ABSTRACTS

THURSDAY
14 MAY 2009
13.30 – 15.00

OP03.1 WHAT KIND OF SUPPORT DO GENERAL PRACTITIONERS WANT WHILE DEVELOPING THE STRUCTURE IN THEIR OWN PRACTICE

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The Danish health care system is confronted with big challenges the coming years. An ageing population with larger needs, an increasing number of people with chronic diseases, the health system becomes more specialized and complex. GP is intended to have a continuous central role in the Danish health care system, as the local and primary health service, securing the coherence in treatment, being proactive in relation to patients with chronic diseases and a gatekeeper to the specialized health system. At the same time there is an increasing lack of general practitioners. In order to meet these challenges, it will be necessary to modify and develop the structure in GP and transfer some of the tasks to other employees in the primary sector. During the last years there have been efforts to support and contribute to improve the structure in general practice, but very little is known about the wishes and needs among our colleges. In order to imply the right kind of support, we decided to investigate this area. The investigation was carried out using 2 different methods: an electronic questionnaire to 867 doctors and 3 focus-group interviews with GP's. The results showed that there are need of and wishes for individual support. It is important to have economic security in the process of chance. It is necessary to spend time to accomplish chances. Support should be carried out in the individual practices. There is a need of strengthening the skills as a leader among GP.

OP03.2 HEALTH CARE PROVIDER BACK PAIN BELIEFS UNAFFECTED BY A MEDIA CAMPAIGN

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Background: Health care providers play a key role in transmitting knowledge and beliefs about LBP to their patients. There are differences in back pain beliefs between the various professionals groups treating LBP patients. This study examined whether LBP beliefs changed among the health care providers exposed to a media campaign.

Methods: A quasi-experimental postal before-and-after survey of health professional beliefs accompanied a media campaign in two Norwegian counties, with a neighbouring county serving as control. The campaign aimed at improving beliefs about LBP in the general public, and included specific interventions also towards the health care providers.

Results: It was 243 doctors, physiotherapists and chiropractors that answered the questionnaire in 2002 and 2005. We observed a general tendency for all providers to have beliefs more in line with guidelines in 2005 compared to 2002, was irrespective of exposure status. Some baseline differences in beliefs between the professional groups were not only sustained but in fact seemed to increase from 2002 to 2005. This was particularly regarding LBP as a self-limiting condition.

Conclusions: A LBP mass media campaign with educational initiatives aimed at health care providers did not result in important improvement in LBP beliefs of providers exposed to the campaign. Important differences were observed between beliefs of the different health care provider groups in their view of LBP.

Keywords: Low back pain, beliefs, media campaign, health care providers.

OP03.3 CHALLENGES AND PROBLEMS YOUNG DOCTORS FACE IN HEALTH CENTERS

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Aim: All young doctors, regardless of their specialty choice, are required to work for 9 months in a health center during their specific training in general medical practice. We wanted to study what problems they encounter.

Design and methods: A web questionnaire was presented to 121 doctors taking part in a course on social insurance during their specific training in general medical practice. The response rate was 81%. Altogether 98 responded; 79 women and 19 men. Median age was 28 years. From those who had worked in a health center after graduation (on average for 6 months) 90 responded to the open-ended question: "What are the main challenges and problems when working in a health center?"

Results: Two thirds of respondents mentioned being pressed for time as the main problem. About one third felt that they have too little control over their own work. Difficulty in reaching consultants, lack of guidance from GP colleagues and working alone were seen as problems. Some felt uncomfortable when treating patients with minor ailments or mainly social problems. Patients with multiple or complicated health problems were seen as a challenge. Feelings of uncertainty and inadequacy were mentioned, caused partly by demanding patients or patients with unexplained symptoms. Only a minority commented on organization and resources.

Conclusions: Young doctors working in health centers need more support and guidance from colleagues. Control over own work and a deeper understanding of GP's role when dealing with different kind of patients might make general practice more appealing.

OP03.4 FINANCING HEALTH CARE SYSTEM AND THE ROLE OF CAPITATION IN THE SERBIAN CONTEXT

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Objectives: Starting the capitation system requires various changes and new tools to be developed and put in place not only in financial administration and management but also in many other functions in the Primary Health Care services delivery. Capitation project aims to assist Serbia to develop its Primary Health Care further to meet the changing needs of the people. One of the tools for better health services is the so called Capitation Payment System. The project has tested the implementation of the new capitation system in 28 Primary Health Care Centers (PHCC) in Serbia. The 28 PHCC are situated in 22 regions out of the 25 regions Serbia. Seven PHCC of the total of 16 PHCC in Belgrade are included. One of them is PHCC "Zemun". As Manager for Medical Programs in PHCC "Zemun" I everyday copy with serial problems according to successful implementation of named project. We started implementation 6 later then others. It was serious problem according to 191,000 habitants that PHCC "Zemun" cover.

Results:

- New management competencies of managers
- Changes of management skills (through education)
- Competencies in information technology and use of specific software (e.t. one third of the managers reported they have low competence or no competence at all in general IT skills)
- Capitation specific skills among managers, middle management and other staff
- In January 2009 119. 286 habitants were registered (62%).

Conclusions: Capitation has future in Serbia if we keep formulae transparent, simple and flexible.

Keywords: Capitation, financing, primary health care.

OP03.5 STRENGTHENING CENTER FOR PREVENTION IN PRIMARY HEALTH CARE CENTER 'ZEMUN'

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Objectives: The highest burden of diseases in Serbia is attributed to non-communicable diseases. Until now, health service in Serbia was not effective in addressing the problem. Cardio-vascular diseases and malignant tumours contribute to more than three quarters of all causes of death in 2005. More than half of deaths in Serbia (56.8%) were deaths due to cardio-vascular diseases and almost every 5th death (18.5%) was a malignant tumour victim. Injuries and intoxications were responsible for additional 3.6% of deaths in Serbia, 2.7% were due to COPD (chronic obstructive pulmonary diseases), and complications of diabetes account for 2.4% of deaths. Taking all this into consideration a new organisational form was proposed. Center for Prevention as a new department within primary health care centers has a role to coodinate and conduct preventive activities on local level as well as to develope cooperation with partners in a community. Center for prevention in Zemun was establish in 2006, but just since end of 2007 started with everyday work in deffferent fields.

Results: In 2008 medical teams did:
- 4 subunits fuly developed (Mobile, Counseling, Unit for Education and coordination and Open Line)
- More then 3000 visits
- School „Quit smoking" (27 patients)
- Screening carcinoma mammae passed 440 patients
- 12 workshop themes chosen by patients
- 3 carcinoma screening programs
- 12 „Health Market" events

Conclusions: This unit has shown an extremely important way to reach vulnerable citizens and should be develop as high priority.

Keywords: Center for prevention, general practice, health policy.

OP03.6 A SYSTEMATIC REVIEW OF 4 INJECTION THERAPIES FOR LATERAL EPICONDYLOSIS

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Objective: Lateral epicondylosis (LE, tennis elbow) is a common, expensive and often refractory repetitive motion tendinopathy. We appraised existing evidence for prolotherapy, polidocanol, autologous whole blood and platelet-rich plasma injections for LE, each intended to address underlying "failure of healing" pathology of LE. Design: Systematic Review Data sources: Medline, Embase, CINAHL, Cochrane Central Register of Controlled Trials, Allied and Complementary Medicine. Study Selection: All human studies assessing the 4 therapies for LE.

Results: Results of 5 prospective case series and four controlled trials (3 prolotherapy, 2 polidocanol, 3 autologous whole blood and 1 platelet-rich plasma) suggest each of the 4 therapies is effective for LE. In follow-up periods ranging from 9 to 108 weeks, studies reported sustained, statistically significant ($p<0.05$) improvement on visual analog scale primary outcome pain score measures and disease specific questionnaires; relative effect sizes ranged from 51% to 94%; Cohen's d ranged from 0.68 to 6.68. Secondary outcomes also improved, including biomechanical elbow function assessment (polidocanol and prolotherapy), presence of abnormalities and increased vascularity on ultrasound (autologous whole blood and polidocanol). Subjects reported satisfaction with therapies on single-item assessments. All studies were limited by small sample size.

Conclusions: There is strong pilot-level evidence supporting the use of these 4 injection therapies in the treatment of LE. Each can be performed in the primary care physician's office. Rigorous studies of sufficient sample size are needed to determine long-term effectiveness and safety.

Keywords: Lateral epicondylosis, injection therapy, systematic review.

OP04.1 HYPERTENSION IN GENERAL PRACTICE – AN APO-AUDIT

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Objective: To identify the population of hypertensive patients in general practice and to improve treatment and monitoring of these patients.

Methods: More than 400 GPs from 189 Danish practices registered 7342 hypertensive patients on a simple APO registration chart during November 2007. Duration of hypertension, actual level of blood pressure, risk factors, complications and treatment were registered. The participating doctors were randomised into two groups, where one group attended courses and participated in other implementation activities directly after this first registration. A Second registration will be carried out after one and a half year by both groups, and the second group will subsequently receive the same courses as the first. A questionnaire to the patients was also included in the project.

Results: Main results from the first registrations showed that 50% of the patients included reached the target value (systolic BP below 140 mm Hg). More than 50% of the patients had a duration of the disorder of more than 5 years. The pattern of treatment showed that 1/3 received one drug, 1/3 two drugs and 25% received 3 or more drugs.

Conclusions: A large multipractice audit in Denmark with a complicated design is demonstrated and the primary results are shown. The study aims to elucidate whether intervention with registration of data from own patients together with training courses can improve the quality of treatment of hypertensive patients.

Keywords: Hypertension, clinical audit, drug therapy.

OP04.2 USE AND EFFECT OF DIFFERENT COMBINED MEDICATIONS OF HYPERTENSION IN FINNISH PHC

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Objectives: The aim of the study was to look at the use of different medications of hypertension in Finnish PHC and to find out what kind of combinations were used and what the effects of these were.

Methods: Finnish Quality Networks has measured the quality indicators of diabetes, hypertension and coronary disease once a year since 1994. All networks are run by Conmedic, a private company, started for this purpose. Conmedic does the coordination, teaching, measuring and benchmarking for the health centres. The Cardiovascular Prevention Network consists of 50 health centres in Finland. From the results of the last two week survey in autumn 2008 we analyzed the use of hypertension medication and compared it to the achieved blood pressure levels.

Results: 5310 patients were included. Medication data was obtained from 90% of the patients. Half of the patients were treated with monotherapy, 30% with a combination of two drugs, 10% with three drugs and less than 5% with more than three. 40% of all patients had a systolic blood pressure less than 140mmHg. Depending on the drug, with monotherapy between 37-45%, with 2 drugs between 29-59% and with 3 drugs 31-53% reached this level. Most of the differences were not significant, but a combination of a diuretic with another agent seemed to be most effective.

Conclusions: It seems that GP:s are reluctant to increase the medication from monotherapy although the effect remains unsatisfactory and more emphasis should be put on combined therapy. On behalf of Finnish Quality Networks.

OP04.3 DOES THE WEIGHT HISTORY OF PATIENTS WITH NEWLY DIAGNOSED TYPE 2 DIABETES INFLUENCE THE WEIGHT CHANGES AFTER DIABETES DIAGNOSIS?

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Background: During the last 10 years before diabetes diagnosis, relatively young patients often gain weight while weight loss is common among elderly patients. After diagnosis an average weight loss is observed. Objective. We studied the predictive value of patients' weight history before diabetes diagnosis for the observed weight changes after diagnosis.

Methods: Data were from a population-based cohort of 885 persons newly diagnosed in general practice with clinical type 2 diabetes. Patients' weight before and after diabetes diagnosis was recalled and measured, respectively. Analyses were done with multivariate linear regression models.

Results: More than 80% of patients were overweight at diagnosis. While patients generally were inclined to lose weight after diabetes diagnosis, 36% still gained weight. Similarly weight gain was common from 10 to 1 year before diagnosis, but 44% actually lost weight. Of all the weight changes before diabetes diagnosis only the weight change during the last year before diagnosis influenced the weight changes after diagnosis. Those patients who tended to gain weight during the year before diagnosis on average lost weight after diagnosis and vice versa for weight loss before diagnosis. Age and BMI at diabetes diagnosis were the only other statistically significant concomitants of weight change after diabetes diagnosis.

Conclusions: In an effort to facilitate weight reduction in newly diagnosed diabetic patients the general practitioner has to pay special attention to the last year of weight change before diagnosis, but it seems even more important to take into account age and degree of obesity.

OP04.4 PREDICTORS OF 5-YEAR MORTALITY OF 1,323 PATIENTS NEWLY DIAGNOSED WITH CLINICAL TYPE 2 DIABETES IN GENERAL PRACTICE

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Background: At diabetes diagnosis major decisions about life-style changes and treatments are made based on characteristics measured shortly after diagnosis. The predictive value for mortality of these early characteristics is widely unknown.

Objective: We examined the predictive value of patient characteristics measured shortly after diabetes diagnosis for 5-year all-cause and cardiovascular mortality with special reference to self-rated general health.

Methods: Data were from a population-based sample from 311 general practices of 1,323 persons newly diagnosed with clinical diabetes and aged 40 years or over. Possible predictors of mortality were investigated in Cox regression models.

Results: Multivariately patients who rated their health less than excellent experienced increased all-cause and cardiovascular mortality. These end-points also increased with sedentary life-style, relatively young age at diagnosis and presence of cardiovascular disease at diagnosis. Further predictors of all-cause mortality were male sex, low body mass index and cancer, while cardiovascular mortality increased with urinary albumin concentration.

Conclusions: We found that patients who rated their health as less than excellent had increased 5-year mortality, similar to that of patients with prevalent CVD, even when biochemical, clinical and life-style variables were controlled for. This finding could motivate general practitioners and practice nurses to discuss perceptions of health with newly diagnosed diabetic patients and be attentive to patients with suboptimal health ratings. Our findings also confirm that life-style changes and optimising treatment are particularly relevant for relatively young and inactive patients and those who already have CVD or (micro)albuminuria at the time of diabetes diagnosis.

OP04.5 THE EFFECT OF GPS' SEMINAR ATTENDANCE ON THE TREATMENT OF THEIR PATIENTS WITH DIABETES

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Background: During the 5-year follow-up of patients newly diagnosed with diabetes in the Diabetes Care in General Practice study, the GPs in the intervention arm of the study were invited to attend up to six study seminars about the treatment of type 2 diabetes.

Objective: We investigate whether the GPs' attendance to these seminars affects the quality of treatment. Here, quality is measured by their patients' level of Haemoglobin A1c, which was measured approximately yearly for each patient during follow-up.

Results: Data includes 641 patients, covering 201 GPs. Relating the patients' level of Haemoglobin A1c, measured at the final follow-up examination, to the number of study seminars attended by their GP shows a clear trend (p=0.0106) of low control for GPs that attended one seminar only, to high control for GPs that attended all six seminars. However, a more careful analysis reveals that this gradient is a product of the natural course of glycaemic control and the effect of seminar attendance is small.

Conclusions: GP seminar attendance has, if any, only a marginal influence on their patients' glycaemic control and is only beneficial when all study seminars are attended.

Keywords: Diabetes mellitus, type 2, continuing medical education, haemoglobin A glycosylated.

OP04.6 END-OF-LIFE CARE IN A PHYSICIAN'S WORK IN FINNISH HEALTH CENTRES

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Objectives: Primary health care is expected to share the growing workl OPd of end-of-life (EOL) care related to cancer. Here, the aim was to study general practitioners involvement and experiences of cancer patients' EOL care in health centres in Finland.

Methods: A questionnaire was mailed in April 2003 to all health centre physicians (N=319) in Pirkanmaa Hospital District, 196 responded. Of them, 141 had completed the questionnaire and 55 reported that they did not belong to the target group. Thus, RR was 53%.

Results: GPs' mean age was 44 years, 93 were female, and 39 % had worked as a doctor more than 20 years. 68% were specialists/in specialist training in general practice. Most of the respondents (84%, n=118) had sometimes treated EOL cancer patients, 17% (n=24) had these patients at the moment (14 in health centre wards, 7 in home care and 3 in both). The physicians were mostly satisfied with co-operation with hospitals, except when transfer of patient information was concerned. Economic aspects had affected treatment choices, most often when choosing the unit for EOL care. 72 % reported that ethical decisions about treatment options had caused emotional distress, 33 % reported of feeling guilty sometimes because of these decisions. Most of the respondents had no supervision. Almost all thought they need more education and training in palliative care.

Conclusions: EOL care is not usual in primary health care, and thus, there is room to improve daily practices and collaboration as well as to increase supervision, education and training.

OP05.1 THE RISK-DRINKING* PROJECT – AN EFFECTIVE APPROACH TO ACHIEVE CHANGES IN YOUR PATIENTS HABITS OF DRINKING ALCOHOL

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* Use of alcohol that is/may become harmful, but where no addiction is present. Introduction Risky drinking has large impact on many of the common diagnoses in family medicine. The GP's most effective intervention is to raise the question with the patient and motivate change. This has been acknowledged by the Swedish government, which has initiated the largest concentration on further education and quality development in the history of Swedish health-care. The Risk-drinking project was started to coordinate and inspire regional authorities in their efforts to reach doctors and other healthcare workers with this message. Aims The Project commissioned a study to set a baseline for evaluation of further achievements, and map out knowledge and attitudes to alcohol prevention among Swedish GPs. Design and methods 3845 questionnaires were sent out to Swedish GPs. Reply-rate was 46.1% nationally, and varied in different counties from 37.0% to 67.5 %. Results GPs agree that it is important that patients with a risk-drinking profile are identified and get advice on changing habits. Contrary to this, only 50% ask patients about use of alcohol. 75% think they cannot influence how much their patients drink, while 97,1% wish to get more education in the field. Conclusions There is great need of education on how to handle the patients risky drinking practices. Our strategy on how to do this will be further adressed at the oral presentation.

Keywords: Risk-drinking preventive alcohol.

OP05.2 WHEN STATE-OF-THE-ART MEDICAL TECHNOLOGIES FOR PREVENTION OF LIFESTYLE RELATED HARM MEETS EVERYDAY GENERAL PRACTICE

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Pro-active prevention with regard to alcohol, tobacco, food and exercise is in focus for the role of the general practitioner (GP). Technologies for screening and brief intervention to prevent alcohol related harm have been trend-setting for preventive general practice.

Objectives: We critically reviewed the evidence base and we implemented and researched such prophylactic activity for alcohol related harm in real-life circumstances (everyday practice of 39 highly motivated Danish GPs) to evaluate effectiveness and compatibility of the proposed technologies.

Methods: Meta-analysis of the screening and intervention efficacy evidence base, validation of a state-of-the-art screening tool, a pragmatic RCT to evaluate impact on drinking, qualitative methods to explore the GPs' experiences.

Results: Mostly published. The existing evidence base consisted mostly of efficacy trials and we found no evidence to support screening for risky drinking. The GPs who implemented the technologies in their practice reported mainly negative experiences and had concerns regarding the doctor-patient relationship. The effectiveness study revealed that only 17.9% of subjects exposed to a brief intervention attended a suggested follow-up consultation. At one-year follow-up, average weekly consumption had increased in both intervention and control groups. Adverse intervention effects for women on secondary drinking outcomes were observed.

Conclusions: The evidence base of recommended technologies to modify risky drinking is fragile and the technologies are incompatible with everyday practice. Health behaviours are not necessarily positively affected just because such pro-active technologies are implemented by the GP. Negative effects of advice-giving should be considered.

Keywords: Family practice, health promotion, preventive medicine, alcohol drinking.

OP05.3 STRENGTHENING THE PATIENT'S POWER TO IMPLEMENT LIFE STYLE CHANGES

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Motivating patients to implement life style changes to prevent and treat diseases is a great challenge to physicians. Traditional information concerning risk factors and treatment is important, but successful changes of life style also have to be anchored in the patient's identity, affiliation and values. This project examines how physicians can stimulate the patient to implement life style changes by focusing on ethical reflection, using Habermas' theory of communicative action as a theoretical framework. Habermas offers a dialogue procedure which focuses on openness, no abuse of power and exploration of and reflection upon the life world. The procedure has a potential for leading patients and physicians to a new understanding of clinical reality and better answers to practical ethical questions raised by the prospect of life style changes. The study is based on observation of 15 consultations with subsequent interviews of patients and physicians. 3 months later the patients were interviewed once more. All consultations and interviews were recorded for transcription and qualitative analysis. Preliminary analysis of the data reveals the following categories as significant for life style changes: existing trust between the doctor and the patient, knowing the patient's history, the professional authority of the physician, time and focus on the patient's life world. An analysis of "physician authority" in light of Habermas' theory will be presented.

Keywords: Preventive medicine, decision making, physician patient relation.

OP05.4 SELF-REPORTED COGNITIVE AND EMOTIONAL EFFECTS AND LIFESTYLE CHANGES SHORTLY AFTER PREVENTIVE CARDIOVASCULAR CONSULTATIONS IN GENERAL PRACTICE

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Objective: To describe patients' evaluation of the contents of preventive cardiovascular consultations and to analyse whether their evaluation is shaped by self-reported cognitive and emotional effects and lifestyle changes 2 to 6 weeks after the consultations. Design Questionnaire developed by means of qualitative studies. Setting Two counties in Denmark. Subjects 2,450 subjects who had participated in a preventive cardiovascular consultation with their GP received a questionnaire; 1,714 responded (70%); 1,226 fulfilled the inclusion criteria: viz. to be at increased risk of cardiovascular disease (CVD) but without having CVD. Main outcome measures Cognitive and emotional effects and lifestyle changes. Odds ratios (ORs) were calculated between self-reported issues raised during the consultations and self-reported lifestyle changes, cognitive and emotional effects.

Results: 58 -79% reported cognitive effects (knowledge about risk and disease), 22-57% lifestyle changes (diet, exercise and smoking), 80-97% emotional effects related to relief and satisfaction and 23% worries. Those who reported that a dialogue had taken place (e.g. information about risk of disease, life habits, life circumstances / daily living, perception of risk, knowledge about disease and own possibilities for prevention) had ORs between 1.7 and 4.3 for reporting three or more cognitive effects and one or more lifestyle changes ($p<0.05$). These issues were also significantly related to emotional effects such as feeling relieved and satisfied.

Conclusions: Patients report cognitive and emotional effects and healthy lifestyle changes following a cardiovascular preventive consultation and the magnitude of the effect is associated with the nature of the issues raised.

Keywords: Preventive consultation, general practice.

S04 DOES THE HEALTH CARE SYSTEM INDUCE HARM? REFLECTIONS FROM GENERAL PRACTICE

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First, not to harm' (Primum non nocere) – so runs one of the precepts in the Hippocratic OPth. However, any medical intervention risks doing harm, and the examination of healthy persons with a view to prevention is no exception. Explaining risks and risk reductions in easily comprehensible ways – to doctors and patients – remains a considerable challenge. Harmful effects of prevention and medicalisation are rarely discussed among medical specialist and even less so in public. When evidence is found that a preventive measure is effective, the harmful effects tend to be downplayed for the sake of the 'good cause'. Even though medical science saves lives and postpones suffering and death for many people, there is nevertheless good reason to stop and ask: in what direction are we moving towards? Straight talk about disease prevention is needed to foster shared decision making and patient empowerment. Furthermore, there is a need for reflection on medical practice and for a critical scrutiny of the theories behind what we do. At this symposium, general practitioners from the Nordic Risk Group will present and discuss risk and resource-thinking, medicalisation and medical colonisation and how these phenomena have an impact on doctors, individuals and society. The Nordic Risk Group is launching a Swedish book in May 2009 titled 'Skapar vården ohälsa? Allmänmedicinska reflektioner' (literally translated: Does the health care system produce illness? Reflections from the perspective of general practice). The present symposium will encompass a short presentation from each author based on different chapters from the book.

Keywords: Prevention, risk and harm.

S05 IMPROVING THE HEALTH IN PERSONS WITH TYPE 2 DIABETES – RESULTS FROM INTERVENTION STUDIES TARGETING PATIENTS, PRACTICE STAFF AND GPS WITH FOCUS ON IMPLEMENTATION CHALLENGES

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Aim: In an attempt to raise discussion concerning optimal planning and implementation of research projects, the aim of this symposium is to present and discuss challenges in the evaluation' of interventions targeting behavior of patients, practice staff and GPs in the field of improving diabetes care. Content:

1. Translation of results from research projects into daily life. (AS)
2. Reach, process evaluation and effects of the 'Ready to Act' intervention targeted people with screen-detected prediabetes and T2-diabetes in primary care. (HT) The study is finished and the presentation will focus at reach of intervention, process evaluation, and 1 -year effects on motivation, perceived competence and activation
3. A patient addressed electronic facility for optimizing the treatment of type 2 diabetes. (MJ) The implementation process in the research project will provide new knowledge on structural and IT technological possibilities and barriers and patients' will and ability to use electronic access to treatment results and decision support.
4. A pr OPctive nurse-intervention in persons with type 2 diabetes. (LJ) The project will develop and evaluate a pr OPctive nurse-led intervention in people with type 2 diabetes in general practice. Implementation of tools, and effect of the intervention on patient outcomes will be assessed.
5. Development and evaluation of electronic feedback – for optimizing the treatment of type 2 diabetes in general practice. (TG) The results presented here concerns understanding the impact of electronic feedback on type 2 diabetes to general practitioners and are obtained from a qualitative study.

S06 HJEM TIL BABEL – BABEL REVISITED. DO WE NEED OUR NORDIC PROFESSIONAL LANGUAGES?

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In academia there has been a rapid decline in the use of national languages in favour of English. We want to address the normative centripetal forces of English as opposed to the centrifugal particularity of the national languages.The scholar George Steiner describes a language as "the clef of a civilisation". Each different language gives its fluent speakers access to different arenas and different subtleties of human experience. Seamus Heaney writes: "The world is different after it has been read by a Shakespeare or an Emily Dickinson or a Samuel Beckett because it has been augmented by their reading of it." The world is also different after it has been read by a Tomas Tranströmer or a Tarjei Vesaas in a way that is unreachable in English. The care of patients encompasses the whole of human experience and necessarily explores the limits of language. If we are to understand the content and transactions of clinical practice, we will need the resources offered by every language available to us. If the world is only to be described in English, it becomes a smaller place. Language policies in the Nordic countries have been heavily debated since major domains of research and education have undergone "anglification" during recent decades. The consequences and dangers of this development are reflected on, as well as a brief orientation of the Nordic Language Declaration adopted by the Nordic governments 2006.

Keywords: Language, knowledge.

S07 HOW TO INCREASE KNOWLEDGE OF REASON FOR ENCOUNTER AND ACTIVITIES IN GENERAL PRACTICE

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General practice plays an important role in the delivery and coordination of care and as gatekeeper to specialized care. Patients suffering from chronic diseases make up half of the patients in the GP's waiting room. The remaining half is equally split between patients with acute physical disease and patients with medically unexplained symptoms. However, little is known about symptoms leading to medical help-seeking in primary care, the complexity of patient complaints, consultation burden, and how GPs respond to patient needs. We need a thorough insight into the activities in general practice to be able to educate, dimension and support general practice and to continue improvements in patient care. The aim of this symposium is to discuss prerequisites and methods of registration of reason for encounter, symptoms, diagnoses and activities in primary care as well as the implications and possibilities of such a registration.

1) An overview – international experiences on general practice databases, Peter Vedsted, MD, PhD, Senior Researcher, 2) International Classification of Primary Care – the ICPC-2, Marianne Rosendal, MD, PhD, Senior Researcher, 3) Classification of medically unexplained symptoms in general practice, Mette Rask, MHSc, 4) The Danish primary care contact registration project, Grete Moth, MHSc, PhD, Senior Researcher.

Keywords: Database, classification, quality of health care.

W06 A DANISH "MODEL" FOR QUALITY IMPROVEMENT IN GENERAL PRACTICE – KEEPING THE BALANCE?

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Objective: The aim of this workshop is to explore and discuss the necessary elements and their balance in a Danish "Model" for Quality Improvement (QI) in General Practice. This type of development is complex in many ways. For example, different views on quality originating from biomedical, patient centred, preventive medicine/public health and business angles on family medicine must be balanced. The aims of developing a "Model" may include: Reducing the gab between knowledge and medical practice, accreditation, transparency, quality based fees, ensuring QI and learning, shared care between sectors – and for the practices – marketing.

Methods: The workshop will be using a blended learning appr OPch, incorporating a PowerPoint presentation, followed by group work and open floor discussion. The Quality "Model" suggested is based on quality measurement in participating practices on three main areas: Clinical and organisational quality and patient satisfaction. ITC based feedback, facilitated g OPl setting and audit, planned CME of GPs and staff, time management, and external evaluation are important elements. The process will organised in 3 year circles and piloted in 50 practices.

Results: The learning objectives of the workshop are that by the end of this workshop, people should be acquainted with the possible elements of a quality/accreditation "Model". Participant's views are taken into account in the further development of the "Model". Conclusion: The development of a flexible, meaningful and adjustable Quality "Model" for General Practice based on learning rather than external control continues to be our goal.

Keywords: Quality Indicators Accreditation.

W07 DO YOU VOTE FOR PENICILLIN? WORKSHOP ON RESPIRATORY TRACT INFECTIONS.

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An interactive workshop on Respiratory Tract Infections, based on "Happy Audit". Happy Audit is an EU-supported multicenter study on management of respiratory tract infections (RTI), using the APO-method. APO is a clinical audit instrument where the participants register their own clinical performance. Its been in use for more than 20 years with a wide range of topics. Happy Audit focuses on diagnoses and treatment of Respiratory Tract Infections. Within this study we have published a set of evidence-based recommendations compiled in guidelines to the participating countries. In the workshop we aim to elucidate difficult situations regarding patients with signs of RTI, using interactive case-discussions where the participants take part using voting devices. Their suggested management of patients with suspected RTI will be compared with the results of the Happy Audit and recommendations from the guidelines. Who should attend? If you have an interest in and would like to know more about:

- The APO-method
- The Happy Audit Study
- Diagnosis and treatment of RTI Aims
- Describe the APO-method
- Present the preliminary results of the Happy Audit Study
- Discuss and disseminate evidence-based guidelines on RTI Object We will present patient-cases with typical signs of RTI and relate them to the Happy Audit results and guidelines. Method
- Case presentations of frequent RTIs.
- Multiple Choice Questions regarding diagnosis and treatment of patients with symptoms and/or signs of RTI.
- Wireless, electronic Audience Response System (Clicker) with instant presentation of voting results.

Keywords: APO-audit, Respiratory Tract Infections.

W08 GP TRAINEE: FUTURE GATEKEEPER OR ADVISOR? WHAT IS YOUR IDENTITY?

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General Medicine is a relatively new specialty in Denmark and worldwide. But do we share a common identity? The breadth and comprehensiveness of general practice make it a challenge. Can we agree on a joint definition? Where are we in this ever expanding world of specialisation, whilst working in the front line of our healthcare system? Continuing education is a must for GPs to ensure a working knowledge of the entire medical spectrum. We highlight supervision as a educational tool. What to do: Come and spend some time with your future international GP colleagues doing a SWOT analysis. SWOT means S: strengths, W: weaknesses, O: opportunities, T: threats. After a quick introduction to the method, you will have the opportunity to work in smaller groups on the following: 1: SWOT analysis on the comprehensiveness of General Practice: Acute Treatment, Chronic Illness Care, Medically Unexplained Symptoms, where does it leave our identity? 2: SWOT analysis on supervision as an educational tool during your GP training.

Keywords: GP Trainee, SWOT analysis, supervision.