glucose, HbA1c, insulin, cholesterol, triglycerides, HDL, c-LDL, uric acid). Nutritional survey and physical activity level will be performed, as well as annual interventions in nutrition and physical exercise for children/parents.

Ethical–legal aspects

It will be approved by the Health Area III Ethics Committee. Signing of the informed consent. Declaration of Helsinki.

Challenges and experiences of primary healthcare providers during initial implementation of abortion services at Family Planning Australia

Ms Gianna Robbers, Clare Clare Boerma, Dr Yen Li Lim

Family Planning Australia

Globally, nearly half of all pregnancies are unintended, with social, health and economic implications for individuals, communities and societies. Family Planning Australia (FPA), a non-government organisation, commenced abortion services in 2020, following New South Wales abortion decriminalisation.

Aims

This study aims to assess the experiences of clinic staff during the implementation of abortion services, which can inform both the implementation and ongoing improvement of primary care abortion services.

Clinic staff (medical, allied health, administrative) involved in abortion services were invited to participate in two surveys from May 2020 to Apr 2021 with one follow-up interview after the second survey to investigate their experiences of FPA abortion services.

Initial challenges reported included limited number of appointments available for abortion services, difficulties in ensuring recommended follow-up and the complexity of steps required to organise appropriate abortion care with external service providers, especially during the COVID pandemic. Staff also reflected on factors that supported the adoption of this new scope of practice, including having a supportive team environment, the development of consultation support tools, engaging in regular feedback and quality improvement meetings and applying a multidisciplinary team management approach.

Feedback provided by FPA staff included a desire to continue working towards removing remaining barriers for women accessing abortion care, increase streamlining of abortion services and improve collaboration between other primary healthcare providers and tertiary services. FPA staff also expressed an interest in continuous training to manage complex cases and to learn counselling strategies to support women seeking abortions.

Goals

- To illustrate the experiences of clinic staff in the implementation of abortion services
- To extrapolate learned experiences on the implementation of other primary health services

Views and experiences of young migrant and refugee women in Australia regarding the contraceptive implant

Ms Gianna Robbers[1], Dr Jessica Botfield[1,2], Dr Yen Li Lim[1], Jane Estoesta[1]

[1]Family Planning Australia, [2]Monash University

Global international migration rates continue to increase despite the COVID pandemic. Australia is very culturally diverse, with young people comprising a significant proportion of migrant and refugee women. Migrant and refugee women can encounter challenges in accessing and obtaining contraception and complex factors can influence their choice of contraception. This study aimed to explore young migrant and refugee women's views and experiences of the contraceptive implant and investigate factors influencing their decision making.

We interviewed 33 migrant and refugee women, aged 15–24 years, who live in NSW, Australia, and speak a language other than English at home.

First-generation migrant and refugee women had more knowledge of contraception options compared to women who emigrated to Australia as young adults. Many participants were able to balance the contradictory messaging between their own cultural/religious backgrounds and mainstream Australian ideas concerning contraception and made contraception choices independent of their families despite a reported stigma within their culture/religion regarding contraception and sex. Most participants sought out contraception experiences from close friends and social media platforms to guide their decision making. Additionally, doctors from a different cultural background to their own, or sexual health clinics, were preferred when accessing contraception services.

In terms of views regarding the implant itself, participants generally regarded the use of the implant as convenient, cost-effective and confidential. However, the side effect of irregular cycles/bleeding was seen as a barrier for daily activities. However, most participating women viewed this as acceptable if only temporary. Implant insertion was viewed as a less invasive, and therefore preferable, procedure than an intrauterine device insertion. Most participants would recommend the implant to peers.

We anticipate this presentation will encourage primary healthcare providers to challenge their perceptions of migrant and refugee women's contraception needs and to identify opportunities to support women in making informed contraception choices.

Connecting to patients: Asynchronous medicine preconsult questionnaires

Dr Alice Roche

Hariold's Cross Medical Centre

The way we connect to our patients has changed significantly over the past decade. We can see this in the private medicine sector; however, public-based general practitioners are still in the early stages of this.

Asynchronous telemedicine – also know as 'store and forward' – is a method of virtual care in which communication between patient and practitioner is not live. Patients answer health questionnaires for straightforward medications and health queries. Due to its ease of use and accessibility, it is popular with private providers in Ireland.

The workload of primary care is becoming unmanageable going forward and we need to create efficiencies. Being able to identify a patient's specific concerns and picking up patients with multiple and complex issues prior to them walking through the door could be helpful to GPs.

The aim of this study was to assess if online preconsultation health questionnaires could improve efficiency and increase patient satisfaction in primary care.

The results were mixed. The uptake by patients was low, especially older and more complex patients. While doctors found it beneficial to drill down to specific concerns, the efficiency was negated by the additional workload it took to review implement these questionnaires.

The goal of this study is to assess whether asynchronous telemedicine preconsultation checklists have a role to play in primary care. Asynchronous telemedicine has a promising role to play; however, it needs to become more integrated with the consultation software and patients need to become more familiar with its use.

Roundtable reconnection: The quest to revive and restore the female rural medical workforce

Dr Christie Rodda, Kaylene Girgenti[2], Adj A/Prof Belinda O'Sullivan

[1]RACGP Rural, [2]RACGP Doctors for Women in Rural Medicine Committee

This roundtable session will tap into the collective experience of female rural general practitioners (GPs) and provide an opportunity to collaboratively contribute recommendations to policy makers with the aim of increasing the recruitment and retention of a female rural generalist workforce. Fewer female new graduates take up rural practice even though the proportion of women in medicine is increasing. Policy makers have not accounted for female needs and interests in the design of training, recruitment and retention strategies.

Participants will be briefed with existing research on factors influencing female-specific rural medical workforce training and participation around the world. They will then work collaboratively in small groups to identify solutions to enabling women's work in rural areas, building positive exemplars. Together, this work will inform strategies for enabling growth of the female rural GP workforce.

The use of personal narrative and lived experience will generate creative and novel solutions and reconnect participants with colleagues from across the world and revive the passion that exists among rural primary care practitioners for their work and communities. The result will be a draft position paper that can be used to advocate female-focused training, recruitment and retention strategies.

If I die young: A palliative case presentation

Dr Karen Angelica Rodil

Jose R. Reyes Memorial Medical Center

Palliative care in the young is uniquely managed and approached differently in consideration of their various and possibly unrecognised and unmet developmental and psychosocial needs that impacts how palliative care may proceed.

Such a case was enrolled into our service: a 17-year-old male with gastric carcinoma Stage IV who came in with his elderly adoptive parents. On referral, diagnosis was already established two months after onset of intermittent abdominal pain and weight loss, and a month of hospital admission.

He was bed-ridden, with cachexia and sleeping difficulty, and had to be assisted in his ADLs. Gastrostomy tube feeding proved difficult as the non-healing stoma caused severe pain. He was withdrawn and anxious and had cut connections with friends. A stark contrast to expected developmental goals of body image acceptance, building relationships and self-reliance.

The patient's elderly parents were grappling with sadness over the impending demise of their child and grieving the loss of his expected milestones as the prognosis became clearer. They also struggled with fully disclosing the situation to their son.

The palliative team was able to assist the parents in diagnosis disclosure. Despite the restrictions of the pandemic, counselling was done for the family every step of the way and multidisciplinary family meetings were held online to encourage communication and correct any emotionally critical misperception. As treatment goals shifted from curative to palliative, advanced directives were discussed and care was focused on alleviating emotional distress.

The patient lost his battle to cancer with both his parents by his side. The parents are at peace with the fact that they were able to spend his last days together as they were given the chance to assure him that they will be fine. The palliative team is still in contact with the parents through teleconsultation supporting them in their grief.

Assessing mental health care needs and gaps in Latin America: Exploring family doctors' and primary care physicians' practice competencies

Ms Michelle Rodriguez[1], Ms Mary Ales[1], Prof. Andre Luis Bezerra Tavares[3], Christopher Dowrick, MD[5], Sol Durand Arias[2], Adriana Maldonado Martinez[6], Prof Alfredo de Oliveira Neto[7], Karin Kopitowski, MD[8], E/Prof Christos Lionis[4], Marilena Anastasaiki, MSc[4]

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Rates of depression/anxiety are growing globally. It is fundamental to develop a system that provides access and treatment; it is also vital to provide educational offerings that increase the confidence and competence of family medicine/primary care physicians (FM/PCP) in the care of patients with mental health disease.

This project identified and quantified practice gaps of FM/PCP in Argentina, Brazil, Chile, Colombia and Mexico so education is targeted to bridge gaps. The findings demonstrate significant opportunities to enhance mental health care and mental health education.

The assessment included:

- literature review on competencies, delivery of care and care systems within Latin America
- work with an expert advisory panel (EAP) during the project
- interviews with practising physicians in the five selected countries
- survey of Latin American FM/PCP on attitudes, behaviours and barriers in caring for patients with depression/anxiety
- outreach, engagement and collaboration with organisations/institutions in the five countries
- EAP review of survey results to provide recommendations on educational offerings to be shared with interested organisations/institutions and WONCA.

These themes should serve as the backbone of future work.

- While COVID lessened the stigma, continued focus and addressing stigma and attitudes towards mental health are needed.
- Training and education on mental health conditions are not currently part and parcel of the FM/PCP curricula but need to be integrated.
- The five countries do not have enough physicians trained or willing to care for the number of patients.
- Education/training needs to be supported by easily accessible, easy-to-use, literacy-level appropriate tools and resources for clinicians and patients.
- The division of private versus public sectors creates alternative care pathways with varied resources, access and costs.
- Mental health care is provided by individuals with different educational backgrounds and experiences; education needs to address everyone working in primary care.

New RACGP post-Fellowship recognition launch at WONCA

Dr Lara Roeske

Come along to this session to learn about RACGP post-Fellowship recognition, the new quality-assured and RACGP-endorsed process of recognising the extended knowledge, skills and experience GPs gain over the course of their careers. It is not a qualification, it is an acknowledgement that a GP's skills meet a defined recognition standard.

Post-Fellowship recognition will launch at WONCA, opening up for applications in the following subject matter areas: addiction medicine, dermatology, developmental disability, integrative medicine and psychological medicine.

At the point of Fellowship, a GP's core skills and knowledge are documented in the RACGP curriculum for Australian general practice. Throughout their career journey, GPs continue to develop skills in response to patient, community or clinical need, as well as through their own area/s of personal and professional interest.

GPs applying for post-Fellowship recognition will provide evidence that they have extended skills in a particular area, at the level of the predefined recognition standard.

The applicants who are assessed as successfully meeting this standard will receive a certificate of recognition from the RACGP. This can be used to promote their extended skills to patients, practices and colleagues.

The application form and self-assessment checklist can be found at the RACGP website (URL TBC).

Addressing inequity in cervical cancer prevention: Self-collection in your practice

Dr Lara Roeske[1], Prof Deborah Bateson[2]

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Cervical cancer is preventable and treatable if detected early and managed effectively. In May 2018, the WHO Director-General announced a global call for action to eliminate cervical cancer, and in 2020 the World Health Assembly adopted the global strategy for cervical cancer elimination. The strategy has three key elements: vaccination, screening and treatment.

Australia is on track to be the first country to eliminate cervical cancer as a public health problem, potentially by 2035, thanks to a free school vaccination program, a national screening program and high levels of community engagement. However, it is important that this is achieved equitably.

This practice-based session will provide an interactive overview of Australia's major 2022 National Cervical Screening Program policy change which supports all eligible people with a cervix to choose to screen either with a self-collected vaginal sample or clinician-collected cervical sample.

This session will cover the practical aspects of implementing self-collection into your practice and the consideration of screen and treat approaches outside Australia in resource-constrained settings, including through telehealth models of care, rural and remote areas and an overview of screening pathways through a case-based approach focusing on under-screened populations.

How do general practitioners reflect on working with patients' stories of painful and adverse life experiences?

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Aims
To highlight general practitioners' reflections on working with patients' stories of painful and adverse life experiences.

Background
It is well documented that painful and adverse life experiences increase the risk of health problems in a life-course perspective. However, little is known about how general practitioners (GPs) reflect on and work with such stories.

Methods
Focus group discussions among 18 Norwegian and 10 Danish GPs.

Results
When reflecting on their work with patients' stories of painful and adverse life experiences, GPs did not share a common ground. For one thing, they took two main stances regarding the medical relevance of such stories. The first position, the 'confident-accepting stance', was characterised by an explicit acknowledgement of the medical relevance of such stories. The majority of the participating GPs took the second position, termed an 'ambivalent and conditional stance', to addressing patients' stories of painful and adverse experiences. Second, GPs also represented two opposing perspectives regarding the purposes of working with patients' stories of painful and adverse life experiences: the instrumental purposes of story work and the intrinsic values of story work. Lastly, GPs experienced – in a number of different ways – a clash between working with patients' stories and adhering to guidelines.

Conclusions
GPs' differing stances in relation to stories of adversity can be associated with indefinite and competing understandings of causality (regularity theory of causation vs causal dispositionalism) within medicine. The concept epistemic injustice, referring to how certain kinds of knowledge (eg guidelines) are given primacy over others (like stories), can help us understand the clash between stories and guidelines.

Goals
Contribute insight into GPs' different understandings of the medical relevance of patients' stories and introduce theoretical concepts (causality and epistemic injustice) that can prove helpful to analysing the differences.

Stress and work-related well-being in primary healthcare professionals: Self-knowledge as a prevention strategy

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Introduction and aim

Primary healthcare teams have a closer and regular interaction with the patient, a fact that subjects them to increased stress. New instruments have been tested in order to promote coping mechanisms for everyday professional and personal situations, but there are few reports of interventions aimed at reducing stress levels and improving wellbeing at work. Thus, the present study aims to understand whether training in self-knowledge, based on the Enneagram, has this effect on participants, improving their quality of life.

Content and methods

In a longitudinal exploratory intervention study, a pilot of a clinical trial, we applied an online questionnaire with seven scales to a sample of 14 professionals from a health team – Perceived Quality of Life (EQ-VAS), Perceived Stress (PSS), Job-Related Affective Well-Being (JAWS), Self-Reflection and Insight (SRIS), Self-Awareness (SAOQ), Rumination and Reflection (RRQ) and Self-Compassion (SELFCS) – before and after a self-awareness course based on the Enneagram of Personalities. The data obtained were submitted to descriptive and inferential statistical analysis.

Results

It was demonstrated that the quality of life increased significantly after the intervention (P = 0.038). We did not observe any significant difference of the intervention in the other scales and subscales. However, all scores tended to improve in the second phase, except for the SRIS scale.

Goals, discussion and conclusion

Despite the limitations of our sample, such as the reduced number of elements, self-knowledge has shown to have an impact on quality of life, consistent with the gains perceived by the participants, described by them qualitatively. This improvement was expected considering the already known ability of the Enneagram to promote psychological growth, favour interpersonal relationships and improve quality of life, observed in other studies. However, studies with more representative samples are still needed to obtain scientific evidence in this area.

Strategies to improve asthma care in a culturally and linguistically diverse population in general practice: A qualitative study

Dr Maithri Rupasinghe[1,2]

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Background
Asthma is a common condition in general practice; however, opportunities to optimise management can be missed. People with asthma often overestimate the degree to which their asthma is controlled.

Aim/hypothesis
To explore how GPs and PNs deliver asthma care, with particular attention to team roles, and how to improve management.

Method
Qualitative interviews were conducted with nine GPs and 10 PNs working in an area of cultural diversity and socioeconomic disadvantage in Western Sydney. Inductive thematic analysis was undertaken.

Results
Care focused on treating acute asthma over controlling asthma. This focus appeared to be reinforced by the discordant general practice team approach and by patients due to poor perception of asthma as a chronic disease. Poor health literacy, barriers in communication and strong beliefs and practices adopted by patients affected adherence to preventer therapy. PNs believed that they were underutilised in preventative asthma care.

Discussion
Lack of recognition of asthma as a chronic disease by patients and GPs leads to missed opportunities for improved management. Utilisation of usual chronic disease models of care such as systematised follow up, CALD PN-delivered health education and care plans may assist in asthma control and avoiding the dangers of acute presentations.

Conclusion
Asthma care in general practice may be improved by a greater focus on prevention, follow up after acute presentations, enhanced collaboration between GPs and PNs and supportive practice models of care targeting CALD populations.

What do GPs need from clinical pathways? A qualitative study from Australia

Prof Grant Russell, Ms Susan Saldanha, Sharon Clifford, Riki Lane, Christopher Barton

Monash University

Background

Clinical pathways can help clinicians negotiate an increasingly complex healthcare system. These structured web-based plans translate clinical evidence into local settings to help standardise care. They have been shown to improve referral quality and have been associated with modest improvements in clinical outcomes. However, little is known as to the attitudes of primary care providers to their use.

Aim/objective

We aimed to explore the attitudes and experiences of general practitioners (GPs) towards clinical pathways, with particular focus on those designed for local use.

Methods: Our narrative qualitative study was set in urban Melbourne, Australia, in 2022. We used semistructured interviews with a maximum variation sample of GPs, GP staff, staff of Primary Health Networks and hospital liaison officers. Interviews were audio recorded and transcribed. Data analysis was aided by NVivo 1.0. A community reference group informed the work.

Findings

We conducted 35 interviews with 43 participants. Several interviews were performed as dyads. Most GP participants supported the concept of clinical pathways. They were most familiar with disease-based guidelines curated by professional organisations, colleges and government bodies. By contrast, recent graduates were enthusiastic about (and often quite reliant upon) pathways that combined clinical evidence with local advice on referrals (ie HealthPathways). While acknowledging the potential value of platforms such as HealthPathways, GPs were frustrated by a lack of training and promotion and disappointed about the lack of integration of platforms into their clinical software.

Conclusion

Locally tailored clinical pathways are becoming a popular strategy to improve access, standardise care and increase efficiency. Our findings highlighted a surprising lack of implementation strategies associated with locally tailored clinical pathways. Future iterations of these pathways should come with marketing and educational strategies and attempts to make the resource consistent with the needs of the modern general practice.

Addressing the social determinants of health in primary care: A game-based solution

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Background

There is growing recognition that addressing the social determinants of health (SDoH) is fundamental to providing holistic patient care and tackling health inequalities in primary care; however, evidence of the most effective methodologies in SDoH education is lacking. Game-based learning offers a powerful approach to improve learner engagement and motivation in a safe learning environment. An interactive board game developed by a team of educators and clinicians explores the SDoH from the perspective of a patient profile as they are exposed to risk and protective factors.

Aim

The purpose of this session is to introduce participants to the Social Determinants of Health board game. Participants will engage directly with the game and be led through a discussion of the purpose and learnings of the game.

Content

Participants will play the board game in small groups, mirroring the experience of student learners. The board game explores the impact of the SDoH on the experiences of patients accessing the Australian health system, with a strong focus on people living in rural contexts. The board game is purposely designed to limit the agency of players and demonstrate the impact of the SDoH on players' overall health and wellbeing. Progress in the game is modulated by the SDoH and is supported by robust evidence to enrich the learning experience. Following the game, participants will engage in discussion focusing on SDoH education and game-based learning.

Goals

Participants will be invited to consider how this game may be used to support teaching of the SDoH and primary care education more broadly. The benefits and potential pitfalls of game-based lear ning will be explored, along with potential adaptations to the game for various learning contexts. The Social Determinants of Health Board game will be available to all participants to use or adapt to their own curricula.

Group cognitive behaviour therapy for managing stress in healthcare workers

Prof Saniya Sabzwari, Rafay Iqbal

Aga Khan University

Aim

To introduce a brief CBT tool to counter stress for healthcare workers

Content

This will be a 90-minute mini workshop where enrolled participants will go through the following:

- Stress Scale – this will be shared with the participants to be filled in before the workshop
- ABC (Adversity, Beliefs, Consequences) Tool – this will be used in the workshop to help identify stress and its impact
- 4 Steps to Reframing – these steps will allow participants to go through cognitive reframing to manage their stress
- Reflection – the participants will spend the last 10 minutes sharing their reflection about the tool and the reframing exercise.

Goals

By the end of the workshop, the participants should be able to apply a brief practical intervention to recognise and manage their stress.

Acknowledgement

This resource is based on materials developed by the Center for Pediatric Traumatic Stress (CPTS), a treatment and services adaptation centre in the National Child Traumatic Stress Network (NCTSN).

The educational impact of fieldwork and lodging trip for medical students who have an obligation to work in a rural area

Dr Michito Sadohara, Hiroshi Takayanagi, Kunihiko Matsui

Kumamoto University Hospital

Introduction

Kumamoto University Hospital provides a special program of summer fieldwork and lodging trip in a rural area as an extracurricular activity for medical students who have an obligation to work in a rural area. 'Knowing the community' is the aim of program for students who will work there in the future. The schedule consists of the following: preliminarily searching about regional medical/welfare, industrial and tourism resources based on administrative materials; visiting to medical, care facilities and town offices as fieldwork; presentation of results learned.

Purpose

The purpose of this study was to estimate educational impacts on community medicine by rural exposure for medical students.

Methods

A two-day trip to a rural area was held in 2019. All 26 participants answered the self-administered questionnaire. The questionnaire included statements asking about their perspectives on the area and community medicine (12 items, 10-cm visual analogue scale) and self-evaluation of knowledge comprehension (20 keywords, six rating) comparing before and after the program.

Results

In terms of views on the community, points significantly increased for items including 'community medicine has some dream', 'comfortable to live in rural area', 'want to work in area of doctor shortage', 'ready to take their roles in rural medicine in the future' and 'highly expected from the community'. Self-rating of points for knowledge increased significantly in 18 of 20 keywords such as 'community-based integrated case system', 'regional healthcare vision', 'medical cooperation between facilities', 'multi- and inter-professional collaboration', 'team-based healthcare', 'home care and visiting care', 'shortage and maldistribution of doctors in rural area', 'aging society with fewer children', 'death-ridden society', 'health life expectancy', 'health promotion campaign', 'marginal village' and 'advance care planning'.

Conclusion

Fieldwork to a rural area had educational effects to increase favourable perception and knowledge towards community medicine for medical students.

5th map: General practice standards on one page

Mr Keith Saggers[1]

[1]5th map, [2]Bayside Family Medical & Musculoskeletal Practice

Australian general practices operate within RACGP's 184-page, 5th Standards.

Practices are assessed against these Standards on a three-yearly accreditation cycle via a visit of external assessors.

Success provides Accredited status.

The Standards include Modules, Standards, Criteria and a final layer of Indicators.

All 120+ Indicator tasks must be adhered to.

Accreditation preparation often commences a year before and is a significant and resource-intensive task.

Concerns are often complexity of tasks, time pressures, focus constraints, information overload, inaccessibility of information, disinterest of those not involved and a lack of an overarching understanding.

Standards and Accreditation are often thought of as one.

An analogy of: 'Standards are like the rules of the road and the Accreditation is the day a police officer is sitting in your car' is accurate.

Much can change in general practice during the 1000 days between visits.

The 5th map (a map of the 5th Standards) is the mapping of all layers onto one page summarising the overall Standards visually and the specific content into concise seven- or eight-word descriptions in lieu of long sentences and paragraphs.

The maps are specifically hard copy, often on the practice kitchen wall, to be seen all day, everyday by everybody for opportunistic learning.

They encourage whole-of-practice understanding that the Standards are a cohesive and structured plan for practice and patient safety.

With the 'What' now easily accessible, the 'Why' can be understood and answered.

Managers who often felt they themselves were being Accredited can maintain oversight, delegate easier and spread knowledge across the practice with less effort.

The 5th map has a formal RACGP license for use of their copyrighted information and is in 600 Australian practices.

This large-format, always-visible mapping concept can certainly be applied beyond the Australian context.

Stress predictors in a medical school environment: A cross-sectional study at Ibn El Jazzar Medical School Sousse, Tunisia

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Introduction

University students, particularly those in medical schools, frequently encounter various stressful situations and preoccupations. Medical schools are renowned for their highly competitive and stress-inducing environment. The aim of our study was to assess stress predictors in Ibn El Jazzar medical school, Sousse (Tunisia).

Methods

We conducted a cross-sectional study among all the undergraduate medical students registered at the Faculty of Medicine of Sousse during the university year 2022–2023. Perceived stress was assessed via the Perceived Stress Scale. The questionnaire was hosted on Google Forms and electronically distributed over three months in 2023.

Results

A total of 141 participants were included, with a female predominance (70.4%). The majority of participants had a moderate stress level (73.9%), while only 12% reported low stress levels and 14.1% reported high stress levels. Individuals who were spiritually satisfied had a lower percentage of high stress levels than those who lacked spiritual satisfaction (7.4% vs 20.9%, p=0.05). We also found that 28% of those who had frequent use of painkillers (such as for chronic diseases) had high stress levels compared to 10.8% of those who did not use those medications (p=0.049). Factors such as gender, medical school course of study satisfaction, emotional stability, environmental satisfaction and social satisfaction were not found to be predictors of lower stress levels in medical students.

Conclusion

It is important to address spiritual wellbeing as a protective factor against stress in the medical education setting. Further research is warranted to better understand the underlying mechanisms and to explore other stress predictors.

Lifestyle profiles of young physicians: A 2023 cross-sectional study

Badreddine Sakouhi[1], Mohamed Ben Raje[1,2], Asma Ben Cheikh[1,2], Houyem Said Laatiri[1,2], Sana Bhiri[1,2], Raed Kadhi[1], Hela Ghali[1,2], Rania Rebai[1], Marwa Louati[1], Salma Balhi[1,2], Amani Maatoug[2]

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Introduction

Young physicians are said to be healthy lifestyle advocates. Physician wellbeing has recently become a focus of international concern. The aim of our study was to draw a lifestyle profile of undergraduate young physicians in 2023 registered at the Faculty of Medicine of Sousse, Tunisia.

Methods

We conducted a cross-sectional study via an online survey. All undergraduate medical students registered at the Faculty of Medicine of Sousse during the university year 2022–2023 were eligible to participate. A 10-item structured questionnaire inspired from the World Health Organization healthy lifestyle criteria was developed to assess the lifestyle among young physicians. It was distributed over three months in 2023.

Results

A total of 141 undergraduate medical students were enrolled. Females accounted for 70.4% of them. Only 41.5% reported engaging in physical exercise for more than 30 minutes each day. Regarding dietary habits, 41.5% of participants managed to meet the recommended daily intake of three portions of fruits and vegetables. Regarding tobacco use, 85.2%, identified as non-smokers. A majority of participants (78%) reported abstaining from alcohol, and 33.1% reported experiencing insufficient sleep. Emotional stability rated for 52.1% of participants. In terms of medication use, 17.6% reported frequently relying on painkillers. Only 50% experienced regularities in their daily routines. Financial problems were reported by 14.8% of young physicians. Lastly, 24.6% of the participants expressed dissatisfaction with their social lives.

Conclusion

Our study revealed a mixed picture of positive and negative findings among young physicians' lifestyle profiles. While certain aspects, such as non-smoking, absence of alcohol consumption and emotional stability, show promise, areas such as physical exercise, dietary habits, sleep quality, financial challenges, medication use, daily routines and social satisfaction require attention. It is imperative to address these issues and consider tailored interventions to promote healthier lifestyles.

Deep dive into eHealth: A descriptive study on the development of a mobile app for improving hypertension care among physicians

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Mobile health (mHealth) applications have become increasingly popular as a tool for healthcare education and training. This study aimed to develop an mHealth application for learning hypertension care among primary care doctors, with the goal of improving their knowledge and skills in the management of this common condition, which continues to be the leading cause of death and disability worldwide. The study used a mixed-methods design, including a literature review, stakeholder interviews and a pilot test of the developed application. The literature review focused on the current state of mHealth in medical education and hypertension management, while the stakeholder interviews involved doctors, patients and healthcare experts to gather input on the content and design of the application. The pilot test was conducted with a small group of doctors and assessed the feasibility, acceptability and usefulness of the application. The results of the study showed that the mHealth application was well received by the participating doctors and was considered to be a useful tool for learning about hypertension care. The doctors reported that the educational resources provided by the application were relevant, engaging and easily accessible. Overall, the study provides evidence for the potential of mHealth applications to improve medical education and healthcare outcomes for patients with hypertension. Further research is needed to assess the long-term impact of the application on physicians' knowledge and patient outcomes.

Holding on: A case of compassionate care for patient and his family in palliative and terminal stage of illness

Dr Sitti Khadija Salabi[1,2,3,4]

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Palliative care can offer relief from physical and emotional distress, provide support and improve quality of life for both the patient and their family during the terminal phase of an illness. This case presentation discusses the care provided for a 55-year-old male diagnosed with metastatic colon cancer who received palliative and hospice care from the time of diagnosis until his eventual passing. The patient's physical and emotional symptoms were managed through a combination of medications, counselling and emotional support using family medicine and palliative medicine tools. The patient's family was also offered emotional and practical support throughout the patient's illness, with the goal of enhancing the patient's quality of life and providing comfort to the family during this difficult time. The case highlights the importance of a multidisciplinary approach to palliative care, and the critical role of family medicine and hospice care in the terminal phase of an illness. It also underscores the significance of providing compassionate care that respects the patient's wishes and values, as well as the needs of their family. Moreover, the case brought to light the gaps of the healthcare system in providing equitable access to high-quality palliative care for all patients, irrespective of their socioeconomic status.

Workplace violence in the emergency department of tertiary care hospitals in Kathmandu, Nepal

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Workplace violence (WPV) in healthcare settings has become a matter of global concern. Violence, particularly in the emergency department (ED), is a well-known phenomenon across the globe. In Nepal, however, there is not much data regarding WPV in healthcare settings.

This study was conducted to explore the extent and various aspects of WPV in the ED of two tertiary care hospitals within Kathmandu, the capital city of Nepal.

This was a multicentre cross-sectional descriptive study that was conducted among ED staff working in emergency rooms of Bir and Patan hospitals. Data were collected during a two-week period in October 2021 by using a self-report modelled questionnaire whereby the researcher himself met the ED staff and collected data, where the respondents were asked to recall the forms of WPV in the recent three-month period.

There was a total of 100 respondents (valid response rate 93%). Verbal abuse/threat was experienced by 75 ED staff and three of them reported to have experienced physical violence also. Nurses (94%; n = 34) and paramedics (89%; n = 8) were the most common victims of WPV. Female staff were most at risk (84%; n = 46). Visitors of the patient were identified as most common perpetrators of WPV (80%) and non-reporting to hospital authority by victims of WPV was found to be very high (75%; n = 56).

Hospital administration, government bodies and other stakeholders of healthcare services must seriously work together on ways to create a safer working environment for healthcare providers working in emergency departments.

Diagnosing abdominal tuberculosis in an 11-year-old boy

Dr Jill Sanders, Dr Joseph Mashale

Lesotho Boston Health Alliance

Aim

The Lesotho Boston Health Alliance Family Medicine Specialty Training Program has identified point-of-care ultrasound (POCUS) as a key clinical competency. Registrars receive didactic and practical instruction on POCUS throughout their training. One noted benefit is the diagnostic use in HIV-associated tuberculosis. Lesotho has the highest incidence of tuberculosis and second-highest prevalence of HIV globally. Over 70% of patients treated for tuberculosis are co-infected with HIV. Children continue to be infected with HIV despite remarkable improvements in the uptake of prevention of mother-to-child transmission interventions.

Content

An 11-year-old boy presented to Motebang District Hospital with primary complaints of shortness of breath and abdominal distension. He had been diagnosed with HIV two months prior and started on an antiretroviral treatment regimen of abacavir/lamivudine/dolutegravir. At the time of presentation, he also complained of fever, cough and two-pillow orthopnoea. Some abdominal distension had been noted at his HIV diagnosis but it had dramatically worsened. Physical examination was notable for wasting, tachypnoea and massive abdominal organomegaly.

Abdominal POCUS was added to traditional tuberculosis diagnostic tools of sputum examination and radiography. No ascites was present. The liver was enlarged with normal architecture and echogenicity. The spleen was massively enlarged with complete loss of normal architecture and the presence of multiple abscesses, consistent with tuberculosis disease. Four-drug treatment for tuberculosis was begun with steady improvement in clinical symptoms. Repeat POCUS after one month showed a reduction in organomegaly and normal splenic architecture.

Goals

POCUS can support clinical diagnosis and management of HIV-associated tuberculosis and many other conditions encountered at district hospitals in Lesotho. Comprehensive primary healthcare provision is enhanced by the inclusion of POCUS competency in the training of family medicine registrars in Lesotho.

Determining clinical features and biomarkers for enhancing equitable and comprehensive care of post-COVID syndrome in primary practices

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The emergence of the SARS-CoV-2 Omicron variants has been associated with the milder acute disease compared to earlier variants. However, the incidence and clinical features of post-COVID-19 syndrome (PCS) after Omicron variant infection remain poorly understood. This study aimed to estimate the incidence of PCS, identify common clinical complaints and investigate potential risk factors and biomarkers of PCS among Thai patients who survived COVID-19.

A bidirectional prospective cohort study was conducted involving 209 Thai patients who had recovered from COVID-19 and received both hospitalised and non-hospitalised care during their acute infection. Patients were randomly selected and evaluated for PCS between three and four months after the acute onset. The diagnostic process involved a questionnaire of PCS symptoms and a physical examination to rule out other potential causes. Additionally, routine blood tests, CRP, D-dimer, anti-spike IgG and anti-NCP IgG were performed during the same visit.

Among the 209 patients, 44% (91/209) developed PCS within three months of acute onset. The top five clinical complaints were fatigue (21%), abnormal hair loss (19%), cognitive dysfunction (8%), continuous cough (8%) and dyspnoea (6%). Patients who experienced severe acute disease, were female or had comorbidity had a higher risk of PCS. Treatment with antiviral drugs did not reduce the risk of PCS. While alkaline phosphatase was significantly higher in patients with PCS, AUROC value was low. No other blood tests showed significant associations with PCS in multivariable analysis adjusted for age, sex and disease severity.

This cohort study provides new information on the incidence and clinical complaints of PCS following Omicron variant infection among Thai patients. The study identifies key risk factors and highlights the lack of an effective biomarker for PCS. These findings have significant implications for the clinical management of PCS and underscore the need for continued research on the long-term effects of COVID-19.

Effectiveness of home visits for dwelling adjustments in preventing falls among elderly patients: An interventional study

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[1]Surin Hospital Medical Education Center, [2]Surin Provincial Public Health Office

Background
Falls in the elderly are an increasingly common public health issue due to the ageing population, with devastating consequences of injury, disability and mortality. Dwelling adjustment and continuous home care is proposed to help reduce the incidence of falls and improve the quality of life in the elderly and their family members.

Rationale
To compare the incidence of falls in the elderly with and without the support of home visit and dwelling adjustment.

Methods
A prospective randomised controlled interventional study consisting of patients above 70 years of age living in Surin Province between 1 January and 30 June 2022.

Measurements and outcomes
Forty patients from each district were chosen by random sampling and were assessed for baseline fall risk scores. These patients were then centrally randomised to receive two home visits with a dwelling adjustment-based protocol with follow-up monitoring of falls within six months.

Results
Six-hundred and thirty-eight patients were studied, with an average age of 79 years. The 319 patients who received dwelling-adjustment home visits had a lower incidence of falls ($P < 0.001$). The number of patients needed to treat was eight to prevent a fall in one patient (95% CI: 6, 12 patients).

Conclusions
Physicians should consider providing dwelling adjustment-based home visits for patients above the age of 70 to significantly reduce the risk of falls.

Key words
home visit, dwelling adjustment, fall, elderly, home environment.

Impact of general practice on medicine and vaccine safety in New Zealand

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Background
The NZPhvC Centre for Adverse Reactions Monitoring (CARM) assesses voluntary reports of suspected adverse reactions (sADRs) to medicines and vaccines from healthcare professionals (HCPs) and others. Patterns of reporting vary according to HCP discipline. Analysing variations can support appropriate feedback. General practitioners (GPs) and practice nurses (PNs) have made major contributions to the CARM 58-year-old database.

Aim
To demonstrate patterns of sADR reporting from general practice.

Goals
To compare recent sADR reporting patterns in the CARM database according to HCP disciplines.

Methods
Reports for medicines and vaccines (excluding COVID-19 vaccines) received in 2022 were assessed for HCP type and seriousness. From 2012 to 2016, HCP reports were assessed by seriousness categories – fatal, life-threatening, hospitalisation, congenital disorders, persisting disabilities – and most reported reaction groups.

Results
In 2022, of 1908 reports for medicines, 497 were serious. GPs contributed 16.7% (5.6% of serious), hospital doctors 20.7% (40.0%) and hospital pharmacists 11.7% (24.0%). In contrast, for vaccines, PNs submitted 66.7% of 1125 reports, GPs 10.8%, community pharmacists 3.4% and hospital doctors 2.3%.

From 2012 to 2016, fatal and life-threatening sADRs were reported more often by hospital HCPs. GPs reported a greater proportion of congenital abnormalities and persisting disabilities. Of the patient alerts entered by CARM into the national Medical Warning System, 30% originated from GPs. Psychiatric reactions appeared in the top three reaction groups only for GPs. The value of GP reports will be demonstrated in three international CARM publications.

Discussion
For medicines, GPs provide insights into patients' experiences that may not be identified in hospital. For vaccines, PN reporting has provided an invaluable background that can enable early recognition of safety issues with new vaccines or specific batches. sADR reporting has decreased with pandemic pressures. This study indicates that it is a worthwhile part of clinical practice.

Predictors for success and failure in international medical graduates: A systematic review of prognostic studies

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Aim

International medical graduates (IMGs) are an important part of the international physician workforce and exploring the predictors of success and failure for IMGs could help international and national physician labour workforce planning.

Methods

Medline, PubMed Cochrane Central Register of Controlled Trials, BIOSIS Citation Index, CINAHL, Embase, ERIC, DARE, Global Health, LILACS via Global Index Medicus, Health Technology Assessment Database, Web of Science, Science Citation Index, ClinicalTrials.gov, PsycINFO, Scielo and the grey literature were searched for studies that explored the predictors of success and failure in IMGs. Baseline probability, effect size (in relative risk [RR], odds ratio [OR] or hazard ratio [HR]) and absolute probability change for success and failure were reported.

Results

Twenty-four studies (373,784 participants) reported the association of 93 predictors of success and failure for IMGs. Female sex, English language proficiency, being graduated five years or less and a higher score in the USMLE Step 2, Clinical Problem-Solving Test and Situational Judgment Test were associated with success in qualifying exams.

IMGs who got a higher score on the USMLE 2 clinical knowledge and in-training examination in postgraduate years 1, 2 and 3 were more likely to pass the American Board of Family Medicine certificate.

IMG residents who previously completed an internship were more likely to pass the Royal College of Physicians and Surgeons of Canada exam on first try.

IMGs and candidates who attempt PLAB Part 1 four or more times (vs first attempters) and candidates who attempt PLAB Part 2 three or more times (vs first attempters) were more likely to be censured.

Patients of non-US IMGs versus US medical graduates had significantly lower mortality than US graduates and patients of non-US IMGs had lower mortalities than patients of US IMGs.

Conclusions

This study informed factors associated with success and failures for IMGs. Rigorously conducted studies are required on the topic.

Evaluating integrated primary care and public health service data models to equitably prioritise chronic conditions during Belgian COVID-19 vaccination campaigns

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Aim

To better protect people with chronic conditions from pandemics and future health crises and to build resilient primary healthcare systems, by evaluating an innovative integrated and equitable primary care–public health prioritisation model used during the Belgian COVID-19 vaccination campaign, being the first worldwide to implement this.

Content

The High Health Council selected relevant diseases, and developed an algorithm utilising centralised data from the Intermutualistic Agency (IMA) database and decentralised data from electronic Global Health Records (GHR), which identified over 900,000 eligible individuals, enabling the vaccination of high-risk individuals two months earlier than the general population. Such integrated tools, which are called for at World Health Organization level, may prove valuable for resilient health disease surveillance and monitoring purposes, to better protect those at risk for current and future environmental challenges of the 21st century. Such strategies require further analysis for potential implementation in Belgian healthcare and beyond, as information in this area is lacking.

Goal

A process evaluation, health impact analysis and implementation exploration of the prioritisation model will be presented using a mixed-methods approach, including qualitative stakeholder in-depth interviews with the developers of the model, primary care and health policy experts and quantitative multivariate mixed-model analysis of the LINK-VACC data (an integrated database linking seven Belgian data sources). An overview of the following objectives will be presented:

1. A description of the outcomes of the model in terms of vaccine uptake and coverage reached in the population identified.
2. An assessment of the health impact of the prioritisation of people with comorbidities increasing the risk of severe COVID-19, in terms of COVID-19-related medication and primary care use, hospitalisations, and deaths.
3. Policy recommendations on implementation, primary (health) care resilience and preparedness for future pandemics and public health shocks, contributing to a comprehensive post-COVID-19 strategy.

General practice-led urgent care practice versus emergency room: Satisfaction of ambulatory patients with low-urgency medical problems

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Background

Ambulatory patients with low-urgency medical problems often present to the emergency room (ER), which results in long waiting times for the patients and the use of ER resources. Establishing general practice (GP)-led urgent care practices (UCP) adjacent to ERs allows to triage patients from the ER to the UCP. However, patients may perceive themselves as an emergency case and expect ER treatment, including extensive diagnostics.

Aim

To access satisfaction of patients with low-urgency medical problems treated in the UCP versus ER. To find out what factors influenced their satisfaction.

Methods

From October 2019 to January 2020, a survey was conducted at the University Medical Center Hamburg-Eppendorf addressing ambulatory patients that received ER treatment and ambulatory patients that were treated in the adjacent UCP. UCP patients either presented directly to the UCP or were sent by ER triage staff during UCP opening hours (Monday–Friday 6 pm–12 am, Saturday/Sunday 8 am–12 am).

Results

In all, 1378 ER patients and 2121 UCP patients answered the survey. ER patients had lower overall satisfaction rates regarding their treatment (90.3% vs 95.7%; $P < 0.001$). They also deemed the waiting time as too long (32.8% vs 21.4%; $P < 0.001$), which correlated with the actual waiting time of 199 min (95% CI: 185, 214) in the ER versus 98 min (95% CI: 93.9, 101) in the UCP. Of the ER patients, 85.6% disagreed with the statement that today's problem could have been treated by a GP (vs 42.1% of UCP patients) or by another specialist in an outpatient clinic (61.9% ER vs 31% UCP). Only 20% of ER patients reported that no further treatment regarding today's problem had been recommended to them (vs 76.9% of UCP patients). Of the ER patients, 32% were advised to see a specialist, whereas UCP patients were told to follow up with their GP (39.9%). Uncertainty regarding the health problem after the visit was equivalent in both groups (38.1% vs 39.7%).

Discussion

Most patients were satisfied with their treatment in the UCP.

Exploring parents' decisions regarding HPV vaccine for their daughters in Jakarta, Indonesia: A qualitative study

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Background
Cervical cancer, caused by the human papillomavirus (HPV), is one of the most common cancers among women worldwide. Despite numerous countries having introduced HPV vaccination programs, many girls worldwide remain unprotected. As part of a demonstration project in 2016, the Indonesian government provided the HPV vaccination free of charge to all Year five and six female students in Jakarta and several other cities, with a plan to roll out the program nationally in the future. Understanding parents' decisions regarding HPV vaccination for their daughters is important to ensure optimum uptake.

Aim
To explore what factors shaped parents' decisions regarding free school-based HPV vaccination for their daughters.

Methods
Twenty-four parents in Jakarta were interviewed and analysed thematically using The Theory of Planned Behaviour constructs: attitudes, subjective norms and perceived behavioural control.

Results
Having the vaccine provided free of charge seemed to increase parents' perceived behavioural control in being able to have their daughters vaccinated. Some parents had limited knowledge about cervical cancer and the HPV vaccine; others did not even realise that the free HPV vaccination program had been offered in their daughters' schools. Those who had better knowledge and positive attitudes trusted their general practitioners as a source of information. Peer approval was also important to guide their decisions.

Conclusion
Parents' attitudes towards cervical cancer and HPV vaccination are influenced, in part, by their knowledge. Sufficient and non-ambiguous information from trusted sources is vital to improve parents' knowledge and attitudes towards HPV vaccination. Shaping positive initial attitudes is important, as, once formed, attitudes are often difficult to change. General practitioners are a trusted source of information, are able to advocate for HPV vaccination and should be included as important stakeholders in national programs.

Creutzfeldt–Jacob disease: It is still out there

Dr Debra Scott[1]

[1]CJD Support Group Network, [2]NSW health

Aim

To highlight that CJD cases remain at the same prevalence in Australia and to outline the multidisciplinary care required, often with the GP coordinating care.

Creutzfeldt–Jacob disease (CJD) is a rare, rapidly progressive, invariably fatal neurodegenerative disease. CJD remains prevalent at the same epidemiological rate. Sporadic CJD affects approximately one to two in one million people each year. Although rare, some GPs will see this disease and are in a prime position to consider it in differential diagnoses. Awareness of possible presenting symptoms, which may occur in patients already in a residential aged care facility, will facilitate appropriate referral and support for the patient, family and GP.

A case of CJD from initial presentation to specialist referrals, investigation and subsequent supportive care by a GP (then registrar) will be presented. The purpose is to highlight the importance of early referral to specialist teams, the need for ongoing collaboration with specialty teams and allied health, to outline the progression of the disease and to delineate some of the unique features in its trajectory.

As the ongoing supportive and palliative care is often continued by GPs, this presentation also aims to emphasise the value of close and regular collaboration with care providers (if at home) or nursing staff given its unique trajectory.

This presentation will touch on the role of neuropathology and on the even rarer genetic form of CJD (10–15% of CJD cases; of note, 60% of genetic cases have no known family history) which is relevant for practice.

It will outline recent research into possible future treatment agents and highlight the support available to families and the GP, including by the CJD Support Group Network (CJDSGN).

Clinical dashboards: Developing clinically relevant data tools for primary care teams that reduce health outcome inequities

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Aim

To learn about the 'clinical dashboard' approach to sharing clinically relevant information that improves health outcomes and reduces inequities in health. Participants will develop a new 'mental health' clinical dashboard scaffold.

Content

Clinical dashboards have been developed by clinicians across a range of primary healthcare organisations in New Zealand. In collaboration with Māori health teams, a series of domains where inequities are greatest was identified, including diabetes, cardiovascular disease, respiratory disease, cancer and mental health. In addition, a dashboard approach was taken to share data relevant to COVID management which was shared with Māori hauora (health provider) partners to direct where immunisation services needed to be provided.

Clinical dashboards will be presented to illustrate how they work and the diabetes dashboard will be explained in detail, with a descriptor of how this was developed and the scaffold of questions and data definitions that underpin it shared with participants to use in their own health service.

Facilitated discussions will aim to develop a scaffold of questions and data definitions that will provide clinically relevant and actionable data to primary care teams that will identify gaps between standards of care and current outcomes in the domain of mental health.

Transforming medical education in primary care

Dr Darren Seah

National Healthcare Group Polyclinics

Aim

Singapore is undergoing a major healthcare shift with greater emphasis being placed on the role of general practitioners to meet the challenges of an ageing population with a greater chronic disease burden. We explore the transformation our medical education department, which is based in a public-sector primary care institution, has made to deliver training and education that will meet the needs of the future.

Content

We showcase the changing healthcare landscape in Singapore and describe the '4P' framework that guides the changes we have implemented in our department to transform educational practices across undergraduate, postgraduate and continuing medical education, namely Pedagogy, People, Place and Platform.

In undergraduate medical education, we will describe how we engage students to consider a career in family medicine and how we continue to innovate our student attachments to ensure fulfilling learning in primary care.

We will showcase how our postgraduate Family Medicine Training Program continues to adapt its curriculum and assessments to ensure future-ready family physicians.

We will describe our approach to ensure continuing medical education will meet future challenges that our physicians will face in light of rapidly changing needs of patients that will require physicians to take a more active role in social prescribing, deliver more comprehensive care in the primary care setting and provide care for more complex and multimorbid patients.

Goals

Attendees can gain insights into the considerations and experience of our department which has keenly worked to ensure clinical service and medical education are deeply integrated such that educational activities translate to produce better clinical outcomes.

Our experience that links medical education across three broad trainee audiences verticals against our '4P' horizontal framework will help medical educators futureproof their own family medicine training programs.

Thriving in the Deep End: What is required for high quality general practice in deprived communities?

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Australia is a rich country but, like many other rich countries, there are deep pockets of deprivation and poverty. Australia has the 15th highest poverty rate out of the OECD countries, and over 13% of Australians live below the poverty line, including over 16% of children. This poverty is not spread evenly across the country but occurs in pockets in particular areas.

The health problems caused by poverty – more chronic diseases, more multimorbidity at a younger age – are well known, and this, combined with the social circumstances and lack of resources, provides particular challenges for general practices servicing these communities.

This roundtable will outline the specific context of providing general practice in deprived communities in Australia, and link these to the international experience of GPs working in similar communities across the world, which has come to be called working at the Deep End. The effect on particular communities will be outlined, and challenges in workforce, health funding and policy will be discussed, with the likely effect on providing general practice in these communities. Potential opportunities and solutions to enable the provision of high-quality general practice in deprived communities will be discussed, with lessons from Australian and international contexts used. The role of the new RACGP Specific Interests Network in Deprivation and Poverty will be discussed in providing peer support and policy advocacy.

Effects of doctor attributes and behaviours on patients attending public primary healthcare (PHC) clinics in Botswana

A/Prof Vincent Setlhare, Sphiwe Madiba

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This was part of a larger qualitative study into the doctor attributes and behaviours that patients in Botswana desire and those they do not desire during consultations. The study was conducted in public PHC clinics in different districts of Botswana. Non-specialist doctors and patients in public PHC clinics were interviewed using a semistructured interview guide. Adult interviewees were purposively selected to maximise variety of participants regarding age, professional working experience and gender (doctors), while selected patients varied in age, gender, employment and education status, and had to have at least two previous doctor consultations.

Thirty-two adult patients from south-eastern, central, north-western and western Botswana participated in the study. The patients had consulted a doctor in a public PHC clinic two or more times in the previous 12 months. Ten patients were males, 13 were rural dwellers and nine and 10 were semi-urban and urban dwellers, respectively. Fourteen patients were employed, 18 had 8–12 years of formal education, two had no formal education, four had primary school education and six had more than 12 years of formal education. The ages of the patients ranged from 19 to 67 years (mean age 38).

There were 17 doctor participants. The doctors were from the same areas of Botswana as the patients. Ten of the doctors were male, and their ages ranged from 28 to 58 years (mean age 37). All participating doctors worked in selected public PHC clinics. Their work experience ranged from three to 15 years. Ten of 17 doctors had work experience of more than five years.

The doctor attributes and behaviours that patients desired and those that they did not were grouped into communication, social and clinical skills. Desirable attributes and behaviours facilitated patient care and health-seeking behaviour while undesirable ones were detrimental to both.

Association of interpersonal conflict in suicidal ideation in suicide-attempted patients visiting tertiary care centre of Nepal

Dr Aarati Shah

Tribhuvan University Teaching Hospital

Introduction

Suicide is an important, largely preventable public health problem. Unfortunately, the occurrence of suicide and suicidal behaviour has been increasing dramatically. Recent research efforts have yielded that there is a growing recognition of conflict within the family (interpersonal conflict) as one of the important risk factors for suicidal ideation. The aim of the study was to analyse the association between suicidal ideation due to family conflict and to assess the mode of suicide and suicidal ideation in different ages, gender, ethnicity, social status and occupations.

Methods

An observational study was conducted among suicide-attempted patients presenting to the tertiary hospital emergency department TUTH. There were 128 patients who met the inclusion criteria and gave consent and were included in the study. Patients were interviewed after primary treatment and sociodemographic information was collected using the self-designed proforma.

Results

Among the 128 participants, 66 (51.56%) were affected by conflict within the family member with a mean age of 35.2 (± 11.24); there were 62 (48.44%) with other than family conflict, with a mean age of 25.6 (± 10.22). Independent t-test P =< 0.001. This study shows that 59.38% of participants were married and 35.94% were housemakers. Among the participants, most (80; 62.5%) were female and 116 (90.63%) used poison as a mode of suicide.

Conclusion

There is an association between suicidal ideation with relation to family conflict (interpersonal conflict). In this study, 51.56% of participants had a conflict with one or another member of the family. Young females are mostly affected and used poison as a mode of suicide.

Key words

suicide, interpersonal conflict, poison.

Rural metabolic syndrome: Assessing barriers and facilitators to appropriate management

Dr Aniruddha Sheth

RACGP

Aim

The aim of this research project is to understand the perceptions of rural general practitioners (GPs) in Western Australia regarding the management of metabolic syndrome in rural areas and to identify the facilitators and barriers to its management.

Content

Metabolic syndrome is a growing global epidemic with severe health implications for individuals, communities and healthcare systems. It has also been identified as a significant risk factor for poor COVID-19 outcomes. Rural populations in Australia have a higher prevalence of metabolic syndrome compared to urban populations. Diet and lifestyle interventions are playing an increasing role in the management of this condition with an increasing evidence base for their use. These interventions also avoid the complications associated with the management of metabolic syndrome with pharmacological or surgical methods. While diet and lifestyle interventions for metabolic syndrome can be provided by GPs or allied health practitioners in primary care, the ability to deliver interventions is limited in the rural setting. Costs of interventions are high and access to care is frequently challenging. Given that the incidence of metabolic syndrome is increasing globally, including in rural areas, it is imperative that best practice for management of metabolic syndrome is addressed at the level of primary care in a cost-effective and scalable way. Data still to be collected.

Goals

The research aims to explore the specific barriers to delivering interventions for metabolic syndrome in the rural setting and to provide insights into overcoming these barriers to improve health outcomes for patients. The findings of the research will inform the development of targeted interventions to improve the management of metabolic syndrome by rural GPs and ensure that patients in rural areas receive the best possible care.

Data collection pending currently.

Shared medical appointments and group sessions in general practice: An innovative answer to relieve general practice burdens?

Dr Bernard Shiu, Dr Michael Axtens

Deakin University

Shared medical appointments (SMAs) and programmed shared medical appointments (PSMAs) have been well recognised as suitable alternative consultation models in many clinical settings, from management of overweight and obesity, diabetes (including prediabetes), cardiovascular diseases, chronic kidney disease, etc. We examined two models of care carried out in the Geelong region that each promise to help alleviate the overall burdens of chronic disease management and practitioner burnout. In this presentation Drs Shiu, Dwyer and Axtens will present their experience and research in delivery of care to a group of patients. The educational and clinical components of each model will be discussed.

Evaluating the implementation of online research training and mentorship among early career family physicians in Sub-Saharan Africa

Dr Darcelle Shouw[1], Prof Bob Mash, Dr Pius Ameh, Dr Bolatito Fatusin, Stephen Engmann

[1]University Of Stellenbosch

Background

Research is needed to improve the performance of primary healthcare. In Africa, few family physicians conduct research, and therefore an online research training and mentorship program was developed to build research capacity among novice and early career researchers.

Aim

To evaluate the implementation of the AfriWon Research Collaborative (ARC) training and e-mentorship program in Sub-Saharan Africa.

Methods

A 10-module online curriculum was supported by peer and faculty e-mentorship, to mentor participants in writing a research protocol. A convergent mixed-methods study combined quantitative and qualitative data to evaluate nine implementation outcomes.

Findings

Fifty-three participants (20 mentees, 19 peer mentors and 14 faculty mentors), mostly male (70%), participated in the ARC online program. The program was seen as an acceptable and appropriate initiative. Mentees were mostly postgraduate students from African countries. Faculty mentors were mostly experienced researchers from outside of Africa. There were issues with team selection, orientation, communication and role clarification. Only 35% of the mentees completed the program. Alignment of mentoring in teams and engagement with the online learning materials was an issue. Costs were relatively modest and dependent on donor funds.

Conclusion

Despite many challenges, the majority of participants supported the sustainability of the program. The evaluation highlights the strengths and weaknesses of the ARC program and e-mentoring. The ARC working group needed to ensure better organisation and leadership of the teams. Going forward the program should focus more on developing peer mentors and local supervisory capacity as well as the mentees.

Evaluating the implementation of group empowerment and training (GREAT) for diabetes in South Africa: Convergent mixed methods

Dr Darcelle Shouw[1], Prof Bob Mash

[1]University Of Stellenbosch

Background

Diabetes is a leading contributor to the burden of disease in SA. The National Strategic Plan for NCDs aims to achieve control in 50% of patients. Currently, in the Western Cape, only 25% are controlled and a lack of patient education and counselling is a key factor. Group empowerment and training (GREAT) for diabetes is a feasible and cost-effective intervention. This study aimed to evaluate implementation of GREAT for diabetes in primary care across five provinces.

Methods

A convergent mixed-methods study evaluated a range of implementation outcomes. Descriptive exploratory semistructured interviews were conducted with 31 key stakeholders from national policy makers to primary care providers. Five FGIs were held with patients. Qualitative data explored the acceptability, appropriateness, adoption, feasibility, fidelity and sustainability of GREAT. Quantitative data were collected on the training course, observations of GREAT, coverage and cost.

Results

Five of nine provinces implemented GREAT, despite the challenges of the COVID-19 pandemic. The findings informed the design of a program theory using a health system framework. Health system structures required support from national- and provincial-level policy makers, identification of high-prevalence districts and allocation of funds. Health system inputs required attention to physical space for groups, sufficient staff numbers to facilitate groups, availability of the resource materials and monitoring within the health information system. Key activities included adaptation to the model of care, training of facilitators and trainers and inclusion in systems for quality improvement. Identified outputs related to the availability of GREAT and improved quality of care. Expected outcomes related to improved coverage, diabetic control and patient satisfaction.

Conclusions

Key lessons were learnt on how to implement GREAT for diabetes in a middle-income country primary care system. The program theory will guide further scale-up in each province and scale-out to provinces that have not yet implemented.

Role of GP special interest on provision of dermatology services at Cairns Hospital

Dr Lubna Siddiq, Ilsphi Browne

Cairns Hospital

Aims

Cairns and Hinterland Hospital and Health Service (CHHHS) serves Far North Queensland with a catchment population of about 289,000 (including Torres and Cape Hospital and Health Service population). Geography, demographics and climatic conditions present peculiar challenges in the provision of dermatological services in this region. A higher prevalence of melanomas, non-melanoma skin cancers and other dermatological conditions, along with paucity of specialist services, can impact on timely diagnosis and management of these conditions. CHHHS allocated GP with special interest in dermatology (GPSI or GPwSI) to Cairns Hospital Dermatology Department in 2018. We discuss implementation and service delivery of this alternative care model, analysing its impacts on the dermatology service at Cairns Hospital.

Methods

A literature review of related articles and annual reports of organisations (public hospitals where relevant model of service care was implemented) was conducted to ascertain and compare the effectiveness of the GPSI model in Australia.

Results

This model augments the workforce and efficiency of the department, therefore reducing waiting times for patients. This provides training registrar on rotation opportunity to focus on diverse dermatological conditions in addition to skin cancer. It enhances the capacity of supervising specialist to spare dedicated teaching time. Given GPSI positions can be retained for 12–24 months, this model provides continuity of care for skin cancer surveillance. The clinic provides significant upskilling for GPs working to then provide services in the community and upskill their colleagues.

Conclusions

GPSI service model supported by specialists can be integrated in large regional dermatology services within the hospitals. This can be further extended in communities as an outreach service supported by a dedicated teledermatology service. Formalisation and standardisation of GPSI training in collaboration between respective training institutions is recommended.

Disease pattern among long-term users of weak opioids (codeine, tramadol) and benzo/Z-drugs

Kristjan Linnet[1], E/Prof Johann Sigurdsson[1,2], Brynjar Bjarkason[1], Emil Sigurdsson[1,3], Larus Gudmundsson[4], Margret Olafia Tomasdottir[1,3]

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Background
In a recent study, we showed that long-term (three years) use of weak opioids (codeine and/or tramadol), combined with benzodiazepines/Z-drugs (BZD/Z), was associated with an increased dose-dependent risk of all-cause mortality. Therefore, preventing measures targeting this group, especially heavy drug users, by a deprescribing approach could be of benefit for these patients. However, being multimorbid might make this approach more complicated.

Aim
To analyse disease patterns, index conditions and possible clustering of diseases among long-term users of weak opioids and BZD/Z-drugs.

Methods
Of 221,804 patients contacting the primary healthcare centres in the capital area of Iceland, 124,436 were selected for further analysis. Exposure time for long-term drug use was three years. The 88,832 participants who fulfilled the inclusion criteria, aged 10–69 years, were divided into four groups: Group I, neither used BZD/Z nor opioids (n = 78,248); Group II, used opioids but no BZD/Z-drugs (n = 304); Group III, used BZD/Z but no opioids (n = 7,881); and Group IV, used both BZ/Z and opioids (n = 2,399). Chronic medical diseases were analysed according to ICD-10.

Results
Preliminary results show that most of the long-term users of weak opioids were multimorbid, where the chronic pain-related diseases were to a great extent combined with mental diagnoses. Further subgroups, especially within mental diseases (F group) and musculoskeletal diseases (M group) with possible clustering of disease patterns will be presented at the conference.

Considerations and learning issues
Disease patterns, multimorbidity, index diseases and index conditions, as well as polypharmacy, have to be taken into consideration among long-term users of opioids and BZD/Z when considering deprescribing drugs.

Family medicine core values and the UN Sustainable Development Goals: A guide to advocacy

Dr Anna Stavdal[2,3], Prof Linn Okkenhaug Getz[4], A/Prof Karen Flegg[5,6], Dr Nina Monteiro[7], Dorien Zwart[8], E/Prof Johann Sigurdsson[1,4]

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Aim

Strengthen the argumentative toolbox of family medicine/general practice (FM/GP) advocates.

Background

Throughout the world, governments and organisations claim adherence to the United Nations' 2030 Sustainable Development Goals (SDGs). A fundamental premise for sustainability thinking is to consider the 17 SDGs as interrelated. Changes in one sector will always impact on the other domains and their interplay, for better or worse.

SDG3 is 'Good Health and Well-being'. The World Health Organization emphasises how other SDGs (education, equity, climate, etc) have direct or indirect impacts on the fundamental premises for health in human societies. Furthermore, good health status is evidently a premise for high performance in the other 16 SDG domains. However, little emphasis has been put on the relationship between prudent organisation and delivery of healthcare and overall sustainability, including planetary health. This is where the core values of FM/GP enter the picture.

In the spirit of the Declaration of Alma-Ata (1978) and WHO's *Primary health care: Now more than ever* (2008), the interest in core values in healthcare has increased. The Nordic countries launched seven core values and principles for FM/GP in 2020, followed by WONCA Europe in 2022. Navigation by 'soft' moral principles can at first sight represent at blunt strategy. The mission becomes clearer once we realise that core values in FM/GP point not only to high achievement in Health (SDG3), but concomitantly in the other domains, for example Gender Equality (SDG5), Reduced Inequality (SDG10), Sustainable Communities (SDG11), Responsible Production and Consumption (SDG12), Climate Action (SDG13) and Partnerships for the Goals (SDG17).

Method and Goal

In brief introductions we will outline and compare the SDGs and core values in FM/GP and exemplify how the resulting framework can be used to promote FM/GP as the most sustainable foundation for healthcare worldwide. This will be followed by an interactive discussion.

Women Doctors and COVID-19: An international, sex-disaggregated survey of experiences and concerns raised by women doctors working during a pandemic

A/Prof Magdalena Simonis[1], Antonella Vezzani, Magda Carneiro-Sampaio

[1]The University of Melbourne Department of General Practice

Aim

This survey aimed to explore the experiences of women doctors working in diverse medical settings around the globe during the COVID-19 pandemic, and how this affected their work life and sense of wellbeing. The study fills a significant gap in the research during COVID-19.

Methods

Members and non-members of Medical Women's International Association (MWIA) were invited by email to participate in an online survey during the COVID-19 pandemic from 30 December 2020 to 30 April 2021.

Findings

There were 27 questions with 1478 responses and a 1110 (75%) full completion rate. Free text responses were thematically analysed and identified issues for pregnant doctors, those with children and carers of family members. Of the respondents, 51% were MWIA members and 48.9% were non-members. Forty per cent were working face to face, 36% had been working for more than 30 years with 27% in general practice and 17% listed as physicians.

Eighty-six per cent of the doctors worked in urban settings and 13% worked in remote and rural areas.

More than 50% described the impact on their ability to work as moderate to severe and 50% reported that personal protective equipment (PPE) supplies were insufficient sometimes (18.3%) to nearly always (34%). More than 65% had not been fit tested for masks, and up to 38.8% had treated patients with COVID-19. Interestingly, 26.3% had never been tested for COVID-19 and 12.68% had contracted COVID-19. Community education was provided by 34.5% of the women doctors and 15.9% informed government, while 50.47% were engaged in updating colleagues.

Conclusion

This survey reveals there are significant issues for women doctors working during a pandemic and the results suggest ways to improve the workplace and the safety for frontline women doctors.

#NavigatingHealth: Building a global approach to enable health systems navigation

Kaylene Ryan, Mrs Siân Slade[1]

[1]Nossal Institute For Global Health

Background

While health reviews talk about system shifts from reactive 'one size fits all' to proactive personalised healthcare, the lived reality is that health systems are challenging for patients and carers to navigate. Patients frequently experience gaps and barriers in healthcare. The challenges are not new and were extensively researched >30 years ago.

Audience

This roundtable is for a multidisciplinary audience of patients, health professionals, policy managers and politicians focused on enabling patient-centred at a systems level.

Methods

Patients, professionals and policy makers in Australia and globally have been involved in a national community of practice in Australia, 'Mind the Gap: #NavigatingHealth'. The approach was tested for audience interest with two webinars in September 2021 setting the scene of navigating health across a life journey with speaker dyads of patient and provider experiences focused on a solutions approach. Following the initial interest we developed an open forum bimonthly community of practice. Our focus in Year 1 was to make visible the many solutions and develop an engaged, connected, collaborative and participatory community. The approach has now been expanded globally with one webinar in 2022 and three planned for 2023 with speakers from Australia, the USA, Canada, the UK and Europe interweaving micro, meso and macro approaches (eg included American Cancer Society, NHS England).

Results/outcome

Problems that patients and their providers face navigating health systems in countries are common and consistent. Setting up a global approach allows accelerated systems thinking in diffusion of innovation.

Discussion

Consolidation of the learnings, scale, measures of success and future policy development in high-, middle- and low-income settings.

Remote patient monitoring: Connecting patient care

Mr Jared Slater

Gippsland Primary Health Network

This presentation outlines a partnership approach between Gippsland Primary Health Network and participating general practices that aims to improve the health outcomes of people with chronic disease using real-time data to support comprehensive clinical decision making and care coordination within or close to home through remote monitoring.

Chronic health conditions (eg diabetes, cardiovascular and respiratory disease) are causes of high levels of preventable hospitalisations in Gippsland, Victoria. Limited progress addressing longstanding structural challenges, including access to health services, service coordination and health workforce shortages, highlight the urgent need for new approaches to assist people to manage chronic health conditions.

General practitioners and practice nurses are monitoring patients with chronic health conditions to undertake regular home-based monitoring and access comprehensive clinical decision making and care coordination at home.

The platform allows real-time patient–health provider connectivity via a mobile app for patients and a desktop application and app for health practitioners.

Monitoring is mobilised through patients regularly reporting health-related information defined in monitoring templates. Developed by a clinical reference group, the suite of monitoring templates was developed across chronic and acute conditions with predefined clinically significant thresholds for vital signs and patient-reported outcomes. When one or more monitoring templates are allocated to a patient, information reported outside a threshold alerts the health provider, signalling deterioration and enabling timely intervention. This model of care offers rural health services an innovative approach to prioritising and responding to patients' healthcare needs, with 12 general practices actively monitoring over 100 patients via 17 monitoring templates.

This presentation will share insights into the use of real-time longitudinal data to inform clinical decision making during patient interactions, the importance of a team-based care approach to chronic disease and the value to strong interactive relationships between Primary Health Networks and general practices to tailor models of care.

Influence of a pre-visit ADHD video/question prompt list intervention on rural youth question-asking and provider education during US medical visits

Prof Betsy Sleath, Kathleen Thomas, Delesha Carpenter, Nacire Garcia

University of North Carolina-Chapel Hill

Prior work conducted internationally has found that youth often are not involved and do not ask questions during medical visits. A pragmatic randomised controlled trial to test the effectiveness of an attention deficit hyperactivity disorder (ADHD) pre-visit video/question prompt list intervention to increase youth question-asking and provider education about ADHD during visits was conducted. Youth aged 11–17 years with ADHD were recruited from two paediatric clinics in rural US counties and randomised. Intervention youth watched an 11-minute video that encouraged them to ask questions and completed a one-page ADHD question prompt list where they checked the questions that they wanted to ask their providers. One hundred and two youth participated; 32% were Black, 13% were Native American, 1% were Hispanic. Thirty-six per cent were female. Youth in the intervention group were significantly more likely to ask their providers one or more questions about ADHD and its treatment than youth in the usual care group (40% vs 12.5%, Pearson Chi-squared = 9.8, P = 0.002). Parents in the intervention group were not significantly more likely to ask questions about ADHD than parents in the usual care group (34.6% vs 10.4%, Pearson Chi-squared = 0.03, P = 0.86). Providers were significantly more likely to educate youth in the intervention group about more non-medication treatments than youth in the usual care group (t-test = 2.32, P = 0.02). The intervention did not significantly increase visit length (14.7 vs 11.7 minutes, t-test = 1.57, P = 0.12). Providers were not significantly more likely to educate youth in the intervention group about school, relationships or medications than youth in the usual care group. Youth are being followed for six months to examine how the intervention impacts school performance and ADHD symptoms. The intervention has the potential to improve ADHD management in rural practices as well as youth self-management. Further research should explore distal impacts on health, school success and relationships.

Evaluating authentic and servant leadership development in The Royal Australian College of General Practitioners' Future Leaders program

Dr Catherine Sloan[1,2], Dr Vani Arjunamani[1,2]

[1]RACGP Future Leaders 2023, [2]RACGP

Aim

To show whether The Royal Australian College of General Practitioners' (RACGP) Future Leaders program successfully fosters authentic and servant leadership styles among its participants.

Content

Using pre- and post-program surveys, including the Authentic Leadership Questionnaire (ALQ) and the Servant Leadership Survey (SLS), this study assesses changes in leadership behaviour and attitudes among program participants. The results provide insight into both the participants' perceptions and experiences of the program, and their leadership development journey.

Participants report increased confidence and capability in leading with authenticity and a service-orientated mindset, suggesting that the RACGP Future Leaders program is effective in promoting authentic and servant leadership characteristics.

Goal

To encourage other GP colleges, worldwide, to offer leadership programs to reconnect and revive their members, resulting in the recovery of primary care across the globe.

Perspectives of primary care professionals from around the world on COVID-19 vaccination programs: Early results from a cross-sectional study

Dr Sumeet Sodhi[1,2,3], Rifka Chamali[1], Devarsetty Praveen[4,5,6], Manushi Sharma[4], Marcelo Garcia Dieguez[7], Prof Bob Mash[8], Prof Felicity Goodyear-Smith[9], Prof David Ponka[1,10]

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Aim

The aim of the study is to describe the perspectives of a diverse group of international primary healthcare professionals (PHC-P) in supporting COVID-19 vaccination programs with a focus on their experiences of public health and primary care integration during implementation of national COVID-19 vaccination programs in their own jurisdictions.

Content

We conducted a cross-sectional online survey among a convenience sample of international PHC-P through member-based organisations and professional networks from November 2021 to February 2022, via email and online newsletters. Survey development followed an iterative validation process with a formative committee developing the survey instrument based on study objectives, existing literature and best practices, and a summative committee verifying and validating content. Inclusion criteria included: adults who self-define as a PHC-P: academics, researchers, government staff, policy makers, primary care providers such as general practitioners, family physicians, mid-level healthcare providers, nurses and community pharmacists.

We received 477 responses from 84 countries. Forty per cent of respondents identified as general practitioners or family physicians. The majority of respondents felt that vulnerable and high-risk groups were prioritised for COVID-19 vaccination, and that cold chain requirements for vaccine storage were met; some felt that political commitment was a barrier to implementation. Additional barriers identified were: lack of vaccine supply, vaccine hesitancy, misinformation, lack of communication and coordination and difficulties with access/transportation of clients to vaccination sites. Successful practices included: involvement of PHC-Ps, use of online registration, mobile vaccination clinics, rapidity of scale-up and teamwork at the community level. Suggestions for improvement were: better procurement policies, more use of public awareness campaigns through social media and more public–private partnerships.

Goals

Future goals include advocating for strengthening primary care through better integrating primary care and public health efforts in mass vaccination programs. We anticipate this could lead to a more agile response for future pandemics.

Who should be involved in the patient's care? 'Episodic relatedness' and the involvement of network in socioeconomically disadvantaged families

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[1]Center for Research and Education in General Practice at the University of Copenhagen, [2]Department of Anthropology, University of Copenhagen

Background and aim

Social relationships and health are strongly associated. However, important gaps remain in our understanding of the mechanisms behind the associations, as well as knowledge about how it is played out in everyday life. In the current study, we explore social relationships within socioeconomically precarious young families with a multimorbid parent, as well as their extended networks, to understand this connection.

Methods

During a two-phased anthropological fieldwork investigation, data were gathered from six chosen case families and their wider networks. Participant observation as well as repeated semistructured and open-ended interviews were used to gather the data.

Results

Participants in the study reported experiencing life as a series of uncontrollable events. The participants' networks were unstable and of fleeting value since this style of being in the world was associated with a recurrent pattern of unstable relationships.

Conclusions and goal

The expectation that family members and wider networks should be involved in a patient's care and treatment is becoming more common in healthcare systems around the world. Our findings point to potential challenges in the application of this approach. We advise medical professionals to inquire about their patients' social networks and relationships and to be aware that a patient's key connections can change significantly and frequently over short periods of time.

Association between systemic inflammatory markers and carotid atherosclerosis in middle-aged adults: A cross-sectional study

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Background

Atherosclerosis is a condition associated with systemic inflammation, and markers of systemic inflammation such as C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), neutrophil-to-lymphocyte ratio (NLR) and platelet-to-lymphocyte ratio (PLR) have been identified as potential indicators. In this study, we investigated the association between these inflammatory markers and carotid atherosclerotic indices in a population of relatively healthy middle-aged adults.

Methods

A cross-sectional study of relatively healthy adults aged 40–65 was conducted. The subjects were tested for CRP, ESR, NLR and PLR, as well as measurements of carotid intima–media thickness (cIMT), plaque number (PN), plaque stenosis score (PSS) and plaque severity score (PS). Linear regression, logistic regression and ROC curve analysis were used to analyse the relationship between the inflammatory markers and carotid atherosclerotic indices.

Results

ESR and CRP had a significant correlation with PN in males ($P < 0.001$ and $P = 0.048$, respectively), and ESR showed a correlation with PN in females ($P = 0.004$). NLR and PLR had a correlation with PS in both males ($P < 0.001$ and $P = 0.015$, respectively) and females ($P = 0.015$ and $P = 0.023$, respectively). Increased NLR was associated with increased cIMT, PN and PS ($P < 0.05$). The odds ratio (OR) was 1.15 (95% confidence interval [CI]: 1.03, 2.15; $P = 0.032$) for males and 1.05 (95% CI: 1.01, 1.29; $P = 0.009$) for females in the NLR group. PLR was also associated with increased cIMT, PS and PN ($P < 0.05$). The AUC for NLR was 0.556 (95% CI: 0.517, 0.596) for males and 0.666 (95% CI: 0.542, 0.790) for females. The AUC for PLR was 0.597 (95% CI: 0.524, 0.624) for males and 0.635 (95% CI: 0.544, 0.697) for females.

Conclusion

Our study found a significant correlation between systemic inflammatory markers and carotid atherosclerosis indices in middle-aged adults. Further research is required to validate their usefulness as predictive tools.

Prediction of cardiometabolic risk using anthropometric indices among adult patients in south-west Nigeria

Dr Bolajoko Sosanwo, Dr Adekunle Ariba, Oluseun Adeko

Olabisi Onabanjo University Teaching Hospital, Sagamu

Background

Mortality from cardiovascular disease (CVD) is increasing globally, especially in low- and middle-income countries where 75% of the mortality occurs. CVDs are largely driven by risk factors, most of which are modifiable. Cardiometabolic risk factors include hypertension, diabetes mellitus (DM), dyslipidaemia and obesity. Traditionally, assessment of cardiovascular risks includes laboratory investigations, which are burdensome in resource-constrained settings. Obesity is directly linked with other cardiometabolic risk factors and can be easily assessed in primary care using anthropometric indices (AI). The study aimed to assess the ability of AI to predict cardiometabolic risk factors.

Methods

A hospital-based descriptive cross-sectional study of 388 adult patients without obvious cardiovascular disease, selected using systematic random sampling. Anthropometric measurements were taken and the body mass index (BMI), waist circumference (WC), waist/hip ratio (WHR), waist/height ratio (WHtR) and conicity index were calculated. BP was measured and blood samples were taken for FBG and FLP. Receiver operating characteristic (ROC) curve and area under the curve (AUC) were used to estimate the predictive ability of the AI.

Results

The prevalence of hypertension, DM and dyslipidaemia was 45.1%, 9.5% and 45.1%, respectively. The prevalence of overweight and obesity based on BMI and WC was 51.0% and 61.1%, respectively. BMI had the widest AUC (0.699; P = 0.001) for hypertension in males, while WC had the widest AUC for hypertension in females (0.748; P = 0.001). CI had the widest AUC for DM in males and females (0.568 [P = 0.383] and 0.798 [P = 0.001], respectively). WHtR had the widest AUC for dyslipidaemia in males (0.618; P = 0.026) while BMI had the widest AUC in females (0.578; P = 0.029).

Conclusion

AI had varying ability in predicting cardiometabolic risks and none was consistently the best predictor. For instance, BMI was the best predictor of hypertension in males while WC was the best predictor in females.

The cycle of care: Your care, their careers

Dr Phillipa Southwell[1], Hollie Day[2], Ms Frances Trench[3], Ms Linda Cutler[1]

[1]Western NSW Regional Training Hub, [2]Far West Regional Training Hub, [3]Riverina Regional Training Hub

There is increasing evidence for the positive impact of representation in supporting the career aspirations of rural students to overcome barriers to tertiary study. The Student Series of Destination Medicine© aims to foster the aspirations of rural people to pursue a career in medicine and support their early steps towards that goal. Destination Medicine has produced 30 semistructured conversations with current medical students. The students were generally of rural origin, but no age, university or demographic restrictions were used through the voluntary talent recruitment process. An iterative thematic analysis of the student series was undertaken. Interviews were transcribed and analysed to establish the three emergent themes: reciprocity, the rural pipeline in action and building social capital. The culture of 'giving back' commonly associated with medicine resonated through their narratives. The students spoke about early exposure to the blend of continuous care, excellence in practice and community engagement modelled in general practice that fostered their own ideas of how they wanted to practise medicine. This pattern of observing the care taken of them and extending that care to others is consistent with the theory of indirect generalised reciprocity: giving without the expectation of receiving, but rather passing on the benefit to another. Their podcast episode became a small but important aspect of student 'paying it forward' by contributing to a social capital repository to connect with and equip prospective rural medical students. This presentation will unpack the ways in which rural primary care doctors have influenced the lives of these young people, functioning as early and critical drivers in the rural medical pipeline, unknowingly encouraging those young people to consider the welfare of those coming after them and continue this cycle of care.

Making sense of eating disorders in primary care

Dr Karen Spielman, Ms Sally Corry, Peta Marks, Sarah Maguire

Insideout Institute, The University of Sydney

Not only has the incidence of eating disorders (ED) increased over the course of the pandemic, but the assessment, diagnosis and management has fallen increasingly to GPs who are busier and less supported than ever . The introduction of Australia's Medicare ED treatment items in November 2020 with GP assessment and referral key, showed courage and prescience. Consequently, GPs have become increasingly involved in the space through both interest and necessity, and creative responses are needed to support them. As whole-person carers with expertise in mind and body, GPs can be the gateway to and coordinators of the specialised multidisciplinary care that is necessary to intervene early and to manage longitudinally and provide the right care at the right time in the right place.

This GP case presentation aims to illustrate the complexity and supports available for managing an adolescent with a recent onset of anorexia nervosa in any setting. It will contain reference to a locally developed and validated screening tool for both online and face-to-face use, as well as innovative digital resources designed for primary care. Through the voice of the treating GP and lived experience family/carer advocates, it will demonstrate best-practice collaborative care and explore the supports available to translate this information to other transdiagnostic ED presentations.

The goal is to demonstrate that managing EDs is just like managing hypertension, diabetes or depression and must be core business for GPs everywhere. Instituting acceptable screening, informed assessment and careful evidence-based treatment options in a collaborative multidisciplinary setting will bring treatment to consumers and carers at a disease stage where treatment is likely to be more successful and cost-effective with better outcomes.

Utilising HealthPathways to understand the availability of public abortion in Australia

Dr Sonia Srinivasan, Dr Jessica Botfield, Professor Danielle Mazza

Monash University

Background

Access to publicly funded abortion in Australia is limited, with a considerable proportion carried out by private providers. There are no nationally reported data on public abortion services, and referral pathways are poorly coordinated between hospital and primary care sectors. HealthPathways is an online system for use in primary care that provides information on referral pathways to local services. The aim of this study was to describe abortion referral pathways for each HealthPathways portal in Australia.

Methods

A review of Australian HealthPathways content on abortion was undertaken between January and June 2022. For each HealthPathways portal, data were extracted on referral options to abortion services.

Results

Seventeen of 34 Australian HealthPathways consented to be included. Nearly half (47%) had no public services listed for surgical abortion, and 35% had no public services for medical abortion. The majority (64% for surgical abortion, 67% for medical abortion) emphasised that public services should be considered only as a last resort. There was variation in information regarding gestation-specific options, the time-critical nature of referrals and the importance of women's own preference when deciding between medical or surgical abortion.

Conclusion

Despite few remaining legal restrictions to abortion, many regions across Australia either do not have public abortion services or do not provide information about them. There is an urgent need for transparency around public abortion service availability, clear guidelines to support referral pathways and commitment from state and federal governments to expand the availability of accessible, no-cost abortion in Australia.

The Core Values project

Dr Anna Stavdal

We family doctors must know who we are if we hope to strengthen our sense of identity, and we also need to have a clear idea of what we share. What unites us? Do we share a clear definition of our speciality? Do we have a common understanding of our core values, of what they mean for our clinical work; do we recognise when and how they are being challenged by changing societal trends?

We need common ground if we want our collective efforts to be effective – when training programs are developed, research agendas defined, advocacy actions planned, with activities that are dimensioned appropriately.

Our values are our guiding principles. But practices and standards vary in different contexts, particularly when it comes to local needs and what the public demands. Societal trends are always reflected in health systems, and first and foremost in primary care.

Defining our core values and our speciality has been a main interest of mine during the last 25 years. I have had the privilege of being deeply engaged in phase after phase of brainstorming and consensus processes on the Norwegian, Nordic and, recently, European level. Similar things have been going on elsewhere, such as in Canada and the Netherlands.

Massive efforts have been invested in WONCA during its half-century-long life. The purpose of the proposed brainstorming process is to engage our global community in far-reaching exchanges about our core values and the definition of ‘family medicine’. For a definition to impact identity, members need to have a stake in it, that sense of ownership that comes from having won it for themselves. Understanding our field is not something we do once and then we’ve got it. It’s an ongoing process. Lifelong.

Behaviours of concern in people with developmental disabilities: Rationalisation of medications historically prescribed

Dr Megan Stewart

Centre for Developmental Disability Health, Monash Health

Aim

To encourage the use of safer medications for management of behaviours of concern for people with a developmental disability.

Content

Persons with intellectual and developmental disabilities frequently have behaviours of concern for which they are prescribed multiple medications. Any medication that is prescribed with the primary purpose of behavioural control can be considered a form of chemical restraint. Victorian legislation and published evidence supports the importance of reviewing and rationalising medications of 'chemical restraint'. Rationalisation of medications is a frequent reason for referral to the Centre for Developmental Disability Health (CDDH), which is a government-funded clinic for the state of Victoria.

Pharmacological recommendations from CDDH:

1. Antipsychotic medications and benzodiazepines should not be the predominant medication. Effectiveness is limited and side effects of weight gain may increase challenges and risks for both the patient and the carer.
2. SSRIs (fluoxetine, sertraline) should be considered. High doses may be required for anxiety and OCD, which are both common in ASD.
3. Mood stabilisers (lamotrigine, valproate) should be considered. Downregulation of the limbic system gives a calming effect without sedation by reducing emotional dysregulation (meltdowns).
4. Clonidine can be used for almost all patients with behaviours of concern. It reduces catecholamine levels that cause mental inflexibility, and increased stimulus response associated with increased stress. It has a calming sedative effect, improves sleep quality (reduced REM sleep) and has an analgesic effect. Although an 'off-licence' use, it is considered extremely safe (monitor for orthostatic hypotension).

Goals

To consider the importance of medication review for patients with developmental disabilities

To increase confidence in making evidence-based medication changes for patients with developmental disabilities in primary care

Effects of COVID on medical education

Dr Terrence Steyer[1], Dr Nazlie Beckett[2], Dr Esther Johnston[3]

[1]Medical University of South Carolina, [2]University of Cape Town, [3]University of Washington

COVID-19 has had a disruptive and varied impact on medical education throughout the world. Medical schools in some countries (such as Zambia) continued to function without disruption to undergraduate medical education, with students joining the front lines of COVID-19 response. In other countries, such as Uganda, prolonged and severe lockdowns led to medical school closures, resulting in the delay of medical school graduates to enter the workforce at the precise moment when they were most needed to support the health system. In still other countries, such as the US and South Africa, the impact fell in between, with medical schools remaining open while many students found their clinical rotations converted to online or virtual experiences, in order to ensure their safety during a time when the transmission patterns and infectivity of the virus were not fully known. In these settings, the impact on medical education has had a long-lasting impact, as undergraduate medical students with dramatically less hands-on clinical experience and reduced clinical preparedness than their predecessors enter into clinical practice and graduate medical education programs.

During this roundtable presentation, speakers from the US and South Africa will lead a discussion on how their medical schools and residency training programs have responded to ensure the clinical competency of these students and respond to training disruptions. The strategies discussed will have utility in many situations, including future pandemics as well as times of social and political unrest, environmental disasters and many other situations.

Effect of automatic patient reminders on influenza vaccination uptake among adults with chronic conditions: Implementation study in Australian general practice

Prof Nigel Stocks, David Gonzalez-Chica, Elizabeth Hoon, Jessie Edwards, Dr Oliver Frank

Discipline Of General Practice, University Of Adelaide

Background

Despite influenza vaccination being recommended for Australians 18+ years old with medical risk factors, coverage for those under 65 years old is suboptimal. This study investigated whether automatic patient reminders (SMS and/or printed) before a booked appointment could increase uptake of influenza vaccination in these patients.

Methods

This clustered, non-randomised controlled study included 'active' (RACGP definition) patients aged 18–64 years with at least one at-risk chronic condition who attended a participating practice between April and September 2021 and for whom influenza vaccination is highly recommended. Software installed at the practice automatically identified unvaccinated eligible adults, sent the reminders (intervention clinics only: SMS on booking, SMS one hour before the appointment and/or printed reminders on arrival) and generated deidentified datasets for analysis. Clustered analyses adjusted for sociodemographic differences among practices were performed using logistic regression.

Results

In all, 12,786 adults, with one or more chronic conditions, attended 15 intervention practices (received reminders = 4066; internal control who received usual care = 8720) and there were 5082 patients from nine usual-care control practices. The frequency of influenza vaccination uptake among eligible patients the year before the intervention (2020) was similar in intervention and control practices (~34%). In 2021, rates of immunisation were on average lower and similar in all groups: control practices = 29.4%; internal control = 30.1%; intervention who received any form of reminder = 31.1%. However, examining the specific reminder they received, an SMS sent one hour before the appointment, alone or in combination with other reminders, had the largest effect, increasing the immunisation rate to 38.8% (adjusted odds ratio 1.60; 95% CI: 1.17, 2.21). Eligibility for a funded vaccine increased uptake in control and intervention groups.

Conclusion

Patient reminders, especially one hour before an appointment, represent a low-cost and effective intervention to increase influenza vaccination in Australian general practice among adults at higher risk of severe disease.

#MeToo in medicine: The role of GPs caring for survivors of sexual harm in the medical profession

A/Prof Louise Stone[1], Prof Christine Phillips[1], Mx Elizabeth Waldron[2], Marie Bismark[3], Prof Rosalind Searle[4]

[1]Australian National University, [2]Flinders University, [3]The University of Melbourne, [4]University of Glasgow

Background

Sexual harassment is common in the medical workplace, affecting around 33% of doctors. Junior doctors in dependent relationships with their senior colleagues are at higher risk, as are doctors who live with intersectional discrimination. The consequences can be severe, not only for the survivors, but also for the whole profession and for the patients under their care.

Despite the efforts of a multitude of organisations and individuals, sexual harassment remains entrenched, hidden and profoundly damaging. Like other professions that rely on hierarchical systems of management, education and professional advancement, sexual harassment in medicine is profoundly difficult to address.

In Australia, we have recently held a summit for medical leaders to address the unacceptable rate of sexual harms in medicine. The summit was based on our recently completed international, interdisciplinary edited text, and brought together students, junior doctors, senior doctors and leaders from a broad range of organisations, including universities, professional colleges, advocacy groups, regulatory organisations, medical defence organisations and doctors' health services. Together, this diverse group mapped the various roles of different organisations and disciplines, and began the process of synthesising multiple policies and processes into an accessible framework for GPs and survivors.

Format of the workshop

In this workshop, we will use the learnings from this symposium to enhance GP skills in managing survivors. Using a variety of scenarios, we will work in small groups to consider the challenges of supporting a doctor reporting sexual harms. Each small group will consider a different organisational perspective, and discuss the issues a survivor may need to consider if they choose to disclose.

Participants will also address barriers to care, including shame and stigma. At the end of the workshop, participants will have a broader understanding of the options available to survivors, and the ways in which GPs can facilitate recovery.

Exploring the nexus between employment, supervisory relationships and trainee assessment in GP training practices

Dr Sophie Vasiliadis[1], A/Prof Nancy Sturman[1,2], Dr Samia Toukhsati[3], Carla Taylor[3]

[1]The Royal Australian College of General Practitioners, [2]University of Queensland, [3]General Practice Supervision Australia

Australian GP trainees and supervisors work together in training practices that are predominantly small businesses operating on fee-for-service models. Practices employ trainees, and some supervisors are also practice owners. Trainees contribute to practice income and workflow, and the demand from practices currently exceeds the supply of new trainees. These factors contribute to some complex power dynamics in training practices. Recent medical education literature has highlighted the importance of reducing power imbalances during in-practice assessment (IPA). We explored the power dynamics at play when supervisors directly employ trainees, and identified strategies to mitigate any negative impacts on in-practice assessment and learning.

Focus group discussions were conducted using a semistructured discussion guide and audio recorded with a total of 51 participants, including trainees, recent RACGP Fellows, supervisors, practice managers and medical educators. Transcripts were transcribed professionally, coded descriptively and analysed inductively using qualitative descriptive analysis.

Diverse impacts of supervisor employment status were reported, and included minimal impact, foregrounding the business aspects of practice, opportunities to learn useful workplace skills and increasing the supervisor–trainee power differential. Some trainees reported being reluctant to admit mistakes or seek ad hoc assistance from employer-supervisors. Power dynamics also affected other practice staff, and disgruntled trainees had a negative impact on the work environment and practice reputation. Trainees identified a tendency to supervisor leniency bias in IPA. Strategies to mitigate these impacts included allocating employer and supervisor roles to different people and using external clinician assessors. Alternative trainee employment models were debated.

Participants had diverse experiences of power dynamics and their impacts on the learning and working environment of training practices. A leniency bias may have an impact on the fairness and defensibility of IPA. Several strategies may mitigate negative impacts, although there was no generally accepted proposal for modifying the current business model of Australian GP training.

Solving 'wicked problems': Conceptual and research approaches

A/Prof Joachim Sturmberg[1], A/Prof Carmel Martin[2]

[1]University Of Newcastle, [2]Monash Health

Background

Many problems encountered in general practice are 'wicked problems', problems that are highly contextual and have no single right solution; however, they still need to be managed in their clinical context. Just consider patients with chronic multimorbidity or mental health issues.

Aim

To apply a newly developed framework to analyse the relational nature of wicked problems and the most appropriate research approaches that can lead to their best possible understanding.

Content

A short introduction will introduce the nature of 'wicked problems', followed by a presentation on how to untangle the characteristics of these problems. Participants then will apply the framework to explore their own 'wicked problems'. Participants will share their problems and receive feedback from the presenters and fellow participants. A second short presentation will introduce several research methodologies that are best suited to answer 'wicked problem' questions which participants then will consider for their own issue. The workshop will conclude with a group discussion about the applicability of the framework to future research projects.

Goals

Workshop participants will be able to explore their own 'wicked problems', identify the relational nature of their problem before formulating a research question. Participants will then consider which research approach is most suitable to answer their question. The workshop encourages participants to build a 'wicked problem' research community.

How much?! Findings from the Weight GAin in Early Psychosis (WeightGAP) study in South Western Sydney

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Background
People living with severe mental illness die over 20 years earlier in South Western Sydney. Poor physical health is a major factor, with rapid weight gain frequently occurring in the first two years after the diagnosis of psychosis. Limited local data exist to inform the implementation of targeted population health initiatives.

Aims
To describe the trajectory of weight gain in patients admitted to the Early Psychosis Intervention Program at Liverpool Hospital and explore the influence of potential predictors of the weight gain trajectories.

Methods
This was a retrospective observational study using routinely collected data from the South Western Sydney Local Health District electronic medical records system. Data extracted from patients admitted to the Early Psychosis Intervention Program from 2017 to 2020 (n = 110) were analysed using generalised additive models to produce descriptive, smooth weight gain trajectories up to a year after admission.

Results
Patients admitted to the Early Psychosis Intervention Program experienced rapid weight gain, with body weight increasing by 4.8% from baseline at one month. This continued, reaching an overall gain of 18% by 12 months; 60.5% of patients experienced clinically significant weight gain within 5 months. Olanzapine and clozapine were associated with substantially faster increases in body weight compared to other atypical antipsychotics.

Conclusion
Weight gain in patients living with early psychosis in South Western Sydney is rapid and substantial. Treatment should avoid the unnecessary use of olanzapine or clozapine. This study demonstrated generalised additive models as a feasible method to construct detailed results from routinely collected data that can be used for local benchmarking and target setting for quality improvement initiatives.

Prevalence and associated factors of chronic kidney disease in older individuals: A cross-sectional study from northern Sri Lanka

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Background
Chronic kidney disease (CKD) is a major public health problem in Sri Lanka and the prevalence of CKD has increased over the past decade. Early detection of CKD and associated factors is a key step to prevent CKD. This study aimed to determine the prevalence and associated factors of CKD in older individuals in the northern part of Sri Lanka.

Methodology
This community-based cross-sectional analytical study was conducted from February 2020 to November 2022 among 10,000 individuals aged 50 years and above living in all five districts in Northern Province, Sri Lanka, by using a multistage cluster sampling technique. The interviewer-administered questionnaire employed included sociodemographic factors, present medical history, including CKD verified by medical records, and Patient Health Questionnaire-2. Binary logistic regression was performed by using SPSS (v25).

Results
The response rate was 91.9% (10,000/10,872): the mean (SD) age was 65.3 (9.06) years; 61.8% female; 95.7% Sri Lankan Tamil. The prevalence of CKD was 4.1% (95% CI: 3.7, 4.5). CKD increased with Kilinochchi district (adjusted odds ratio [aOR] 2.1; 95% CI: 1.3, 3.3), Mullativu district (aOR 5.6; 95% CI: 3.8, 8.2), Vavuniya district (aOR 12.1; 95% CI: 9.2, 15.8), increasing age (aOR 1.04; 95% CI: 1.02, 1.05), male sex (aOR 3.9; 95% CI: 3.0, 5.1), lower education level (aOR 1.8; 95% CI: 1.3, 2.4), unemployed (aOR 2.3; 95% CI: 1.6, 3.3), ischaemic heart disease (aOR 2.2; 95% CI: 1.7, 2.8), heart failure (aOR 3.0; 95% CI: 2.1, 7.6), diabetes mellitus (aOR 1.5; 95% CI: 1.2, 1.9), hypertension (aOR 5.7; 95% CI: 4.3, 7.5) and anxiety (aOR 1.6; 95% CI: 1.1, 2.4).

Conclusion
In this large community-based cohort, living in certain districts, older age, male, lower education level, presently not having an occupation, ischaemic heart disease, heart failure, diabetes mellitus, hypertension and anxiety were higher among individuals with CKD.

Key words
CKD, Sri Lanka, prevalence.

Photovoice: A reflection tool in primary care medicine clinical rotation in Universiti Malaya Medical Programme (UMMP)

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Universiti Malaya

Photovoice is a visual arts-based methodology developed by Wang and Burris based on the idea that images and words can effectively express needs, problems and desires. It has been used in teaching students' reflection in health sciences, with students reporting more emotional and moral undercurrents in their learning experiences. Photovoice reflections are more thoughtful compared to traditional reflective essays. Reflective learning has been used in the professional field since the 1930s. It has helped students develop their ability to formulate their learning objectives and raise their awareness of their learning styles.

This study aims to explore the learning experiences among medical students in a primary care medicine clinical rotation during the COVID-19 pandemic and to seek the impact of the pandemic on their learning process. This study was conducted with final year medical students during their primary care medicine clinical rotation at Universiti Malaya. At the start of this study, the students were briefed about photovoice, the ethics of taking photographs and the guidelines for submitting their photographs. They were required to submit their photographs at the end of the rotation, with a sharing session scheduled a few days after that. These sessions were conducted as focus group discussions (FGDs).

Five themes emerged from this study: Uncertainty; Coping; Loneliness and despair; Challenges; and Hope. Most students felt that the pandemic had significantly disrupted their learning experience, having to adapt to the sudden change in learning format and method. However, they were eager to complete their medical program as planned. Students reported that they enjoyed using photovoice as a reflection tool compared to writing a reflective essay. In conclusion, photovoice should be considered as a teaching method to enhance medical students' learning and to encourage the practice of self-reflection.

Transgender people's experiences of healthcare providers: Positive and negative qualitative factors impacting the patient–provider relationship

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Universite Claude Bernard Lyon 1

Context

The medical care of trans(gender) people is currently under scrutiny in France with the publication in 2022 of the report on the health and care pathways of trans people. Access to healthcare for the trans population is marked by stigmatisation. Their relationship with healthcare providers is underinvestigated.

Aim

To explore trans people's experiences in relation to all healthcare providers, whether within or outside the transition process, in order to highlight the positive and negative qualitative factors impacting their relationship with healthcare providers.

Method

Qualitative study by semistructured individual interviews with people self-identifying as trans from April 2021 to July 2022. The interviews were double coded and analysed by themes.

Results

All 20 participants reported having experienced violence from healthcare providers. Conversely, some reported what they considered to be good practice. They described strategies they had developed to deal with the violence they had experienced or anticipated. The involvement in their care was present on an individual level, but also for some on a community level. Finally, they shared their expectations regarding healthcare providers.

Conclusion

This study describes the violence suffered by trans people in their patient–provider relationships, but also the good practices implemented by healthcare providers. It also identifies the strategies developed in response to violence, and reinforces the status of trans people as expert patients. The recognition of these strategies and this status by healthcare providers can lead to an improvement in the patient–provider relationship with trans people.

Association between types of home healthcare and emergency house calls, hospitalisation and end-of-life care: A nationwide study in Japan

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Background

To meet the increasing demand for home healthcare in Japan, home care support clinics/hospitals (HCSCs) and enhanced HCSCs were introduced in 2006 and 2012, respectively. This study aimed to evaluate whether HCSCs has succeeded in providing 24-hour home care services through the end of life.

Methods

A retrospective cohort study was conducted using the national database in Japan. Participants were ≥65 years of age, had newly started regular home visits between July 2014 and September 2015 and used general clinics, conventional HCSCs, enhanced HCSCs with or without beds. Each patient was followed up for six months after the first visit. The outcome measures were: (1) emergency house call(s); (2) hospitalisation(s); and (3) end-of-life care defined as in-home death. Multivariable logistic regression analyses were performed.

Results

The analysis included 160,533 patients, of which 13,477, 64,616, 35,150 and 47,290 patients received regular home visits by general clinics, conventional HCSCs, enhanced HCSCs without beds and enhanced HCSCs with beds, respectively. Compared to general clinics, the use of conventional HCSCs, enhanced HCSCs without beds and enhanced HCSCs with beds was associated with an increased likelihood of emergency house calls (adjusted odds ratio [aOR] and 95% confidence intervals [CIs] of 1.62 [1.56, 1.69], 1.92 [1.84, 2.00] and 1.81 [1.74, 1.88] respectively) and a decreased likelihood of hospitalisations (aOR [95% CIs] of 0.86 [0.82, 0.90], 0.82 [0.79, 0.86], and 0.92 [0.88, 0.96], respectively). Among 39,035 patients who died during the follow-up period, conventional HCSCs, enhanced HCSCs without beds and enhanced HCSCs with beds had more in-home deaths (aOR [95% CIs] of 1.46 [1.33, 1.59], 1.69 [1.54, 1.85] and 1.53 [1.39, 1.67], respectively) compared to general clinics.

Conclusions

HCSCs (especially enhanced HCSCs) provided more emergency house calls, reduced hospitalisation and enabled expected deaths at home, suggesting further promotion of HCSCs (especially enhanced HSCSs) would be advantageous.

Acceptability and challenges for implementing community-based COVID-19 vaccination in Indonesia: An exploratory qualitative study

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Aim

Despite the efficacy of COVID-19 vaccine in reducing infection rates and severe morbidity, the coverage of complete vaccination remains low in many countries due to issues of availability, health service and delivery and hesitancy. To address these issues, the implementation of locally contextualised approaches, often through primary care and community-based settings, is crucial. This study aims to explore acceptability and challenges to implement a community-based COVID-19 vaccination program in Indonesia.

Content

A qualitative study was conducted by interviewing 45 informants across nine districts of Bali Province. The majority of COVID-19 vaccines were delivered through community-based settings in partnership with community health centres. Community members are more inclined to attend vaccination in their proximity than visiting health facilities for COVID-19 vaccination. Active participation of community leaders, including religious figures and community cadres, have led to higher acceptability and participation rates. The study found that despite its effectiveness in improving vaccination coverage, existing structural and institutional issues impede the implementation of community-based COVID-19 vaccination: health staff workload and COVID-redeployment, procurement and supply chain, complex recording and reporting procedures and difficulty in identifying and listing of target population.

Goals

The study suggests the effectiveness of the community-based model in partnership with primary care providers for improving the coverage of COVID-19 vaccination in Bali Province. Several key tenets leading to the success of this model include using the existing and organically formed community systems, appropriate to local contexts, multisectoral involvement and availability of skilled health workforce, community health workers and volunteers. Ongoing initiatives to strengthen community health and primary care systems are vital in strengthening health system preparedness and resilience for future public health emergencies.

Strengthening digital health literacy for patients with chronic conditions in primary care settings in Indonesia: A concurrent mixed methods study

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Aim

During the COVID-19 pandemic, digital health has become an important strategy to deliver health services, promote effective self-management and improve healthy lifestyles to patients with chronic diseases, especially in primary care settings. This study aims to identify patterns of digital health utilisation in primary care settings among patients with chronic conditions, and to explore various strategies to strengthening digital health literacy in primary care settings.

Content

A concurrent mixed-methods study was conducted in three community health centres of Bali Province, involving a quantitative survey of 150 patients and in-depth interviews with 30 informants (15 patients and 15 health staff). Quantitative data were analysed using descriptive statistics, and qualitative data were analysed using a thematic approach. Around 26% of respondents never used digital health platforms and disagreed that access to eHealth is essential for their health status. Primary care providers used social media platforms to share health education events, online booking and online consult. Health staff in the study suggest the importance of digital health literacy among patients to manage hoaxes and incorrect information, particularly those obtained through social media platforms. Patients were comfortable with social media platforms, and these must be capitalised for improving self-management and patient outcomes. However, informants in the study seem to have sporadic understanding regarding the benefits of digital health in promoting self-management, indicating a lack of digital health literacy.

Goals

Digital health platforms provide an opportunity for service adaptations in primary care settings, and these must be contextualised to patients' need and local capacity. This study confirms that digital health can complement the existing clinical management and prevention strategies. More importantly, the study suggests an urgent call to develop digital health literacy strategies in primary care settings and to provide comprehensive digital health literacy skills for health providers and patients.

Critical elements of inclusive care while caring for adolescent and young adults

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In this era of global health, population health, and health equities, the compartmentalised–individualised healthcare setting structure is a present urgent barrier to peeling off the many layers of development and bringing the context and environment of our youth's lives to the centre of our care. Social factors are the more potent determinants of health. Minority youth and immigrant youth/families have a higher share of negative social determinants of health on their shoulders. Helping them thrive requires a new model of care that embraces wellness and positive youth development at its centre. Adolescence is also one of the most challenging intergenerational transitions for families, particularly those with parents and youth with unmet health needs or those who migrate to a new culture, as this usually widens the intergenerational gap, highlighting the need for integrative family-focused care. Finding ways to respond to the care of our minority/immigrant community is a critical challenge in the middle of the clinic. This workshop will share why cultural identity is so relevant to adolescent development and ways of designing inclusive, developmentally appropriate and family-centred teams while grounded in confidential care (depending on the country's laws). The authors will describe a blueprint for inclusive, developmentally appropriate care design in this workshop. Participants will obtain concrete tools to implement some workshop contents into their clinical practices.

If accepted, this proposal presented by the Adolescent and Young Adult SIG will be one of several workshops aiming to create a TRACK. Participants will receive a certificate if they attend them all and complete each workshop evaluation.

Coaching family physicians to form partnerships with parents of teens for success

Dr Maria Veronica Svetaz

Hennepin Healthcare System, U of MN Division of Fam and Com Medicine

Parents receive advice about optimal parenting strategies from multiple sources, including physicians, when their children are young, often beginning with prenatal classes and continuing through early childhood education. Yet, similar opportunities are not as widely available during adolescence, a critical developmental transition that impacts family relationships. Over the past decades, research has reaffirmed that parents play a protective and promotive role in adolescents' lives and health. Given parents' importance, research has identified attributes and skills that characterise parenting associated with optimal youth health outcomes, and it importantly has shown that these parenting behaviours can be developed. Achieving adolescent health-promoting practices and improving family interactions is challenging, especially in the context of high levels of family stress (eg living in poverty or high-risk neighbourhoods) and low support (eg immigrants and single parents). Parenting adolescents themselves can generate stress that undermines parenting efficacy for many. This workshop will train family physicians on the essential core elements of how to coach parents to be an asset for positive, healthy youth development. It will also stress the importance of parents in promoting pride in their culture and roots, being cultural (racial/ethnic) identity one of the most potent and promotive factors in adolescent health outcomes.

If approved, this skill-building presentation will be one of several submitted by the AYA (Adolescents and Young Adults) SIG. These presentations will create a TRACK, and the AYA SIG will provide a certificate to all clinicians who attended and submitted their proper evaluation.

Understanding and communicating with adolescents and young adults: Using a strength-based, trauma-responsive and culturally informed approach

Dr Maria Veronica Svetaz[1], Dr Joy Karamana Mugambi[2]

[1]Hennepin Healthcare and U of MN Division of Fam and Com Medicine,
[2]Member-at-Large WONCA Africa

Characterising adolescents and their health status by such traditional measures as injury and illness does not adequately capture the developmental and behavioural health of adolescents of different ages and in diverse circumstances. Adolescent and young adult medicine are based on resilience, how spaces can help youth develop skills and behaviours that allow them to use their strengths and identities to cope with challenges that arise in their life trajectories, wherever they live, learn, play and grow. This presentation is intended to affirm and refine skills to create safe spaces for teens to disclose important information while learning to interact with them using strength-based, trauma-sensitive and culturally responsive communication and care. This presentation intends to be one of several topics presented by the AYA SIG that, if approved, will constitute a TRACK, from where attendees will receive a special certification of the AYA WONCA SIG.

Exploring doctors' perceptions of digital tools' impact on the doctor–patient relationship in Singapore's primary healthcare setting: A qualitative study

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Introduction

Digital transformation has altered doctors' and patients' roles and relation dynamics in health encounters. While the clinical impact of telemedicine may be well studied, little emphasis has been placed on the impact of digital tools on the doctor–patient relationship. The study aims to explore and understand doctors' perceptions of digital tools' impact on the doctor–patient relationship in primary care.

Methods

This is an exploratory qualitative descriptive study using individual in-depth interviews. Doctors from National Healthcare Group Polyclinics in Singapore were sampled using maximum variation sampling. Semistructured topic guide and thematic analysis were used to identify emergent themes.

Results

Twelve interviews were conducted. The six key themes which emerged were experiences with technological changes, problems of digital tools faced in primary care, changing roles of doctors and patients in digital age, positive and negative impact on doctor–patient relationship and strategies to strengthen doctor–patient relationship.

Conclusion

The study showed that doctors perceived digital tools usage as a double-edged sword on doctor–patient relationship. Although digital tools improved accessibility, collaboration and clinical decision making, they affected the consultation dynamics and posed extra challenges to the doctors' advocacy role. Our study pointed to the need for a bio-psycho-social-digital approach in patient engagement, the need to educate both primary care clinicians with the soft skills in patient communication and the technical skills of digital tools, as well as the need for a multidisciplinary approach towards patient education and adoption. Lastly, patients should also be interviewed to explore their perspectives in the next study.

Enhancing culturally competent primary healthcare to reduce domestic violence among South Asian communities: HARMONY a pragmatic cluster randomised controlled trial

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High-income countries include diaspora communities from low- and middle-income countries. Domestic violence and abuse (DVA) is globally prevalent and harmful to mental health and wellbeing. Immigrant women are more likely to experience severe DVA together with migration trauma. Immigrant victim/survivors frequently attend primary care clinics poorly resourced to manage their DVA trauma. Improving culturally safe primary care requires augmenting the whole clinic system.

HARMONY was a pragmatic whole-clinic cluster RCT, whose objectives were to:

- increase DVA first identification and referral and second safety planning among all women, but targeting South Asian (SA) women attending general practitioner (GP) clinics
- improve routine recording of DVA and ethnicity.

Methods

Twenty-four (GP) clinics randomised in Melbourne, Australia, in 2019. Eligible clinics required one or more SA GPs using one of two medical software programs for routine outcome data extraction.

Culturally competent DVA training for intervention clinics co-facilitated by a GP educator and bilingual DVA advocate from October 2020 to May 2021. With COVID-19, training moved online. Following training, all intervention staff and DVA affected women ≥18 were supported for 12 months by the DVA advocate. All clinics trained to record ethnicity and DVA data.

Routine anonymised, aggregated data extracted from both arms identified DVA, safety planning, referrals and an SA population estimate among female patients ≥18. Outcome data are deidentified and aggregated. CONSORT consistent. Adjusted regression analysis by intention-to-treat. Process evaluation interviews of clinic staff using normalisation process theory.

Outcomes

Despite COVID-19 and a six-month suspension (May – September 2021), <70% participating GPs completed all three training sessions. GPs identified DVA victim/survivors from baseline of 0.58% (251/45,438 women) to 0.93% at 12 months and 1.05% at 15 months. A fully adjusted analysis and process evaluation will be presented.

Conclusion

Culturally competent DVA GP care for diaspora communities can be improved in systemic but simple ways.

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Prevalence and correlates of inappropriate use of benzodiazepines in Kosovo

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Main Family Medicine Center

Aim

In post-war Kosovo, the magnitude of inappropriate use of benzodiazepines is unknown to date. The aim of this study was to assess the prevalence and correlates of continuation of intake of benzodiazepines beyond prescription (referred to as 'inappropriate use') in the adult population of Gjilan region in Kosovo.

Methods

A cross-sectional study was conducted in Gjilan region, including a representative sample of 780 individuals attending different pharmacies and reporting use of benzodiazepines (385 men and 395 women; age range 18–87 years; response rate: 90%). A structured questionnaire was administered to all participants inquiring about the use of benzodiazepines and sociodemographic characteristics.

Results

Overall, the prevalence of inappropriate use of benzodiazepines was 58%. In multivariable-adjusted models, inappropriate use of benzodiazepines was significantly associated with older age (OR 1.7; 95% CI: 1.1, 2.7), middle education (OR 1.8; 95% CI: 1.2, 2.7), daily use (OR 1.4; 95% CI: 1.1, 2.0) and addiction awareness (OR 2.7; 95% CI: 2.0, 3.8). Furthermore, there was evidence of a borderline relationship with rural residence (OR 1.2; 95% CI: 0.9, 1.7).

Conclusion

Our study provides novel evidence about the prevalence and selected correlates of inappropriate use of benzodiazepines in Gjilan region of Kosovo. Health professionals and policy makers in Kosovo should be aware of the magnitude and determinants of drug misuse in this transitional society.

Virtual health in the COVID-19 era: Creating a framework for a comprehensive geriatric assessment

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Clinical diagnosis and management of neurocognitive disorders and other geriatric conditions requires clinical analysis with a detailed history, in-depth clinical analysis and investigations. [The restrictions on direct evaluations following the global COVID-19 pandemic has placed

Ensuring that patients and their care partners have access to timely assessments.]

This is a summary of the services that our team has provided over the past three years. At the outset of the COVID-19 pandemic and prior to the restrictions being placed, we contacted the residential care facilities informing them that no physical visits would be undertaken and assuring them of our availability for phone consults. We were in regular contact (weekly and sometimes multiple times a week) with some of the residential care facilities. The restrictions on movement and absence of visits from family members had some negative effects with reports of disruptive behaviours and emotional distress from care partners.

We also developed a framework which we have used for our assessments in a rural First Nations community.

We have been seeing both existing and new patients using telemedicine. The feedback from patients and care partners has been very positive. Some family members who had been unable to attend in-person appointments are now able to be involved because of the access to telemedicine. Telemedicine has also afforded our team with some flexibility. We are able to see more patients than can be accommodated at a clinic appointment. It saves on travel time – for patients, care partners and the team. It has cut back considerably on red tape.

Some of the challenges faced by patients, practitioners and care partners include:

- lack of social stimulation
- delays in investigations – lab tests, brain imaging scans etc
- rehabilitation and recreational therapy services
- decreased confidentiality.

Frontotemporal lobar degeneration: Recognising the neurocognitive disorder and the associated conditions

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Background

Frontotemporal lobar degeneration (FTLD) is an increasingly recognisable neurocognitive disorder. There is increasing awareness of the association between FTLD and a spectrum of other neurodegenerative conditions. This association has been shown with amyotrophic lateral sclerosis (ALS), corticobasal degeneration (CBD) and progressive supranuclear palsy (PSP). [Many patients with newly diagnosed frontal or behavioural frontotemporal dementia.]

Genetic testing is usually offered to all patients and families newly diagnosed with FTLD but there is a dearth of evidence in the literature regarding uptake.

Methods

A retrospective chart review of all patients seen in the Specialized Geriatric Service outpatient clinic between January 2017 and December 2022 was conducted. Information was collected from chart and clinic notes. Diagnosis of FTLD was made based on the suggestive subjective accounts and cognitive assessments and structural and functional brain imaging scans. All the patients (100%) underwent positron emission tomography (PET) brain scans. All newly diagnosed patients were offered genetic testing. Information on demographic, cognitive test scores, imaging reports, family and social history was collected from consultation reports, clinic letters and charts.

Results

Twenty-seven patients were diagnosed with FTD during this period. Of these, the majority (79.4%) were females and 20.6 % (three) were males. The age range was 54–79 years at diagnosis. The average age of diagnosis was 66.2 years.

Two patients had a positive history of amyotrophic lateral sclerosis in a first-degree relative. Four of the patients had a family history of suspected Alzheimer's dementia. Three patients had a family history of Parkinsonism and three had positive family histories of suspected FTLD (one patient's brother had been diagnosed with primary progressive aphasia).

All newly diagnosed patients were offered genetic testing. However, only two patients and their families agreed to undergo genetic testing.

Study of the relationship between facial expression and depression using mechanical learning

Prof Yousuke Takemura

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Introduction and aim

Suicides in Japan, especially among middle-aged people, have become a social problem. Therefore, the diagnosis of depression is important. Our former study suggested that it was difficult to obtain feeling like depression from patient verbally. Human would transfer majority of feeling by non-verbal communication, for example, by face expression or by voice. We reveal the association between depression and facial expression by using mechanical learning.

Methods

Subject is 500 medical interviews at the outpatient department of the university hospital. We videotaped medical interviews and asked patients to answer the SDS questionnaire to measure the depression level of the patients. Patient approval was obtained beforehand.

Machine learning was used to decide the relationship between various features of facial expressions using depression as the supervised data.

Results

Eyebrow movement and the distance between the lower eyelid and cheek are being found to be associated with depression level. Final results will be provided on the day of the presentation.

Discussion

By taking videos during medical examinations and analysing them through machine learning, it may be possible to find depressed patients.

The August 2020 COVID-19 outbreak in Aotearoa New Zealand: Strengthening health system responses for minority populations

Dr Apisalome Talemaitoga[1], Gerard Sonder[2], Debbie Ryan[2]

[1]Cavendish Doctors, [2]Pacific Perspectives

After COVID-19 arrived in New Zealand, a national system was developed to improve contact tracing. The first outbreak was followed by a period of 'COVID-19 elimination', until a community outbreak occurred in August 2020. Pacific community primary healthcare providers stepped up to provide outreach services across all phases of the pandemic response.

Methods

We worked with a multiethnic Pacific advisory group of community leaders and providers who provided guidance on context and the services provided by community PHC providers.

We describe the characteristics of cases and their contacts, focused on the results of contact tracing. Demographic and clinical characteristics of cases, number of contacts and timeliness of contact tracing were analysed by ethnicity.

Findings

Most of the 179 cases were Pacific peoples (59%) or Māori (25%), living in areas of high socioeconomic deprivation, who had higher rates of comorbidity and accounted for almost all (21/22) hospitalisations, all eight ICU admissions and all three deaths. Six per cent belonged to the European majority ethnic group.

Of 2528 registered contacts, 46% were Pacific, 14% Māori and 19% European. Overall, 41% of contacts were reached within four days of onset of disease of the case, which was significantly lower for Pacific (31%) than for other ethnic groups.

Our findings confirm the greater health burden that ethnic minorities faced from COVID-19 in NZ. The significant delay in the timeliness of care for Pacific shows that the public health response was inequitable for those at highest risk.

Tailored public health responses and better registration of marginalised groups are necessary to provide better access to services and to improve insights for optimal future outbreak management. Learning from this project about involving Pacific communities in the preparedness phase of pandemic and infectious diseases planning is important for achieving equity in the New Zealand health system reforms.

My patient is asking for low-value or harmful care. How do we manage this across the world?

Dr Michael Tam[1,2], Prof Mark Morgan[1,3]

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People are increasingly undertaking research into their health conditions, and will often get information from unreliable sources with limited or no evidence to support the claims. Subsequently, GPs will receive requests for tests and treatments that may cause more harm than benefit to the patient. It is important for GPs to have effective tools and communication strategies to undertake positive and constructive patient–doctor shared decision making.

Launched in 2022, *First do no harm: a guide to choosing wisely in general practice* is an evidence-based resource from The Royal Australian College of General Practitioners (RACGP) with a growing library of topics with information on tests and treatments that provide little benefit or may even cause harm to patients. Focusing on topics released in 2023, the presenters will discuss strategies to reduce patient harms in primary care.

The workshop will provide an exciting opportunity for participants to share their experience of reducing patient harms from factors such as overtesting and overdiagnosis, and interact with peers from around the world.

Participants in this interactive workshop will:

- share experiences in patient–doctor communication
- discuss successful shared decision-making strategies that GPs can use
- learn from the international experience of avoiding overtesting and overdiagnosis
- share ideas for positive and constructive conversations with patients to help them make informed decisions about their health
- propose and discuss current and future key priorities in this area
- connect with international peers who have an interest in overdiagnosis and overtesting.

The thriving GP trainee in today's world

Dr Shu Li Tan, Dr Ranjan Dass

[1]Primary Care Education, Portsmouth and Isle of Wight

The way GPs consult has changed significantly over the past three years. In the UK, there have been changes to the GP speciality training examination as well.

As training program directors (TPDs), we have seen increased stressors among the trainees and current expectations of a GP is testing their resilience. In recognition of this, we have implemented changes in the way we design education sessions for our GP trainees.

Our final-year trainees meet almost once weekly for four hours for these sessions. We continued inviting our secondary care (hospital-based) colleagues to speak about updates in their speciality. In addition to this, we have incorporated sessions to address the 'softer skills' of being a GP, such as medical humanities, medicine and the arts, as well as lifestyle medicine; sessions for 'resilience', such as team building, small group work and mindfulness; 'exam support' focusing on tips on how to pass the exams; and 'career planning', such as practice management, CV writing, job applications and finances.

Have our changes equipped them sufficiently to be a happy and confident GP in today's world?

We performed a retrospective survey of our recently qualified GPs who trained in our local training area to answer the question above.

Based on these results, we look to further develop our educational sessions to prepare our next generation of GPs for a sustainable and fulfilling career in family medicine.

Designing research for busy primary care practices: Tips for researchers and clinicians

A/Prof Wern Ee Tang, Shu Yun Tan, Ms Hui Li Koh, Mr Jeremy Kaiwei Lew

National Healthcare Group Polyclinics

Internationally, there is an increasing recognition of the central role of primary care in the healthcare system. Primary care research is necessary to advance scientific knowledge, clinical care and care delivery in the community. However, conducting research in primary care is not without its challenges. The thoughtful design of research studies that takes into consideration the distinctive features of the primary care context, infrastructure and ecosystem will optimise the conduct and success of research in busy primary care practices.

This workshop aims to introduce to participants principles and frameworks to be considered in the design of research in the primary care setting. Ways to address the various challenges encountered when conducting research in primary care will be discussed.

Activities during the workshop include interactive lectures, group work and presentations.

Workshop program:

1. Introduction (10 minutes)
2. Research conceptualisation (10 minutes)
3. Data collection and methodological approach (10 minutes)
4. Logistical and operational considerations (10 minutes)
5. Small group case-based learning activity (25 minutes)
6. Group presentations and discussions (20 minutes)
7. Close (five minutes)

Recovery, reconnection and revival: The role of family physicians in providing basic rehabilitation

Dr Abena Tannor

Kwame Nkrumah University of Science and Technology

Rehabilitation is a set of interventions designed to optimise functioning and reduce disability in individuals with health conditions in interaction with their environment. There is, however, a large unmet need for rehabilitation due to population ageing, increasing non-communicable diseases prevalence and consequences of conflict and injury. Majority of persons experiencing this unmet need are in primary care settings where there are few to no rehabilitation workers. Family physicians can, however, meet this need.

Family physicians work in primary care, are closest to the community and easily accessible. They can therefore ensure that persons with rehabilitation needs in primary care receive continuous and comprehensive care including rehabilitation through the process of recovery, reconnection and revival.

Reconnection and collaboration with rehabilitation physicians and other rehabilitation professionals will teach family physicians how to coordinate rehabilitation care for their patients, identify red flags and follow referral protocols for patients with complex needs to specialist rehabilitation centres if required.

COVID-19 has come to stay with us. Along with it came long-term effects including easy fatigability, muscle weakness and breathlessness as a person recovers and goes about their daily activities. The important role of rehabilitation using basic exercises, breathing techniques and approaches to daily activities has been highlighted in research. Family physicians encounter these persons daily and can deliver basic COVID-19 rehabilitation interventions to facilitate recovery.

Finally, the future of high-quality, sustainable primary care anticipated in revival involves making rehabilitation more accessible and affordable while bringing services closer to people's homes. A task-sharing approach of training family physicians to deliver a limited set of evidence-based, low-cost and high-impact rehabilitation interventions within their usual clinic time can be used to achieve this, especially in settings where there are limited or no rehabilitation workers. This overcomes the challenge of long distance coupled with financial difficulties faced by many.

End-of-life care in the remote primary healthcare setting: Lessons from the Northern Territory

Dr Georgina Taylor

NT Health

Background

The Northern Territory (NT) is a vast region of Australia with a population of around 250,000 people in a geographical area of over one million square kilometres. Thirty per cent of the NT population are Aboriginal, and there are a number of small remote communities with majority Aboriginal populations served by primary healthcare centres.

Most Australians express a preference to die at home. In remote NT, end-of-life care at home is typically delivered by the local primary healthcare team with consultation by specialist palliative care services based in regional centres as required. Local care is provided by a multidisciplinary team that may include Aboriginal health practitioners and community workers, remote area nurses and general practitioners.

Aim

1. To present learnings from work as a general practitioner with a special interest in palliative care in remote Northern Territory.
2. To share practical and adaptable tips for palliative care practice relevant to other remote or low-resource settings.

Content

This clinical practice session will use short clinical vignettes of both malignant and non-malignant palliative care presentations to illustrate practical tips for palliative care work in the remote setting. With a focus on end-of-life care, it will cover essential topics including symptom control, managing the impacts of heat and resource shortages, and the importance of self-care for remote primary care staff.

Making ‘space’ for adolescents in your community practice

Dr Pierre-Paul Tellier[1,2]

[1]CLSC Côte-des-Neiges, [2]McGill University

This presentation uses the World Health Organization (WHO) document *Making health services adolescent friendly* as a guide for family physicians to make their office space welcoming and appropriate for adolescents. Adolescence is an important part of an individual’s life cycle. During this period a person experiences major physical and psychological changes that affect social interactions and relationships. Using a framework developed by the WHO, the presenter draws on his experience to present an approach to deal with adolescents in their community practice. The WHO states that an adolescent-friendly space is accessible, acceptable, equitable, appropriate and effective. During the presentation each of these terms is defined, and practical examples of how to achieve this in your working environment are presented and discussed.

Exploring the prevalence of vitamin D deficiency in Quito: A comparative analysis of the pre-pandemic and pandemic periods (2018–21)

Dr Betzabé Tello[1,2], Iván Dueñas-Espín[3], Jeannete Zurita[4], Camilo Zurita[4]

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Vitamin D is a prohormone that plays a crucial role in various biological processes, including immunological responses, phosphocalcic metabolism and detoxification. Recent discoveries have fuelled research interest in understanding the diverse functions of vitamin D. However, determining the optimal level of 25(OH)D3, the major circulating form of vitamin D, remains a subject of debate, with studies suggesting potential overestimation of deficiency prevalence and controversies surrounding supplementation in healthy individuals.

The COVID-19 pandemic has led to lifestyle changes that may impact vitamin D synthesis, such as modified diets, reduced outdoor activities and decreased exercise. This study aimed to explore differences in mean vitamin D concentrations between the pre-pandemic and pandemic periods (2018–21) using 8905 laboratory-based samples from a private laboratory in Quito.

The results showed significant differences in average vitamin D deficiency between the pre-pandemic and pandemic periods. However, there was an increase in the prevalence of vitamin D toxicity during the pandemic, with toxicity rates rising from 0.12% in 2018 to 0.88% in 2021. Over the study period, average annual serum 25OHD levels increased by 2.4 ng/mL.

Addressing both deficiency and toxicity issues through supplementation interventions and public education is crucial. By providing insights into the impact of the pandemic on vitamin D levels, this study emphasises the importance of maintaining optimal vitamin D status for overall health.

Decisions regarding antibiotic prescribing in the management of acute sinusitis in Norwegian general practice: A qualitative focus group study

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University of Oslo

Background

Acute sinusitis is a frequent contact reason in general practice. Acute sinusitis is most frequently caused by viral agents, and most patients recover within two weeks without antibiotic treatment. Despite this, about 50% of patients with acute sinusitis in Norwegian general practice are still prescribed antibiotics. We do not know the reason behind this discrepancy.

Aim

To explore the clinical decision-making process and reasons for treatment with antibiotics for acute sinusitis among Norwegian general practitioners (GPs).

Methods

Five focus group interviews were conducted (n = 25) in different parts of Norway. The participants were GPs of various age, gender and experience. The interviews were analysed using a descriptive and explorative thematic cross-case method.

Results

The results showed a very diverse management of acute sinusitis among GPs. Decisions regarding antibiotics were not always in line with recommendations in the guidelines. Clinical findings emphasised in decision making were complaints about pain, and how exhausted the patient appeared. Pragmatic factors like weekday, travel plans or full waiting room could also influence the decision.

Conclusion

For several of the GPs the degree of pain was one of the decisive reasons for prescribing antibiotics for sinusitis. Many of the GPs did not agree with the Norwegian guidelines for antibiotics and chose something else than phenoxymethylpenicillin as their first choice. The results may indicate a need for reassessments of guideline contents and the way they are communicated to GPs.

Exploring deep GP–patient relationships: A qualitative study with GP–patient dyads

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Background

General practitioner (GP)–patient relationships are the basis of general practice whole-person care. According to Ridd et al., deep doctor–patient relationships are characterised by trust, knowledge, loyalty and regard, and have been shown to improve patient outcomes. This study aimed to further our understanding of GP–patient relationships that patients identify as having depth, through exploring how these relationships are cultivated and experienced from the perspective of GP–patient dyads.

Methods

Qualitative thematic design. Participating GPs' patients were surveyed regarding their depth of relationship with their GP. Patients reporting deep relationships were purposively selected for interview. Interviews were conducted with patients and their GPs separately, regarding how they experience and cultivate the GP–patient relationship. Interview participants also completed a survey regarding their attachment style and (for patients) the person-centredness of their GP's practice. Interviews were analysed using inductive thematic analysis.

Findings

Five GPs and 13 patients were interviewed. Data suggest that deep GP–patient relationships are asymmetrical professional relationships underpinned by genuine, realistic 'real relationships'. These relationships were valued by patients, and display some, but not all, features of 'attachment relationships' as described in the psychological literature. Deep relationships were cultivated through the GPs' clinical expertise and genuine interpersonal care, and came at some cost (but also reward) to the GP.

Implications

These findings further emphasise the importance of relational work in general practice care, which is more than a series of transactional encounters. Health system policy that fails to recognise this, risks sacrificing the foundation of effective primary care. Additionally, this research summarises specific actions of GPs and patients to cultivate deep relationships, which could inform training and practice.

'*Nabad iyo Caano*' peace and milk: The recipe for distinctiveness of family physicians in Somaliland

Dr Kara Thompson[1,2], Toni Ungaretti[2]

[1]Amoud University, [2]Johns Hopkins University

In 2012, Amoud University started Hope Family Medicine as the first postgraduate training program in Somaliland. Little has been published on the Somaliland program. This study investigated the underlying factors which contributed to its success in creating well-trained family physicians, with excellent knowledge, skills and behaviours. A descriptive qualitative pilot study using grounded theory guided the interview process among five of the family medicine graduates of the program. Through an iterative process of constant comparison, transcripts were developed and themes were identified describing the distinctive behaviours of family medicine specialists and the experiences, structures and relationships that helped to produce them. Mezirow's transformational learning theory provides a framework for how the residents developed their professional identities as family medicine specialists. Social learning theory describes the impact that mentoring relationships served in the residents' professional formation. The promising outcome of this pilot study requires validation from future investigations. As future family medicine residency programs are implemented in Somaliland and other African or global contexts, lessons from this study can help formulate best practices.

Postgraduate family medicine training at Fiji National University: Evaluating a new distance learning program designed specifically for the Pacific

Dr Esther Tilly[1], Dr Ruth Eagles[1,2], Dr Krupali Tappoo, Nadim Cody[1,2], Odille Chang[1]

[1]Fiji National University, [2]James Cook University

Providing a skilled medical workforce to meet healthcare needs in regional, rural and remote areas is a major challenge in Fiji and other Pacific Island countries. These challenges are exacerbated when doctors relocate from rural to urban areas or leave their home country for postgraduate speciality training. The Pacific region is experiencing a rising burden of non-communicable diseases and, combined with persisting communicable diseases and climate change, this has made primary care increasingly complex. This research will be looking at the experiences of graduates of the diploma component of an innovative postgraduate medical training program, using online and remote teaching methodologies to train primary care doctors to meet these challenges without leaving their home communities with content designed specifically to the needs of the Pacific.

In 2019, Fiji National University, in partnership with James Cook University, introduced a new program, the Postgraduate Diploma in Family Medicine. This one-year foundational program provides comprehensive education for doctors already working in primary care. There is a strong focus on evidence-based, patient-centred approaches to non-communicable chronic diseases and topics such as mental health. Using advances in information and communication technology, participants can live and work in rural as well as urban areas throughout their studies. Through a partnership with the Ministry of Health of the Kingdom of Tonga and the non-government organisation Rocketship Pacific Ltd, Tongan trainees have been included as well. Future cohorts are likely to include other regional Pacific countries. From 2020, a further three-year Master's level qualification has been available, providing specialist-level training. This presentation is an evaluation of the distance methodology, graduates' experiences and impact on patient care of this innovative program. This research focuses on the postgraduate diploma, as higher numbers are needed to provide adequate information on the Master's program.

Acceptability and appropriateness of patient-centred, family-focused and community-oriented (PFC) lens in the Ortho-Geriatric Fracture Liaison Service (OG-FLS) among family and community medicine trainees: A cross-sectional study

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Background

In family and community medicine (FCM) residency training in the Philippines, the biopsychosocial approach to care was translated to a teaching strategy and cognitive framework called the patient-centred, family-focused and community-oriented (PFC) lens. However, the PFC lens documented in a matrix, its implementation acceptability and appropriateness for the users as a strategy in the FCM training program have nil evidence.

Objectives

To determine the acceptability and appropriateness of the integration of the PFC lens in the Ortho-Geria Fracture Liaison Service (OG-FLS) in applying the family medicine principles and achieving family practice required competencies of the residents in a tertiary hospital FCM training program.

Methods

A cross-sectional survey was conducted using a 15-item self-administered pretested online questionnaire to gather feedback and experiences on the PFC lens integration. Answers to open-ended questions were coded and analysed with MaxQDA and synthesised into themes while numerical rating scales were analysed with Microsoft Excel into means and standard deviation.

Results

Nineteen residents answered the questionnaire. There were 47 OG-FLS patients referred to the service with an average of two per resident. Overall, the acceptability of the approach among FCM residents had an average of 9.26 (SD = 0.99) while appropriateness was rated 9.26 (SD = 1.09) (10 as the highest). In the PFC integration, the residents gained the skill of concise data organisation and understanding of the patient context. The impactful concepts were the utility of the PFC lens documented in a matrix, the PFC approach to care and the comprehensive approach it contributes to the management of elderly patients with fractures. It also strengthened the concepts of family-focused care, community-oriented care, home care and system-based thinking. It is relevant to the practice of family and community medicine because it emphasises caring for the whole person, gives structure to the practice and promotes continuity of care. The competencies achieved were communicating effectively, collaborating with interprofessional teams, demonstrating clinical competence and practice of biopsychosocial approach.

Conclusion

The PFC lens integration in OG-FLS is acceptable and appropriate in the practice of multidisciplinary care in the in-patient setting among FCM residents. Through the PFC integration, the FCM residents achieved competencies expected of a family physician and applied the family medicine principles. This study showed the utility of the PFC lens in a service-learning activity but more considerations will be needed in the integration to electronic health records and contributions to quality improvement in health services.

Improving perinatal health at Ortum Mission Hospital, West Pokot County

Miss Celestine Todosia

Rural Seeds

Ortum Mission Hospital is located in the deep rural setting of West Pokot County. It is the only hospital in the region that is equipped to deliver maternal health.

The hospital serves a region with very rough terrain and costly means of transport. Over the years mothers have missed to come for antenatal visits, giving birth at home has been the norm. Coming back for post natal services is a luxury. Due to that, there has been very high maternal and infant mortality rates.

In its quest to uphold rural and primary health, the hospital has come up with a dorm facility to host pregnant mothers who are nearing their EDD.

Over the past two years, the infant and maternal mortality has drastically dropped. A simple effort of mitigating transport difficulty that pregnant mothers face in a rough terrain region has saved lives of mothers and babies.

Primary health is the backbone of health. I present to you how one simple effort of transport has increased maternal and infant lives.

Process of establishing a patient–doctor relationship of trust from patients' perspectives: A qualitative study

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Background
Trust constitutes an important component in healthcare, as it is pivotal to the establishment of robust patient–doctor relationships. Better relationships of trust can result in increased patient satisfaction, improved compliance with treatment and enhanced health outcomes. However, the underlying factors and processes that contribute to the development of patient–doctor trust remain elusive. The aim of this study was to shed light on the various factors and processes that contribute to the formation of trust between patients and doctors in primary care settings.

Summary of work
We conducted a qualitative research approach utilising semistructured interviews. The data collected were used for inductive thematic analysis in collaboration with general practitioners, internists, a public health researcher, a philosopher and an anthropologist. The theoretical framework used was Niklas Luhmann's concept of trust. The study was approved by the Okayama University Ethics Committee.

Summary of results
Nine patients (five women and four men) in their 40s to 80s were interviewed. Patients' expectations were key roles in the process of establishing a patient–doctor relationship of trust. Patients' expectations were categorised into four themes: expectation for psychological and emotional closeness to patients; expectation for appropriate medical diagnosis and treatment; expectation for future care; and expectations of the organisation and healthcare system.

Discussion and conclusion
Luhmann noted that the concept of trust, in the broadest sense of confidence in one's expectations, is a basic fact of social life. Trust plays an important role in reducing social complexities that cause personal anxieties. In this study, patients had a wide range of expectations that included expectations for individual doctors and expectations for organisations and healthcare systems, and their hope was to reduce their complexities and anxieties by trusting doctors and healthcare systems. A reduction of complexities, facilitated by trust, has the potential for improving the healthcare outcomes of patients.

Association between serum levels of polyfluoroalkyl substances and metabolic syndrome in Okinawa, Japan

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Background

Polyfluoroalkyl substances (PFAS) are man-made chemicals used in a wide range of manufactured products, which can accumulate in the environment and in the human body. Everyday products, including shampoo or dental floss, contain PFAS. People can intake them by drinking contaminated well water, or eating fish with high levels of PFAS. Although the mechanism of pathogenesis and homogametic effects in different races are unclear, PFAS exposure has previously been linked to adverse health effects such as metabolic syndrome and dyslipidaemia. The aim of this study was to determine the association of serum PFAS levels with markers of metabolic syndrome and other clinical conditions, using the clinical data of participants from Okinawa Prefecture, Japan.

Methods

A cross-sectional study was conducted using blood samples and clinical data collected from outpatients of a clinic in Okinawa, one of the highest PFAS-exposed prefectures in Japan. Linear regression analysis was used to investigate the relationship between serum PFAS levels and body mass index (BMI), as well as other markers of metabolic syndrome, dyslipidaemia and fatty liver.

Results

Of the 403 participants, the mean age was 53.5 (standard deviation [SD]: 15.3), and 220 participants (54.6%) were male. Mean serum levels of perfluorooctanoic acid (PFOA) and perfluorooctanesulfonic acid (PFOS), which are types of PFAS, were 2.81 ng/mL (SD: 1.93) and 7.58 ng/mL (SD: 5.85), respectively. Higher serum levels of PFAS were not significantly associated with: higher BMI, higher serum levels of triglyceride, alanine transaminase and low-density lipoprotein cholesterol; lower levels of high-density lipoprotein cholesterol; diabetes or hypertension.

Conclusion

Greater PFAS exposure was not associated with increased prevalence of obesity, metabolic syndrome, dyslipidaemia, diabetes or hypertension in the Okinawan patient cohort. Further studies with different cohorts will be needed to solidify the effects of PFAS on the human body.

Wellbeing support for GP registrars: Misaligned perspectives and experiences of GP supervisors and GP registrars

Dr Samia Toukhsati[1,2,3], Rebecca Kippen[2], Carla Taylor[1], A/Prof Jill Benson[4], Dr Simon Morgan[1], Dr Justin Coleman[1,5], Ms Jo-anne Chapman[6]

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Background

GP registrars require access to wellbeing support throughout their training. GP supervisors may be well positioned to provide wellbeing support; however, the responsibilities associated with this role lack clarity.

Aim

To explore the perspectives and experiences of GP supervisors and GP registrars as providers and recipients of wellbeing support in GP training.

Method

Consenting GP supervisors and GP registrars anonymously completed an online survey about their sociodemographics, attitudes, perceived norms, barriers and wellbeing support experiences (five-point Likert-type scales from 'strongly disagree to 'strongly agree').

Results

A total of 94 GP supervisors (age = 54 ± 11 years, 60% women) and 27 GP registrars (age = 35 ± 9 years, 74% women) participated between September 2022 and January 2023. There was good representation across all Australian states/territories and metropolitan/non-metropolitan locations. Almost all GP supervisors (95%) were willing to provide wellbeing support; however, only 48% of GP registrars were willing to seek it from them. GP supervisors held more positive attitudes as providers of wellbeing support than GP registrars held as recipients (3.79 ± 0.47 vs 3.59 ± 0.45, respectively; $P < 0.05$), but both agreed that GP supervisors were responsible for it (4.19 ± 0.39 vs 4.01 ± 0.45, respectively; $P > 0.05$). GP supervisors perceived significantly greater pressure from valued colleagues to provide wellbeing support than GP registrars perceived from their peers to seek it from them (3.71 ± 0.64 vs 3.33 ± 0.74, respectively; $P < 0.05$). GP supervisors had significantly greater confidence in their capacity to provide wellbeing support than GP registrars had of them (3.80 ± 0.48 vs 3.31 ± 0.86, respectively; $P < 0.01$).

Discussion

GP supervisors were willing to provide wellbeing support to GP registrars, but most GP registrars were reluctant to seek it from them, possibly due to perceived barriers. Research is needed to explore areas of misalignment related to wellbeing support to ensure that high-quality support is available in GP training.

Brave enough to be vulnerable in GP training? The benefits of reciprocity in the GP supervisor–registrar relationship

Dr Samia Toukhsati[1,2,3,4], Rebecca Kippen[2], Carla Taylor[1], Liam McDonald[4], Elizabeth Molloy[3], A/Prof Jill Benson[5], Nicholas Ladany[6], Lachlan Butcher[1], Ms Jo-anne Chapman[7]

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Background
The GP supervisor–registrar relationship is the foundation for successful training in general practice. Mutual willingness to disclose areas of professional or personal uncertainty can deepen the supervisor–registrar relationship and foster learning opportunities.

Aim
To explore reciprocity in disclosures about professional and personal matters between GP supervisors and GP registrars.

Methods
GPSA and GPRA members were invited to complete an online survey titled, 'How do self-disclosures influence the GP supervisor–registrar relationship?' Consenting respondents anonymously completed questions about their sociodemographics, the likelihood of self-disclosures (13-items, five-point Likert-type scale from 'not at all' to 'very'), and their exposure to disclosures (nine-items, five-point Likert-type scale from 'not at all' to 'often').

Results
A total of 58 GP supervisors (mean age = 51.4 ± 10.5, 55% women) and 58 GP registrars (mean age =34.72 ± 6.10, 66% women) completed the survey in June – July 2022. There was good representation across all Australian states/territories and metropolitan/non-metropolitan locations. GP supervisors self-reported significantly greater likelihood to make self-disclosures than GP registrars (3.78 vs 3.25; $P < 0.001$). However, GP registrars reported significantly lower exposure to GP supervisor disclosures than vice versa (3.03 vs 3.24; $P < 0.05$, one-tailed). Higher exposure to disclosures was significantly correlated with increased likelihood of making disclosures for both GP supervisors ($r = 0.28$, $P < 0.05$) and GP registrars ($r = 0.47$, $P < 0.001$). After controlling for sociodemographic factors, exposure to GP supervisors' disclosures significantly predicted GP registrars' likelihood of making disclosures ($r = 0.28$, $P < 0.01$). A significant model predicting GP supervisor disclosures did not emerge.

Discussion
Although GP supervisors reported significantly greater likelihood of making disclosures than GP registrars, both cohorts perceived their exposure to disclosures as only occasional. These results highlight the importance of GP supervisor modelling to encourage GP registrars to make reciprocal disclosures about areas of uncertainty.

Reveal or conceal? Self-disclosures build trust in the GP supervisor–registrar relationship

Dr Samia Toukhsati[1,2,3,4], Rebecca Kippen[2], Carla Taylor[1], Liam McDonald[4], Elizabeth Molloy[3], A/Prof Jill Benson[5], Nicholas Ladany[6], Lachlan Butcher[1], Ms Jo-anne Chapman[7]

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Background

Trust between GP supervisors and GP registrars is the cornerstone of a successful training relationship.

Aim

To explore the role of self-disclosures on trust in the GP supervisor–registrar relationship.

Methods

GPSA and GPRA members completed an anonymous online survey about their exposure to disclosures (nine-item, five-point scale from 'not at all' to 'often'), and the impact of disclosures on trust (nine-item, five-point scale from 'strongly erodes' to 'strongly builds') in the GP supervisor–registrar relationship.

Results

A total of 58 GP supervisors (mean age = 51.4 ± 10.5, 55% women) and 58 GP registrars (mean age =34.7 ± 6.1, 66% women) were recruited in 2022. For GP supervisors, trust was built when GP registrars made more disclosures about their past ($\rho = 0.32$, $P < 0.05$) and present ($\rho = 0.32$, $P < 0.05$) experiences; intimate ($\rho = 0.62$, $P < 0.001$) and non-intimate ($\rho = 0.50$, $P < 0.001$) information, similar ($\rho = 0.32$, $P < 0.05$) and dissimilar ($\rho = 0.36$, $P < 0.01$) issues to those of supervisors and their experiences in supervision ($\rho = 0.39$, $P < 0.01$). For GP registrars, trust was built when GP supervisors shared more disclosures about intimate information ($\rho = 0.48$, $P < 0.001$), their experiences in supervision ($\rho = 0.46$, $P < 0.001$) and similar issues to those of registrars ($\rho = 0.39$, $P < 0.01$). Exposure to disclosures about failures built trust for GP supervisors and GP registrars (4.43 vs 4.55, respectively; $z = -0.58$, $P > 0.05$); more exposure increased trust for GP registrars ($\rho = 0.27$, $P < 0.05$) but not for GP supervisors ($\rho = 0.22$, $P > 0.05$).

Discussion

Increased exposure to self-disclosures is associated with greater trust in the GP supervisor–registrar relationship. Research is needed to identify self-disclosure boundaries to optimise trust in the GP supervisor–registrar relationship.

Healthcare professionals should encourage people to bring question prompt lists – find out why! (Findings from a longitudinal qualitative study)

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Introduction

Question prompt lists (QPLs) have been found to support patients to ask questions and improve the information they receive from doctors. However, some QPL tools, which have been available online for over 15 years, have little published data on their impact in real-world settings. This study's aim was to understand patients' attitudes and experiences accessing health information and to assess the impact of introducing two generic QPLs over three months.

Methods

A longitudinal qualitative study consisting of three semistructured interviews over a three-month period was conducted with 31 purposively selected participants, adults ≥18 years, recruited online and through social media. Participants were introduced to two different QPLs currently available online (Question Builder or the Ask Share Know questions). Inductive thematic analysis was performed on transcripts of a total of 92 semistructured telephone interviews which were conducted during May – November 2020.

Results

Three main themes are described. (1) Participants described barriers and facilitators to accessing health information: navigating a complex health system; difficulty asking questions of their healthcare professionals and that they value doctors with good communication skills. (2) QPLs helped some participants recognise the role of question asking in consultations, made them feel more empowered and helped them prepare and prioritise. (3) Participants wanted QPLs to be easier to use, be accessible when needed and that question asking and QPLs should be normalised in medical consultations.

Conclusions

Well-designed and easily accessible QPLs can empower people to ask questions and be more involved in decisions about their healthcare. Endorsement of question asking in consultations by healthcare professionals and providing QPL tools at the point of contact with health services will be key to realising the potential of QPLs.

‘It’s a fragile open door’: Enhancing COVID-19 vaccination rates in people receiving treatment for substance use disorder

Bridin Murnion[1,2], Jane Carland[3,4], Meryem Jefferies[5], Michael Au[5], Dr Marguerite Tracy[1,5]

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Background

People with substance use disorder (SUD) frequently have physical health comorbidities such as hepatic and cardiovascular disease and are at high risk of harms from COVID-19 infection. However, several studies have shown that many people with SUD are less likely to be vaccinated for COVID-19 for reasons such as poor vaccine access, and lack of trust in the health system and/or vaccines. Vaccine hesitancy is common in this population and compounds the barriers already experienced by this group to accessing healthcare. Drug Health Services in Western Sydney developed a model of care to enhance COVID-19 vaccine uptake commencing 22 March 2021.

Objectives

This study sought to retrospectively evaluate vaccine uptake within the service and explore staff perceptions of strategies employed during the COVID19 pandemic.

Methods

This study used mixed methods: a retrospective audit of COVID-19 vaccination rates in people accessing care and semistructured interviews with staff who delivered vaccination interventions.

Findings

Of the 984 patients that were engaged with the opioid treatment program on 9 December 2021, 90.9% had received the first COVID vaccination and 86.7% the second. Australia-wide vaccination rates on that date were 93.1% and 88.7% for first and second doses, respectively.

Interview participants commented that having a deep knowledge, understanding and connection with the patient group drove implementation and success of vaccination interventions. This was further supported by communication and sharing information, both among staff and with patients, as well as staff engagement with the vaccination interventions.

Conclusions

Extensive collaboration across drug health services, and with the local public health unit, assisted overcoming logistical barriers to vaccination. Engaged staff providing information and facilitating access to healthcare underpin this success. High rates of COVID-19 vaccination can be achieved in a vulnerable population.

Key messages to minimise harms from alcohol: NACCHO-RACGP National guide to preventive healthcare for Aboriginal and Torres Strait Islander people

Dr Marguerite Tracy[1], Belinda Hammond[2], Mary Belfrage[2]

[1]General Practice Clinical School, Faculty of Medicine and Health, The University of Sydney, [2]RACGP NACCHO Partnership Project | RACGP Aboriginal and Torres Strait Islander Health

Background

The NACCHO-RACGP national guide to preventive healthcare for Aboriginal and Torres Strait Islander people (National Guide) is a flagship resource supporting best-practice health-promoting and disease-preventing activities for Aboriginal and Torres Strait Islander people in primary healthcare settings. Originally conceived by NACCHO in the early 2000s, the now-fourth edition of the National Guide is being developed through a NACCHO-RACGP partnership project and will be published in October 2023.

The purpose of the National Guide is to provide guidance for primary healthcare teams on health issues that are preventable, actionable in primary healthcare settings and important (priorities) for Aboriginal and Torres Strait Islander communities. A key aim of the National Guide is to provide practical guidance that is useful for clinical decision making, including in areas where there is uncertainty or variation in clinical practice, or where an issue is contentious.

Methodology

The development of the National Guide comprises three key stages:

- user review of the third edition
- evidence review and formulation of recommendations by authors
- expert review, editorial review and stakeholder consultation.

Implementation has been a key focus from the start and has been part of scoping conversations with authors to include:

- positively stating what promotes, supports, protects and strengthens health and wellbeing
- using concise plain language with key messages at the start of the topic
- addressing the whole of the primary healthcare team as the audience
- emphasising translation into practice.

Results

This presentation will focus on updates and recommendations from the chapter on prevention of harms from drinking alcohol.

Conclusion

Recommendations, aimed at the whole of the primary healthcare team, positively state what promotes, supports, protects and strengthens health and wellbeing, using concise plain language with key messages.

Recommendations emphasise translation into practice.

Finding your path: Discovering the breadth of careers in general practice

Dr Sean Black-Tiong, Hester Wilson, John Kramer OAM, A/Prof Penny Abbott

RACGP

Join this facilitated session involving a panel of fellow GPs and family physicians, a 60-minute professional forum showcasing the breadth of careers available through the general practice specialisation.

While all GPs deliver comprehensive care covering the full breadth of patient demographics and case presentations, many GPs develop expertise and skills in specific areas of general practice throughout their career. The result is that GPs often craft unique careers within and alongside general practice, exploring their own interests while meeting the specific needs of their community. GPs also often have opportunities to get involved in advocacy, community development and leadership.

The panel will discuss their individual areas of specific interest within general practice: addiction medicine, paediatric ADHD and custodial health. Delegates will hear how panellists discovered their areas of interest, what their day-to-day role looks like and the impact on them and their communities.

This panel discussion will explore and celebrate GP careers, providing a unique and inspiring opportunity for GPs and family physicians to reflect on their career journey, and reconnect with their own continuing development as a practitioner, while encouraging early career GPs to explore their strengths, develop a sustainable career and have continued passion for their profession. There will be a dedicated Q&A session at the end of the forum.

Presented by the RACGP GPiT (GPs in Training) and the RACGP Specific Interests faculties.

Innovating formative assessment tools: How do we adapt to changing educational requirements while meeting the specific needs of the learner?

Dr Owen Tsao[1], Rula Ali[1]

[1]GP Synergy and RACGP

The needs of general practitioners in training (GPiT) vary according to time, context and professional experience. This is the journey of how educators of a general practice (GP) training program devised new formative assessment tools to address GPiT-specific needs while meeting the expected standards of a changing program. Despite limited resources, ongoing changes to training and the recent healthcare environment, the quality of the educational outcomes was maintained and enriched in the process.

This team of GP educators faced critical challenges in delivering formative assessments to a cohort of GPiT largely in rural and remote areas, consisting mostly of international medical graduates. Some of those challenges included: rapid growth of the number of GPiT in the program; an increase in the number of assessments required to successfully complete the program; and the isolation and disconnect from peers faced by this vulnerable GPiT cohort, made worse by COVID restrictions. It was also identified that clinical performance deficiencies common to GPiT of this program were only addressed opportunistically through the original iteration of assessment tools. Additionally, some GPiT of this program struggled to demonstrate their clinical skills when observed by assessors due to performance anxiety.

Through different iterations of learning activities and assessments, the program educators innovated group activities to address learning needs in a standardised fashion. Common learning needs identified included communication in difficult consultations; clinical reasoning; ethics and professionalism; Fellowship examination preparation; and doctor wellbeing. The use of video platforms and online forums, and being responsive to feedback from evaluation surveys, helped to keep learning relevant and individualised. Group activities not only delivered the program more efficiently, but also improved GPiT satisfaction through peer-to-peer learning.

Willingness to engage in a process of innovation and proactive feedback, from both educators and GPiTs, resulted in a more efficient and effective learning experience for all.

Primary care workforce shortages: How to recruit medical students into general practice?

Dr Tim Tse, Dr Bosco Wu, Prof Simon Willcock, Prof Sanjyot Vagholkar, Dr Darran Foo, Dr Janani Mahadeva, Patrick Mcneil

Macquarie University

Australia, like other parts of the world, is experiencing a general practitioner (GP) workforce collapse. An estimated 25% of GPs plan to retire within the next five years and there is a projected shortfall of 11,517 GPs by 2032. Primary care forms the essential cornerstone of a health system and patients with a regular GP have significantly reduced utilisation of out-of-hours services, hospital admissions and reduction in mortality by up to 25%. Consequently, if the primary care workforce issue is not addressed, there will be subsequent increases in the use of downstream health services such as emergency departments, outpatient clinics and hospital admissions.

There are various potential time points during a medical career to make substantial impacts on an individual's choice regarding speciality. In chronological order, this can be during premedical studies, during medical school and at prevocational training. In 2022, only 13.8% of medical students considered general practice as a preferred career path. This continues the sustained pattern of decline from 16.5% in 2017 and 16.1% in 2021. With 31,620 (30%) of the 105,293 medical practitioners in Australia practicing as GPs in 2020, increased interest from students in medical school is vital for the sustainability of the speciality.

We present a literature review on the demographics and factors that attract students to general practice. Influences on career choice can occur due to a variety of reasons including, but not limited to, positive role modelling from mentors, good-quality teaching and increased exposure to the speciality. We discuss the positive aspects of general practice, such as continuity of care, patient–doctor interactions and diversity of practice. We then link how the evidence has resulted in the development of the Macquarie University General Practice Intensive Stream launching in 2024 and the projected benefits this model may have for students and the workforce.

Implementation of comprehensive geriatric assessment among community-dwelling older adults in a rural primary care setting in Botswana

Dr Stephane Tshitenge, A/Prof Billy Tsima

University of Botswana

Background

Botswana, like most African countries, lacks a well-established community-based comprehensive geriatric assessment program (CGA). We intended to implement a CGA in the Mahalapye Health District (MHD), Botswana. This project provided training opportunities in community-oriented primary care (COPC) and CGA for the University of Botswana (UB) medical students (MS) and family medicine residents (FM-R).

Methods

This was a COPC initiative. In June 2020, UB family medicine academics met with a non-governmental organisation called 'Ntshegetse-Ke-Go-Tshegetse' and MHD health professionals. The team implemented a CGA in MHD – a rural setting – that would target at-risk community-dwelling older adults (AR-CDOA). AR-CDOA patients were those over the age of 65 years who had at least one geriatric syndrome. We derived the screening tool from the Brief Assessment Tool for Screening Geriatric Syndromes. MS and FM-R screened older adults or reviewed AR-CDOA in the community in 10 minutes. We established criteria for referring patients to relevant healthcare professionals. MS and FM-R organise health education, while volunteers help AR-CDOA with laundry, bathing, feeding, grocery shopping and medication collection through the CGA.

Results

Every Thursday or Friday afternoon, MS or FM-R conduct home visits for AR-CDOA. Since the program's inception, each of the 16 MS in an eight-week FM rotation and the nine FM-R have had at least one home visit every four weeks. They provide health education once every eight weeks. Ten volunteers assisted the 124 AR-CDOA enrolled in the program. During the COVID-19 outbreak, the team assisted AR-CDOA in obtaining vaccines and medications.

Conclusion

We implement CGA in MHD to provide community service and to assist MS and FM in practising CGA. We intend to expand this program in the future to other family medicine training sites.

Complementary or alternative: Ways besides biomedicine

Dr Sonia Tsukagoshi[1], Dr Sankha Randenikumara, Patrick Reichel, Dr Uma Senthilkumar, Dimitrios Alepedis, Gabriela Di Croce

[1]Blithehale Health Centre

Are you interested in acupuncture, Chinese medicine, Ayurveda, Siddha, yoga or meditation as treatment modalities? Have you wished to learn more about these areas and how they can be integrated into 'Western' biomedicine? Throughout the world, there are many different frameworks of medicine that have centuries of practice behind them which view the person, not as a body with the potential for disease, but as a delicate balance between mind, body and soul. Can we learn more about holistic patient care from what we consider 'complementary' medicine?

There are many cultures worldwide where family physicians work side by side with traditional healers. Learning skills from other forms of healing can be a tool in our kit both as treatment options (eg acupuncture for pain control) which will improve patient satisfaction. In some instances, knowledge can also identify the potential risks that some traditional methods could pose, especially if used in conjunction with biomedicine. By having skills to bridge the gap, family physicians will be able to advise patients who wish to try other modalities ensuring patient-centred and safe care.

We propose a roundtable with a panel of experts where we hope to create a safe space to present the challenges and to have a lively discussion on the benefits and pitfalls of integrative medicine.

How COVID-19 hit healthcare twice, and why agile leadership offers solutions to current disruptions

Dr Chinue Uecker[2], Dr Freimut Juengling[1]

[1]LPI Consultants LLC, [2]SEI

Background

When the COVID-19 pandemic began, no one could imagine what would happen to healthcare. While senior leaders established organisational disaster preparedness policies and practices within healthcare globally, the impact of a highly transmissive and potentially deadly disease as COVID-19 revealed to be, on individuals, families, organisations, the workforce, society and healthcare providers was unprecedented. 'Unprecedented' became one of the most used words during the pandemic.

Content

As healthcare organisations adapt to disruptions, leadership structures and governance style changes are inevitable. Agile leadership is a leadership practice that fosters innovation, collaboration and continuous improvement to ensure organisations survive in competitive environments riddled with uncertainties. Agile leadership is a crucial leadership practice in healthcare, enabling leaders to respond quickly and effectively to changing circumstances and deliver high-quality patient care. Agile leadership applies to clinical and non-clinical leaders. This qualitative study encompassing observations, interviews and secondary research explores why many traditional leadership models in healthcare need to prepare their organisations for the cluster risk of a fully fledged pandemic.

Take-home message for practice

Healthcare leaders faced unfathomable challenges during the COVID-19 pandemic. The key themes that emerged from the preliminary research were leadership, operational agility, strategic thinking, collaboration and continuous improvements. Agile leadership offers solutions to current challenges and disruptions. Highly agile leaders leverage strategic decision making, problem solving, effective external communication and flexibility to enhance their organisation's success.

An exploration of strategies and initiatives to enhance rural maternal health

Dr Chinue Uecker[4]

[1]The Chicago School of Professional Psychology, [2]LPI Consultants LLC, [3]Cornell University, [4]SEI

Introduction

Since 2014, over 50% of rural counties in the United States have had limited access to hospital-based obstetric services. For rural residents, further access instability surfaced during the COVID-19 pandemic, contributing to increased maternal mortality and morbidities. The struggle to access quality care has been a systemic barrier for rural women of colour.

Aim

Improving access to quality care and specialised clinicians is a valuable strategic and patient-focused goal for rural hospital leaders, rural communities and the patients served.

Methods

This case study explored strategies rural hospital leaders implemented to enhance access to maternity services in rural areas.

Results and conclusion

Developing synergies with providers and health systems, utilising technology and creating effective telehealth programs were central themes that evolved from this study.

Point-of-care ultrasound practice applied to home visits in northernmost Japan

Dr Wahei Uemura

Hokkaido Center For Family Medicine

Aim

To clarify the usefulness of POCUS in home healthcare settings where means of imaging tests are limited.

Contents

The COVID-19 epidemic has increased the demand for home healthcare in Japan. Home healthcare is a field with limited medical resources compared to hospital care. Therefore, the quality of medical care that can be provided depends on the experience and skills of the doctor who performs home visits. Since the purpose of regular home visits is daily health management, in many cases it is only a medical interview and a physical examination. However, it is often difficult to determine the diagnosis and treatment policy for medical problems that occur during temporary home visits when sudden changes occur, based only on interviews and physical examinations.

By making good use of pocket-sized echocardiograms, which could only be done with highly skilled examination techniques, doctors can now greatly expand their diagnosis capabilities. A stethoscope is carried around during home visits, but the pocket echo may be able to play an active role as a new form of stethoscope. We will introduce specific cases in which the pocket echo is used in home visits, and report on its use not only in conventional fields, but also in new fields such as orthopaedics.

Goals

To report cases in which POCUS was useful.

Management of heavy menstrual bleeding in a multidisciplinary team setting

Dr Munawwara Uppal[3]
[1]Womens Health Road, [2]University of Sydney, [3]Northern Beaches Hospital

Aim

Reflections on setting up a multidisciplinary team-based service for women's health.

Women's Health Road is a medical centre located opposite Northern Beaches Hospital in Frenchs Forest, with onsite sessions from both GP and non-GP specialists.

The practice is a digitally integrated structured service providing multidisciplinary, holistic medical care including women's health.

Heavy menstrual bleeding (HMB) is common in perimenopause and has been defined as 'excessive menstrual blood loss which interferes with the woman's physical, emotional, social and material quality of life, and which can occur alone or in combination with other symptoms.'

GP management of HMB is dependent on the severity and likely cause of bleeding, future fertility plans, medical contraindications and personal preferences.

The six quality statements from the HMB clinical care standard released by the Australian Commission on Safety and Quality in Health Care are relevant to general practice, highlight some areas for quality improvement.

This presentation will cover the management of women, particularly at midlife with heavy menstrual bleeding, in the context of multiple services under one roof, including access to pelvic ultrasound, a digitally empowered healthcare HMB pathway using the digital patient portal and proactive iron replacement in the medical centre. Discussion will briefly include what happens after referral for surgical management and use of menopause hormone therapy for suitable women.

This presentation is hence an overview of end-to-end HMB management and the benefits of a proactive approach to this condition that unfortunately many women suffer so much morbidity and loss of quality of life from.

When nationals and refugee LGBTQ face the same living burdens, would their survival strategies differ? The Lebanese experience

Prof Jinan Usta[1], Shirine Heidari[2], Monica Onyango[3], Ali Chaito[4]

[1]AUBMC, [2]Geneva Graduate Institute, [3]Boston University, [4]Lebanese University

Lebanon has been home to several crises in the past few years, including the Beirut Port explosion, financial crisis and COVID. This study examined the current situation of queer individuals living in Lebanon with a focus on the challenges they face in meeting their basic needs in a country with a deteriorating financial situation, and the strategies they use to cope with the discrimination on the basis of sexual orientation and gender identity and expression. The findings show that both Lebanese queer individuals and refugees face significant difficulty in securing viable employment and meeting basic needs such as food and housing. However, the refugee respondents claimed their living situation was far worse in Lebanon than in their countries of origin due to facing double discrimination: for being queer and for being refugees. The survival strategies, including transactional sex, were similar, yet there was differential access to healthcare services.

In summary, these results point to the intersectional structural vulnerabilities that the refugee LGBTQI community faces in the context of political instability and financial collapse in Lebanon, where, in addition to facing similar challenges as the national queer community, they risk additional exploitation as refugees.

Intimate partner violence and health: Does resilience mitigate its effect?

Prof Jinan Usta[1], Rola Itani[1], Afifa Shatila

[1]AUBMC

The relationship between intimate partner violence (IPV) and poor health outcomes is well established. However, the relationship between resilience and health, especially among survivors of violence, was not adequately studied. The current study aims to address this research gap by exploring the effect of resilience on certain health outcomes (healthcare utilisation, perception of health, mental wellbeing and reproductive health) among women exposed to IPV.

In this quantitative cross-sectional study, a questionnaire was administered by telephone to 242 married women aged between 18 and 45 years and exposed to IPV. Most of the sample was Lebanese (139; 57.4%) or Syrian (91; 37.6%). The participants scored 6.9 ± 13.8 on violence as measured by the Composite Abuse Scale. A total of 80 participants (33.1%) did not disclose or seek assistance for violence. Overall, there was more physical abuse disclosed among non-Lebanese as compared to Lebanese. There was more sexual abuse disclosed by participants living in the city than in rural or refugee camps. The participants scored 58.0 ± 17.5 on the CD-RISC 25 resilience scale. There was a positive association between resilience and age, personal income and place of residence. Resilience was negatively associated with crowding index, depression, anxiety, PHQ15 and PTSD. Moreover, resilience was negatively associated with food and clothes insecurity, feeling safe and community support. Using the Sobel test, the results confirmed that resilience significantly mediates the relationship between violence and health ($Z = 3$).

The findings of the study can help advance the field of violence research by identifying potential protective variables related to resilience that would help improve the care of IPV survivors. Such research could be applied to develop strength-based interventions, like promoting resilience, for violence-exposed women; the mental wellbeing and reproductive health of the survivors may be improved, as well as their ability to have an informed decision.

The OECD International Survey of People Living with Chronic Conditions (PaRIS survey): Field trial in 18 countries

Prof Jose Maria Valderas Martinez[1,3,4], Miekex Rijken[2,3], Oliver Gröne[5,3], Judith de Jong[2,3], Rachel Williams[6,3], Rosa Suñol[7,3], Candan Kendir[8], Katherine Debienassis[8], Frederico Guanais[8], Michael van den Berg[8]

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Introduction

The Organisation for Economic Cooperation and Development (OECD) aims to support countries in improving care through the PaRIS International Survey of People Living with Chronic Conditions by collecting information on how people experience the quality and performance of primary and ambulatory care services. The implementation of the survey instruments and data collection methods have been piloted in a field trial. We present here the evaluation of this pilot.

Methods

In 2022, 18 countries participated in the field trial across Europe, Australia, Canada and Saudi Arabia. National project managers (NPMs) worked with the PaRIS-SUR Consortium, OECD and national stakeholder groups in the multilevel pilot design and implementation. Practices were identified at random (stratified) in each country and patients aged ≥45 years seen in each practice were also randomly selected. Data were collected through patient and practice questionnaires (presented at previous WONCA conferences). Structured feedback was gathered on country experiences with the field trial.

Results

Out of 11,999 patients providing consent across the 18 countries, 10,894 completed the patient questionnaire (91%). Only five questions (out of 118) had >10% missing answers. Furthermore, 570 practices provided consent across 17 countries, and 540 (95%) completed the practice questionnaire. Psychometric performance of measurements was largely confirmed, with minor adjustments needed. Countries provided rich feedback on their experiences and proposed several improvements.

Conclusion

The field trial yielded valuable lessons for the main survey in 2023, including the need to intensify national efforts for engagement and recruitment, consider challenges of the nested design, further harmonise sampling and data collection, revise instruments and further develop country-specific implementation plans together with stakeholders.

Development of the WHO primary care patient experience survey

Prof Jose Maria Valderas Martinez[1], Jee-ae Kim[2], Kavitha Viswanathan[2], Briana Rivas-Morello[2], Nuria Polanco Toro[2], Matthew Nielson[2], Kathryn O'Neill[2]

[1]National University of Singapore, [2]World Health Organization

Background

Capturing and reporting patient experience is a crucial part of the overall health system performance measurement efforts in moving towards integrated people-centred care. To support the implementation of the WHO primary health care measurement framework, we aimed to develop a questionnaire to assess patient experience with primary care services.

Methods

A pragmatic approach was implemented for the development of a prototype tool. The design included the following steps: (1) identification of core domains from previously available sources; (2) selection of the most promising items for each domain based on expert evaluation; (3) development of a core tool (selection and modification as needed based on predefined criteria); and (4) development of a plan for ensuring and testing the cross-cultural equivalence and the metric performance of the draft instrument.

Results

The draft version of the instrument includes 37 items across eight domains (First contact accessibility; Continuity; Comprehensiveness; Coordination; People-centred care; Professional competence; Safety; Overall experience). Algorithms have been developed to elicit scores on a range from 100 (best possible experience) to 0 (worst possible experience), including domain scores for each of the core functions of primary care and for patients' perceived professional competency, as well as an overall weighted score including the additional items of patient safety and overall experience. For simplicity, both patient experience domain and overall scores are elicited on the range 0–100, with 100 representing the best possible experience and 0 the worst possible experience of primary care.

Conclusion

The current draft instrument represents a relevant advancement in the measurement of patient experiences in primary care, which will benefit from additional refinement: additional work will be needed to test the feasibility of the survey and further modifications may be needed.

Patient and family engagement in patient safety in primary care: An evidence synthesis

Prof Jose Maria Valderas Martinez[1,2,3], Darla Darla Carvallo[4], Adrian Paul Vasquez Mejia[4], Marta Dora Ornelas[2], Gouveia Alexandre[2], Leonardo Graever[2], Prof Jinan Usta[2], Dr Mercy Wanjala[2], Oana Bulilete Bulilete[4], Irvy Etta[2], Dr Joy Karamana Mugambi[2], Maria Antònia Fiol de Roque[4], A/Prof Mehmet Akman[3], Ignacio Ricci Cabello[4]

[1]National University of Singapore, [2]WONCA Working Party in Quality and Safety, [3]WONCA Working Party in Research, [4]Institut d'Investigació Sanitària Illes Balears, Palma de Mallorca, Spain

Background
Patient and family engagement is a high priority for improving patient safety in primary care.

Aim
To identify and synthesise the scope of available research about tools, interventions and quality improvement initiatives which aim at improving patient safety in the primary care setting through patient and family engagement.

Methods
This scoping review's protocol followed Joanna Briggs Institute and PRISMA guidelines. Specifically tailored electronic algorithms with a combination of controlled vocabulary and search terms in MEDLINE, EMBASE and the Cochrane Library were used. Eligible studies were evidence syntheses in English that reported the development, implementation or impact of relevant interventions, tools or quality improvement initiatives. References were screened with Rayyan. Study data regarding publication, aims, study population, methodology, scope, level of engagement were extracted.

Outcomes
Out of initial 1115 references, 26 syntheses were included. Most of them (76%) consisted of systematic literature reviews, and 70% were published from 2016 onwards. Five reviews focused on primary care whereas the rest were not setting specific. Most frequently researched topics included medication management across transitions of care, medication side effects and detection errors. Only a minority of reviews focused on specific ways of involving patients, such as individual information-sharing sessions for proactively involving patients in symptom monitoring and understanding their medications; or on different approaches to encouraging patients to ask questions.

Discussion and take-home message
A body of research supports best evidence for improving patient safety in the primary care setting by supporting patient and family engagement.

Using a child's antibiotic history as a data-enabled brief intervention to optimise antibiotic prescribing

Dr Oliver Van Hecke

University Of Oxford

Background

One in four GP appointments are for children. Many of these appointments are for 'respiratory tract infections' (RTIs). At least one in three children are prescribed an unnecessary course of antibiotics for these illnesses. Recent research from over 250,000 UK children highlighted those children who had taken two or more antibiotic courses for RTIs in the past year had around a 30% greater chance of not responding to treatment for future RTIs compared to children who had not taken any antibiotics.

Question

What is the feasibility of using a child's antibiotic history as a data-enabled brief intervention to optimise antibiotic prescribing?

Methods

This research has two phases. In Phase 1, through a series of 'think-aloud' workshops and interviews, we worked together with parents and clinicians on how best to design the computer screen prompt and personalised consultation print-out and whether this would be acceptable for parents and clinicians.

In Phase 2, GPs/nurses have the opportunity to explore and use a prototype computer-based prompt and consultation print-out, developed from Phase 1 and integrated into the GP computer software, and share their feedback through a series of 'think-aloud' interviews.

Outcomes

We have co-developed two components of an electronically embedded intervention (computer-screen prompt, print-out) with parents of young children, clinicians and information design specialists. Phase 2 is currently in progress.

Discussion

Delivering such interventions, integrated into practice workflow, could be scaled up to promote effective antimicrobial stewardship and reduce unnecessary antibiotic use in primary care.

‘Ouch, don’t ever say that again!’ A workshop in providing respectful and effective feedback

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Background and aim

Adequate patient-centred communication between professionals and patients has a positive impact on health outcomes, and can be trained effectively. Most healthcare professions training programs therefore include communication skills training in their educational programs, with both formal ‘classroom’ training courses and workplace learning. However, transfer from classroom to clinical practice is difficult. And (communication) skills deteriorate over time if no feedback is provided in clinical practice. However, providing respectful, constructive and non-judgmental feedback that leads to changes in behaviour is not easy. If feedback is vague or perceived as disrespectful, it might be ignored or encounter resistance. In both cases it will be ineffective. To avoid these problems, providing feedback should be trained.

The aim of this workshop is training of skills and techniques in providing effective feedback that can be used in any (cultural) context.

Content/methods

The topic is providing feedback. The workshop will be highly interactive throughout. It starts with an interactive introduction of participants, followed by a mini presentation and discussion about feedback. A short video of a primary care consultation will then precede a feedback demo. This will be followed by eliciting feedback rules from the audience in a playful way, using brainstorming in pairs and summarising in plenary. Participant role-play using another video of a family practice consultation will then provide an opportunity to practice feedback in small groups of three (family doctor-learner, supervisor and observer). A final discussion will bring everything together and lead to a conclusion with learning points and take-home messages.

Goals

To introduce participants to the principles of respectful, constructive and non-judgmental feedback and give them the opportunity to put feedback skills into practice.

A need for action: A systematic review of risks factors for, and causes of, suicide mortality among medical students

Mr Karan Varshney, Hinal Patel, Mansoor Panhwar

School of Medicine, Deakin University

Medical students have been known to face a wide array of mental health issues at disproportionately high rates. Of pertinence, medical students have been shown to have high rates of suicide. However, little is known about the risks for death by suicide for this group. We therefore conducted a systematic review regarding the risk factors and causes of death by suicide among medical students. Following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, we conducted searches in six different databases. Studies with stratified data on at least one suicide death by a medical student were eligible for inclusion. Searches produced a total of 1748 articles and, of those, 13 articles were eligible for inclusion. There was a pooled total of 362 suicide deaths of medical students across five different countries; 73.4% of deaths occurred among male students, and the majority of all deaths occurred for students who were single and in their early 20s. Students in their later years of medical school were more likely to die by suicide, as were those with a history of psychiatric issues such as depression. Frequently discussed reasons for suicide were academic stress/poor academic performance, and familial/relationship issues. The most commonly reported cause of death by suicide was hanging (65.2%), followed by jumping from a height/building (11.6%) and poison/overdose (11.6%). Our findings indicate that rates of completed suicide are particularly high among medical students of certain, specific demographics. Notably, there were few large-scale studies analysing risks and causes for medical student suicide. Hence, there is a need for more transparency of data and reporting regarding suicide among medical students. In conclusion, it is imperative that medical schools continually aim to identify students who at high risk of suicide, and offer appropriate wellness services and programs.

Generative AI tools in medical education and research: A discussion of challenges and opportunities

Dr Sophie Vasiliadis, Lyndon Walker

The Royal Australian College of General Practitioners

The branch of AI known as 'generative AI' generates new content and data, such as text, images and video, using machine learning algorithms. With improved algorithms and computing power, AI tools are set to have a significant impact on medical education and research.

The use of ChatGPT by OpenAI, a generative language model that produces human-like text using deep learning, is a prime example, as seen in its use by students for assessments and essays, and its passing of law and medical exams. This has included researchers using the tool to pass bar exams and the US Medical Licensing Examination, raising major ethical and academic integrity concerns.

However, this emergent technology also provides opportunities for both educators and researchers by creating realistic simulations to challenge students and help them to develop their clinical reasoning skills, while also reducing privacy concerns. Generative AI models can simulate patient encounters and provide customised scenarios, including medical images, simulated cases and electronic health records.

Researchers can take advantage of AI tools such as Elicit and SciSpace to more efficiently and effectively collate and summarise existing research and language models to refine their research questions and writing.

Beyond generative AI tools, there is a growing body of medical education research examining the need for AI to become part of the curriculum as it becomes an increasingly important part of diagnostic equipment and procedures, as well as patient care.

This presentation will provide an overview of some important AI tools and summarise the growing body of research on AI in medical education, including the ethical implications and educational opportunities presented by this new technology.

Appreciative inquiry: A new way to approach research, evaluation and reconnection in primary care communities

Dr Sophie Vasiliadis[1], Lisa Glassborow[2], Chelsey Cooper[2]

[1]RACGP, [2]Hatrick and Co

Appreciative inquiry is a methodology with the philosophy of a strengths-based, systematic approach to change and innovation, and offers a framework for collaborative, analytical and creative inquiry and codesign. It can be an empowering methodology for participants in highly stressful, uncertain or disempowering conditions. Through participatory activities and a systems-level perspective, the resulting recommendations are often innovative and aspirational, as opposed to the traditional focus on solving problems or reducing deficits.

Its philosophy and methods promote a high level of participant engagement, contribution and ownership of the process and outcomes. As a data collection tool, it offers researchers and evaluators novel insights and rich storytelling.

Appreciative inquiry is a four-step process where participants: (1) collectively identify their achievements and strengths ('Discovery' phase); (2) articulate opportunities and future possibilities (a 'Dream' phase); (3) form a direction to plan and aspire towards ('Design' phase); and (4) develop sustainability of the shared direction and use of appropriate indicators of its success ('Destiny' phase). The process is participatory and includes a program of activities where small groups of people with diverse perspectives, knowledge or skills apply strengths-based inquiry to discover what might be. While participants move between groups to 'cross-pollinate' ideas, the final 'destiny' phase is often negotiated collectively.

This presentation will discuss how Appreciative inquiry can be used as an alternative data collection tool for research and evaluation projects, and ethical considerations. We will describe how it was used in a research project to collect data on best practices in GP training with medical educators, while the sector was in a state of flux. The framework generated data on best practice, as well as the roles and interrelationships between individuals and teams. Participants offered feedback that, more than other workshops, it reconnected and inspired them at a challenging time of organisational change.

Defining workforce needs prioritisation

Mr Matthew Vincent

GPEx

Funded by the Department of Health and Aged Care (DoHA), the Workforce Planning and Prioritisation (WPP) program aims to address the gap in evidence-based, consolidated information and analysis on strengthening current and future workforce needs for the Australian General Practice Training (AGPT) program.

To enable accurate advice to the DoHA and GP Colleges on workforce need in each state (to inform training capacity, placements and pathways), a workforce needs framework (WNF) has been developed. It is a quantitative prioritisation framework that produces assessments of the highest GP workforce need for defined areas to inform GP workforce strategy and planning, drawing on demand and supply indicators.

The WNF methodology, defined and evaluated through a national working group, involved the development of separate demand (community need) and supply (access to GP services) indices for each area. Indicators of both demand and GP workforce supply from data available were separately incorporated into two quantitative scores. Evaluative criteria were used to rate the impact/relevance, feasibility, sensitivity and governance of each of the indicators.

A key objective was national consistency for the framework's elements, including data sources, indicator definitions and parameters applied. However, the model was then localised through application of knowledge specific to South Australia, including qualitative data and feedback.

The development of the draft WNF identified challenges with access, analysis and currency of available data sources, and underscored the role of clear communication in building traction with stakeholders. This presentation will showcase the development of the framework methodology, including the challenges encountered, and discuss the current and future landscape of quantitative workforce need modelling in the sector.

Declarative AI in primary care: Assessment of usability, usefulness and adherence to Indian Standard Treatment Guidelines

Robert Dunlop, Ms Samantha Vincent

Elsevier Clinical Solutions

The UK Department for International Trade (DIT) and the National Institution for Transforming India (NITI Aayog) funded a Health Artificial Intelligence Catalyst (HAIC) Pilot Study in 2021.

The objective was to assess the usability, usefulness and adherence to Standard Treatment Guidelines (STGs) in Indian public healthcare settings with the use of Elsevier's declarative AI technology through a pilot intervention.

In Phase 1, 10 Indian Standard Treatment Guidelines for maternal and child health have been transformed into computer-interpretable guidelines (CIGs). The validity of the CIGs content was systematically examined through simulated cases. The content reliability was tested through an inter-rater agreement which compared outputs from CIGs with subject matter expert (SME) assessment. Content validation was performed in clinical practice, in accordance with ethics committee approval.

In Phase 2, feasibility testing was carried out in Bahraich District, Uttar Pradesh, India. Forty-nine frontline health workers (FLHWs) in Bahraich enrolled in the pilot study and initiated clinical decision support (CDS) for 4460 beneficiaries.

The pilot demonstrated that multiple STGs can be implemented as CIGs and can be delivered as a seamless CDS experience to FLHWs via a mobile app. STG adherence for maternal indicators was 77.28% (95% CI: 65.0, 89.6). STG adherence for paediatric indicators was 74.96% (95% CI: 58.1, 91.8).

Overall, the satisfaction of FLHWs with this technology was high. In the usability testing, 76.09% (mean Likert score 3.99; 95% CI: 3.41, 4.57) of respondents agreed or strongly agreed on the usability of CDSS; 80.43% (mean Likert score 4.03; 95% CI: 2.38, 4.77) of respondents agreed or strongly agreed on the usefulness of CDSS.

Coaching future clinical leaders: A revised approach to delivering a leadership and clinical governance module in family medicine

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Introduction

Family physicians are seen as leaders of interventions aimed at strengthening the health service within their sphere of influence by working within clinical teams. Interviews with district managers highlighted the need for family physicians to develop their leadership qualities, build resilience and become change agents able to shape their context. The updated programmatic learning outcomes for the training of South African family physicians were published in 2021 and provided an opportunity for curriculum renewal at the University of Cape Town's Division of Family Medicine. A review of the leadership and governance module in the third year of registrar training showed that the sessions were content heavy with insufficient opportunities for reflection.

The module convenors plan to evaluate a revised module implemented in 2022 that aims to support registrars in their emerging understanding of their roles as leaders tasked with strengthening primary care teams and services.

Methods

The module convenors collaborated in the design and delivery of a revised module blueprinted on the updated national learning outcomes. The module is presented over a longer period and incorporates a group-coaching style to increase self-awareness among registrars on how best to manage themselves and their teams. Through this process of codesigning and collaboration, we aim to provide a transformative learning experience centred on reflection on how the theory relates to practice, professional identity formation and building resilience.

Results

This presentation will share preliminary insights from the revised module in its developmental phase, to inform an ongoing iterative evaluation process.

Conclusion

Family physicians should add value through their leadership ability across all their roles. Efforts should focus on how best to create formal and informal learning opportunities aimed at facilitating their growth as leaders and helping them to meet the health needs of communities served by an evolving healthcare system.

Formulating a framework for faculty development of family medicine educators throughout the career course

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Family medicine education relies on clinicians to fulfil a range of expected roles that evolve throughout the career course. Preparing clinicians as family medicine educators requires a nuanced approach to faculty development that takes into consideration various factors including the setting (urban vs rural) and the degree of resources available from both educational and health services, as well as the make-up of the educator and their contribution to the program ('pure' academics vs clinician-educators in joint roles, career stage and scholarly focus on teaching, research or both). Furthermore, one may argue that faculty development for educators in family medicine programs has discipline-specific needs given the complexity of primary care service-learning platforms. These roles and responsibilities require a nuanced approach and consideration of various factors that may impact faculty development.

A framework for developing excellence as a clinical educator by Hesketh et al. was published 22 years ago and describes 12 learning outcomes in relation to the three-circle model by Harden et al. – these outcomes are grouped according to the performance of tasks, the approach to these tasks and the teacher's commitment to their self-development. This mirrored the outcomes-based educational approach to curriculum development at the time. Recent developments in health professions education have built on this model, including adopting a competency-based orientation and the advent of entrustable professional activities in strengthening workplace-based assessment. Additionally, milestones for faculty development have been developed.

We are a group of academicians, Family Medicine Global Education Network (FamMedGEN), researching the role of academic departments in producing graduates fit for the changing primary care landscape. This interest includes how best to tailor faculty development of primary care educators based on their unique perspectives. We propose a review of frameworks of faculty development that would benefit family medicine training all over the world.

Measuring the core primary care functions: Engaging with lessons learnt from the African PCAT experience

A/Prof Klaus von Pressentin[1], Prof Bob Mash[2], Dr Innocent Besigye[3], E/Prof Gulnaz Mohamoud[4], Luckson Dullie[5]

[1]University of Cape Town, [2]Stellenbosch University, [3]Makerere University, [4]Aga Khan University, [5]Partners In Health

In 2022 the World Health Organization (WHO) proposed a new framework for the measurement of primary healthcare performance. At the heart of primary care delivery are the core functions of first contact access, continuity, coordination, comprehensiveness and person centredness. The WHO proposes that these core functions should be evaluated by facility-based patient surveys and exit interviews. In the African context, several countries (South Africa, Uganda, Kenya and Malawi) have now successfully adapted and validated the Primary Care Assessment Tool (PCAT) so that it can measure the core primary care functions in this way, and guide improvement in primary care.

We are a group of African researchers connected to the Primafamed network (Primary Care and Family Medicine Network for Sub-Saharan Africa) who have built local evidence of the value of the PCAT in our respective countries. We are convinced that our discipline of family medicine should play a central role in expanding primary care measurement and improvement capability in the different WONCA world regions, particularly in similar low- and middle-income countries. The PCAT can be adapted as the preferred tool to measure the core primary care functions.

The speakers will outline:

- the background and principles of using the PCAT instrument
- the experience of using the PCAT in applied research in South Africa, Uganda, Kenya and Malawi
- the contribution of family doctors, primary care team members and user voices to strengthen primary care as informed by the PCAT findings
- the possible role of the PCAT in applied research and practice improvement through regional family doctor networks.

This will be followed by a discussion on the applicability of the PCAT to different contexts: its use in research and performance evaluation to strengthen PHC.

Case report of atypical presentation of reactive arthritis

Dr Siew Lian Voon[1], Charmaine Shuyi Kwan[2], Mark Chung Wai Ng[2]

[1]SingHealth Family Medicine Residency, [2]SingHealth Polyclinics

Polyarthritis has many diagnostic possibilities and identifying a cause can be difficult. We present an atypical case of an acute polyarthritis. On presentation the patient had a two-day history of symmetrical polyarticular joint pain and swelling involving bilateral shoulders, elbows, wrists, knees and interphalangeal joints. He had high fever on admission, but otherwise had no constitutional symptoms or significant exposures. Preliminary blood culture was positive for Gram-positive cocci, with final culture of *Streptococcus pneumoniae*. Joint aspiration of his left knee had mild leucocytosis with negative Gram stain and no crystals. He was started on empiric antibiotics. Reactive arthritis is an uncommon sequela following pneumococcal infection.

Rural emergency department (ED) triage revisited: A pilot evaluation study conducted by senior medical students

Prof Judith Walker, Ollie Markey

University of Tasmania

Triage nurses are expected to analyse differentials, recognise patterns and notice heuristics responsible for 'gut feeling' in order to formulate a perspective that is relevant to a patient's disposition, within a five-minute time frame, to ensure timely access to clinical treatment. The gold standard for nurses is set in the College of Emergency Nurses specialist nurse guidelines.

Results of a recent survey of triage in Australian EDs concluded that for triage decisions to be accurate and remain consistent, influencing factors must include:

- ongoing education
- ongoing professional development at triage
- regular revision of the Australian Triage Scale
- quality frameworks to audit triage processes and to self-audit triage.

There is minimal evidence of these factors for triage-trained nurses in the EDs at our two local rural hospitals. Auditing occurs infrequently, there are incidences of unprofessional behaviour concerning patient care at triage, particularly the under-triaging of elderly patients, putting patient safety increasingly at risk. Poor documentation standards and lack of auditing are of concern in EDs which are getting busier each day.

To address this the hospitals are putting in place several strategies to increase awareness and vigilance around triage auditing, including tracking triage audits and introduction of regular 'Triage Revisited' workshops.

The Triage Revisited Workshop is an in-person 'refresher' workshop targeting triage nurses with a minimum of 24 months experience in the area.

The pilot project evaluation study, undertaken by senior medical students, aimed to evaluate the effectiveness of one of these workshops in raising the accuracy of triage-making decisions.

Broadly the results suggested that triage accuracy may be improved by triage refresher workshops; however, more research is required to measure the impact in a real-life ED department setting. It demonstrated that ongoing education specific to triage nursing is valued by triage nursing staff.

GP practices want a social prescribing protocol, but link-workers may be detrimental: Barriers and enablers in rural and remote Tasmania

Prof Judith Walker, Claire Griffiths

University of Tasmania

Objective

To explore the barriers and enablers to social prescribing for primary healthcare workers in rural and remote Tasmanian general practices.

Design

A mixed-methods approach consisting of an online demographic survey, interviews and focus groups.

Setting: GPs and other health workers were recruited from five rural and remote Tasmanian general practices in 2021.

Participants

Twenty-seven participants with experience in rural general practice ranging between less than one year to 47 years.

Main outcomes measures

Enhanced understanding of knowledge and attitudes about social prescribing, its efficacy, enablers and barriers.

Results

Rural Tasmanian GP practices identified various barriers to social prescribing, including lack of service knowledge, inadequate time, service transience and lack of collated community services information. Enablers were described as trusting doctor–patient relationships, increased time availability and belief in the efficacy of the benefits of social prescribing. A proposed social prescribing pathway and link-worker position received mixed responses, with concerns about creating an unnecessary intermediary, lack of a defined role, loss of health promotion opportunities and dependence on the capacity of individual workers. The potential benefits included having a contact for current advice on local resources, providing patient advocacy, increased time availability for GPs and providing a closed-loop feedback system.

Conclusion

While this study identified a need for an Australian social prescribing protocol, it also highlighted a perceived decisive view of the viability of link-worker roles. An accessible and centralised information centre within local areas is required to enable social prescribing in general practices in rural and remote Tasmania.

The 3-Domains screening toolkit for older driver medical assessment: Validation study in a specialist occupational therapy driving assessment clinic

Prof Katharine Wallis

University of Queensland

Background

Health and fitness to drive assessments in older drivers can be challenging for family doctors. There is no objective measure of an older person's health and fitness to drive.

The 3-Domains screening toolkit measures across the three functional domains essential for driving: sensory, using the Snellen chart visual acuity; motor, using the functional reach test; and cognitive, using the road signs recognition test (a subset of the Stroke Drivers' Screening Assessment). The toolkit calculator generates a combined score predicting likelihood the older driver would pass a specialist occupational therapy driving assessment (%). The toolkit has been found to be feasible during routine older driver medical assessment in general practice and acceptable to older drivers and practice staff.

Aim

To improve accuracy of the 3-Domains toolkit predictive equation for older drivers (aged 75 years or older) in Queensland, Australia.

Methods: Validation study in the Occupational Therapy Driving Assessment and Rehabilitation Service, Brisbane. Participants are older drivers referred to the clinic by their family doctor for specialist occupational therapist driving assessment. The predictive validity of the toolkit will be displayed in a table with five rows (0–20% | 20–40% | 40–60% | 60–80% | 80–100% prediction of passing) and three columns (pass | conditionally pass | fail) with absolute numbers and row percentages given. A receiver operating characteristic (ROC) curve will be produced, and the area under the ROC curve (AUC) calculated (larger areas indicating better predictive accuracy). The driving assessment outcome will be dichotomised into pass/fail categories. Participants in the category 'conditional' will be merged with the category 'fail'.

Results

Not yet available.

Conclusions

The 3-Domains screening toolkit could be used regularly in older driver medical assessments in practice to inform clinical judgement and support communication about the need to plan for eventual transition to non-driving.

Optimising resources to support discontinuation of long-term antidepressants in general practice: A think-aloud study with patients

Prof Katharine Wallis[1], Maria Donald[1], Suzanne McDonald[1], Mark Horowitz[2], Esther Mann[1], Vilany Le[1]

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Around half of people who attempt to discontinue long-term (>12 months) antidepressants experience unpleasant withdrawal symptoms. Withdrawal symptoms are often misconstrued by both patients and doctors as relapse, leading to ongoing and long-term antidepressant use. If we are to address increasing long-term antidepressant use, we need to raise awareness and recognition of withdrawal symptoms and guide safe discontinuation, minimising withdrawal symptoms.

To this end, we developed three resources: (1) a medicines information brochure; (2) a decision aid; and (3) drug-specific tapering protocols.

Aim

To optimise acceptability and utility of these resources based on patient feedback.

Methods

A think-aloud study with people with lived experience of long-term antidepressant use. The think-aloud method involves asking participants to verbalise their thoughts, impressions and feelings while engaging with a resource to elicit perspectives about the nature of the content and usability.

Results

One-to-one interviews based on the think-aloud method were conducted with 14 participants. Resources were iteratively modified through several rounds of feedback. Participants reported that the brochure was informative about antidepressant use, clinical guideline recommendations and withdrawal symptoms; the decision aid was clearly set out and helped decision making regarding whether to continue or discontinue antidepressants by comparing the pros and cons of each option; and the tapering protocol set out clearly how to safely taper and stop antidepressants to minimise and mitigate withdrawal symptoms. Several participants expressed frustration that they had not had these resources earlier, with one participant reporting that the information could have been life changing for her. Many participants commented on the need for better access to these resources, and that the protocols should be made widely available to both patients and doctors.

Conclusion

Feedback from patients informed optimisation of the three resources. Effectiveness of the resources in clinical practice will be tested in a planned trial.

Australian rural clinical school experiences of supporting rural GPs to supervise medical students

Prof Lucie Walters[1], Ms Catherine Ward[2], Prof Lizzi Shires[3], A/Prof Riitta Partanen[4]

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Australian rural clinical schools now have 20 years' experience providing medical students with one or more years of clinical training in rural areas during their medical student training. The geography of Australia necessitates that many of these students are placed in small rural communities where they are based in general practice and follow patients and their supervisors into small rural hospitals. In Australia, many of these general practices are small owner-occupied businesses, although in more remote areas they may be state government-run or corporate-owned entities. This professional forum will draw on the experience of the presenters to describe four aspects of supervision support: (1) contracts with GP practices (2) direct clinician engagement (3) student contributions and (4) audit and research.

This forum will be presented by members of the Federation of Rural Australian Medical Educators (FRAME), who have senior leadership roles in four Australian rural clinical schools. It will appeal to GPs interested in or already engaged in medical student supervision as well as practice managers, students and university staff involved in medical student clinical placements.

Clinical courage: The stuff rural generalists are made of

Prof Lucie Walters[1], David Campbell[2]

[1]Adelaide Rural Clinical School, [2]Australian College of Rural and Remote Medicine

Clinical courage in rural generalists has the following features: standing up to serve anybody and everybody in the community; accepting uncertainty and persistently seeking to prepare; deliberately understanding and marshalling resources in context; humbly seeking to know one's own limits; clearing the cognitive hurdle when something needs to be done for your patient; and collegial support to stand up again.

Further work has illustrated that, as a collective, rural doctors can learn, use and strengthen clinical courage and support its development in new members of the discipline. Relationships with rural communities, rural patients and urban colleagues can support the clinical courage of rural doctors. When detractors challenge the value of clinical courage, it requires individual rural doctors and their community of practice to champion rural doctors' way of working.

This interactive workshop will present a short summary of the more recent research into clinical courage.

Participants will have an opportunity to discuss:

- How relevant is clinical courage to your rural practice?
- How can this exploratory research be translated into educational practice to develop the next generation of rural generalists?
- What next for clinical courage?

Patients' experiences and multimorbidity treatment burden in primary care: An assessment of the process of care

Prof Harry HX Wang[1,2,3], Prof Jia Ji Wang[4], Xiu Jing Hu[1], Martin CS Wong[2], Samuel YS Wong[2], Stewart W Mercer[3]

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Background
Multimorbidity presents growing challenges experienced by patients, particularly in the absence of healthcare gatekeeping. The 'family doctor team' in China is emerging to deal with the increasing need for high-quality routine primary care.

Aim
To explore the extent to which reduced treatment burden was associated with improved patient experiences among multimorbid subjects in the context of service delivery.

Design
Multisite crosssectional surveys in 18 primary care facilities with diverse geographic locations in Guangdong Province, China.

Participants
Subjects who had two or more clinically diagnosed long-term conditions and one or more clinical encounter with the family doctor team in the past 12 months.

Main measures
Interviewer-administered questionnaires were used to collect participants' self-report data on demographics, socioeconomic status, health characteristics and process of care. A previously validated Mandarin Chinese version of the Primary Care Assessment Tool (PCAT) – Adult Edition and the Treatment Burden Questionnaire (TBQ) were used to capture process of care. The multistage sample design was taken into account in the statistical analysis.

Key results
The mean age of the participants (n = 2160) was 61.4 years and slightly over half were females. Patients who had a family doctor team as the primary source of care reported better experiences, as reflected in significantly higher PCAT scores (mean difference 7.2 points' 95%CI: 4.6, 9.8; $P < 0.001$) and lower treatment burden scores (mean difference –6.4 points; 95%CI: –9.6, –3.1; $P < 0.001$) compared to those who often bypassed primary care. Better experiences were associated with lower treatment burden (ß coefficient –0.252, $P < 0.001$).

Conclusions
Poorer experiences and suboptimal treatment burden were more prevalent in subjects with multimorbidity who had the absence of usual source of primary care. The significant inverse association between patients' experiences and treatment burden may imply a positive contribution of the family doctor team in the process of service delivery.

Physicians' follow-up care delivery in community-based disease management for hypertension and diabetes: Multicentre surveys in remote and rural areas

Prof Jia Ji Wang[1], Prof Harry HX Wang[2,4,5], Yu Ting Li[3], Samuel YS Wong[4], Martin CS Wong[4], Stewart W Mercer[5]

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Background
Follow-up care is crucial for disease management, particularly in areas with limited healthcare resources, yet few studies have been conducted from the perspective of primary care physicians (PCPs) in remote and rural areas in China.

Aim
We aimed to assess the frequency of follow-up care delivered by PCPs in remote and rural areas for managing hypertension and type 2 diabetes – the two most common long-term conditions in the community.

Methods
We conducted multicentre, self-administered surveys among Chinese village physicians from 52 township-level administrative regions who attended general practice teaching sessions. Binary logistic regression analysis was performed to examine physician-level factors associated with less frequent follow-up care for hypertension and diabetes after controlling for confounders. A Complex Samples module was used to take into account the multistage sample design in the statistical analysis.

Results
Around one-fifth of PCPs were unable to achieve the target frequency of follow-up care delivery (18.7% for hypertension; 21.6% for diabetes) in remote and rural areas according to the practice guideline in China. Higher education level, increased daily patient volume and no provision of home visits were factors associated with a physician-reported follow-up of less than four times per year for both long-term conditions. In addition, village physicians with less working experiences tended to have less follow-up care delivery in the management of type 2 diabetes.

Conclusion
Efforts that are solely devoted to enhancing physicians' education in remote and rural areas may not suffice given the possible existence of clinical inertia and workload-related factors. The risk factors identified in our study for less follow-up care delivery may provide areas for capacity building among village physicians in remote and rural clinical practice.

Association between serum γ-glutamyltransferase and insulin resistance in cardiometabolic high-risk subjects

Miss Kai Yu Wang[1], Jau-Yuan Chen[1,2]

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Background/aims

Insulin resistance has become the most important public health issue, which is the burden of healthcare in numerous countries. Serum γ-glutamyltransferase (GGT) level elevates in liver disease or bile duct problems, and some research indicated GGT may represent the insulin resistance state. This study aimed to investigate the association between serum GGT and insulin resistance markers and to assess the role of GGT as a biomarker of insulin resistance in health workers of high cardiometabolic risk.

Methods

This cross-sectional study included data collected from the medical records of Chinese adults undergoing annual health check-up examinations between 2020 and 2021 in Linkou Chang Gung Hospital. Study individuals were at high cardiometabolic risk. The following data included age, sex, body height, weight, waist circumference, blood pressure, fasting plasma glucose, triglycerides, low-density lipoprotein, high-density lipoprotein, insulin and homeostasis model assessment of insulin resistance (HOMA-IR) index. We used Pearson's correlation test to determine cardiometabolic risk factors and serum GGT levels. Furthermore, we conducted multiple linear regression analysis to measure the association between serum GGT and the HOMA-IR index.

Results

We included a total of 96 health workers with high cardiometabolic risk in the analysis. Fasting plasma glucose, insulin levels and HOMA-IR index were significantly different between high and normal serum GGT groups ($p < 0.05$). Pearson's correlation analysis revealed a positive correlation between serum GGT and HOMA-IR index ($r = 0.3$, $P < 0.05$). In multiple linear regression analysis with adjustment for confounding factors, serum GGT remained significantly associated with the HOMA-IR index (95% confidence interval 0.0001, 0.02; $P < 0.05$).

Conclusion/goals

In our study, high serum GGT levels may lead to an increased HOMA-IR index among health workers of high cardiometabolic risk.

Mums, bubs and women's business: Three generations of community-controlled care for Aboriginal and Torres Strait Islander women, families and community

Dr Erin Waters, Heather Lee

[1]Townsville Aboriginal And Islander Health Service

The Townsville Aboriginal and Torres Strait Islander Health Services (TAIHS) was one of the first Aboriginal community-controlled health services in Australia established in 1974 and now serving an Aboriginal and Torres Strait Islander population of 21,180.

In 1999, Wuthathi woman Heather Lee recognised a need for women to have their own space within the service and set about founding the TAIHS 'Mums and Bubs' clinic, initially with just 34 women, to become Australia's first Aboriginal and Torres Strait Islander community-controlled maternal and child health unit. Mums and Bubs was an instant success with women voting with their feet and patient numbers tripling within three months.

The Mums and Bubs clinic provides parents with a safe, welcoming and supportive space and provides comprehensive healthcare and support to Aboriginal and Torres Strait Islander women, children and families in the Townsville region and other women who travel from remote communities to access healthcare they trust.

Sustained access to community-based integrated antenatal services in Townsville has been shown to significantly improve perinatal outcomes among Aboriginal and Torres Strait Islander women. Furthermore, the Mums and Bubs clinic has played a strong role in educating, training and empowering Aboriginal and Torres Strait Islander women and healthcare professionals, including one of its former 'bubs' who is now the TAIHS CEO.

Mums and Bubs is currently seeing its third generation of families and is proud to harness the strong influence of grandmothers within community and utilise their knowledge and skills in supporting today's mums.

Come and have a yarn with Heather and learn how TAIHS continues to strive to provide the best care possible to our Aboriginal and Torres Strait Islander community, providing the best opportunity to access a service that is culturally appropriate and responsive for our future generation for a better future.

Prevalence of physical activity counselling in primary care: A systematic review

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Background
Physical activity (PA) counselling is an effective practice to promote PA among patients in primary care. Previous studies showed a wide range of prevalence of PA counselling in different settings and populations.

Objective
This systematic review aims to investigate the prevalence of PA counselling in primary care.

Methods
Five databases (CINAHL Complete, Embase, Medline, PsycInfo and Web of Science) were searched. The search terms related to PA counselling in primary care (intervention) and prevalence (outcome). Epidemiological studies published in English were included. Non-primary studies (eg review articles, protocol articles) were excluded. Two independent reviewers were involved in study selection and data extraction. The Joanna Briggs Institute critical appraisal checklist for studies reporting prevalence data was used for quality assessment. A meta-analysis of pooled prevalence is ongoing.

Results
A total of 4259 articles were screened after duplicate record removal. Ninety-three full-text articles were assessed. Thirty-five studies conducted in 16 countries (USA [n = 10], Australia [n = 5], Barbados [n = 2], Brazil [n = 2], Germany [n = 2], Lithuania [n = 2], New Zealand [n = 2], UK [n = 2], Canada [n = 1], China [n = 1], Jamaica [n = 1], Poland [n = 1], Spain [n = 1], Sweden [n = 1], Switzerland [n = 1] and Tanzania [n = 1]) were included in the review. The quality assessment scores of studies were between 5 and 9 (out of 9). The overall prevalence of PA counselling extracted from 30 studies ranged from 4.5% (adults aged 35–64 years who visited general practitioners in the past 12 months) to 88.5% (people with obesity who received exercise counselling in the past two years). The prevalence of PA counselling by gender was 7.7–58.2% in females (nine studies) and 7.6–50.4% in males (nine studies).

Conclusion
Most studies were conducted in North America, Europe and Oceania. The prevalence of PA counselling in primary care varies among the studies. A meta-analysis of the prevalence should be performed.

Registration
PROSPERO (CRD42021284570).

The impact of transitional care for geriatric patients with chronic diseases: A literature review

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Objective

As sociodemographic shifts have occurred over the past few decades and affected the healthcare system in many nations, Indonesia has gradually become an ageing society. A new challenge has been an increased hospital readmission rate and prolonged hospitalisation in elderly patients due to chronic illness. Improved long-term management requires a comprehensive plan to guarantee coordination and continuity of care following hospital discharge.

Methods

For this review, literature was searched using the keywords transitional care, geriatric and chronic disease in the electronic databases PubMed, ScienceDirect and Cochrane. RCT, systematic review or meta-analysis studies that implemented transitional care intervention (TCis) for people over 60 with chronic diseases met the inclusion criteria. Studies were limited to those published in the last 10 years and in Bahasa/English. The PRISMA guidelines were used to evaluate critical appraisal.

Results

We found 107 records. The inclusion criteria were met by seven articles. Outcome assessments were performed from 1 to 12 months after discharge. TCis were divided into three categories: before discharge; at home after discharge; and throughout the entire period. Most studies (n = 7) measured readmission, mortality (n = 4) and emergency department visits (n = 3). The majority of the studies found that intervention groups (IG) outperformed control groups (CG).

Conclusion

Transitional care benefits geriatrics with chronic diseases by lowering hospital readmission rates, mortality rates and emergency department visits. To provide effective transitional care, five domains must be addressed: comprehensive assessment; planning and communication; self-care and caregiver support; access facilitation; and a competent healthcare team.

Between referral program and transitional care: A reflection from a family medicine residency program

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Background and aim

Continuity of care is an important principle in comprehensive healthcare that every patient requires. Similarly, the concept is used in transitional care. The family physician must continue the patient's care plan and engage with all social components surrounding the patient during the patient's transition from hospital to community. The purpose of this study is to identify the gap between transitional care theory and implementation in Indonesia.

Method

Residents in the family medicine specialist program were asked an open-ended question. The questions focused on current transitional care implementation, challenges and recommendations for better practice. The response was examined for themes and keywords.

Results

The only type of transitional care provided in Indonesia today is referrals, also known as return referrals, from hospitals to primary care, especially for patients who previously used a BPJS (national health insurance). This system's flaw is that it only concentrates on diagnosing patients and dispensing the same medications that the prior doctor prescribed, rather than providing comprehensive care for the patient. Implementing transitional care in Indonesia is difficult because of a lack of human resources, health financing and understanding of areas and responsibilities. Patients in Indonesia typically have chronic illnesses and require comprehensive care, not just medication therapy.

Conclusion

In order to maintain patient quality of life and lower readmission rates of the patient to the hospital, it is necessary to evaluate the implementation of existing return referrals, outreach to health workers and mapping of patient care needs, including policies on the role of a family physician.

How far has patient-centred care been carried out in Indonesia health facilities: The reflection of family medicine residency program

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Background and aim

The individual's unique healthcare requirements and expectations serve as the primary determinants of decision making in patient-centred care (PCC). PCC implementation in Indonesia is still unknown. The purpose of this research is to determine how far PCC has been implemented in Indonesia, as well as its recommendations, through the reflection of family medicine residency programs located in various types of health facilities.

Methods

Residents in the family medicine specialist program were asked an open-ended question. The questions focused on current implementation, difficulties and suggestions for better practice. The resident's response was analysed for themes and keywords.

Results

Indonesia has a diverse culture as well as patients from various socioeconomic backgrounds who visit healthcare facilities. Doctors have communicated with patients from various backgrounds to find the best management for patient complaints, but there is still a lack of an active role and discussion space with the patient's family. The causes that can be identified are that not all health workers recognise the importance of patient and family participation in determining the treatment process, the patient's personality tends to be passive and the limited service time. To overcome this, effective communication with patients and families is required: build trust, ask open questions, actively listen, respect patients as individuals and provide education based on their biopsychosocial factors. By system, it is necessary to educate health workers about PCC and conduct evaluations through periodic patient satisfaction surveys.

Conclusion

The involvement of patients and families is critical to maximising the treatment program in the hope that the patient's problems can be addressed holistically and comprehensively. Family physicians who act as a liaison between professional care providers facilitate collaboration and open an active communication space for patients and families to discuss treatment plans tailored to the patient's needs.

2023 National initiatives and activities scan summary report

Ms Eve West, Lee Cobb, Russell Roberts, Victoria Erskine

Equally Well

People living with mental illness have poorer physical health, yet they receive less and lower-quality healthcare than the rest of the population – and die younger. This report aimed to improve the quality of life of people living with mental illness by providing equal access to quality healthcare. By championing physical health as a priority, the report aimed to reduce the life expectancy gap that exists between people living with a mental illness and the general population.

To do this the project team established a survey that was website based with portal and an integrated set of response options for organisations. The response options included videoconference interviews, phone call interviews, online survey and downloadable hard copy survey forms. Qualtrics was used to populated data based on the questions in the survey.

The scan achieved a response rate of 73%, which was above the target response rate and significantly higher than the 2018 and 2019 response rates. It was also evident in our findings that 78% of responses incorporated lived experiences into their initiative design, which aligns with Australia's best practice reforms.

In total the scan revealed 169 activities underway with 104 resources submitted. This is a strong indication of engaging the Australian mental health sector in improving the physical health of people living with mental illness. This is encouraging and indicates that the physical health of people living with mental illness is very much on the reform agenda.

It appears the policy priority of improving the physical health and life expectancy of people living with mental illness is being actively implemented across Australian mental health. We highlight these findings to emphasise the initiatives displayed, but to provide insight into the sector and pathway forward. We provide sustainable recommendations into the current mental health care system.

Implementation of a nasal high flow guideline and the impact on retrieval rates from Thursday Island, Cooktown and Weipa, Australia

Ms Sally West[1], A/Prof Donna Franklin[2]

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Background

Acute respiratory failure (ARF) is the most frequent reason for non-elective hospital admissions in children aged less than five years, with a high global health burden. ARF is the common end point for many underlying specific diagnoses such as bronchiolitis, asthma and pneumonia. Rural and remote Queenslanders account for approximately 38% of Queensland's total population, with approximately 47% of First Nations people living in rural and remote regions. Aboriginal and Torres Strait Islander children have a higher incidence rate of ARF, including bronchiolitis, than non-Indigenous people.

While mortality due to ARF has improved in high-income countries (1–2%), mortality remains between 13% and 20% in less well-resourced settings. In Far North Queensland 50%, mostly Aboriginal and Torres Strait Islander children with ARF, require transfer to a metropolitan hospital, whereas in South-East Queensland only 9–12% of these children require interhospital transfer. The Torres Strait and Cape York Hospitals admitted 216 infants with bronchiolitis with bronchiolitis between July 2016 and June 2018 with 108 (50%) infants airlifted to tertiary hospitals due to higher care needs at an average cost of $24,500 per patient.

Proposed practice change

To address this inequality, we evaluated a measured model of care using a comprehensive clinical guideline including nasal high-flow oxygen therapy for children with ARF in remote hospitals in Queensland. The practice change included a comprehensive training package to empower the bedside nurses and doctors to apply the model of care which had been normally provided in metropolitan/tertiary hospitals. The change was implemented in November 2021 – October 2022 and practise was compared to a period between January 2018 and October 2021. The admission rate dropped from 34 to 12 hospital admissions per months as a result of the COVID-19 pandemic-related isolation measures in the region.

Over the one-year implementation period there were no adverse events recorded and the proportion of transfers was reduced.

Rural Family Medicine Cafe Australia: The family physician's role in rural proofing

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The Rural Family Medicine Cafe (RFMC) is a social media project that consists of panel discussions with rural health professionals and those interested in rural medicine. For each cafe, a topical issue in rural medicine is chosen for discussion and participants can join the discussion live or interact on YouTube, Facebook or Twitter using #ruralcafe. The discussions are informal and each participant has equal power of voice. The RFMC has grown into a virtual community and an informal learning environment with international participation. The RFMC was created in response to the current global shortage of rural family doctors. This shortage is thought to be due to medical students having little exposure to rural medicine and the poor support and engagement of rural medical professionals. The RFMC aims to overcome geographical and professional isolation by using social media platforms to connect people and share ideas. This session seeks to provide a forum for discussion while demonstrating how participants can create RFMCs locally. This will be done through an interactive forum where participants will take part in a cafe designed for the conference discussing rural proofing strategies for policies in rural health. Healthcare policies are often made with an urban point of view and are not as easily applied to rural settings. During the session, a moderator will guide the discussion and allow participants to share their experiences of rural proofing including what works and what does not. By the end of the session participants will understand how an RFMC works, be aware of rural proofing strategies and be provided with the opportunity to share their ideas and experiences around healthcare policy in rural health. Rural cafes are a great way for participants to network, expand their knowledge and improve overall morale.

Changes in the attitudes of Caribbean medical students on family medicine after COVID19

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Objective

Previous research has shown that early interaction with family physicians positively influences medical students' perceptions and attitudes towards family medicine as a career. While students acknowledge the important role family physicians play in the community, there was a perception that family medicine was below hospital specialities or respected less. This study sought to elucidate if this had changed due to the COVID-19 pandemic restricting placements.

Methods

A cross-sectional descriptive study was conducted using an anonymous self-administered online survey sent to students enrolled at the University of the West Indies.

Results

In all, 23% reported a change in their desired career following the COVID-19 pandemic primarily due to being exposed to different specialities during clinical rotations. The greatest influencer to pursue FM was found to be having a good personal experience with their family physician. Students associated FM with continuity of care, holistic care, career flexibility and being community based. They recognised FM as having an important role in society but felt that it did not have a high status in the medical profession. They also felt that their peers and non-FM doctors would associate FM with being less intellectually challenging. The majority of participants had not experienced any negative attitude towards family doctors.

Conclusions

The majority of students reported a positive attitude towards FM. The greatest influence on this was the students' experience with their own family physician. Negative attitudes towards FM stem from a belief that non-FM doctors, other medical staff and their peers hold FM in low regard. The students' views of FM as a career were not directly influenced by the COVID-19 pandemic, but their own experience with managing their health became a more prominent positive influence compared to previous studies.

Telehealth in general practice: A mixed-methods examination to support evidence-based improvement

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[1]University of New South Wales, [2]Macquarie University, [3]MQ Health

The unprecedented increase in telehealth due to COVID-19 has changed general practitioners' (GP) and patients' engagement in healthcare. Examining these changes allows opportunities to produce evidence-based guidance for optimal use of telehealth in a safe and effective way.

This presentation summarises a project that aimed to:

1. Systematically analyse interactional practices of GPs and patients in telehealth consultations to develop evidence-based resources based on interactional elements and patterns associated with desired consultation outcomes.
2. Examine how telehealth influences both GPs' and patients' perceptions of the clinical relationship to ensure that guidelines developed support both parties to build positive clinical relationships through this alternative mode of communication.
3. Determine the key concerns of GPs in relation to communication through telehealth to inform new evidence-based advice and resources that directly address these concerns.

The process and findings of the research will be presented, including the mixed-methods approach and translation of the results from findings to codesigned best-practice principles.

The first two phases of this research involved recording telehealth consultations (n = 42), conducting surveys (n = 152) and qualitatively interviewing patients (n = 10) and GPs (n = 11). These were examined using interaction analytical methods, thematic analyses and quantitative analysis to create a robust, connected picture of telehealth practice and perspectives.

From these synthesised analyses, three key themes relating to communication in telehealth were identified: relationship building, conversational flow and safety netting. These themes will be presented, with examination of similarities and differences between stakeholder perspectives and observed practice.

The process of translating the findings from the first two phases of research into best-practice principles will then be presented. This process included engaging with providers, patients and policy makers to facilitate development of evidence-based principles that focus on supporting effective communication when using telehealth. Final principles and associated resources will also be presented.

Saving life and limbs: Role of family physicians in holistic care of diabetic patients with hard-to-heal wounds

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Background

Family physicians (FPs) often care for diabetic patients with hard-to-heal wounds (D-patients with HHWs). Patient-related factors, wound-related factors, skill and knowledge of the healthcare professional, resources and treatment-related factors are considered in holistic care of patients with HHWs. FPs mostly concern in patient-related factors applying a biopsychosocial approach in treating diabetes and comorbidity – vasculopathy, peripheral neuropathy; and support on the patients' psychosocial issues and care environment. Regarding wound-related factors, diagnostic, therapeutic and interventional skill and knowledge of FPs are crucial to get early identification and provide appropriate wound care management to D-patients with HHWs. Although management of resources and treatment-related factors – healthcare system, financial issues, cost and reimbursement – is beyond clinical competency of FPs, it is a possible way to reduce these factors at the individual level by empowering patients and their family members in their glycaemic control and wound care. Thus, FPs become potential key member of the wound care team to save life and limbs of D-patients with HHWs.

Methods

First, the role of FPs in holistic care of D-patients with HHWs; management of HHWs with peripheral neuroischaemia and financial aspect of management of D-patients with HHWs will be presented by three facilitators. Then, experiences of global family physicians will be explored and discussed in terms of the holistic care of D-patients with HHWs and the patients' empowerment for their glycaemic control and wound care.

Outcomes

Identifying role of FPs in the holistic care to save life and limbs of D-patients with HHWs may encourage all workshop participants to engage in the wound care team as active team members. Exploring financial issues for HHW management and FPs' support on empowerment of the patients in glycaemic control and wound care may highlight the role of FPs in these issues.

Recurrent boils and abscesses: Could it be HS?

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Hidradenitis suppurativa (HS) is a chronic inflammatory skin condition that is characterised by recurrent and painful nodules, abscesses and sinus tracts that affects approximately 1% of the population. These lesions particularly form in the intertriginous regions, such as the axillary, inguinal and gluteal skin folds, but can develop anywhere on the body.

The exact pathogenesis of HS is still not completely understood, but several factors have been implicated in its development, including genetics, bacterial colonisation, hormonal changes and abnormal immune response. HS nodules form by an abnormal keratinisation process in the hair follicle, resulting in the formation of occluded hair follicles. The resulting inflammatory response results in rupture of the hair follicle which spreads inflammatory cytokines into the local tissues which, in turn, worsens the local inflammation. These can ultimately create exquisitely tender abscesses and discharging sinus tracts, with significant scarring.

HS has been described as one of the most painful skin conditions, yet, unfortunately, historically there have been often significant delays to diagnosis. Treatment of hidradenitis suppurativa is multifactorial, combining lifestyle modifications (particularly smoking cessation, avoidance of friction in intertriginous regions, weight optimisation and management of comorbidities), topical medications (such as compounded resorcinol and antibiotics), intralesional corticosteroid injections, systemic medications and surgical interventions (including reroofing surgery).

The general practitioner plays an important role in the diagnosis and multidisciplinary management of HS. This workshop will provide an overview of the diagnosis, staging and primary care management of this complex condition, including approaches to topical therapies, delivery of intralesional steroids and an overview of systemic and surgical therapies.

Warts and all! A novel approach to treating plantar warts in general practice

Dr Anneliese Willems[1,2], Alvin Chong[1,2]

[1]The University of Melbourne, [2]Skin Health Institute

Introduction

Plantar warts (verruca plantaris) are contagious benign tumours caused by the human papillomavirus (HPV). Although very common, the management of plantar warts in general practice can be a challenging and time-consuming presentation owing to difficulties in their definitive removal and pain associated with some therapeutic modalities. Treatments encompass those which are chemically destructive, physically destructive, antiproliferative or immunostimulatory. These include cryotherapy, silver nitrate and topical agents such as podophyllotoxin, salicylic acid and imiquimod. This case will outline a novel therapeutic approach for the definitive treatment of plantar warts.

Clinical case

A 46-year-old male presented with a four-year history of multiple persistent plantar warts in the context of immunosuppression. He had a past history of Crohn's and rheumatoid arthritis for which he was managed with infliximab and methotrexate. The location of the warts to his forefoot caused significant discomfort with walking. They had been unsuccessfully treated with numerous applications of cryotherapy, topical salicylic acid and imiquimod.

The plantar warts were successfully managed by being pared back and then painted with a compounded solution of cantharidin 1%, podophyllum 5% and salicylic acid 30%. The solution caused no discomfort at the time of application. An occlusive dressing was applied for six hours and then removed. He was seen and treated on two occasions, one month apart, with full resolution noted following the second application.

Clinical lessons

This case highlights a novel way of treating intractable plantar warts within the general practice setting. Colloquially referred to as 'Cantharidin Plus', this compounded solution comprises cantharidin 1%, podophyllum 5% and salicylic acid 30%. Cantharidin is a substance derived from the blister beetle *Cantharis vesicatoria* which causes blistering to the epidermal layer. When the blister heals, the wart is lifted off the underlying dermal layer below, so that healing can occur.

Safe at the front desk? A solutions-focused roundtable tackling patient aggression towards primary care receptionists

Dr Fiona Willer[1], David Chua[1], Prof Lauren Ball[1], Charlee Lock[2]

[1]UQ Centre for Community Health and Wellbeing, [2]Inala Primary Care

Medical receptionists are the 'welcoming face' of general practice and play a central role in creating a safe and caring environment for patients and their loved ones. However, their contribution is far from basic. In addition to typical receptionist tasks, primary care receptionists often must negotiate conflicting demands between patients and doctors, provide support to people in distress, manage emerging events in the waiting room, provide triage and assist with patient first aid, advocate for patients' needs and clean clinic facilities. Unfortunately, they are also exposed to frequent acts of incivility and aggression from patients, only exacerbated by the recent stressors of the COVID-19 pandemic.

In many jurisdictions worldwide, it is an employer's legal obligation to mitigate psychosocial risks associated with work. Evidence from over three decades of literature overwhelmingly highlights the detrimental physical and psychological impacts of patient-initiated hostility and aggression on medical receptionists. Previous efforts have mostly examined management strategies to mitigate harms. Evidence-based and effective strategies to prevent these incidents are scant.

We believe that the safety of primary care receptionists is a pressing issue and should be a concern for everyone in the sector. This forum is designed to raise awareness and generate ideas for targeted prevention and management initiatives. All primary care stakeholders are invited to attend. We will briefly discuss the findings of our recent systematic review on patient-initiated hostility and aggression towards medical receptionists. Then, we will seek input from the attendees, including what resonates with you, what measures have you tried in your context, what supports for medical receptionists exist in your context and what else could be done to address this issue. Our intent is that a diverse coalition consisting of receptionists, practice managers, patient advocates, nurses, general practitioners, researchers and policy makers will emerge from this forum and spearhead future action.

Weight-inclusive general practice: Recovering from diet culture, reconnecting with the patient, and reviving patient-centred care

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Fat phobia and weight-based discrimination are commonly reported experiences of larger-bodied people accessing medical care, often leading to delays in seeking medical assessment and treatment, and contributing to poor health outcomes. Behavioural weight loss interventions have ultimately been proven ineffective for most. Weight loss advice, frequently accompanied by offerings of pharmaceuticals and surgery, is not appropriate, feasible or desired by many patients with higher weight. Accordingly, recent position statements from The Royal Australian College of General Practitioners (RACGP) and the Royal Australasian College of Physicians (RACP) recommend offering 'health gain' rather than 'weight loss' approaches for people with a BMI greater than 30 kg/m2. Such approaches are referred to as 'weight inclusive'. However, due to the historical perception of weight as a marker of health, and emphasis on weight loss recommendations, weight-inclusive approaches are poorly understood by clinicians trained in a weight-centric paradigm.

Weight-inclusive primary care focuses on providing non-judgmental, respectful and holistic care that is centred around individual health needs and goals, regardless of their body size or weight. This approach recognises that weight is not a reliable indicator of health in individuals, and instead focuses on promoting behaviours and habits that are evidence based and can improve overall health, such as physical activity, balanced nutrition and stress management. Additionally, weight-inclusive care providers reject weight stigma and do not restrict access to medical treatment based on weight or BMI.

This workshop will strengthen your understanding of weight-inclusive practice, including conceptual and philosophical frameworks (eg Health at Every Size/HAES, Intuitive Eating), weight science, weight stigma and weight-inclusive practice. Using a participatory model informed by lived experience, attendees will identify areas of concern in their own practice setting and develop strategies to move towards weight-inclusive practice and a 'body safe' environment for patients, staff and colleagues.

Facilitated telehealth for relocated homeless people during the COVID pandemic

A/Prof Stephen Wilson[1], Chee Khoo[2]

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Public health experts expressed concern regarding the spread of COVID within the homeless community of Sydney (2021). Many homeless people were housed in vacant hotels in response to this crisis. This benevolent housing intervention raised another concern regarding the mental health of people in forced isolation. The Haymarket Foundation charity sought to provide welfare support for these people with daily visits from case managers. Local general practitioners were under extreme workload pressure and there was government support for telehealth options.

A project was initiated by a team of two general practitioners (GP) and two nurses to train non-medical case managers who were domiciliary visitors to perform basic vital signs and conduct a Kessler 10 questionnaire. Two managers were trained to perform finger oximetry, pulse, blood pressure, temperature, BGL and record respiratory rate. Confirmation of their technical skills was checked by an external registered nurse to confirm their skills. The case managers were not trained to interpret any signs.

A telehealth consultation with a GP was trialled on 10 consecutive patients to test the feasibility of this service.

Six of the patients were followed up with two further consultations and multidisciplinary case conferences. Three showed a high level of psychological distress.

Overall this pilot project was well received by case managers and patients. The facilitation of a telehealth consultation by trained community visitors may be an option in times of crisis with an acute shortage of health workers. The two GPs (authors) agreed that this was an efficient communication process for patient management. The Haymarket Foundation charity continues to support health initiatives for homeless people.

Use, satisfaction and preference of online health services among older adults with multimorbidity in Hong Kong primary care

A/Prof Carmen Wong, Zijun Xu, Prof Yeung Shan Samuel Wong

The Chinese University of Hong Kong

The use of online and mobile internet and social media has been increasing in healthcare service delivery. This study aims to explore the use of social media in older adults with multimorbidity in Hong Kong primary care and to assess the feasibility and usage of online health services in this population, including satisfaction, preference and problems encountered.

This was a cross-sectional study among older adults with multimorbidity conducted between November 2020 and March 2021 in a Hong Kong primary care program. Online and face-to-face services were offered based on the needs of the participants. Demographic characteristics and health conditions were assessed at baseline. Participants using online services were invited to complete a feedback questionnaire.

The study included 752 participants, of which 66.1% use social media every day. Participants who declined to use online services were found to be significantly older, live alone, have lower income, have social security assistance, have greater cognitive decline and be less depressed ($P < 0.05$). Non-responders to the online questionnaire had fewer years of education and greater cognitive decline ($P < 0.05$). The median satisfaction with the online services was 8 (interquartile range: 7–9), and 14.6% of the participants preferred online more than face-to-face services. Lower education levels, fewer internet connection issues and more self-efficacy on mobile apps were associated with a higher level of online satisfaction after adjustment ($P < 0.05$). Fewer internet connection issues and more self-efficacy on mobile apps were associated with participants' preference for online services ($P < 0.05$).

More than half of Hong Kong older adults with multimorbidity in primary care use social media daily. Prior use and training can be beneficial to enhance use and satisfaction in older adults.

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A latent profile analysis of psychological, self-efficacy and knowledge profiles in type 2 diabetes and its association with outcomes

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Background

Self-management is a challenge for many people with type 2 diabetes and interventional approaches have inconsistent outcomes. Diabetes-related distress (DRD), mental and physical health (health-related quality of life), self-efficacy and diabetes knowledge (DQSK) have been found to impact on lifestyle behaviours and outcomes. Therefore, stratification of patients by DQSK profiles may support a population approach to developing self-management programs. Our study aimed to identify DQSK profiles and to explore the association between DQSK profiles with lifestyle behaviours, haemoglobin A1c (HbA1c) and body mass index (BMI).

Methods

A cross-sectional survey was conducted in 518 participants with type 2 diabetes at the National Healthcare Group Polyclinics (Singapore), and included assessment of DRD (diabetes-distress scale), mental and physical component scores (SF-12), self-efficacy (diabetes empowerment scale), diabetes knowledge (Michigan diabetes knowledge test), diet and physical activity (summary of diabetes self-care scale), medication adherence (medication adherence report scale) and social support (medical outcomes study social support survey). An mixed-model latent profile analysis identified unique profiles on eight DQSK variables, and sociodemographic characteristics, self-care behaviours, HbA1c and BMI were compared across the profiles using multinomial regression analysis.

Results

Four unique DQSK profiles were identified: Profile 1 (carefree), Profile 2(distressed, diabetes-specific), Profile 3 (distressed, global) and Profile 4 (activated). Profile 3 was associated with the poorest self-care scores (diet, exercise and medication adherence), metabolic profiles (HbA1c and BMI) and social support scores, while Profile 4 was associated with the best self-care behaviours, metabolic profiles and social support scores. Self-care behaviours and metabolic profiles were also different in Profiles 1 and 2.

Conclusions

Our study identified four novel DQSK profiles which were associated with differential self-care behaviours and metabolic profiles. This suggests that identifying DQSK profiles may help stratify people with type 2 diabetes by their care needs, supporting the development of more targeted approaches.

Gay men's health workshop

Dr Wee-Sian Woon[1], William Wong[2], Dr Eriko Yoshida[3,9], E/Prof Murilo Moura Sarno[4], Julien Artigny[5], Dr Yuki Sakai[6,9], Dr Hiromitsu Yamashita[7,9], Yusuke Kanakubo[8,9]

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Men who have sex with men (MSM) are a very diverse group with specific health needs compared to their heterosexual counterparts.

This skills-building workshop will cover different health issues of MSM from an Australian perspective with comparisons of other countries. Participants will be able to take away knowledge and apply principles in their respective countries.

First, the workshop will cover why MSM are an often hidden and vulnerable group who face stigma and discrimination. There will be case discussions covering sexual health and HIV topics including sexual history taking, STI screening and pre-exposure prophylaxis. Other issues covered include recreational drugs, chemsex and alcohol issues, mental health, partner violence and the older gay man.

General practitioners and family physicians from Japan, Brazil, France and Hong Kong will also present the situation and issues in their countries. There will be opportunities for facilitated discussion groups for workshop participants to discuss the situation in their respective countries. The discussion group will also cover potential barriers for healthcare delivery and brainstorming solutions to ensure practices are culturally sensitive and gay friendly.

There is a need for the GP, as a generalist, to deliver patient-centred care which is non-judgemental and comprehensive to MSM for their overall health and wellbeing.

Factors associated with mental health among Hong Kong children: A population-based study of 4884 individuals

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Objective

This study aimed to investigate the association between factors on demographic characteristics, socioeconomic background, health-related parameters and mental health outcomes (psychological distress, depression and self-harm) in both primary and secondary school students.

Methods

A self-administrated survey was conducted and investigated the prevalence of negative mental health outcomes psychological stress, depression and self-harm in students from 30 primary schools and 25 secondary schools. The Kessler Psychological Distress Scale (K6) was chosen as the instrument to evaluate non-specific psychological distress. Measurement of depression and self-harm assessed prolonged feelings of despair, self-harm intentions and suicidal ideation.

Results

In all, 4884 responses were collected, with 2650 (54.3%) from secondary school students and 2234 (45.7%) from primary school students. The overall prevalence of psychological distress, depression and self-harm was 14.4%, 28.4% and 18.7%, respectively.

Conclusions

The prevalence of psychological distress, depression and self-harm were substantial in children of Hong Kong. Primary school students were vulnerable to stressful events, such as bullying. More support from teachers and parents should be provided to deal with school bullying incidents in primary schools. Parents should be aware of risky behaviours in children and be more involved in their daily lives. For secondary school students, as the importance of friends is greatly increased, schools should organise friendship activities to help students know each other and form friendships. Non-government organisations could launch campaigns to promote body image positivity and encourage teenagers to accept and appreciate their bodies. Further studies could be conducted to investigate the effectiveness of the interventions on mental health outcomes.

Factors associated with weight gain during the COVID-19 pandemic: A global study

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Background
Concerns regarding weight gain and its impact on health outcomes has always been prevalent, with obesity being one of the highest causes of mortality in current society. Factors contributing to a higher likelihood of weight gain during the COVID-19 pandemic were examined. It was hypothesised that an increase in weight would be observed in association with COVID-19-related experiences, behaviours and negative thoughts.

Methods
A self-reported questionnaire was conducted across 26 countries and regions from October 2020 to December 2021. Demosociographic and clinical information regarding existing chronic health conditions was obtained from participants aged 18 years and above. A logistic regression examined the associations between weight gain and COVID-19-related data on experiences, behaviours and perspectives.

Results
The sample included 2533 participants, with 1087 (42.6%) reporting an increase in weight over the past six months. Participants belonging to a younger age group, those who had received a higher level of education, lived in an urban area, lived with family members, were employed full-time and had existing chronic health conditions were found to be more vulnerable to weight gain. After adjusting for sociodemographic factors, participants who had been quarantined, exercised less prior to the pandemic, consumed unhealthy foods and reported negative thoughts, such as helplessness and the perceived risk of COVID-19, were more likely to experience weight gain.

Conclusion
An association was established between weight gain during the pandemic and certain sociodemographic and COVID-19-related factors. Future research should explore preventative interventions that target subgroups of high-risk individuals vulnerable to weight gain. To improve health outcomes for the general public during this time, a longitudinal evaluation on the long-lasting effects of COVID-19 experiences upon health choices should be conducted.

How can practising rural general practitioners collaborate with a rural hospital network to rapidly increase the rural medical workforce?

Prof Paul Worley[1,2,3], Dr Caroline Phegan[1], Hamish Eske[1], Mrs Sharon Frahn[1], James McLeod[1,2], Wayne Champion[1]

[1]Riverland Mallee Coorong Local Health Network, [2]Flinders University, [3]Stellenbosch University

Aim

The COVID-19 pandemic has exacerbated the medical workforce maldistribution in rural Australia and decreased enrolments in general practice training. The Riverland region of South Australia has successfully reversed this trend. This presentation seeks to understand why.

Content

The Riverland region of South Australia, with 12 small hospitals and associated private general practices serving 65,000 people, has been at the forefront of rural medical student training for 25 years through Flinders University's Parallel Rural Community Curriculum. However, there was minimal postgraduate training, so most graduates developed careers elsewhere.

In 2021, the region's general practices and the local public health service, the Riverland Mallee Coorong Local Health Network (RMCLHN), all significantly affected by medical workforce shortages, decided to take responsibility together for creating their own medical workforce by implementing the National Rural Generalist Pathway. The first step was to develop the postgraduate component of the pathway by creating the Riverland Academy of Clinical Excellence (RACE).

The RACE medical pathway was designed and led by practising rural GPs to take advantage of local strengths and integrate private general practice and hospital experience throughout the junior doctor and registrar years. Interns are offered a length of training contract by the LHN, contingent on them joining either the RACGP or ACRRM training programs, that enables them to accrue and take advantage of ongoing employment benefits while undertaking both hospital and general practice training.

The RACE program has achieved full accreditation and recruited 26 locally trained trainee medical officers who are pursuing general practice training in its first two years. This has resulted in an immediate increase of over 20% in the medical workforce (public and private) in the region.

Goals

This presentation will explain the pedagogic, philosophical and practical rationales behind this success story.

General practice funding reforms: What is the key to success?

Dr Michael Wright

Purpose

To understand the future of primary care funding by examining the historical approach since the introduction of Medicare in 1984.

Discussion

The focus of most general practice funding reforms has been on supporting the delivery of coordinated, integrated and continuous care through general practices and their teams. The Coordinated Care Trials, undertaken 1997–99 and 2002–05, highlighted the importance of reform buy-in from primary care providers, investment that is commensurate with the delivery of care and flexible funding approaches. These findings were affirmed by the later Diabetes Care Project, run between 2011 and 2014, which also iterated the role of the 'healthcare home' in funding reform. More recently, the Health Care Homes trial built on these earlier learnings and demonstrated how funding needs to be designed with a clear incentive to provide better care, and with appropriate practice support.

The chronic disease management item numbers introduced to the Medicare Benefits Schedule (MBS) in 2005 demonstrated the potential to utilise fee-for-service funding models to support enhanced multidisciplinary care. The rollout of funding for general practice respiratory clinics, telehealth and COVID-19 vaccination programs also represent reforms that used fee-for-service funding to support care. While not without its flaws, the COVID-19 approach underlined the value of aligned objectives across multiple funders and integrating funding reforms with the business models in general practice.

Conclusions

A key failing of numerous approaches has been their short-term nature. Funding reforms can take decades to show their impact, both intended and unintended. The reality also is that reforms are likely to require significant upfront investment before leading to downstream savings. However, the evidence we do have from decades of trials and interventions has shown the key elements required for successful general practice funding reform.

Reasons for claims or complaints against Australian GPs: A medical indemnity perspective

Dr Michael Wright, Dr Ruth Crampton, Georgie Haysom

Patients complain for a variety of reasons. Avant has a wealth of information based on our claims data from our membership base of over 50% of Australian doctors. These insights have international relevance. With this information we can determine what patients complain about. In addition, we recently engaged in research to explore the reasons behind why patients complain. In today's increasingly complex healthcare landscape, it is crucial for doctors to understand why patients are complaining and to develop strategies to address the issues.

One common reason for patient complaints is a lack of communication. Patients may feel that they are not being listened to or that their concerns are not being taken seriously. This can lead to feelings of frustration and anger, which may, in turn, result in formal complaints. To address this issue, doctors need to prioritise open and effective communication with their patients, actively listening to their concerns and working to address their needs and concerns in a timely manner.

Poor quality of care is another common reason for patient complaints. Patients who feel that their needs are not being met or that the care they receive is subpar may file formal complaints, leading to negative impacts on the reputation of the healthcare provider. To address this issue, healthcare providers need to prioritise high-quality care and ensure that their patients receive the care they need to achieve optimal health outcomes.

The implications of a patient complaint can be significant, damage to reputation, regulatory investigation and stress to name a few. In this session we explore the what and why of patient complaints as well as address ways to reduce the instance of complaints and the management of them when they occur.

Communication insights: Case study-based communication discussion

Dr Michael Wright, Ruanne Brell, Georgie Haysom, Dr Ushma Narsai

Avant claims data and other international studies have identified poor communication as a leading cause of patient complaints. For example, with Avant data, one in eight claims was found to involve perceived disrespect towards the patient, of which 72% listed communication as the concern.

When the patient behaviour presents additional challenges, such as is the situation with aggression or anger, the medical practitioner needs additional skills to manage these situations. These skills include managing the patient behaviour but additionally a strong self-awareness and critical reflection to consider what part they play in any difficult situation and how they might manage it better in the future.

In this session we will use case studies to frame a panel discussion that reviews and develops communication skills in primary care environments.

Reviving student interest in primary care: A parallel consulting 'teaching clinic' within a university general practice

Dr Bosco Wu, Wendy King, Mark Lee, Anjali Prakash, Amy Kwan, Prof Simon Willcock, Prof Sanjyot Vagholkar, Dr Tim Tse

Macquarie University

Observational learning provides lower levels of satisfaction, engagement and limited development of clinical skills. Career selection in general practice (GP) is low among Australian medical students and requires revival as the global primary care workforce continues to decrease. Generalist abilities are important foundations for students in the increasingly fragmented healthcare model.

We describe a novel parallel consulting clinic (teaching clinic) within the Macquarie University Medical Degree (MD), with a focus on the development of clinical acumen, promoting trainee autonomy and increasing interest in primary care. The Macquarie MD is a four-year postgraduate medical program established in 2018 in Sydney, Australia, with an embedded GP clinic and teaching hospital.

We highlight the benefits of this parallel consulting model for supervisors, trainees, patients and the organisation. Logistics of the model's creation and operation since 2020 will be discussed. Briefly, students undertake the teaching clinic with an experienced GP supervisor and initially see undifferentiated patients unknown to them. They are each given 15 minutes to take a history and examination independently. They will then present their findings in a structured manner to their supervisor with discussion focused on management. The supervisor will then finalise the consultation with the student before debriefing on learning points. While this is occurring, an alternative student will be reviewing a second patient allowing effective workflow. Students are required to document each consultation into the medical record.

Insights gained from feedback with supervisors and students about their experience and lessons learnt will be presented. This unique concept of clinical service delivery occurring in parallel with medical education will allow attendees to understand the benefits of the teaching clinic model, the operational framework and how they might implement it within their own clinical setting.

Training future doctors in telehealth

Dr Bosco Wu, Prof Sanjyot Vagholkar, Prof Simon Willcock, Dr Tim Tse

Macquarie University (MQ Health)

The COVID pandemic has changed the delivery of medical care around the world. Consultations via phone and videoconference have become part of a 'new normal' in general practice (GP) where they were once reserved for patients in remote areas. Despite the widespread uptake of these modalities by patients, clinicians have been forced to adapt out of necessity without significant guidance. GP consultations conducted over telehealth presents additional challenges outside of the standard face-to-face appointments. Some differences include patient selection, risk management, agenda alignment, therapeutic rapport and virtual physical examination. The pandemic has accelerated uptake of telehealth and there is a need for medical schools and GP training providers to address the educational deficits.

Prior to the COVID-19 pandemic, medical students had limited exposure to telehealth delivery in their curricula. Education of students mainly focuses on face-to-face interactions and few programs offer specific training on quality telehealth care. Recognising this gap in the traditional curriculum, we introduced a telehealth-focused education session in the primary care discipline for a postgraduate medical program. Teaching focused on delivery of telehealth to enhance patient satisfaction, maximise quality of care and ensure clinical safety. The sessions were conducted over 60 minutes and were designed to maximise student engagement by utilising live polling, open discussions and role-playing. Student perspectives before and after the sessions were obtained from open forum and polling. The feedback provides additional avenues for future curricula redesign.

Student and GP educator perspectives on telehealth pre- and postintervention will be presented. We will discuss the telehealth-specific challenges outlined above and provide an approach to deliver quality telehealth in the GP setting. We aim to empower attendees with ideas that may facilitate similar curricula inclusions to ensure that medical graduates and GP trainees are equipped with the essential skills to provide care in the new healthcare landscape.

Getting cardiovascular risk assessment right with Aboriginal and Torres Strait Islander people

Dr Rosemary Wyber[1], Belinda Hammond[2], Mary Belfrage[2], Vicki Wade[3]

[1]Australian National University, Telethon Kids Institute, [2]The Royal Australian College of General Practitioners, [3]Heart Foundation

The NACCHO-RACGP national guide to preventive healthcare for Aboriginal and Torres Strait Islander people (National Guide) is a flagship resource supporting best practice health promoting and disease preventing activities for Aboriginal and Torres Strait Islander people in primary healthcare settings. Developing the cardiovascular disease (CVD) chapter for the 4th edition of the National Guide has provided an opportunity to review a range of cardiovascular clinical guidelines in Australia and consider how they address the cultural, clinical and contextual needs of Aboriginal and Torres Strait Islander people. In particular, exploring CVD risk assessment in the National Guide revealed a range of important considerations for clinicians: how is 'family history' defined for the purposes of CVD risk assessment? When should Aboriginal and Torres Strait Islander ethnicity be considered as a reclassification factor which increases calculated CVD risk? How can protective factors for CVD health be identified and celebrated? How do people feel or respond when offered CVD risk assessment?

These questions, and choices made in drafting the National Guide, reflect the decisions made by general practitioners and other primary care staff daily. Addressing these issues is critical for reducing the disproportionate burden of premature CVD for Aboriginal and Torres Strait Islander people and the trauma of early CVD deaths. This session will provide space for primary care staff to reflect on their experiences of CVD risk-reducing care with Aboriginal and Torres Strait Islander people and other Indigenous communities. Facilitated discussion, grounded in cultural safety, will provide an opportunity to highlight research and resources on biomedical CVD risk factors and cultural considerations of care. Participants will gain insight into the process of guideline adaptation for different population groups, explore clinical best practice, resources and reflective opportunities to advance their own practice.

Climate and Environmental Medicine Specific Interest Group: Greening up your practice with audit tools

Dr Katriona Wylie

General practices can actively contribute to preserving our environment and planetary health by taking action to minimise their environmental footprint.

In this presentation, Dr Kate Wylie, Chair the RACGP Specific Interests Climate and Environmental Medicine will discuss how the audits developed by the specific interest group members can help GPs make a difference, and contribute to reducing the adverse health effects of climate change.

The audits will provide GPs with the tools to reduce the environmental impact of their practice, while reducing practice overheads, and improving outcomes for patients and staff.

No coughing allowed: Why the continued fight against TB is important for us all

Kate Turnbull[1], Dr Katriona Wylie, Dr Ben Marais, Ms J'Belle Foster

[1]RACGP Rural

Tuberculosis (TB) remains one of the world's most deadly diseases, responsible for over one million deaths annually. In recent years, COVID has opened the eyes of many people in more economically developed countries to how an increasingly connected world leaves us all vulnerable to the spreading footprint of disease. Furthermore, the changing climate is likely to result in increased severity of risk factors for TB transmission, potentially bringing TB to new places and with larger numbers then seen before. Combating TB requires not only timely and effective treatment, but also cooperation between regional allies.

This professional forum will explore how TB is managed, and how the understanding of both domestic and regional considerations is important against its spread. The presenters will also be invited to give their thoughts as to potential future challenges in the fight against TB and how these challenges can be met. Primary care physicians are at the front line of managing infectious diseases both in endemic and outbreak environments. Treatment of TB should remain a priority globally, even in places and for doctors who would not have historically thought of TB as a threat.

On the frontline of climate distress: A conversation about climate change and youth mental health

Dr Anna Seth[1], Dr Katriona Wylie[2], Cybele Dey[3,4]

[1]John Street Medical Centre, [2]The University of Melbourne, [3]Sydney Children's Hospital Network, [4]University of Sydney

Climate change has significant impacts on the mental health of young people. Evidence indicates that 80% of Australians have been impacted by climate-driven extreme weather and more than half of Australians are worried about climate change, particularly young Australians, with some experiencing functional impairment and significant mental distress as a result.

The impacts on the mental health of young indigenous Australians, may, in line with the experience of First Nations people around the world, be anticipated to be even more pronounced due to the intersection with existing socioeconomic, cultural and geographic determinants of health.

There is growing recognition that 'climate anxiety' and other emotional responses to the overarching awareness of climate change are, in general, a rational response to a challenging reality, which must be addressed without pathologising. However clinicians must assess these presentations in the context of the background high prevalence of anxiety and mood disorders in Australian youth. The rising worldwide burden of youth mental ill health, of which climate change is a recognised driver, and the parallel crisis in access to mental health care present a substantial challenge for our response as primary care physicians.

This session will hear from young people with lived experience of climate distress in conversation with general practitioners, exploring how they have navigated their emotional response to climate change, and their encounters with health professionals when seeking help. The session will provide an overview of the epidemiology and presentation of climate distress, consider what current evidence and clinical experience says about how this may be best approached within primary care settings and provide opportunity for reflection on the clinical role and how we engage with rational existential distress in a way which supports resilience and adaptive coping.

The practice and reflection of the 'Zhongshan community model' in the community teaching of general practitioner standardised training

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Objective

Community rotation training is very important in the standardised training of general practitioners. It is particularly important to explore effective and feasible community teaching models. In this paper, we conduct an in-depth study on the application of the 'Zhongshan community model' in community teaching, in order to provide reference for other regions to carry out better community teaching in general practice.

Methods

In this study, semistructured interviews were conducted with the Department of General Practice of Zhongshan Hospital of Fudan University, Fenglin Community Health Service Centre of Xuhui District, Changfeng Community Health Service Centre of Putuo District and Xidu Community Health Service Centre of Fengxian District in Shanghai to understand their views on the current situation of community-based general practice teaching and to summarise the current situation of the 'Zhongshan community model'.

Results

It is expected that seven physicians from Zhongshan Hospital will be interviewed (including four physicians with senior titles), four community teaching managers, 10 community teaching teachers and 18 general practice. The 'Zhongshan community teaching model' is taught by physicians with senior titles from Zhongshan Hospital, with the participation of trainees from the community health service centres, who attend the teaching clinic at a fixed time each week. At the end of the consultation, the trainees give a case report and teacher's comments, as well as PPT lectures on difficult problems and relevant clinical theory. At the end of the study period, trainees receive the appropriate discharge assessment.

Conclusion

At present, there is no unified model and standard for community rotation of general practitioners in China. The implementation of the 'Zhongshan community teaching model' has better compensated for the deficiency of community teaching faculty, which is conducive to the improvement of the overall teaching level and ensures the quality of community general teaching.

Multicomponent intervention to enhance cognitive function among older adults with mild cognitive impairment: Preliminary results of a randomised controlled trial

Prof Yeung Shan Samuel Wong[1], Zijun Xu[1], Dexing Zhang[1], Benjamin Hon-Kei Yip[1], A/Prof Eric Kam-Pui Lee[1], Paul Kwok-Ming Poon[1], Eliza Lai-Yi Wong[1], Allen Ting-Chun Lee[2], Linda Chiu-Wa Lam[2]

[1]Jockey Club School of Public Health and Primary Care, The Chinese University of Hong Kong, [2]Department of Psychiatry, The Chinese University of Hong Kong

Objective

To examine the effects of a multicomponent intervention, namely cognitive training, mind–body physical exercise and nurse-led risk factor modification (CPR) and a nurse-led risk factor modification (RFM) alone, on cognitive function and other health outcomes when compared to health advice (HA) among older adults with MCI.

Methods

This randomised controlled trial included 456 older adults with MCI from the community and primary care in Hong Kong, with 152 participants randomised to CPR, RFM or HA each. CPR and RFM groups met the nurse quarterly over 15 months. CPR group received Tai Chi and cognitive training three times a week for three months. HA group received advice and education booklets from a nurse. All participants met the study clinicians at screening for a detailed medical history and physical examination. Assessments were conducted at baseline and 6, 12 and 15 months. the assessors and data analyst were blinded to group allocation. The primary outcome was the Alzheimer's Disease Assessment Scale – Cognitive subscale (ADAS-Cog) score. Linear mixed model was used for analysis.

Results

Participants were 70.1 ± 4.9 years old, and 72.4% were female. In the first 272 participants who completed the study, pairwise comparison found a significant group difference between CPR and HA ($F_{1,213} = 6.06$, $P = 0.015$) adjusting for imbalanced baseline factor (age). No pairwise between-group difference was found between CPR and RFM and between RFM and HA. Both CPR and RFM groups showed significant within-group improvement at 6, 12 and 15 months of follow-up ($P < 0.05$). HA group had significant within-group improvement at 12 and 15 months ($P < 0.05$).

Conclusions

Preliminary results show that the multidomain intervention CPR is feasible and may reduce cognitive decline in older adults with MCI. A larger sample of this study could inform a potentially effective service model for MCI in primary care.

Study of profile, pattern and outcomes of oral poisoning cases admitted in emergency department of Janakpur Provincial Hospital, Nepal

Dr Sharad Yadav

Madhesh Institute of Health Science

Oral poisoning patients admitted to our emergency department between 16 December 2021 and 15 June 2022 at the Emergency Department of the Provincial Hospital in Janakpur Dham, Nepal, were the subject of a retrospective study. The patient files contained information regarding age, gender, occupation, type of agent, route of poisoning, clinical effects of cholinergic overactivity, laboratory findings and mortality rate. During the study period, 220 patients were admitted to the ED with oral poisoning caused by a known agent. The estimated mean time of admission to the emergency department after exposure was 3.9 3.1 (1–14) hours. There were 131 female patients (59.5%) and 89 male patients (40.5%); 40.5% of both males and females between the ages of 15 and 24 were affected. Oral ingestion was found to be the most common route of poisoning (86.5%). Attempted suicide was the most frequent cause of poisoning (75.9 %). The most frequently encountered oral compounds were dichlorvos, diazinon and parathion-methyl. Miosis, respiratory system findings, tachycardia, loss of consciousness and hypertension were the most common clinical manifestations. Twenty patients (9.1%) perished as a result of respiratory and cardiac arrest (45%), respiratory failure (25%), CNS depression (5%) and septic shock (25%).

Impact of setting up a sexually transmitted disease (STD)-friendly clinic in rural area in Malaysia

Dr Choo Soon Yak

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Sexually transmitted diseases (STD) is a major public health concern in both resource-rich and -limited clinical settings. The main aim of an STD-friendly clinic is to screen, identify, educate and treat infected persons and their sex partners. There were two HIV and five syphilis cases detected in Ayer Tawar Health Clinic (KKAT) from 2018 to 2021. After utilising existing resources and manpower, STD Clinic KKAT was established on 25 March 2022. Within a two-month period, a total of 39 clients utilised this service. The strategies implemented for the success of this STD-friendly clinic included allocating a private room and waiting area with a fast-track service. A day and time were fixed to be on Fridays, 3–5 pm. This allowed privacy for clients away from other patients. Appointments were obtained via mobile line (012-59120520) to avoid overcrowding and reduce waiting time. This STD-friendly clinic service was promoted in the key populations dating app such as Grindr for men who have sex with men (MSM). Non-governmental organisations (NGO) nearby (eg PEKASIH) were involved to identify and refer clients to the clinic. By 31 December 2022, 75 new clients utilised this service. Ethnicity distribution was 56% (n = 42) Malays, 25.3% (n = 19) Chinese and 18.6% (n = 14) Indians. In all, 82.6%(n = 62) of the clients were from the age group of 20–34 years old, predominantly within the age range 20–24 years (32% [n = 24]). The highest risk factor identified was (MSM) behaviour 82.7% (n = 62). A total of 11 HIV cases was detected. Nine of them are still actively under KKAT follow up and adhered to the antiretroviral therapy prescribed. Furthermore, 14 syphilis cases have been detected and treated. Eleven confirmed chronic hepatitis C cases were detected, and all achieved sustained virologic response (SVR12) after completing direct acting antiviral (DAA) for three months. Lastly, there were one hepatitis B and gonorrhoea detected respectively.

Association between systolic blood pressure control and patient–physician gender concordance in secondary prevention: A cross-sectional study

Dr Hiromitsu Yamashita, Shuhei Naomiya, Nozomi Kubota, Eiichiro Yahagi, Kenji Nishimura, Masayoshi Shiota

Kawakita Family Clinic Minamiasagaya

Introduction

It has been pointed out that not only the sex of the patient, but also the gender of the physician may affect various patient outcomes. In the prevention of atherosclerotic diseases, gender differences may play a role in modifying risk factors, but the extent of this effect remains unclear. This study aims to investigate whether there is an interaction between the gender of the patient and the gender of the physician in relation to the achievement of systolic blood pressure (SBP) control targets.

Methods

This cross-sectional study utilised electronic medical records from an urban clinic in Japan. Participants were aged 40–79 years and had a history of coronary artery disease or non-cardioembolic stroke. Multivariable logistic regression models were employed to evaluate the associations between the patient's sex, the physician's gender and the proportion of patients achieving the SBP targets. The interaction between the patient's sex and the physician's gender was also considered in this model. Relevant covariates were patient sex, physician gender, age, body mass index and smoking history.

Results

A total of 232 participants were included in this study (28.7% were women). Regarding the patient's sex, the proportion of SBP target achievement was 61.0% for men and 65.6% for women. Male physicians were less likely to achieve SBP goals (53.8% of male physicians vs 72.0% of female physicians). After adjusting for covariates, female physicians were more likely to achieve SBP targets (adjusted odds ratio 2.39; 95% CI: 1.28, 4.46). There was no apparent interaction between the patient's sex and the physician's gender.

Conclusions

There was no apparent interaction between the patient's sex and the physician's gender. Male physicians were less likely to achieve SBP targets compared to female physicians. Quality improvement interventions aimed at improving this situation are warranted.

Spatial-temporal distribution analysis of registered general practitioners using geographic information system

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General Practice Ward/International Medical Center Ward, General Practice Medical Center, West China Hospital, Sichuan University

Objective

This study used geographic information technology (GIS) to comprehensively explore the rational allocation and optimisation of general practitioners provide a basis.

Methods

This research through the questionnaire survey with basic information of registered general practitioners from 2015 to 2018 in all primary health institutions in Chengdu China. Global autocorrelation and local autocorrelation are used to reflect the clustering of the spatial distribution, The spatial-temporal scanning statistics are further used to analyse the clustering of registered general practitioners in different time and space; and the influencing factors are identified through panel data regression analysis.

Results

The clustering results of the local autocorrelation LISA map at the district level show there was high-high and high-low agglomeration in the east; low-low and low-high agglomeration in the west. Using time–space scanning statistics to analyse the number of registered the density of general practitioners in various districts and counties of Chengdu from 2015 to 2018, the most likely cluster is Pengzhou City. The density of registered general practitioners are respectively 1.74 times and 1.71 times outside the cluster area. The results of the study showed that institutional service population, building area, active employees, outpatient treatment volume, inpatient institutional service population, building area, active employees, outpatient treatment volume, inpatient service and population density in socioeconomic factors are related to the density of registered general practitioners, and the difference is statistical learn meaning.

Conclusion

The analysis of spatial distribution of primary medical institutions in Chengdu has shown a certain amount of spatial agglomeration. The temporal and spatial distribution of registered general practitioners is mainly affected by the internal characteristics of the institution.

Development of atrial fibrillation diagnostic model using Lorenz scattergram and convolutional neural network

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Background
Atrial fibrillation (AF) is highly correlated with heart failure, stroke and deaths. Screening increases the detection of AF and reduces the combined end points of cardiovascular and cerebrovascular events. In recent years, long-range wearables have become increasingly popular in screening for atrial fibrillation. How to interpret data obtained by long-range wearable ECG devices is a problem.

Aims
To establish a deep learning model to detect AF episodes based on a non-linear Lorenz scattergram and tested it in long-term ECG data from primary care.

Method
We conducted a cross-sectional study. The MIT-BIH Normal Sinus Rhythm Database, MIT-BIH Arrhythmia Database and Long Term AF Database were used to train and validate the convolutional neural networks model. We built a MOBILE-SCREEN-AF dataset, which came from a single-lead wearable ECG from a wearable device in primary care and was used for test. Performance is quantified using a confusion matrix and standard classification metrics.

Results
During evaluation of model performance based on Lorenz scattergram, the sensitivity of the model diagnosis of AF was 0.992, the specificity was 0.973, and the accuracy was 0.983 in the validation set. The sensitivity of the model diagnosis of AF was 0.989, the specificity was 0.956, the accuracy was 0.967 in the test set. During the evaluation of model performance based on ECG records in MOBILE-SCREEN-AF dataset, the sensitivity, specificity and accuracy of the model in the diagnosis of paroxysmal AF were 1.000, 0.870 and 0.876 in long-term ECG records, respectively. The sensitivity, specificity and accuracy were 0.927, 1.000 and 0.973, respectively, for the diagnosis of persistent AF in long-term ECG records.

Conclusion
The model based on non-linear Lorenz scattergram and CNN has high accuracy and has promotion and application value in the screening of AF in primary care.

Significant improvement of Jaccoud's arthropathy by active physical therapy

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A 31-year-old man presented with fever, purpura-like rash and polyarthralgia, was diagnosed as systemic lupus erythematosus 15 years ago, with high-titre antinuclear antibody, low complement levels, positive anti-dsDNA antibody and Coombs' test. Unfortunately, he gradually progressed to systemic lesions with poor compliance of treatment. Meanwhile, sudden deformities of joints in bilateral hands were presented during a relapse. After treatment with glucocorticoids, his general condition was improved, but the finger deformity persisted. Physical examination revealed bilateral ulnar deviation and swan neck deformities of fingers (A B), which seriously affected his life. However, most of the joints were reducible without joint swelling or pain, besides, anti-cyclic citrullinated peptide antibodies and rheumatoid factor were negative, and erosive lesions were absent in the X-ray (C). As a whole, he was diagnosed as Jaccoud's arthropathy, and was treated with active rehabilitation exercises on the joints of both hands with the guidance of rehabilitation physician. Surprisingly, after three weeks, the range of motion of joints were significantly improved (D) and he could grasp large objects. Jaccoud's arthropathy, a non-erosive arthropathy, was described in chronic rheumatic diseases, especially in systemic lupus erythematosus. The arthropathy presents with correctable deformity, due to ligament and/or joint capsule laxity with rare primary articular involvement and bone erosions. Although the best treatment has no consensus so far, supportive treatments, including physical therapy and orthotic devices, have been proved to be effective in Jaccoud's arthropathy, and should be strengthened, which is of great significance to improve the life quality for patients.

The value of olfactory test in screening cognitive decline in community patients with cerebral small vessel disease

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Aim

To explore the correlation between olfactory function and cognitive decline in patients with cerebral small vessel disease (CSVD) by analysing the olfactory test and functional MRI scan data, and to explore the value of olfactory test in screening cognitive decline.

Content

A total of 80 CSVD patients and 44 age-, gender- and education-matched healthy controls underwent neuropsychological tests, olfactory tests, 3DT1WI and rs-fMRI scans. DPABI, SPM12 and SPSS software were used to compare and analyse the difference of amplitude of low-frequency fluctuation (ALFF), regional homogeneity (ReHo) and functional connectivity (FC) between CSVD and HC, and to evaluate the correlation between rs-fMRI indices of the brain regions with differences and olfactory function and cognitive function.

Goals

The ALFF of the right superior frontal gyrus and the ReHo of the left cuneus in CSVD were significantly lower than those in HC. In the right superior frontal gyrus as seed point, there were significant differences in the right precuneus and right inferior temporal gyrus. The left cuneus was the seed point of FC, and there were significant differences in the right precentral gyrus, left temporal lobe, bilateral postcentral gyrus, left inferior temporal gyrus, left lingual gyrus and right superior frontal gyrus. Olfaction was positively correlated with cognition in CSVD, and ReHo in the left cuneus was negatively correlated with MoCA.

Value-based care: What is it and why does it matter?

Dr Kim Yu

Aledade

Value-based care is growing fast in the United States. Learn what it is in this informative session that will highlight definitions and why value-based care is making a difference for family doctors. In this interactive session, brainstorm and share what and how value-based care could be implemented in your country and consider the possibilities in outcomes.

WONCA Special Interest Group in Health Equity preconference workshop

Dr Kim Yu[1], Viviana Martinez-Bianchi[2]

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WONCA's Special Interest Group in Health Equity is proud to present a four-hour workshop to be held preconference during WONCA World Conference 2023. In this informative and interactive workshop, learn the latest updates in health equity from around the world, explore implicit bias and techniques to address it, identify and explore how to enhance the health equity lens for your practice and learn how to address social determinants of health. There will be breakout sessions and time for discussion as well as interactive games and Q&A to enhance learning. In addition, participate and learn more about the SIG in Health Equity. Research into health equity impact assessments will be discussed and time for brainstorming and collaboration.

Patients' experiences in the making of future doctors

Dr Yee Tak Esther Yu[1], Sze Nga Liu[1], Pauline Po Ling Luk[2,3], Hoi Yan Wong[1], Amy Pui Pui Ng[1], Linda Chan[1,2], Dr Julie Chen[1,2,3]

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Aim

Proficiency in clinical consultation skills requires repetitive practise with timely feedback. Real patients are best positioned to provide authentic learning experience and may further add value by providing feedback from the patient's perspective. In 2022, a 'living library of patient-educators' was piloted among Year 4 medical students. Eighteen patients with common symptoms encountered in primary care were trained as 'patient-educators', to give a history of their own illnesses in a standardised manner during virtual consultation with students, assess students' interpersonal skill and provide individualised constructive feedback. This qualitative study explored the patient-educators' experiences with this project.

Content

All patient-educators were invited to participate in focus group interviews via text messages between May and June 2022. Each group consisted of two to five participants, led by an experienced researcher, and lasted for 50–80 minutes. All interviews were audio taped, transcribed and independently reviewed by two investigators to identify recurrent themes using thematic analysis. Inconsistencies were resolved by discussion between the investigators.

Four interviews were conducted among 14 patient-educators. Five main themes were constructed: benefits of the project, qualities of good patient-educators, content and provision of feedback and operation of the library. The patient-educators agreed that the library offered valuable and convenient opportunities for students to practise consultation skills and to learn about patients' perspectives, as well as allowed themselves to contribute to the society. Crucial qualities of good patient-educators included compassion, willingness to share and good time management.

Goals

At the conclusion of my presentation, attendees will appreciate that:

- patients can be trained to become 'patient-educators' to offer medical students virtual consultation practice opportunities, to assess students' performance and provide constructive feedback on their consultation skills
- a good patient-educator should be open to discuss both the student's strengths and weaknesses
- patients treasure the opportunity to contribute to the society and medical education as 'patient-educators'.

Transitional care for adolescent management by GP: Oncology and prevention of non-transmissible chronic diseases

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Background

Transitional care with the global management of the adolescent from GP needs psychological support but also the prevention of non-transmittable chronic diseases and oncological pathologies. Our NHS (National Health System) does not provide all the needs of adolescents: the major criticalities of transitional care are the absence of guidelines shared between GPs, paediatrics of primary care (PIs) and oncologists.

Aim

To evaluate the perception of the adolescent age (13–19 years) by GPs and PIs, the doctor–patient relationship during transitional care, the management of neoplasms in adolescents (0.2% between 14 and 19 years) and long-term survivors (30,000 in Italy; survival = five years = 80%).

Materials and methods

Survey disclosed online to GPs and PIs of health local agency in Bari from April to July 2022.

Results

In all, 102 physicians: 50.5% PIs–49.5% GPs; 62% female; 58.66% between 60 and 70 years, 36.4% between 40 and 59 years, <40 years 5.1%; 800/1300 assisted for 46.5%, about 30 adolescents for 60%, for which only 12.2% carry out a monthly visit useful for the evaluation of neurobiological development. Of the adolescents, 90% go to the GPs/PIs with their parents or other relatives, 86% go for acute events, 45% for vaccinations and 3% for cardiovascular diseases or addictions. Of the GPs/PIs, 57.6% identified a tumour pathology in adolescents, for 13.7% leukaemia/lymphomas. The management of oncological diseases in adolescents is the same as for adults for 33.7% of GPs, 89% are sent to the adolescent oncological centre and 11.1% to the adult one; 80.6% do not know the oncological guidelines (and diagnostic and therapeutic strategies in primary care) for adolescents and 79.4% do not know the management of long-term survivors.

Conclusions

Found differences: approach and management of adolescent health between GPs and PIs; lack of appropriate adolescent screening protocols and cancer patient management. Need of multidisciplinary outpatient clinics for transitional care and of guidelines and diagnostic/therapeutic strategies in adolescents for the prevention of non-transmittable chronic and oncological diseases and for the follow-up of cancer survivors.

E-cig and heat-not-burn smoking cessation devices? The need of correct information on benefits and risks by general practitioners

Dr Maria Zamparella[1], Annamaria Catino[2], Chiara Buono[1], Amedeo Ambron[1], Maria Zinfollino[1], Stefania Manzari[1], Daniela Bafunno[2], Nicola Calabrese[1], Domenico Galetta[2]

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Background

Smoking causes the death of six million people every year. In Italy 24.2% of the population is smoker and has been growing in the past year, including subjects smoking heated tobacco (3.3% in 2022 vs 1.1% in 2019).

Information and prevention are essential tools of tobacco control and MAP are actively involved.

Aims

To evaluate the smoking habits of enrolled subjects, to assess their opinion about e-Cigarettes (e-Cig) and heat-not-burn (HnB) devices, about smoke cessation approaches and antismoking centres available within the area of residence.

Materials and methods

From April 2022 to April 2023, 130 questionnaires were collected online (website of Oncology Institute and FIMMG) and in paper form during Open Days held in the MAP office with pneumologists, oncologists and psychologist belonging to the Antismoking Center of Oncology Institute of Bari.

Results

Among the subjects enrolled (56.7% females, 43.3% males), 74.6% smoke cigarettes, 22.3% uses HnB devices, 3.1% e-Cig.

Of the subjects, 67% had previously tried to quit smoking; the reasons were health preservation in 53.5% of cases and cost saving in 16.7%. Among those who quit, 47.6% used E-Cig or HnB devices, 28.6% nicotine gums or sublingual tablets, 16.7% by psychotherapeutic approach. Forty per cent of subjects had not been informed about cessation by anyone; family members and MAP advised about it in 32.1 % and 6.1% of cases, respectively.

Conclusions

Our findings confirm the lack of correct information about devices and smoke cessation approaches, as well as about the availability of antismokng centres. The MAP is a key figure to achieve the 'empowerment' of the smoking cessation journey, both through information and advising on smoke cessation approaches. The forthcoming evaluation of the final results from the participants to the Open Days will add useful information about the paths undertaken and their outcome.

Special training in ambulatory cardiac rehabilitation reduces depression in patients: A randomised controlled trial

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West Kazakhstan Marat Ospanov Medical University

Introduction

The development of depression in cardiovascular diseases worsens the prognosis for patients. In the present study, the impact of educational technology on depressive symptoms in patients with a prior myocardial infarction was tested.

Methods

A total of 146 patients were randomly allocated to main (n = 77) or control groups (n = 69). It was a two-arm open randomised controlled trial with a 12-month follow-up comparing educational intervention plus standard cardiac rehabilitation (CR) in primary care (intervention) with standard CR in primary care alone (control). The intervention was home visits to patients by medical students who had undergone specially designed training in CR. Standard care was medicines, laboratory tests, ECG, cardiologist consultations, 10-day rehabilitation course in a hospital once a year. None of the groups was treated with psychotherapy and/or antidepressants. The outcomes were cardiovascular events and mental health. This abstract presents the results of the intervention using the Hamilton Rating Scale for Depression (HDRS). The Wilcoxon test was used to evaluate the intervention and the standardised mean difference (SMD) was calculated.

Results

At the beginning of the study, depression was diagnosed in 14.48% of patients in the intervention group and in 13.05% in the control group (P = 0.665). A year later, in the intervention group, depression decreased by an average of 1 point (P = 0.02), while in the control group there was no significant decrease. The difference ('before and after') in the studied outcome in the intervention group (2.7 points) was statistically significantly higher compared to the difference in the control group (1.4 points [P = 0.016]; SMD 0.35 [95% CI: –0.48, 1.18]).

Conclusion

Intervention group improved depression compared with standard care. Study strengths include a structured intervention, randomisation and use of longer-term follow-up. Limitations include no blinding of study participants, small sample. Nonetheless, results demonstrated that educational intervention had beneficial effects on mental health symptoms.

Anti-interferon-γ antibody-associated disseminated opportunistic infections: A case report and literature review

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Objectives

Anti-interferon-γ antibody (AIGA) is a rare cause of adult-onset immunodeficiency, leading to severe disseminated opportunistic infections with varying outcomes. We report a case of AIGA-associated disseminated non-tuberculosis mycobacterium (NTM) infection and reviewed current reports to summarise the disease characteristics and to explore factors associated with disease outcome.

Case report

A 32-year-old female presented to our clinic with persistent bone pain, fever and lymphadenopathy for 2 years. She was suspected for lung carcinoma or Rosai-Dorfman disease, but no pathological evidence was found. During her hospitalisation, she had recurrent fever and haemoptysis. NTM was found in her sputum and lymph node drainage. AIGA titre was found to be high.

Literature review

A total of 288 patients were enrolled during literature review, including 130 (50.6%) males and 127 (49.4%) females. The medium age at presentation was 54 years (range 10–87 years); 97.5% were from South-East Asia. The medium time to diagnosis was 11 months (0–612 months). A total of 499 pathogens have been reported, with NTM (259/499, 51.9%) and *Talaromyces marneffei* (TM; 81/499; 16.2%) as the leading infections. The effective rate of antibiotic alone, antibiotic with rituximab and antibiotic with cyclophosphamide were 48.7% (109/224), 71.4% (25/35) and 71.4% (15/21), respectively. The recurrence rate was 57.0%. Among these patients, 147 (65.0%) reached disease control, 79 (35.0%) had uncontrolled disease and 62 had no recorded outcome. Thirty-one (13.7%) patients died and 30 of them died from persistent infection.

Conclusion

AIGA could cause severe opportunistic infections with unsatisfactory control. Antibiotic alone was ineffective in controlling the disease, and efforts should be made to closely monitor the disease and regulate immune system.

Effectiveness of synchronous teleconsultation for patients with type 2 diabetes mellitus: A systematic review and meta-analysis

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Teleconsultation's prominence during the COVID-19 epidemic boosted accessibility for people with type 2 diabetes mellitus (T2DM). Previous research, however, could not differentiate the effectiveness between synchronous and asynchronous teleconsultation. We investigated the efficacy of simultaneous teleconsultation for T2DM patients. From conception to July 2021, we searched Medline, Embase, Cochrane Central Register of Controlled Trials, Cochrane Library and Cochrane Database of Systematic Reviews, ClinicalTrials.gov and the World Health Organization International Clinical Trials Registry Platform databases. All of the research considered were randomised controlled trials of synchronous teleconsultation for persons with T2DM versus standard care. Reviewers collected data separately and used the Cochrane method to assess the risk of bias. Random-effects models were used in meta-analyses. A pooled mean difference was determined for HbA1c (%) and BMI (kg/m^2), SBP (mmHg), DBP (mmHg) and LDL-cholesterol (mg/dL). Depression, medication adherence and quality of life were also evaluated as patient-reported outcomes. A total of 9807 abstracts were identified, with 27 trials included. When compared to the usual care group, synchronous teleconsultation resulted in a larger drop in HbA1c (n = 8746, 0.35, 95% CI: 0.20, 0.49, I^2 = 73%, P < 0.001). There were no significant effects on BMI (n = 699, 0.08 kg/m^2, 95% CI: –0.54, 0.69), SBP (n = 5512, 1.32 mmHg, 95% CI: 0.09, 2.73), DBP (n = 2898, 0.17 mmHg, 95% CI: –1.18, 1.52) or LDL-cholesterol (n = 5276, 3.21 mg/dL, 95% CI: –1.75, 8.17). The effect of teleconsultation in improving patient-reported outcomes was uncertain. Thus, synchronous teleconsultation could be an alternative to usual care.

A case report of nutcracker syndrome with hypertension as the chief complaint

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Nutcracker syndrome (NCP) is a high-pressure state of left renal vein (LRV) caused by the compression of the LRV, resulting in a series of clinical symptoms such as albuminuria, lumboabdominal pain, male left varicocele, chronic fatigue syndrome and rare hypertension. The case was a 22-year-old male with a thin body only with hypertension as the chief complaint, which has a maximum blood pressure of 170/100 mmHg. After receiving metoprolol succinate tablets 47.5 mg a day plus olmesartan 20 mg a day, the blood pressure was controlled around 120/70 mmHg. The patient had no family history of hypertension. Most common secondary hypertension test such as Cushing's syndrome, phaeochromocytoma and primary hyperaldosteronism were normal. Renal vascular CT indicated that the angle between the abdominal aorta and superior mesenteric artery was about 18°, and the narrowest width near the left renal vein was about 3.5 mm. The widest part of the left renal vein is about 10.8 mm. Ultrasound showed nutcracker signs in the LRV and left varicocele. Urine routine test indicated normal, but the patient's renin level was significantly increased, and creatinine and uric acid were increased. After left renal vein stent implantation, patient's pressure of LRV and left varicoceles were relieved, and the blood pressure decreased gradually, and all antihypertensive drugs were stopped at the time of discharge. The creatinine, uric acid and renin decreased to normal in the re-examination two months after the operation, and the blood pressure remained around 120–130/70–88 mmHg without taking antihypertensive drugs. In addition, there have been relevant literature reports of cases of NCP complicated with hypertension, and the blood pressure was relieved after the relief of LRV compression, so the possibility of hypertension caused by NCP should be considered after excluding hypertension caused by other reasons. However, there is still no exact explanation of the relevant mechanism and further research is needed.

Mediating effect of serum lipids on the association between body composition indices and hyperuricaemia in Chinese adults

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Objective

To investigate the relationship between body composition indices and hyperuricaemia (HUA) in Chinese adults, and the mediating effect of serum lipid on the association between body composition indices and HUA.

Methods

Using data from the Diverse Life-Course Cohort (DLCC) 2, serum uric acid (SUA) levels and body composition data (body fat percentage [BFP], fat mass index [FMI], fat-free mass index [FFMI], visceral adiposity index [VAI]) were collected. Binary logistic regression analysis and restricted cubic spline analysis examined the association between body composition indexes and HUA. Mediation analysis was conducted to investigate whether low-density lipoprotein cholesterol (LDL-C) or triglyceride (TG) mediated above association.

Results

BFP and FMI were positively associated with the risk of HUA, FFMI was inversely associated with the risk of HUA. About 16.0%, 5.58% and 5.63% of the total effect of BFP, FMI and FFMI on HUA were mediated by TG, about 13.2%, 10.0% and 10.1% of the total effect of BFP, FMI and FFMI on HUA were mediated by LDL-C.

Conclusion

This study suggested that BFP and FMI were positively associated with the risk of HUA and FFMI was inversely associated with the risk of HUA. Serum TG and LDL-C might partly mediate above association.

Effect of frailty status on mortality risk among Chinese community-dwelling older adults: A prospective cohort study.

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Background

Frailty is associated with mortality in the elderly. We aimed to determine the appropriate time and frailty index (FI) threshold for frailty intervention in Chinese community-dwelling older adults.

Methods

In this prospective cohort study, we used data from the 2011 wave of the Chinese Longitudinal Healthy Longevity Study. Follow-up was performed for seven years from baseline. Using the FI to evaluate frailty and define frailty status, we explored the best time point and FI score for frailty intervention, by comparing the relationships of FI and frailty status with mortality.

Results

From 2011 to 2018, 8642 participants were included and followed up. A total of 4458 participants died during the study period. After adjusting for variables such as age, sex, marital status, education level and living conditions, the hazard ratio (HR) of mortality risk based on the FI at baseline was 37.484 (95% confidence interval [CI]: 30.217, 46.498; $P < 0.001$); female sex, living in the city, being married and living with spouse were found to be protective factors, whereas ageing was a risk factor of frailty. The mortality risk was higher in prefrail than in frail participants (HR 3.588; 95% CI: 3.212, 4.009; $P < 0.001$). Piecewise linear regression analysis revealed an FI score threshold of 0.5. When the FI score was >0.5, the HR of mortality based on the FI was 15.758 (95% CI: 3.656, 67.924; $P < 0.001$); when the FI score was ≤0.5, the HR of mortality based on the FI was 48.944 (95% CI: 36.162, 66.244; $P < 0.001$).

Conclusion

The FI is a stronger predictor for mortality than the frailty status. The advancement of early interventions for mortality risk reduction is more beneficial in prefrail than in frail patients, and an FI score of 0.5 was found to be the threshold for mortality prediction using the FI.

Development of evidence-based peridischarge interventions for reducing 30-day hospital readmissions among COPD patients using GRADE evidence to decision framework

Dr Chenwen Zhong, Charlene Wong, Chi-Tim Hung, Eng-kiong Yeoh, Eliza LY Wong, Vincent CH Chung

The Chinese University of Hong Kong

Background

Previous network meta-analyses (NMAs) synthesised evidence on the effectiveness of peridischarge interventions for reducing 30-day hospital readmissions among COPD patients. However, as the benefits of interventions may vary across health system contexts, evidence should be translated into local adaptable intervention options before implementation. Using the GRADE evidence to decision (EtD) framework, this study aimed to develop local stakeholder-endorsed evidence-based peridischarge interventions for reducing 30-day hospital readmissions among COPD patients in Hong Kong.

Methods

An 18-expert panel was recruited to perform a two-step process. In Step 1, stakeholders were invited to prioritise NMA-supported peridischarge interventions and suggest important intervention combinations based on experience from local practice. In Step 2, based on the priority list from Step 1, stakeholders were asked to conduct a two-round Delphi study to determine whether these interventions should be implemented in the local context. The GRADE EtD framework was used to guide the decision making process, taking into account benefits and harms, values and preferences, equity, acceptability and feasibility.

Results

Six out of ten peridischarge interventions reached positive consensus and were endorsed by stakeholders for reducing 30-day avoidable hospital readmissions among COPD patients in Hong Kong. The percentage agreement ratings for these six endorsed interventions ranged from 70.6% to 94.1%. After considering all the criteria mentioned above, over 60% of local stakeholders agreed that the desirable consequences of implementing these six endorsed interventions probably or clearly outweigh the undesirable effects. Preliminary implementation issues are in the areas of financing, governance and leadership, health workforce development, service access and readiness and empowerment of patients and caregivers.

Conclusions

A list of stakeholder-endorsed evidence-based peridischarge interventions was established for reducing 30-day hospital readmissions among COPD patients in Hong Kong. Before scaling up the implementation of these interventions, further studies should be conducted to improve intervention-context fit and to assess real-world implementation effectiveness.

Patient experiences of primary care and their satisfaction with primary care physician performance in China: A multicentre investigation

Dr Chenwen Zhong[1,2], Junjie Huang[1], Lina Li[2], Zhuojun Luo[2], Cuiying Liang[2], Mengping Zhou[3], Li Kuang[2]

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Objective

To explore the association between patient experience of primary care and their satisfaction with primary care physician performance.

Methods

This study was conducted in 16 primary care settings in China. We assessed patient experience of primary care using the Assessment Survey of Primary Care (ASPC) scale, which comprised six domains (ie first-contact care, continuity, comprehensiveness, accessibility, coordination and patient-centredness). Items in ASPC were assessed using a four-point Likert-type scale. Patients were invited to rate their satisfaction with the consultation time length, the primary care physician's communication, technical and interpersonal skills, and the overall satisfaction level with the primary care physician's performance. Patient satisfaction levels ranged from 1 to 100. Multiple linear regression models were performed to explore the relationship between patient experience of primary care and their satisfaction levels.

Results

In total, 1185 patients were included. The mean total score of patient experience of primary care was 2.79 ± 0.438. The mean overall satisfaction score was 86.3 ± 13.6. Multiple linear regression analyses showed that patients with better experience of primary care had a higher overall satisfaction score, with an effect estimate of 14.2 (95% CI: 12.7, 15.9; $P < 0.001$). Patient-centred care was considered the most critical predictor of patient overall satisfaction (11.0; 9.9 to 12.0; $P < 0.001$), followed by coordination (8.5; 7.1 to 9.8; $P < 0.001$). Surprisingly, patients experiencing better comprehensiveness seemed to have lower satisfaction with the consultation time length (–5.7; –9.7 to –1.7; $P = 0.005$) and primary care physician's interpersonal skills (–3.6; –6.2 to –0.9; $P = 0.008$).

Conclusion

Patient experience of primary care could be considered a predictor of patient satisfaction with primary care physician performance, especially in the two domains of patient-centred care and coordination. Attention should be paid to improving patients' experiences of comprehensiveness and enhancing primary care physicians' interpersonal skills performance considering the consultation time length.

Association between the patient-perceived quality of primary care and hospital utilisation in China: A cross-sectional study

Dr Chenwen Zhong[1,2], Junjie Huang[1], Lina Li[2], Zhuojun Luo[2], Cuiying Liang[2], Mengping Zhou[3], Li Kuang[2]

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Objective

To explore the relationship between patient-perceived quality of primary care and hospital utilisation, as measured by hospital outpatient visits, hospital admissions and emergency department visits in China.

Methods

Data were collected from 16 primary care settings at 10 cities in Guangdong Province in southern China from January to March 2019. Patient-perceived quality of primary care was measured using the Assessment Survey of Primary Care (ASPC) scale, by assessing the six domains, including first-contact care, continuity, comprehensiveness, accessibility, coordination and patient-centredness. Patient hospital utilisation was measured by patient self-reported outpatient visits, hospital admissions and emergency department visits in the past six months. The association between hospital utilisation, patient-perceived quality of primary care, including the six domains were assessed using Spearman correlation coefficients. The impact of patient-perceived quality of primary care on the patient hospital utilisation was explored using logistic regression analysis after adjustment for confounders.

Results

A total of 1185 patients were recruited, 398 (33.6%) of whom reported having hospital utilisation during the past six months, while the remaining 787 (66.4%) patients reported not. Correlation analysis showed negative association between total score of patient-perceived quality of primary care and overall hospital utilisation. A higher score on the coordination, accessible and comprehensive domains was also found to be associated with lower overall hospital utilisation. Logistic regression analysis showed that the total score of patient-perceived quality of primary care had a negative impact on the odds of overall hospital utilisation ($P < 0.001$), outpatient visits ($P < 0.001$) and hospital admissions ($P = 0.029$).

Conclusion

Better-developed primary care structure with higher patient-perceived quality negatively impacted overall hospital utilisation during the past six months in China. This may inform policy decision making to reinforce primary care structure and establish a stronger family practice system, thus reduce hospital utilisation, and relieve healthcare system's burden.

Occupational safety and health for family medicine practices: Intercontinental perspectives

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Background

Data from the World Health Organization (WHO) suggests that 115,000 healthcare workers died from COVID-19 between January 2020 and May 2021 worldwide. Many of the casualties were a part of the primary care workforce, responding to the crisis at the front line. Following the COVID-19 pandemic, it is now the time for the focus to shift to 'Recovery, reconnection, and revival. A celebration of primary care'. This should be enabled by addressing and prioritising the occupational health needs of the primary care health workforce. As a tribute to the lost colleagues, we should aim to assess the current occupational safety and health (OSH) practices in hospitals as well as in the primary care clinics, and share the best ones – enabling to protect health workers, not only through potential breakthroughs of another pandemic, but also for any other occupational hazards induced diseases or injuries. As OSH among health workers remains undermined and often unaddressed, a research collaboration between Indonesia and Lithuania joins intercontinental efforts in the exploration of best OSH practices in both countries aiming to share the idea of OSH implementation among other colleagues in the WONCA World Conference.

Run-down

The workshop will start by sharing the findings of the Lithuanian context and will be followed by an Indonesian perspective. The 20-minute presentation will be followed by a questionnaire to be filled in about local and/or international occupational safety and health practices known to the audience. The participants will be then divided into groups to discuss the findings and asked to map out recommendations on how to best address primary care OSH issues locally and internationally (30 minutes). At the end of the session, the floor will be opened for group representatives to share their perspectives (10 minutes).

Views of South Asian physicians on climate related health effects: A multinational cross-sectional pilot study

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Aim

This study aimed to assess the views of physicians from four South Asian countries (Bangladesh, Bhutan, India and Pakistan) on their knowledge about climate change-related health conditions.

Content

A cross-sectional online survey of 201 physicians was conducted between March and July 2022, and data were analysed using the Kruskal–Wallis test and Dunn's post hoc method.

The study found that 86.6% of physicians from Bangladesh, Bhutan, India and Pakistan believe that climate change is happening and will make health conditions in their countries more severe or frequent. The physicians identified health conditions greatly affected by climate change include those related to reduced outdoor air quality (54.3%), water and food-borne diseases (49.8%), vector-borne diseases (46.7%), heat-related conditions, such as stroke, cardiorespiratory illnesses (46%), drought-related physical or mental harm (43.7%), increased poverty due to economic hardships (43%), hunger and malnutrition due to rising food prices (42.5%), anxiety, depression and mental health conditions (40.1%) and loss of housing and displacement due to extreme weather (37.3%).The common barriers to discussing climate change with patients are lack of knowledge, time and belief that patients have no interest. More than half (56.2%) of the physicians reported no training in climate change-related health effects.

Goals

The goal of this study was to raise awareness among policy makers about the training needs of family physicians and the need to incorporate climate-related modules into medical education.



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