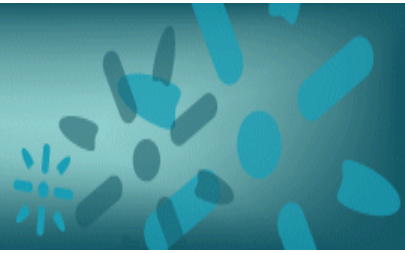




NATIONAL PRIMARY CARE RESEARCH
AND DEVELOPMENT CENTRE



CURRENT AWARENESS BULLETIN

September – October 2009

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Where possible, a digital object identifier (doi) and a PubMed identifier have been provided for each article. Please inform the Library staff if any of these do not work, so the matter can be investigated. These citations have been derived from PubMed.

ACCESS TO CARE

Croker, Joanne E. and Campbell, John L. 2009. Satisfaction with access to healthcare: qualitative study of rural patients and practitioners. *Primary Health Care Research & Development* 10(04), 309-319.

<http://dx.doi.org/10.1017/S1463423609990156>

Aim To gain insight into factors affecting patient and practitioner satisfaction with access to healthcare in a remote rural island community. **Background** General practice based primary care is the focus of health service delivery in rural areas of the UK. Individuals from rural populations have reported inequalities in access to healthcare. User satisfaction with service performance is recognised as an important outcome of healthcare. Further investigation into factors underpinning patient and practitioner satisfaction with access to rural healthcare is required. **Design of Study** Qualitative interviews with patients and primary healthcare practitioners. **Setting** Isles of Scilly, Cornwall, UK. **Methods** A topic guide was developed following review of the literature. In-depth, semi-structured interviews with a purposive sample of 23 participants were conducted with individuals from all inhabited islands. Detailed field notes were kept, and interview content was partially transcribed and analysed thematically. **Findings** Principal themes identified were common to patient and practitioner participants. These were: concerns expressed regarding the equitable provision of services; obstacles to using health services; and the outlook of patients and professionals, including expectations, choice, patient-practitioner relationships and community cohesiveness. Emerging themes gave insight into a range of factors affecting satisfaction with access to healthcare. **Conclusion** Despite numerous policy initiatives aimed at reducing inequities in health service provision, problems with access and uptake of health services persist amongst individuals from remote rural populations. If implemented, recent National Health Service proposals may address some of the challenges identified by participants. Service developments need to take account of local priorities, expectations, geography and demography to achieve favourable outcomes

Howard, M., Agarwal, G., & Hilts, L. (2009). Patient satisfaction with access in two interprofessional academic family medicine clinics. *Family Practice* 26(5), 407-412.

<http://dx.doi.org/10.1093/fampra/cmp049>

<http://pmid.us/19592414>

Background: Satisfaction with access to primary care is one component of overall patient satisfaction. The objectives of this paper were to describe patient satisfaction with access

in interprofessional family practices and to examine predictors of being less than satisfied with access. Methods: A survey was mailed to 770 randomly selected patients in two academic interprofessional family practices in Hamilton, Canada. Most items were positively worded statements on a five-point scale from strongly agree to strongly disagree. Outcomes were the proportion of respondents agreeing with statements regarding access. For items where $>$ or $=25\%$ of respondents did not agree, we examined socio-demographic predictors of disagreement using multiple variable logistic regression. Results: The response rate was 49.9% (384/770). One-quarter or more of respondents did not agree that they received an explanation if the appointment was delayed at the office, obtain urgent appointments, obtain prescription refills without a visit or that wait times at the office were reasonable. Predictors of not agreeing included younger age, being married or single, more educated, employed and of non-white ethnicity. Less than 10 minutes was the most satisfactory wait time for the appointment to begin; however, the most common wait time reported was 11-20 minutes. One-quarter of respondents had visited the weekend/holiday clinic in the past 12 months; however, use was not associated with perceived ability to obtain an appointment in 1-2 days. Conclusions: While satisfaction was generally high, some aspects of access could be improved by changes in practice organization or patient education regarding expectations

Taylor, K. 2009 Asylum seekers, refugees, and the politics of access to health care: a UK perspective. *British Journal of General Practice* 59(567), 765-772.

<http://dx.doi.org/10.3399/bjgp09X472539>

<http://pmid.us/19732492>

The UK government has recently consulted on proposals to prohibit access to health care for some asylum seekers. This discussion paper considers the wider ethical, moral, and political issues that may arise from this policy. In particular, it explores the relationship between immigration and health and examines the impact of forced migration on health inequalities. It will be argued that it is both unethical and iniquitous to use health policy as a means of enforcing immigration policy. Instead, the founding principle of the NHS of equal access on the basis of need should be borne in mind when considering how to meet the needs of this population

Tjerbo, T. 2009 Does competition among general practitioners increase or decrease the consumption of specialist health care? *Health Economics Policy and Law* , 1-18. Epub ahead of publication 28-8-2009.

<http://dx.doi.org/10.1017/S1744133109990156>

<http://pmid.us/19712538>

Studies of the effects of capacity and competition among general practitioners (GPs) on the use of specialist health care services are inconclusive. Some studies indicate that an increase in the number of GPs leads to increased consumption of specialist health care, while other studies point in the opposite direction. This article adds to the literature in

two ways; first by testing out different operationalization of capacity and competition among GPs, and then by testing out effects of capacity and competition on use of specialist health care services as this is disaggregated into ambulatory and inpatient activities. The empirical tests indicate that GP capacity in itself does not affect use of specialist health care services. Increased competitions among GPs do, however, reduce the use of ambulatory care while the effects on the use of inpatient services are unaffected

Street, A., et al Are English treatment centres treating less complex patients?
Health Policy Epub ahead of publication 15-10-2009.

<http://dx.doi.org/10.1016/j.healthpol.2009.09.013>

<http://pmid.us/19836851>

Activity-based funding involves remunerating healthcare providers a fixed price per patient in each payment category. However, no categorisation system can account perfectly for differences in patient complexity. Differences may be systematic if providers routinely attract high-risk patients or engage in patient selection. Such differences may be evident in the English National Health Service (NHS) following the introduction of treatment centres that concentrate on providing a small number of high-volume procedures. We analyse data for more than 3.3 million patients to assess whether the complexity of those treated in hospitals and treatment centres differs within twenty-nine payment categories, defined by Healthcare Resource Groups (HRGs). We find that patients treated in hospitals were more likely to come from more deprived areas, to have more diagnoses and to undergo significantly more procedures than patients seen by treatment centres, suggesting that hospitals are treating more complex cases. If these observed differences between hospitals and treatment centres drive costs, then payments should be refined to ensure fair reimbursement

CHRONIC ILLNESS

Corbett,M., Foster,N., & Ong,B.N. (2009). GP attitudes and self-reported behaviour in primary care consultations for low back pain. *Family Practice*, 26(5), 359-364.

<http://dx.doi.org/10.1093/fampra/cmp042>

<http://pmid.us/19546118>

Background. The implementation of guideline recommendations in primary care has become widespread. The treatment of low back pain (LBP) has followed suite. Research shows that the use of LBP guidelines is influenced by the believability of the underlying evidence, the GPs consultation style and uncertainties surrounding diagnosis and treatment. Objective. To qualitatively examine the attitudes and self-reported behaviour

of GPs in relation to guideline adherence for patients with LBP. Method. A mixed-method design combining a national UK-based survey of GPs and physiotherapists with an embedded qualitative study. This report focuses only on the GP interviews. We explored GPs' experience of managing LBP patients and the rationale for treatment offered to a patient described in a written vignette. All interviews were digitally recorded, fully transcribed and analysed using the constant comparative method. Results. GPs encountered difficulties adhering to guideline recommendations for LBP patients. They experienced particular tensions between recommendations to stay active versus the expectation of being prescribed rest. GPs expressed that chronic LBP often poses an intractable problem requiring specialist advice. The perception that guideline recommendations are imposed' may create resistance, and the evidence base is not always considered believable. Conclusions. GPs acknowledge guideline recommendations but divergence occurs in implementation. This is due to GPs focussing on the whole person--not just one condition--and the importance of maintaining the doctor-patient relationship, which relies on effective negotiation of mutual perceptions and expectations. Further exploration on how consultation processes can be constructed to effectively combine evidence with patient-centred care is needed

Crosson,J.C., et al (2009). A comparison of chronic illness care quality in US and UK family medicine practices prior to pay-for-performance initiatives. *Family Practice* Epub ahead of print 11/02/2009

<http://dx.doi.org/10.1093/fampra/cmp056>

<http://pmid.us/19748914>

Background: The Quality and Outcomes Framework (QOF) has contributed to modest improvements in chronic illness care in the UK. US policymakers have proposed similar pay-for-performance (P4P) approaches to improve care. Since previous studies have not compared chronic illness care quality in US and UK primary care practices prior to the QOF, the relative preparedness of practices to respond to P4P incentives is unknown. Objective: To compare US and UK practices on P4P measures prior to program implementation. Methods: We analysed medical record data collected before QOF implementation from randomly selected patients with diabetes or coronary artery disease (CAD) in 42 UK and 55 US family medicine practices. We compared care processes and intermediate outcomes using hierarchical logistic regression. Results: While we found gaps in chronic illness care quality across both samples, variation was lower in UK practices. UK patients were more likely to receive recommended care processes for diabetes [odds ratio (OR), 8.94; 95% confidence interval (CI), 4.26-18.74] and CAD (OR, 9.18; 95% CI, 5.22-16.17) but less likely to achieve intermediate diabetes outcome targets (OR, 0.50; 95% CI, 0.39-0.64). Conclusions: Following National Health Service (NHS) investment in primary care preparedness, but prior to the QOF, UK practices provided more standardized care but did not achieve better intermediate outcomes than a sample of typical US practices. US policymakers should focus on reducing variation in

care documentation to ensure the effectiveness of P4P efforts while the NHS should focus on moving from process documentation to better patient outcomes

Goyder, E., et al 2009 Informed choice and diabetes screening in primary care: qualitative study of patient and professional views in deprived areas of England. *Primary care diabetes* 3(2), 85-90.

<http://dx.doi.org/10.1016/j.pcd.2009.04.001>

<http://pmid.us/19464976>

Aims: To examine perceived need for, and provision of, information prior to participation in a diabetes screening programme in English general practices. Methods: Case studies using qualitative semi-structured interviews with patients and practitioners in five participating practices. Results: Participating patients generally demonstrated a lack of understanding of issues in relation to the benefits and disadvantages of diabetes screening or the implications of screening test results. Posted invitation letters provided written information but did not necessarily ensure that patients were better informed than those invited by telephone or opportunistically when attending the practice for another reason. Not all patients interviewed wanted the extent of information that would be required to enable them to give fully informed consent to screening. Conclusions: The ways in which information is provided to patients requires careful consideration so that a patient has sufficient understanding to make a decision about undergoing a screening test and understands the implications of test results. There is a potential conflict between the ideal of fully informed choice and patient expectations that they can depend on professionals to make the appropriate decision on their behalf

Ham, C. 2009 The ten characteristics of the high-performing chronic care system. *Health Economics Policy and Law* , 1-20. Epub ahead of publication 7-9-2009.

<http://dx.doi.org/10.1017/S1744133109990120>

<http://pmid.us/19732475>

The purpose of this paper is to describe the characteristics of the high-performing chronic care system and the four implementation strategies needed to achieve such a system. The paper starts with a description of the Chronic Care Model and summarises evidence on its impact. This is followed by a review of international evidence on gaps in the quality of chronic care. These gaps suggest that, useful and influential as the Chronic Care Model is, more is needed to help health care decision makers bring about the reorientation required to meet the needs of populations in which chronic diseases predominate. The second half of the paper therefore sets out the ten characteristics and four implementation strategies required to achieve a high-performing chronic care system. In doing so, it provides practical guidance to policy makers and health care leaders on the most promising strategies for improving the provision of chronic care, drawing on evidence from the experience of England, New Zealand and USA:

Heisler, M., et al 2009 Physicians' participatory decision-making and quality of diabetes care processes and outcomes: results from the triad study. *Chronic Illness* 5(3), 165-176.

<http://dx.doi.org/10.1177/1742395309339258>

<http://pmid.us/19675116>

Objectives: In participatory decision-making (PDM), physicians actively engage patients in treatment and other care decisions. Patients who report that their physicians engage in PDM have better disease self-management and health outcomes. We examined whether physicians' diabetes-specific treatment PDM preferences as well as their self-reported practices are associated with the quality of diabetes care their patients receive. Methods: 2003 cross-sectional survey and medical record review of a random sample of diabetes patients (n = 4198) in 10 US health plans across the country and their physicians (n = 1217). We characterized physicians' diabetes care PDM preferences and practices as no patient involvement,' physician-dominant,' shared,' or patient-dominant' and conducted multivariate analyses examining their effects on the following: (1) three diabetes care processes (annual hemoglobin A1c test; lipid test; and dilated retinal exam); (2) patients' satisfaction with physician communication; and (3) whether patients' A1c, systolic blood pressure (SBP), and low-density lipoprotein cholesterol (LDL) were in control. Results: Most physicians preferred shared' PDM (58%) rather than no patient involvement' (9%), physician dominant' (28%) or patient dominant' PDM (5%). However, most reported practicing physician-dominant' PDM (43%) with most of their patients, rather than no patient involvement' (13%), shared' (37%) or patient-dominant' PDM (7%). After adjusting for patient and physician-level characteristics and clustering by health plan, patients of physicians who preferred shared' PDM were more likely to receive A1c tests [90% vs. 82%, AOR: 2.05, 95% CI: 1.03--3.07] and patients of physicians who preferred patient-dominant' treatment decision-making were more likely to receive lipid tests [60% vs. 50%, AOR: 1.58, 95% CI: 1.04--2.39] than those of providers who preferred no patient involvement' in treatment decision-making. There were no differences in patients' satisfaction with their doctor's communication or control of A1c, SBP or LDL depending on their physicians' PDM preferences. Physicians' self-reported PDM practices were not associated with any of the examined aspects of diabetes care in multivariate analyses. Conclusions: Patients whose physicians prefer more patient involvement in decision-making are more likely than patients whose physicians prefer more physician-directed styles to receive some recommended risk factor screening tests, an important first step toward improved diabetes outcomes. Involving patients in treatment decision-making alone, however, appears not to be sufficient to improve biomedical outcomes

Heyworth, I. T. , et al 2009 . How do common chronic conditions affect health-related quality of life? *British Journal of General Practice* 59(568), e353-e358.

<http://dx.doi.org/10.3399/bjgp09X453990>

<http://pmid.us/19656444>

Background: Comorbidity is common. National Institute for Health and Clinical Excellence (NICE) guidelines have been created to make best use of resources to improve patients' quality of life but do not currently take account of comorbidity. The effect of multiple chronic conditions with regard to health-related quality of life (HRQoL) is poorly researched. Criticisms of previous research have been due to patient-defined chronic conditions, lack of quantification of the effects of confounding factors, selection of affected patients only, small sample sizes, and upper age limits. AIM: This study aims to address these issues, looking into the impact of combinations of chronic conditions on HRQoL. Design of the study: Participants filled in a questionnaire containing general health information, specific respiratory questions, and the EQ-5D measure of HRQoL. The questionnaires were then matched up to their GP records to obtain their disease status for six common chronic diseases (asthma, chronic obstructive pulmonary disease, ischaemic heart disease, hypertension, diabetes, and cerebrovascular disease). Method: Data from a mailed questionnaire were analysed from 5169 patients aged >16 years from two general practices in Wythenshawe, Manchester in 2004. Completion of the questionnaire was taken to indicate consent to participate. Results: Significant correlations were found between a lower HRQoL and increasing numbers of chronic conditions ($P<0.001$), increasing age, possible obstructive airway disease, lack of higher education, smoking, and female sex. These all remained significant following regression, except for sex, with number of chronic conditions being a strong predictor of the weighted health state index score, EQ-5D(index) (coefficient = -0.079, $P<0.001$). Conclusion: Increasing numbers of chronic conditions have a strong negative effect on HRQoL

Hivert, Marie France, et al 2009 Identifying primary care patients at risk for future diabetes and cardiovascular disease using electronic health records. *BMC Health Services Research* 9(1), 170.

<http://dx.doi.org/10.1186/1472-6963-9-170>

<http://www.biomedcentral.com/1472-6963/9/170>

<http://pmid.us/19772639>

Background: Prevention of diabetes and coronary heart disease (CHD) is possible but identification of at-risk patients for targeting interventions is a challenge in primary care. Methods: We analyzed electronic health record (EHR) data for 122,715 patients from 12 primary care practices. We defined patients with risk factor clustering using metabolic syndrome (MetS) characteristics defined by NCEP-ATPIII criteria; if missing, we used surrogate characteristics, and validated this approach by directly measuring risk factors in a subset of 154 patients. For subjects with at least 3 of 5 MetS criteria measured at baseline (2003-2004), we defined 3 categories: No MetS (0 criteria); At-risk-for MetS (1-2 criteria); and MetS (= 3 criteria). We examined new diabetes and CHD incidence, and

resource utilization over the subsequent 3-year period (2005-2007) using age-sex-adjusted regression models to compare outcomes by MetS category. Results: After excluding patients with diabetes/CHD at baseline, 78,293 patients were eligible for analysis. EHR-defined MetS had 73% sensitivity and 91% specificity for directly measured MetS. Diabetes incidence was 1.4% in No MetS; 4.0% in At-risk-for MetS; and 11.0% in MetS ($p < 0.0001$ for trend; adjusted OR MetS vs No MetS = 6.86 [6.06-7.76]); CHD incidence was 3.2%, 5.3%, and 6.4% respectively ($p < 0.0001$ for trend; adjusted OR = 1.42 [1.25-1.62]). Costs and resource utilization increased across categories ($p < 0.0001$ for trends). Results were similar analyzing individuals with all five criteria not missing, or defining MetS as = 2 criteria present Conclusion: Risk factor clustering in EHR data identifies primary care patients at increased risk for new diabetes, CHD and higher resource utilization

Klein Woolthuis, E. P., et al 2009 Yield of opportunistic targeted screening for type 2 diabetes in primary care: the diabscreen study. *Annals of Family Medicine* 7(5), 422-430.

<http://dx.doi.org/10.1370/afm.997>

<http://pmid.us/19752470>

Purpose: In screening for type 2 diabetes, guidelines recommend targeting high-risk individuals. Our objectives were to assess the yield of opportunistic targeted screening for type 2 diabetes in primary care and to assess the diagnostic value of various risk factors. Methods: In 11 family practices (total practice population = 49,229) in The Netherlands, we conducted a stepwise opportunistic screening program among patients aged 45 to 75 years by (1) identifying high-risk individuals (=1 diabetes risk factor) and low-risk individuals using the electronic medical record, (2) obtaining a capillary fasting plasma glucose measurement, repeated on a separate day if the value was greater than 110 mg/dL, and (3) obtaining a venous sample if both capillary fasting plasma glucose values were greater than 110 mg/dL and at least 1 sample was 126 mg/dL or greater. We calculated the yield (percentage of invited patients with undiagnosed diabetes), number needed to screen (NNS), and diagnostic value of the risk factors (odds ratio and area under the receiver operating characteristic curve). Results: We invited for a first capillary measurement 3,724 high-risk patients seen during usual care and a random sample of 465 low-risk patients contacted by mail. The response rate was 90% and 86%, respectively. Ultimately, 101 high-risk patients (2.7%; 95% confidence interval [CI], 2.2%-3.3%; NNS = 37) and 2 low-risk patients (0.4%; 95% CI, 0.1%-1.6%; NNS = 233) had undiagnosed diabetes ($P < .01$). The prevalence of diabetes among patients 45 to 75 years old increased from 6.1% to 6.8% as a result. Among diagnostic models containing various risk factors, a model containing obesity alone was the best predictor of undiagnosed diabetes (odds ratio = 3.2; 95% CI, 2.0-5.2; area under the curve=0.63). Conclusions: The yield of opportunistic targeted screening was fair; obesity alone was the best predictor of undiagnosed diabetes. Opportunistic screening for type 2 diabetes in primary care could target middle-aged and older adults with obesity

Lutfiyya, M. et al 2009. Are there disparities in diabetes care? A comparison of care received by US rural and non-rural adults with diabetes. *Primary Health Care Research & Development* 10(04), 320-331.

<http://dx.doi.org/10.1017/S146342360999017X>

Aim Are there differences in diabetes care between rural and non-rural US adults with diabetes? **Background** Rural Healthy People 2010 includes diabetes as a major health priority, suggesting a possible disparity between diabetes care in rural settings as compared to non-rural locales. **Methods** This cross-sectional study using population-based survey data sought to determine if there was a difference in the quality of diabetes care between rural and non-rural US adults (18 years). A diabetes care index was computed from five separate dichotomous care-related variables (HbA1c checked, lipids checked, dilated eye exam, feet checked by health care provider, and diabetes education), with adequate care defined as receiving at least four of these interventions. Multivariate methods were used to detect differences in diabetes care received by individuals living in rural compared to non-rural settings. **Results** Multivariate regression analysis revealed that US adults with diabetes living in rural communities were more likely to receive inadequate care than non-rural residents (OR = 1.205; 95% CI 1.201, 1.209). Rural residents were more likely to receive inadequate diabetes care if they were: <40 years of age, male, Caucasian, not a high school graduate, not partnered, without health insurance, inactive or without an identified health care provider. Those deferring medical care because of cost, or who did not have an annual routine physical or had fewer than two diabetes related office visits annually were also at greater risk for suboptimal care. Routine physical checkups and deferring medical care because of cost had a greater impact on diabetes care for rural adults compared to non-rural adults. **Conclusion** The results of this study indicated that rural residents were less likely to receive adequate diabetes care compared to their non-rural counterparts. The findings suggest that efforts to identify and to address this disparity would likely improve the outcomes for diabetic individuals living in rural communities

Maher, D et al A global framework for action to improve the primary care response to chronic non-communicable diseases: a solution to a neglected problem. *BMC Public Health* 9(1), 355. 2009.

<http://dx.doi.org/10.1186/1471-2458-9-355>

<http://www.biomedcentral.com/1471-2458/9/355>

<http://pmid.us/19772598>

Background: Although in developing countries the burden of morbidity and mortality due to infectious diseases has often overshadowed that due to chronic non-communicable diseases (NCDs), there is evidence now of a shift of attention to NCDs. **Discussion** :Decreasing the chronic NCD burden requires a two-pronged approach: implementation of the multisectoral policies aimed at decreasing population-level risks for NCDs, and effective and affordable delivery of primary care interventions for patients with chronic

NCDs. The primary care response to common NCDs is often unstructured and inadequate. We therefore propose a programmatic, standardized approach to the delivery of primary care interventions for patients with NCDs, with a focus on hypertension, diabetes mellitus, chronic airflow obstruction, and obesity. The benefits of this approach will extend to patients with related conditions, e.g. those with chronic kidney disease caused by hypertension or diabetes. This framework for a "public health approach" is informed by experience of scaling up interventions for chronic infectious diseases (tuberculosis and HIV). The lessons learned from progress in rolling out these interventions include the importance of gaining political commitment, developing a robust strategy, delivering standardised interventions, and ensuring rigorous monitoring and evaluation of progress towards defined targets. The goal of the framework is to reduce the burden of morbidity, disability and premature mortality related to NCDs through a primary care strategy which has three elements: 1) identify and address modifiable risk factors, 2) screen for common NCDs and 3) and diagnose, treat and follow-up patients with common NCDs using standard protocols. The proposed framework for NCDs borrows the same elements as those developed for tuberculosis control, comprising a goal, strategy and targets for NCD control, a package of interventions for quality care, key operations for national implementation of these interventions (political commitment, case-finding among people attending primary care services, standardised diagnostic and treatment protocols, regular drug supply, and systematic monitoring and evaluation), and indicators to measure progress towards increasing the impact of primary care interventions on chronic NCDs. The framework needs evaluation, then adaptation in different settings. Summary: A framework for a programmatic "public health approach" has the potential to improve on the current unstructured approach to primary care of people with chronic NCDs. Research to establish the cost, value and feasibility of implementing the framework will pave the way for international support to extend the benefit of this approach to the millions of people worldwide with chronic NCDs

COMORBIDITY

Morrow, L.A., et al (2009). High medical co-morbidity and family history of dementia is associated with lower cognitive function in older patients. *Family Practice*, 26(5), 339-343

<http://dx.doi.org/10.1093/fampra/cmp047>

<http://pmid.us/19584123>

Background. Risk factors for cognitive decline in ageing are multifactorial, including medical co-morbidities and familial genetic risk. Objectives. To assess the effect of medical co-morbidity and family history of dementia on cognitive performance in older outpatients of family practitioners. Methods. Analysis of 535 outpatients from 11

practices aged 65 and older, without a diagnosis of dementia. Information on medical co-morbidities, family history of dementia and cognitive test data were obtained. Results. Patients were classified into high or low medical co-morbidities (<7 versus >8) and positive or negative family history of dementia. After controlling for age, education, gender and depression, global cognitive test scores, as well as memory, executive function, spatial ability and attention were significantly lower for persons having a high number of medical co-morbidities. Cognitive test scores were not significantly different for persons with or without a family history of dementia. A significant interaction between medical co-morbidities and family history of dementia was observed for the global cognitive score, executive function and spatial ability. Those persons with a high number of medical co-morbidities and positive family history of dementia had the lowest performance. Separate regression analysis assessing individual disease risk factors (e.g. hypertension and diabetes) did not find any relationship between specific medical variables and cognitive test scores for any of the subgroups. Conclusions. A high number of medical co-morbidities in addition to a reported family history of dementia are particularly detrimental to cognitive performance in elderly non-demented family practice patients

Price, Hermione C., et al 2009 Use of focus groups to develop methods to communicate cardiovascular disease risk and potential for risk reduction to people with type 2 diabetes. *Family Practice* 26(5), 351-358.

<http://dx.doi.org/10.1093/fampra/cmp041>

<http://pmid.us/19546119>

Background. People need to perceive a risk in order to build an intention-to-change behaviour yet our ability to interpret information about risk is highly variable. Objectives. We aimed to use a user-centred design process to develop an animated interface for the UK Prospective Diabetes Study (UKPDS) Risk Engine to illustrate cardiovascular disease (CVD) risk and the potential to reduce this risk. In addition, we sought to use the same approach to develop a brief lifestyle advice intervention. Methods. Three focus groups were held. Participants were provided with examples of materials used to communicate CVD risk and a leaflet containing a draft brief lifestyle advice intervention and considered their potential to increase motivation-to-change behaviours including diet, physical activity, and smoking in order to reduce CVD risk. Discussions were tape-recorded, transcribed and coded and recurring themes sought. Results. Sixty-two percent of participants were male, mean age was 66 years (range = 47-76 years) and median age at leaving full-time education was 18 years (range = 15-40 years). Sixteen had type 2 diabetes and none had a prior history of CVD. Recurring themes from focus group discussions included the following: being less numerate is common, CVD risk reduction is important and a clear visual representation aids comprehension. Conclusion. A simple animated interface of the UKPDS Risk Engine to illustrate CVD risk and the potential for reducing this risk has been developed for use as a motivational tool, along with a brief lifestyle advice intervention. Future work will investigate whether use of this interactive version of the UKPDS Risk Engine and brief lifestyle advice is associated with increased

behavioural intentions and changes in health behaviours designed to reduce CVD risk

GOVERNANCE

Harnden, A., et al 2009 Child deaths: confidential enquiry into the role and quality of UK primary care. *British Journal of General Practice* 59(568), 819-824. 2009.

<http://dx.doi.org/10.3399/bjgp09X472520>

<http://pmid.us/19728902>

Background: In 2006 the Confidential Enquiry into Maternal and Perinatal Deaths was extended to pilot a collection of child deaths. This helped optimise data collection for local safeguarding children's boards, which, since April 2008, have a statutory responsibility to review all child deaths. Reviewing primary care records may highlight areas in which systems, skills, and care could be improved. AIM: To review the role and quality of primary care in child deaths. Design of study: Confidential enquiry into child deaths. Setting: Five regions of the UK: North-East, South-West and West Midlands, Wales, and Northern Ireland. Method: The confidential enquiry collected core data for all child deaths (age range 28 days to 17 years) and an age-stratified sample was assessed by multidisciplinary panels for avoidable factors. An independent detailed review was conducted of the primary care records on all children in the North-East region and all children who were reviewed by panel in the other four regions. Results: Primary care records were reviewed for 168 child deaths. There were 25 (15%) deaths from acute infection, 22 (13%) from cancer, and 11 (7%) from asthma or epilepsy. Fifty-nine (35%) deaths were sudden: sudden unexplained death in infancy, suicides, and assaults. Of 149 with immunisation records, only 88 (59%) had been fully vaccinated on time. One or more primary care professionals were involved in the management of 90 (54%) children. Avoidable primary care factors were identified in 18 (20%) of these deaths. Avoidable primary care factors included failure in the recognition and management of serious infection, failure to vaccinate, and inadequate management of asthma and epilepsy. Conclusion: Decisions made about diagnosis and management in primary care may affect the cause, time, and circumstances of a child's death. Maintaining skills in assessing the acutely ill child remains an essential part of good clinical practice.

HEALTH ECONOMICS

Halladay, J. R., et al **Cost to primary care practices of responding to payer requests for quality and performance data.** *Annals of Family Medicine* 7(6), 495-503. 2009.

<http://dx.doi.org/10.1370/afm.1050>

<http://pmid.us/19901308>

Purpose: We wanted to determine how much it costs primary care practices to participate in programs that require them to gather and report data on care quality indicators. Methods: Using mixed quantitative-qualitative methods, we gathered data from 8 practices in North Carolina that were selected purposively to be diverse by size, ownership, type, location, and medical records. Formal practice visits occurred between January 2008 and May 2008. Four quality-reporting programs were studied: Medicare's Physician Quality Reporting Initiative (PQRI), Community Care of North Carolina (CCNC), Bridges to Excellence (BTE), and Improving Performance in Practice (IPIP). We estimated direct costs to the practice and on-site costs to the quality organization for implementation and maintenance phases of program participation. Results: Major expenses included personnel time for planning, training, registry maintenance, visit coding, data gathering and entry, and modification of electronic systems. Costs per full-time equivalent clinician ranged from less than \$1,000 to \$11,100 during program implementation phases and ranged from less than \$100 to \$4,300 annually during maintenance phases. Main sources of variation included program characteristics, amount of on-site assistance provided, experience and expertise of practice personnel, and the extent of data system problems encountered. Conclusions: The costs of a quality-reporting program vary greatly by program and are important to anticipate and understand when undertaking quality improvement work. Incentives that would likely improve practice participation include financial payment, quality improvement skills training, and technical assistance with electronic system troubleshooting

Heins, E., Pollock, A. M., and Price, D. 2009 **The commercialisation of GP services: a survey of APMS contracts and new GP ownership.** *British Journal of General Practice* 59 (567), e339-e343.

<http://dx.doi.org/10.3399/bjgp09X472638>

<http://pmid.us/19843414>

Background: Alternative provider of medical services (APMS) legislation enables private commercial firms to provide NHS primary care. There is no central monitoring of APMS adoption by primary care trusts (PCTs), the new providers, or market competition. AIM: The aims were to: examine APMS contract data on bidders and providers, patient numbers, contract value, duration, and services; present a typology of primary care providers; establish the extent of competition; and identify which commercial providers

have entered the English primary care market. Design of study: Cross-sectional study. Setting: All PCTs in England. Method: A survey was carried out in March 2008 gathering information on the number of APMS contracts, their value and duration, patient numbers, the successful tender, and other bidders. Results: A total of 141 out of 152 PCTs provided information on 71 APMS contracts that had been awarded and 66 contracts that were out to tender. Of those contracts awarded, 36 went to 14 different commercial companies, 28 to independent GP contractors, seven to social enterprises, and two to a PCT-managed service; one contract is shared by three different provider types. In more than half of the responses information on competition was not disclosed. In a fifth of those contracts awarded to the commercial sector, for which there is information on other bidders, there was no competition. Contracts varied widely, covering from one to several hundred thousand patients, with a value of pound6000-12 million, and lasting from 1 year to being open-ended. Most contracts offered standard, essential, additional, and enhanced services; only a few were for specialist services. Conclusion: The lack of data on cost, patient services, and staff makes it impossible to evaluate value for money or quality, and the absence of competition is a further concern. There needs to be a proper evaluation of the APMS policy from the perspective of value for money and quality of care, as well as patient access and coverage

Kreisz, F. P. and Gericke, C. 2009. User choice in European health systems: towards a systematic framework for analysis. *Health Economics, Policy and Law* , 1-18. 1-9-

<http://dx.doi.org/10.1017/S1744133109990132>

<http://pmid.us/19723352>

This article proposes a systematic framework for analysis of the increasingly popular concept of user choice in European health systems. The development of such a framework is exemplified using one category of potential choice: the choice of health service provider. In the first part, the paper summarises the conceptual background of the user choice debate. Subsequently, the paper theoretically analyses the concept of user choice alongside a stringent set of standard dimensions embracing technical, administrative and allocative efficiency, as well as equity in access and finance. Reference to available evidence is made where applicable. The employed dimensions are critically discussed and finally mapped against the identified determinants within a systematic matrix framework for analysis. Furthermore, the paper underlines that user choice is by no means a panacea but rather a highly complex and ambiguous political strategy. Extended choice in some sectors and levels of health systems may lead to inefficiencies and may therefore lead to loss of benefits, including choice, for individuals and society

Le, Grand J. 2009 Choice and competition in publicly funded health care. *Health Economics Policy and Law* 4(Pt 4), 479-488.

<http://dx.doi.org/10.1017/S1744133109990077>

<http://pmid.us/19715629>

There are four basic models of health service delivery: those that rely on trust, on command and control, on voice, and on choice and competition. All have their merits and demerits; but there are both theoretical and empirical arguments for preferring choice and competition in many situations. However, the relevant policies do have to be properly designed

Louviere, J. J. and Lancsar, E. 2009 Choice experiments in health: the good, the bad, the ugly and toward a brighter future. *Health Economics Policy and Law* 4(Pt 4), 527-546.

<http://dx.doi.org/10.1017/S1744133109990193>

<http://pmid.us/19715635>

Compared to many applied areas of economics, health economics has a strong tradition in eliciting and using stated preferences (SP) in policy analysis. Discrete choice experiments (DCEs) are one SP method increasingly used in this area. Literature on DCEs in health and more generally has grown rapidly since the mid-1990s. Applications of DCEs in health have come a long way, but to date few have been 'best practice', in part because 'best practice' has been somewhat of a moving target. The purpose of this paper is to briefly survey the history of DCEs and the state of current knowledge, identify and discuss knowledge gaps, and suggest potentially fruitful areas for future research to fill such gaps with the aim of moving the application of DCEs in health economics closer to best practice

Mason, A., et al 2009 Should prospective payments be differentiated for public and private healthcare providers? *Health Economics, Policy and Law* 4(Pt 4), 383-403.

<http://dx.doi.org/10.1017/S1744133109004873>

<http://pmid.us/19195409>

The English government has encouraged private providers - known as Independent Sector Treatment Centres (ISTCs) - to treat publicly funded (NHS) patients. All providers are to be remunerated under a prospective payment system that offers a price per case treated, adjusted by the Market Forces Factor (MFF) to reflect geographical variation in specific input costs. This payment system presupposes that any remaining cost

differentials between providers result from inefficiencies. However, the validity of this assumption is unclear. This article describes the constraints that could cause public and private provider costs to differ for reasons outside their control. These constraints may be regulatory in nature, such as taxes and performance management regimens, or relate to the production process, such as input costs, the provision of emergency care, and case mix issues. Most of these exogenous cost differentials can be rectified by adjustments either to the regulatory system or to the payment method. However, differences in capital costs appear less tractable and further investigation into possible solutions is warranted

Tinghog, G., Carlsson, P., and Lyttkens, C. H. 2009 Individual responsibility for what? - A conceptual framework for exploring the suitability of private financing in a publicly funded health-care system. *Health Economics, Policy and Law* , 1-23.

<http://dx.doi.org/10.1017/S174413310999017X>

<http://pmid.us/19723367>

Policymakers in publicly funded health-care systems are frequently required to make intricate decisions on which health-care services to include or exclude from the basic health-care package. Although it seems likely that the concept of individual responsibility is an essential feature of such decisions, it is rarely explicitly articulated or evaluated in health policy. This paper presents a tentative conceptual framework for exploring when health-care services contain characteristics that facilitate individual responsibility through private financing. Six attributes for exploring the suitability of private financing for specific health-care commodities are identified: (i) it should enable individuals to value the need and quality both before and after utilization; (ii) it should be targeted toward individuals with a reasonable level of individual autonomy; (iii) it should be associated with low levels of positive externalities; (iv) it should be associated with a demand sufficient to generate a private market; (v) it should be associated with payments affordable for most individuals; and finally, (vi) it should be associated with 'lifestyle enhancements' rather than 'medical necessities'. The tentative framework enables exploration of individual responsibility connected to health care as a heterogeneous group of commodities, and allows policymakers to make decisions on rationing by design rather than default

Weale, A. and Clark, S. 2009 Co-payments in the NHS: an analysis of the normative arguments. *Health Economics, Policy and Law* , 1-22.

<http://dx.doi.org/10.1017/S1744133109990211>

<http://pmid.us/19723355>

During 2008, some forms of patient co-payments - in particular, patients paying privately for additional medicines as part of an episode of care in the National Health Service - became controversial in political and policy terms in the UK. In response, the UK Government published a report, the Richards' Review, examining the issues. Richards offered a particular policy solution, but also touched on fundamental principles of social value. Using the methods of normative policy analysis, we seek to understand these principles of social value, accepting the Richards' framework according to which the relevant arguments can be grouped under the broad headings of equity and autonomy. None of the arguments on either side are decisive, and, in part, the policy decision turns on uncertain empirical conjectures

HEALTH INEQUALITIES

Cooper, Z. N., et al 2009 Equity, waiting times, and NHS reforms: retrospective study. *British Medical Journal* 339, b3264. 3/09/2009

<http://dx.doi.org/10.1136/bmj.b3264>

<http://pmid.us/19729415>

Objective: To determine whether observable changes in waiting times occurred for certain key elective procedures between 1997 and 2007 in the English National Health Service and to analyse the distribution of those changes between socioeconomic groups as an indicator of equity. Design: Retrospective study of population-wide, patient level data using ordinary least squares regression to investigate the statistical relation between waiting times and patients' socioeconomic status. Setting: English NHS from 1997 to 2007. Participants: 427,277 patients who had elective knee replacement, 406,253 who had elective hip replacement, and 2,568,318 who had elective cataract repair. Main outcome measures: Days waited from referral for surgery to surgery itself; socioeconomic status based on Carstairs index of deprivation. Results: Mean and median waiting times rose initially and then fell steadily over time. By 2007 variation in waiting times across the population tended to be lower. In 1997 waiting times and deprivation tended to be positively related. By 2007 the relation between deprivation and waiting time was less pronounced, and, in some cases, patients from the most deprived fifth were waiting less time than patients from the most advantaged fifth. Conclusions: Between 1997 and 2007 waiting times for patients having elective hip replacement, knee replacement, and cataract repair in England went down and the variation in waiting times for those procedures across socioeconomic groups was reduced. Many people feared that the government's NHS reforms would lead to inequity, but inequity with respect to waiting times did not increase; if anything, it decreased. Although proving that the later

stages of those reforms, which included patient choice, provider competition, and expanded capacity, was a catalyst for improvements in equity is impossible, the data show that these reforms, at a minimum, did not harm equity:

De Vogli R., Gimeno, D., and Mistry, R. 2009 The policies-inequality feedback and health: the case of globalisation. *Journal of Epidemiology and Community Health* 63(9), 688-691.

<http://dx.doi.org/10.1136/jech.2008.081588>

<http://pmid.us/19414444>

Background: Major research contributions aimed at explaining the association between economic inequality and health have concentrated on the plausibility of the material deprivation and psychosocial factors pathways. However, little work has analysed the reciprocal associations between public policies and inequality and their effect on health. Methods: A conceptual framework was first proposed explaining how the public policies-inequality feedback can influence health outcomes via material deprivation and psychosocial factors. Then, a critical review of the literature was conducted and an analysis of the health effects of the globalisation-inequality feedback as a case study. Results: Different bodies of evidence seem to give support to the hypothesis of a public policies-inequality feedback influencing health-related outcomes. This seems to be particularly true when considering globalisation policies. Since the widespread adoption of the so-called "Washington Consensus", economic inequalities have sharply increased worldwide. The rise in inequality has, in turn, further consolidated the adoption of these policies through an increasing "democratic deficit". The reciprocal effects of globalisation and inequality have produced adverse health outcomes between and within societies through both material deprivation and psychosocial stress. Conclusions: Public policies and economic inequality are inextricably interrelated and can affect health through multiple, indirect, reciprocal pathways

Glazier, R. H., et al 2009 Universal health insurance and equity in primary care and specialist office visits: a population-based study. *Annals of Family Medicine* 7(5), 396-405.

<http://dx.doi.org/10.1370/afm.994>

<http://pmid.us/19752467>

Purpose: Universal coverage of physician services should serve to reduce socioeconomic disparities in care, but the degree to which a reduction occurs is unclear. We examined equity in use of physician services in Ontario, Canada, after controlling for health status using both self-reported and diagnosis-based measures. Methods: Ontario respondents to the 2000-2001 Canadian Community Health Survey (CCHS) were linked with physician claim files in 2002-2003 and 2003-2004. Educational attainment and income were based on self-report. The CCHS was used for self-reported health status and Johns Hopkins Adjusted Clinical Groups was used for diagnosis-based health status. Results: After

adjustment, higher education was not associated with at least 1 primary care visit (odds ratio [OR] = 1.05; 95% confidence interval [CI], 0.87-1.24), but it was inversely associated with frequent visits (OR = 0.77; 95% CI, 0.65-0.88). Higher education was directly associated with at least 1 specialist visit (OR = 1.20; 95% CI, 1.07-1.34), with frequent specialist visits (OR = 1.21; 95% CI, 1.03-1.39), and with bypassing primary care to reach specialists (OR = 1.23, 95% CI 1.02-1.44). The largest inequities by education were found for dermatology and ophthalmology. Income was not independently associated with inequities in physician contact or frequency of visits. Conclusions: After adjusting for health status, we found equity in contact with primary care for educational attainment but inequity in specialist contact, frequent visits, and bypassing primary care. In this setting, universal health insurance appears to be successful in achieving income equity in physician visits. This strategy alone does not eliminate education-related gradients in specialist care

Gregory, I. N. 2009 Comparisons between geographies of mortality and deprivation from the 1900s and 2001: spatial analysis of census and mortality statistics. *British Medical Journal* 339, b3454.

<http://dx.doi.org/10.1136/bmj.b3454>

<http://pmid.us/19744974>

Objectives: To examine the geographical relation between mortality and deprivation in England and Wales at the start of the 20th and 21st centuries. To explore the evidence for a strengthening or weakening of this relation over the century and test for relations between the mortality and deprivation patterns of a century ago and modern mortality and causes of death. Design: Census and mortality data for 634 districts from the 1900s directly compared with interpolated ward level data from 2001. Setting: Census data and national statistics for England and Wales in the 1900s and 2001. Population Entire population in both periods. Main outcome measures: Standardised mortality ratios for all districts for both periods with additional cause specific ratios calculated for 2001. Deprivation (Carstairs) scores for each district in 2001, with comparable measure created for the 1900s. Correlations and partial correlations between deprivation scores and standardised mortality ratios in the 1900s and 2001 for the 614 districts for which all data were available. Results: There was no evidence of a significant change in the strength of the relation between deprivation and mortality between the start and end of the 20th century. Modern patterns of mortality and deprivation remain closely related to the patterns of a century ago. Even after adjustment for modern deprivation, standardised mortality ratios from the 1900s show a significant correlation with modern mortality and most modern causes of death. Conversely, however, there was no significant relation between deprivation in the 1900s and modern mortality for most causes of death after adjustment for modern deprivation. Conclusions: Despite all the medical, public health, social, economic, and political changes over the 20th century, patterns of poverty and mortality and the relations between them remain firmly entrenched. There is a strong relation between the mortality levels of a century ago and those of today. This goes

beyond what would have been expected from the continuing relation between deprivation and mortality and holds true for most major modern causes of death

Smith, S. 2009 Equity in Irish health care financing: measurement issues. *Health Economics, Policy and Law* , 1-21.

<http://dx.doi.org/10.1017/S1744133109990168>

<http://pmid.us/19723353>

This paper employs widely used analytic techniques for measuring equity in health care financing to update Irish results from previous analysis based on data from the late 1980s. Kakwani indices are calculated using household survey data from 1987/88 to 2004/05. Results indicate a marginally progressive financing system overall. However, interpretation of the results for the private sources of health financing is complicated. This problem is not unique to Ireland but it is argued that it may be relatively more important in the context of a complex health financing system, illustrated in this paper by the Irish system. Alternative options for improving the analysis of equity in health care financing are discussed

HEALTH POLICY

Coleman A et al. (2009) Local histories and local sensemaking: a case of policy implementation in the English National Health Service. *Policy and Politics* . Epub ahead of publication. 25/09/2009

<http://dx.doi.org/10.1332/030557309X462547>

Central policies that are only loosely specified might be expected to result in local variations in interpretation and implementation, and practice-based commissioning in the English National Health Service (NHS) is no exception. We show how local 'sensemaking' in relation to this policy has been influenced by local histories and by conceptual schemata derived from earlier reorganisations of the NHS. Changes to organisational formalities do not necessarily, therefore, result in reappraisals of sensemaking on the part of local actors. We also employ our data to address issues raised by commentators critical of the way the concept of sensemaking has been previously employed.

Hunter, D. J. 2009 Relationship between evidence and policy: A case of evidence-based policy or policy-based evidence? *Public Health* 123(9), 583-586.

<http://dx.doi.org/10.1016/j.puhe.2009.07.011>

<http://pmid.us/19748107>

The use (or non-use) of evidence in health policy is an issue of growing interest and concern among both academic researchers and policy makers. Most public health research is government funded, yet the extent to which its findings are used to shape and inform policy is variable in the extreme. Part of the problem lies in the nature of the evidence itself and the extent to which it addresses the complexities of the issue being researched. However, part of it also lies in the way that evidence gets communicated and transmitted to those intended to benefit from, or act on, it. This paper reviews such matters and argues in favour of research that is more attuned to the needs of policy makers and practitioners. To achieve this, a paradigm shift is needed in the way in which research is produced and consumed. Rather than academics exclusively setting the agenda, a new approach to knowledge co-creation is overdue whereby researchers, and those they are seeking to address, work together to define the research questions, agree the methods, and assess the implications of the data analysis and findings for policy and practice

Hunter, D. J. 2009 The case against choice and competition. *Health Economics Policy and Law* 4(Pt 4), 489-501.

<http://dx.doi.org/10.1017/S1744133109990089>:

<http://pmid.us/19715630>

Choice and competition are central planks of the English government's health reforms and modernisation programme. Wales and Scotland have chosen a different path, which calls into question the suggestion that in an age of consumerism there is no other way to secure overdue changes in the provision and management of health care to improve their quality and responsiveness to user preferences. Yet pro-market enthusiasts pursue their agenda in the face of evidence that calls into question the claims they make. It is a curious position for a government that is wedded to evidence-based policy to find itself in. The policy puzzle is why, despite the contested nature of the alleged virtues of choice and competition, policy-makers persist with introducing a set of reforms which appear to threaten the very values and principles they profess to uphold. An alternative reform paradigm exists which acknowledges what makes public services public. This paper sets out the key features of what rediscovering public service entails adopting the notion of co-production as a means of bringing about a new relationship between professionals and the public that remains true to the National Health Service's social purpose

INFORMATION AND COMMUNICATIONS TECHNOLOGY

Bostock, Yvonne, et al 2009 The acceptability to patients and professionals of remote blood pressure monitoring using mobile phones. *Primary Health Care Research & Development* 10(04), 299-308.

<http://dx.doi.org/10.1017/S1463423609990107>

Aim To establish the acceptability of telemetric monitoring of blood pressure to patients and clinicians. **Background** Telemetric monitoring of blood pressure (BP) may allow clinicians and patients, in partnership, to more quickly control high BP through medication and lifestyle alterations. However, it is not clear if patients and clinicians would find such a system acceptable. **Methods** Questionnaire study followed by focus groups of patients with high BP, and clinicians involved in managing BP. **Findings** We received responses from 25 (50%) practice nurses, 76 (50%) general practitioners and 126 (62%) patients. We ran three focus groups of patients and clinicians. Participants were supportive of the technology, willing to try it, thought it would encourage adherence to medication and lifestyle and felt it would diagnose problems sooner than current methods. However, both groups thought the technology would be more useful for new patients or those whose BP was uncontrolled. They were concerned that individual high readings might provoke anxiety and thought patients would need reassurances about this. Clinicians were concerned about workload and the responsibility to act immediately when faced with a continuous stream of readings, regardless of how inconvenient this may be. **Conclusion** Participants, in general, welcomed this technology and thought it would aid adherence to medication and lifestyle advice, but felt it was most suitable to those with newly diagnosed or uncontrolled hypertension. Patients will need to be educated and reassured about the nature of occasional high readings and the need to consider average BP

Fourie, I. 2009 Learning from research on the information behaviour of healthcare professionals: a review of the literature 2004-2008 with a focus on emotion. *Health Information and Libraries Journal* 26(3), 171-186.

<http://dx.doi.org/10.1111/j.1471-1842.2009.00860.x>

<http://pmid.us/19712210>

Objective: A review, focusing on emotion, was conducted of reported studies on the information behaviour of healthcare professionals (2004-2008). Findings were intended to offer guidelines on information services and information literacy training, to note gaps in research and to raise research interest. **Method:** Databases were searched for literature published from January 2004 to December 2008 and indexed on eric, Library and Information Science Abstracts, medline, PsycINFO, Social Services Abstracts, Sociological Abstracts, Health Source: Nursing/Academic Edition; Library, Information Science & Technology Abstracts; Psychology and Behavioral Sciences Collection; Social Work Abstracts; SocINDEX with Full Text; SPORTDiscus; cinhal; and the ISI Web of Knowledge databases. Key journals were manually scanned and citations followed. Literature was included if reporting on issues concerning emotion. **Results:** Emotion in

information behaviour in healthcare contexts is scantily addressed. This review, however, offers some insight into the difficulty in identifying and expressing information needs; sense making and the need to fill knowledge gaps; uncertainty; personality and coping skills; motivation to seeking information; emotional experiences during information seeking; self-confidence and attitude; emotional factors in the selection of information channels; and seeking information for psychological or emotional reasons. Conclusion: Suggestions following findings, address information literacy programs, information services and research gaps

Gray, Nicola, et al 2009 Evaluation of the community pharmacy element of an information prescriptions pilot. *Primary Health Care Research & Development* 10(04), 332-342.

<http://dx.doi.org/10.1017/S1463423609990181>

Aim The aim of this paper is to describe the experience of community pharmacists participating in a pilot of an information prescription service aimed at children and their parents, in the wider context of factors relevant to the adoption of new services in community pharmacies. **Background** Information prescriptions (IP) are conceived to signpost patients to information and advice that will increase self-efficacy. The Department of Health for England has supported IP development with a national programme of pilots, only one of which incorporated distribution of IP through community pharmacies. The new contract for community pharmacy, implemented in 2005, formalized cognitive services, including information-giving about medicines and health, and positioned signposting as a core activity. There are, however, concerns about the impact of such services on the capacity of community pharmacy. **Methods** Qualitative semi-structured telephone interviews were conducted with key informants: seven pharmacists in four IP pilot community pharmacies in England (), and 22 other pharmacy and medicines information stakeholders. Two interviews were conducted with each IP pilot pharmacist (before and during the pilot), and one with all other stakeholders. **Findings** IP pharmacists, and other stakeholders, identified a number of benefits for parents of children with long-term conditions in receiving IP, and hoped that most parents would welcome the service. Many anticipated operational challenges consistent with those of other new cognitive community pharmacy services, such as medicines use review. Pharmacists completing IP for parents found it satisfying and straightforward. Recruitment of parents to the pilot, however, fell below IP pharmacists condition, was both surprising and disappointing to them. IP should be integrated into a wider, integrated medicines and information strategy

Hivert, M.F., et al (2009). Identifying primary care patients at risk for future diabetes and cardiovascular disease using electronic health records. *BMC Health Services Research* 9 170.

<http://dx.doi.org/10.1186/1472-6963-9-170>

<http://pmid.us/19772639>

Background: Prevention of diabetes and coronary heart disease (CHD) is possible but identification of at-risk patients for targeting interventions is a challenge in primary care. Methods: We analyzed electronic health record (EHR) data for 122,715 patients from 12 primary care practices. We defined patients with risk factor clustering using metabolic syndrome (MetS) characteristics defined by NCEP-ATPIII criteria; if missing, we used surrogate characteristics, and validated this approach by directly measuring risk factors in a subset of 154 patients. For subjects with at least 3 of 5 MetS criteria measured at baseline (2003-2004), we defined 3 categories: No MetS (0 criteria); At-risk-for MetS (1-2 criteria); and MetS (≥ 3 criteria). We examined new diabetes and CHD incidence, and resource utilization over the subsequent 3-year period (2005-2007) using age-sex-adjusted regression models to compare outcomes by MetS category. Results: After excluding patients with diabetes/CHD at baseline, 78,293 patients were eligible for analysis. EHR-defined MetS had 73% sensitivity and 91% specificity for directly measured MetS. Diabetes incidence was 1.4% in No MetS; 4.0% in At-risk-for MetS; and 11.0% in MetS ($p < 0.0001$ for trend; adjusted OR MetS vs No MetS = 6.86 [6.06-7.76]); CHD incidence was 3.2%, 5.3%, and 6.4% respectively ($p < 0.0001$ for trend; adjusted OR = 1.42 [1.25-1.62]). Costs and resource utilization increased across categories ($p < 0.0001$ for trends). Results were similar analyzing individuals with all five criteria not missing, or defining MetS as ≥ 2 criteria present. Conclusion: Risk factor clustering in EHR data identifies primary care patients at increased risk for new diabetes, CHD and higher resource utilization

Segal, Judy Z. (2009) Internet health and the 21st-century patient: a rhetorical view. *Written Communication* 26(4), 351-369. 1-10-2009.

<http://dx.doi.org/10.1177/0741088309342362>

Internet health--here, the public use of information Web sites to facilitate decision making on matters of health and illness--is a rhetorical practice, involving text and trajectories of influence. A fulsome account of it requires attention to all parts of the rhetorical triangle--the speaker, the subject matter, and the audience--yet most scholarship on Internet health focuses on the speaker only: it typically raises concerns primarily about the dangers of unreliable sources, suggesting that, where speakers are reliable and information is accurate, Internet health simply empowers patients. This essay turns attention to the other elements of the triangle. It argues that health information is a complex entity--not only transmitted but also transformed by the Web--and, further, that Internet-health users are a complex audience--not only informed but also transformed by the Web. Rhetorically-minded researchers are well positioned to study not simply the informed patient but rather, more comprehensively, the wired one

Williams, B., et al 2009 Developing a longitudinal database of routinely recorded primary care consultations linked to service use and outcome data. *Social Science and Medicine* . 4-11-2009.

<http://dx.doi.org/10.1016/j.socscimed.2009.10.025>

<http://pmid.us/19896255>

The primary care consultation provides access to the majority of health care services and is central to obtaining diagnoses, treatment and ongoing management of long-term conditions. This paper reports the findings of an interdisciplinary feasibility study to explore the benefits and practical, technical and ethical challenges (and solutions) of creating a longitudinal database of recorded GP consultations in Tayside, Scotland which could be linked to existing routine data on intermediate and long-term health outcomes. After consultation we attempted to recruit and audio-record the consultations of all patients attending three general practices over a two week period. Background patient data, and patient and staff experiences of participation were also collected. Eventually, two practices participated with 77% of patients approached agreeing to participate. The findings suggest that the perceived integrity of the consultation was preserved. The overwhelming majority of patients believed that recording was worthwhile and did not feel it impacted on communication or the treatment they received; 93% indicated they would be willing to have subsequent consultations recorded and 81% would recommend participation to a friend. Staff had similar beliefs but raised concerns about potential increases in workload, confidentiality issues and ease of software use. We conclude that practice participation could be increased by providing safeguards on data use, financial reward, integrated recording software, and procedures to lessen the impact on workload. The resulting Scottish Clinical Interactions Project (SCIP) would provide the largest and most detailed longitudinal insight into real world medical consultations in the world, permitting the linking of consultation events and practices to subsequent outcomes and behaviours

MEDICINES MANAGEMENT

Garfield, S et al Quality of medication use in primary care - mapping the problem, working to a solution: a systematic review of the literature. *BMC Medicine* 7(1), 50. 2009.

<http://dx.doi.org/10.1186/1741-7015-7-50>

<http://www.biomedcentral.com/1741-7015/7/50>

<http://pmid.us/19772551>

Background: The UK, USA and the World Health Organization have identified improved patient safety in healthcare as a priority. Medication error has been identified as one of the most frequent forms of medical error and is associated with significant medical

harm. Errors are the result of the systems that produce them. In industrial settings, a range of systematic techniques have been designed to reduce error and waste. The first stage of these processes is to map out the whole system and its reliability at each stage. However, to date, studies of medication error and solutions have concentrated on individual parts of the whole system. In this paper we wished to conduct a systematic review of the literature, in order to map out the medication system with its associated errors and failures in quality, to assess the strength of the evidence and to use approaches from quality management to identify ways in which the system could be made safer. Methods: We mapped out the medicines management system in primary care in the UK. We conducted a systematic literature review in order to refine our map of the system and to establish the quality of the research and reliability of the system. Results: The map demonstrated that the proportion of errors in the management system for medicines in primary care is very high. Several stages of the process had error rates of 50% or more: repeat prescribing reviews, interface prescribing and communication and patient adherence. When including the efficacy of the medicine in the system, the available evidence suggested that only between 4% and 21% of patients achieved the optimum benefit from their medication. Whilst there were some limitations in the evidence base, including the error rate measurement and the sampling strategies employed, there was sufficient information to indicate the ways in which the system could be improved, using management approaches. The first step to improving the overall quality would be routine monitoring of adherence, clinical effectiveness and hospital admissions. Conclusion: By adopting the whole system approach from a management perspective we have found where failures in quality occur in medication use in primary care in the UK, and where weaknesses occur in the associated evidence base. Quality management approaches have allowed us to develop a coherent change and research agenda in order to tackle these, so far, fairly intractable problems

Haslbeck, Jorg W. and Schaeffer, Doris. 2009 Routines in medication management: the perspective of people with chronic conditions. *Chronic Illness* 5(3), 184-196.

<http://dx.doi.org/10.1177/1742395309339873>

<http://pmid.us/19656813>

Objective: To focus on the challenges and problems of medication management in everyday life experienced by people with chronic conditions, giving special attention to chronic illness trajectories. Methods: Using a grounded theory approach, in-depth and follow-up interviews with 27 chronically ill people were conducted and analysed. Results: From the perspective of people with chronic conditions, the main challenge in everyday medication management was to develop, maintain, and adjust routines. Routines were affected by the chronic illness trajectory and a variety of barriers. Developing and adjusting routines was further complicated by inadequate information and counselling, asymmetric relationships and communication with healthcare professionals, restrictive healthcare conditions, increasing complexities in medication regimens as well as healthcare professionals' lack of interest in the problems of chronically ill people balancing their chronic condition and medication regimen in

everyday life. Discussion: Chronically ill persons have to deal with numerous difficulties in everyday medication management on their own. They are often overwhelmed by problems related to both their medication regimen and their routines in medication (self-) management. Thus, they require individualized long-term self-management support. Future research should address the dynamic nature of chronic illness trajectories and focus on later phases of chronic conditions

Sheaff, R. O. D. Medicine and Management in English Primary Care: A Shifting Balance of Power? *Journal of Social Policy* 38(04), 627-647.

<http://dx.doi.org/10.1017/S0047279409990183>

The English NHS has been repeatedly restructured since 1991. Drawing on multiple case studies in English primary health care from 1998 to 2005 and on (other) published studies, this article uses Therborn's theory of power to make a framework analysis of how these reforms redistributed power between medicine and management in NHS primary care. Legal changes ended the GP monopoly of primary medical care provision and, with greater managerial discretion in NHS spending, allowed more diverse organisational forms of primary care provision to appear, although general practice remained predominant. Changes in managerial and professional ideologies relaxed the restrictions on managerial decisions about general practice. Re-negotiations between the medical profession and the state mostly tended to increase managerial power. Evidence-based medicine has tended to weaken the impersonal sources of medical power. On balance, these events have tended to increase managerial power over medical practice. They also suggest adjustments to Therborn's conceptualisation of power

Wagner, A., et al (2009). Equity in the distribution of community pharmacies in England: impact of regulatory reform. *Journal of Health Services Research and Policy* 14(4), 243-248.

<http://dx.doi.org/10.1258/jhsrp.2009.008167>

<http://pmid.us/19770123>

Objectives: To examine whether relaxation of control of entry regulations for community pharmacy contracts in England, introduced in 2005, affected the distribution of

community pharmacies relative to population need indicators. Methods: Community pharmacy locations and population need indicators were used to calculate three summary measures of distributional equity across Primary Care Trust (PCT) areas (n = 152): the Gini coefficient, Atkinson Index and community pharmacies per PCT population. The indicators were adjusted for need using data from NHS GP contract Quality and Outcomes Framework disease registers, deprivation, all-cause mortality and elderly population rates. Results: Numbers of community pharmacies increased by 397 (4%) between 2005 and 2007 with three supermarket chains accounting for 152 (38%) of new pharmacies. Over one-quarter of PCTs experienced increases of 5% or more in community pharmacies per capita between 2005 and 2007. Gini and Atkinson indicators showed small increases in distributional equity across all population needs indicators. Conclusion: Deregulation was associated with more community pharmacies per capita and a small increase in geographic equity of community pharmacy distribution at PCT level. Future research should continue to monitor how pharmacy distribution changes over time and assess the extent to which the new regulatory framework has allowed clustering of pharmacies which could result in increased inequity below PCT level

MENTAL HEALTH

Gensichen,J., et al (2009). Case management for depression by health care assistants in small primary care practices: a cluster randomized trial. *Annals of Internal Medicine* 151(6), 369-378.

<http://pmid.us/19755362>

Background: Case management by health care assistants in small primary care practices provides unclear benefit for improving depression symptoms. Objective: To determine whether case management provided by health care assistants in small primary care practices is more effective than usual care in improving depression symptoms and process of care for patients with major depression. Design: Cluster randomized, controlled trial. A central automated system generated the randomization scheme, which was stratified by urban and rural practices; allocation sequence was concealed until groups were assigned. Setting: 74 small primary care practices in Germany from April 2005 to September 2007. Patients: 626 patients age 18 to 80 years with major depression. Intervention: Structured telephone interview to monitor depression symptoms and support for adherence to medication, with feedback to the family physician. Measurements: Depression symptoms at 12 months, as measured by the Patient Health Questionnaire-9 (PHQ-9); secondary outcomes were patient assessment of chronic illness

care, adherence to medication, and quality of life. Results: A total of 310 patients were randomly assigned to case management and 316 to usual care. At 12 months, 249 intervention recipients and 278 control patients were assessed; 555 patients were included in a modified intention-to-treat-analysis (267 intervention recipients vs. 288 control patients). Compared with control patients, intervention recipients had lower mean PHQ-9 values in depression symptoms (-1.41 [95% CI, -2.49 to -0.33]; P = 0.014), more favorable assessments of care (3.41 vs. 3.11; P = 0.011), and increased treatment adherence (2.70 vs. 2.53; P = 0.042). Quality-of-life scores did not differ between groups. Limitation: Patients, health care assistants, family physicians, and researchers were not blinded to group assignment, and 12-month follow-up of patients was incomplete. Conclusion: Case management provided by primary care practice-based health care assistants may reduce depression symptoms and improve process of care for patients with major depression more than usual care.

Giron, Manuel, et al Self-reported chronic mental health problems and mental health service use in Spain. *Chronic Illness* 5(3), 197-208.

<http://dx.doi.org/10.1177/1742395309341901>

<http://pmid.us/19666955>

Objectives: To determine the prevalence of self-reported chronic mental health problems (MHPs) and mental health service use and their determinants, among the Spanish population over 14 years of age. Methods: Data from the 1999 Spanish Survey on Disabilities, Deficiencies, and State of Health were used. The survey is a cross-sectional study based on a multi-stage stratified sample of all the non-institutionalized Spanish population aged over 14 years (n=59,101, 11% non-responders). Multivariate logistic regression analysis were used. Results: 10.7% of the Spanish population suffer from an MHP. The highest prevalences were found in women, divorced/separated persons, those with a lower level of education and income, and those suffering from a chronic somatic problem. The number of days of daily activity lost was 2-fold greater among those with an MHP than among those with a chronic somatic problem. Greater use of mental health services was associated with loss of daily activity, having a higher level of education, invalidity or disability. The probability of MHP being referred from primary to mental healthcare is reduced if somatic comorbidity is present. Conclusion: MHPs have a high prevalence and a significant repercussion on the patient's life. An inverse relationship was found between certain risk factors for MHPs and the use of services, which suggests inequality. Problems of accessibility are identified

Hodge,S.M. (2009). User involvement in the construction of a mental health charter: an exercise in communicative rationality? *Health Expectations.*, 12(3), 251-261.

<http://dx.doi.org/10.1111/j.1369-7625.2009.00561.x>

<http://pmid.us/19754689>

Background: This paper uses Jurgen Habermas's Theory of Communicative Action as a lens through which to examine the development of a local mental health charter. Objective: To assess whether the Charter represents the product of a communicatively rational process. Research design and setting: The paper is based on an analysis of the text of the Charter, and on documentation relating to its development, including notes of discussion groups used to identify its themes. Findings: An analysis of the notes of the discussion groups against the text of the Charter shows that the Charter's themes are based broadly on the views generated in the discussion groups. However, they also draw on norms derived from wider discourses not reflected in the discussion groups, and exclude other specific local issues. The strength of feeling expressed in the discussion groups is also toned down in the language of the Charter. Discussion: The development of the Charter was based on a participatory process that can be said to have contained elements of both communicative and strategic rationality. The strategic rationality involved in translating service users' views into language that would be acceptable to those working in the system can be seen as necessary for the Charter to succeed in bringing about change. In drawing also on communicatively generated norms from the wider public sphere the Charter can be seen as reflecting a form of generalized communicative rationality. Conclusion: The Charter represents a 'sluice' by which communicative rationality is drawn into the mental health system

Kessler,D., et al (2009). Therapist-delivered internet psychotherapy for depression in primary care: a randomised controlled trial. *The Lancet*, 374(9690), 628-634.

[http://dx.doi.org/10.1016/S0140-6736\(09\)61257-5](http://dx.doi.org/10.1016/S0140-6736(09)61257-5)

<http://pmid.us/19700005>

Summary Background Despite strong evidence for its effectiveness, cognitive-behavioural therapy (CBT) remains difficult to access. Computerised programs have been developed to improve accessibility, but whether these interventions are responsive to individual needs is unknown. We investigated the effectiveness of CBT delivered online in real time by a therapist for patients with depression in primary care. Methods In this multicentre, randomised controlled trial, 297 individuals with a score of 14 or more on the Beck depression inventory (BDI) and a confirmed diagnosis of depression were recruited from 55 general practices in Bristol, London, and Warwickshire, UK. Participants were randomly assigned, by a computer-generated code, to online CBT in addition to usual care (intervention; n=149) or to usual care from their general practitioner while on an 8-month waiting list for online CBT (control; n=148). Participants, researchers involved in recruitment, and therapists were masked in advance to allocation. The primary outcome was recovery from depression (BDI score <10) at 4 months. Analysis was by intention to treat. This trial is registered, number ISRCTN 45444578. Findings 113 participants in the intervention group and 97 in the control group completed 4-month follow-up. 43 (38%) patients recovered from depression (BDI score <10) in the intervention group versus 23 (24%) in the control group at 4 months (odds ratio 2.39, 95% CI 1.23-4.67; p=0.011), and 46 (42%) versus 26 (26%) at 8 months (2.07, 1.11-3.87; p=0.023). Interpretation CBT seems to be effective when delivered

online in real time by a therapist, with benefits maintained over 8 months. This method of delivery could broaden access to CBT.

Konig, H. H., et al (2009) Cost-effectiveness of a primary care model for anxiety disorders. *British Journal of Psychiatry* 195(4), 308-317.

<http://dx.doi.org/10.1192/bjp.bp.108.058032>

<http://pmid.us/19794198>

Background: Individuals with anxiety disorders often do not receive an accurate diagnosis or adequate treatment in primary care. Aims: To analyse the cost-effectiveness of an optimised care model for people with anxiety disorders in primary care. METHOD: In a cluster randomised controlled trial, 46 primary care practices with 389 individuals positively screened with anxiety were randomised to intervention (23 practices, 201 participants) or usual care (23 practices, 188 participants). Physicians in the intervention group received training on diagnosis and treatment of anxiety disorders combined with the offer of a psychiatric consultation-liaison service for 6 months. Anxiety, depression, quality of life, service utilisation and costs were assessed at baseline, 6-month and 9-month follow-up. Results: No significant differences were observed between intervention and control group on the Beck Anxiety Inventory, Beck Depression Inventory and EQ-5D during follow-up. Total costs were higher in the intervention group (euro4911 v. euro3453, P = 0.09). The probability of an incremental cost-effectiveness ratio <euro50 000 per quality-adjusted life year was below 10%. Conclusions: The optimised care model did not prove to be cost-effective

Martin-Merino, E. et al 2009 . Prevalence, incidence, morbidity and treatment patterns in a cohort of patients diagnosed with anxiety in UK primary care. *Family Practice* 1-11-2009. Epub ahead of print

<http://dx.doi.org/10.1093/fampra/cmp071>

<http://pmid.us/19884124>

Background: Anxiety disorders are common and can cause substantial quality of life impairment. Objective: The aim of this study was to investigate the frequency of anxiety in UK primary care. Treatment patterns and factors associated with an anxiety diagnosis were also assessed. Methods: The Health Improvement Network was used to identify all patients aged 10-79 years with a new diagnosis of anxiety in 2002-04 (n = 40 873) and age-, sex- and calendar-year-matched controls (n = 50 000). A nested case-control analysis was used to quantify potential risk factors for anxiety by multivariate logistic regression. Results: The prevalence of anxiety was 7.2% and the incidence was 9.7 per 1000 person-years. Incidence and prevalence were highest in women and young adults (20-29 years). Anxiety was associated with heavy alcohol use, smoking and addiction problems as well as stress, sleep and depression disorders. Anxiety patients used health care services more frequently than controls. Among patients diagnosed with anxiety, 63% were treated pharmacologically. Antidepressants accounted for almost 80% of

prescriptions. Conclusions: The prevalence and incidence of anxiety are high in UK primary care and are almost twice as high in women than in men. Anxiety is associated with other psychiatric morbidity as well as frequent health care use. Antidepressants are the most commonly used pharmacological treatment

Mitchell,A.J., Vaze,A., & Rao,S. (2009). Clinical diagnosis of depression in primary care: a meta-analysis. *The Lancet*, 374(9690), 609-619 22/08/2009

[http://dx.doi.org/10.1016/S0140-6736\(09\)60879-5](http://dx.doi.org/10.1016/S0140-6736(09)60879-5)

<http://pmid.us/19640579>

Summary Background Depression is a major burden for the health-care system worldwide. Most care for depression is delivered by general practitioners (GPs). We assessed the rate of true positives and negatives, and false positives and negatives in primary care when GPs make routine diagnoses of depression. Methods We undertook a meta-analysis of 118 studies that assessed the accuracy of unassisted diagnoses of depression by GPs. 41 of these studies were included because they had a robust outcome standard of a structured or semi-structured interview. Findings 371 patients were pooled across 41 studies and examined. GPs correctly identified depression in 47+3% (95% CI 41+7% to 53+0%) of cases and recorded depression in their notes in 33+6% (22+4% to 45+7%). 19 studies assessed both rule-in and rule-out accuracy; from these studies, the weighted sensitivity was 50+1% (41+3% to 59+0%) and specificity was 81+3% (74+5% to 87+3%). At a rate of 21+9%, the positive predictive value was 42+0% (39+6% to 44+3%) and the negative predictive value was 85+8% (84+8% to 86+7%). This finding suggests that for every 100 unselected cases seen in primary care, there are more false positives (n=15) than either missed (n=10) or identified cases (n=10). Accuracy was improved with prospective examination over an extended period (3-12 months) rather than relying on a one-off assessment or case-note records. Interpretation GPs can rule out depression in most people who are not depressed; however, the modest prevalence of depression in primary care means that misidentifications outnumber missed cases. Diagnosis could be improved by re-assessment of individuals who might have depression.

Richards, D. A., et al 2009 Collaborative Depression Trial (CADET): multi-centre randomised controlled trial of collaborative care for depression--study protocol. *BMC Health Services Research* 9, 188.

<http://dx.doi.org/10.1186/1472-6963-9-188>

<http://www.biomedcentral.com/1472-6963/9/188>

<http://pmid.us/19832996>

Background: Comprising of both organisational and patient level components, collaborative care is a potentially powerful intervention for improving depression treatment in UK primary Care. However, as previous models have been developed and evaluated in the United States, it is necessary to establish the effect of collaborative care in the UK in order to determine whether this innovative treatment model can replicate benefits for patients outside the US. This Phase III trial was preceded by a Phase II patient level RCT, following the MRC Complex Intervention Framework. Methods/design: A multi-centre controlled trial with cluster-randomised allocation of GP practices. GP practices will be randomised to usual care control or to "collaborative care" - a combination of case manager coordinated support and brief psychological treatment, enhanced specialist and GP communication. The primary outcome will be symptoms of depression as assessed by the PHQ-9. Discussion: If collaborative care is demonstrated to be effective we will have evidence to enable the NHS to substantially improve the organisation of depressed patients in primary care, and to assist primary care providers to deliver a model of enhanced depression care which is both effective and acceptable to patients:

Roca, M. et al Prevalence and comorbidity of common mental disorders in primary care. *Journal of Affective Disorders*, Epub ahead of print 09/04/2009

<http://dx.doi.org/10.1016/j.jad.2009.03.014>

<http://pmid.us/19361865>

Objective To estimate the prevalence and comorbidity of the most common mental disorders in primary care practice in Spain, using the Primary Care Evaluation of Mental Disorders (PRIME-MD) questionnaire. Design A systematic sample of 7936 adult primary care patients was recruited by 1925 general practitioners in a large cross-sectional national epidemiological study. The PRIME-MD was used to diagnose psychiatric disorders. Setting 1356 primary care units proportionally distributed throughout the country. Results 53.6% of the sample presented one or more psychiatric disorder. The most prevalent were affective (35.8%), anxiety (25.6%), and somatoform (28.8%) disorders. 30.3% of the patients had more than one current mental disorder. 11.5% presented comorbidity between affective, anxiety, and somatoform disorders. Conclusions The study provides further evidence of the high prevalence and high comorbidity of mental disorders in primary care. Given the large overlap between affective, anxiety and somatoform disorders, future diagnostic classifications should reconsider the current separation between these entities

Simon, G. E., Ludman, E. J., and Rutter, C. M. (2009) Incremental benefit and cost of telephone care management and telephone psychotherapy for depression in primary care. *Archives of General Psychiatry* 66(10), 1081-1089.

<http://dx.doi.org/10.1001/archgenpsychiatry.2009.123>

<http://pmid.us/19805698>

Context: Effectiveness of organized depression care programs is well established, but dissemination will depend on the balance of benefits and costs. Objectives: To estimate the incremental benefit, incremental cost, and net benefit of 2 depression care programs. Design: Randomized trial comparing 2 interventions with continued usual care, conducted between November 2000 and June 2004. Setting: Seven primary care clinics of a prepaid health care plan in Washington. Participants: Consecutive primary care patients starting antidepressant treatment were invited to a telephone assessment 2 weeks later. Of 634 patients with significant depressive symptoms, 600 consented and were randomized. Interventions: The telephone care management intervention included up to 5 outreach calls for monitoring and support, feedback to treating physicians, and care coordination. The care management plus telephone psychotherapy intervention added an 8-session structured cognitive behavioral therapy program with up to 4 additional calls for reinforcement. Main outcome measures: Independent, blinded telephone assessments at 1, 3, 6, 9, 12, and 18 months included the Symptom Checklist 90 depression scale. Health services costs were measured using health care plan accounting records. Results: Over 24 months, telephone care management led to a gain of 29 depression-free days (95% confidence interval, -6 to +63) and a \$676 increase in outpatient health care costs (95% confidence interval, \$596 lower to \$1974 higher). The incremental net benefit was negative even if a day free of depression was valued up to \$20. Care management plus psychotherapy led to a gain of 46 depression-free days (95% confidence interval, +12 to +80) and a \$397 increase in outpatient costs (95% confidence interval, \$882 lower to \$1725 higher). The incremental net benefit was positive if a day free of depression was valued at \$9 or greater. Conclusion: Compared with current primary care practice, a structured telephone program including care management and cognitive behavioral psychotherapy has significant clinical benefit with only a modest increase in health services cost

Vuorilehto, M. S., Melartin, T. K., and Isomets, E. T. 2009 Course and outcome of depressive disorders in primary care: a prospective 18-month study. *Psychological Medicine* 39(10), 1697-1707.

<http://dx.doi.org/10.1017/S0033291709005182>

<http://pmid.us/19250580>

Background Depressive disorders are known to often be chronic and recurrent both in the general population and in psychiatric settings. However, despite its importance for public health and services, the outcome of depression in primary care is not well known. Method In The Vantaa Primary Care Depression Study (PC-VDS), 1111 consecutive primary-care patients were screened for depression with the Prime-MD screen, and 137 diagnosed with DSM-IV depressive disorders by interviewing with the Structured Clinical Interview for DSM-IV (SCID)-I/P and SCID-II. This cohort was prospectively followed-up at 3, 6 and 18 months. Altogether 123 patients (90%) completed the 18-month follow-up, including 79 with major depressive disorder (MDD) and 44 with subsyndromal disorders. Duration of the index episode and the timing of relapses/recurrences were examined using a life-chart. Results Of the patients with MDD,

only a quarter [25% (20/79)] achieved and remained in full remission, while another quarter [25% (20/79)] persisted in major depressive episode for 18 months. The remaining 49% (39/79) suffered from residual symptoms or recurrences. In Cox regression models, time to remission and recurrences were robustly predicted by severity of depression, and less consistently by co-morbid substance-use disorder, chronic medical illness or cluster C personality disorder. Of the subsyndromal patients, 25% (11/44) proceeded to MDD. Conclusions This prospective medium-term study verified the high rate of recurrences and chronicity of depression also in primary care. Severity of depressive symptoms and co-morbidity are important predictors of outcome. Development of chronic disease management for depression is warranted in primary care

Yiend, J., et al (2009). Long term outcome of primary care depression. *Journal of Affective Disorders*, 118(1-3), 79-86.

<http://dx.doi.org/10.1016/j.jad.2009.01.026>

<http://pmid.us/19246103>

We conducted a follow up over 23 years of depressed patients originally presenting to general practice in 1981 and studied in detail at that time. Aims were to assess the long term course and outcome of depression in primary care. Patterns of recovery and recurrence of major depressive episodes, together with other aspects of course, treatment and current state, were assessed at interview. 78% (129) of the original sample were traced to current general practice and outcome data obtained on 54. One third had a prior history of depression. Interview data were obtained on 37 patients. Time to recovery from baseline averaged 10.3 months. The recurrence rate was 64% (23). Most participants suffered at least 2 further episodes that were frequently chronic lasting 2 years on average. Time before first recurrence appeared considerably longer than in comparable psychiatric inpatient samples. No participants were continuously ill. Although loss to follow up limits our conclusions, the course of primary care depression appears worse than suggested by previous, shorter follow ups. Our data suggest that long term risk of a recurrence may be high, but with recurrence delayed

PATIENT AND PUBLIC INVOLVEMENT

Barnes, M., & Coelho, V.S. (2009). Social participation in health in Brazil and England: inclusion, representation and authority. *Health Expectations*, 12(3), 226-236.

<http://dx.doi.org/10.1111/j.1369-7625.2009.00563.x>

<http://pmid.us/19754687>

Aim: This article offers a brief description and analysis of public participation in health in

Brazil and England in order to highlight different motivators and tensions within an acceptance of participation as official policy. Sources/methods: The article draws on a range of research in both countries and an analysis of official documents relating to participation. It is based on collaboration between researchers deriving from broad programmes of work on public participation in which the authors are involved. Argument: There is a tension between different principles underpinning collective public involvement in health both within and between countries. Different aspirations or claims have been made about what such participation will achieve and there are trade-offs between design principles that have consequences for issues such as who takes part and thus also for what can be achieved. The democratic origins of public participation are more evident in the Brazilian situation than in England, but there are still questions about the inclusivity of the practices through which this is achieved. The English picture is both more diverse and dynamic, but formal decision-making power of participatory forums is less than in Brazil. Whilst social justice claims for participation have been made in both countries, there is as yet limited evidence that these have been realized

Dyas, J et al 2009 Strategies for improving patient recruitment to focus groups in primary care: a case study reflective paper using an analytical framework. *BMC Medical Research Methodology* 9(1), 65.

<http://dx.doi.org/10.1186/1471-2288-9-65>

<http://www.biomedcentral.com/1471-2288/9/65>

<http://pmid.us/19772603>

Background: Recruiting to primary care studies is complex. With the current drive to increase numbers of patients involved in primary care studies, we need to know more about successful recruitment approaches. There is limited evidence on recruitment to focus group studies, particularly when no natural grouping exists and where participants do not regularly meet. The aim of this paper is to reflect on recruitment to a focus group study comparing the methods used with existing evidence using a resource for research recruitment, PROSPeR (Planning Recruitment Options: Strategies for Primary Care). Methods: The focus group formed part of modelling a complex intervention in primary care in the Resources for Effective Sleep Treatment (REST) study. Despite a considered approach at the design stage, there were a number of difficulties with recruitment. The recruitment strategy and subsequent revisions are detailed. Results: The researchers' modifications to recruitment, justifications and evidence from the literature in support of them are presented. Contrary evidence is used to analyse why some aspects were unsuccessful and evidence is used to suggest improvements. Recruitment to focus group studies should be considered in two distinct phases; getting potential participants to contact the researcher, and converting those contacts into attendance. The difficulty of recruitment in primary care is underemphasised in the literature especially where people do not regularly come together, typified by this case study of patients with sleep problems. Conclusion: We recommend training GPs and nurses to recruit patients during consultations. Multiple recruitment methods should be employed from the outset and the need to build topic related non-financial incentives into the group meeting should be

considered. Recruitment should be monitored regularly with barriers addressed iteratively as a study progresses

Pawlikowska,T.R., et al . (2009). Patient involvement in assessing consultation quality: a quantitative study of the Patient Enablement Instrument in Poland. *Health Expectations* Epub ahead of print 28/08/2009

<http://dx.doi.org/10.1111/j.1369-7625.2009.00554.x>

<http://pmid.us/19719536>

Background Promoting a more patient-responsive service has been the focus of policy initiatives in newer EU states. One measure of success should be the patient's assessment of their consultation with their doctor. Objectives To measure consultation quality in Polish primary care using patient enablement (a patient-driven instrument developed in the UK) and to test its theoretical framework. To compare the patient enablement outcome of different types of doctor delivering primary care in Poland following reform. Design Cross-sectional quantitative questionnaire survey. Setting Random sample of primary care doctors practising within a 60-km radius of Gdansk, Poland. Subjects and outcome measures Patient Enablement Instrument and correlates were measured in 7924 consecutive adult consultations of 48 doctors, stratified according to training: family medicine specialists (diploma holders), non-diplomates and general medicine doctors (polyclinic internists). Results Completion was high (78%). The mean patient enablement score in Poland was 4.0 (SD 3.3) and mean consultation length was 10.3 min (SD 5.4 min). Consultation length and knowing the doctor are independently related to patient enablement in the Polish context. Variation between doctors is significant, but earlier differences in enablement between alternative providers have largely been ameliorated in practice. Conclusion It is feasible to use patient enablement on a large scale at routine consultation in primary care in Poland: acceptability was good in diverse environments. The internal consistency of enablement and its relationships broadly mirror those found in the UK. The effect of patient expectations shaped by social and cultural issues influencing enablement outcome requires further investigation

Tritter,J.Q. (2009). Revolution or evolution: the challenges of conceptualizing patient and public involvement in a consumerist world. *Health Expectations.*, 12(3), 275-287.

<http://dx.doi.org/10.1111/j.1369-7625.2009.00564.x>

<http://pmid.us/19754691>

Background: Changing the relationship between citizens and the state is at the heart of current policy reforms. Across England and the developed world, from Oslo to Ontario, Newcastle to Newquay, giving the public a more direct say in shaping the organization and delivery of healthcare services is central to the current health reform agenda.

Realigning public services around those they serve, based on evidence from service user's experiences, and designed with and by the people rather than simply on their behalf, is challenging the dominance of managerialism, marketization and bureaucratic expertise. Despite this attention there is limited conceptual and theoretical work to underpin policy and practice. Objective: This article proposes a conceptual framework for patient and public involvement (PPI) and goes on to explore the different justifications for involvement and the implications of a rights-based rather than a regulatory approach. These issues are highlighted through exploring the particular evolution of English health policy in relation to PPI on the one hand and patient choice on the other before turning to similar patterns apparent in the United States and more broadly. Conclusions: A framework for conceptualizing PPI is presented that differentiates between the different types and aims of involvement and their potential impact. Approaches to involvement are different in those countries that adopt a rights-based rather than a regulatory approach. I conclude with a discussion of the tension and interaction apparent in the globalization of both involvement and patient choice in both policy and practice

van de Bovenkamp,H.M., Trappenburg,M.J., & Grit,K.J. (2009). Patient participation in collective healthcare decision making: the Dutch model. *Health Expectations* Epub ahead of print 29/08/2009

<http://dx.doi.org/10.1111/j.1369-7625.2009.00567.x>

<http://pmid.us/19719537>

Objective To study whether the Dutch participation model is a good model of participation. Background Patient participation is on the agenda, both on the individual and the collective level. In this study, we focus on the latter by looking at the Dutch model in which patient organizations are involved in many formal decision-making processes. This model can be described as neo-corporatist. Design We did 52 interviews with actors in the healthcare field, 35 of which were interviews with representatives of patient organizations and 17 with actors that involved patient organizations in their decision making. Results Dutch patient organizations have many opportunities to participate in formal healthcare decision making and, as a result, have become institutionalized. Although there were several examples identified in which patient organizations were able to influence decision making, patient organizations remain in a dependent position, which they try to overcome through professionalization. Discussion Although this model of participation gives patient organizations many opportunities to participate, it also causes important tensions. Many organizations cannot cope with all the participation possibilities attributed to them. This participation abundance can therefore cause redistribution effects. Furthermore, their dependent position leads to the danger of being put to instrumental use. Moreover, professionalization causes tensions concerning empowerment possibilities and representativeness. Conclusion Although the Dutch model tries to make patient organizations an equal party in healthcare decision making, this goal is not reached in practice. It is therefore important to study more closely which subjects patients can and should contribute to, and in what way

QUALITY

Bjertnaes, Oyvind A., et al 2009 . The association between GP and patient ratings of quality of care at outpatient clinics. *Family Practice* 26(5), 384-390. 1-10-2009.

<http://dx.doi.org/10.1093/fampra/cmp043>

<http://pmid.us/19584122>

Background. GPs and patients are frequently asked to evaluate mental health care, but studies including evaluations from both groups are rare. Objective. To assess the association between GPs' and patients' assessment of mental health outpatient clinic in Norway and identify important health care predictors for patient and GP satisfaction with the clinics. Methods. Two cross-sectional national surveys were carried out: survey of GPs in 2006 and patients in 2007 evaluating outpatient clinics at 69 community mental health centres in Norway. A total of 2009 GPs and 9001 outpatients assessed the clinics by means of a postal questionnaire. Main outcome measures were correlations between GP and patient ratings of the outpatient clinics at the clinic level and health care predictors for patient satisfaction and GP satisfaction with the clinics. Results. Clinic scores for GPs' and patients' assessment of waiting time were moderate to highly correlated (0.65), while clinic scores for GP and patient satisfaction had a lower but significant positive association (0.37). Significant positive correlations between clinic scores for GP and patients ratings were found for 38 of the 48 associations tested. The most important predictors for patient satisfaction with the clinics were interaction with the clinician (beta: 0.23) and being met with politeness and respect at the clinic (beta: 0.19), while the most important predictors for GP satisfaction with the clinics were perceived competence (beta: 0.25), rejection of referrals (beta: -0.17) and waiting time for patients (beta: -0.16). Conclusions. A consistent positive association between GP and patient ratings at the clinic level was identified. Mental health services aiming at improving GP and patient satisfaction should be sensitive to the fact that the two groups prioritize different health care factors

Chen, L. M., Farwell, W. R., and Jha, A. K. Primary care visit duration and quality: does good care take longer? *Archives of Internal Medicine* 169(20), 1866-1872. 9-11-2009

<http://dx.doi.org/10.1001/archinternmed.2009.341>

<http://pmid.us/19901138>

Background: It is unclear if increasing pressure on primary care physicians to be more efficient has affected visit duration or quality of care. We sought to describe changes in the duration of adult primary care visits and in the quality of care provided during these visits and to determine whether quality of care is associated with visit duration. Methods: We conducted a retrospective analysis of visits by adults 18 years or older to a nationally

representative sample of office-based primary care physicians in the United States. Results: Between 1997 and 2005, US adult primary care visits to physicians increased from 273 million to 338 million annually, or 10% on a per capita basis. The mean visit duration increased from 18.0 to 20.8 minutes ($P < .001$ for trend). Visit duration increased by 3.4 minutes for general medical examinations and for the 3 most common primary diagnoses of diabetes mellitus (4.2 minutes, $P = .002$ for trend), essential hypertension (3.7 minutes, $P < .001$ for trend), and arthropathies (5.9 minutes, $P < .001$ for trend). Comparing the early period (1997-2001) with the late period (2002-2005), quality of care improved for 1 of 3 counseling or screening indicators and for 4 of 6 medication indicators. Providing appropriate counseling or screening generally took 2.6 to 4.2 minutes. Providing appropriate medication therapy was not associated with longer visit duration. Conclusions: Adult primary care visit frequency, quality, and duration increased between 1997 and 2005. Modest relationships were noted between visit duration and quality of care. Providing counseling or screening required additional physician time, but ensuring that patients were taking appropriate medications seemed to be independent of visit duration

Elger, B. S. 2009 Violations of medical confidentiality: opinions of primary care physicians. *British Journal of General Practice* 59(567), e344-e352.

<http://dx.doi.org/10.3399/bjgp09X472647>

<http://pmid.us/19843415>

Background: Physicians should be able to distinguish situations where they need to protect confidentiality from those where they could be obligated to reveal information. Data are scarce concerning physician's attitudes in daily situations where violations of confidentiality are avoidable. Physicians should be aware of situations where patients are identifiable. Aim: To solicit participation of primary care physicians in a teaching intervention and to explore participants' opinions on violations of confidentiality. Design of study: A questionnaire presented seven vignettes describing avoidable violations of confidentiality (for example, without patient consent a physician mentions a politician's illness their spouse). Participants answered on a scale of 0-3 (0=no violation and 3=serious violation). All contacted physicians were invited to a teaching session during which the study results were discussed. Method: Three-hundred and seventy-eight members of the Association of Physicians in Geneva (community physicians) working in primary care medicine, and 130 GPs and internists working at the University Hospital of Geneva (hospital physicians) took part. Physicians' answers were compared to responses from Swiss, UK, and other European law professors, and from 311 medical and law students in Geneva. Results: Between 4% (case 6) and 57% (case 2), of physicians thought that no violation occurred. Law professors attributed the scores to each case as 3, 3, 2, 3, 2, 3, 3; the means of physicians were: 1.9, 1.4, 0.7, 1.4 (hospital physicians)/1.9 (community physicians), 0.4, 1.6, 2.6. In most cases, physicians' and students' answers were similar. A significantly higher percentage of community physicians than hospital physicians and students thought that a physician violates confidentiality if they provide the list of their patients to the police for the investigation of the theft of a purse in the

waiting room. Conclusion: Physicians need to be fully aware of their obligations towards patient confidentiality. Avoidable breaches of confidentiality occur when colleagues and authorities (such as police and those in a judicial context) ask for information

Fox, F., et al 2009. What happens when doctors are patients? Qualitative study of GPs .*British Journal of General Practice* 59(568), 811-818.

<http://dx.doi.org/10.3399/bjgp09X472872>

<http://pmid.us/19861026>

Background: Current evidence about the experiences of doctors who are unwell is limited to poor quality data. AIM: To investigate GPs' experiences of significant illness, and how this affects their own subsequent practice. Design of study: Qualitative study using interpretative phenomenological analysis to conduct and analyse semi-structured interviews with GPs who have experienced significant illness. Setting: Two primary care trusts in the West of England. Method: A total of 17 GPs were recruited to take part in semi-structured interviews which were conducted and analysed using interpretative phenomenological analysis Results: Four main categories emerged from the data. The category, 'Who cares when doctors are ill?' embodies the tension between perceptions of medicine as a 'caring profession' and as a 'system'. 'Being a doctor-patient' covers the role ambiguity experienced by doctors who experience significant illness. The category 'Treating doctor-patients' reveals the fragility of negotiating shared medical care. 'Impact on practice' highlights ways in which personal illness can inform GPs' understanding of being a patient and their own consultation style. Conclusion: Challenging the culture of immunity to illness among GPs may require interventions at both individual and organisational levels. Training and development of doctors should include opportunities to consider personal health issues as well as how to cope with role ambiguity when being a patient and when treating doctor-patients. Guidelines about being and treating doctor-patients need to be developed, and GPs need easy access to an occupational health service

Friedberg, M. W., et al (2009) Associations between structural capabilities of primary care practices and performance on selected quality measures. *Annals of Internal Medicine* 151(7), 456-463. 6-10-2009.

<http://pmid.us/19805769>

Background: Recent proposals to reform primary care have encouraged physician practices to adopt such structural capabilities as performance feedback and electronic health records. Whether practices with these capabilities have higher performance on measures of primary care quality is unknown. Objective: To measure associations between structural capabilities of primary care practices and performance on commonly used quality measures. Design: Cross-sectional analysis. Setting: Massachusetts. Participants: 412 primary care practices. Measurements: During 2007, 1 physician from each participating primary care practice (median size, 4 physicians) was surveyed about

structural capabilities of the practice (responses representing 308 practices were obtained). Data on practice structural capabilities were linked to multipayer performance data on 13 Healthcare Effectiveness Data and Information Set (HEDIS) process measures in 4 clinical areas: screening, diabetes, depression, and overuse. Results: Frequently used multifunctional electronic health records were associated with higher performance on 5 HEDIS measures (3 in screening and 2 in diabetes), with statistically significant differences in performance ranging from 3.1 to 7.6 percentage points. Frequent meetings to discuss quality were associated with higher performance on 3 measures of diabetes care (differences ranging from 2.3 to 3.1 percentage points). Physician awareness of patient experience ratings was associated with higher performance on screening for breast cancer and cervical cancer (1.9 and 2.2 percentage points, respectively). No other structural capabilities were associated with performance on more than 1 measure. No capabilities were associated with performance on depression care or overuse. Limitation: Structural capabilities of primary care practices were assessed by physician survey. Conclusion: Among the investigated structural capabilities of primary care practices, electronic health records were associated with higher performance across multiple HEDIS measures. Overall, the modest magnitude and limited number of associations between structural capabilities and clinical performance suggest the importance of continuing to measure the processes and outcomes of care for patients.

Hazell, M. L., et al 2009 Temporal change in health-related quality of life: a longitudinal study in general practice 1999-2004. *British Journal of General Practice* 59(568), 839-843..

<http://dx.doi.org/10.3399/bjgp09X472890>

<http://pmid.us/19861028>

Background: In order to assess and plan for changing healthcare needs, the lack of available information regarding temporal changes in the health-related quality of life of a population must be addressed. Aim: This paper aims to describe such changes over 5 years in a general population. Design of study: Longitudinal postal questionnaire study. Setting: UK general practice. Method: This was a longitudinal postal questionnaire study in two general practice populations, using the generic instrument EQ-5D to measure health-related quality of life. Individuals were included if they responded to three postal surveys in 1999, 2001, and 2004 and there were three consecutive values of EQ-5D(index) available between 1999 and 2004. Results: A total of 2498 subjects were included in the study. After adjustment for potential confounders (including ageing), health-related quality of life declined significantly over the observation period. The change in EQ-5D(index) was from 0.79 to 0.74 and for EQ-5D(vas) 76.8 to 73.3 (P for both trends <0.001). Conclusion: Health-related quality of life deteriorated in these populations over 5 years. In an era of improvements in mortality, this has important implications for the use of health-related quality of life data in healthcare planning and resource allocation

Lester, H., Campbell, S. M., and McDonald, R. The present state and future

direction of primary care: a qualitative study of GPs' views. *British Journal of General Practice* Epub ahead of print 3-11-2009.

<http://dx.doi.org/10.3399/bjgp09X473060>

<http://pmid.us/19889257>

Background Over the past decade there has been a sharp increase in the number of non-profit-sharing salaried doctors employed by practices. This has been accompanied by the introduction of mechanisms to facilitate the entry of other providers into the primary care market. **Aim** To explore the views of GP principals and salaried doctors on current working practices and the future direction of primary care in England. **Design of study** Qualitative study using semi-structured interviews. **Setting** Twenty-two nationally representative practices across England, between February and August 2007. **Method** Interviews were conducted with 22 principals and seven salaried doctors. A topic guide included questions on motivations for working in primary care, descriptions of working lives, the way in which clinical time was spent, and predictions for future working conditions. **Results** Significant changes to GP working arrangements were identified, including increasing pursuit of specialist clinical interests by GP principals and increasing employment of salaried GPs. These developments were reported as improving the working lives of principals but also creating a hierarchical structure at practice level that led to resentment among salaried doctors. Many of the salaried GPs felt disenfranchised and disillusioned by the difference in status and autonomy in decision making and the type of work they performed in the practice. Almost all GPs felt uncertain about the future of primary care and were concerned about the potential threat of private providers delivering primary care within the NHS through a largely salaried workforce. **Conclusion** By failing to recognise the problems of employing an increasingly disenfranchised salaried labour force, GP principals may be undermining the very ethos of general practice they otherwise advocate and recreating smaller versions of the private provider organisations they suggest threaten to corrode NHS primary care. **Keywords** primary care; salaried GP; workforce

McKinstry,B. et al (2009) Confidentiality and the telephone in family practice: a qualitative study of the views of patients, clinicians and administrative staff. *Family Practice*, 26(5), 344-350.

<http://dx.doi.org/10.1093/fampra/cmp032>

<http://pmid.us/19497987>

Background. Confidentiality is considered a cornerstone of the medical consultation. However, the telephone, previously used mainly to negotiate appointments, has become increasingly employed as a means of consultation and may pose new problems in respect to maintaining confidentiality. **Objective.** As part of a qualitative investigation into the views of patients, doctors, nurses and administrative staff on the use of telephone consulting in general practice, we set out to explore the impact of the use of this medium

on perceptions of confidentiality. Method. We used focus groups of purposively selected patients, clinicians and administrative staff in urban and rural areas. Results. Fifteen focus groups comprising 91 individuals were convened. Participants concerns centred on overheard conversations, the receptionist role in triage, difficulty of maintaining confidentiality in small close-knit communities, errors in identification, third party conversations and answering machines. Telephone consulting, depending on the circumstances, could pose a risk or offer a solution to maintaining confidentiality. Conclusions. Many of the concerns that patients and health care staff have around confidentiality breaches both on the telephone and face to face are amenable to careful management. Although rare, identification error or fraud can be a potentially serious problem and further thought needs to be given to the problem of misidentification on the telephone and the use of passwords considered

Mead,N., & Roland,M. (2009). Understanding why some ethnic minority patients evaluate medical care more negatively than white patients: a cross sectional analysis of a routine patient survey in English general practices. *British Medical Journal*, 339 (Sep16_3), b3450.

<http://dx.doi.org/10.1136/bmj.b3450>.

<http://pmid.us/19762416>

Objective To examine why patients from ethnic minorities give poorer evaluations of primary health care than white patients. Design Cross sectional analysis of patient surveys collected in general practice. Setting 1098 English general practices that undertook a routine survey of patients using the General Practice Assessment Questionnaire between April 2005 and March 2006. Participants 188 572 survey respondents, 95.8% of whom identified themselves as "white," "black/black British," "Asian/Asian British," or "Chinese." Analyses were restricted to between 133 441 (71%) and 147 686 (78%) respondents with complete data on relevant variables. Main outcome measures Patient evaluations of waiting times for general practitioner appointments, time spent waiting in surgeries for consultations to start, and continuity of care. Results All aspects of care were rated substantially lower by respondents from the three ethnic minority groups than by white patients. Poorer evaluations of time spent waiting for consultations to begin (rated lowest by Asian patients) and continuity of care (rated lowest by Chinese patients) appeared to reflect worse reported experiences by ethnic minority groups. Substantial differences between white and ethnic minority patients' ratings of appointment waiting times persisted, however, even after adjusting for the actual time patients reported waiting. This effect disappeared for Chinese and black respondents after adjusting for evaluations of reception staff and doctors' communication skills, but Asian patients' ratings remained considerably lower than those of white respondents. Conclusions Important differences in assessments of care exist in different ethnic minority groups. Some negative evaluations may reflect communication issues. Among Asian patients, lower ratings of waiting times for appointments may also reflect different expectations of care. Adjusting survey results for ethnicity may be justified when comparing healthcare providers; however, health services also have a responsibility to meet legitimate patient expectations

Roland, M., et al (2009). Reliability of patient responses in pay for performance schemes: analysis of national General Practitioner Patient Survey data in England. *British Medical Journal* 2009; 339:b3851 Epub ahead of print 29th September 2009

<http://dx.doi.org/10.1136/bmj.b3851>

<http://pmid.us/19808811>

Objective To assess the robustness of patient responses to a new national survey of patient experience as a basis for providing financial incentives to doctors. **Design** Analysis of the representativeness of the respondents to the GP Patient Survey compared with those who were sampled (5.5 million patients registered with 8273 general practices in England in January 2009) and with the general population. **Analysis** of non-response bias looked at the relation between practice response rates and scores on the survey. **Analysis** of the reliability of the survey estimated the proportion of the variance of practice scores attributable to true differences between practices. **Results** The overall response rate was 38.2% (2.2 million responses), which is comparable to that in surveys using similar methodology in the UK. Men, young adults, and people living in deprived areas were under-represented among respondents. However, for questions related to pay for performance, there was no systematic association between response rates and questionnaire scores. Two questions which triggered payments to general practitioners were reliable measures of practice performance, with average practice-level reliability coefficients of 93.2% and 95.0%. Less than 3% and 0.5% of practices had fewer than the number of responses required to achieve conventional reliability levels of 90% and 70%. A change to the payment formula in 2009 resulted in an increase in the average impact of random variation in patient scores on payments to general practitioners compared with payments made in 2007 and 2008. **Conclusions** There is little evidence to support the concern of some general practitioners that low response rates and selective non-response bias have led to systematic unfairness in payments attached to questionnaire scores. The study raises issues relating to the validity and reliability of payments based on patient surveys and provides lessons for the UK and for other countries considering the use of patient experience as part of pay for performance schemes

Van Bruggen R., et al (2009). Clinical inertia in general practice: widespread and related to the outcome of diabetes care. *Family Practice* Epub ahead of print 3/09/2009

<http://dx.doi.org/10.1093/fampra/cmp053>

<http://pmid.us/19729401>

Background and aims. Clinical inertia is considered a major barrier to better care. We assessed its prevalence, predictors and associations with the intermediate outcomes of

diabetes care. Materials and methods. Baseline and follow-up data of a Dutch randomized controlled trial on the implementation of a locally adapted guideline were used. The study involved 30 general practices and 1283 patients. Treatment targets differed between study groups [HbA1c \leq 8.0% and blood pressure (BP) $<$ 140/85% versus HbA1c \leq 8.5% and BP $<$ 150/85]. Clinical inertia was defined as the failure to intensify therapy when indicated. A complete medication profile of all participating patients was obtained. Results: In the intervention and control group, the percentages of patients with poor diabetes or lipid control who did not receive treatment intensification were 45% and 90%, approximately. More control group patients with BP levels above target were confronted with inertia (72.7% versus 63.3%, $P < 0.05$). In poorly controlled hypertensive patients, inertia was associated with the height of systolic BP at baseline [adjusted odds ratio (OR) 0.98, 95% confidence interval (CI) 0.98-0.99] and the frequency of BP control (adjusted OR 0.89, 95% CI 0.81-0.99). If a practice nurse managed these patients, clinical inertia was less common (adjusted OR 0.12, 95% CI 0.02-0.91). In both study groups, cholesterol decreased significantly more in patients who received proper treatment intensification. Conclusion: GPs were more inclined to control blood glucose levels than BP or cholesterol levels. Inertia in response to poorly controlled high BP was less common if nurses assisted GPs

RESEARCH AND DEVELOPMENT

Ariss,S.M. (2009). Asymmetrical knowledge claims in general practice consultations with frequently attending patients: Limitations and opportunities for patient participation. *Social Science & Medicine*, 69(6), 908-919

<http://10.1016/j.socscimed.2009.06.045>

<http://pmid.us/19651465>

Asymmetry of knowledge does not simply relate to knowing or not knowing. Participants in consultations also display normative entitlements to knowledge which are related to their identities in the interaction. Claims of entitlement to knowledge are oriented to by the other participant as either straightforwardly acceptable or problematic. Thus research has shown that asymmetry in doctor-patient interactions is collaboratively achieved. Whilst the asymmetry of medical consultations has long been recognised, understanding asymmetry in the context of patient participation is becoming an increasingly important priority. This paper is not concerned with potential benefits or the feasibility of increasing patient participation in general practice (GP) consultations. Rather it seeks to describe specific limitations and opportunities for the participation of patients regarding the discussion of their problems, treatments and management of illness. Using Conversation Analysis this paper investigates GP consultations with frequently attending patients in the UK. It describes how the moral dimensions of epistemic authority constrain the different conversational resources available to GPs and patients. Findings suggest that in maintaining asymmetrical claims to knowledge debate is foregone in favour of efficient progression through the phases of the interaction. Thus interactions militate against the

discussion of areas where alignment of perspectives might be lacking and participants do not pursue actions which might lead towards claiming a greater understanding of each others' point of view. However, there are aspects of consultations with frequently attending patients which display reduced asymmetry with regard to participants' claims to epistemic authority

Checkland, K. et al 2009 Structural Interests? in Health Care: Evidence from the Contemporary National Health Service. *Journal of Social Policy* 38(04), 607-625.

<http://dx.doi.org/10.1017/S0047279409003262>

Alford's theory of structural interests has been used as a framework within which to analyse health systems across the world. However, authors have often been uncritical in their acceptance of Alford's original analytic categories. In this article we use data from a detailed qualitative study of the introduction of Practice Based Commissioning in the UK NHS to interrogate Alford's work more critically. Disrupting Alford's original categories of as dominant interests, challenged by management, we suggest that the new structures established in the NHS since 2002 systematically privilege an interest that we call, and that this is under challenge from 'professional rationalisers'.

Lorenz, L.S., & Kolb, B. (2009). Involving the public through participatory visual research methods. *Health Expectations* 12(3), 262-274.

<http://dx.doi.org/10.1111/j.1369-7625.2009.00560.x>

<http://pmid.us/19754690>

Objectives: To show how providing cameras to patients and community residents can be effective at involving the public in generating understanding of consumer, community, and health system problems and strengths. **Background:** Health-care institutions and systems may seek to include consumer perspectives on health and health care yet be challenged to involve the most vulnerable sectors, be they persons with disabilities or persons with low socio-economic status living in societies where a top-down approach to policy is the norm. **Methods:** Drawing on study examples using photo-elicitation and photovoice in Morocco and the United States, the authors explore issues of planning, data analysis, ethical concerns and action related to using participatory visual methods in different cultural and political contexts. **Results:** Visual data generated by consumers can be surprising and can identify health system problems and strengths omitted from data gathered using other means. Statistical data may convince policy makers of the need to address a problem. Participant visual data may in turn encourage policy maker attention and action. **Conclusion:** Health system decision making may be improved by having a broader range of data available. Participant-generated visual data may support data gathered using traditional methods, or provide a reality check when compared with data generated by organizations, researchers and policy makers. The two study examples model innovative ways to surface health and health-care issues as they relate to

consumers' real lives and engage vulnerable groups in systems change, even in contexts where expressing opinions might be seen as a risky thing to do

Nuesch, E., et al 2009 The effects of excluding patients from the analysis in randomised controlled trials: meta-epidemiological study. *British Medical Journal* 339, b3244. 7/09/2009

<http://dx.doi.org/10.1136/bmj.b3244>

<http://pmid.us/19736281>

Objective: To examine whether excluding patients from the analysis of randomised trials are associated with biased estimates of treatment effects and higher heterogeneity between trials. Design: Meta-epidemiological study based on a collection of meta-analyses of randomised trials. Data sources: 14 meta-analyses including 167 trials that compared therapeutic interventions with placebo or non-intervention control in patients with osteoarthritis of the hip or knee and used patient reported pain as an outcome. Methods: Effect sizes were calculated from differences in means of pain intensity between groups at the end of follow-up, divided by the pooled standard deviation. Trials were combined by using random effects meta-analysis. Estimates of treatment effects were compared between trials with and trials without exclusions from the analysis, and the impact of restricting meta-analyses to trials without exclusions was assessed. Results: 39 trials (23%) had included all patients in the analysis. In 128 trials (77%) some patients were excluded from the analysis. Effect sizes from trials with exclusions tended to be more beneficial than those from trials without exclusions (difference -0.13, 95% confidence interval -0.29 to 0.04). However, estimates of bias between individual meta-analyses varied considerably ($\tau^2=0.07$). Tests of interaction between exclusions from the analysis and estimates of treatment effects were positive in five meta-analyses. Stratified analyses indicated that differences in effect sizes between trials with and trials without exclusions were more pronounced in meta-analyses with high between trial heterogeneity, in meta-analyses with large estimated treatment benefits, and in meta-analyses of complementary medicine. Restriction of meta-analyses to trials without exclusions resulted in smaller estimated treatment benefits, larger P values, and considerable decreases in between trial heterogeneity. Conclusion: Excluding patients from the analysis in randomised trials often results in biased estimates of treatment effects, but the extent and direction of bias is unpredictable. Results from intention to treat analyses should always be described in reports of randomised trials. In systematic reviews, the influence of exclusions from the analysis on estimated treatment effects should routinely be assessed

Shaw, E. and Bailey, Julia. Discourse analysis: what is it and why is it relevant to family practice? *Family Practice* 26(5), 413-419.

<http://dx.doi.org/10.1093/fampra/cmp038>

<http://pmid.us/19556336>

This paper aims to illustrate what discourse analysis is and how it can contribute to our understanding of family practice. Firstly, we describe what discourse analysis is, mapping the discourse analysis terrain by discussing four studies relevant to primary care to illustrate different methodological approaches and key concepts. We then address the practicalities of how to actually do discourse analysis, providing readers with a worked example using one particular approach. Thirdly, we touch on some common debates about discursive research. We conclude by advocating that researchers and practitioners take up the challenge of understanding, utilizing and extending the field of discourse studies within family practice

SELF CARE

Rogers A, Bury M, & Kennedy A (2009). Rationality, rhetoric, and religiosity in health care: the case of England's Expert Patients Programme. *International Journal of Health Services*, 39(4), 725-747.

<http://dx.doi.org/10.2190/HS.39.4.h>

Policymakers have associated the increasing prevalence and incidence of chronic illness with the threat of unsustainable demands for medical services, requiring deployment of effective demand-management strategies. In this article, the authors consider the rise in policy interest in self-management and examine the metaphors, discourse, official statements, policy developments, and goals shaping the field of chronic illness, especially surrounding the promotion and uptake of self-skills training in England's Expert Patients Programme (EPP). They discuss the shift in relationship between individuals and the state since the 1960s and 1970s; the rise in importance of self-management in relation to an aging population; the evidence and rhetoric associated with policy development; and the relationship of self-care to the notion of the "responsible patient," as seen in policy implementation and EPP course promotion. The authors also draw on qualitative research to examine the transmission of ideology and rhetoric in self-skills training. Self-management policies are part of a shift from patient rights to individual responsibilities, a shift that may be less persuasive than its supporters imagine.

Kaissi,A.A., & Parchman,M. (2009). Organizational factors associated with self-management behaviors in diabetes primary care clinics. *Diabetes Education* , 35(5), 843-850.

<http://dx.doi.org/10.1177/0145721709342901>

<http://pmid.us/19783769>

Purpose: The purpose of this article is to examine the relationship between organizational characteristics as measured by the Chronic Care Model (CCM) and patient self-management behaviors among patients with type 2 diabetes. **Methods:** The study design was cross-sectional. The study setting included 20 primary care clinics from South Texas. The sample included approximately 30 consecutive patients that were enrolled from each clinic for a sample of 617 patients. For the data collection procedures, the CCM survey was completed by caregivers in the clinic. Self-management behaviors were obtained from patient exit surveys. For measures, the CCM consisted of 6 structural dimensions: (1) organization support, (2) community linkages, (3) self-management support, (4) decision support system, (5) delivery system design, and (6) clinical information systems. Patient self-management behavior included whether the patient reported always doing all 4 of the following behaviors as they were instructed: (1) checking blood sugars, (2) following diabetes diet, (3) exercising, and (4) taking medications. For data analyses, to account for clustering of patients within clinics, hierarchical logistic regression models were used. **Results:** Self-management support was positively associated with medication adherence, while decision support system was positively associated with exercise and all 4 self-management behaviors. Surprisingly, community linkages were negatively associated with medication adherence, while clinical information system was negatively associated with diet and all 4 behaviors. A total score, including all dimensions, was positively associated with only exercise. **Conclusions:** Health care providers and diabetes educators in primary care clinics should consider how organizational characteristics of the clinic might influence self-management behaviors of patients. The focus should be on better access to evidence-based information at the point of care and self-management needs and activities

Rose, V., et al (2009). A better model of diabetes self-management? Interactions between GP communication and patient self-efficacy in self-monitoring of blood glucose. *Patient Education and Counseling*. ;77(2):260-5. Epub Aug 31 2009

<http://dx.doi.org/10.1016/j.pec.2009.03.026>

<http://pmid.us/19720493>

Objective: The aim of this exploratory study was to investigate the interaction between patient self-efficacy and GP communication in explaining diabetes self-management in a disadvantaged region of Sydney, Australia. **Methods:** This study was undertaken in South West Sydney with the Fairfield Division of General Practice. We used a cross-sectional survey design to assess patients' self-reported beliefs and behaviours about diabetes self-management. We used hierarchical multiple linear regression to test for interaction effects in diabetes self-management, following tests for clustering using multilevel modeling. **Results:** Of those eligible for survey, 105 patients completed the telephone survey (72%). There was a significant interaction between diabetes self-efficacy and GP communication in blood glucose testing; high-ratings of GP communication enhanced

self-monitoring of blood glucose when patient self-efficacy was high but impeded self-monitoring of blood glucose when self-efficacy was low. There were no significant interaction effects for the general diet or exercise scales. Conclusion: This exploratory study suggests a complex relationship between patient self-efficacy and GP communication in self-monitoring of blood glucose. It is likely optimal diabetes self-management behaviours are produced by a fit between high patient self-efficacy and high quality GP communication. Practice implications: There is a risk that GPs who are sensitive to their patients' low self-efficacy in self-monitoring of blood glucose may step in and take over the monitoring role and inadvertently reduce self-management

SERVICE ORGANISATION AND DELIVERY

Schoen, C., et al 2009 . A survey of primary care physicians in eleven countries, 2009: perspectives on care, costs, and experiences. *Health Affairs (Millwood)* 28(6), w1171-w1183. 2009.

<http://dx.doi.org/10.1377/hlthaff.28.6.w1171>

<http://pmid.us/19884491>

This 2009 survey of primary care doctors in Australia, Canada, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, the United Kingdom, and the United States finds wide differences in practice systems, incentives, perceptions of access to care, use of health information technology (IT), and programs to improve quality. Response rates exceeded 40 percent except in four countries: Canada, France, the United Kingdom, and the United States. U.S. and Canadian physicians lag in the adoption of IT. U.S. doctors were the most likely to report that there are insurance restrictions on obtaining medication and treatment for their patients and that their patients often have difficulty with costs. We believe that opportunities exist for cross-national learning in disease management, use of teams, and performance feedback to improve primary care globally

2,562.30. Conclusions Taking into account PPP-adjusted wages, France, Greece and Italy are below the median continental values. The trend of migration of medical trainees to countries where the economic situation is more favourable seems reasonable. Because of both the high salary and the language, the UK represents the most attractive training destination

Dennis,S., et al (2009). What evidence is there to support skill mix changes between GPs, pharmacists and practice nurses in the care of elderly people living in the community? *Australia and New Zealand Health Policy*, 6(1), 23.

<http://dx.doi.org/10.1186/1743-8462-6-23>

<http://www.anzhealthpolicy.com/content/6/1/23>

<http://pmid.us/19744350>

Workforce shortages in Australia are occurring across a range of health disciplines but are most acute in general practice. Skill mix change such as task substitution is one solution to workforce shortages. The aim of this systematic review was to explore the evidence for the effectiveness of task substitution between GPs and pharmacists and GPs and nurses for the care of older people with chronic disease. Published, peer reviewed (black) and non-peer reviewed (grey) literature were included in the review if they met the inclusion criteria. Results: Forty-six articles were included in the review. Task substitution between pharmacists and GPs and nurses and GPs resulted in an improved process of care and patient outcomes, such as improved disease control. The interventions were either health promotion or disease management according to guidelines or use of protocols, or a mixture of both. The results of this review indicate that pharmacists and nurses can effectively provide disease management and/or health promotion for older people with chronic disease in primary care. While there were improvements in patient outcomes no reduction in health service use was evident. Conclusion: When implementing skill mix changes such as task substitution it is important that the health professionals' roles are complementary otherwise they may simply duplicate the task performed by other health professionals.

Gensichen, J., et al 2009 . Health care assistants in primary care depression management: role perception, burdening factors, and disease conception. *Annals of Family Medicine* 7(6), 513-519.

<http://dx.doi.org/10.1370/afm.1037>

<http://pmid.us/19901310>

Purpose: In primary care, the involvement of health care assistants (HCAs) in clinical depression management is an innovative approach. Little is known, however, about how HCAs experience their new tasks. We wanted to describe the perceptions and experiences of HCAs who provided case management to patients with depression in small primary care practices. Methods: This qualitative study was nested in the Primary Care Monitoring for Depressive Patients Trial on case management in Germany. We used a

semi-structured instrument to interview 26 HCAs and undertook content analysis. We focussed on 3 key aspects: role perception, burdening factors, and disease conception. Results: Most HCAs said their new role provided them with personal and professional enrichment, and they were interested in improving patient-communication skills. They saw their major function as interacting with the patient and considered support for the family physician to be of less importance. Even so, some saw their role as a communication facilitator between family physician and patient. Burdening factors implementing the new tasks were the increased workload, the work environment, and difficulties interacting with depressed patients. HCAs' disease conception of depression was heterogeneous. After 1 year HCAs believed they were sufficiently familiar with their duties as case managers in depression management. Conclusion: HCAs were willing to extend their professional responsibilities from administrative work to more patient-centred work. Even if HCAs perform only monitoring tasks within the case management concept, the resulting workload is a limiting factor

Goddard M et al 2009 Where did all the GPs go? Increasing supply and geographical equity in England and Scotland. *Journal of Health Services Research and Policy* 2009 Oct 20 2009 Epub ahead of print

<http://dx.doi.org/10.1258/jhsrp.2009.009003>

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Objectives: To examine the effect on geographical equity of increases in the total supply of general practitioners (GPs) and the ending of entry restrictions in 2002 and to explore the factors associated with the distribution of GPs across England. Methods: Calculation of Gini coefficients to measure geographical equity in GPs per 100,000 population in England and Scotland. Multiple regression of GPs per capita and change in GPs per capita on demographics, morbidity, deprivation and measures of amenity in English Primary Care Trusts (PCTs). Results: Equity in England rose between 1974 and 1994 but then decreased, and in 2006 it was below the 1974 level. After 2002, England had a greater percentage increase in GP supply than Scotland and a smaller increase in inequity. The level of GP per capita supply in 2006 was positively correlated with morbidity and PCT amenity, and negatively correlated with unemployment and poor air quality. The increase in per capita supply between 2002 and 2006 was not significantly associated with morbidity, deprivation or amenities. Conclusions: Reducing geographical inequity in the provision of GPs requires targeted area level policies.

Hewitt,H., McCloughan,L., & McKinstry,B. (2009). Front desk talk: discourse analysis of receptionist-patient interaction. *British Journal of General Practice*, 59(565), 571-577.

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Background GP receptionists are the first point of contact with the NHS for most patients and have an important role in facilitating access to healthcare services. There is evidence that they are often perceived as impersonal, insensitive, or officious. Aim To analyse the communicative styles of GP receptionists when dealing with patients. Design of study Ethnographically situated discourse analysis of audio recordings. Setting Three NHS GP surgeries in Scotland. Method Fine-grained transcription and stage-by-stage analysis of digital audio recordings of 283 encounters between receptionists and patients engaged in front desk business. Participants were 16 receptionists and 283 patients. Results Interaction between receptionists and patients consists mainly of verbal routines that are shaped by the administrative tasks completed through them. Receptionists adhere to these established patterns of use at all times, even when dealing with non-routine situations. Within the routine framework, receptionists communicate with patients using styles that display three dominant approaches: task centred, conventionally polite, and rapport building. Receptionists who adopt a task-centred approach use forms with minimal interpersonal content, while those who use conventionally polite forms or those associated with rapport building, give attention to establishing positive relationships with patients. There is no evidence that any stylistic approach is more efficient than another. There is, however, evidence that excessive adherence to routine verbal behaviour has an adverse impact on problem solving. Conclusion Most receptionist discourse consists of the repetition of established verbal routines. Receptionists adopt verbal styles that are predominantly task centred, conventionally polite, or rapport building. Although all three styles enable the completion of reception work with similar levels of efficiency, task-centred styles may appear over-direct. The use of a routine approach when dealing with problematic situations can inhibit and delay their resolution

Krasner, M. S. et al 2009 . Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA* 302(12), 1284-1293. Online 23-9-2009.

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Context: Primary care physicians report high levels of distress, which is linked to burnout, attrition, and poorer quality of care. Programs to reduce burnout before it results in impairment are rare; data on these programs are scarce. Objective: To determine whether an intensive educational program in mindfulness, communication, and self-awareness is associated with improvement in primary care physicians' well-being, psychological distress, burnout, and capacity for relating to patients. DESIGN, Setting, and participants: Before-and-after study of 70 primary care physicians in Rochester, New York, in a continuing medical education (CME) course in 2007-2008. The course included mindfulness meditation, self-awareness exercises, narratives about meaningful clinical experiences, appreciative interviews, didactic material, and discussion. An 8-week intensive phase (2.5 h/wk, 7-hour retreat) was followed by a 10-month maintenance phase (2.5 h/mo). Main outcome measures: Mindfulness (2 subscales), burnout (3 subscales), empathy (3 subscales), psychosocial orientation, personality (5 factors), and

mood (6 subscales) measured at baseline and at 2, 12, and 15 months. Results: Over the course of the program and follow-up, participants demonstrated improvements in mindfulness (raw score, 45.2 to 54.1; raw score change [Delta], 8.9; 95% confidence interval [CI], 7.0 to 10.8); burnout (emotional exhaustion, 26.8 to 20.0; Delta = -6.8; 95% CI, -4.8 to -8.8; depersonalization, 8.4 to 5.9; Delta = -2.5; 95% CI, -1.4 to -3.6; and personal accomplishment, 40.2 to 42.6; Delta = 2.4; 95% CI, 1.2 to 3.6); empathy (116.6 to 121.2; Delta = 4.6; 95% CI, 2.2 to 7.0); physician belief scale (76.7 to 72.6; Delta = -4.1; 95% CI, -1.8 to -6.4); total mood disturbance (33.2 to 16.1; Delta = -17.1; 95% CI, -11 to -23.2), and personality (conscientiousness, 6.5 to 6.8; Delta = 0.3; 95% CI, 0.1 to 0.5 and emotional stability, 6.1 to 6.6; Delta = 0.5; 95% CI, 0.3 to 0.7). Improvements in mindfulness were correlated with improvements in total mood disturbance ($r = -0.39$, $P < .001$), perspective taking subscale of physician empathy ($r = 0.31$, $P < .001$), burnout (emotional exhaustion and personal accomplishment subscales, $r = -0.32$ and 0.33 , respectively; $P < .001$), and personality factors (conscientiousness and emotional stability, $r = 0.29$ and 0.25 , respectively; $P < .001$). Conclusions: Participation in a mindful communication program was associated with short-term and sustained improvements in well-being and attitudes associated with patient-centered care. Because before-and-after designs limit inferences about intervention effects, these findings warrant randomized trials involving a variety of practicing physicians

Magin,P., et al (2009). Receptionists' experiences of occupational violence in general practice: a qualitative study. *British Journal of General Practice*, 59(565), 578-583.

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Background The significance of occupational violence in general practice is well established, but research has focused almost exclusively on the experiences of GPs. Only limited research has examined the role of general practice receptionists despite their acknowledged vulnerability to violent patient behaviour. No qualitative research has explored this problem. Aim To explore the experiences of general practice receptionists regarding occupational violence and the effects of violence on their psychological and emotional wellbeing and on their work satisfaction and performance. Design of study Qualitative study. Setting Constituent practices of an Australian network of research general practices. Practices were located in a range of socioeconomic settings. Method Semi-structured interviews were conducted with practice receptionists. The interviews were audiotaped, transcribed, and subjected to thematic analysis employing a process of constant comparison in which data collection and analysis were cumulative and concurrent. Qualitative written responses from a cross-sectional questionnaire-based study performed concurrently with the qualitative study were similarly analysed. Results Nineteen interviews were conducted and 12 written responses were received. Violence was found to be a common, sometimes pervasive, experience of many receptionists. Verbal abuse, both 'across the counter' and telephone abuse, was the most prominent form of violence, although other violence, including assault and threats with guns, was reported. Experiences of violence could have marked emotional and psychological effects

and could adversely affect job satisfaction, performance, and commitment. Conclusion It is apparent that occupational violence is a whole-of-practice problem and strategies for GP and staff safety will need to take a whole-of-practice approach

Thompson, M.J., et al . (2009). Do international medical graduates (IMGs) "fill the gap" in rural primary care in the United States? A national study. *Journal of Rural Health*, 25(2), 124-134.

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<http://pmid.us/19785577>

Context: The contribution that international medical graduates (IMGs) make to reducing the rural-urban maldistribution of physicians in the United States is unclear. Quantifying the extent of such "gap filling" has significant implications for planning IMG workforce needs as well as other state and federal initiatives to increase the numbers of rural providers. Purpose: To compare the practice location of IMGs and US medical graduates (USMGs) practicing in primary care specialties. Methods: We used the 2002 AMA physician file to determine the practice location of all 205,063 primary care physicians in the United States. Practice locations were linked to the Rural-Urban Commuting Areas, and aggregated into urban, large rural, small rural, and isolated small rural areas. We determined the difference between the percentage of IMGs and percentage of USMGs in each type of geographic area. This was repeated for each Census Division and state. Findings: One quarter (24.8% or 50,804) of primary care physicians in the United States are IMGs. IMGs are significantly more likely to be female (31.9% vs 29.9%, $P < .0001$), older (mean ages 49.7 and 47.1 year, $P < .0001$), and less likely to practice family medicine (19.0% vs 38%, $P < .0001$) than USMGs. We found only two Census Divisions in which IMGs were relatively more likely than USMGs to practice in rural areas (East South Central and West North Central). However, we found 18 states in which IMGs were more likely, and 16 in which they were less likely to practice in rural areas than USMGs. Conclusions: IMGs fill gaps in the primary care workforce in many rural areas, but this varies widely between states. Policies aimed to redress the rural-urban physician maldistribution in the United States should take into account the vital role of IMGs

