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ACCESS TO HEALTH CARE


http://dx.doi.org/10.3399/bjgp10X483490

http://pmid.us/20202350

Background: Several models of GP out-of-hours provision exist in the UK but there is little detail about their effectiveness to meet users' needs and expectations. Aim: To explore users' needs, expectations, and experiences of out-of-hours care, and to identify proposals for service redesign. Setting: Service providers in urban (GP cooperative), mixed (hospital based), rural (private) locations in Wales. Participants: Sixty recent service users or carers (20 in each location). Method: Semi-structured telephone interviews; thematic analysis. Results: Users' concerns were generally consistent across the three different services. Efficiency was a major concern, with repetitive triage procedures and long time delays at various stages in the process being problematic. Access to a doctor when required was also important to users, who perceived an obstructive gatekeeping function of preliminary contacts. Expectations moderated the relationship between user concerns and satisfaction. Where expectations of outcome were unfulfilled, participants reported greater likelihood of reconsulting with the same or alternative services for the same illness episode. Accurate expectations concerning contacts with the next administrative, nursing, or medical staff professional were managed by appropriate information provision. Conclusion: Users require more streamlined and flexible triage systems. Their expectations need to be understood and incorporated into how services advise and provide services for users, and actively managed to meet the aims of both enhancing satisfaction and enabling users to cope with their condition. Better information and education about services are needed if users are to derive the greatest benefit and satisfaction. This may influence choices about using the most appropriate forms of care.


http://dx.doi.org/10.1186/1472-6963-9-226

http://www.biomedcentral.com/1472-6963/9/226

http://pmid.us/20003275

Background: Common mental health problems impose substantial challenges to patients, carers, and health care systems. A range of interventions have demonstrable efficacy in
improving the lives of people experiencing such problems. However many people are 
disadvantaged, either because they are unable to access primary care, or because access 
does not lead to adequate help. New methods are needed to understand the problems of 
access and generate solutions. In this paper we describe our methodological approach to 
managing multiple and diverse sources of evidence, within a research programme to 
increase equity of access to high quality mental health services in primary care. Methods: 
We began with a scoping review to identify the range and extent of relevant published 
material, and establish key concepts related to access. We then devised a strategy to 
collect - in parallel - evidence from six separate sources: a systematic review of published 
quantitative data on access-related studies; a meta-synthesis of published qualitative data 
on patient perspectives; dialogues with local stakeholders; a review of grey literature 
from statutory and voluntary service providers; secondary analysis of patient transcripts 
from previous qualitative studies; and primary data from interviews with service users 
and carers. We synthesised the findings from these diverse sources, made judgements on 
key emerging issues in relation to needs and services, and proposed a range of potential 
interventions. These proposals were debated and refined using iterative electronic and 
focus group consultation procedures involving international experts, local stakeholders 
and service users. Conclusions: Our methods break new ground by generating and 
synthesising multiple sources of evidence, connecting scientific understanding with the 
perspectives of users, in order to develop innovative ways to meet the mental health 
needs of under-served groups


http://dx.doi.org/10.1080/13557850903418836
http://pmid.us/20077242

Background. Perinatal depression among Black Caribbean women in the UK remains an 
intriguingly under-researched topic. Despite high levels of known psychosocial risks, 
Black Caribbeans remain relatively invisible among those seeking/receiving help for 
depression during and after pregnancy. Methods. In-depth interviews were undertaken 
with a purposive sample of twelve Black Caribbean women selected from a larger sample 
(n=101) to examine prevalence and psychosocial risks for perinatal depression among 
this ethnic group. The study also sought to explore women's models of help-seeking. 
During analysis, the context in which help-seeking/giving is mediated emerged as a key 
issue. We explore the nature of these encounters thereby opening up the possibility of 
finding common ground between service users and providers for enabling women to 
receive the care and support they need. Findings. Whether or not women configure 
depressive feelings as 'symptoms' requiring external validation and intervention is a 
reflection both of the social embeddedness of those individuals and of how 'help-givers' 
perceive them and their particular needs. We suggest that the ways in which help-
seeking/giving are commonly conceptualised might offer at least a partial explanation for
apparently low levels of diagnosed perinatal depression among Black Caribbean women. Conclusions. Popular approaches to health seeking behaviours within health promotion and practice focus on individuals as the fulcrum for change, tending to overlook their embeddedness within 'reflexive communities'. This might serve to reinforce the invisibility of Black Caribbean women both in mainstream mental health services and associated research. Alternative approaches may be required to achieve government targets to reduce inequalities in access, care, and treatment and to deliver more responsive and culturally-appropriate mental health services


http://dx.doi.org/10.3399/bjgp10X483139

http://pmid.us/20132693

Background: The diversity of definitions of frequent attendance in the literature hampers comparison of their precision, validity, and associated factors. AIM: To examine different definitions of frequent attendance in order to identify the sociodemographic and clinical factors associated with frequent attendance in primary care, according to each definition. Design of study: One-phase cross-sectional study. SETTING: Seventy-seven primary care centres in Catalonia, Spain. Method: A total of 3815 primary care patients were interviewed between October 2005 and March 2006. Three definitions of frequent attendance were tested: (1) frequent attenders as the top 25% and the top 10% consulting patients; (2) frequent attenders as the top 25% and the top 10% consulting patients stratified by age and sex; and (3) frequent attenders as the top 25% and the top 10% consulting patients stratified by the presence of physical/mental conditions (patients with only mental disorders, with only chronic physical conditions, with comorbid conditions, and with no condition). Multilevel logistic regressions were used. Results: The following factors were systematically related to frequent attender status: being on sick leave, being born outside of Spain, reporting mental health problems as the main reason for consulting, and having arthritis/rheumatism, or bronchitis. Major depression was related to frequent attendance in two of the three definitions. The factor 'GP' was related to frequent attendance when the top decile cut-off point was used. The models with a 10% cut-off point were more discriminative than those with a 25% cut-off point: the area under the receiver operating characteristic curve for models with a 25% cut-off and a 10% cut-off ranged between 0.71 (95% confidence interval [CI] = 0.70 to 0.73) and 0.75 (95% CI = 0.74 to 0.77) and between 0.79 (95% CI = 0.78 to 0.81) and 0.85 (95% CI = 0.83 to 0.86), respectively. Conclusion: The way frequent attendance is defined is of crucial importance. It is recommended that a more discriminative definition of frequent attendance is used (the top 10%).
Aim  The purpose of this study was to compare return visits in 2 weeks experienced by patients using a retail nurse-practitioner clinic to similar patients using standard drop-in clinic located in a medical office. Background Retail medicine clinics have become widely available. However, their impact on return visit rates compared to drop-in medical office visits for similar patients is unknown. Methods  Medical records of primary care patients (both adults and children) seen in a large group practice in Minnesota in 2008 were analyzed for this study. Patients treated for five common conditions were selected (pink eye, sore throat, viral illness, bronchitis, and cough, n = 279). Two groups of patients were studied: those using a retail walk-in clinic staffed by nurse practitioners (n = 142) and a comparison group using regular office care for same-day visits (n = 137). The dependent variable was a return office visit within 2 weeks. Multiple logistic regression analysis was used to adjust for case mix differences between groups. Findings The percent of office visits within 2 weeks for these groups was 20.4 for retail drop-in patients and 27.7 for same-day medical office patients, respectively (P = 0.15). After adjustment for age, gender, visit reason, and number of office visits in the previous 6 months, no significant difference in risk of early return visits in comparison to an office-based drop-in clinic was found (odds ratio 0.83, confidence interval 0.43–1.63). Our retail nurse-practitioner clinic appeared to increase access without increasing early return visits.


Background: There has been little research on the impact of quality improvement initiatives on ethnic disparities in diabetes management in the UK. Methods: Population-based, repeated cross-sectional survey of recorded measurements, prescribing and achievement of treatment targets among 4309 patients with diabetes mellitus using electronic medical records from 26 general practices in North-West London from 1997 to 2006. Results: Proportions of patients having their blood pressure (BP), cholesterol and HbA1c measured and recorded increased over the study period [from 50.6% to 87.0% (P < 0.0001), 17.0% to 76.7% (P < 0.0001) and 32.9% to 74.1% (P < 0.0001), respectively]. However, some ethnic differences remained. Black patients with diabetes were less likely to achieve target BP (<140/80 mmHg) than the white group [2006 age-sex adjusted odds
ratio (AOR), 0.65; 95% confidence interval (CI), 0.51-0.83]. South Asians were found to have better lipid target control (2006 AOR, 1.57; CI, 1.23-2.00), were more likely to receive oral hypoglycaemic agents (2006 AOR, 2.27; CI, 1.79-2.86) but less likely to receive insulin (2006 AOR, 0.54; CI, 0.42-0.69) than the white group. Conclusions: Although ethnic disparities persist in diabetes management in this study population, these are starting to be addressed, particularly in the South Asian group. All ethnic groups have benefited from recent quality initiatives in the UK.

**CHRONIC ILLNESS**


[http://dx.doi.org/10.1186/1471-2296-10-79](http://dx.doi.org/10.1186/1471-2296-10-79)

[http://www.biomedcentral.com/1471-2296/10/79](http://www.biomedcentral.com/1471-2296/10/79)

[http://pmid.us/20003406](http://pmid.us/20003406)

Background: Chest pain is a common complaint and reason for consultation in primary care. Research related to gender differences in regard to Coronary Heart Disease (CHD) has been mainly conducted in hospital but not in primary care settings. We aimed to analyse gender differences in aetiology and clinical characteristics of chest pain and to provide gender related symptoms and signs associated with CHD. Methods: We included 1212 consecutive patients with chest pain aged 35 years and older attending 74 general practitioners (GPs). GPs recorded symptoms and findings of each patient and provided follow up information. An independent interdisciplinary reference panel reviewed clinical data of every patient and decided about the aetiology of chest pain at the time of patient recruitment. Multivariable regression analysis was performed to identify clinical predictors that help to rule in or out CHD in women and men. Results: Women showed more psychogenic disorders (women 11.2%, men 7.3%, p = 0.02), men suffered more from CHD (women 13.0%, men 17.2%, p = 0.04), trauma (women 1.8%, men 5.1%, p < 0.001) and pneumonia/pleurisy (women 1.3%, men 3.0%, p = 0.04). Men showed significantly more often chest pain localised on the right side of the chest (women 9.1%, men 25.0%, p = 0.01). For both genders known clinical vascular disease, pain worse with exercise and age were associated positively with CHD. In women pain duration above one hour was associated positively with CHD, while shorter pain durations showed an association with CHD in men. In women negative associations were found for stinging pain and in men for pain depending on inspiration and localised muscle tension. Conclusions: We found gender differences in regard to aetiology,
selected clinical characteristics and association of symptoms and signs with CHD in patients presenting with chest pain in a primary care setting. Further research is necessary to elucidate whether these differences would support recommendations for different diagnostic approaches for CHD according to a patient's gender.


http://dx.doi.org/10.1186/1471-2296-11-4

http://www.biomedcentral.com/1471-2296/11/4

http://pmid.us/20082694

Background: Joint pain, specifically chronic knee pain (CKP), is a frequent cause of chronic pain and limitation of function and mobility among older adults. Multiple evidence-based guidelines recommend exercise as a first-line treatment for all patients with CKP or knee osteoarthritis (KOA), yet healthcare practitioners' attitudes and beliefs may limit their implementation. This systematic review aims to identify the attitudes, beliefs and behaviours of General Practitioners (GPs) regarding the use of exercise for CKP/KOA. Methods: We searched four electronic databases between inception and January 2008, using subject headings to identify studies examining the attitudes, beliefs or behaviours of GPs regarding the use of exercise for the treatment of CKP/KOA in adults aged over 45 years in primary care. Studies referring to patellofemoral pain syndrome or CKP secondary to other causes or that occurring in a prosthetic joint were excluded. Once inclusion and exclusion criteria were applied, study data were extracted and summarised. Study quality was independently reviewed using two assessment tools. Results: From 2135 potentially relevant articles, 20 were suitable for inclusion. A variety of study methodologies and approaches to measuring attitudes beliefs and behaviours were used among the studies. Quality assessment revealed good reporting of study objective, type, outcome factors and, generally, the sampling frame. However, criticisms included use of small sample sizes, low response rates and under-reporting of non-responder factors. Although 99% of GPs agreed that exercise should be used for CKP/KOA and reported ever providing advice or referring to a physiotherapist, up to 29% believed that rest was the optimum management approach. The frequency of actual provision of exercise advice or physiotherapy referral was lower. Estimates of provision of exercise advice and physiotherapy referral were generally higher for vignette-based studies (exercise advice 9%-89%; physiotherapy referral 44%-77%) than reviews of actual practice (exercise advice 5%-52%; physiotherapy referral 13-63%). Advice to exercise and exercise prescription were not clearly differentiated. Conclusions: Attitudes and beliefs of GPs towards exercise for CKP/KOA vary widely and exercise appears to be underused in the management of CKP/KOA. Limitations of the evidence base include the paucity of studies directly examining attitudes of GPs, poor methodological quality, limited generalisability of results and ambiguity concerning GPs' expected roles. Further
investigation is required of the roles of GPs in using exercise as first-line management of CKP/KOA

Georgy EE et al 2009 Back pain management in primary care: patients' and doctors' expectations Quality in Primary Care 17(6) December 2009 405-441

http://pmid.us/20051191

Background: Expectations may be a key element for improving quality of health care, yet several barriers interfere with understanding and optimising expectations in back pain primary care. Objective: To review the literature related to expectations, back pain patients' and doctors' expectations and sources of unmatched expectations. Methods: Review of qualitative and quantitative studies investigating back pain management in primary care settings, and eliciting patients' and/or doctors' pre-visit or post-visit expectations. Results: Reviewing the literature reveals that expectations are defined and conceptualised in various ways, with several terms used interchangeably, which suggests a lack of clear definition and conceptual framework. Patients have a wide range of specific expectations for care, which can be measured, and may play a vital role in their satisfaction: doctors also seem to have their own expectations. However, studies of such expectations are scarce and there is a lack of valid measurement tools to capture such aspects. Discussion: Shortcomings in literature included the use of different meanings and definitions for expectations, which interfered with understanding the results of previous research. Previous studies focused on patients' general rather than condition-specific expectations; no study explored doctors' expectations or the congruency between patients' and doctors' back pain-specific expectations. Conclusions: There is a need for standardisation of definition in expectations research and a valid measurement tool that is condition specific. Understanding patients' and doctors' expectations may be a key factor for improving quality of care, in terms of both process and outcome


http://www.implementationscience.com/content/5/1/7

http://pmid.us/20181050

Background: The WISE (Whole System Informing Self-management Engagement) approach encompasses creating, finding, and implementing appropriate self-care support for people with long-term conditions. A training package for primary care to introduce the approach was developed and underwent formative evaluation. This entailed exploring the acceptability of the WISE approach and its effectiveness in changing communication within consultations. The study aimed to refine the patient, practitioner, and patient level
components of the WISE approach and translate the principles of WISE into an operational intervention deliverable through National Health Service training methods. Methods: Normalisation Process Theory provided a framework for development of the intervention. Practices were recruited from an inner city Primary Care Trust in NW England. All practice staff were expected to attend two afternoon training sessions. The training sessions were observed by members of the training team. Post-training audio recordings of consultations from each general practitioner and nurse in the practices were transcribed and read to provide a narrative overview of the incorporation of WISE skills and tools into consultations. Face-to-face semi-structured interviews were conducted with staff post-training. Results: Two practices out of 14 deemed eligible agreed to take part. Each practice attended two sessions, although a third session on consultation skills training was needed for one practice. Fifty-four post-training consultations were recorded from 15 clinicians. Two members of staff were interviewed at each practice. Significant elements of the training form and methods of delivery fitted contemporary practice. There were logistical problems in getting a whole practice to attend both sessions, and administrative staff found some sections irrelevant. Clinicians reported problems incorporating some of the tools developed for WISE, and this was confirmed in the overview of consultations, with limited overt use of WISE tools and missed opportunities to address patients' self-management needs. Conclusions: The formative evaluation approach and attention to normalisation process theory allowed the training team to make adjustments to content and delivery and ensure appropriate staff attended each session. The content of the course was simplified and focussed more clearly on operationalising the WISE approach. The patient arm of the approach was strengthened by raising expectations of a change in approach to self-care support by their practice


http://dx.doi.org/10.1016/S0140-6736(09)62164-4

http://pmid.us/20189241

Background: Low-back pain is a common and costly problem. We estimated the effectiveness of a group cognitive behavioural intervention in addition to best practice advice in people with low-back pain in primary care. Methods: In this pragmatic, multicentre, randomised controlled trial with parallel cost-effectiveness analysis undertaken in England, 701 adults with troublesome subacute or chronic low-back pain were recruited from 56 general practices and received an active management advisory consultation. Participants were randomly assigned by computer-generated block randomisation to receive an additional assessment and up to six sessions of a group cognitive behavioural intervention (n=468) or no further intervention (control; n=233). Primary outcomes were the change from baseline in Roland Morris disability questionnaire and modified Von Korff scores at 12 months. Assessment of outcomes was blinded and followed the intention-to-treat principle, including all randomised
participants who provided follow-up data. This study is registered, number ISRCTN54717854. Findings: 399 (85%) participants in the cognitive behavioural intervention group and 199 (85%) participants in the control group were included in the primary analysis at 12 months. The most frequent reason for participant withdrawal was unwillingness to complete questionnaires. At 12 months, mean change from baseline in the Roland Morris questionnaire score was 1.1 points (95% CI 0.39-1.72) in the control group and 2.4 points (1.89-2.84) in the cognitive behavioural intervention group (difference between groups 1.3 points, 0.56-2.06; p=0.0008). The modified Von Korff disability score changed by 5.4% (1.99-8.90) and 13.8% (11.39-16.28), respectively (difference between groups 8.4%, 4.47-12.32; p<0.0001). The modified Von Korff pain score changed by 6.4% (3.14-9.66) and 13.4% (10.77-15.96), respectively (difference between groups 7.0%, 3.12-10.81; p<0.0001). The additional quality-adjusted life-year (QALY) gained from cognitive behavioural intervention was 0.099; the incremental cost per QALY was pound1786, and the probability of cost-effectiveness was greater than 90% at a threshold of pound3000 per QALY. There were no serious adverse events attributable to either treatment. Interpretation: Over 1 year, the cognitive behavioural intervention had a sustained effect on troublesome subacute and chronic low-back pain at a low cost to the health-care provider.


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http://www.biomedcentral.com/1471-2296/11/7

http://pmid.us/20105323

Background: Chronic pelvic pain (CPP) has a prevalence similar to asthma and chronic back pain, but little is known about how general practitioners (GPs) and practice nurses manage women with this problem. A clearer understanding of current management is necessary to develop appropriate strategies, in keeping with current health care policy, for the supported self-management of patients with long term conditions. The aim of this study was to explore GPs' and practice nurses' understanding and perspectives on the management of chronic pelvic pain. Method: Data were collected using semi-structured interviews with a purposive sample of 21 GPs and 20 practice nurses, in three primary care trusts in the North West of England. Data were analysed using the principles of Framework analysis. Results: Analysis suggests that women who present with CPP pose a challenge to GPs and practice nurses. CPP is not necessarily recognized as a diagnostic label and making the diagnosis was achieved only by exclusion. This contrasts with the relative acceptability of labels such as irritable bowel syndrome (IBS). GPs expressed elements of therapeutic nihilism about the condition. Despite practice nurses taking on increasing responsibilities for the management of patients with long term conditions, respondents did not feel that CPP was an area that they were comfortable in managing. Conclusions: The study demonstrates an educational/training need for both GPs and practice nurses. GPs described a number of skills and clinical competencies which could
be harnessed to develop a more targeted management strategy. There is potential to develop facilitated self-management for use in this patient group, given that this approach has been successful in patients with similar conditions such as IBS.


http://dx.doi.org/10.1093/fampra/cmp100

http://pmid.us/20089573

Background: Several trials have shown the potential of lifestyle intervention programmes for prevention of type 2 diabetes. The effectiveness of implementation of these programmes into daily practice is now being studied in several countries. The 'Active Prevention in High Risk individuals of Diabetes Type 2 in Eindhoven' (APHRODITE) study investigates whether type 2 diabetes prevention by lifestyle intervention is effective in Dutch primary care. In this article we describe the process of recruiting the study participants. Objective: To assess the reach of an active strategy to recruit participants for a programme on type 2 diabetes prevention by lifestyle intervention in Dutch primary care. Methods: A diabetes risk questionnaire was sent to general practice patients aged 40-70 years. Individuals with a risk score above threshold were invited for an admission interview with the GP and an oral glucose tolerance test (OGTT). All individuals with non-diabetic glucose levels were asked to participate in the intervention study. RESULTS: In total, 8752 (54.6%) of the individuals returned the questionnaire in time. Of all high-risk individuals (n = 1533), 73.1% contacted their practice to schedule a consultation with the GP. Response rates varied significantly among practices. Conclusions: Using invitational letters, a substantial amount of individuals could be motivated to participate in a programme on type 2 diabetes prevention by lifestyle intervention in Dutch primary care. Further research is needed on what kind of strategy would be most effective and efficient to screen for individuals at high risk for type 2 diabetes in primary care.


http://dx.doi.org/10.1186/1748-5908-5-3

http://www.implementationscience.com/content/5/1/3

http://pmid.us/20205758

Background: Information exchange networks for chronic illness care may influence the uptake of innovations in patient care. Valid and feasible methods are needed to document and analyse information exchange networks in healthcare settings. This observational study aimed to examine the usefulness of methods to study information exchange
networks in primary care practices, related to chronic heart failure, diabetes and chronic obstructive pulmonary disease. Methods: The study was linked to a quality improvement project in the Netherlands. All health professionals in the practices were asked to complete a short questionnaire that documented their information exchange relations. Feasibility was determined in terms of response rates and reliability in terms of reciprocity of reports of receiving and providing information. For each practice, a number of network characteristics were derived for each of the chronic conditions. Results: Ten of the 21 practices in the quality improvement project agreed to participate in this network study. The response rates were high in all but one of the participating practices. For the analysis, we used data from 67 health professionals from eight practices. The agreement between receiving and providing information was, on average, 65.6%. The values for density, centralization, hierarchy, and overlap of the information exchange networks showed substantial variation between the practices as well as between the chronic conditions. The most central individual in the information exchange network could be a nurse or a physician. Conclusions: Further research is needed to refine the measure of information networks and to test the impact of network characteristics on the uptake of innovations.

Williams, Allison, Manias, Elizabeth, and Walker, Rowan. 2010 The devil is in the detail- a multifactorial intervention to reduce blood pressure in co-existing diabetes and chronic kidney disease: a single blind, randomized controlled trial. BMC Family Practice 11(1), 3. 2010.

http://dx.doi.org/10.1186/1471-2296-11-3

http://www.biomedcentral.com/1471-2296/11/3

http://pmid.us/20064272

Background: About 30-60% of individuals are non-adherent to their prescribed medications and this risk increases as the number of prescribed medications increases. This paper outlines the development of a consumer-centred Medicine Self-Management Intervention (MESMI), designed to improve blood pressure control and medication adherence in consumers with diabetes and chronic kidney disease recruited from specialist outpatients' clinics. Methods: We developed a multifactorial intervention consisting of Self Blood Pressure Monitoring (SBPM), medication review, a twenty-minute interactive Digital Versatile Disc (DVD), and follow-up support telephone calls to help consumers improve their blood pressure control and take their medications as prescribed. The intervention is novel in that it has been developed from analysis of consumer and health professional views, and includes consumer video exemplars in the DVD. The primary outcome measure was a drop of 3-6 mmHg systolic blood pressure at three months after completion of the intervention. Secondary outcome measures included: assessment of medication adherence, medication self-efficacy and general wellbeing. Consumers' adherence to their prescribed medications was measured by manual pill count, self-report of medication adherence, and surrogate biochemical markers of disease control. Discussion: The management of complex health problems is
an increasing component of health care practice, and requires interventions that improve patient outcomes. We describe the preparatory work and baseline data of a single blind, randomized controlled trial involving consumers requiring cross-specialty care with a follow-up period extending to 12 months post-baseline. The trial was registered with the Australian and New Zealand Clinical Trials Register.

COMORBIDITY


http://dx.doi.org/10.1059/0003-4819-151-12-200912150-00005

http://pmid.us/20008761

Background: Recent studies have shown mixed results regarding the effectiveness of intensive glucose-lowering therapy in reducing risk for cardiovascular events. Objective: To determine whether attaining hemoglobin A(1c) (HbA1c) targets of 6.5% or less or 7.0% or less for glycemic control at baseline provides differential benefits for patients with high versus low-to-moderate levels of comorbidity. Design: 5-year longitudinal observational study of patients with type 2 diabetes. Patients were categorized into high and low-to-moderate comorbidity subgroups by using the Total Illness Burden Index (TIBI), a validated patient-reported measure of comorbidity. Setting: 101 diabetes outpatient clinics and 103 general practitioners' clinics in Italy. Patients: 2613 (83%) of 3074 patients with type 2 diabetes, sampled randomly from diabetes outpatient clinic rosters and recruited consecutively from general practitioners' clinics, who completed the baseline questionnaire. Measurements: TIBI score, total mortality, and incident cardiovascular events. Hazard ratios (HRs) were adjusted for age and sex. Results: Attaining an HbA1c level of 6.5% or less at baseline was associated with lower 5-year incidence of cardiovascular events in the low-to-moderate comorbidity subgroup (adjusted HR, 0.60 [95% CI, 0.42 to 0.85]; P = 0.005) but not in the high comorbidity subgroup (adjusted HR, 0.92 [CI, 0.68 to 1.25]; P = 0.61; P for subgroup by HbA1c)
interaction = 0.048). Similarly, attaining a baseline HbA(1c) level of 7.0% predicted fewer cardiovascular events in the low-to-moderate comorbidity subgroup (adjusted HR, 0.61 (CI, 0.44 to 0.83; P = 0.001) but not in the high comorbidity subgroup (adjusted HR, 0.88 [CI, 0.66 to 1.17]; P = 0.38; P for subgroup by HbA(1c) interaction = 0.093).

Limitations: The observational nature of the study does not allow causal inference. The length of the data collection period was limited. Information on clinical management was not available. Conclusion: Patients with the high levels of comorbidity common in type 2 diabetes may receive diminished cardiovascular benefit from intensive blood glucose control. Comorbidity should be considered when tailoring glucose-lowering therapy in patients with type 2 diabetes.


http://dx.doi.org/10.1007/s11606-009-1248-6

http://pmid.us/20108126

Background: Both depression and diabetes have been found to be risk factors for dementia. This study examined whether comorbid depression in patients with diabetes increases the risk for dementia compared to those with diabetes alone. Methods: We conducted a prospective cohort study of 3,837 primary care patients with diabetes (mean age 63.2 +/- 13.2 years) enrolled in an HMO in Washington State. The Patient Health Questionnaire (PHQ-9) was used to assess depression at baseline, and ICD-9 diagnoses for dementia were used to identify cases of dementia. Cohort members with no previous ICD-9 diagnosis of dementia prior to baseline were followed for a 5-year period. The risk of dementia for patients with both major depression and diabetes at baseline relative to patients with diabetes alone was estimated using cause-specific Cox proportional hazard regression models that adjusted for age, gender, education, race/ethnicity, diabetes duration, treatment with insulin, diabetes complications, nondiabetes-related medical comorbidity, hypertension, BMI, physical inactivity, smoking, HbA(1c), and number of primary care visits per month. Results: Over the 5-year period, 36 of 455 (7.9%) patients with major depression and diabetes (incidence rate of 21.5 per 1,000 person-years) versus 163 of 3,382 (4.8%) patients with diabetes alone (incidence rate of 11.8 per 1,000 person-years) had one or more ICD-9 diagnoses of dementia. Patients with comorbid major depression had an increased risk of dementia (fully adjusted hazard ratio 2.69, 95% CI 1.77, 4.07). Conclusions: Patients with major depression and diabetes had an increased risk of development of dementia compared to those with diabetes alone. These data add
to recent findings showing that depression was associated with an increased risk of macrovascular and microvascular complications in patients with diabetes.

GOVERNANCE


[http://dx.doi.org/10.1017/S1474746409990169](http://dx.doi.org/10.1017/S1474746409990169)

The inherent problems and limitations of managing risk and uncertainty are examined in a salient case setting - the English NHS. The 'dark-side' of simply trusting professionals to pursue their own craft, as acknowledged by Sennett, has been politicised to under-gird an increased use of quasi-markets, via the choice agenda, and governance. It is argued that these alternatives to trust - price and control - are further dysfunctional still. The innate tendencies of governance, and therefore choice, to lose sight of patient care are even more pronounced than the fallibility of professionals. A new, qualified form of trust is proposed in resolution.

HEALTH ECONOMICS


The article discusses the objectives of the prospective payment system Payment by Results (PbR) being introduced into the English National Health Service and how it fits into the broader reform programme of health services in England. The continuing challenges for PbR are discussed and some suggestions made about how matters could be improved.

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.


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 £6000-12 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

**Jenkins, R, et al 2009  Recession, debt and mental health. Mental Health in Family Medicine  6(2)  85-90**

Background: During the economic downturn, the link between recession and health has featured in many countries' media, political, and medical debate. This paper focuses on the previously neglected relationship between personal debt and mental health. Aims: Using the UK as a case study, this paper considers the public health challenges presented by debt to mental health. We then propose solutions identified in workshops held during the UK Government's Foresight Review of Mental Capital and Wellbeing. Results: Within their respective sectors, health professionals should receive basic 'debt first aid' training, whilst all UK financial sector codes of practice should - as a minimum - recognise the existence of customers with mental health problems. Further longitudinal research is also needed to 'unpack' the relationship between debt and mental health. Across sectors, a lack of co-ordinated activity across health, money advice, and creditor organisations remains a weakness. A renewed emphasis on co-ordinated 'debt care pathways' and better communication between local health and advice services is needed. Discussion: The relationship between debt and mental health presents a contemporary public health challenge. Solutions exist, but will require action and investment at a time of competition for funds.


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http://pmid.us/19945763

Objective  Identify the economic value the user attributes to the visit to the family physician, in a setting of a National Health System, by the Willingness to Pay (WTP)
expressed. Methods Economic evaluation study, by the contingent valuation method. Questions were asked about WTP using a payment card format. Interviews were conducted with 451 subjects, in areas with different socioeconomic characteristics. An ordered probit was used to evaluate model's validity. Results Median WTP expressed was €18 (interquartile range €8–28), not including “zero-answers” of thirty-four subjects (7.5%). This value represents 2% of average adjusted family incomes. Patients with higher incomes or with chronic illnesses presented a probability of 5–14 percentage points of expressing a high WTP. For every point of increase of patient satisfaction, the probability of presenting a WTP in the lowest range decreases 7.0 percentage points. Subjects with a low education level and those older than 65 expressed a lower WTP. Accessibility, risk perception, nationality and having private insurance were not related to the WTP expressed. Conclusions Users of primary care have a clear perception of the economic value of care received from the family physician, even in a framework of providing services financed by taxes and without cost at the moment of use. This value increases in subjects with higher incomes, with greater need for care, or more satisfied.


http://dx.doi.org/10.1002/hec.1573

http://pmid.us/20127746

We analyse the determinants of annual net income and wages (net income/hours) of general practitioners (GPs) using data for 2271 GPs in England recorded during Autumn 2008. The average GP had an annual net income of pound97 500 and worked 43 h per week. The mean wage was pound51 per h. Net income and wages depended on gender, experience, list size, partnership size, whether or not the GP worked in a dispensing practice, whether they were salaried of self-employed, whether they worked in a practice with a nationally or locally negotiated contract, and the characteristics of the local population (proportion from ethnic minorities, rurality, and income deprivation). The findings have implications for pay discrimination by GP gender and ethnicity, GP preferences for partnership size, incentives for competition for patients, and compensating differentials for local population characteristics. They also shed light on the attractiveness to GPs in England of locally negotiated (personal medical services) versus nationally negotiated (general medical services) contracts.

HEALTH INEQUALITIES

http://dx.doi.org/10.1016/j.jhealeco.2009.07.001
http://pmid.us/19660818

This paper proposes a new approach to the measurement of inequality and inequity in the delivery of health care based on contributions from the literature on poverty and deprivation. This approach has some appealing characteristics: (1) inequity is additively decomposable by population subgroups; (2) the approach does not rely on socio-economic ranks; (3) it provides a graphical representation of the distribution of inequity; (4) it offers a range of indices consistent with dominance. An empirical application is provided investigating the effect of the GP fundholding reform on equity in English NHS. The results show that the most equitable GP practices self-selected into the scheme in 1991; evidence of an inequity-reducing treatment effect as well as a self-selection effect are found in 1992 and 1993; the self-selection process reduces and no evidence of a treatment effect is present thereafter.


http://dx.doi.org/10.1136/jech.2009.089409
http://pmid.us/19622520

Background: Ethnic/racial inequalities in access to and quality of healthcare have been repeatedly documented in the USA. Although there is some evidence of inequalities in England, research is not so extensive. Ethnic inequalities in use of primary and secondary health services, and in outcomes of care, were examined in England. Methods: Four waves of the Health Survey for England were analysed, a representative population survey with ethnic minority oversamples. Outcome measures included use of primary and secondary healthcare services and clinical outcomes of care (controlled, uncontrolled and undiagnosed) for three conditions – hypertension, raised cholesterol and diabetes. Results: Ethnic minority respondents were not less likely to use GP services. For example, the adjusted odds ratios for Indian, Pakistani and Bangladeshi versus white respondents were 1.29 (95% confidence intervals 1.07 to 1.54), 1.32 (1.10 to 1.58) and 1.35 (1.10 to 1.65) respectively. Similarly, there were no ethnic inequalities for the clinical outcomes of care for hypertension and raised cholesterol, and, on the whole, no inequalities in outcomes of care for diabetes. There were ethnic inequalities in access to hospital services, and marked inequalities in use of dental care. Conclusion: Ethnic inequalities in access to healthcare and the outcomes of care for three conditions
hypertension, raised cholesterol and diabetes), for which treatment is largely provided in primary care, appear to be minimal in England. Although inequalities may exist for other conditions and other healthcare settings, particularly internationally, the implication is that ethnic inequalities in healthcare are minimal within NHS primary care.


http://dx.doi.org/10.1007/s10728-010-0144-x

http://pmid.us/20135233

Abstracts are written to summarise documents and to whet the reader's interest. Alas, many readers just use them as a substitute for reading the whole paper, which given the brevity of abstracts can give a somewhat distorted impression. I hope that having read this abstract, you will read on. If you do, you will find that I offer a little personal history and a little impersonal history on the development of interest in the issue of health inequalities in England. I then summarise the policy response of recent Labour administrations, briefly detail the effects of this response, and finally offer my own three-pronged policy attack on our thus far really quite stubborn inequalities in health.

INFORMATION AND COMMUNICATION TECHNOLOGY


http://dx.doi.org/10.1186/1471-2296-10-72

http://www.biomedcentral.com/1471-2296/10/72

http://pmid.us/19917136
Background: Information technology (IT) is increasingly being used in general practice to manage health care including type 2 diabetes. However, there is conflicting evidence about whether IT improves diabetes outcomes. This review of the literature about IT-based diabetes management interventions explores whether methodological issues such as sample characteristics, outcome measures, and mechanisms causing change in the outcome measures could explain some of the inconsistent findings evident in IT-based diabetes management studies. Methods: Databases were searched using terms related to IT and diabetes management. Articles eligible for review evaluated an IT-based diabetes management intervention in general practice and were published between 1999 and 2009 inclusive in English. Studies that did not include outcome measures were excluded. Results: Four hundred and twenty-five articles were identified, sixteen met the inclusion criteria: eleven GP focussed and five patient focused interventions were evaluated. Nine were RCTs, five non-randomised control trials, and two single-sample before and after designs. Important sample characteristics such as diabetes type, familiarity with IT, and baseline diabetes knowledge were not addressed in any of the studies reviewed. All studies used HbA1c as a primary outcome measure, and nine reported a significant improvement in mean HbA1c over the study period; only two studies reported the HbA1c assay method. Five studies measured diabetes medications and two measured psychological outcomes. Patient lifestyle variables were not included in any of the studies reviewed. IT was the intervention method considered to effect changes in the outcome measures. Only two studies mentioned alternative possible causal mechanisms. Conclusion: Several limitations could affect the outcomes of IT-based diabetes management interventions to an unknown degree. These limitations make it difficult to attribute changes solely to such interventions.


http://dx.doi.org/10.1016/j.socscimed.2009.12.034
http://pmid.us/20185218

The UK National Health Service is grappling with various large and controversial IT programmes. We sought to develop a sharper theoretical perspective on the question “What happens – at macro-, meso- and micro-level – when government tries to modernise a health service with the help of big IT?” Using examples from data fragments at the micro level of clinical work, we considered how structuration theory and actor-network theory (ANT) might be combined to inform empirical investigation. Giddens (1984) argued that social structures and human agency are recursively linked and co-evolve. ANT studies the relationships that link people and technologies in dynamic networks. It considers how discourses become inscribed in data structures and decision models of software, making certain network relations irreversible. Stones' (2005) strong structuration theory (SST) is a refinement of Giddens' work, systematically concerned with empirical research. It views human agents as linked in dynamic networks of
position-practices. A quadripartite approach considers [a] external social structures (conditions for action); [b] internal social structures (agents' capabilities and what they ‘know’ about the social world); [c] active agency and actions and [d] outcomes as they feed back on the position-practice network. In contrast to early structuration theory and ANT, SST insists on disciplined conceptual methodology and linking this with empirical evidence. In this paper, we adapt SST for the study of technology programmes, integrating elements from material interactionism and ANT. We argue, for example, that the position-practice network can be a socio-technical one in which technologies in conjunction with humans can be studied as ‘actants’. Human agents, with their complex socio-cultural frames, are required to instantiate technology in social practices. Structurally relevant properties inscribed and embedded in technological artefacts constrain and enable human agency. The fortunes of healthcare IT programmes might be studied in terms of the interplay between these factors.


http://pmid.us/20021585

Context: The extensive research literature on electronic patient records (EPRs) presents challenges to systematic reviewers because it covers multiple research traditions with different underlying philosophical assumptions and methodological approaches. Methods: Using the meta-narrative method and searching beyond the Medline-indexed literature, this review used "conflicting" findings to address higher-order questions about how researchers had differently conceptualized and studied the EPR and its implementation. Findings: Twenty-four previous systematic reviews and ninety-four further primary studies were considered. Key tensions in the literature centered on (1) the EPR ("container" or "itinerary"); (2) the EPR user ("information-processor" or "member of socio-technical network"); (3) organizational context ("the setting within which the EPR is implemented" or "the EPR-in-use"); (4) clinical work ("decision making" or "situated practice"); (5) the process of change ("the logic of determinism" or "the logic of opposition"); (6) implementation success ("objectively defined" or "socially negotiated"); and (7) complexity and scale ("the bigger the better" or "small is beautiful"). Conclusions: The findings suggest that EPR use will always require human input to recontextualize knowledge; that even though secondary work (audit, research, billing) may be made more efficient by the EPR, primary clinical work may be made less efficient; that paper may offer a unique degree of ecological flexibility; and that smaller EPR systems may sometimes be more efficient and effective than larger ones. We suggest an agenda for further research.


http://dx.doi.org/10.1186/1748-5908-5-12

http://www.implementationscience.com/content/5/1/12

http://pmid.us/20181104

Background: Computerized clinical decision support systems are information technology-based systems designed to improve clinical decision-making. As with any healthcare intervention with claims to improve process of care or patient outcomes, decision support systems should be rigorously evaluated before widespread dissemination into clinical practice. Engaging healthcare providers and managers in the review process may facilitate knowledge translation and uptake. The objective of this research was to form a partnership of healthcare providers, managers, and researchers to review randomized controlled trials assessing the effects of computerized decision support for six clinical application areas: primary preventive care, therapeutic drug monitoring and dosing, drug prescribing, chronic disease management, diagnostic test ordering and interpretation, and acute care management; and to identify study characteristics that predict benefit.

Methods: The review was undertaken by the Health Information Research Unit, McMaster University, in partnership with Hamilton Health Sciences, the Hamilton, Niagara, Haldimand, and Brant Local Health Integration Network, and pertinent healthcare service teams. Following agreement on information needs and interests with decision-makers, our earlier systematic review was updated by searching Medline, EMBASE, EBM Review databases, and Inspec, and reviewing reference lists through 6 January 2010. Data extraction items were expanded according to input from decision-makers. Authors of primary studies were contacted to confirm data and to provide additional information. Eligible trials were organized according to clinical area of application. We included randomized controlled trials that evaluated the effect on practitioner performance or patient outcomes of patient care provided with a computerized clinical decision support system compared with patient care without such a system.

Results: Data will be summarized using descriptive summary measures, including proportions for categorical variables and means for continuous variables. Univariable and multivariable logistic regression models will be used to investigate associations between outcomes of interest and study specific covariates. When reporting results from individual studies, we will cite the measures of association and p-values reported in the studies. If appropriate for groups of studies with similar features, we will conduct meta-analyses.

Conclusion: A decision-maker-researcher partnership provides a model for systematic reviews that may foster knowledge translation and uptake.

Background: Sampling in the absence of accurate or comprehensive information routinely poses logistical, ethical, and resource allocation challenges in social science, clinical, epidemiological, health service and population health research. These challenges are compounded if few members of a target population know each other or regularly interact. This paper reports on the sampling methods adopted in ethnographic case study research with a 'hard-to-reach' population. 

Methods: To identify and engage a small yet diverse sample of people who met an unusual set of criteria (i.e., pet owners who had been treating cats or dogs for diabetes), four sampling strategies were used. First, copies of a recruitment letter were posted in pet-friendly places. Second, information about the study was diffused throughout the study period via word of mouth. Third, the lead investigator personally sent the recruitment letter via email to a pet owner, who then circulated the information to others, and so on. Fourth, veterinarians were enlisted to refer people who had diabetic pets. The second, third and fourth strategies rely on social networks and represent forms of chain referral sampling. 

Results: Chain referral sampling via email proved to be the most efficient and effective, yielding a small yet diverse group of respondents within one month, and at negligible cost. 

Conclusions: The widespread popularity of electronic communication technologies offers new methodological opportunities for researchers seeking to recruit from hard-to-reach populations.


On August 20, 2009, the US government announced $1.2 billion in new grants as part of the American Recovery and Reinvestment Act to promote "meaningful use" of electronic health records (EHRs) by all individuals in 2011 and to support the development of mechanisms for information sharing through EHRs in the United States. This investment is happening at a time of massive reduction in the costs of data collection, exchange, and storage; of convergence of technologies; and massive public adoption of smart telephones and online social media. In this Commentary, we propose some components for consideration during the development of the EHR network that will emerge in the United States. This proposal recognizes that these important trends create a unique opportunity for the emergence of a national system of interconnected EHRs in the United States and for a rethinking of how EHRs are constructed and used, and to promote a truly people-centered health care system. This proposed framework includes seven components based
on resources and knowledge that exist today, and may contribute to current efforts to provide the public with access to tools that meet the public’s needs and expectations.

**Turnbull J et al**  2010  *Do telephones overcome geographical barriers to general practice out-of-hours services? Mixed-methods study of parents with young children*  
*Journal of Health Services Research and Policy*  
Epub ahead of print 1/01/2010  
[http://dx.doi.org/10.1258/jhsrp.2009.009023](http://dx.doi.org/10.1258/jhsrp.2009.009023)

Objective: To examine if telephones overcome geographical barriers to accessing primary care out-of-hours by parents of young children.  
Methods: Mixed methods including quantitative analysis of 5697 calls about children aged 0–4 years, 30 hours of observation at primary care centres, eight interviews with parents and a review of 80 telephone call recordings.  
Results: Call rates for children (0–4 years) decreased with increasing distance: the 20% of people who lived furthest from a primary care centre made fewer calls, 570 per 1000 patients/year (95% CI 558 to 582) than the 20% living closest, 652 (95% CI 644 to 661). Overall, call rates decreased with increasing rurality. Qualitative analysis suggested that this geographical variation was linked to familiarity with the system (notably previous contact with health services) and the availability of services, legitimacy of demand (particularly for children) and negotiation about mode of care.  
Conclusions: People already disadvantaged by their distance from facilities or socioeconomic circumstances may continue to be at a disadvantage when services are provided by telephone.

**Wong G et al**  2010  *Internet-based medical education: a realist review of what works, for whom and in what circumstances.*  
*BMC Medical Education*  
[Epub ahead of print]  
[http://dx.doi.org/10.1186/1472-6920-10-12](http://dx.doi.org/10.1186/1472-6920-10-12)  
[http://www.biomedcentral.com/1472-6920/10/12](http://www.biomedcentral.com/1472-6920/10/12)  
[http://pmid.us/20122253](http://pmid.us/20122253)

Background: Educational courses for doctors and medical students are increasingly offered via the Internet. Despite much research, course developers remain unsure about what (if anything) to offer online and how. Prospective learners lack evidence-based guidance on how to choose between the options on offer. We aimed to produce theory driven criteria to guide the development and evaluation of Internet-based medical courses.  
MethodS: Realist review - a qualitative systematic review method whose goal is
to identify and explain the interaction between context, mechanism and outcome. We searched 15 electronic databases and references of included articles, seeking to identify theoretical models of how the Internet might support learning from empirical studies which (a) used the Internet to support learning, (b) involved doctors or medical students; and (c) reported a formal evaluation. All study designs and outcomes were considered. Using immersion and interpretation, we tested theories by considering how well they explained the different outcomes achieved in different educational contexts. Results: 249 papers met our inclusion criteria. We identified two main theories of the course-in-context that explained variation in learners' satisfaction and outcomes: Davis's Technology Acceptance Model and Laurillard's model of interactive dialogue. Learners were more likely to accept a course if it offered a perceived advantage over available non-Internet alternatives, was easy to use technically, and compatible with their values and norms. 'Interactivity' led to effective learning only if learners were able to enter into a dialogue - with a tutor, fellow students or virtual tutorials - and gain formative feedback. Conclusions: Different modes of course delivery suit different learners in different contexts. When designing or choosing an Internet-based course, attention must be given to the fit between its technical attributes and learners' needs and priorities; and to ways of providing meaningful interaction. We offer a preliminary set of questions to aid course developers and learners consider these issues.

MEDICINES MANAGEMENT


http://dx.doi.org/10.3399/bjgp09X454061

http://pmid.us/19761665

Background: Since the 1990s, Scottish community-based antidepressant prescribing has increased substantially. Aim: To assess whether GPs prescribe antidepressants appropriately. Design of study: Observational study of adults (aged \( \geq 16 \) years) screened with the Hospital Anxiety and Depression Scale (HADS) attending a GP. Setting: Four practices in Grampian, Scotland. Method: Patients (n = 898) completed the HADS, and GPs independently estimated depression status. Notes were scrutinised for evidence of antidepressant use, and the appropriateness of prescribing was assessed.
Results: A total of 237 (26%) participants had HADS scores indicating 'possible' (15%) or 'probable' (11%) depression. The proportion of participants rated as depressed by their GP differed significantly by HADS depression subscale scores. Odds ratio for 'possible' versus 'no' depression was 3.54 (95% confidence interval [CI] = 2.17 to 5.76, P<0.001); and for 'probable' versus 'possible' depression was 3.59 (95% CI = 2.06 to 6.26, P<0.001). Similarly, the proportion of participants receiving antidepressants differed significantly by HADS score. Odds ratio for 'possible' versus 'no' depression was 2.79 (95% CI = 1.70 to 4.58, P<0.001); and for 'probable' versus 'possible' was 2.12 (95% CI = 1.21 to 3.70, P = 0.009). In 101 participants with 'probable' depression, GPs recognised 53 (52%) participants as having a clinically significant depression. Inappropriate initiation of antidepressant treatment occurred very infrequently. Prescribing to participants who were not symptomatic was accounted for by the treatment of pain, anxiety, or relapse prevention, and for ongoing treatment of previously identified depression. Conclusion: There was little evidence of prescribing without relevant indication. Around half of patients with significant symptoms were not identified by their GP as suffering from a depressive disorder: this varied inversely with severity ratings. Rather than prescribing indiscriminately (as has been widely assumed), it is likely that GPs are initiating antidepressant treatment conservatively.

Respect Trial Team 2010 Cost-effectiveness of shared pharmaceutical care for older patients: RESPECT trial findings. *British Journal of General Practice* 60(570), e20-e27. 2010

http://dx.doi.org/10.3399/bjgp09X482312

http://pmid.us/20040164

Background: Pharmaceutical care serves as a collaborative model for medication review. Its use is advocated for older patients, although its cost-effectiveness is unknown. Although the accompanying article on clinical effectiveness from the RESPECT (Randomised Evaluation of Shared Prescribing for Elderly people in the Community over Time) trial finds no statistically significant impact on prescribing for older patients undergoing pharmaceutical care, economic evaluations are based on an estimation, rather than hypothesis testing. AIM: To evaluate the cost-effectiveness of pharmaceutical care for older people compared with usual care, according to National Institute for Health and Clinical Excellence (NICE) reference case standards. Methods: An economic evaluation was undertaken in which NICE reference case standards were applied to data collected in the RESPECT trial. RESULTS: On average, pharmaceutical care is estimated to cost an incremental 10 000 UK pounds per additional quality-adjusted life year (QALY). If the NHS's cost-effectiveness threshold is between 20 000 and 30 000 UK pounds per extra QALY, then the results indicate that pharmaceutical care is cost-effective despite a lack of statistical significance to this effect. However, the statistical uncertainty surrounding the estimates implies that the probability that pharmaceutical care is not cost-effective lies between 0.22 and 0.19. Although results are not sensitive to assumptions about costs, they differ between subgroups: in patients aged >75 years pharmaceutical care appears more cost-effective for those who are younger or on fewer repeat medications.
Conclusion: Although pharmaceutical care is estimated to be cost-effective in the UK, the results are uncertain and further research into its long-term benefits may be worthwhile.


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

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.


http://dx.doi.org/10.3399/bjgp09X472593

http://pmid.us/19843411

Background: Substantial variation in antibiotic prescribing rates between general practices persists, but remains unexplained at national level. AIM: To establish the degree of variation in antibiotic prescribing between practices in England and identify the characteristics of practices that prescribe higher volumes of antibiotics. Design of study: Cross-sectional study. SETTING: 8057 general practices in England. Method: A dataset was constructed containing data on standardised antibiotic prescribing volumes, practice characteristics, patient morbidity, ethnicity, social deprivation, and Quality and Outcomes Framework achievement (2004-2005). Data were analysed using multiple regression
modelling. Results: There was a twofold difference in standardised antibiotic prescribing volumes between practices in the 10th and 90th centiles of the sample (0.48 versus 0.95 antibiotic prescriptions per antibiotic STAR-PU [Specific Therapeutic group Age-sex weightings-Related Prescribing Unit]). A regression model containing nine variables explained 17.2% of the variance in antibiotic prescribing. Practice location in the north of England was the strongest predictor of high antibiotic prescribing. Practices serving populations with greater morbidity and a higher proportion of white patients prescribed more antibiotics, as did practices with shorter appointments, non-training practices, and practices with higher proportions of GPs who were male, >45 years of age, and qualified outside the UK. Conclusion: Practice and practice population characteristics explained about one-sixth of the variation in antibiotic prescribing nationally. Consultation-level and qualitative studies are needed to help further explain these findings and improve our understanding of this variation

MENTAL HEALTH


http://www.implementationscience.com/content/5/1/15

Background: There is a considerable evidence base for 'collaborative care' as a method to improve quality of care for depression, but an acknowledged gap between efficacy and implementation. This study utilises the Normalisation Process Model (NPM) to inform the process of implementation of collaborative care in both a future full-scale trial, and the wider health economy. Methods: Application of the NPM to qualitative data collected in both focus groups and one-to-one interviews before and after an exploratory randomised controlled trial of a collaborative model of care for depression. Results: Findings are presented as they relate to the four factors of the NPM (interactional workability, relational integration, skill-set workability, and contextual integration) and a number of necessary tasks are identified. Using the model, it was possible to observe that predictions about necessary work to implement collaborative care that could be made from analysis of the pre-trial data relating to the four different factors of the NPM were indeed borne out in the post-trial data. However, additional insights were gained from the post-trial interview participants who, unlike those interviewed before the trial, had direct experience of a novel intervention. The professional freedom enjoyed by more senior mental health workers may work both for and against normalisation of collaborative care as those who wish to adopt new ways of working have the freedom to change their practice but are not obliged to do so. Conclusions: The NPM provides a useful structure
for both guiding and analysing the process by which an intervention is optimized for testing in a larger scale trial or for subsequent full-scale implementation.


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.


http://dx.doi.org/10.1177/1077558709356357

http://pmid.us/20093400

Depression is often diagnosed and treated in primary care settings. Organizational and systems interventions that restructure primary care practices and train staff have been shown to be cost-effective strategies for treating depression. Funders are increasingly calling for a cost-benefit assessment of such programs. In this study, the authors review existing cost-effectiveness studies of primary care depression treatments, classify them
into categories, translate the results into net benefit terms, and assess whether more costly programs generate greater net benefit. The authors find that interventions that provide training to primary care teams in how to manage depression most consistently produce net benefits, with more costly interventions of this type generating larger net benefits than less costly interventions. Collaborative care interventions, which add specialized staff to primary care practices, and therapy interventions, in which clinicians are trained to provide therapy, also generate net social benefits at conventional valuations of quality-adjusted life years


http://dx.doi.org/10.1001/archinternmed.2009.530

http://pmid.us/20177034

Background Anxiety often remains unrecognized or untreated among patients with a chronic illness. Exercise training may help improve anxiety symptoms among patients. We estimated the population effect size for exercise training effects on anxiety and determined whether selected variables of theoretical or practical importance moderate the effect. Methods Articles published from January 1995 to August 2007 were located using the Physical Activity Guidelines for Americans Scientific Database, supplemented by additional searches through December 2008 of the following databases: Google Scholar, MEDLINE, PsycINFO, PubMed, and Web of Science. Forty English-language articles in scholarly journals involving sedentary adults with a chronic illness were selected. They included both an anxiety outcome measured at baseline and after exercise training and random assignment to either an exercise intervention of 3 or more weeks or a comparison condition that lacked exercise. Two co-authors independently calculated the Hedges $d$ effect sizes from studies of 2914 patients and extracted information regarding potential moderator variables. Random effects models were used to estimate sampling error and population variance for all analyses. Results Compared with no treatment conditions, exercise training significantly reduced anxiety symptoms by a mean effect $\Delta$ of 0.29 (95% confidence interval, 0.23-0.36). Exercise training programs lasting no more than 12 weeks, using session durations of at least 30 minutes, and an anxiety report time frame greater than the past week resulted in the largest anxiety improvements. Conclusion Exercise training reduces anxiety symptoms among sedentary patients who have a chronic illness.


http://dx.doi.org/10.1186/1745-6215-11-13
Background: The National Dementia Strategy seeks to enhance general practitioners' diagnostic and management skills in dementia. Early diagnosis in dementia within primary care is important as this allows those with dementia and their family care networks to engage with support services and plan for the future. There is, however, evidence that dementia remains under-detected and sub-optimally managed in general practice. An earlier unblinded, cluster randomised controlled study tested the effectiveness of educational interventions in improving detection rates and management of dementia in primary care. In this original trial, a computer decision support system and practice-based educational workshops were effective in improving rates of detecting dementia although not in changing clinical management. The challenge therefore is to find methods of changing clinical management. Our aim in this new trial is to test a customised educational intervention developed for general practice, promoting both earlier diagnosis and concordance with management guidelines. Design/Method: The customised educational intervention combines practice-based workshops and electronic support material. Its effectiveness will be tested in an unblinded cluster randomised controlled trial with a pre-post intervention design, with two arms; normal care versus the educational intervention. Twenty primary care practices have been recruited with the aim of gaining 200 patient participants. We will examine whether the intervention is effective, pragmatic and feasible within the primary care setting. Our primary outcome measure is an increase in the proportion of patients with dementia who receive at least two dementia-specific management reviews per year. We will also examine important secondary outcomes such as practice concordance with management guidelines and benefits to patients and carers in terms of quality of life and carer strain. Discussion: The EVIDEM-ED trial builds on the earlier study but the intervention is different in that it is specifically customised to the educational needs of each practice. If this trial is successful it could have implications for the implementation of the National Dementia Strategy.


http://dx.doi.org/10.1111/j.1365-2753.2009.01166.x

http://pmid.us/19522912

Context: Although symptoms of anxiety and depression correlate, they may covary in irregular and unpredictable ways. This non-linear covariation may be important to psychiatric diagnosis, treatment and relapse. This non-linear anxiety-depression interaction suggests that power laws may be observed. Power laws are statistical
distributions found when systems vary in complex ways at the interface between chaotic dynamics and periodic dynamics, such that data points vary randomly but are still partially correlated with each other. Such non-linear dynamics and relationships should result in characteristic patterns of interaction among patients, stressors and treatment. This is important because non-linear dynamics could affect our understanding of mental disorders, the need for varied treatment approaches and patterns of early response to treatment. Objective: To determine whether the relationships between anxiety and depression levels, changes and rates of change follow power law distributions among patients with newly diagnosed major depressive episode (MDE), panic disorder (PD) and neither disorder (controls). Design: Time series of hourly mood variation. Setting Acute and continuity primary care clinics. Patients or other participants: Five adult patients presenting each with MDE, PD and controls based on DSM-IV criteria. Four patients in each group completed 30 days of assessments. MAIN AND Secondary outcome measures: Hourly self-assessments (while awake) of levels of anxiety and depression using visual analogue scales for a 30-day period. Covariation in level of symptoms, in the change of symptoms and in the rate of change were assessed. Anxiety-depression matrices were prepared for pooled subjects. Power laws were sought using log-log plots of frequency versus order of that frequency. ResultS: Although visual inspection of plots for symptoms levels, change and rates of change all suggest power laws, statistical assessments provide stronger support for power laws in symptom change than for either symptom levels or rates of change. Adjusted R(2) terms are larger for MDE and PD subjects compared with controls while the inverse slope is about 2.5 for controls and 1.7-1.9 for those with MDE or PD. This study found that power laws may be present in both the symptom change data for all three diagnostic groups. Evidence for power laws in symptom levels and rates of change was less compelling. The inverse slopes suggest that the anxiety-depression relationships among subjects with PD and major depression are similar but differ from those among controls. Conclusions: First, power laws suggest a scale-free relationship; the differences seen in transition from symptom level to change level may reflect that complex events at the level of mood assessment affect change in mood. Second, this covariation may be due to external factors acting on the patient or multiple internal interrelated factors. Third, different factors and populations can yield different slopes. Future research is needed to confirm these preliminary findings and to understand the origin of these dynamics.

McGarry H et al 2009 Managing depression in a changing primary mental healthcare system: comparison of two snapshots of Australian GPs’ treatment and referral patterns Mental Health in Family Medicine 6 (2) 75-84

Background: Significant government spending has resulted in substantial changes to the Australian primary mental healthcare system. Initially producing the Better Outcomes in Mental Health Care (BOiMHC) initiative, this has been replaced by the Better Access to Mental Health Care programme, which allows all general practitioners (GPs) to refer patients for allied psychological health care under Medicare. Aim: To examine changes in patient management and referral for care following the BOiMHC initiative. Method:
Comparison of results of a 2006 postal survey of Australian GPs examining self-reported management of patients with depression with a similar survey conducted in 2001-2002, prior to the BOiMHC initiative. Results: One hundred and thirty-three (33%) GPs responded. The main self-reported strategies for managing patients with depression were similar to the previous study: supportive counselling and medication. No significant difference was found in rates of self-reported formal training in psychological treatments. Significantly higher rates of referral for psychological treatments were reported in 2006 than in 2002. Small trends towards higher reported referral for and reported use of psychological treatments by GPs registered for the BOiMHC initiative were noted when compared with those who were not registered. Conclusion: While GPs' main reported strategies for managing patients with depression were unchanged, reported referral for psychological therapies was significantly higher in 2006, possibly reflecting the impact of changes to the primary mental healthcare system. Ongoing rigorous evaluation of further changes to the primary mental healthcare system are needed to determine whether they deliver effective, evidence-based care, and thus to inform future programmes.


http://dx.doi.org/10.1192/bjp.bp.109.064089
http://pmid.us/20118451

Background: High rates of emotional distress and depressive symptoms in the community can reflect difficult life events and social circumstances. There is a need for appropriate, low-cost, non-medical interventions for many individuals. Befriending is an emotional support intervention commonly offered by the voluntary sector. Aims: To examine the effectiveness of befriending in the treatment of emotional distress and depressive symptoms. Method: Systematic review of randomised trials of interventions focused on providing emotional support to individuals in the community. Results: Compared with usual care or no treatment, befriending had a modest but significant effect on depressive symptoms in the short term (standardised mean difference SMD = -0.27, 95% CI -0.48 to -0.06, nine studies) and long term (SMD = -0.18, 95% CI -0.32 to -0.05, five studies). Conclusions: Befriending has a modest effect on depressive symptoms and emotional distress in varied patient groups. Further exploration of active ingredients, appropriate target populations and optimal methods of delivery is required.

Mount L, Lambert, MC, 2009 Mental ability performance among adults with type 2 diabetes in primary care Mental Health in Family Medicine 6(2), 99-106

Aim and method: The present university-based outpatient clinic, cross-sectional study assessed cognitive performance in a sample of 137 adults, with the primary objective of determining differences in cognitive performance as a function of gender and
hypertension status in a type 2 diabetes cohort. Results: Approximately 64% of the sample was 65 years old and younger, and 50 subjects had ≥ 13 years of education. Global mental ability scores were relatively similar by age grouping, and higher-ordered cognitive functioning and reading literacy were strongly correlated, $r (98) = 0.62$, $P < 0.01$. Approximately 30% of the sample posted global mental ability scores in the slow learner range on tasks measuring attention, immediate memory and verbal reasoning. Males achieved higher cognitive functioning scores compared to females on multiple mental ability tasks. The presence of hypertension was associated with significantly worse cognitive performance compared to those subjects without hypertension, $t = 2.11$, $P = 0.03$. Approximately 57% of the hypertension group was classified as mild cognitive impaired. Conclusion: While approximately half of the general population can be expected to demonstrate an average range of performance on cognitive ability measures, such an expectation could be inappropriately generalised to persons diagnosed with type 2 diabetes, even among those who were high school educated.


http://dx.doi.org/10.3399/bjgp09X472881

http://pmid.us/19861027

Background: Previous studies have reported differing rates of consultation with GPs prior to suicide. Patients with a psychiatric history have higher rates of consultation and consult closer to the time of their death. AIM: To investigate the frequency and nature of general practice consultations in the year before suicide for patients in current, or recent, contact with secondary mental health services. Design of study: Retrospective case-note study and semi-structured interviews. Setting: General practices in the northwest of England. Method: General practice data were obtained by a retrospective review of medical records (n = 247) and semi-structured interviews with GPs (n = 159). Results: GP records were reviewed in 247 of the 286 cases (86%). Overall, 91% of individuals (n = 224) consulted their GP on at least one occasion in the year before death. The median number of consultations was 7 (interquartile range = 3-10). Interviews were carried out with GPs with regard to 159 patients. GPs reported concerns about their patient's safety in 43 (27%) cases, but only 16% of them thought that the suicide could have been prevented. Agreement between GPs and mental health teams regarding risk of suicide was poor. Both sets of clinicians rated moderate to high levels of risk in only 3% of cases for whom information was available (n = 139) (overall kappa = 0.024). Conclusion: Consultation prior to suicide is common but suicide prevention in primary care is challenging. Possible strategies might include examining the potential benefits of risk assessment and collaborative working between primary and secondary care

Background  The role of the primary care mental health worker (PCMHW) in providing self-help and signposting to people referred for mild-moderate anxiety and depression is currently being complemented by low-intensity workers training under the government written reflective papers provide a qualitative exploration of issues and concerns raised by PCMHWs during a fortnightly reflective practice group. Results Themes emerging from participants' written accounts highlight: difficulties in applying academic and skills training to the real-life world of clinical practice; difficulties in managing issues of risk and complexity; role confusion; and the need for a visible and coherent career structure. Conclusions The study highlights the psychological impact on PCMHWs of managing complex client referrals. This is discussed in the context of the high volume case turnover anticipated by IAPT training curricula. Implications for the training and education of IAPT low-intensity workers are briefly considered.


Social stress models are the predominant theoretical frame for studies of the relationship between social statuses and mental health ([Dressler et al., 2005] and [Horwitz, 1999]). These models propose that prejudice, discrimination and related social ills exert an added burden on socially disadvantaged populations (populations subjected to stigma, prejudice and discrimination) that can generate mental health problems. Researchers have used a variety of methodological approaches to study this hypothesis. In this paper we argue that researchers have not paid sufficient attention to the implications of this methodological variability, particularly the distinction between studies of within-group and studies of between-groups variation, in interpreting empirical tests of social stress theory. To fully evaluate the evidence, we need to carefully consider the convergence and divergence of results across diverse methodologies.

Smolders M et al 2010  Which Physician and Practice Characteristics are Associated With Adherence to Evidence-Based Guidelines for Depressive and Anxiety Disorders?  Medical Care  2010 Feb 1. [Epub ahead of print]

http://dx.doi.org/10.1017/S1463423609990375

http://dx.doi.org/1016/j.socscimed.2009.11.032

http://dx.doi.org/10.1097/MLR.0b013e3181ca27f6

http://pmid.us/20125045
Background:: Research on quality of care for depressive and anxiety disorders has reported low rates of adherence to evidence-based depression and anxiety guidelines. To improve this care, we need a better understanding of the factors determining guideline adherence. Objective:: To investigate how practice- and professional-related factors are associated with adherence to these guidelines. Design:: Cross-sectional cohort study. Participants:: A total of 665 patients with a composite interview diagnostic instrument diagnosis of depressive or anxiety disorders, and 62 general practitioners from 21 practices participated. Measures:: Actual care data were derived from electronic medical record data. The measurement of guideline adherence was based on performance indicators derived from evidence-based guidelines. Practice-, professional-, and patient-related characteristics were measured with questionnaires. The characteristics associated with guideline adherence were assessed by multivariate multilevel regression analysis. Results:: A number of practice and professional characteristics showed a significant univariate association with guideline adherence. The multivariate multilevel analyses revealed that, after controlling for patient characteristics, higher rates of guideline adherence were associated with stronger confidence in depression identification, less perceived time limitations, and less perceived barriers for guideline implementation. These professional-related determinants differed among the overall concept of guideline adherence and the various treatment options. Conclusions:: This study showed that rates of adherence to guidelines on depressive and anxiety disorders were not associated with practice characteristics, but to some extent with physician characteristics. Although most of the identified professional-related determinants are very difficult to change, our results give some directions for improving depression and anxiety care.


http://dx.doi.org/10.1186/1472-6963-10-19

http://www.biomedcentral.com/1472-6963/10/19

http://pmid.us/20082727

Background: The effectiveness of collaborative care for patients with major depressive disorder in primary care has been established. Assessing its cost-effectiveness is important for deciding on implementation. This review therefore evaluates the cost-effectiveness of collaborative care for major depressive disorder in primary care. Methods: A systematic search on economic evaluations of collaborative care was conducted in Pubmed and PsychInfo. Quality of the studies was measured with the Cochrane checklist and the CHEC-list for economic evaluations. Cost-effectiveness and costs per depression-free days were reported. Results: 8 studies were found, involving 4868 patients. The quality of the cost effectiveness studies, according to the CHEC-list, could be improved. Generally, the studies did not include all relevant costs and did not perform sensitivity analysis. Only 4 out of 8 studies reported cost per QALY, 6 out of 8 reported costs per depression-free days. The highest costs per QALY reported were $49,500, the highest costs per depression-free day were $24. Conclusions: Although
studies did not fulfil all criteria of the CHEC-list, collaborative care is a promising intervention and it may be cost-effective. However, to conclude on the cost-effectiveness, depression research should follow economic guidelines to improve the quality of the economic evaluations:

**PATIENT AND PUBLIC INVOLVEMENT**

**Boote J et al 2010** Public involvement at the design stage of primary health research: A narrative review of case examples  *Health Policy* 95(1) 10-23

[http://dx.doi.org/10.1016/j.healthpol.2009.11.007](http://dx.doi.org/10.1016/j.healthpol.2009.11.007)

Objective  To review published examples of public involvement in research design, to synthesise the contributions made by members of the public, as well as the identified barriers, tensions and facilitating strategies. Design  Systematic literature search and narrative review. Findings  Seven papers were identified covering the following topics: breast-feeding, antiretroviral and nutrition interventions; paediatric resuscitation; exercise and cognitive behavioural therapy; hormone replacement therapy and breast cancer; stroke; and parents’ experiences of having a pre-term baby. Six papers reported public involvement in the development of a clinical trial, while one reported public involvement in the development of a mixed methods study. Group meetings were the most common method of public involvement. Contributions that members of the public made to research design were: review of consent procedures and patient information sheets; outcome suggestions; review of acceptability of data collection procedures; and recommendations on the timing of potential participants into the study and the timing of follow-up. Numerous barriers, tensions and facilitating strategies were identified. Conclusions  The issues raised here should assist researchers in developing research proposals with members of the public. Substantive and methodological directions for further research on the impact of public involvement in research design are set out.

**Box, G  Patient participation groups : the national picture.**  *Quality in Primary Care* 2009; 17 (4): 291-297

[http://pmid.us/19807964](http://pmid.us/19807964)

This article brings together research carried out by the National Association for Patient Participation from 2005 to 2009. Its aim was to capture the views of GP surgeries that have patient participation groups (PPGs) as well as those who do not. It also studied the views of PPGs affiliated to the National Association for Patient Participation (NAPP) about their role, their organisation and the support that they require to maximise their
success. With the exception of the online, UK-wide members' survey, the research was carried out through postal surveys sent to more than 4,000 English practices in three separate studies. The main results relate to the prevalence of PPGs, their geographical location, their activities, the attitudes of practices towards PPGs (especially those that do not have one) and the future needs of PPGs. PPGs are seen to play an important role in providing the practice with the patient perspective but they are active in several other areas, including health promotion, information provision, influencing commissioning, supporting other patients and fundraising (for their own needs as well as those of the practice). Three central challenges are highlighted, relating to (a) the most successful strategies to promote more PPGs; (b) the importance of support from primary care trusts (or their equivalent organisations); and (c) ways in which PPGs can increase their ability to represent the wider patient perspective. A future research agenda is also proposed that would evaluate the costs and benefits of PPGs across their broad range of activities.


http://dx.doi.org/10.1017/S1463423609990405

Background  Public involvement, both in the National Health Service (NHS) and in clinical research, is promoted as an important democratic principle. The declared aims are to reduce professional autocracy and allow a broader ownership of the research agenda; also to improve the design of, and recruitment and retention of patients to, clinical studies. There have been a number of national initiatives in the UK to improve public input to clinical research activities, but very few reports of effective and sustainable partnerships over time. This study reports the evaluation of one example, which is embedded in the NHS and university partnerships in the Norfolk area of England.

Objectives  Evaluate: How the model contributes to, and impacts upon, all stages of the research process. Key factors and strengths of this project, and areas for improvement.

Methods  A mixed methods approach related to the 5 years from start of 2003 to end of 2007. This used descriptive statistics of volunteer activity, interviews with key stakeholders (13), questionnaires (53% response rate), and focus group with 10 volunteers to explore emergent themes. We analysed findings using a policy framework approach.

Results  About 47 of the original 55 volunteers remained on the panel after 5 years. All have undertaken training, 38% have been involved in the full range of research activities offered, and 75% have attended at least one research project meeting. Some are active in governance, ethics, and advisory committees. Both the research community and the volunteers are very positive about the project. The researchers find it provides well prepared personnel, and gives a speedy and efficient way of fulfilling the expectations of funders for lay input. The volunteers find it gives them important opportunities to influence the quality of research and thus support improvements in patient care. Areas for improvement include increasing social diversity among the volunteers, and improving feedback on input from volunteers, without which volunteers tend to lose confidence and motivation.

Conclusion  Long-term sustainable and valuable public input to research is possible. Key factors are committing resources, embedding the service in the infrastructure of a research consortium, and ongoing responsiveness by NHS staff and
researchers. Additional activity to recruit and support access may be needed to attract people from a broad range of sociodemographic backgrounds. Some volunteers want more involvement than this model currently offers.

Towle A 2010 Active patient involvement in the education of health professionals. Medical Education Jan;44(1):64-74. 2010

http://dx.doi.org/10.1111/j.1365-2923.2009.03530.x

http://pmid.us/20078757

Context: Patients as educators (teaching intimate physical examination) first appeared in the 1960s. Since then, rationales for the active involvement of patients as educators have been well articulated. There is great potential to promote the learning of patient-centred practice, interprofessional collaboration, community involvement, shared decision making and how to support self-care. Methods: We reviewed and summarised the literature on active patient involvement in health professional education. Results: A synthesis of the literature reveals increasing diversity in the ways in which patients are involved in education, but also the movement's weaknesses. Most initiatives are 'one-off' events and are reported as basic descriptions. There is little rigorous research or theory of practice or investigation of behavioural outcomes. The literature is scattered and uses terms (such as 'patient!') that are contentious and confusing. Conclusions: We propose future directions for research and development, including a taxonomy to facilitate dialogue, an outline of a research strategy and reference to a comprehensive bibliography covering all health and human services.

PRIMARY/SECONDARY CARE INTERFACE


http://dx.doi.org/10.1016/j.pec.2009.07.032
Objective: Hospitals in the Netherlands have recently made certain performance data public, allowing patients to choose the location of their care. The objective of this study is to assess (a) patient preferences and experiences concerning the transition between primary and secondary health care, (b) patients' needs for choice and information and how these are influenced by personal and morbidity factors. Methods: Two different types of questionnaires were used. The first questionnaire concerns the importance that patients attach to the care provided. The second questionnaire concerns the actual experiences of the patient with the care provided. For the selection of patients, we used the databases of the registration networks of the Departments of General Practice of the Universities of Groningen and Leiden. The questionnaires were returned by 513 patients (Importance 69%) and 1404 patients (Experience 65%). Results: Many patients prefer the GP advising them regarding which hospital or specialist they should be referred to: a quarter of the patients preferred that the GP decided for them. Patients with a curable condition and patients aged between 25 and 65, highly educated and with stable personal characteristics as measured by a purposive scale, more often wished to use information from internet or newspapers to make a decision. The amount of information that was needed on illness or treatment varied greatly. Young people, older people, and those with less stable personal characteristics more often desired only practical information. Conclusions: In spite of making performance data of different health care institutions public, only a limited number of patients want to use this information on a limited number of health problems. Practice implications: Care providers should take differences into account concerning patients' need for information on their illness.


Background: Whether collaborative care models that enable interactive communication (timely, 2-way exchange of pertinent clinical information directly between primary care and specialist physicians) improve patient outcomes is uncertain. Purpose: To assess the effects of interactive communication between collaborating primary care physicians and key specialists on outcomes for patients receiving ambulatory care. Data Sources: PubMed, PsycInfo, EMBASE, CINAHL, Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effects, and Web of Science through June 2008 and secondary references, with no language restriction. Study Selection: Studies that evaluated the effects of interactive communication between collaborating primary care physicians and specialists on outcomes for patients with diabetes, psychiatric conditions, or cancer. Data Extraction: Contextual, intervention, and outcome data from 23 studies were extracted by one reviewer and checked by another. Study quality was assessed with
a 13-item checklist. Disagreement was resolved by consensus. Main outcomes for analysis were selected by reviewers who were blinded to study results. Data Synthesis: Meta-analysis indicated consistent effects across 11 randomized mental health studies (pooled effect size, -0.41 [95% CI, -0.73 to -0.10]), 7 nonrandomized mental health studies (pooled effect size, -0.47 [CI, -0.84 to -0.09]), and 5 nonrandomized diabetes studies (pooled effect size, -0.64 [CI, -0.93 to -0.34]). These findings remained robust to sensitivity analyses. Meta-regression indicated studies that included interventions to enhance the quality of information exchange had larger effects on patient outcomes than those that did not (-0.84 vs. -0.27; P = 0.002). Limitations: Because collaborative interventions were inherently multifaceted, the efficacy of interactive communication by itself cannot be established. Inclusion of study designs with lower internal validity increased risk for bias. No studies involved oncologists. Conclusion: Consistent and clinically important effects suggest a potential role of interactive communication for improving the effectiveness of primary care-specialist collaboration.


http://dx.doi.org/10.1093/fampra/cmp076

Background: Supported discharge care of patients with complex medical problems is associated with improved health outcomes. GPs are ideally placed to provide post-discharge care in the community. Knowledge of factors that influence patients’ decisions to attend such follow-up is thus important to improve health care outcomes of these patients. Objectives: To explore factors that influence complex medical patients’ decision to attend GP follow-up after discharge and factors affecting their level of satisfaction with such follow-up. Methods: Qualitative investigation using semi-structured telephone interviews of 26 patients with complex medical issues conducted two weeks after hospital discharge. Results: Complex medical patients experienced varying degrees of concern and information needs after discharge from hospital. Patients’ understanding of the role of the GP and experiences of continuity of care also influence patients’ decisions to attend follow-up with their GP. In addition, practical factors such as GP availability, presence of discharge instructions, access to transport and level of social support also affect patients’ ability to attend early GP follow-up after hospital discharge. Patients’ satisfaction with GP follow-up was influenced by perceived competence and personal continuity with the GP. Conclusions: Patients’ decisions to attend GP follow-up after hospitalization are influenced by a number of factors. Interventions to support post-hospital care that address these issues need to be developed and tested. Key issues are patients’ understanding of their condition, understanding of the role of the GP in follow-up and continuity of care.

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


http://pmid.us/19807960

The recent introduction and successful application of Lean Thinking in health is generating a belief that continuous improvement (a product of Lean) can be delivered in
the context of health care, as long as key organisational principles are in place. This paper offers case studies to illustrate where Lean methods are being introduced into a primary care commissioning organisation and are delivering, as part of an integrated organisational approach that embraces Lean principles and improvement in the patient experience and eliminates the potential for error in patient care.

Laurence CO et al 2010 Patient satisfaction with point-of-care testing in general practice British Journal of General Practice Volume 60, Number 572, March 2010 , pp. e98-e104(1)

http://dx.doi.org/10.3399/bjgp10X483508
http://pmid.us/20202351

Background: Point-of-care testing is increasingly being used in general practice to assist GPs in their management of patients with chronic disease. However, patient satisfaction and acceptability of point-of-care testing in general practice has not been widely studied. Aim: To determine if patients are more satisfied with point-of-care testing than with pathology laboratory testing for three chronic conditions. Design of study: As part of a large multicentre, randomised, controlled trial assessing the use of point-of-care testing in Australian general practice, satisfaction was measured for patients having pathology testing performed by point-of-care testing devices or pathology laboratories. Patients in the trial were managed by GPs for diabetes, hyperlipidaemia, and/or anticoagulant therapy. Method: Patient satisfaction was measured using level of agreement with a variety of statements at the end of the study with a patient satisfaction questionnaire for both the intervention and control groups. Analysis was performed using a mixed model analysis of variance (ANOVA) with allowance for clustering at the practice level following Box-Cox transformations of the data to achieve normality. Results: Overall, intervention patients reported that they were satisfied with point-of-care testing. In comparison with the control group, the intervention group had a higher level of agreement than control patients with statements relating to their satisfaction with the collection process ($P<0.001$) and confidence in the process ($P<0.001$). They also viewed point-of-care testing as strengthening their relationship with their GP ($P = 0.010$) and motivational in terms of better managing their condition ($P<0.001$). Conclusion: The results from this trial support patient satisfaction and acceptability of point-of-care testing in a general practice setting.


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

Natanzon, I et al 2010 Does GPs' self-perception of their professional role correspond to their social self-image? - A qualitative study from Germany. BMC Family Practice 2010 Feb 4;11(1):10. [Epub ahead of print]

http://dx.doi.org/10.1186/1471-2296-11-10

http://www.biomedcentral.com/content/pdf/1471-2296-11-10.pdf

http://pmid.us/20132534

Background: There is a decline in the relative numbers of general practitioners in Germany. Earlier research showed that the professional relationship between general practitioners and specialists is overshadowed by conflicts which could influence medical students not to choose a career in general practice. The aim of the study is to analyse potential discrepancies between general practitioners' self-perception of their professional role and their social self-image in relation to medical specialists and to identify potential barriers that might prevent medical students from becoming a general practitioner. Methods: A qualitative study design consisting of 16 interviews with general
practitioners was chosen. Data analysis was carried out using the qualitative content analysis by Philipp Mayring. Results: There is a discrepancy between general practitioners' professional self-perception and how they perceive they are viewed by specialists. General practitioners communicate a positive self-perception of their professional role. While general practitioners think that specialists in outpatient care have a positive view on general practice, it is assessed to be negative by specialists working in hospitals and as medical teachers. Conclusion: The negatively influenced social self-image may originate particularly from "badmouthing" general practitioners at universities and in hospitals. "Badmouthing" demonstrates the importance of the consideration of psychological aspects in medical teachers and hospital specialists acting as role models. Negative comments should be considered as an important factor in influencing medical students and trainees' career choices. These aspects should be more integrated in future medical education curricula.


[http://dx.doi.org/10.1177/1356389009350026](http://dx.doi.org/10.1177/1356389009350026)

The Netherlands and England are near neighbours whose health care systems have much in common and whose health policy communities have also usually been well aware of what is going on in the other country. Nevertheless, for the two decades from 1982, England adopted and repeatedly redeveloped performance indicator (PI) systems in the health care field while the Netherlands virtually shunned them. A broad institutional explanation for this divergence is provided by England's majoritarian and adversarial political system that leaves governments with fewer constraints and compromises than in the more consociational Dutch system. More recently, however, a Dutch national system of health care PIs has appeared, suggesting that this explanation needs to be supplemented. This paper draws on an empirical study of PI systems in the two countries over the period from 1982 to 2007 to suggest that two further factors are at work. Established institutional patterns may be disrupted by punctuations', while technical and political factors endogenous to PI systems may exert a logic of their own


[http://pmid.us/19927412](http://pmid.us/19927412)

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.

Van der Voort H, Kerpershoek E 2010 Measuring measures: introducing performance measurement in the Dutch health care sector Public Money and Management Volume 30 (1) 2010 63 – 68

http://dx.doi.org/10.1080/09540960903492406

The Dutch government has sought to increase transparency in the performance of medical institutions. For hospitals this has presented three challenges for performance measures, each related to gaining authority and support from all those (public and private) bodies already involved in quality assurance. The experience raises issues about the speed of implementation, scope, burden and impact on hospital image of performance measurement regimes. It also suggests a tension between market-based and other mechanisms used to ensure quality.


http://dx.doi.org/10.1186/1748-5908-5-17

http://www.implementationscience.com/content/5/1/17

http://pmid.us/20158896

Background: Many interventions shown to be effective through clinical trials are not readily implemented in clinical practice. Unfortunately, little is known regarding how clinicians construct their perceptions of the effectiveness of medical interventions. This study aims to explore general practitioners' perceptions of the nature of 'effectiveness'.

Methods: The design was qualitative in nature using the repertory grid technique to
elicit the constructs underlying the perceived effectiveness of a range of medical interventions. Eight medical interventions were used as stimuli (diclofenac to reduce acute pain, cognitive behaviour therapy to treat depression, weight loss surgery to achieve weight loss, diet and exercise to prevent type 2 diabetes, statins to prevent heart disease, stopping smoking to prevent heart disease, nicotine replacement therapy to stop smoking, and stop smoking groups to stop smoking). The setting involved face-to-face interviews followed by questionnaires in London Primary Care Trusts. Participants included a random sample of 13 general practitioners. Results: Analysis of the ratings showed that the constructs clustered around two dimensions: low patient effort versus high patient effort (dimension one), and small impact versus large impact (dimension two). Dimension one represented constructs such as 'success requires little motivation', 'not a lifestyle intervention', and 'health-care professional led intervention'. Dimension two represented constructs such as 'weak and/or minimal evidence of effectiveness', 'small treatment effect for users', 'a small proportion of users will benefit' and 'not cost-effective'. Constructs within each dimension were closely related. Conclusions: General practitioners judged the effectiveness of medical interventions by considering two broad dimensions: the extent to which interventions involve patient effort, and the size of their impact. The latter is informed by trial evidence, but the patient effort required to achieve effectiveness seems to be based on clinical judgement. Some of the failure of evidence-based medicine to be implemented may be more explicable if both dimensions were attended to


http://dx.doi.org/10.1093/fampra/cmp082

Background: Medical consultations are replete with conflicts, particularly in the current era of explicit and implicit rationing practices in health care organizations. Although such conflicts may challenge the doctor-patient relationship, little is known about them or their consequences. Aims: To systematically describe the nature of doctor-patient conflicts in medical encounters and the strategies physicians use when faced with conflicts. Methods: Analysis of 291 videotaped routine encounters with 28 general practitioners, using a novel adaptation of the Roter interaction analysis system software, provided quantitative empirical data on the conflicts and on the communication process. Seven focus groups (56 GPs) provided qualitative insights and guided the analysis. Results: Conflicts were identified in 40 per cent of consultations; 21 per cent of these were related to the rationing of health care resources. In conflictual encounters, both the opening and closing phases of the encounter were shorter than in non-conflictual encounters. In coping with resource rationing, the commonest strategy was to accept the dictates of the system without telling the patients about other options. When conflict of this type occurred, doctors showed more opposition to the patients rather than empathy. Conclusions: Doctors often face conflicts in their routine work, but resource-related conflicts are especially difficult and expose the dual loyalties of the doctor to the patient and to the system. Insights derived from this research can be used to design training interventions
that improve doctors' efficacy in coping with conflicts and ultimately allow them to provide better patient care.

**RESEARCH AND DEVELOPMENT**


[http://www.implementationscience.com/content/5/1/14](http://www.implementationscience.com/content/5/1/14)

**Background:** There is growing interest in the use of cognitive, behavioural and organisational theories in implementation research. However the extent of use of theory in implementation research is uncertain. **Methods:** Systematic review of use of theory in 235 rigorous evaluations of guideline dissemination and implementation studies published between 1966 and 1998. Use of theory was classified according to type of use (explicitly theory based, some conceptual basis, and theoretical construct used) and stage of use (choice/design of intervention, process/mediators/moderators and post hoc/explanation). **Results:** Fifty-three of 235 studies (22.5%) were judged to have employed theories including 14 studies that explicitly used theory. The majority of studies (n=42) used only one theory; the maximum number of theories employed by any study was three. Twenty five different theories were used. A small number of theories accounted for the majority of theory use including PRECEDE, Diffusion of Innovations, Information overload and Social marketing (Academic detailing). **Conclusions:** There was poor justification of choice of intervention and use of theory in implementation research in the identified studies until at least 1998. Future research should explicitly identify the justification for the interventions. Greater use of explicit theory to understand barriers, design interventions and explore mediating pathways and moderators is needed to advance the science of implementation research.


[http://www.implementationscience.com/content/5/1/11](http://www.implementationscience.com/content/5/1/11)

**Background:** Well-designed trials of strategies to improve adherence to clinical practice guidelines are needed to close persistent evidence-practice gaps. We studied how the number of these trials is changing with time, and to what extent physicians are participating in such trials. **Methods:** This is a literature-based study of trends in evidence-practice gap publications over 10 years and participation of clinicians in
intervention trials to narrow evidence-practice gaps. We chose nine evidence-based guidelines and identified relevant publications in the PubMed database from January 1998 to December 2007. We coded these publications by study type (intervention versus non-intervention studies). We further subdivided intervention studies into those for clinicians and those for patients. Data were analyzed to determine if observed trends were statistically significant. Results: We identified 1,151 publications that discussed evidence-practice gaps in nine topic areas. There were 169 intervention studies that were designed to improve adherence to well-established clinical guidelines, averaging 1.9 studies per year per topic area. Twenty-eight publications (34%; 95% CI: 24% - 45%) reported interventions intended for clinicians or health systems that met Effective Practice and Organization of Care (EPOC) criteria for adequate design. The median consent rate of physicians asked to participate in these well-designed studies was 60% (95% CI, 25% to 69%). Conclusions: We evaluated research publications for nine evidence-practice gaps, and identified small numbers of well-designed intervention trials and low rates of physician participation in these trials.


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.

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.


http://dx.doi.org/10.3109/13814780903563725

http://pmid.us/20100109

At the WONCA Europe conference 2009 the recently published 'Research Agenda for General Practice/Family Medicine and Primary Health Care in Europe' was presented. It is a background paper and reference manual, providing advocacy of general practice/family medicine (GP/FM) in Europe. The Research Agenda summarizes the evidence relating to the core competencies and characteristics of the WONCA Europe definition of GP/FM, and its implications for general practitioners/family doctors, researchers and policy makers. The European Journal of General Practice publishes a series of articles based on this document. In a first article, background, objectives, and methodology were discussed. In this second article, the results for the core competencies 'primary care management' and 'community orientation' are presented. Though there is a large body of research on various aspects of 'primary care management', it represents a
very scattered rather than a meta view. Many studies focus on care for specific diseases, the primary/secondary care interface, or the implications of electronic patient records. Cost efficiency or process indicators of quality are current outcomes. Current literature on community orientation is mainly descriptive, and focuses on either care for specific diseases, or specific patient populations, or on the uptake of preventive services. Most papers correspond poorly to the WONCA concept. For both core competencies, there is a lack of research with a longitudinal perspective and/or relevant health or quality of life outcomes as well as research on patients’ preferences and education for organizational aspects of GP/FM

**SELF CARE**

Audulv, A et al 2010  *Who's in charge? The role of responsibility attribution in self-management among people with chronic illness*  *Patient Education and Counseling*  Online 8/01/2010  


Objective  To explore how responsibility attribution influences self-management regimens among people with chronic illness. Methods  This qualitative content analysis included 26 interviews with people living with chronic illness . Results  The participants attributed responsibility to internal, external or a combination of these factors, meaning that they either assumed responsibility for self-management or considered other people or factors responsible. Internal responsibility was associated with a multifaceted self-management regimen, whereas external responsibility was related to “conventional” self-management such as taking medication, managing symptoms and lifestyle changes. Conclusion  How responsibility is attributed is vital for the way in which individuals perform self-management. In this study, those who attributed responsibility to external factors mainly performed recommended behaviours to control their illness. In contrast, to take charge of their illness and be an active participant in the care, individuals must take responsibility for themselves, i.e. internal responsibility. Practice implications  Health-care providers should acknowledge and support individuals’ wishes about various levels of responsibility as well as different kinds of patient–provider relationships.
Beard E et al 2009  Do people with diabetes understand their clinical marker of long-term glycemic control (HbA1c levels) and does this predict diabetes self-care behaviours and HbA1c?  Patient Education and Counseling  Dec 23 2009  [Epub ahead of print]

http://dx.doi.org/10.1016/j.pec.2009.11.008

http://pmid.us/20036098

Objective: Research demonstrates that patients have a poor understanding of glycosylated haemoglobin A1c (HbA1c) and that this impacts on effective diabetes self-management. This study attempted to replicate these findings in a UK outpatient sample of people with diabetes. Method: 83 participants were recruited and asked to fill in a questionnaire assessing their understanding of HbA1c, diabetes self-care behaviours and diabetes-specific self-efficacy in relation to carrying out these self-care behaviours. Results: Only 26.5% of the participants were classified as having a good understanding of HbA1c. Correlational and univariate analyses indicated that this level of understanding was related to demographic variables, HbA1c levels and certain aspects of self-care and self-efficacy. A series of multiple regressions found that understanding was a significant predictor of HbA1c levels. Conclusion: The majority of participants seemed to have a poor understanding of HbA1c and this was related to aspects of their diabetes management, self-efficacy and HbA1c levels. Practical implications: These findings provide support for the application of programmes and initiatives aimed at improving patients understanding of clinical disease markers.


http://dx.doi.org/10.1017/S1463423609990296

Aim We aimed to compare recalled information on medication use, self-care activities and pain intensity among primary care low back pain consulters with diary records of the same events. Background Concerns are often expressed regarding the validity of recalled information about past experience of health events such as pain or its treatment. Comparing with information collected using daily diaries is one method of validating recalled findings. Methods Patients completed diaries recording their medication use, self-care activities and pain intensity each day for two weeks. Immediately following this period, patients completed questionnaires asking for recall of their medication use, self-care activities and least, worst, usual and current pain for the previous two weeks. The recalled information obtained from the questionnaires was compared with data from the daily diaries using intraclass correlation coefficients (ICC) and = 1.0). However, some specific medications (eg, diclofenac) were over-reported in the questionnaires, and some self-care activities (eg, exercises) were under-reported. Combinations of pain intensity
ratings were more accurate than single ratings; the mean of the recalled least, usual and current pain intensities was closest to the diary ratings (ICC 0.94, mean difference 0.13). The generalisability of these findings to other settings, recall periods and patient groups remains to be established


http://dx.doi.org/10.1016/j.pec.2009.11.007

http://pmid.us/20006458

Objective: To explore the way that patient-centred care is realised within a tele-carer behavioural change intervention. Method: In-depth, semi-structured interviews undertaken at years 1 and 3 with a purposively selected sample from the intervention group within a 3-year randomised controlled trial (RCT) of a telephone-based education and support for persons with type 2 diabetes, and interviews with the non-medically trained tele-carers and supervising diabetes specialist nurse. Results: A four-phased flow of the patient-centred interactions was identified, which evolved over the process of the intervention. Initially, attention centred on building a picture for and of the patient and assessing their knowledge base. Later, focus moved towards understanding diabetes from the patient's perspective and advice-giving became more individualised. Throughout, the interaction dynamics varied for patients. Conclusion: This study provides insight into the development of patient-centred behaviours over time and the influence of patients on tele-carer communication styles. Practice implication: When adopting a patient-centred approach, tele-carers need to be flexible and recognise that patients vary in their knowledge, skills and psychological adaption to diabetes. Continuity of care and consistent contact is pivotal to patients being able to move through the various phases of their illness trajectory and make the transition towards improved self-care management.

Giordano N et al 2009 The impact of changes in different aspects of social capital and material conditions on self-rated health over time: A longitudinal cohort study Social Science and Medicine Available online 21 December 2009.

http://dx.doi.org/10.1016/j.socscimed.2009.10.044

Individual aspects of social capital have been shown to have significant associations with health outcomes. However, research has seldom tested different elements of social capital simultaneously, whilst also adjusting for other well-known health determinants over time. This longitudinal individual-level study investigates how temporal changes in social capital, together with changes in material conditions and other health determinants affect associations with self-rated health over a six year period. We use data from the British
Household Panel Survey, a randomly selected cohort which is considered representative of the United Kingdom's population, with the same individuals \(N = 9303\) providing responses to identical questions in 1999 and 2005. Four measures of social capital were used: interpersonal trust, social participation, civic participation and informal social networks. Material conditions were measured by total income (both individual and weighted household income), net of taxation. Other health determinants included age, gender, smoking, marital status and social class. After the baseline sample was stratified by health status, associations were examined between changes in health status and changes in all other considered variables. Simultaneous adjustment revealed that inability to trust demonstrated a significant association with deteriorating self-rated health, whereas increased levels of social participation were significantly associated with improved health status over time. Low levels of household and individual income also demonstrated significant associations with deteriorating self-rated health. In conclusion, it seems that interpersonal trust and social participation, considered valid indicators of social capital, appear to be independent predictors of self-rated health, even after adjusting for other well-known health determinants. Understandably, how trust and social participation influence health outcomes may help resolve the debate surrounding the role of social capital within the field of public health.


http://dx.doi.org/10.1111/j.1464-5491.2009.02886.x

http://pmid.us/20121894

Objective To assess the preferences of patients with Type 2 diabetes regarding self-care activities and diabetes education. Research design and methods Questionnaire survey carried out in general practices and outpatient clinics across the Netherlands. Outcomes: preferred setting for education, preferred educator, and preferred and most burdensome self-care activity. Multinomial logistic regression analysis assessed associations between outcomes and patient characteristics, preferences and opinions. Results Data of 994 consecutive individuals were analysed (mean 65 years; 54% male; 97% Caucasian; 21% low education level; 80% primary care). Of these, 19% thought they had poor to average glycaemic control, 61% thought they were over-weight and 32% thought they took too little exercise. Eighty per cent of respondents preferred diabetes education during regular diabetes check-ups. Patients taking insulin preferred education to be given by nurses [odds ratio (OR) 2.45; 95% confidence interval (CI) 1.21-4.96]. Individuals who thought their health to be poor/average preferred education to be given by doctors (OR 1.65; 95% CI 1.08-2.53). Physical exercise was the preferred self-care activity of those who thought they took too little exercise (OR 1.97; 95% CI 1.32-2.93) but was preferred less by patients with mobility problems (OR 0.65; 95% CI 0.43-0.97). Patients with eating disinhibition reported keeping to a healthy diet (OR 4.63; 3.00-7.16) and taking medication (OR 1.66; 95% CI 1.09-2.52) as the most burdensome self-care activities. Age was not an independent determinant of any preference. Conclusions When providing
education for patients with newly diagnosed Type 2 diabetes, healthcare providers should consider making a tailored education plan, irrespective of the patient's age.

SOCIAL CAPITAL

Berry HL, Welsh, JA 2010 Social capital and health in Australia: An overview from the household, income and labour dynamics in Australia survey. Social Science and Medicine Feb; 70(4):588-96.

http://dx.doi.org/10.1016/j.socscimed.2009.10.012

http://pmid.us/19931236

Social capital is associated with better health, but components of social capital and their associations with different types of health are rarely explored together. The aim of this study was to use nationally representative data to develop population norms of community participation and explore the relationships between structural and cognitive components of social capital with three forms of health - general health, mental health and physical functioning. Data were taken from Wave 6 (2006) of the Household, Income and Labour Dynamics in Australia Survey. Using individual-level data, the structural component of social capital (community participation) was measured using a twelve-item short-form of the Australian Community Participation Questionnaire, and the cognitive component (social cohesion) by sense of belonging, tangible support, trust and reciprocity. Three subscales of the SF-36 provided measures of health. Multiple hierarchical regression modelling was used to investigate multivariate relationships among these factors. Higher levels of participation were related to higher levels of social cohesion and to all three forms of (better) health, particularly strongly to mental health. These findings could not be accounted for by sex, age, Indigenous status, education, responsibility for dependents, paid work, living alone or poverty. Controlling for these and physical health, structural and cognitive components of social capital were each related to mental health, with support for a possible mediated relationship between the structural component and mental health. Social capital was related to three forms of health, especially to mental health. Notable gender differences in this relationship were evident, with women reporting greater community participation and social cohesion than men, yet worse mental health. Understanding the mechanisms underlying this apparent anomaly needs further exploration. Because community participation is amenable to intervention, subject to causal testing, our findings may assist in the development of programs which are effective in promoting social cohesion and, thereby, mental health.
Individual aspects of social capital have been shown to have significant associations with health outcomes. However, research has seldom tested different elements of social capital simultaneously, whilst also adjusting for other well-known health determinants over time. This longitudinal individual-level study investigates how temporal changes in social capital, together with changes in material conditions and other health determinants affect associations with self-rated health over a six year period. We use data from the British Household Panel Survey, a randomly selected cohort which is considered representative of the United Kingdom's population, with the same individuals (N=9303) providing responses to identical questions in 1999 and 2005. Four measures of social capital were used: interpersonal trust, social participation, civic participation and informal social networks. Material conditions were measured by total income (both individual and weighted household income), net of taxation. Other health determinants included age, gender, smoking, marital status and social class. After the baseline sample was stratified by health status, associations were examined between changes in health status and changes in all other considered variables. Simultaneous adjustment revealed that inability to trust demonstrated a significant association with deteriorating self-rated health, whereas increased levels of social participation were significantly associated with improved health status over time. Low levels of household and individual income also demonstrated significant associations with deteriorating self-rated health. In conclusion, it seems that interpersonal trust and social participation, considered valid indicators of social capital, appear to be independent predictors of self-rated health, even after adjusting for other well-known health determinants. Understandably, how trust and social participation influence health outcomes may help resolve the debate surrounding the role of social capital within the field of public health.

Suzuki E et al 2010 Does Low Workplace Social Capital Have Detrimental Effect on Workers' Health? Social Science and Medicine Available online 12 February 2010

While the majority of studies of social capital and health have focused on conceptualizing social capital at the geographic level, evidence remains sparse on workplace social capital. We examined the association between workplace social capital and health status among Japanese private sector employees in a cross-sectional study. By employing a two-stage stratified random sampling procedure, 1,147 employees were identified from 46 companies in Okayama in 2007. Workplace social capital was measured based on two components; trust and reciprocity. Company-level social capital was based on
aggregating employee responses and calculating the proportion of workers reporting mistrust and lack of reciprocity. Multilevel logistic regression analysis was conducted using Markov Chain Monte Carlo methods to explore whether individual- and company-level mistrust and lack of reciprocity were associated with poor self-rated health. Odds ratios (ORs) and 95% credible intervals (CIs) for poor health were obtained for each variable. Workers reporting individual-level mistrust and lack of reciprocity had approximately double the odds of poor health even after controlling for sex, age, occupation, educational attainment, smoking, alcohol use, physical activity, body mass index, and chronic diseases. While we found some suggestion of a contextual association between company-level mistrust and poor health, no association was found between company-level lack of reciprocity and health. Despite the thorough examination of cross-level interaction terms between company-level social capital and individual characteristics, no clear patterns were observed. Individual perceptions of mistrust and lack of reciprocity at work has adverse effects on self-rated health among Japanese workers. Although the present study possibly suggests the contextual effect of workplace mistrust on workers’ health, the contextual effect of workplace lack of reciprocity was not supported.

WORKFORCE


http://dx.doi.org/10.3399/bjgp10X482077

http://pmid.us/20040165

Background: As studies evaluating substitution of care have revealed only limited evidence on cost-effectiveness, a trial was conducted to evaluate nurse practitioners as a first point of contact in Dutch general practices. AIM: To estimate costs of GP versus nurse practitioner consultations from practice and societal perspectives. DESIGN OF Study: An economic evaluation was conducted alongside a randomised controlled trial between May and October 2006, wherein 12 nurse practitioners and 50 GPs working in 15 general practices (study practices) participated. Consultations by study practices were also compared with an external reference group, with 17 GPs working in five general practices without the involvement of nurse practitioners. Method: Direct costs within the healthcare sector included resource use, follow-up consultations, length of consultations, and salary costs. Costs outside the healthcare sector were productivity losses. Sensitivity analyses were performed. Results: Direct costs were lower for nurse practitioner consultations than for GP consultations at study practices. This was also the case for direct costs plus costs from a societal perspective for patients aged <65 years. Direct costs of consultations at study practices were lower than those of reference practices,
while practices did not differ for direct costs plus costs from a societal perspective for patients aged <65 years. Cost differences are mainly caused by the differences in salary. Conclusion: By involving nurse practitioners, substantial economic 'savings' could be used for redesigning primary care, to optimise the best skill mix, and to cover the full range of primary care activities


http://dx.doi.org/10.1370/afm.1059

http://pmid.us/19901309

Purpose Most primary care patients have at least 1 major behavioral risk: smoking, risky drinking, low physical activity, or unhealthy diet. We studied the effectiveness of a medical assistant-based program to identify and refer patients with risk behaviors to appropriate interventions. Methods We undertook a randomized control trial in a practice-based research network. The trial included 864 adult patients from 6 primary care practices. Medical assistants screened patients for 4 risk behaviors and applied behavior-specific algorithms to link patients with interventions. Primary outcomes were improved risk behaviors on standardized assessments. Secondary outcomes included participation in a behavioral intervention and the program's effect on the medical assistants' workflow and job satisfaction. Results Follow-up data were available for 55% of participants at a mean of 12 months. The medical assistant referral arm referred a greater proportion of patients than did usual care (67.4 vs 21.8%; P <.001) but did not achieve a higher success rate for improved behavioral outcomes (21.7 vs 16.9%; P=0.19). Qualitative interviews found both individual medical assistant and organizational effects on program adoption. Conclusion Engaging more primary care team members to address risk behaviors improved referral rates. More extensive medical assistant training, changes in practice culture, and sustained behavioral interventions will be necessary to improve risk behavior outcomes


http://pmid.us/19843638

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

Griffiths, P., et al 2010 Nurse staffing and quality of care in UK general
practice: cross-sectional study using routinely collected data. British Journal of
General Practice 60(570), 36-48.

http://dx.doi.org/10.3399/bjgp10X482086

Background: In many UK general practices, nurses have been used to deliver results
against the indicators of the Quality and Outcomes Framework (QOF), a 'pay for
performance' scheme. Aim: To determine the association between the level of nurse
staffing in general practice and the quality of clinical care as measured by the QOF.
Design of the study: Cross-sectional analysis of routine data. Setting: English general
practice in 2005/2006. Method: QOF data from 7456 general practices were linked with a
database of practice characteristics, nurse staffing data, and census-derived data on
population characteristics and measures of population density. Multi-level modelling
explored the relationship between QOF performance and the number of patients per full-
time equivalent nurse. The outcome measures were achievement of quality of care for
eight clinical domains as rated by the QOF, and reported achievement of 10 clinical
outcome indicators derived from it. Results: A high level of nurse staffing (fewer patients
per full-time equivalent practice-employed nurse) was significantly associated with better
performance in 4/8 clinical domains of the QOF (chronic obstructive pulmonary disease,
coronary heart disease, diabetes, and hypertension, P = 0.004 to P<0.001) and in 4/10
clinical outcome indicators (diabetes: glycosylated haemoglobin [HbA1C] < or =7.4%,
HbA1C < or =10% and total cholesterol < or =193 mg/dl; and stroke: total cholesterol <
or =5 mmol/L, P = 0.0057 to P<0.001). Conclusion: Practices that employ more nurses
perform better in a number of clinical domains measured by the QOF. This improved
performance includes better intermediate clinical outcomes, suggesting real patient
benefit may be associated with using nurses to deliver care to meet QOF targets

Putnik K et al 2010 Road to help-seeking among (dedicated) human service
professionals with burnout. Patient Education and Counseling 2010 Feb 9. [Epub
ahead of print]

http://dx.doi.org/10.1016/j.pec.2010.01.004

http://pmid.us/20149954
Objective: Describe and interpret the process of help-seeking among human service professionals with burnout. Methods: Semi-structured interviews were conducted with 14 participants. Analysis was conducted using principles of grounded theory. Results: All participants were dedicated and responsible workers, selflessly giving themselves to their work. Work was demanding, and often included some form of organisational change. After a period of time the problems of ill health appeared, since persons were overstretching their resources. However, the symptoms were denied, since the image of the ideal worker has been internalised and persons expected maximum performance from themselves. They kept on working hard and delayed the help-seeking process. Eventually, help was sought for medical symptoms or by talking to the supervisors. If postponed for too long, persons experienced a breaking point. Conclusion: Human service professionals with burnout internalise the ideal image of their professional role. They strive to keep this ideal image at the cost of their own needs, taking a long time to seek help for the obstacles they encounter. Practice implications: More awareness raising is needed in order to recognise early burnout symptoms. Particularly crucial in this process are supervisors and doctors, who have an authority role over employees.

van den Berg, Michael, et al 2009 Labour intensity of guidelines may have a greater effect on adherence than GPs' workload. BMC Family Practice 10(1), 74. 2009.

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Background: Physicians' heavy workload is often thought to jeopardise the quality of care and to be a barrier to improving quality. The relationship between these has, however, rarely been investigated. In this study quality of care is defined as care 'in accordance with professional guidelines'. In this study we investigated whether GPs with a higher workload adhere less to guidelines than those with a lower workload and whether guideline recommendations that require a greater time investment are less adhered to than those that can save time. Methods: Data were used from the Second Dutch National survey of General Practice (DNSGP-2). This nationwide study was carried out between April 2000 and January 2002. A multilevel logistic-regression analysis was conducted of 170,677 decisions made by GPs, referring to 41 Guideline Adherence Indicators (GAIs), which were derived from 32 different guidelines. Data were used from 130 GPs, working in 83 practices with 98,577 patients. GP-characteristics as well as guideline characteristics were used as independent variables. Measures include workload (number of contacts), hours spent on continuing medical education, satisfaction with available time, practice characteristics and patient characteristics. Outcome measure is an indicator score, which is 1 when a decision is in accordance with professional guidelines or 0 when the decision deviates from guidelines. Results: On average, 66% of the decisions GPs made were in accordance with guidelines. No relationship was found between the objective workload of GPs and their
adherence to guidelines. Subjective workload (measured on a five point scale) was negatively related to guideline adherence (OR = 0.95). After controlling for all other variables, the variation between GPs in adherence to guideline recommendations showed a range of less than 10%. 84% of the variation in guideline adherence was located at the GAI-level. Which means that the differences in adherence levels between guidelines are much larger than differences between GPs. Guideline recommendations that require an extra time investment during the same consultation are significantly less adhered to: (OR = 0.46), while those that can save time have much higher adherence levels: OR = 1.55). Recommendations that reduce the likelihood of a follow-up consultation for the same problem are also more often adhered to compared to those that have no influence on this (OR = 3.13). Conclusion: No significant relationship was found between the objective workload of GPs and adherence to guidelines. However, guideline recommendations that require an extra time investment are significantly less well adhered to while those that can save time are significantly more often adhered to.


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Background: A substantial part of cardiovascular disease prevention is delivered in primary care. Special attention should be paid to the assessment of cardiovascular risk factors. According to the Dutch guideline for cardiovascular risk management, the heavy workload of cardiovascular risk management for GPs could be shared with advanced practice nurses. AIM: To investigate the clinical effectiveness of practice nurses acting as substitutes for GPs in cardiovascular risk management after 1 year of follow-up. Design of study: Prospective pragmatic randomised trial. Setting: Primary care in the south of the Netherlands. Six centres (25 GPs, six nurses) participated. Method: A total of 1626 potentially eligible patients at high risk for cardiovascular disease were randomised to a practice nurse group (n = 808) or a GP group (n = 818) in 2006. In total, 701 patients were included in the trial. The Dutch guideline for cardiovascular risk management was used as the protocol, with standardised techniques for risk assessment. Changes in the following risk factors after 1 year were measured: lipids, systolic blood pressure, and body mass index. In addition, patients in the GP group received a brief questionnaire. Results: A larger decrease in the mean level of risk factors was observed in the practice nurse group compared with the GP group. After controlling for confounders, only the larger decrease in total cholesterol in the practice nurse group was statistically significant (P = 0.01, two-sided). Conclusion: Advanced practice nurses are achieving results, equal to or better than GPs for the management of risk factors. The findings of this study support the involvement of practice nurses in cardiovascular risk management in Dutch primary care.