ABSTRACTS

FRIDAY
15 MAY 2009
15.30 – 17.00

OP10.1 CURRENT EUROPEAN GUIDELINES FOR MANAGEMENT OF ARTERIAL HYPERTENSION: ARE THEY ADEQUATE FOR USE IN PRIMARY CARE?

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Objectives: Previous studies indicate that clinical guidelines using combined risk evaluation for cardiovascular diseases (CVD) may overestimate risk. The aim of the present study was to model the implications of recent guidelines for the management of hypertension in a general population, estimate the prevalence of individuals with unfavorable CVD risk levels according to the guidelines and estimate the clinical workl OPd associated with reaching recommended treatment g OPls.

Methods: Implications of the current European Guidelines for the Management of Arterial Hypertension were modelled on data from a cross-sectional, representative Norwegian population study (The Nord-Tröndelag Health Study 1995-97), comprising 65,028 adults, aged 20-89, of whom 51,066 (79%) were eligible for modelling.

Results: Among individuals with blood pressure >120/80 mmHg, 93% (74% of the total population) would need regular clinical attention and/or drug treatment, based on their total CVD risk profile. This translates into 296,624 consultations /100,000 adults/year. In the Norwegian healthcare environment, at least 99 general practitioner (GP) positions would be required in the study region for this preventive task alone. The number of GPs currently serving the adult population in the study area is 87 per 100,000 adults.

Conclusions: The potential workl OPd associated with the European hypertension guidelines could destabilize the healthcare system in Norway, one of the world's most long- and healthy-living nations, by international comparison. Large-scale, preventive medical enterprises can hardly be regarded as scientifically sound and ethically justifiable, unless issues of practical feasibility, sustainability and social determinants of health are considered.

Keywords: Hypertension guidelines, combined risk estimate, cardiovascular risk.

OP10.2 INCREASING INCIDENCE OF STATIN PRESCRIBING FOR THE ELDERLY WITHOUT PREVIOUS CARDIOVASCULAR CONDITIONS. A NATION WIDE REGISTER STUDY

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Supported by the growing evidence of statins' beneficial effects in a range of conditions, statin utilization has increased considerably in most Western countries over the last decade.

Objectives: To estimate to what extent a widening of indication scope for statins accounts for the increasing Danish statin utilization during 1996-2005, applying treatment incidence as a measure of changing prescribing behaviour

Methods: From three nationwide registers, we retrieved individual records on demographics, dispensed prescription drugs and hospital discharges. Danish inhabitants were followed with respect to dispensed prescriptions of cardiovascular drugs and antidiabetica during 1996-2005 and with respect to discharge diagnoses and surgical procedures performed during 1977-2005. The disease status for all cohort members during the observation period was assigned by means of disease markers for seven cardiovascular conditions, corresponding to a hierarchy of statin indications. Poisson regression analyses were applied to quantify the incidence growth, according to age and indication.

Results: Treatment incidence increased from 4/1000 person years in 2000 to 17/1000 in 2005, the increase being slow until 2000. The relative increase was largest among those with no disease markers and lowest among those with ischemic heart disease. The largest growth was found among the elderly (75+) with no disease markers.

Conclusions: Growing statin utilization reflects the br OPder range of condition for initiating statin treatment, including the "abolition of ageism". The fact that treatment incidence grew most among elderly without disease markers reflects a changing prescribing behaviours among general practitioners, presumably related to an increased use of risk scoring.

OP10.3 THE EUROPEAN HEART SCORE SYSTEM – A USEFUL TOOL IN PRACTICE?

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The European developed SCORE chart provides estimates of ten year risk of fatal cardiovascular disease based on joint information on individual risk factors of patient. The chart is intended to aid general practitioners and their patients when deciding whether or not to initiate treatment with cholesterol lowering statins. It has been incorporated in the official guidelines concerning prevention of cardiovascular disease in Scandinavian countries and is consequently widely used. The model itself has however received less attention. In this presentation we first show that the underlying stochastic model is mathematically flawed. Secondly, we highlight that the SCORE model predicts CVD mortality, not all-cause mortality, even though findings within decision psychology indicate that patients can only meaningfully consider all-cause mortality. We finally discuss the common misunderstanding that the colored chart invites: that changing a risk factor directly moves a patient from one cell of the chart to another.

Keywords: Preventive medicine, decision making.

OP10.4 GP'S DECISIONS ON STATIN THERAPIES BY NUMBER NEEDED TO TREAT (NNT)

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Objective: To explore how the NNT might influence general practitioners (GPs) when considering lipid lowering therapy.

Methods: A random sample of GPs (n=450) was mailed a vignette presenting a male patient with an unfavourable cardiovascular risk factor profile and a new drug, "Neostatin". The benefit of "Neostatin" was described in terms of the NNT to observe 1 less patient with cardiovascular disease after 20 years of therapy. Each GP was randomly allocated to 1 of 3 versions of the vignette, in which NNT was set at 10, 19 or 37, respectively. We asked them to evaluate "Neostatin" on a likert type scale anchored at zero (a very bad choice) and ten (a very good choice), whether they would recommend "Neostatin" for the patient, and whether they use qualitative or numeric terms when explaining risk reductions to patients.

Results: The response rate was 48%. With NNT set at 10, 19 and 37, 80%, 74% and 66% would recommend "Neostatin", respectively (chi-square for trend 3.9, $p=0.05$). On the rating scale corresponding mean values were 6.0, 5.6 and 4.7, respectively (one way ANOVA for linear trend: $F=8.2$, $p = 0.005$). About 20% of the respondents indicated that they usually explain risk reductions to patients in terms of NNT, whereas 66% stated that they use qualitative, non-numeric terms, only.

Conclusion: Although GPs may be sensitive to effect size in terms of NNT when considering lipid lowering drug therapies, the majority do not use NNT or any other number when explaining risk reductions to patients.

Keywords: Decision making, risk.

OP10.5 EVALUATING A PSA DECISION AID (PROSDEX) FOR INFORMED DECISIONS: A WEB-BASED RCT

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Background: "Informed decision making" is promoted in the UK for men considering Prostate Specific Antigen (PSA) testing for prostate cancer.

Objectives: We sought to evaluate the effect of a web-based PSA decision-aid, Prosdex, on informed decision making, defined as congruent knowledge, attitudes and intention regarding PSA testing. We also assessed two secondary outcomes: decisional conflict and anxiety.

Methods: Four group RCT: two intervention groups, one viewing Prosdex online and the other receiving a paper-version; two control groups, one controlling for Hawthorne effects of the questionnaire. Men aged 50- 75, without previous PSA tests, were recruited from 25 South Wales (UK) General Practices. Outcomes assessed by online questionnaire.

Results: were reported with Mann-Whitney U-statistic (U/mn: line of no effect =0.50). Results 514 men participated. Prosdex increased knowledge about PSA test/prostate cancer (0.69 U/mn; 95% CI 0.61-0.76; p<0.001), but with less favourable attitude to testing than controls (0.39 U/mn, 95% CI 0.32-0.47; p=0.001); intention to be tested was reduced in the Prosdex group (0.39 U/mn, 95% CI 0.32-0.47; p=0.02); decisional conflict was reduced (0.31 U/mn, 95% CI 0.24-0.39; p<0.001); there was no effect on anxiety (0.506 U/mn, 95% CI 0.425 – 0.586; p>0.5). There was no significant difference between online Prosdex and the paper-version with respect to these outcomes.

Conclusions: Prosdex appears to promote informed decision making, identified by congruence of knowledge, and attitude and intention for PSA testing. This evidence base now provides justification for designing wider dissemination and implementation strategies.

Keywords: PSA, decision aid, randomised trial.

OP11.1 THE GALKER TEST; A SPEECH RECEPTION IN NOISE TEST FOR 3 TO 6 YEAR-OLD CHILDREN

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Background: We have developed a speech reception in noise test to identity children with problems hearing and understanding verbal communication due to middle ear problems.

Methods: The test has 35 test words presented by a speaker under heavy background noise. The child has to point at one of two alternative pictures on the screen. The child uses hearing, lip-reading, knowledge about the used words, interpretation of the drawings illustrating the spoken word. The Galker test has been evaluated on 370 children in a PhD study by Maj-Britt Glen Lauritsen in Hillerød. Now the test is used by several speech and language therapists. The test is available on DVD and takes 5½ minutes.

Results: The Galker score is now standardised to children between three and six years. The children find the test interesting and only a few in the youngest group have problems completing the test. Some results from the testing in Århus County will be presented. We have found god correlation between tympanometry, Galker score, the language test Reynell, and the observation of functional hearing in the daycare centre. The test can be seen at the poster session.

Perspective: At the moment the test is pilot-tested at the four-year examination in the University Practice in Odense. We hope this testing will show that the test can be used in general practice to identify children with problems understanding the spoken word.

Keywords: Preschool children, hearing problems, launguage problems, otitis media.

OP11.2 SLEEP HABITS AND SLEEP PROBLEMS IN THE POSTMODERN FAMILY. A STUDY OF CHILDREN ATTENDING CHILD DAY CARE CENTER

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In the postmodern society, the family life have changed towards more children attending child day care centers (DCC). This may have changed the sleep habits of the children. This study explore sleep habits and problems in preschool children.

Methods: A questionnaire to parents of children attending DCC regarding both recalled and current sleeping problems/habits, sleep time in relation to current health, daily life of the child, and family situation. In all, six selected DCC (nine departments) with 129 of 142 eligible children 1-6 years of age in southern Sweden participated.

Results: Sleep habits have changed to more parents co-sleeping with their children. 13 (10%) of the children were classified as having sleep problem and this was related to having more infections. Children with <7 hours stay per day at DCC had more sleep problems, longer sleep latency and early awakenings compared to those children with longer stay at DCC.

Conclusions: There was a diminished total sleep time (> 1 hour) in pre-school children compared to age matched children studied thirty years ago with a considerable increase of sleep problems/habits towards more habits negative for sleep. Family physicians knowledge of circardiell rythms could be a tool for discussion sleep problems with parents as it could affect childrens health.

Keywords: Sleep; sleep habits, child nursery.

OP11.3 PARACETAMOL FOR FEVERISH CHILDREN: PARENTAL MOTIVES AND EXPERIENCES

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Objective: The sale of paracetamol products for children is increasing and more children receive overdoses, despite lack of evidence on the use of paracetamol against fever. This study explores Danish parents' use of paracetamol for fevers in children and their motives for this use.

Methods: A cross-sectional survey using structured interviews, conducted in four general practices located in city, suburb and rural area. 100 Danish parents with at least one child under the age of ten years were included. Questions covered if parents administrated paracetamol to feverish children, situations triggering medication of their child, parental views regarding fever and effects of paracetamol, and sources of information on fever treatment.

Results: 75 % of parents used paracetamol for feverish children, mainly to reduce temperature, to decrease pain and to help the child fall asleep. Highly educated parents medicated more frequently than less educated. Parents often feared fever but this did not clearly relate to their use of paracetamol. Many parents believed in beneficial effects of paracetamol, such as increased appetite and wellbeing, better sleep and prevention of fever seizures. The expectations of paracetamol influenced parental use of the drug. Parents' main source of information on fever and paracetamol was their general practitioner.

Conclusions: Danish parents regularly treat feverish children with paracetamol. Although parents contact their GP for advice on fever treatment, paracetamol is given to children on vague or false indications. More information and clearer guidelines for parents on the use of paracetamol as an antipyretic is needed.

Keywords: Parents, fever, paracetamol.

OP11.4 GROMMET INSERTION IN PRE-SCHOOL CHILDREN

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Objective: To evaluate patients' and families' short-time benefit from insertion of grommets in children with middle ear conditions.

Background and methods: In Denmark treatment with grommets for middle ear conditions, (SOM and acute otitis media (AOM)), is still a much debated issue. During 2007 approx. 75 000 grommets have been inserted in Denmark, mostly in children. A total of 24 ENTs in private practice in Region Southern Denmark conducted an audit based on questionnaires to evaluate the benefit of this treatment. Some 423 children aged between 0 - 6 years due to have grommets inserted for the first time were included in the study. Both parents and ENTs completed a questionnaire prior to the treatment and three months after.

Results: The study showed that the recommended guidelines for observation time and indications for treatment were complied with. The patients experienced symptom relief and the post-operative quality of life for both the patients and their families highly improved immediately or after a few days.

Conclusions: The study demonstrated convincing, short-term effect of grommet treatment in infants, and the ENT specialists to a large extent comply with the guidelines.

OP12.1 PEER-BASED LEARNING OF COMMUNICATION AND MEDICAL SKILLS FOR NURSES HANDLING PHONE CALLS IN OUT-OF-HOURS PRIMARY HEALTH CARE SERVICES

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Objectives: Registered nurses handle phone calls in out-of-hours primary health care services. They triage medical problems and give medical advice to the callers, frequently without involving a physician. We wanted to assess the quality of this service, to train nurses by using audio logged phone calls and peer-based learning in small groups, and to study possible effects on their communication and medical skills.

Methods: We describe a method for peer-based learning in small groups, where nurses listen to their own audio logged phone calls and then reflect on their communication and medical skills. A tool rating ten aspects of these skills was developed and utilized. Phone calls logged before and after two sessions of peer-based learning were assessed.

Results: The nurses expressed positive feedback with this method of addressing communication and medical skills. The quality of the handling was generally good; the average scores both for the communication and medical skills were 3.6 on a scale from one to five, where one was very poor and five excellent handling. We found a statistically significant improvement of the communication skills in the phone calls audio logged after the two sessions of peer-based learning, but no significant change in the medical skills.

Conclusions: This method of peer-based learning in small groups is useful to train nurses who handle phone calls in out-of-hours primary health care services. The developed tool can be used to assess the communication and medical skills of nurses.

Keywords: After hours care, peer group, professional competence.

OP12.2 THE EPIDEMIOLOGY OF OUT-OF-HOSPITAL EMERGENCIES AND GPS PARTICIPATION IN NORWAY

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Background: In Norway there is a lack of epidemiological data on emergency situations. As a part of a multicenter study on how out-of-hospital emergency patients are administrated, we also collected data on epidemiology. The aim of this substudy was to describe the epidemiology of emergency patients (red responses, highest priority) outside hospitals in Norway and GPs' participation.

Methods: In the period October to December 2007 three dispatch centres recorded every emergency patient. We collected ambulance records, air ambulance records and records from the GPs when they had been involved. The dispatch centres are covering 840 000 inhabitants. NACA score was used to define severity of the emergencies.

Results: 5 105 cases were included in the study. Rate of red responses were six per 1 000 inhabitants. In 4 607 cases we could define medical cause of emergency and NACA score. Heart problems were 28 % of the cases, trauma 17 %, asthma and COPD 7 %, neurological problems 7 %, psychiatry 3 % and other medical problems 38 %. Life-threatening conditions or deaths (NACA 4-7) were indentified in 29 % of the cases, where deaths represented 4 %. GPs were alarmed in 47 % of all cases. Main response was turn out in 41 % of all cases, and 51 % for life-threatening conditions.

Conclusions: GPs take part in clinical judgement and treatment of emergencies. They are an important part of the out-of-hospital emergency system in Norway. GPs should be alarmed more often.

OP12.3 EXPERIENCES WITH A LOCAL EMERGENCY PLAN

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Objectives: All Norwegian local communities (municipalities) have prepared emergency-plans for the local health services. We have investigated how such an emergency plan can be designed as an electronic decision support tool, and thus used actively at the local emergency medical communication centre in emergency situations. We have also investigated the usefulness of the plan in quality improvement of emergency medicine services.

Methods: During a period of 20 months all events where the emergency plan was activated were registered and evaluated. We used evaluation meetings or individual follow up of the services and collaborators. We registered and systemized what worked well, less well, mistakes and follow up actions.

Results: We registered ten emergency situations in the project period and found 38 single items that worked well, 52 items with potential for improvement and 16 items of mistakes. Examples of issues evaluated are alarming, cooperation and organisation at the site and the practical use of the electronic emergency plan. The evaluations were followed up by feedback to the leaders of the services, changes in routines and procedures, information initiatives or changes in the emergency-plan.

Conclusions: An emergency plan for the health services can be a valuable tool in describing and evaluating emergency services. When designed as an electronic decision tool and used in the local emergency medical communication centre it can also be used in regular quality improvement in emergency medicine.

Keywords: Emergency medicine, community medicine, health planning.

OP12.4 ARE PSYCHIATRIC EMERGENCY CARE PATIENTS IN TOUCH WITH THEIR GP?

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Objectives: To assess whether patients attending emergency primary health care for problems related to psychiatric disease, including substance abuse disorders, are in touch with their regular general practitioner (rGP).

Methods: Cross sectional study. Data from the whole of 2006 was extracted from electronic medical records in a rural GP out-of-hours cooperative and the rGP's surgeries in the same catchment area (26336 inhabitants). The variables addressed were gender, age, first diagnosis given and municipality of origin.

Results: Throughout 2006, 11976 consultations and home visits were identified at the casualty clinic. The corresponding number for rGP surgeries was 65040. All consultations and home visits at the casualty clinic were generated by 7304 unique patients. Of these, 179 patients were given at least one diagnosis related to mental illness or substance abuse. Due to insufficient information in the electronic medical record, 25 patients could not be traced with their rGP. Of the remaining patients, most (n=118) had been in touch with their rGP during the same period of time, and two thirds of this group had received at least one diagnosis related to mental illness or substance abuse with their rGP. The diagnoses given at the casualty clinic corresponded well with the diagnoses given at the rGP's surgeries.

Conclusions: Most patients attending emergency primary health care for problems related to mental illness were also in touch with their rGP. This might imply that casualty clinics represent a complementary health care institution for patients with mental disease.

Keywords: After-hours care, emergency medical services, psychiatry.

OP12.5 ACTIVITY IN OUT-OF-HOURS SERVICES IN NORWAY IN 2007

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Objectives: To investigate the use of casualty clinics and out-of-hours services and estimate national figures for these services in Norway in 2007, based on a representative sample. Methods The National Centre for Emergency Primary Health Care has initiated an enterprise called "The Watchtowers" which consists of a representative sample of seven casualty clinics covering 18 Norwegian municipalities. All contacts to the casualty clinics are registered day and night by the attending nurses.

Results: 85 288 contacts were recorded during 2007 (399 per 1000 inhabitants) and 77 % of the contacts were not- urgent. The rate of medical consultations by doctor was 250 per 1 000 inhabitants, and telephone consultations by doctor was 38 per 1000. Home visits and call-outs by doctor made up 13 per 1000 inhabitants, and rate for patient managed by nurse was 96 per 1000. The most common mode of contact was by telephone. When patients attended the casualty clinic directly, 91.2 % of the contacts resulted in consultation by a doctor as opposed to 56.5 % when patient or family called the clinic. Women, young children and elderly had the highest share of contact.

Conclusions: Norway has a high rate of contacts to the out-of-hours services compared to other countries. Valid national figures and future research and monitoring of these services are important both for local services and policy makers. No conflicts of interest.

Keywords: Out-of hours services, sentinel network, activity rates.

OP12.6 LOW PREDICTIVE VALUE OF MECILLINAM RESISTANCE IN PIVMECILLINAM THERAPY FOR MOST UROPATHOGENS BUT HIGH SELECTION OF ENTEROCOCCI IN LOWER UTI

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Objectives: To analyze the predictive value of mecillinam resistance on both clinical and bacteriological outcome of pivmecillinam (PIV) therapy in lower UTI in women (LUTIW).

Methods: A prospective, multicentre, double-blind, therapy study in northern Sweden including 1143 women with symptoms suggestive of LUTIW (urgency, dysuria, suprapubic or loin pain) registered in 4-graded scores (0-3) at inclusion, during therapy and follow-up visits after 8-10 and 35-49 days. Urine cultures with significant bacteriuria (SBU) defined according to European guidelines. Patients randomized to placebo or PIV therapy with 200 mg tid for 7 days, 200 mg bid for 7 days or 400 mg bid for 3 days.

Results: At inclusion 77,9% had SBU with E. coli (62,1%), S. saprophyticus (6,4%), Klebsiella (2,5%) and Enterococci (1,9%). Mean values of all symptoms scores were 5,3 points, with no significant differences between negative culture, bacterial counts or species. PIV showed superior clinical efficacy in SBU but similar as placebo in negative culture. Bacteriological outcome of PIV therapy was not influenced by mecillinam resistance in most common uropathogens with exception above all for enterococci, which raised to10,4 % at first but reduced to 4,4% at last follow-up.

Conclusions: Empirical antibiotic therapy should not be given on symptoms suggestive of LUTIW only but first since SBU is confirmed. The predictive value of in vitro resistance in LUTIW was low concerning outcome of PIV therapy in most common uropathogens with exception above all for enterococci, which were highly selected at 8-10 days but mostly eradicated spontaneously within 5-7 weeks.

S23 TRACING DEPRESSION AMONG ADOLESCENTS

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The proportion of adolescents suffering from depressive disorders is increasingly high. Depressive disorders may be hard to distinguish from adjustment disorders in general practice. How could GPs improve their diagnostic performance in order to improve mental health care among adolescents?

A study group on depression in adolescents has recently been established. A multi-centred study involving the Section for General Practice, University of Oslo, and the Research Unit for General Practice, University of Aarhus is currently in progress. Adolescents aged 14-16 years are invited for depression screening using a self report questionnaire (including the SCL and WHO-5) and three verbally asked key questions. Diagnostic evaluation is performed using the depression module of the CIDI interview. The CIDI diagnoses will be compared with GPs' awareness of any current depressive disorder. Results will be presented and discussed at the symposium.

1. Ole Rikard Haavet: Literature suggests a high prevalence, but poor GP identification of depression in adolescents. Non-recognition may partly be associated with GPs' lack of regular contact with young people, lack of diagnostic skills and instruments, and with families' lack of awareness of depressive symptoms in adolescents. Should general practice adopt new strategies in order to improve recognition rates?

2. Manjit Sirpal: High risk screening for depression is recommended among adults. Which demographic and ethnic characteristics are associated with increased risk of depressive disorders among adolescents? Should high risk screening be recommended among youngsters?

3. Kaj Sparle Christensen: Routine screening for depression seems of little benefit among adults in general practice. Is opportunistic screening for depression in adolescents likely to be more effective than usual GP identification? If so, which questionnaire is the most valid and suitable to be recommended?

4. Wenche Haugen: Three key questions have been found valid in diagnosing depression among adults. Will the same questions be as valid in diagnosing depression among adolescents?

S24 TEACH THE TEACHER: NORDIC EXPERIENCES IN PEDAGOGICAL DEVELOPMENTS IN A PREGRADUATE MEDICAL CURRICULUM IN GENERAL PRACTICE

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What does it take to be a good teacher of medical students in the art of general practice? And how do we plan and implement a program of teaching the teachers? The problems presented to doctors in general practice are often simple, but may be complicated and ambiguous. Teaching the students the basics of this is a complex task involving clinical skills, consultation skills and interpersonal skills and a solid medical background. Experiences from different scandinavian countries will be presented for discussion In close collaboration with the Center for Pedagogical Development (CPD) at the Medical School at Copenhagen University, the department of general practice organized a course for teachers. During the fall of 2008 most of the teachers participated in the partly residential nine day course. The themes varied from general principles of teaching and learning to the development of materials for specific courses. From 2003, general practice has been a major teaching topic for medical students in Tromsø. A pedagogical introductory course is offered to the scientific staff, but for the different teaching elements, the Department of general practice has a continuous challenge of teaching the teachers. A new curriculum for undergraduate medical education has bee introduced at Karolinska Institute in 2007. An educational collaboration has been build including all health centres, their local teachers, numerous supervisors and organisational staff. The overall subject of teaching the teachers will be discussed in this symposium.

S25 ADDICTION AND DRUG/ALCOHOL ABUSE AS A COMPLEX BIO-PSYCHO-SOCIAL HEALTH PROBLEM – A CHALLENGE FOR PRIMARY HEALTH CARE

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Addiction and drug and alcohol abuse is a major global health problem and can be considered as a complex bio-psycho-social syndrome. Drug addicts suffer a substantially increased mortality and morbidity compared to the general population. Substance abuse causes big and complex problems for the single individual, the family and social networks, the local communities and the society. Addiction and the patient with alcohol or drug abuse may be a challenging task for the general practitioner (GP). However, these patients are among those who have the greatest need for health care, both from hospitals and GPs. In this symposium we will shed light on different health problems related to addiction and drug and alcohol abuse. The participants are all GPs with long experience in treating this patient group within the GP setting and they are all engaged in addiction research. Responsible Chair: Ivar Skeie Presentations: Dagfinn Haarr: Treatment of opiate-dependent patients in a general practice Bjørg Hjerkinn: Birth and developmental outcome among children of substance abusing women attending a Special Child Welfare Clinic in Norway Knut Boe Kielland: Mortality and end-stage liver disease related to hepatitis C in injecting drug users Torgeir Gilje Lid: Brief intervention of alcohol problems in general practice – effects of reduced consumption Ivar Skeie: Does Opioid Maintenance Treatment with methadone or buprenorphine reduce the burden of somatic disease among opioid addicts? Harald Sundby: How might drug dependent patients be our teachers in complex medicine?

Keywords: Alcohol-related disorders, substance-related disorders, family practice.

W21 VALUE BASED MEDICINE IN GENERAL PRACTICE

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Introduction: There is a growing need to define the core work of GPs. Value Based Medicine (VBM) is a new an challenging way to regard our daily work in general practice. Just like Evidence Based Medicine (EBM) has been an important step to improve our work we want to draw attention to the qualities of VBM. What is VBM? Why has it become important now? And what will be the pro and cons for using VBM?

Methods: For years GPs have trained the patient-centered method in the consultation. What are the values the patients are looking for? What do doctors want to achieve, what are our values? Health authorities want GPs to be more active in the prophylaxis of smoking, drinking, eating and prescribing physical exercise. When seen from a VBM perspective will this be what we as GPs should be devoted to do? And which methods are we expected to use? How will patients perceive this? How can we choose between VBM and EBM when they are in conflict?

Results: Using the concepts of VBM we expect during the workshop to illuminate what we really want to do as GPs. Discussion: We want to integrate VBM when assessing medical technologies and clinical methods in family medicine.

Keywords: Value based medicine, patient-centeredness, consultation, medical ethics.

W22 EDUCATIONAL GROUP LEADERSHIP – THE NORDIC WAYS

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Aim: The aim of the workshop is to exchange experiences of different concepts of small group work in vocational training in Norway and Denmark, to discuss the role of the group leader and the meaning of different methods of group facilitating and supervision.

Background: In Norway, facilitator-led groups have been a mandatory part of specialist training in general practice for more than 20 years. The curriculum of the group programme has been continuously renewed. In Denmark, supervision groups have been introduced lately as part of the last year of specialist training; the first trainees have completed 10 sessions of group supervision in the course of one year. An overall objective is given but a specified curriculum has yet to be developed. Which models are used? What is the advantage of group work? What is the difference between educational groups in vocational training and supervision groups? Which meaning has the concept of supervision in the specialty of general practice? These are some of the questions that will be raised in the discussion.

Form: After a short introduction from the group leaders from Norway and Denmark, this workshop will let the participants experience group sessions run by the Norwegian and Danish group leaders. We suggest that Norwegian participants join Danish run groups and vice versa. Participants from the other countries are free to choose. There will be a brief plenary round to summon up the major experiences of both ways of group leadership.

Keywords: Educational activities, specialist training, general practice.

W23 DEVELOPING AND EVALUATING COMPLEX INTERVENTIONS. WHAT TO CAUTION?

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Introduction: Gaps between evidence based medicine incorporated into clinical guidelines and real world exist. How to construct interventions that works has been a crucial topic for all partners interested in developing patient care. Lots of different strategies have been tried out, but often initiators are sitting back with limited knowledge of what worked, why it worked and how much did it work. Traditionally RCT has been the method of first choice for getting the evidence of the effect of the intervention. This kind of design can be very hard to carry through and other designs might be reasonable to use instead. Strategies in how to develop complex interventions and how to evaluate and translate interventions have to be focused on. In UK MRC has been into this discussion for years and has presently published new guidelines.

Aim: To discuss the challenges in developing interventions for use at patient or GP/practice staff level aiming a better health of patients. Furthermore to discuss how to evaluate complex interventions and how to translate the results into real life.

Content: A short presentation of the MRC frame of developing complex interventions will open the workshop. We will work with participants own projects. The questions for further discussion in smaller groups and plenum will among others be:

1. Do you know your intervention?
2. Do you know your target group?
3. How to evaluate the intervention?
4. Which outcomes correlate to the intervention?
5. How to translate the results into the real world?

W24 COMMUNICATING TEST RESULTS: CONSIDERING DIAGNOSTIC AND SCREENING TESTS

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Medical providers in general practice often discuss test results with patients, who then take those results, and their understanding of them, to other medical professionals. These patients may then be involved in making decisions about additional diagnostic tests and interventions or decisions about treatment options. In making such decisions, patients can be influenced by their understanding of the initial test result and of what it might mean for them personally. The objective of this workshop is to explore how medical providers' think about and communicate with patients about test results. In particular, we will do this by considering a test that might be used in the diagnosis of a symptomatic patient, or, alternatively, for population screening of asymptomatic people. Participants will share their opinions about what must be communicated when discussing test results, and how best to convey this information. Workshop organizers will "set the stage" by having an actor-patient present two test result scenarios. We will present test result data in an intuitive format and discuss whether thinking about results in this way affects participants' beliefs about communication with patients. Participants will be asked to write down some of their thoughts at the start and end of the workshop. The session will be video-recorded to allow for analysis of the discussion as part of an on-going research project.

Keywords: Risk, communication, decision making.