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May – June 2008



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ACCESS TO CARE

Bellon J, et al. Successful GP intervention with frequent attenders in primary care: randomised controlled trial. *British Journal of General Practice* 2008 58 (550) 324-30.

<http://dx.doi.org/10.3399/bjgp08X280182>

Background: Frequent attenders to GP clinics can place an unnecessary burden on primary care. Interventions to reduce frequent attendance have had mixed results. Aim: To assess the effectiveness of a GP intervention to reduce frequent-attender consultations. Design of study: Randomised controlled trial with frequent attenders divided into an intervention group and two control groups (one control group was seen by GPs also providing care to patients undergoing the intervention). Setting: A health centre in southern Spain. Method: Six GPs and 209 randomly-selected frequent attenders participated. Three GPs were randomly allocated to perform the new intervention: of the 137 frequent attenders registered with these three GPs, 66 were randomly allocated to receive the intervention (IG) and 71 to a usual care control group (CG2). The other three GPs offered usual care to the other 72 frequent attenders (CG1). The main outcome measure was the total number of consultations 1 year post-intervention. Baseline measurements were recorded of sociodemographic characteristics, provider-user interface, chronic illnesses, and psychosocial variables. GPs allocated to the new intervention received 15 hours' training which incorporated biopsychosocial, organisational, and relational approaches. After 1 year of follow-up frequent attenders were contacted. An intention-to-treat analysis was used. Results: A multilevel model was built with three factors: time, patient, and doctor. After adjusting for covariates, the mean number of visits at 1 year in IG was 13.10 (95% confidence interval [CI] = 11.39 to 14.94); in the CG1 group was 19.37 (95% CI = 17.31 to 21.55); and in the CG2 group this was 16.72 (95% CI = 14.84 to 18.72). Conclusion: The new intervention with GPs resulted in a significant and relevant reduction in frequent-attender consultations. Although further trials are needed, this intervention is recommended to GPs interested in reducing consultations by their frequent attenders.

Collins K, Gough S, Clancy M. Screening for hypertension in the emergency department. *Emergency Medicine Journal* 2008;25 (4) 196-9.

<http://dx.doi.org/10.1136/emj.2007.050112>

<http://pmid.us/18356346>

Objective: A study was undertaken to answer the question: "For those ambulatory patients who attend the emergency department, does routinely measuring their blood pressure and

providing written information about hypertension and advising them to see their general practitioner if indicated, compared with no measurement or advice, lead to subsequent interventions (drug therapy, life style advice) to control blood pressure?" Method: A randomised controlled trial was performed in 400 patients attending the emergency department of Southampton General Hospital, a large UK teaching hospital serving a mainly urban population. Patients were randomised to the intervention and control groups. Outcome measure: New drug treatment for hypertension at follow-up at 3 and 6 months. Results: No new antihypertensive drug treatment was started for any of the participants (n = 377) in the trial. Conclusion: Although screening was successfully completed, no differences were seen between the intervention and control groups. The high level of blood pressure screening within primary care became evident as the trial progressed. This, combined with the fact that the trial was limited to patients registered with a general practitioner, possible expectation bias in control subjects and poor compliance with follow-up instructions, may explain the result

Donker GA, et al Infrequent attendance in general practice after a major disaster: a problem? A longitudinal study using medical records and self-reported distress and functioning. *Family Practice* 2008; 25 (2) 92-7.

<http://dx.doi.org/10.1093/fampra/cmn007>.

Objective. To assess the characteristics and implications for care of infrequent attendance in general practice in the aftermath of disaster. Methods. A study of the content of electronic medical records (EMRs) in pre- and post-disaster periods linked to an enquiry using self-reported questionnaires administered 3 weeks and 18 months post-disaster. The disaster (explosion of a firework depot in Enschede, The Netherlands) caused 23 deaths, about 1000 people injured and 1200 people who had to relocate. Sample included survivors (N = 922) who participated in two surveys and whose data could be linked to EMRs of GPs. A comparison of reported morbidity in infrequent' (a maximum of three times in men and four times in women in the first two post-disaster years) and more frequent attenders' (frequency determined post-disaster) in general practice examined in relation to health status (measured by diagnoses in EMRs, symptom checklist and quality of life instrument) was the main outcome measure. Results. Infrequent attenders reported approximately three times as few contacts as more frequent attenders in the pre-disaster year (P < 0.001). Multivariate logistic regression analyses revealed that infrequent attenders were likely to be younger, less depressed, have better subjective health and physical functioning and exhibited more hostile behaviour (measured by questionnaire). Infrequent attenders were less often personally bereaved by the disaster, but more often relocated, and had a lower prevalence of psychological problems pre- and post-disaster although this increased stronger (by 10-fold). Conclusions. Both groups showed the same type of psychological problems post-disaster, but differed in the frequency of contacting the GP

Gerard K. Is fast access to general practice all that should matter? A discrete choice experiment of patients' preferences. *Journal of Health Services Research and Policy* 2008; 13: Suppl. 2 3-10.

Objectives: To determine the relative importance of factors that influence patient choice in the booking of general practice appointments for two health problems. Methods: Two discrete choice experiments incorporated into a survey of general practice patients and qualitative methods to support survey development. Results: An overall response of 94% (1052/1123) was achieved. Factors influencing the average respondent's choice of appointment, in order of importance, were: seeing a doctor of choice; booking at a convenient time of day; seeing any available doctor; and having an appointment sooner rather than later (acute, low worry condition). This finding was the same for an ongoing, high worry condition but in addition the duration of the appointment was also of (small) value. Patients traded off speed of access for more convenient appointment times (a willingness to wait an extra 2.5-3 days longer to get a convenient time slot for an acute low worry/ongoing, high worry condition, respectively). However, contrary to expectation, patients were willing to trade off speed of access for continuity of care (e.g. willingness to wait five days longer to see the doctor of their choice for an acute, low worry condition). Preferences varied by a person's gender, work and carer status. Conclusions: Patients hold strong preferences for the way general practice appointment systems are managed. Contrary to current policy on improving access to primary care patients value a more complex mix of factors than fast access at all costs. It is important that policy-makers and practices take note of these preferences.

Greener I. Are the assumptions underlying patients choice realistic?: a review of the evidence. *British Medical Bulletin* 200783 (1) :249-58.

<http://dx.doi.org/10.1093/bmb/ldm024>

<http://pmid.us/17913793>

Introduction: This paper presents a thematic review of the assumptions underlying patient choice in the NHS to examine who is meant to be making choices in the policy, what choices they are meant to be making and how those choices are meant to be made. Discussion: This paper suggests that policies to increase patient choice require a significant investment in terms of restructuring primary-care services to allow them to happen, as well as to present relevant information to patients, but that patients may not want to make choices about where and what type of treatment they receive for the most part, being content with having a larger say in when they are treated

Lega F, Mengoni A. Why non-urgent patients choose emergency over primary care services? Empirical evidence and managerial implications. *Health Policy* 2008.

<http://dx.doi.org/10.1016/j.healthpol.2008.04.005>

<http://pmid.us/18502533>

Objective: To investigate structural and psychological factors that lead non-urgent patients to choose the Accidents & Emergency Department (A&ED) rather than primary care services. Data sourceS: Data were collected through interviews by means of a structured questionnaire. Data regarding the A&ED sample were also drawn from the

database of the department. Study design: Hypotheses were tested in a survey comparing A&ED non-urgent patients and patients using GP surgeries. Different perceptions of the characteristics of A&ED and primary care services were measured and a perceptual map was created using the linear discriminant analysis (LDA). Data collection: Emergency services users were interviewed in the A&ED of the General Hospital of the Province of Macerata (Italy). Primary care users were interviewed in four GP surgeries. 527 patients were interviewed between December 2006 and February 2007. Principal findings: A&ED and primary care patients look for different characteristics as diagnostic and therapeutic potentialities, empathy and competence, quick access or long-lasting relationship. Information asymmetry explains part of the behaviour. Conclusions: Use of A&ED services for non-urgent care can be reduced. The understanding of reasons underlying the choice and a change in access, timing and contents of care/services provided by general practitioners (GPs) might provide incentives for shifting from A&ED to GPs surgeries

Muir J, Lucas L. Tele-dermatology in Australia. Studies in Health Technology and Informatics 2008 131 245-53.

<http://pmid.us/18305334>

Australia is a large country with a small and scattered population. Specialist dermatology services are concentrated in the capital cities and larger urban centers on the coast. This has meant access to these services for Australians in rural and remote areas has been limited to those able to travel the often long distances to their nearest dermatologist. Due to a considerable shortage of dermatologists, waiting times to see one are more than six months. The challenge was to provide a dermatology service that overcame these twin obstacles of distance and demand. Telecommunication infrastructure in Australia is good and most towns have at least one general practitioner. More than 75% of all general practices are equipped with computers and have broadband internet access. Dermatology is a specialty with few life threatening disorders. However short delays in diagnosis and management of a skin condition rarely have any serious impact on a patient's long-term health. At the same time many skin problems are distressing, and difficult to diagnose and treat. Many skin conditions last for considerable periods of time and patients need ongoing care. Due to the highly visual nature of the specialty, most skin conditions can be diagnosed from an image especially if there is some history available. This often requires a trained specialist. Paradoxically, any needed investigations such as skin biopsy or blood tests can be performed by any qualified doctor. Dermatological treatments can be instituted and monitored by these same practitioners without any specialist training. These factors make tele-medicine an ideal solution to the problems of isolation from and excess demand for specialist dermatological services. In 2004 the Australian College of Rural and Remote Medicine (ACRRM) in a joint initiative with Queensland Divisions of General Practice (QDGP) set up Tele-Derm with funding from the Commonwealth Department of Health and Ageing under the Medical Specialist Outreach Assistance Program (MSOAP). Tele-Derm was set up as an online consultation service combined with a central portal for online dermatology education, resources, links, discussions and professional development activities. It was set up with the belief that a teledermatology service must offer ongoing education as well as a specific case consultation service. If the remote doctor does not have the skills to perform required procedures such as biopsy and

excision then the patient will still need to travel. The common misconception about tele-dermatology is that this form of consultation is not as good as a face-to-face one with a dermatologist. But, in the majority of cases it is [1]. In any event Tele-Derm is not trying to provide a service that is necessarily better than the traditional mode of delivery. It wishes to provide a service where none currently exists. To this end, Tele-Derm provides teleconsultation and online education in dermatology to doctors Australia wide

Miller R. The somatically preoccupied patient in primary care: use of attachment theory to strengthen physician-patient relationships. *Osteopathic Medicine and Primary Care* 2008 2:6.

<http://dx.doi.org/10.1186/1750-4732-2-6>

<http://pmid.us/18445285>

Background :Individuals with somatic preoccupation constitute a substantial number of primary care patients. Somatically preoccupied patients are challenging to primary care physicians for several reasons including patient complaints consuming a great deal of physician time, expense to diagnose and treat and strain on the physician-patient relationship. This paper examines and discusses how disruptions in early attachment relationships such as often occurs when a female is a victim of child sexual abuse may result in somatic preoccupation in adulthood. Treatment Utilizing Attachment Theory Attachment theory provides a useful framework for primary care physicians to conceptualize somatic preoccupation. Utilization and containment techniques grounded in an understanding of attachment dynamics aid the physician in developing a sound physician-patient relationship. Successfully engaging the patient in treatment prevents misunderstandings that frequently derail medical care for somatically preoccupied patients

Salmon P, et al. Doctors' attachment style and their inclination to propose somatic interventions for medically unexplained symptoms. *General Hospital Psychiatry* 2008 30 (2) 104-11.

<http://dx.doi.org/10.1016/j.genhosppsy.2007.12.002>

<http://pmid.us/18291292>

Objective: We tested the theory that general practitioners (GPs) offer somatic intervention to patients with medically unexplained symptoms (MUS) as a defensive response to patients' dependence. We predicted that GPs most likely to respond somatically after patients indicated symptomatic or psychosocial needs had attachment style characterised by negative models of self and others. **Method:** Twenty-five GPs identified 308 patients presenting MUS and indicated their own models of self and others. Consultations were audio recorded and coded speech-turn-by-speech-turn. We modeled the probability of GPs proposing somatic intervention on any turn as a function of their models of self and other and the number of prior turns containing symptomatic or psychosocial presentations. **Results:** Prior psychosocial presentations decreased the

likelihood of GPs offering somatic intervention. The decrease was greatest in GPs with most positive models of self and, contrary to prediction, least positive models of others. The positive relationship between prior somatic presentations and the likelihood that GPs offered somatic intervention was unrelated to either model. Conclusion: Findings are incompatible with our theory that GPs propose somatic interventions defensively. Instead, GPs may provide somatic intervention because they value patients (positive model of others) but devalue their own psychological skills (negative model of self)

Townsend A, Wyke S, Hunt K. Frequent consulting and multiple morbidity: a qualitative comparison of 'high' and 'low' consulters of GPs. *Family Practice* Advance Access 2008.

<http://dx.doi.org/10.1093/fampra/cmn017>

<http://pmid.us/18448858>

Background: Frequent consulting is associated with multiple and complex social and health conditions. It is not known how the impact of multiple conditions, the ability to self-manage and patient perception of the GP consultation combines to influence consulting frequency. Objective: To investigate reasons for frequent consultation among people with multiple morbidity but contrasting consulting rates. Methods: Qualitative study with in-depth interviews in the west of Scotland. Participants were 23 men and women aged about 50 years with four or more chronic illnesses; 11 reported consulting seven or more times in the last year [the frequent consulters (FCs)] and 12, three or fewer times [the less frequent consulters (LFCs)]. The main outcome measures were the participants' accounts of their symptoms, self-management strategies and reasons for consulting a GP. results: All participants used multiple self-management strategies. FCs described: more disruptive symptoms, which were resistant to self-management strategies; less access to fewer treatments and resources and more medical monitoring, for unstable conditions and drug regimens. The LFCs reported: less severe and more containable symptoms; accessing more efficacious self-management strategies and infrequent GP monitoring for stable conditions and routine drug regimens. All participants conveyed consulting as a 'last resort'. However, the GP was seen as 'ally', for the FCs, and as 'innocent bystander', for the LFCs. Conclusions: This qualitative investigation into the combined significance of multiple morbidities and self-management on the GP consultation suggests that current models of self-management might have limited potential to reduce utilization rates among this vulnerable group. Severity of symptoms, stability of condition and complexity of drug regimens combine to influence the availability of effective resources and influence frequency of GP consultations

CHRONIC ILLNESS

Armstrong N, Powell J. Preliminary test of an Internet-based diabetes self-management tool. *Journal of Telemedicine and Telecare*. 2008;14 (3) :114-6.

<http://dx.doi.org/10.1258/jtt.2008.003002>

Self-care is a way of helping the health service to manage the growth in long-term chronic conditions. We developed an Internet-based self-management tool for diabetes following detailed consultations with patients. The Virtual Clinic allows a patient to communicate with their health professionals, find information about their condition and share support and advice with others through peer-to-peer discussions. We conducted a test of the Virtual Clinic with five patients prior to the start of a six-month pilot study to evaluate its feasibility, acceptability and effectiveness. The test session involved an interactive computer-based element followed by a focus group to gather feedback. All five patients were positive about the Virtual Clinic. A user-centred approach to developing an Internet intervention is important to ensure that it will meet patients' needs and that they will be enthusiastic about using it

Bellary S, *et al.* Enhanced diabetes care to patients of south Asian ethnic origin (the United Kingdom Asian Diabetes Study): a cluster randomised controlled trial. *Lancet* 2008; 371 (9626):1769-76.

[http://dx.doi.org/10.1016/S0140-6736\(08\)60764-3](http://dx.doi.org/10.1016/S0140-6736(08)60764-3)

<http://pmid.us/18502301>

Background: Delivery of high-quality, evidence-based health care to deprived sectors of the community is a major goal for society. We investigated the effectiveness of a culturally sensitive, enhanced care package in UK general practices for improvement of cardiovascular risk factors in patients of south Asian origin with type 2 diabetes. Methods: In this cluster randomised controlled trial, 21 inner-city practices in the UK were assigned by simple randomisation to intervention (enhanced care including additional time with practice nurse and support from a link worker and diabetes-specialist nurse [nine practices; n=868]) or control (standard care [12 practices; n=618]) groups. All adult patients of south Asian origin with type 2 diabetes were eligible. Prescribing algorithms with clearly defined targets were provided for all practices. Primary outcomes were changes in blood pressure, total cholesterol, and glycaemic control (haemoglobin A1c) after 2 years. Analysis was by intention to treat. This trial is registered, number ISRCTN 38297969. Findings: We recorded significant differences between treatment groups in diastolic blood pressure (1.91 [95% CI -2.88 to -0.94] mm Hg, p=0.0001) and mean arterial pressure (1.36 [-2.49 to -0.23] mm Hg, p=0.0180), after adjustment for confounders and clustering. We noted no significant differences between groups for total cholesterol (0.03 [-0.04 to 0.11] mmol/L), systolic blood pressure (-0.33 [-2.41 to 1.75] mm Hg), or HbA1c (-0.15% [-0.33 to 0.03]). Economic analysis suggests that the nurse-

led intervention was not cost effective (incremental cost-effectiveness ratio pound28 933 per QALY gained). Across the whole study population over the 2 years of the trial, systolic blood pressure, diastolic blood pressure, and cholesterol decreased significantly by 4.9 (95% CI 4.0-5.9) mm Hg, 3.8 (3.2-4.4) mm Hg, and 0.45 (0.40-0.51) mmol/L, respectively, and we recorded a small and non-significant increase for haemoglobin A1c (0.04% [-0.04 to 0.13]), p=0.290). Interpretation: We recorded additional, although small, benefits from our culturally tailored care package that were greater than the secular changes achieved in the UK in recent years. Stricter targets in general practice and further measures to motivate patients are needed to achieve best possible health-care outcomes in south Asian patients with diabetes

Dennis SM Chronic disease management in primary care: from evidence to policy Medical Journal of Australia 2008 188 (8) Suppl S53-56

<http://pmid.us/18429737>

Objectives: To review the effectiveness of chronic disease management interventions for physical health problems in the primary care setting, and to identify policy options for implementing successful interventions in Australian primary care. Methods: We conducted a systematic review with qualitative data synthesis, using the Chronic Care Model as a framework for analysis between January 1990 and February 2006. Interventions were classified according to which elements were addressed: community resources, health care organisation, self-management support, delivery system design, decision support and/or clinical information systems. Our major findings were discussed with policymakers and key stakeholders in relation to current and emerging health policy in Australia. Results: The interventions most likely to be effective in the context of Australian primary care were engaging primary care in self-management support through education and training for general practitioners and practice nurses, and including self-management support in care plans linked to multidisciplinary team support. The current Practice Incentives Payment and Service Incentives Payment programs could be improved and simplified to encourage guideline-based chronic disease management, integrating incentives so that individual patients are not managed as if they had a series of separate chronic diseases. The use of chronic disease registers should be extended across a range of chronic illnesses and used to facilitate audit for quality improvement. Training should focus on clear roles and responsibilities of the team members. Conclusion: The Chronic Care Model provides a useful framework for understanding the impact of chronic disease management interventions and highlights the gaps in evidence. Consultation with stakeholders and policymakers is valuable in shaping policy options to support the implementation of the National Chronic Disease Strategy in primary care.

Fursse J, et al . Early experience in using telemonitoring for the management of chronic disease in primary care. *Journal of Telemedicine and Telecare*. 2008; 14 (3) 122-4.

<http://dx.doi.org/10.1258/jtt.2008.003005>

<http://pmid.us/18430275>

We have investigated the use of telemonitoring in three long-term conditions: chronic heart failure (CHF), type 2 diabetes and essential hypertension. Participants were provided with a home telemonitoring unit for a 12-week period and entered physiological data each day. The data were sent automatically via the participant's telephone line to a server and could be viewed via a web browser. An intervention algorithm was developed to improve the accuracy with which patients requiring intervention were recognized compared to existing systems based on a simple threshold. Thirty patients completed the 12-week trial. One patient dropped out, giving data on 29 patients (mean age 70 years, 17 women). The algorithm prompted a clinical intervention in 11 patients (38%). The average time that elapsed before the first intervention was 47 days (SD 21). Primarily the interventions (72%) resulted in changes to medication and health advice. The results suggest that four weeks is sufficient time in which to recognize the need to intervene clinically and that in 12 weeks it is possible to effect a change towards a target

Glasgow RE, Peeples M, Skovlund SE. Where is the patient in diabetes performance measures? The case for including patient-centered and self-management measures. *Diabetes Care* 2008; 31 (5) 1046-50.

<http://dx.doi.org/10.2337/dc07-1845>

<http://pmid.us/18445728>

Objective: Health policies are important determinants of clinician and patient behavior, and an important policy issue is what items are included in healthcare quality and performance measures. There is consensus that patient-centered care and self-management support are essential evidence-based components of good diabetes care. However, most major diabetes performance measures such as the National Committee for Quality Assurance (NCQA)/American Diabetes Association (ADA) Provider Recognition Program indexes have not included self-management or psychosocial items. Research design and methods and results: We review the case for and propose a set of patient-centered, self-management indicators to be included as a standard part of diabetes quality indicators. The proposed indicators include: patient self-management goal(s), measures of health behaviors (e.g., healthy eating, medication taking, physical activity, and smoking status), quality of life, and patient-centered collaborative care. We discuss the evidence and the concerns about patient-report measures and summarize successful incorporation of such patient-centered measures in other countries and by the American Association of Diabetes Educators (AADE). Conclusions: The adage that "what gets measured, gets done" applies to diabetes management and many other areas of healthcare. Inclusion of the proposed indicators in national diabetes performance measures would be consistent with Institute of Medicine (IOM), ADA, Centers for Disease Control (CDC), Diabetes Attitudes, Wishes, and Needs (DAWN), AADE, and

Society of Behavioral Medicine (SBM) recommendations. Such action would enhance both the priority and delivery of quality, patient-centered care, and diabetes self-management support

Gorter K, et al. Overall quality of diabetes care in a defined geographic region: different sides of the same story. *British Journal of General Practice* 2008 58 (550) 339-45.

<http://dx.doi.org/10.3399/bjgp08X280209>

<http://pmid.us/18482488>

Background: In diabetes care, knowledge about what is achievable in primary and secondary care is important. There is a need for an objective method to assess the quality of care in different settings. A quality-of-care summary score has been developed based on process and outcome measures. An adapted version of this score was used to evaluate diabetes management in different settings. **Aim:** To evaluate the quality of diabetes management in primary and secondary care in a defined geographic region in the Netherlands, using a quality score. **Design of study:** Cross-sectional study. **Setting:** Thirty general practices in the Netherlands. **Method:** A study of 2042 patients with type 2 diabetes (1640 primary care and 402 secondary care) was conducted. Quality of diabetes management was assessed by a score of process and outcome indicators (range 0-40). Clustering at practice level and differences in patient characteristics (case mix) were taken into account. **Results:** At the outpatient clinic, patients were younger (mean age 64.1 years, standard deviation (SD) = 12.5 years, versus mean age 67.1 years, SD = 11.7, $P < 0.001$), had more diabetes-related complications (macrovascular: 39.7% versus 24.3%, $P < 0.001$; and microvascular: 25.9% versus 7.3%, $P < 0.001$), and lower quality-of-life scores (EuroQol-5D: mean = 0.60, SD = 0.29, versus mean = 0.80, SD = 0.21, $P < 0.001$). After adjusting for case mix and clustering, there was a weak association between the setting of treatment and haemoglobin A1c (primary care: mean 7.1%, SD = 1.1, versus secondary care: mean 7.6%, SD = 1.2, $P < 0.016$), and between setting and systolic blood pressure (primary: mean 145.7 mmHg, SD = 19.2, versus secondary care: 147.77 mmHg, SD 21.0, $P < 0.035$). Quality-of-care summary scores in primary and secondary care differed significantly, with a higher score in primary care (mean 19.6, SD = 8.5 versus, mean 18.1, SD = 8.7, $P < 0.01$). However, after adjusting for case mix and clustering, this difference lost significance. **Conclusion:** GPs and internists are treating different categories of patients with type 2 diabetes. However, overall quality of diabetes management in primary and secondary care is equal. There is much room for improvement. Future guidelines may differentiate between different categories of patients.

Harvey PW, et al. Self-management support and training for patients with chronic and complex conditions improves health-related behaviour and health outcomes. *Australian Health Review* . 2008 32 (2) 330-8

<http://pmid.us/18447824>

The Sharing Health Care SA chronic disease self-management (CDSM) project in rural South Australia was designed to assist patients with chronic and complex conditions (diabetes, cardiovascular disease and arthritis) to learn how to participate more effectively in the management of their condition and to improve their self-management skills. Participants with chronic and complex conditions were recruited into the Sharing Health Care SA program and offered a range of education and support options (including a 6-week peer-led chronic disease self-management program) as part of the Enhanced Primary Care care planning process. Patient self-reported data were collected at baseline and subsequent 6-month intervals using the Partners in Health (PIH) scale to assess self-management skill and ability for 175 patients across four data collection points. Health providers also scored patient knowledge and self-management skills using the same scale over the same intervals. Patients also completed a modified Stanford 2000 Health Survey for the same time intervals to assess service utilisation and health-related lifestyle factors. Results show that both mean patient self-reported PIH scores and mean health provider PIH scores for patients improved significantly over time, indicating that patients demonstrated improved understanding of their condition and improved their ability to manage and deal with their symptoms. These results suggest that involvement in peer-led self-management education programs has a positive effect on patient self-management skill, confidence and health-related behaviour

Jerant A ,et al . Depressive symptoms moderated the effect of chronic illness self-management training on self-efficacy. *Medical Care* 2008;46 :523-31.

<http://dx.doi.org/10.1097/MLR.0b013e31815f53a4>

<http://pmid.us/18438201>

Background Identifying moderators of the effects of self-efficacy enhancing interventions could facilitate their refinement and more targeted, cost-effective delivery. Current theories and data concerning the potential moderating effect of depressive symptoms on interventions to enhance patient chronic illness self-management self-efficacy are conflicting. Objectives:: To explore the moderating effect of depressive symptoms on the effect of an intervention to enhance patient self-efficacy for self-managing chronic illness. Research design:: Regression analyses using baseline and postintervention (6 weeks) data from an ongoing randomized controlled trial. SUBJECTS:: Patients (N = 415) aged ≥ 40 years recruited from a primary care network in Northern California with arthritis, asthma, chronic obstructive pulmonary disease, congestive heart failure, depression, and/or diabetes mellitus, plus impairment in ≥ 1 basic activity, and/or a score of ≥ 4 on the 10-item Center for Epidemiologic Studies Depression Scale (CES-D). Measures:: Stanford self-efficacy scale, self-reported depression, CES-D, and Medical Outcomes Study Short Form health status questionnaire (SF-36) Mental Component Summary score. RESULTS:: Regression analyses revealed the intervention was effective primarily in those with self-reported depression (interaction effect $F = 8.24$, $P = 0.0003$), highest CES-D score category ($F = 5.68$, $P = 0.0037$), and lowest (most depressed) Mental Component Summary-36 tercile ($F = 4.36$, $P = 0.0135$). Conclusions:: Individuals with more depressive symptoms seem more likely to experience self-efficacy gains from chronic illness self-management training than individuals with less depressive

symptoms. Future self-management training studies should stratify subjects within study groups by depressive symptom level to further explore its potential moderating effect

Lanting LC, et al Ethnic differences in outcomes of diabetes care and the role of self-management behavior. *Patient Education and Counseling* 2008.

<http://dx.doi.org/10.1016/j.pec.2008.03.008>

<http://pmid.us/18455354>

Objective: Ethnic differences in outcomes of outpatient diabetic care and the role of self-management behavior and its determinants in explaining observed differences. Methods: Face-to-face interviews were held with 102 Turkish or Moroccan, and 102 native Dutch diabetic patients to measure self-management behavior and determinants of self-management (as derived from the Attitudes-Social support self-Efficacy model, and Personal Models and Barriers). A medical record review was conducted to measure ethnic differences in outcomes of diabetes care. Data were analyzed using multiple linear regression. Results: Outcomes differed significantly with ethnic minorities having higher levels of lipids (risk difference=RD=0.7%; CI: 0.3-1.2) and HbA1c (RD=0.9%; CI: 0.4-1.4) than native Dutch patients. Differences in self-management could not explain the ethnic differences in outcomes. Self-efficacy explained 18% of the ethnic differences in HbA1c. Beliefs about seriousness of diabetes and social support regarding diabetes management together explained 47% of the ethnic differences in lipids. Conclusion: This study provides evidence for ethnic differences in outcomes of diabetes care. Self-efficacy is the most important determinant in explaining the differences in HbA1c. Practice implications: For diabetes practice this suggests that strengthening patients' self-efficacy may improve the control of HbA1c and may result in a decrease of ethnic differences. The relationship between behavioral determinants like seriousness and social support and outcomes of diabetes care was differential by ethnic group, implying that caution is required when applying behavioral models to different ethnic groups

Leveille SG, et al Screening for chronic conditions using a patient internet portal: recruitment for an internet-based primary care intervention. *Journal of General Internal Medicine* 2008 23 (4) 472-5.

<http://dx.doi.org/10.1007/s11606-007-0443-6>

<http://pmid.us/18373147>

Background: Patient Internet portals have created new opportunities for assessment and management of chronic conditions. Objective: To conduct an online screening survey for a study recruitment using a secure patient Internet portal to identify primary care patients with untreated depression, chronic pain, or mobility difficulty before nonurgent office visits. DESIGN: Internet-based screening survey for a randomized trial. Participants: Patients who were registered portal users who had scheduled primary care appointments. APPROACH: Electronic study invitations via the portal were sent to 4,047 patients with scheduled visits to 34 primary care physicians participating in the study. After clicking on

a link in the study invitation, patients were consecutively shown the study description, consent form, and lastly, the screening survey to determine final eligibility for study participation. Results: Of the 2,113 (52%) patients who opened the study invitation, 1,001 consented online to join the study and 981 (98%) of these completed the screening survey. Of the respondents, 319 (33%) screened positive for 1 or more of the 3 conditions. Conclusions: The online screening survey conducted through the patient portal was effective in identifying patients with chronic conditions in advance of scheduled primary care visits for participation in an intervention study

Patel S, et al GPs' experience of managing chronic pain in a South Asian community--a qualitative study of the consultation process. *Family Practice* 2008 25 (2) 71-7.

<http://dx.doi.org/10.1093/fampra/cmn012>.

<http://pmid.us/18375527>

Background. Chronic pain is one of the most common reasons for seeking primary care consultations. GPs' experience of managing patients with pain from a multicultural community has not previously been examined. Objectives. We explored GPs' experiences of managing patients with chronic pain from a South Asian community in Leicester. Methods. Qualitative semi-structured interviews were conducted with GPs from practices in two primary care trusts within Leicester. Eighteen GPs (11 males and 7 females) were interviewed in this study. Results. Several emerging themes were identified from the data including consulting behaviour, presentation of pain, GPs personal challenges, psychosomatic interpretations and communication. Overall, GPs find that managing South Asian patients with chronic pain can be challenging as a consequence of the way in which patients present with pain. Difficulties for GPs were created not only by language differences but also by cultural differences, which were not seen in second or third generation South Asians. GPs felt that self-management was difficult to address, and compliance with medication difficult to determine. In such consultations, GPs perceived that patients were more likely to present with psychosomatic symptoms. Conclusions. Cultural influences play an important role in the consultation process where patients' behaviour is often bound in their cultural view of health care. Patients' presentation of their condition makes diagnosis difficult but can also lead to miscommunication. Whether South Asian people are more likely to present mental health problems as chronic pain is not clear and warrants further investigation

Rowley KG, et al. Lower than expected morbidity and mortality for an Australian Aboriginal population: 10-year follow-up in a decentralised community. *Medical Journal of Australia* 2008 188 (5) 283-7.

<http://pmid.us/18312192>

Objective: To examine mortality from all causes and from cardiovascular disease (CVD),

and CVD hospitalisation rate for a decentralised Aboriginal community in the Northern Territory. Design and participantS: For a community-based cohort of 296 people aged 15 years or older screened in 1995, we reviewed hospital and primary health care records and death certificates for the period up to December 2004 (2800 person-years of follow-up). Main outcome measures: Mortality from all causes and CVD, and hospitalisation with CVD coded as a primary cause of admission; comparison with prior trends (1988 to 1995) in CVD risk factor prevalence for the community, and with NT-specific Indigenous mortality and hospitalisation rates. Results: Mortality in the cohort was 964/100,000 person-years, significantly lower than that of the NT Indigenous population (standardised mortality ratio [SMR], 0.62; 95% CI, 0.42-0.89). CVD mortality was 358/100,000 person-years for people aged 25 years or older (SMR, 0.52; 95% CI, 0.23-1.02). Hospitalisation with CVD as a primary cause was 13/1000 person-years for the cohort, compared with 33/1000 person-years for the NT Indigenous population. Conclusion: Contributors to lower than expected morbidity and mortality are likely to include the nature of primary health care services, which provide regular outreach to outstation communities, as well as the decentralised mode of outstation living (with its attendant benefits for physical activity, diet and limited access to alcohol), and social factors, including connectedness to culture, family and land, and opportunities for self-determination

Williams NH, et al Functional illness in primary care: dysfunction versus disease. *BMC Family Practice* 2008;9:30.

<http://dx.doi.org/10.1186/1471-2296-9-30>

<http://pmid.us/18482442>

Background: The Biopsychosocial Model aims to integrate the biological, psychological and social components of illness, but integration is difficult in practice, particularly when patients consult with medically unexplained physical symptoms or functional illness. Discussion: This Biopsychosocial Model was developed from General Systems Theory, which describes nature as a dynamic order of interacting parts and processes, from molecular to societal. Despite such conceptual progress, the biological, psychological, social and spiritual components of illness are seldom managed as an integrated whole in conventional medical practice. This is because the biomedical model can be easier to use, clinicians often have difficulty relinquishing a disease-centred approach to diagnosis, and either dismiss illness when pathology has been excluded, or explain all undifferentiated illness in terms of psychosocial factors. By contrast, traditional and complementary treatment systems describe reversible functional disturbances, and appear better at integrating the different components of illness. Conventional medicine retains the advantage of scientific method and an expanding evidence base, but needs to more effectively integrate psychosocial factors into assessment and management, notably of 'functional' illness. As an aid to integration, pathology characterised by structural change in tissues and organs is contrasted with dysfunction arising from disordered physiology or psychology that may occur independent of pathological change. Summary: We propose a classification of illness that includes orthogonal dimensions of pathology and dysfunction to support a broadly based clinical approach to patients; adoption of which may lead to

fewer inappropriate investigations and secondary care referrals and greater use of cognitive behavioural techniques, particularly when managing functional illness

COMMISSIONING

Ashton T, et al **Decentralizing resource allocation: early experiences with district health boards in New Zealand.** *Journal of Health Services Research and Policy* 2008;13 (2) :109-15.

<http://dx.doi.org/10.1258/jhsrp.2008.007133>

<http://pmid.us/18416917>

Objectives: In New Zealand in 2001, a system of purchasing health services by a centralized purchasing agency was replaced by 21 district health boards (DHBs) which are responsible for both providing health services directly and for purchasing services from non-government providers. This paper describes the processes associated with the allocation of health resources in the decentralized system and considers the extent to which four of the government's stated objectives are likely to be achieved. Methods: Two rounds of interviews with national stakeholders and senior DHB personnel plus case studies in five districts which included key informant interviews, observation at board meetings and document analysis. Results: The re-structuring of the health sector in New Zealand appears to have simultaneously enhanced and inhibited the achievement of government objectives. Local decision-making has encouraged greater local responsiveness and new funding arrangements have allayed concerns about inter-regional equity. The system is less commercially oriented than it was during the 1990s and collaboration between DHBs is improving. However, the combination of increased integration of purchasing and provision within DHBs and the focus on financial deficits in the early years appears to have inhibited the development of partnership relationships between DHBs and non-government providers, and of longer-term funding arrangements for high quality providers. Non-government providers perceive that DHBs have a tendency to favour their own providers when allocating contracts. Conclusions: Decentralized decision-making is starting to make some inroads towards achieving some of the government's objectives with respect to resource allocation and purchasing

Charlton R. **Practice-based commissioning: implications for secondary care.** *Clinical Medicine* 2008; 8 (1) 61-4.

<http://pmid.us/18335672>

General practitioner (GP) practice-based commissioning (PBC) is a much debated politically driven NHS innovation at a time of ongoing change. Unlike GP fundholding it is envisaged that PBC will involve all GP practices by 2008. A possible outcome is that

some current secondary care services may be commissioned in primary care in the form of local enhanced services or intermediate clinics and run by GPs with special interests. Examples where this has occurred are diabetes and anticoagulation. Similarly, private providers may be commissioned. Inevitably there will be an impact on hospital services through a possible reduction in funding and consultants being subcontracted to provide services in primary care. Issues such as clinical governance and cost-effectiveness, however, require evaluation to determine the potential effect on the working relationships and so the interface between generalists and specialists

Dusheiko M, et al. Explaining trends in concentration of healthcare commissioning in the English NHS. *Health Economics* published online 12/10/2007.

<http://dx.doi.org/10.1002/hec.1301>

In recent years there have been marked changes in organisational structures and budgetary arrangements in the English National Health Service, potentially altering the relationships between purchasers (primary care organisations (PCOs) and general practices) and hospitals. We show that elective admissions from PCOs and practices became significantly more concentrated across hospitals between 1997/98 and 2002/03. There was a reduction in the average number of hospitals used by PCOs (16.7-14.2), an increase in the average share of admissions accounted for by the main hospital (49-69%), and an increase in the average Herfindahl index (0.35-0.55). About half the increase in concentration arose from the increase in the number of purchasing organisations as 100 health authorities were replaced by 303 primary care trusts. Most of the remainder was probably due to hospital mergers. Fundholding general practices that held budgets for elective admissions had less concentrated admission patterns than non-fundholders whose admissions were paid for by their PCO. Around 1/10th of the increase in concentration at practice level was due to the abolition of fundholding in April 1999. Our results have implications for the effects of the recent reintroduction of fundholding and the halving of the number of PCOs

Ham C. World class commissioning: a health policy chimera? *J Health Serv Res Policy* 2008; 13 (2) 116-21.

<http://dx.doi.org/10.1258/jhsrp.2008.007177>

<http://pmid.us/18416918>

The health reforms in England have entered a phase in which greater emphasis is being placed on market-like mechanisms. The ability of the commissioners of care to negotiate on equal terms with providers will be of critical importance in the emerging market. The government has set out plans to develop 'world class commissioning' and this essay reviews experience in Europe, New Zealand and the United States to understand what is involved in working towards this goal. The evidence reviewed shows that in no system is commissioning done consistently well and highlights the obstacles to the development of world class commissioning. The reasons for this centre on the complexity of health care and the inherent difficulty of commissioning health services in publicly financed systems.

Commissioners will need to be able to access a range of expertise and are likely to incur significant expenditure in so doing. There are warning signs from other systems of health reforms that result in adversarial and legalistic approaches, and do not give sufficient attention to relational contracting. Even if world class commissioning is developed, it may fall short of its potential in the absence of other changes in the design of the reforms, such as autonomous providers and appropriate payment systems. In view of these challenges, a more promising alternative would be to develop competing integrated systems

EMPOWERMENT

Fisher P. Wellbeing and empowerment: the importance of recognition. *Sociology of Health & Illness* 2008;30 (4) 583-98.

<http://dx.doi.org/10.1111/j.1467-9566.2007.01074.x>

<http://pmid.us/18298628>

Health and wellbeing are now located within a policy framework that emphasises the empowerment of the individual consumer. Within this paradigm, empowerment is writ large and wellbeing is seen as a civic duty. The role of the health and social care services has been identified as one of enabling service users to promote their own wellbeing. In this paper, it is argued that dominant narratives relating to achievement and normality may result in forms of misrecognition that act to undermine the positive sense of self that is crucial for self-empowerment. It is suggested that while the parents of disabled babies often act reflexively to create empowering life narratives within the private sphere, this is not always facilitated by their encounters with health and social care organisations where neo-liberal ideas and biomedical narratives, based on a modernist view of identity as individual and existing prior to society, mean that parents and children are attributed deficient identities in ways that undermine empowerment. With reference to the politics of recognition it is argued that services that seek to empower must value diversity and alterity whilst respecting human dependency on intersubjective recognition.

Lemire M, Sicotte C, Paré G. Internet use and the logics of personal empowerment in health. *Health Policy* 2008 In press.

<http://dx.doi.org/10.1016/j.healthpol.2008.03.006>

<http://pmid.us/18436330>

Objectives The development of personal involvement and responsibility has become a strategic issue in health policy. The main goal of this study is to confirm the coexistence of three logics of personal empowerment through health information found on the Internet. **Methods** A theoretical framework was applied to analyze personal empowerment from the user's perspective. A well-established Canadian Web site that offers information on personal health was used as a case study. A close-ended questionnaire was completed online by 2275 visitors and members of the Web site. **Results** The findings confirm that the development of feelings of competence and control through Internet use is structured around three different logics. This implies three types of aptitudes that are fostered when the Internet is used to seek health information: doing what is prescribed (the professional logic), making choices based on personal judgment (the consumer logic), and mutual assistance (the community logic). **Conclusions** A recurring issue in three logics is the balance of roles and responsibilities required between the individual and the health provider

Rohrer J E, et al Patient-centredness, self-rated health, and patient empowerment: should providers spend more time communicating with their patients? *Journal of Evaluation in Clinical Practice* 2008.

<http://dx.doi.org/10.1111/j.1365-2753.2007.00914.x>

<http://pmid.us/18462285>

Objective Patient-centred communication is often employed as a strategy for empowering patients. The purpose of this study was to investigate the relationship between a direct measure of patient empowerment, feeling that one is in control of one's own health and patient satisfaction with communication. **Design** A cross-sectional survey of family medicine patients was used to test the theory that, in primary care patients, empowerment is related to satisfaction with several aspects of communication after adjusting for health status, age and gender. Interviews were completed with 680 adult patients for whom complete data were available. **Results** Multiple logistic regression analysis revealed that being highly satisfied with overall communication [adjusted odds ratio (AOR) = 2.08], explanations (AOR = 2.04), listening (AOR = 2.63), use of understandable words (AOR = 2.41) and involvement in decisions (2.34) were positively associated with empowerment. Self-rated health was more strongly related to empowerment than satisfaction with communication in every model tested (AORs ranged from 2.8 to 3.0). **Conclusions** Reliance solely on patient-centred communication to promote empowerment may be insufficient as well as costly. Instead, improved one-to-one communication between patients and providers should be reserved for clinically complex and urgent situations. For other health matters, referral of patients to community health promotion and education programmes should be considered because this may offer a lower-cost approach to empowerment

HEALTH ECONOMICS

Campbell SM, McDonald R, Lester H. The Experience of Pay for Performance in English Family Practice: A Qualitative Study. *Annals of Family Medicine* 2008; 6 228-34.

<http://dx.doi.org/10.1370/afm.844>

Purpose We conducted an in-depth exploration of family physicians' and nurses' beliefs and concerns about changes to the family health care service as a result of the new pay-for-performance scheme in the United Kingdom (Quality and Outcomes Framework [QOF]). **Methods** Using a semistructured interview format, we interviewed 21 family doctors and 20 nurses in 22 nationally representative practices across England between February and August 2007. **Results** Participants believed the financial incentives had been sufficient to change behavior and to achieve targets. The findings suggest that it is not necessary to align targets to professional priorities and values to obtain behavior change, although doing so enhances enthusiasm and understanding. Participants agreed that the aims of the pay-for-performance scheme had been met in terms of improvements in disease-specific processes of patient care and physician income, as well as improved data capture. It also led to unintended effects, such as the emergence of a dual QOF-patient agenda within consultations, potential deskilling of doctors as a result of the enhanced role for nurses in managing long-term conditions, a decline in personal/relational continuity of care between doctors and patients, resentment by team members not benefiting financially from payments, and concerns about an ongoing culture of performance monitoring in the United Kingdom. **Conclusions** The QOF scheme may have achieved its declared objectives of improving disease-specific processes of patient care through the achievement of clinical and organizational targets and increased physician income, but our findings suggest that it has changed the dynamic between doctors and nurses and the nature of the practitioner-patient consultation

Gravelle H, Sutton M. Income, relative income, and self-reported health in Britain 1979-2000. *Health Economics* Epub ahead of print 10/4/2008

<http://dx.doi.org/10.1002/hec.1354>

<http://pmid.us/18404665>

We test the relative income hypothesis that an individual's health depends on the distribution of income in a reference group, as well as on the income of the individual. We use data on 231 208 individuals in Great Britain from 19 rounds of the General Household Survey between 1979 and 2000. Results are insensitive to the measure of self-assessed health used but the sign and significance of the effect of relative income depend on the reference group (national or regional) and the measure of relative income (Gini coefficient, absolute or proportional difference from the reference group mean, Yitzhaki absolute and proportional relative deprivation and affluence). Only one model (relative

deprivation measured as income proportional to regional mean income) performs better than the model without relative income and has a positive estimated effect of absolute income on health. In this model the increase in the probability of good health from a *ceteris paribus* reduction in relative deprivation from the upper quartile to zero is 0.010, whereas an increase in income from the lower to the upper quartile increases the probability by 0.056. While our results provide only very weak support for the relative deprivation hypothesis, the inevitable correlation of measures of individual income and relative deprivation measured by comparing income and incomes in a reference group makes identification of the separate effects of income and relative deprivation problematic

Gravelle H, Siciliani L. Ramsey waits: Allocating public health service resources when there is rationing by waiting. *Journal of Health Economics* Epub ahead of print 4/4/2008.

<http://dx.doi.org/10.1016/j.jhealeco.2008.03.004>

<http://pmid.us/18468707>

The optimal allocation of a public health care budget across treatments must take account of the way in which care is rationed within treatments since this will affect their marginal value. We investigate the optimal allocation rules for public health care systems where user charges are fixed and care is rationed by waiting. The optimal waiting time is higher for treatments with demands more elastic to waiting time, higher costs, lower charges, smaller marginal welfare loss from waiting by treated patients, and smaller marginal welfare losses from under-consumption of care. The results hold for a wide range of welfarist and non-welfarist objective functions and for systems in which there is also a private health care sector. They imply that allocation rules based purely on cost effectiveness ratios are suboptimal because they assume that there is no rationing within treatments

Hole AR. Modelling heterogeneity in patients' preferences for the attributes of a general practitioner appointment. *Journal of Health Economics* 2007.

<http://dx.doi.org/10.1016/j.jhealeco.2007.11.006>

<http://pmid.us/18179837>

This paper examines the distribution of preferences among respondents to a discrete choice experiment on the choice of general practitioner appointments. In addition to standard logit, mixed and latent class logit models are used to analyse the data from the choice experiment. It is found that there is significant preference heterogeneity for all the attributes in the experiment and that both the mixed and latent class models lead to significant improvements in fit compared to the standard logit model. Moreover, the distribution of preferences implied by the preferred mixed and latent class models is similar for many attributes

INFORMATION AND COMMUNICATIONS TECHNOLOGY

Greenhalgh, T, Patients' attitudes to the summary care record and HealthSpace: qualitative study *British Medical Journal* 2008 336 (7656) 1290-1295

<http://dx.doi.org/10.1136/bmj.a114>

<http://pmid.us/18511764>

Objective: To document the views of patients and the public towards the summary care record (SCR, a centrally stored medical record drawn from the general practice record) and HealthSpace (a personal health organiser accessible through the internet from which people can view their SCR), with a particular focus on those with low health literacy, potentially stigmatising conditions, or difficulties accessing health care. DESIGN: 103 semistructured individual interviews and seven focus groups. Setting: Three early adopter primary care trusts in England where the SCR and HealthSpace are being piloted. All were in areas of relative socioeconomic deprivation. Participants: Individual participants were recruited from general practice surgeries, walk-in centres, out of hours centres, and accident and emergency departments. Participants in focus groups were recruited through voluntary sector organisations; they comprised advocates of vulnerable groups and advocates of people who speak limited English; people with HIV; users of mental health services; young adults; elderly people; and participants of a drug rehabilitation programme. Methods: Participants were asked if they had received information about the SCR and HealthSpace and about their views on shared electronic records in different circumstances. Results: Most people were not aware of the SCR or HealthSpace and did not recall receiving information about it. They saw both benefits and drawbacks to having an SCR and described a process of weighing the former against the latter when making their personal choice. Key factors influencing this choice included the nature of any illness (especially whether it was likely to lead to emergency care needs); past and present experience of healthcare and government surveillance; the person's level of engagement and health literacy; and their trust and confidence in the primary healthcare team and the wider NHS. Overall, people with stigmatising illness were more positive about the SCR than people who claimed to speak for "vulnerable groups." Misconceptions about the SCR were common, especially confusion about what data it contained and who would have access to it. Most people were not interested in recording their medical data or accessing their SCR via HealthSpace, but some saw the potential for this new technology to support self management and lay care for those with chronic illness. Conclusion: Despite an extensive information programme in early adopter sites, the public remains unclear about current policy on shared electronic records, though most people view these as a positive development. The "implied consent" model for creating

and accessing a person's SCR should be revisited, perhaps in favour of "consent to view" at the point of access

Hannan A. The paradigm shift in healthcare - overcoming challenges in giving patients access to their electronic records. *Journal of Communication in Healthcare* 2008 1 (1) 7-19.

MEDICINES MANAGEMENT

Lamden KH, Gemmell I. General practice factors and MMR vaccine uptake: structure, process and demography. *Journal of Public Health (Oxf)* 2008.

<http://dx.doi.org/10.1093/pubmed/fdn036>

<http://pmid.us/18487248>

Background: Despite the fall in MMR uptake between 1998 and 2004, some general practices managed to sustain remarkably high MMR coverage. Methods: The aim of the study was to identify general practice factors associated with high MMR vaccine coverage. The study population included 257 general practices in Cumbria and Lancashire in 2005. Practice level MMR coverage data for 2002-04 were obtained from the child health information systems of eight Primary Care Trusts (PCTs) and linked to information on practice structure, census indicators for deprivation and ethnicity data at lower level super output area and information from a questionnaire survey of practice nurses. Results: Mean MMR uptake was 86.4% with a range from 59 to 98%. Twenty-eight per cent (74/257) practices achieved the Department of Health higher target payment level of 90%. The uptake was not associated with practice size, the number of general practitioners (GPs) or practice nurses. There was no correlation between uptake and deprivation or the percentage of non-white population. There was a strong negative association between MMR uptake and barriers to housing and services ($r = -0.230$, $P < 0.001$). On the basis of a questionnaire response rate of 75.9%, having a strategic approach to MMR with clear objectives was associated with MMR uptake of 90% or above (odds ratio, 3.76, 1.26-12.04). There was no association between immunization by GP, practice nurse or health visitor. Conclusions: There are no easily identifiable characteristics of high-uptake MMR practices although having a strategic approach to MMR is important. Practices in rural areas should endeavour to ensure easy access to child vaccination. High uptake can be achieved by practices in deprived areas. Further research is needed to identify practice system factors associated with high MMR uptake

Lapane KL, et al A mixed method study of the merits of e-prescribing drug alerts in primary care. *Journal of General Internal Medicine* 2008 23 (4) 442-6.

<http://dx.doi.org/10.1007/s11606-008-0505-4>

<http://pmid.us/18373142>

Objectives: The objective of this paper was to describe primary care prescribers' perspectives on electronic prescribing drug alerts at the point of prescribing. **DESIGN:** We used a mixed-method study which included clinician surveys (web-based and paper) and focus groups with prescribers and staff. **Participants:** Prescribers (n = 157) working in one of 64 practices using 1 of 6 e-prescribing technologies in 6 US states completed the quantitative survey and 276 prescribers and staff participated in focus groups. **Measurements:** The study measures self-reported frequency of overriding of drug alerts; open-ended responses to: "What do you think of the drug alerts your software generates for you?" **Results:** More than 40% of prescribers indicated they override drug-drug interactions most of the time or always (range by e-prescribing system, 25% to 50%). Participants indicated that the software and the interaction alerts were beneficial to patient safety and valued seeing drug-drug interactions for medications prescribed by others. However, they noted that alerts are too sensitive and often unnecessary. **Participant suggestions included:** (1) run drug alerts on an active medication list and (2) allow prescribers to set the threshold for severity of alerts. **Conclusions:** Primary care prescribers recognize the patient safety value of drug prescribing alerts embedded within electronic prescribing software. Improvements to increase specificity and reduce alert overload are needed

Roberts AS et al Practice change in community pharmacy: quantification of facilitators. *Annals of Pharmacotherapy* 2008;42 (6) 861-8.

<http://dx.doi.org/10.1345/aph.1K617>

<http://pmid.us/18477730>

Background: There has been an increasing international trend toward the delivery of cognitive pharmaceutical services (CPS) in community pharmacy. CPS have been developed and disseminated individually, without a framework underpinning their implementation and with limited knowledge of factors that might assist practice change. The implementation process is complex, involving a range of internal and external factors. **Objective:** To quantify facilitators of practice change in Australian community pharmacies. **Methods:** We employed a literature review and qualitative study to facilitate the design of a 43-item "facilitators of practice change" scale as part of a quantitative survey instrument, using a framework of organizational theory. The questionnaire was pilot-tested (n = 100), then mailed to a random sample of 2000 community pharmacies, with a copy each for the pharmacy owner, employed pharmacist, and pharmacy assistant. The construct validity and reliability of the scale were established using exploratory factor analysis and Cronbach's alpha, respectively. **Results:** A total of 735 (37%) pharmacies responded, with 1303 individual questionnaires. Factor analysis of the scale

yielded 7 factors, explaining 48.8% of the total variance. The factors were: relationship with physicians (item loading range 0.59-0.85; Cronbach's alpha 0.90), remuneration (0.52-0.74; 0.82), pharmacy layout (0.52-0.79; 0.81), patient expectation (0.52-0.85; 0.82), manpower/staff (0.49-0.66; 0.80), communication and teamwork (0.37-0.65; 0.77), and external support/assistance (0.47-0.69; 0.74). Conclusions: All of the factors demonstrated good reliability and construct validity and explained approximately half of the variance. Implementing CPS requires support not only with the clinical aspects of service delivery, but also for the process of implementation itself, and remuneration models must reflect this. The identified facilitators should be used in a multilevel strategy to integrate professional services into the community pharmacy business, engaging pharmacists and their staff, policy makers, educators, and researchers. Further research is required to determine additional factors impacting the capacity of community pharmacies to implement change

Ylanne V, John DN. Roles of medicines counter assistants in advice giving in community pharmacies: a discourse analysis. *Pharmacy World and Science* 2008 30 (2) 199-207.

<http://dx.doi.org/10.1007/s11096-007-9165-4>

<http://pmid.us/17914661>

Objective: Research in interaction and communication in community pharmacies has been reported in a number of countries but to date, talk at the micro-level in the community pharmacy context in the UK has received virtually no study. The objective of this exploratory study was to identify what light a Discourse Analytic approach could shed to describe the role(s) of Medicines Counter Assistants (MCAs) when dealing with clients relating to health, illness or medicines. Methods: Discourse Analysis is a growing field of study which has its roots in linguistics, but also in critical theory, philosophy, sociology, psychology and more. It is used in various ways by social scientists studying spoken and written language in use. Following research ethics approval and informed consent from participants, audio-recordings of staff-client interactions in three community pharmacies in Wales, UK were transcribed and analysed from a Discourse Analytic perspective, focussing on the emerging role of the MCA in the negotiation of advice. Main outcome measure Transcripts of interactions in community pharmacies analysed using Discourse Analysis. Results: Ten hours of recordings were made. Of the 41 recorded interactions obtained, 29 involved an MCA regarding health and/or medicines. Example extracts represent different ways in which MCAs are involved in the interactions, ranging from dealing solely with the client, to the MCA dealing with the client but checking advice with the pharmacist, the MCA acting as a gatekeeper, the pharmacist intervening in the MCA-client interaction, the MCA keeping the client 'on hold' until the pharmacist is ready to interact with them and the MCA acting as an active intermediary. With the differing involvement, slightly different institutional and participant roles emerge for the MCAs through talk and interaction. Conclusion: This exploratory study succeeded in producing transcripts of interactions between MCAs, and clients and indicated that Discourse Analysis is helpful in assisting our understanding of the involvement of MCAs in UK community pharmacy encounters. With regards the

negotiation of advice, we have shown how the physical and legal contexts, in addition to the discursive/interactional context, play a part in information delivery, as does the different staff's access to knowledge

MENTAL HEALTH

Cape J, et al. Complexity of GPs' explanations about mental health problems: development, reliability, and validity of a measure. *British Journal of General Practice* 2008; 58 (551) 403-10.

<http://dx.doi.org/10.3399/bjgp08X299281>

<http://pmid.us/18505616>

Background How GPs understand mental health problems determines their treatment choices; however, measures describing GPs' thinking about such problems are not currently available. **Aim** To develop a measure of the complexity of GP explanations of common mental health problems and to pilot its reliability and validity. **Design of study** A qualitative development of the measure, followed by inter-rater reliability and validation pilot studies. **Setting** General practices in North London. **Method** Vignettes of simulated consultations with patients with mental health problems were videotaped, and an anchored measure of complexity of psychosocial explanation in response to these vignettes was developed. Six GPs, four psychologists, and two lay people viewed the vignettes. Their responses were rated for complexity, both using the anchored measure and independently by two experts in primary care mental health. In a second reliability and revalidation study, responses of 50 GPs to two vignettes were rated for complexity. The GPs also completed a questionnaire to determine their interest and training in mental health, and they completed the Depression Attitudes Questionnaire. **Results** Inter-rater reliability of the measure of complexity of explanation in both pilot studies was satisfactory (intraclass correlation coefficient = 0.78 and 0.72). The measure correlated with expert opinion as to what constitutes a complex explanation, and the responses of psychologists, GPs, and lay people differed in measured complexity. GPs with higher complexity scores had greater interest, more training in mental health, and more positive attitudes to depression. **Conclusion** Results suggest that the complexity of GPs' psychosocial explanations about common mental health problems can be reliably and validly assessed by this new standardised measure.

Charlesworth G, et al. Befriending carers of people with dementia: randomised controlled trial. *British Medical Journal* 2008; 336(7656) 1295-7.

<http://dx.doi.org/10.1136/bmj.39549.548831.AE>

<http://pmid.us/18505757>

Objective: To evaluate the effectiveness of a voluntary sector based befriending scheme in improving psychological wellbeing and quality of life for family carers of people with dementia. DESIGN: Single blind randomised controlled trial. Setting: Community settings in East Anglia and London. Participants: 236 family carers of people with primary progressive dementia. Intervention: Contact with a befriender facilitator and offer of match with a trained lay volunteer befriender compared with no befriender facilitator contact; all participants continued to receive "usual care." MAIN Outcome measureS: Carers' mood (hospital anxiety and depression scale-depression) and health related quality of life (EuroQoL) at 15 months post-randomisation. RESULTS: The intention to treat analysis showed no benefit for the intervention "access to a befriender facilitator" on the primary outcome measure or on any of the secondary outcome measures. Conclusions: In common with many carers' services, befriending schemes are not taken up by all carers, and providing access to a befriending scheme is not effective in improving wellbeing.

Christensen H, et al Models in the delivery of depression care: A systematic review of randomised and controlled intervention trials. *BMC Family Practice* 2008 ;9:25.

<http://dx.doi.org/10.1186/1471-2296-9-25>

<http://pmid.us/18454878>

Background:There is still debate as to which features, types or components of primary care interventions are associated with improved depression outcomes. Previous reviews have focused on components of collaborative care models in general practice settings. This paper aims to determine the effective components of depression care in primary care through a systematic examination of both general practice and community based intervention trials. Methods:Fifty five randomised and controlled research trials which focused on adults and contained depression outcome measures were identified through PubMed, PsycInfo and the Cochrane Central Register of Controlled Trials databases. Trials were classified according to the components involved in the delivery of treatment, the type of treatment, the primary focus or setting of the study, detailed features of delivery, and the discipline of the professional providing the treatment. The primary outcome measure was significant improvement on the key depression measure. Results:Components which were found to significantly predict improvement were the revision of professional roles, the provision of a case manager who provided direct feedback and delivered a psychological therapy, and an intervention that incorporated patient preferences into care. Nurse, psychologist and psychiatrist delivered care were effective, but pharmacist delivery was not. Training directed to general practitioners was significantly less successful than interventions that did not have training as the most important intervention. Community interventions were effective. Conclusions:Case management is important in the provision of care in general practice. Certain community models of care (education programs) have potential while others are not successful in their current form (pharmacist monitoring)

Haynes JC, et al. Alcohol consumption as a risk factor for non-recovery from common mental disorder: results from the longitudinal follow-up of the National Psychiatric Morbidity Survey. *Psychological Medicine* 2008;38 (3) 451-5.

<http://dx.doi.org/10.1017/S0033291707002000>

<http://pmid.us/17977480>

Background: Alcohol is commonly considered to be associated with persistence of common mental disorder (CMD; anxiety/depression). However no community-based longitudinal studies have investigated the direction of causality. Method: We examined the association between alcohol consumption and recovery from CMD using data on 706 community-based subjects with CMD who were followed for 18 months. Alcohol consumption at baseline was defined as hazardous drinking [Alcohol Use Disorders Identification Test (AUDIT) 8], binge drinking (defined as six or more units of alcohol on one occasion, approximately two to three pints of commercially sold beer) and dependence. Results: When compared with a non-binge-drinking group, non-recovery at follow-up was associated with binge drinking on at least a monthly basis at baseline, although the confidence interval (CI) included unity [adjusted odds ratio (OR) 1.47, 95% CI 0.89-2.45]. There was also weak evidence that alcohol dependence was associated with non-recovery (adjusted OR 1.37, 95% CI 0.67-2.81). There was little evidence to support hazardous drinking as a risk factor for non-recovery (adjusted OR 1.12, 95% CI 0.67-1.88). Conclusions: Binge drinking may be a potential risk factor for non-recovery from CMD, although the possibility of no effect cannot be excluded. Larger studies are required to refute or confirm this finding

Ivbijaro, G O et al, Addressing long-term physical healthcare needs in a forensic mental health inpatient population using the UK primary care Quality and Outcomes Framework (QOF): an audit *Mental Health in Family Medicine* 2008 5 (1) 51-60

Objectives: This audit aims to evaluate the effectiveness of delivering an equivalent primary care service to a long-term forensic psychiatric inpatient population, using the UK primary care national Quality and Outcomes Framework [QOF]. Method: The audit compares the targets met by the general practitioner with special interest [GPwSI] service, using local and national QOF benchmarks (2005-2006), and determines the prevalence of chronic disease in a long-term inpatient forensic psychiatry population. Results: The audit results show that the UK national QOF is a useful tool for assessment and evaluation of physical healthcare needs in a non-community based population. It shows an increased prevalence of all QOF-assessed long-term physical conditions when compared to the local East London population and national UK population, confirming previously reported elevated levels of physical healthcare need in psychiatric populations. Conclusions: This audit shows that the UK General Practice QOF can be used as a standardized instrument for commissioning and monitoring the delivery of physical health services to inpatient psychiatric populations, and for the evaluations of the effectiveness of clinical interventions in long-term physical conditions. The audit also

demonstrates the effectiveness of using a GPwSI in healthcare delivery in non-community based settings. We suggest that the findings may be generalisable to other long-term inpatient psychiatric and prison populations in order to further the objective of delivering an equivalent primary care service to all populations. The QOF is a set of national primary care audit standards and is freely available on the British Medical Association website or the UK Department of Health website. We suggest that primary care workers in health economies who have not yet developed their own national primary care standards can access and adapt these standards of care given to the primary care populations that they serve.

King M, et al. Prevalence of common mental disorders in general practice attendees across Europe. *The British Journal of Psychiatry* 2008 192 (5) 362-7.

<http://dx.doi.org/10.1192/bjp.bp.107.039966>

<http://pmid.us/18450661>

Background There is evidence that the prevalence of common mental disorders varies across Europe. **Aims** To compare prevalence of common mental disorders in general practice attendees in six European countries. **Method** Unselected attendees to general practices in the UK, Spain, Portugal, Slovenia, Estonia and The Netherlands were assessed for major depression, panic syndrome and other anxiety syndrome. Prevalence of DSM-IV major depression, other anxiety syndrome and panic syndrome was compared between the UK and other countries after taking account of differences in demographic factors and practice consultation rates. **Results** Prevalence was estimated in 2344 men and 4865 women. The highest prevalence for all disorders occurred in the UK and Spain, and lowest in Slovenia and The Netherlands. Men aged 30-50 and women aged 18-30 had the highest prevalence of major depression; men aged 40-60 had the highest prevalence of anxiety, and men and women aged 40-50 had the highest prevalence of panic syndrome. Demographic factors accounted for the variance between the UK and Spain but otherwise had little impact on the significance of observed country differences. **Conclusions** These results add to the evidence for real differences between European countries in prevalence of psychological disorders and show that the burden of care on general practitioners varies markedly between countries

Learmonth D, Rai S. Taking computerized CBT beyond primary care. *Br J Clin Psychol* 2008;47:111-8.

<http://dx.doi.org/10.1348/014466507X248599>

<http://pmid.us/17939879>

Objectives: This study seeks to determine whether the effectiveness of Beating the Blues (BtB), an established computer-based CBT (CCBT) programme, can extend beyond primary care. Design: BtB was delivered and evaluated in an NHS specialist CBT care centre as part of routine care. Method: A sample of 104 service users, typically displaying chronic levels of depression and/or anxiety received CCBT. Results: Completers' scores on the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM), as well as on single-item rating scales for anxiety and depression, improved significantly following the intervention. Statistically significant differences held during intention-to-treat analyses. Almost half of the completer sample achieved reliable and clinically significant change. The results were benchmarked against national data sets. Conclusions: These preliminary findings suggest a potential role for CCBT within secondary care as a first step, self-help treatment tool for anxiety and depression

Lester H, et al Barriers and facilitators to partnership working between Early Intervention Services and the voluntary and community sector. *Health and Social Care in the Community* 2008.

<http://dx.doi.org/10.1111/j.1365-2524.2008.00760.x>

<http://pmid.us/18328058>

Partnership working between health and the voluntary and community sector has become an increasing political priority. This paper describes and explores the extent and patterns of partnership working between health and the voluntary and community sector in the context of Early Intervention Services for young people with a first episode of psychosis. Data were collected from 12 Early Intervention Services and through semistructured interviews with 47 voluntary and community sector leads and 42 commissioners across the West Midlands of England. Most partnerships were described as ad hoc and informal in nature although four formal partnerships between Early Intervention Services and voluntary and community sector organizations had been established. Shared agendas, the ability to refer clients onto an organization that could provide a service they could not and shared training facilitated partnership working in this context. Barriers to closer working included differences in culture such as managing risk, the time required to make and maintain relationships and recognition of the advantages of remaining a small and autonomous organization. The four more formal partnerships were also built on the organizations' experience of working together informally, in one case through a specific pilot project. The voluntary and community organizations involved were also branches of larger national organizations for whom finding sustainable funding was less of an issue. In theoretical terms, eight Early Intervention Service: voluntary and community sector partnerships were at a stage of 'pre-partnership collaboration', three at 'partnership creation and consolidation' and one at 'partnership programme delivery'. The empirical data viewed through the lens of the partnership life-cycle model could help early intervention services, and voluntary and community sector professionals better understand where they are, why they are there and the conditions needed to realise the full potential of partnership working

McIntyre RS, et al Measuring depressive symptoms in the naturalistic primary-care setting. *International Journal of Clinical Practice* 2007 61 (8) 1278-82.

<http://dx.doi.org/10.1111/j.1742-1241.2007.01448.x>

<http://pmid.us/17590219>

Summary Background: The majority of individuals with major depressive disorder are diagnosed and treated in the primary-care setting. A quantifiable critical objective in the management of depression is to achieve and sustain full symptomatic remission. The HAMD-7 is a depression metric validated in both tertiary and primary-care settings. Methods: Herein, we further characterise the psychometric properties of the HAMD-7 in depressed patients treated in primary-care settings. Several cut-scores were evaluated for maximum agreement; diagnostic efficacy statistics with the original HAMD-7 items were also evaluated. We compared performance of the HAMD-7 in primary care to a previously characterised tertiary sample. Results: The depressive symptoms most frequently endorsed ($\geq 70\%$) and most sensitive to change during antidepressant treatment in depressed primary-care patients were depressed mood, guilt, work and activities, psychic and somatic anxiety and fatigue. Limitations: This is a post hoc analysis of a primary-care database; assumptions regarding the definition of symptomatic remission in depression affect interpretation. Conclusion: Measurement-based care with the HAMD-7 quantifies the severity of commonly reported depressive items and their responsiveness to treatment. The HAMD-7, inclusive of the suicide item, is capable of tracking symptom progress, with a validated remission cut-score

Nease DE, Jr. et al. Inducing sustainable improvement in depression care in primary care practices. *Joint Commission journal on quality and patient safety / Joint Commission Resources* 2008 34 (5) 247-55.

<http://pmid.us/18491688>

Background: Improving primary care depression care is costly and challenging to sustain. The feasibility and potential success of a modified improvement collaborative model to create sustained improvements in depression care was assessed. Methods: Sixteen practices from the American Academy of Family Physicians National Research Network and the American College of Physicians Practice-based Research Network completed a nine-month program. Two practice champions (PCs) from each practice attended three two-day learning sessions, where practice change strategies and key depression care elements were discussed. The nine-item Patient Health Questionnaire (PHQ-9) was used for screening, diagnosis, surveillance, tracking and care management, and self-management support. Pre- and postintervention depression care survey data were gathered from all practice clinicians, and qualitative data were collected via interviews with PCs and field notes from learning sessions. Results: On the basis of PC reports at nine months, 16 practices had implemented the PHQ-9 for depression case-finding and 13 for monitoring severity; 5 practices had implemented tracking and care management and 1, self-management support. At the 15-month follow-up, nearly all changes had been sustained, and additional practices had implemented tracking/care management and self-

management support. Significant pre-post improvements were reported on several subscales of the clinician survey, demonstrating substantial diffusion from the PC to other clinicians in the practice. Discussion: The program led to measurable improvements in implementation of office procedures and systems known to improve depression care. The improvements were both sustained beyond the end of the program and substantially diffused to the other clinicians in the practice

Nolan, E, Hewison, A, Teamwork in primary care mental health: a policy analysis. *Journal of Nursing Management* 2007 Online early article

<http://dx.doi.org/10.1111/j.1365-2934.2007.00766.x>

Aim This paper reports a policy analysis conducted to examine the potential impact of recent mental health policy on team working in Primary Care Mental Health in England. **Method** An analysis of relevant policy documents was conducted. From an original selection of 49 documents, 15, which had significant implications for Primary Care Mental Health Teams, were analysed thematically. **Findings** There were no clear guidelines or objectives for Primary Care Mental Health Teams evident from the policy analysis. Collaborative working was advocated, yet other elements in the policies were likely to prevent this occurring. There was a lack of clarity concerning the role and function of new professions within Primary Care Mental Health Teams, adding further uncertainty to an already confused situation. **Conclusion** This uncertainty has the potential to reinforce professional barriers and increase the current difficulties with team working. **Implications to nursing managers** An analysis of recent policy contributes to our understanding of the context of care. The lack of clarity in current health policy presents a significant challenge for those managing primary care mental health teams. Team working is likely to improve if targets, processes and responsibilities are made clearer

Rafanelli C, Fava GA, Sonino N. Sequential treatment of depression in primary care. *International Journal of Clinical Practice* 2007 61 (10) 1719-29.

<http://dx.doi.org/10.1111/j.1742-1241.2007.01342.x>

<http://pmid.us/17537191>

Background: In the past decade, in clinical psychiatry several investigations suggested the usefulness of a sequential way of integrating pharmacotherapy and psychotherapy in mood disorders. The aim of this paper was to illustrate the practical implications of sequential treatment strategy for depression in primary care, with particular reference to the increasingly common problem of recurrent depression. **Methods:** The Authors tried to integrate the evidence which derives from meta-analyses and comprehensive general reviews with the insights which derive from controlled studies concerned with specific populations. **Conclusions:** The sequential treatment of mood disorders is an intensive,

two-stage approach, which derives from the awareness that one course of treatment with a specific tool (whether pharmacotherapy or psychotherapy) is unlikely to entail solution to the affective disturbances of patients, both in research and in clinical practice settings. The aim of the sequential approach is to add therapeutic ingredients as long as they are needed. In this sense, it introduces a conceptual shift in clinical practice

Rudell K, Bhui K, Priebe S. Do 'alternative' help-seeking strategies affect primary care service use? A survey of help-seeking for mental distress. *BMC Public Health* 2008 8:207.

<http://dx.doi.org/10.1186/1471-2458-8-207>

<http://pmid.us/18547400>

Background: Epidemiological studies suggest that only some distressed individuals seek help from primary care and that pathways to mental health care appear to be ethnically patterned. However few research studies examine how people with common mental disorder manage their mental distress, which help-seeking strategies they employ and whether these are patterned by ethnicity? This study investigates alternative help-seeking strategies in a multi-ethnic community and examines the relationship with primary care use. Methods: Participants were recruited from four GP practice registers and 14 community groups in East London. Of 268 participants, 117 had a common mental disorder according to a valid and structured interview schedule (CIS-R). Participants were of Bangladeshi, black Caribbean and White British ethnic background. For those with a common mental disorder, we examined self-reported help-seeking behaviour, perceived helpfulness of care givers, and associations with primary care service use. Results: We found that alternative help-seeking such as talking to family about distress (OR 15.83, CI 3.9-64.5, P<.001), utilising traditional healers (OR 8.79, CI 1.98- 38.93, p=.004), and severity of distress (1.11, CI 1.03-1.20, p=.006) was positively associated with primary care service use for people with a common mental disorder. Ethnic background influenced the choice of help-seeking strategies, but was less important in perceptions of their helpfulness. Conclusions: Primary care service use was strongly correlated with lay and community help-seeking. Alternative help-seeking was commonly employed in all ethnic groups. A large number of people believed mental distress could not be resolved or they did not know how to resolve it. The implications for health promotion and integrated care pathways are discussed

Shirazi M, et al. Effects on readiness to change of an educational intervention on depressive disorders for general physicians in primary care based on a modified Prochaska model--a randomized controlled study. *Family Practice* 2008 25 (2) 98-104.

<http://dx.doi.org/10.1093/fampra/cmn008>.

<http://pmid.us/18304971>

Background. The Prochaska model of readiness to change has been proposed to be used in educational interventions to improve medical care. Objective. To evaluate the impact

on readiness to change of an educational intervention on management of depressive disorders based on a modified version of the Prochaska model in comparison with a standard programme of continuing medical education (CME). Methods: This is a randomized controlled trial within primary care practices in southern Tehran, Iran. The participants included 192 general physicians working in primary care (GPs) were recruited after random selection and randomized to intervention (96) and control (96). Intervention consisted of interactive, learner-centred educational methods in large and small group settings depending on the GPs' stages of readiness to change. Change in stage of readiness to change measured by the modified version of the Prochaska questionnaire was the main outcome measure. Results. The final number of participants was 78 (81%) in the intervention arm and 81 (84%) in the control arm. Significantly ($P < 0.01$), more GPs ($57/96 = 59\%$ versus $12/96 = 12\%$) in the intervention group changed to higher stages of readiness to change. The intervention effect was 46% points ($P < 0.001$) and 50% points ($P < 0.001$) in the large and small group setting, respectively. Conclusions. Educational formats that suit different stages of learning can support primary care doctors to reach higher stages of behavioural change in the topic of depressive disorders. Our findings have practical implications for conducting CME programmes in Iran and are possibly also applicable in other parts of the world

Slade M, Gask L, *et al.* Failure to improve appropriateness of referrals to adult community mental health services--lessons from a multi-site cluster randomized controlled trial. *Family Practice Advance Access* 30/5/ 2008.

<http://dx.doi.org/10.1093/fampra/cmn025>

<http://pmid.us/18515810>

Background: Non-clinical factors impact on decisions about whether to refer a patient from primary care to specialist mental health services. The aim of this study was to investigate whether introducing a standardized assessment of severity improves agreement on referrals. Methods: multi-site mixed-method cluster randomized controlled trial, investigating GP referrals from 73 practices (408 839 patients) to 11 community mental health teams (CMHTs). Intervention group GPs were asked to complete a Threshold Assessment Grid (TAG) rating of mental health problem severity. CMHTs rated referral appropriateness (ISRCTN86197914). Results: Two hundred and eighty-one GPs made 1061 mental health referrals. The intervention was only partly implemented with 25% of intervention group GPs completing TAGs. No difference was found in appropriateness (OR 1.18, 95% CI 0.91-1.53) or secondary outcomes. Post-referral primary care contact rates were higher for the intervention group (IRR 1.36, 95% CI 1.07-1.73). Qualitative data identified professional and organizational barriers to implementation. Conclusions: Asking GPs to complete a TAG when referring to CMHTs did not improve primary-secondary care agreement on referrals. Low implementation means that uncertainty remains about whether introducing a severity-focussed measure into the referral process is beneficial. Introducing local protocols to manage demand at this interface may not be successful and more attention needs to be paid to human and organizational factors in managing interfaces between services

Smolders M, et al. Depressed and a co-morbid condition: More psychotropics prescribed! *The European Journal of General Practice* 2008 14 (1) 10-8.

<http://dx.doi.org/10.1080/13814780701855724>

<http://pmid.us/18464167>

Background: Depression often occurs simultaneously with a variety of somatic, psychiatric, and social conditions. Knowledge about differences in the pharmacological treatment of depressed patients with and without co-morbidity is lacking. Objective To compare GPs pharmacological treatment of depressed patients with and without co-morbidity. Methods: Data were extracted from the computerized medical records of 77 general practices participating in the Dutch National Information Network of General Practice (LINH). We used diagnosis and prescription data of newly diagnosed depressed patients aged 18–65 years (n=4372). A mixed-model technique was used for analyzing the medical data. Results> During the year after diagnosing depression, depressed patients who also suffered from chronic somatic or psychiatric morbidity were prescribed more psychotropics than patients with depression only. Prescription patterns of psychotropic drugs for depressed patients with and without co-morbid social problems differed only during the first 3 months after diagnosis. For the whole 1-year period after diagnosis, the pharmacological treatment of depression in patients with and without co-morbid social problems did not differ Conclusion: Our results indicate that chronic somatic or psychiatric co-morbidity in depressed patients leads to higher GP prescription levels of psychotropics, whereas co-morbid social problems do not seem to influence GPs pharmacological treatment decisions for depression

Unutzer J, et al. Care management for depression and osteoarthritis pain in older primary care patients: a pilot study. *International Journal of Geriatric .Psychiatry* 2008.

<http://dx.doi.org/10.1002/gps.2048>

<http://pmid.us/18489009>

Objective: To establish the feasibility of and to generate preliminary evidence for the efficacy of a care management program addressing both physical and emotional pain associated with late-life depression and osteoarthritis. Methods: Treatment development pilot study in three university affiliated primary care clinics. Participants were patients 60 years or older with depression and osteoarthritis pain. The intervention entailed a nurse administered care management program supporting depression and arthritis treatment by primary care physicians. Outcomes include depression, pain severity and functional impairment from pain assessed at baseline and 6 months. Results: Fourteen patients participated in the pilot program. Between baseline and 6 months, mean HSCL-20 depression scores dropped from 1.78 (SD 0.56) to 1.06 (SD 0.59), a standardized effect size of 1.27 (p = 0.004). Pain intensity scores dropped from 5.67 (SD 1.69) to 4.18 (SD 1.98), an effect size of 0.88 (p = 0.021) and pain interference scores dropped from 4.91

(SD 1.75) to 3.49 (SD 2.14), an effect size of 0.81 ($p = 0.013$). Patients also experienced improvements in self efficacy, in satisfaction with depression care, and in timed 8-m walk and transfer tests. Conclusion: The combined intervention was feasible and well-received by patients. Preliminary outcomes are promising and comparisons to an earlier trial of care management for depression alone suggest that the combined program may be equally effective for depression but more effective for pain. Copyright (c) 2008 John Wiley & Sons, Ltd

Wells KB, et al . The effects of quality improvement for depression in primary care at nine years: results from a randomized, controlled group-level trial. *Health Services Research* Epub ahead of print 3/6/2008.

<http://dx.doi.org/10.1111/j.1475-6773.2008.00871.x>

<http://pmid.us/18522664>

Objective. To examine 9-year outcomes of implementation of short-term quality improvement (QI) programs for depression in primary care. Data Sources. Depressed primary care patients from six U.S. health care organizations. Study Design. Group-level, randomized controlled trial. Data Collection. Patients were randomly assigned to short-term QI programs supporting education and resources for medication management (QI-Meds) or access to evidence-based psychotherapy (QI-Therapy); and usual care (UC). Of 1,088 eligible patients, 805 (74 percent) completed 9-year follow-up; results were extrapolated to 1,269 initially enrolled and living. Outcomes were psychological well-being (Mental Health Inventory, five-item version [MHI5]), unmet need, services use, and intermediate outcomes. Principal Findings. At 9 years, there were no overall intervention status effects on MHI5 or unmet need (largest $F(2,41)=2.34$, $p=.11$), but relative to UC, QI-Meds worsened MHI5, reduced effectiveness of coping and among whites lowered tangible social support (smallest $t(42)=2.02$, $p=.05$). The interventions reduced outpatient visits and increased perceived barriers to care among whites, but reduced attitudinal barriers due to racial discrimination and other factors among minorities (smallest $F(2,41)=3.89$, $p=.03$). Conclusions. Main intervention effects were over but the results suggest some unintended negative consequences at 9 years particularly for the medication-resource intervention and shifts to greater perceived barriers among whites yet reduced attitudinal barriers among minorities

ORGANIZATIONS

Abbott S, et al. Primary Care Trusts: what is the role of boards? *Public Policy and Administration* 2008;23 (1) 43-59.

<http://dx.doi.org/10.1177/0952076707083285>

The role of boards in the public sector is unclear, particularly at a time of increased control of services by central government. This paper looks at the case of primary health

care organizations, which are responsible for providing or commissioning the health care required by their local populations. Documentary analysis of board papers from 15 such organizations showed that boards are more likely to discuss 'second order' functions (finance, governance, administration) than clinical and service issues. In general, they appear to avoid a challenging style in their relationships with officers. Interviews with officers and board members of three organizations found that the possibility that boards might challenge did affect how business is conducted, even though in reality challenge was rare. However, the contribution of boards outside board meetings was also valued, in the work of subcommittees, strategy planning sessions, etc. Though the boards are in no sense representative and their importance in setting strategy and monitoring performance somewhat overshadowed by central government's activity in these areas, they nevertheless do have some authority, which both checks and supports officers.

Brown PR. Trusting in the New NHS: instrumental versus communicative action. *Sociology of Health and Illness*. 2008; 30 (3) 349-63.

<http://dx.doi.org/10.1111/j.1467-9566.2007.01065.x>

<http://pmid.us/18194357>

Recent reforms within the UK National Health Service, particularly the introduction of clinical governance, have been enacted with the apparent aim of rebuilding patient trust. This paper analyses the approach taken by policy makers, arguing that it is based very much on an instrumental conception of trust. The assumptions and limitations of this model are discussed and in so doing, a communicative understanding of trust is proposed as an alternative. It is argued that the instrumental rationality and institutional focus inherent to instrumental trust neglect the importance of the communication between patient and medical professional and its affective dimensions. Communicative trust goes beyond a mere cognitive appreciation of the system and rather is dependent on the qualitative interaction at the access point, where the patient comes to believe that the communicative rationality of their best interests is mirrored by the professional's instrumental rationality. Whilst recent challenges to the confidence of patients in professionals and medical knowledge make some approximation of an ideal speech situation more imperative than previously, the application of an instrumental concept of trust in the NHS makes such interactions less likely, as well as facilitating a divergence between instrumental and communicative rationality in healthcare provision

Chalkley M, McVicar D. Choice of contracts in the British National Health Service: an empirical study. *Journal of Health Economics* In Press

<http://dx.doi.org/10.1016/j.jhealeco.2008.05.005>

Exworthy M, Frosini F. Room for manoeuvre?: Explaining local autonomy in the English National Health Service. *Health Policy* 2008 86 (2-3) 204-12.

<http://dx.doi.org/10.1016/j.healthpol.2007.10.008>

<http://pmid.us/18054111>

Decentralisation has returned as a key theme in English health policy in recent years in policies such as Patient Choice and Foundation Trusts, among many others. The goal of these policies appears to be to stimulate self-sustaining incentives to continuous organisational reform and performance improvement through creating a pluralist model of local provision. However, the ability of local organisations to exercise autonomy and to deliver such performance is highly contingent upon their local context, not least in terms of existing patterns of dependencies. Explaining variation in local outcomes of national policies demands an understanding and explanation of local autonomy and its effect on performance which takes into account the role of the local 'health economy' - the local context within which organizations are embedded. It is this combination of vertical and horizontal autonomy which effectively determines the local room for manoeuvre in decision-making. The aim of the paper is to examine the local dimension of decentralisation policies. It draws from different strands of literature to discuss the room for manoeuvre of local organisations within local health economies in England with specific reference to Primary Care Trusts. It draws conclusions about the nature of decentralisation itself and the impact of such policies

Garcia-Lacalle J. A bed too far: The implementation of freedom of choice policy in the NHS. *Health Policy* 2007; in press

<http://dx.doi.org/10.1016/j.healthpol.2007.10.014>

<http://pmid.us/18078681>

Abstract: Freedom of hospital choice has become a popular policy among the European public health services to ensure better patient rights, reduce waiting times and improve efficiency and quality in public hospitals. The English National Health Service has recently adopted this policy. This organisation needs to introduce important reforms in order to implement this policy, in particular in the information that it provides to patients. This paper presents the Andalusian Health Service (SAS) initiative in the disclosure of information, based on patient surveys, so it can be understood by patients. Andalusia implemented a freedom of choice policy 10 years ago. This paper also studies how SAS hospitals are scored by patients and how the quality of hospitals may affect their choice. Regression analyses indicate that two hospital dimensions, a 'human dimension' and a 'facilities dimension', significantly explain how patients assess the quality of the Andalusian hospitals. Nonetheless, these two dimensions do not explain the reputation of the hospitals, a main aspect when choosing a hospital, to the same extent. The lessons provided by looking at the SAS experience may give an insightful knowledge on whether patients in England will finally opt for the best hospitals

Laamanen R, et al Outsourcing primary health care services--How politicians explain the grounds for their decisions. *Health Policy* 2008; In Press

<http://dx.doi.org/10.1016/j.healthpol.2008.04.001>

<http://pmid.us/18501465>

Objective To explore outsourcing of primary health care (PHC) services in four municipalities in Finland with varying amounts and types of outsourcing: a Southern municipality (SM) which contracted all PHC services to a not-for-profit voluntary organization, and Eastern (EM), South-Western (SWM) and Western (WM) municipalities which had contracted out only a few services to profit or public organizations. **Methods** A mail survey to all municipality politicians (response rate 52%, N=101) in 2004. Data were analyzed using cross-tabulations, Spearman correlation and linear regression analyses. **Results** Politicians were willing to outsource PHC services only partially, and many problems relating to outsourcing were reported. Politicians in all municipalities were least likely to outsource preventive services. A multiple linear regression model showed that reported preference to outsource in EM and in SWM was lower than in SM, and also lower among politicians from "leftist" political parties than "rightist" political parties. Perceived difficulties in local health policy issues were related to reduced preference to outsource. The model explained 27% of the variance of the inclination to outsource PHC services. **Conclusions** The findings highlight how important it is to take into account local health policy issues when assessing service-provision models

Nettleton S, Burrows R, Watt I. Regulating medical bodies? The consequences of the 'modernisation' of the NHS and the disembodiment of clinical knowledge. *Sociology of Health and Illness* 2008 30 (3) 333-48.

<http://dx.doi.org/10.1111/j.1467-9566.2007.01057.x/>

<http://pmid.us/18419693>

The aim of this paper is to explore the consequences of modernisation and regulatory processes for the everyday lives of doctors working the UK National Health Service. We do this by reporting on interview data generated as part of a qualitative investigation into the working lives of 47 doctors. The analysis of the empirical findings is informed by two literatures: that which has sought to theorise the contemporary thrust of regulation and audit and that which has developed a sociology of embodiment. Doctors' views are presented in relation to four areas of work which have--in the loosest sense of the word--been subject to regulation. Drawing on work from the sociology of embodiment we argue that changes in the institutional and cultural context of medical work could be altering both the 'field' and the 'habitus'--to use Bourdieu's terms--of medicine, with a consequence that medical knowledge is becoming less embodied

Sadler M, Lester S. NHS Direct - what challenges has it faced and how have they been overcome? *Journal of Communication in Healthcare* 2008 1 (1) 99-109.

Taylor-Gooby P. Trust and Welfare State Reform: The Example of the NHS. *Social Policy & Administration* 2008 42:288-306.

<http://dx.doi.org/10.1111/j.1467-9515.2007.00592.x>

This article discusses the impact of New Public Management on public trust in welfare state institutions, using the example of NHS reform. Discussion of trust in public institutions across political science, psychology and sociology indicates that it is based on both rational/objective considerations (competence and capacity to deliver the service) and affectual/subjective factors (shared values, belief that the trustee shares the trustor's interests). The New Public Management foregrounds individual responsibility and incentives for both suppliers and users of services, in the NHS example in quasi-markets, management by target and patient choice. These accord with an individualized market rational-actor model rather than with affective considerations. Analysis of attitude survey data on the NHS confirms that rational/objective and affectual/subjective factors contribute to public trust in this field. However, a comparison between perceptions in England, where the internal market has been vigorously pursued, and Scotland, where the purchaser/provider split was discarded after devolution, indicate that the market does not offer a royal road to perceptions of superior quality in the objective factors. Conversely, the more market-centred system can make progress in relation to the more subjective affectual factors

PATIENT AND PUBLIC INVOLVEMENT

Baxter S, et al. . Where have all the copy letters gone? A review of current practice in professional-patient correspondence. *Patient Education and Counseling* 2008;71 (2) 259-64.

<http://dx.doi.org/10.1016/j.pec.2007.12.002>

<http://pmid.us/18222056>

Objective This article reviews the literature in relation to patients receiving copies of health professional correspondence. It examines progress in adopting the practice 3 years on from its introduction as policy in the UK, and considers potential benefits and obstacles to implementation. Methods A review of the literature on copy correspondence, accessed via Medline, PubMed, CINAHL and also online resources, using the search terms "patient letter", "copy letter", "copy correspondence" and "doctor letter". Results Studies describe a range of benefits from copying letters, but implementation remains

inconsistent, ranging from 8 to 87% of patients reporting receiving copy correspondence. A number of concerns are identified which may be delaying whole scale adoption of the policy by health professionals. Conclusion This review suggests that researchers should move from examining the benefits and concerns around copying letters to patients, and instead focus on exploring the quality of correspondence and the optimum process of implementing the practice. As patients can "opt out" of receiving copy correspondence, audit of service delivery may be better assessed by whether patients have been offered a letter, rather than the current measure of whether one has been received. Practice implications Copying letters to patients may have a number of important benefits and should be routine practice where patients wish to receive correspondence. Further discussion regarding the style and content of letters would be beneficial, together with attention paid to the mechanisms for recording patient preference. There is also a need for studies in non-medical professions

Challans, E, Patient involvement in clinical audit at a primary care trust *Journal of Communication in Healthcare* 2008 1 (2): 218-247

This impact evaluation has been conducted to establish the effectiveness of involving patients in clinical audit and service improvement. Due to the national reconfiguration of primary care trusts [PCTs] where PCTs have been dramatically reduced, some trusts need to secure current structures and processes within the new PCT. Therefore a review of patient involvement in clinical audit and service improvement was carried out in order to continue this partnership work in the new PCT arrangements. In June 2003 a Commission for Health Improvement clinical governance review in Sheffield South West Primary Care Trust was conducted, highlighting patients' lack of involvement in developing and improving services within primary care. Based on these findings, the PCT proposed to create and train a panel of patients and carers to be actively involved in clinical audit and service improvement projects. In April 2004, a clinical audit patient panel [CAPP] was introduced, and an impact evaluation was carried out to establish the level of CAPP individual members' influence on a healthcare organisation, identifying patient involvement and partnership working.

Keshishian F, Colodny N, Boone RT. Physician-patient and pharmacist-patient communication: Geriatrics' perceptions and opinions. *Patient Education and Counseling* 2008 71 (2) 265-84

<http://dx.doi.org/10.1016/j.pec.2008.01.004>

<http://pmid.us/18308499>

Objective Earlier research examined the perceptions of the pharmacist-patient relationship quality using data from a systematic random sample of non-institutionalized elderly in the United States. The purposes of this study were to determine: (1) how the findings of this study, conducted in a culturally diverse urban area in Queens, New York, compare with the earlier study; (2) how community-dwelling elderly patients in a metropolitan area perceive their relationship with the pharmacist compared to the physician; and (3) the extent to which their perceived relationship quality predicts

medication-related knowledge, medication-related outcomes, and self-efficacy for medication management. **Methods** One hundred and twenty-one elderly individuals aged 65 and over who took at least one prescription medication, selected from three senior centers, participated in the study. Of the total responses, 102 were useable. **Results** Our sample demonstrated significantly lower levels of perceived quality of relationship with their pharmacist compared to earlier research. In contrast, the participants in this study perceived a better quality of relationship with their physicians than pharmacists. Further, the quality of relationship with physician predicted medication-related knowledge, medication-related outcome expectations, and self-efficacy for medication management. **Conclusion** The findings of this study suggest that pharmacists still have a way to go to fully meet patients' healthcare needs, particularly in culturally diverse urban settings. **Practice implications** Further research is needed to examine ways to improve pharmacist-patient interactions and, therefore, patients' perceptions of pharmacists

Robertson R, Dixon A, Le GJ. Patient choice in general practice: the implications of patient satisfaction surveys. *Journal of Health Services Research and Policy* 2008 13 (2) 67-72.

<http://dx.doi.org/10.1258/jhsrp.2007.007055>

<http://pmid.us/18416910>

Objectives: To identify factors that explain patient satisfaction with general practice physicians and hence that may drive patients' choice of practice. **Methods:** Logistic regression analysis of English National Health Service national patient survey data is used to identify the aspects of general practice care that are associated with high levels of overall satisfaction among patients. **Results:** Confidence and trust in the doctor is the most important factor in explaining the variation in overall patient satisfaction (predicting 82% of satisfaction levels accurately). The seven variables relating to the relationship between patient and doctor have stronger explanatory power than other aspects of the general practitioner (GP) experience. The variables with the lowest overall predictive power are whether the patient was told how long they would have to wait in the surgery (72%), the length of time they had to wait after their appointment time (74%) and ability to get through to the surgery on the phone (74%). **Conclusions:** Patients value the quality of their relationship with their doctor more than the appearance of the surgery, accessibility of appointments and their experience in the waiting room. This suggests that, if current restrictions on choice of GP were removed, we would in theory expect a patient's choice to be driven by the quality of the doctor-patient relationship. Once a patient establishes a good relationship with a GP, however, we might expect them to be loyal and therefore unlikely to change practice unless the relationship with the doctor breaks down. Although relationship factors are important to the satisfaction of patients, it is not clear that they will lead large numbers of people to change their GP

Sanders T, Harrison S, Checkland K. Evidence-based medicine and patient choice: the case of heart failure care. *Journal of Health Services Research and Policy* 2008 13 (2) 103-8.

<http://dx.doi.org/10.1258/jhsrp.2008.007130>

<http://pmid.us/18416916>

Objectives: The implementation of evidence-based medicine and policies aimed at increasing user involvement in health care decisions are central planks of contemporary English health policy. Yet they are potentially in conflict. Our aim was to explore how clinicians working in the field of heart failure resolve this conflict. Methods: Qualitative semi-structured interviews were carried out with health professionals who were currently caring for patients with heart failure, and observations were conducted at one dedicated heart failure clinic in northern England. Results: While clinicians acknowledged that patients' ideas and preferences should be an important part of treatment decisions, the widespread acceptance of an evidence-based clinical protocol for heart failure among the clinic doctors significantly influenced the content and style of the consultation. Conclusion: Evidence-based medicine was used to buttress professional authority and seemed to provide an additional barrier to the adoption of patient-centred clinical practice

Swain, D, Working in partnership with patients: why do it and what benefits can be realized? *Journal of Communication in Healthcare* 2008 1(2) 155-167

In England, numerous government policies and initiatives have been developed to encourage the active participation of patients in their care and to engage the public in the planning and development of health services. Despite an intense focus, progress in this area has been disappointingly slow. The concept of patient and public involvement [PPI] is often dismissed by critics as irrelevant and impractical and true patient engagement is still the exception rather than the rule. In order to move away from a tokenistic approach to PPI there is much work to be done. National patient surveys provide a valuable evidence base for monitoring levels of involvement. Examples from the Patients Accelerating Change programme show the positive difference that effective, well-executed involvement can achieve. Such demonstrations of the added value of partnership working are essential to help ensure that involvement becomes embedded within the culture of healthcare organisations.

PRIMARY/SECONDARY CARE INTERFACE

Huws DW, et al .Impact of case management by advanced practice nurses in primary care on unplanned hospital admissions: a controlled intervention study. *BMC Health Services Research* s 2008; 8:115.

<http://www.biomedcentral.com/1472-6963/8/115>

<http://dx.doi.org/10.1186/1472-6963-8-115>

<http://pmid.us/18510730>

Background: Increasing unplanned hospital admissions disrupt planned health care, lead to additional morbidity and are expensive. A recent review found only weak evidence for case management preventing unplanned admissions, yet case management of older people is being implemented widely in the UK. We aimed to study the effect of advanced practice nurse case management on unplanned medical and geriatric hospital admission rates in patients 50 years and over, and on admission risk in a 'higher risk' sub-group of patients in the UK. Methods: Case management by advanced practice nurses in NHS primary care practices in the Swansea Local Health Board area, Wales, UK. We conducted a prospective non-randomized controlled intervention study comparing unplanned medical and geriatric patient admissions between five intervention and thirty non-intervention practices during a preintervention year and an intervention year. Results: For all lengths of stay, comparing intervention (n=5) with non-intervention practices (n=30) from pre-intervention to intervention year, we found that the unplanned medical and geriatric admission rate was significantly lower in the intervention group - adjusted relative risk of 0.909; relative risk reduction 9.1% (95% credible limit 0.840 to 0.984, p=0.018); absolute risk reduction 0.99 admissions per 100 patients (95% credible limit 0.17 to 1.86, p=0.018). For lengths of stay of one night or more we observed a stronger effect - adjusted relative risk 0.896; relative risk reduction 10.41% (95%, credible limit 0.820 to 0.979, p = 0.015). Most of the rate reduction was due to a reduction in the number of new admissions but much less so for admissions of lengths of stay of at least one night, compared to all lengths of stay. We did not find a statistically significant effect on re-admission or multiple re-admission rates in 'higher risk' patients previously admitted one or more times - adjusted relative risk of further multiple admissions per previously admitted patient 0.908 (95% credible limit 0.765, 1.077); relative risk reduction 9.3%; adjusted relative risk of total admissions per multiple admitter 0.995 (95% credible limit 0.940, 1.053) relative risk reduction 0.6%. Conclusions: Although this study reports a reduction in unplanned admission rates in the intervention practices, this appears to be only in part directly due to nurse case management: most of the reduction did not occur in multiple admitters whom were case managed. Further research is needed to explain this finding, to elucidate how best to target the attention of case managers and to examine the complexity of potential outcomes in terms of the nature and necessity of admissions and most suitable lengths-of-stay in terms of acute care or rehabilitation need

Wong FK, Liu J, Chang K, Chow SK. Factors predicting perceived improved health after emergency room visits. *Journal of Clinical Nursing* 2008 17 (7) 901-10.

<http://dx.doi.org/10.1111/j.1365-2702.2006.01827.x>

<http://pmid.us/17331088>

Aim: This study examines the key factors contributing to perceived improved health after emergency room (ER) visits. **Background:** Perceived health is a subjective measure of health status. It is an important and useful concept in nursing and assessment of health services because it reflects the clients' own assessment of his/her health, which may have led to their subsequent health-seeking behaviour. **Methods:** Secondary analysis of a main study which aimed at examining the effects of nurse follow-up on ER revisits using randomized-controlled trial. In this study, binary logistic regressions were conducted to identify factors associated with the dependent variable, perceived improved health 30 days after the index ER visit. Data were collected from 795 subjects and the sources of data were from medical records and telephone interviews. **Results:** Gender, income, usual practice in managing minor illness, what to do other than attending the ER, nurse follow-up, general self-rated health, triage, considered other doctors on the day of index ER visit, times of attending general outpatient clinic and times of attending general practitioner were found to be significantly associated with perceived improved health 30 days after the index ER visit. **Conclusion:** Many of the variables identified in this study that predicted perceived improved health concurred with previous findings. What is of interest is that nurse follow-up but not multiple medical consultations helped enhance perceived improved health. We speculate that there was no continuity of care in the multiple medical consultations. Where as in the nurse follow-up, the nurse was able to follow through the care of individuals, monitor their progress and make appropriate referrals. This study shows that the nurse is an appropriate person to mediate the health needs of individuals and the healthcare system and to enhance health maintenance for individuals in the community without excessively using medical services. **Relevance to clinical practice:** The nurses providing care during the transitional phase should not only include the traditional clinical or hospital system variables, but should also take into account the general health perception of patients, because these are the predictors of health services utilization and morbidity

QUALITY

Boivin A, Legare F, Gagnon MP. Competing norms: Canadian rural family physicians' perceptions of clinical practice guidelines and shared decision-making. *Journal of Health Services Research and Policy* 2008; 13 (2) :79-84.

<http://dx.doi.org/10.1258/jhsrp.2007.007052>

<http://pmid.us/18416912>

Objectives: Implementation of clinical practice guidelines (CPGs) and shared decision-making are both advocated in primary care. Some authors argue that CPGs can enhance informed decisions by patients and physicians, while others warn that a standardized implementation of CPGs could hinder patients' involvement in decision-making. Our objective was to explore rural family physicians' perception of the interaction between clinical practice guidelines and shared decision-making in medical practice. MethodS: A qualitative study using a semi-structured focus group interview: with 17 family physicians and residents, in a Canadian rural town. Interviews were audio-taped and transcribed verbatim. Thematic content analysis was performed and validated by the constant comparative method, member checking and group debriefing. Results: Two distinct conceptions of how clinical practice guidelines should assist decision-making emerged. On the one hand, guidelines were seen as helping clinicians to make decisions on behalf of their patient about the best course of action. For interventions with uncertain benefit or that carried significant trade-off for patients, guidelines were seen as a tool that should inform decision-making between physicians and patients, providing them with details about risks, benefits, costs and alternative treatments. The pressure to apply guideline recommendations was perceived as a potential barrier to patient participation in decision-making. Conclusion: In circumstances where physicians judge patient participation in decision-making to be important, physicians perceive a tension between the need to respect patients' preferences and the pressure to apply guidelines. CPGs should include information that supports shared decision-making, besides their current focus on influencing prescription patterns, costs and health outcomes

Boyd CM, et al. A pilot test of the effect of guided care on the quality of primary care experiences for multimorbid older adults. *Journal of General Internal Medicine* 2008 23 (5) 536-42.

<http://dx.doi.org/10.1007/s11606-008-0529-9>

Objective: Improving health care of multimorbid older adults is a critical public health challenge. The objective of this study is to evaluate the effect of a pilot intervention to enhance the quality of primary care experiences for chronically ill older persons (Guided Care). DESIGN: Nonrandomized prospective clinical trial. Patients/participants: Older, chronically ill, community-dwelling patients (N = 150) of 4 General Internists in 1 urban community practice setting who were members of a capitated health plan and identified as being at high risk of heavy use of health services in the coming year by claims-based predictive modeling. Interventions: Guided Care, an enhancement to primary care that incorporates the operative principles of chronic care innovations, was delivered by a specially trained, practice-based registered nurse working closely with 2 primary care physicians. Each patient received a geriatric assessment, a comprehensive care plan, evidence-based primary care with proactive follow-up of chronic conditions, coordination of the efforts of health professionals across all health care settings, and facilitated access to community resources. Measurements and main results: Quality of primary care experiences (physician-patient communication, interpersonal treatment, knowledge of patient, integration of care, and trust in physician) was assessed using the Primary Care

Assessment Survey (PCAS) at baseline and 6 months later. At baseline, the patients assigned to receive Guided Care were similar to those assigned to receive usual care in their demographics and disability levels, but they had higher risk scores and were less likely to be married. Thirty-one of the 75 subjects assigned to the Guided Care group received the intervention. At 6 months, intention-to-treat analyses adjusting for age, gender, and risk score suggest that Guided Care may improve the quality of physician-patient communication. In per-protocol analyses, receipt of Guided Care was associated with more favorable change than usual care from baseline to follow-up in all 5 PCAS domains, but only physician-patient communication showed a statistically significant improvement. Conclusions: In this pilot study, Guided Care appeared to improve the quality of primary care experiences for high-risk, chronically ill older adults. A larger cluster-randomized controlled trial of Guided Care is underway

Campbell JL, et al Assessing the professional performance of UK doctors: an evaluation of the utility of the General Medical Council patient and colleague questionnaires. *Quality and Safety in Health Care* 2008 17 (3) 187-93.

<http://dx.doi.org/10.1136/qshc.2007.024679>

<http://pmid.us/18519625>

Objective: To investigate the utility of the GMC patient and colleague questionnaires in assessing the professional performance of a large sample of UK doctors. Design: Cross-sectional questionnaire surveys. Setting: Range of UK clinical practice settings. Participants: 541 doctors gave preliminary agreement to take part in the study. Responses were received from 13 754 patients attending one of 380 participant doctors, and from 4269 colleagues of 309 participant doctors. Main outcome measures: Questionnaire performance and standardised scores for each doctor derived from patient and colleague responses. Results: Participant doctors were similar to non-participants in respect of age and gender. The patient and colleague questionnaires were acceptable to participants as evidenced by low levels of missing data. One patient questionnaire item seemed to cause confusion for respondents and requires rewording. Both patient and colleague responses were highly skewed towards favourable impressions of doctor performance, with high internal consistency. To achieve acceptable levels of reliability, a minimum of 8 colleague questionnaires and 22 patient questionnaires are required. G coefficients for both questionnaires were comparable with internationally recognised survey instruments of broadly similar intent. Patient and colleague assessments provided complementary perspectives of doctors' performance. Older doctors had lower patient-derived and colleague-derived scores than younger doctors. Doctors from a mental health trust and doctors providing care in a variety of non-NHS settings had lower patient scores compared with doctors providing care in acute or primary care trust settings. Conclusions: The GMC patient and colleague questionnaires offer a reliable basis for the assessment of professionalism among UK doctors. If used in the revalidation of doctors' registration, they would be capable of discriminating a range of professional performance among doctors, and potentially identifying a minority whose practice should be subjected to further scrutiny

Checkland K, et al Biomedicine, holism and general medical practice: responses to the 2004 General Practitioner contract. *Sociology of Health and Illness* April 2008. Epub ahead of print.

<http://dx.doi.org/10.1111/j.1467-9566.2008.01081.x>

<http://pmid.us/18444956>

In 2004 a new contract was introduced for General Practitioners in the UK, which introduced a significant element of 'pay-for-performance', including both clinical and organisational targets. The introduction of this contract has caused interest across the world, particularly amongst those responsible for commissioning primary care services. It can be argued that the clinical targets in the contract (known as the Quality and Outcomes Framework, QOF) represent a move towards a more biomedical model of health and illness, which is contrary to the ideal of providing holistic (or biopsychosocial) care that has been traditionally espoused by GPs. This paper reports results from two linked studies (in England and Scotland) investigating the early stages of the new contract. We describe the way in which four practices with different organisational approaches and espoused identities have all changed their practice structures, consultations and clinical care in response to QOF in ways which will result in patients receiving a more biomedical type of care. In spite of these observed changes, respondents continued to maintain discursive claims to holism. We discuss how this disconnection between rhetoric and reality can be maintained, and consider its implications for the future development of GPs' claims to a professional identity

Coleman MT, et al Interprofessional ambulatory primary care practice-based educational program. *Journal of Interprofessional Care* 2008; 22 :69-84.

Although interprofessional teamwork and collaboration are considered key elements for improving patient outcomes, there are few reports of controlled studies involving interprofessional training of health care learners in the ambulatory primary care setting. We describe an educational program for teams of nurse practitioners, family medicine residents and social work students to work together at clinical sites in the delivery of longitudinal care in primary care ambulatory clinics. Year 1 was a planning year. Program evaluation completed at the end of the second curriculum (Year 3) indicated that the changes the team made at the end of the first curriculum (Year 2) resulted in increased appreciation of the training program, greater perception of value of care delivered by interprofessional teams among team learners as compared to non-team learners, and team learner self assessment of improved team skills including working with other professionals, resolving conflict, and integrating prevention and health promotion into health care. Team learners demonstrated an increased awareness of the limits of their own profession's approach to team care. We conclude that interprofessional ambulatory clinical training in primary care where learners work together providing care

to patients can contribute to fostering both positive learner attitudes toward interprofessional work and development of team skills

Evangelou E, Tsianos G, Ioannidis JP. Doctors' versus patients' global assessments of treatment effectiveness: empirical survey of diverse treatments in clinical trials. *British Medical Journal* 2008;336 (7656) 1287-90.

<http://dx.doi.org/10.1136/bmj.39560.759572.BE>

<http://pmid.us/18495634>

Objective: To examine whether doctors' global assessments of treatment effects agree with patients' global assessments. Design: Survey of trials included in systematic reviews of treatments for diverse conditions. Data sources: Cochrane database of systematic reviews. Data extracted Data on patients' global assessments and on doctors' global assessment for the same treatment against the same comparator. MAIN Outcome measures: Relative odds ratio (ratio of odds ratios of global improvement with the experimental intervention versus control according to doctors compared with patients), and improvement rates according to doctors and patients. Results: Doctors' global assessments were compared with patients' global assessments for 63 different treatment comparisons (240 trials) in 18 conditions. The summary relative odds ratio across the comparisons was not significant (0.98, 95% confidence interval 0.88 to 1.08; I(2)=0%, 95% confidence interval 0% to 30%). In 62 of the 63 comparisons the effects of treatment rated by patients and by doctors did not differ beyond chance, but for single comparisons the confidence intervals were large. Rates of improvement on average did not differ between doctors' assessments and patients' assessments (summary relative odds ratio 0.98, 0.88 to 1.06; I(2)=0%, 0% to 24%). Conclusion: Doctors' global assessments of the effects of treatments are on average similar to those of patients

Gene-Badia J, et al . Population and primary health-care team characteristics explain the quality of the service. *Health Policy* 2008; 86 (2-3) 335-44.

<http://dx.doi.org/10.1016/j.healthpol.2007.11.014>

<http://pmid.us/18241954>

Objectives To identify the characteristics of the primary health-care (PHC) team's structure and of the assigned population affecting service quality dimensions, and to check whether the PHC team's performance varies when assessing the service quality using crude values or those adjusted by the structural factors that affect it. Research design Cross-sectional descriptive study. Subjects 213 Catalan PHC teams. Measurements Service quality indicators measured in three dimensions: (1) access and physician-patient relationship; (2) team coordination and (3) evidence-based practice. The PHC team structural factors studied are: experience, setting (urban or rural), geographical dispersion, teaching activities and managerial structure. The catchment population characteristics analysed are: age, socio-economic level, mortality, and the proportion of the population that are immigrants. Results Access and physician-patient relationship

dimension were not affected by the studied structural factors. Team coordination improved in rural teams and in those providing care for older populations. Evidence-based practice was found to be higher in teaching teams, in more experienced teams and in those attending populations with a lower socio-economic level. Adjusted service quality indicator values substantially modify the PHC team quality ranking carried out on the basis of its crude values, especially in the team coordination and evidence-based practice dimensions. Conclusions A fair evaluation of PHC team performance must be based on its health-care service quality indicators adjusted for setting, age and socio-economic level of the catchment population and for the team's experience and teaching activities

Hansson A, et al Two sides of the coin - general practitioners' experience of working in multidisciplinary teams. *Journal of Interprofessional Care* 2008;22 (1) 5-16.

<http://dx.doi.org/10.1080/13561820701722808>

<http://pmid.us/18202982>

Abstract: Multidisciplinary teamwork, defined as the collaboration between different professional groups to achieve a common purpose, is commonly regarded as a means to meet the complex tasks that medicine has to deal with today. However, many attempts to introduce the method in primary care have failed and this is supposed to be partly due to the fact that general practitioners (GPs) did not participate in the implementation of the method. The aim of this investigation was to get a deeper understanding of their attitude to teamwork by interviewing nine GPs at four Swedish health care centres, where successful teamwork had been ongoing since 1997. Themes and categories in the interviews were identified according to content analysis. Although the attitude in general was in favour of teamwork, four major themes: time-consuming versus time-saving; shared responsibility versus main responsibility; medical expert versus generalist; shared knowledge versus all knowing, could be identified, which all revealed ambivalence towards teamwork among the interviewees. It was concluded that, if teamwork is to be successfully introduced into primary care, the GPs' self-perception has to be taken into consideration as has the prestige and status associated with their traditional role and the benefits of teamwork to the profession of medicine. Apart from time, teamwork requires, professional supervision and doctors need to be trained in this method as early as in medical school

Harmsen JAM, et al Patients' evaluation of quality of care in general practice: What are the cultural and linguistic barriers? *Patient Education and Counseling* 2008; In Press,

<http://dx.doi.org/10.1016/j.per.2008.03.018>

<http://pmid.us/18485657>

Objective Increased migration implies increased contacts for physicians with patients

from diverse cultural backgrounds who have different expectations about healthcare. How satisfied are immigrant patients, and how do they perceive the quality of care? This study investigated which patient characteristics (such as cultural views and language proficiency) are related to patients' satisfaction and perceived quality of care. Methods Patients (n=663) from 38 general practices in Rotterdam (The Netherlands) were interviewed. General satisfaction with the general practitioner (GP) was measured by a report mark. Perceived quality of care was measured using the 'Quote-mi' scale (quality of care through the patient's eyes--for migrants), which contains an ethnic-specific subscale and a communication process subscale. Using multilevel regression techniques, the relation between patient characteristics (ethnicity, age, education, Dutch language proficiency, cultural views) and satisfaction and perceived quality of care was analysed. Results In general, patients seemed fairly satisfied. Non-Western patients perceived less quality of care and were less satisfied than Dutch-born patients. The older the patients and the more modern cultural views they had, the more satisfied they were about the GP in general, as well as about the communication process. However, non-Western patients holding more modern views were the most critical regarding the ethnic-specific quality items. The poorer patients' Dutch language proficiency, the more negative they were about the communication process. Conclusion It is concluded that next to communication aspects, especially when the patient's proficiency in Dutch is poor, physician awareness about the patient's cultural views is very important during the consultation. This holds especially true when the immigrant patient seems to be more or less acculturated. Practice implications Medical students and physicians should be trained to become aware of the relevance of patients' different cultural backgrounds. It is also recommended to offer facilities to bridge the language barrier, by making use of interpreters or cultural mediators

Hsiao CJ, Boulton C. Effects of Quality on Outcomes in Primary Care: A Review of the Literature. *American Journal of Medical Quality* 2008.

<http://dx.doi.org/10.1177/1062860608315643>

<http://pmid.us/18487421>

It is widely believed that health care quality affects primary care outcomes, but the evidence is fragmented and incomplete. The authors searched MEDLINE for relevant articles published between 1950 and 2006 and reviewed the evidence to assess the relationship between the personal aspects of primary care quality and patients' health status and health services utilization. These personal aspects, which include patient-physician continuity and communication, are distinct from the technical aspects of primary care, which include ordering tests, treatments, and referrals. Fourteen articles met the inclusion criteria. Results showed that greater continuity of care is associated with less use of hospitals and emergency departments and lower health care costs; effective communication may be associated with better health status. The limited available evidence suggests that higher quality in the personal aspects of primary care is associated with some but not all outcomes of care. Additional research is needed to define these relationships more clearly.

Magin P et al General practitioners' assessment of risk of violence in their practice: results from a qualitative study. *Journal of Evaluation in Clinical Practice* 2008 14 (3) 385-90.

<http://dx.doi.org/10.1111/j.1365-2753.2007.00874.x>

<http://pmid.us/18373581>

Rationale, aims and objectives: Clinicians' means of stratification of risk of violence has been previously studied in health settings, but not in general practice. This study aimed to investigate the means by which general practitioners (GPs) assess risk of violence in their clinical practice. Method: A qualitative design using focus group interviews and written responses on a subsequent questionnaire. Focus group discussions were audiotaped and transcribed. Questionnaires were sent to all members of three Divisions of General Practice offering the opportunity for respondents to make qualitative comments. The focus group transcripts and qualitative questionnaire responses were coded independently by members of the research team and subjected to thematic analysis. The setting was three Urban Divisions of General Practice in New South Wales, Australia. Participants were one hundred and seventy-two urban GPs - 18 participants in four focus groups and 154 GPs providing written responses. Results: Assessment and stratification of risk by GPs conformed to a schema based on the physical environment of the consultation, individual characteristics of the patient, individual characteristics of the doctor, and characteristics of the doctor-patient relationship. Despite this, risk assessment and risk stratification were often on the basis of ad hoc, subjective decision making. An aspect of the ad hoc nature of risk assessment was the pre-eminence afforded 'instinct' or 'intuition' in subjects' responses. Conclusion: A schema of factors involved in GPs' assessment of risk of violence is presented. An appreciation of these will be of clinical and policy importance

Mattke S. When should measures be updated? Development of a conceptual framework for maintenance of quality-of-care measures. *Quality and Safety in Health Care* 2008;17 (3) :182-6.

<http://dx.doi.org/10.1136/qshc.2006.021170>

<http://pmid.us/18519624>

Objective: To document current practices on long-term maintenance of quality measures and to develop a consensus framework to guide the design of maintenance systems. Study Design: Survey of 10 organisations developing measures and selected researchers in the USA about current policies and procedures and desirable properties for a comprehensive system for measures maintenance. Panel discussions with all respondents to arrive at consensus recommendations for a framework for maintenance of measures. Participants: Five measures developers, two provider and three purchaser organisations. Six were private sector organisations, two were governmental agencies, and two were accreditation institutions. Principal findings: All organisations had procedures for measures

maintenance, but the degree of formalisation of the procedures varied. Three key functions for a measures maintenance system emerged: ad hoc review to deal with unexpected problems; annual maintenance to incorporate changes in coding conventions; and regular re-evaluation to thoroughly review measures at predefined intervals. Importance, scientific soundness, feasibility and usability were universally used as evaluation criteria. The panel discussions yielded a consensus set of recommendations for relationships between maintenance functions, evaluation criteria and measures disposition. Conclusions: A sufficient degree of implicit consensus was found among leading measures developers to arrive at a consensus framework for policies and procedures for measures maintenance. Although organisations may choose to implement the framework in a way that is most consistent with their mission and structure, it provides guidance regarding which components should be included

Mead N, Bower P, Roland M. Factors associated with enablement in general practice: cross-sectional study using routinely-collected data. *British Journal of General Practice* 2008 58 (550) 346-52.

<http://dx.doi.org/10.3399/bjgp08X280218>

<http://pmid.us/18482489>

Background: Quality-improvement activities are most often focused on clinical quality indicators. However, patient evaluations are important additional indicators of the quality of general practice consultations, including measures of satisfaction or enablement (that is, the extent to which the consultation enhances the patient's feelings of confidence and ability to cope). There is limited evidence concerning factors associated with enablement in UK general practice. **Aim:** To identify patient and practice characteristics associated with enablement scores following general practice consultations. **Design of study:** Cross-sectional survey using a large routinely-collected dataset of patient evaluations of general practice (190 038 individual patient responses). **Setting:** A total of 1031 UK general practices. **Method:** Relationships between health, demographic factors, evaluations of general practice care, and patient self-reported enablement were estimated using multiple regression. **Results:** The primary predictor of enablement was positive patient evaluation of the GPs' communication. Reported continuity of care accounted for a lower proportion of the variance. Of the included patient demographic variables, ethnicity was a key predictor, with patients from minority ethnic groups reporting greater enablement once other factors were controlled. **Conclusion:** The current results provide support for the construct validity of the enablement measure. However, if enablement is to become a valid and useful measure of quality, it is necessary to understand the mechanisms by which enablement is increased in certain patients and practices. Detailed qualitative research may also be required to explain the relatively high scores of ethnic minority responders, despite lower overall satisfaction scores, and to understand why some items included in the enablement measure are regarded as 'not applicable' by a substantial minority of patients.

Powell Davies, G et al Coordinating primary health care: an analysis of the outcomes of a systematic review. *Medical Journal of Australia* 2008 188 8 Suppl S65-S68

<http://pmid.us/18429740>

Objectives: To identify the types of strategy used to coordinate care within primary health care (PHC) and between PHC, health services and health-related services in Australia and other countries that have comparable health systems, and to describe what is known about their effectiveness; to review the implications for health policy and practice in Australia. Methods: We conducted a systematic review of the literature (January 1995 to March 2006) relating to care coordination in Australia, the United States, the United Kingdom, New Zealand, Canada and The Netherlands. Our review was supplemented by consultations with academic experts and policymakers. Results: Six types of strategy were identified at patient/provider level, falling into two groups: (i) communication and support for providers and patients, and (ii) structural arrangements to support coordination. These were broadly consistent with existing typologies. All were associated with improved health and/or patient satisfaction outcomes in more than 50% of studies, and interventions using multiple strategies were more successful than those using single strategies. Conclusions: The largely incremental approach to improving coordination of care in Australia has involved a broad range of strategy types but has also perpetuated existing structural problems. Reforms in governance, funding and patient registration in primary health care would provide a stronger base for effective care coordination.

Richards SH, et al. Accessing out-of-hours care following implementation of the GMS contract: an observational study. *British Journal of General Practice* 2008 58 (550) 331-8.

<http://dx.doi.org/10.3399/bjgp08X280191>

<http://pmid.us/18482487>

Background: There is widespread concern that the quality of out-of-hours primary care for patients with complex needs may be at risk now that the new general medical services contract (GMS) has been implemented. Aim: To explore changes in the use of out-of-hours services around the time of implementation of the new contract for patients with complex needs, using patients with cancer as an example. Design of study: Longitudinal observational study. Setting: Out-of-hours primary care provider covering Devon (adult population 900 000), UK. Method: Two, 1-year periods corresponding to pre- (April 2003 to March 2004) and post-contract implementation (October 2004 to September 2005) were sampled. Call rates per 1000 of the adult population (age \geq 16 years) were calculated for all calls (any cause) and cancer-related calls. Anonymised outcome and process measures data were extracted. Results: Although overall call rates per 1000 population had increased by 26% (185 pre-contract to 233 post-contract), the proportion of cancer-related calls remained relatively constant (2.08% versus 1.96%). Around half

(56%) of these callers had advanced cancer needs (including palliative care). By post-contract, the time taken to triage had significantly increased ($P<0.001$). Although the proportions admitted to hospital or receiving a home visit remained constant, calls where a special message was sent by the out-of-hours clinician to the in-hours team had decreased ($P<0.001$). Conclusion: The demand for out-of-hours care for patients with cancer did not alter disproportionately after implementation of the contract. While potential quality indicators (for example, hospital admissions, home visiting rates) remained constant, potentially adverse changes to triage time and communication between out-of-hours and in-hours clinicians were observed. Quality standards and provider databases require further refinement to capture elements of care relevant to patients with complex needs.

Waterhouse P, et al The development of a primary dental care outreach course. *European Journal of Dental Education* . 2008 12 8-16.

<http://dx.doi.org/10.1111/j.1600-0579.2007.00464.x>

<http://pmid.us/18257759>

The aim of this work was to develop the first north-east based primary dental care outreach (PDCO) course for clinical dental undergraduate students at Newcastle University. The process of course design will be described and involved review of the existing Bachelor of Dental Surgery (BDS) degree course in relation to previously published learning outcomes. Areas were identified where the existing BDS course did not meet fully these outcomes. This was followed by setting the PDCO course aims and objectives, intended learning outcomes, curriculum and structure. The educational strategy and methods of teaching and learning were subsequently developed together with a strategy for overall quality control of the teaching and learning experience. The newly developed curriculum was aligned with appropriate student assessment methods, including summative, formative and ipsative elements

RESEARCH AND DEVELOPMENT

Gormley G, et al Reporting of research data by GPs: a cautionary tale for primary care researchers. *Family Practice* 2008. Advancd Access 2008

<http://dx.doi.org/10.1093/fampra/cmn013>

<http://pmid.us/18445584>

Background: Given the importance of community-based research, there is a need to ensure the quality of data obtained from such studies. However, research has been considered a low priority for most GPs. Objectives: To assess the quality of data reported by GPs in a large community-based study. Methods: Men were recruited as part of a population-based study on prostate-specific antigen (PSA) testing. Those with elevated initial PSA levels in the mid-1990s and no investigation in the intervening period were invited for repeat PSA testing. The GP of each included man was contacted and asked to report basic clinical information. Trained data extractors independently reviewed each man's GP medical notes and recorded data relating to prostate problems. Data provided by GPs were rematched with data extracted from medical notes. Results: A total of 758 men with 379 GPs were included. In all, 366 (96.6%) GPs agreed to participate. Of 698 men suitable for follow-up, GP and note review data were available in 505 (72.3%) cases (287 GPs). Overall, 245 (85.4%) GPs provided completely accurate data. Male GPs, compared to female GPs, were found to have a higher level of inaccurate reporting ($P = 0.008$). Conclusions: We found that when GPs were asked to record basic clinical information, for the purposes of a primary care-based study, there was a significant level of inaccurate reporting. The results from our study confirm the importance of quality control in primary care research, especially in studies that involve GPs' reporting data

Holtedah K. Research and practice combined--ideas for a life in general practice. *Family Practice* 2008 25 (2) 132-6.

<http://dx.doi.org/10.1093/fampra/cmn002>.

<http://pmid.us/18304976>

The modern era of research in general practice is scarcely more than half a century old. The author has been fortunate enough to be part of this development for more than three decades, sharing his professional life between clinical practice and research. Here is the story. All clinical care should be supported and developed by research evidence, and some of it must be collected where the care is performed. Research may improve the theoretical understanding underlying practice. Some patients probably receive better care because their general practitioner has done research, or their GP has attended a meeting or read an article by a research-minded colleague

Hummers-Pradier E, et al . Simply no time? Barriers to GPs' participation in primary health care research. *Family Practice* 2008 25 (2) 105-12.

<http://dx.doi.org/10.1093/fampra/cmn015>.

<http://pmid.us/18417465>

Background. Non-participation of general practitioners (GPs) is a serious source of bias for practice-based studies. Objective. To elucidate doctors' motives for non-participation in, and subjective barriers to, general practice research. Methods. German GPs that had opted out of a quality assessment project involving electronic patient records (EPRs) were mailed a questionnaire regarding their attitudes towards general practice research and their specific objections to the current project. A sub-sample of doctors was

interviewed. Their statements were coded and classified with regard to the reasons given for non-participation and possible motivating factors. Results. The survey response rate was 37% (96/263); 21 GPs completed an additional qualitative interview. Nearly all respondents (88/96) considered general practice research to be important, but 58% had not previously participated in research projects and 56% would not do so in the future. Nearly half (47/96) were opposed to having data extracted from their EPRs. The qualitative analysis revealed deep concerns related to the collection of EPRs (e.g. potential misuse of data, being subject to control or resulting computer problems). Some GPs expressed concerns about recruiting their own patients for the study. Some doctors complained of not being sufficiently recognized as a partner or not having a voice in the research process. Conclusion. Doctors' negative attitudes, concerns and ambivalent feelings should be addressed in recruitment strategies, especially when the analysis of EPRs or direct patient contact is required. Some doctors do not participate in research out of principle and will be very difficult to convince

Shaw SE, Greenhalgh T. Best research - For what? Best health - For whom? A critical exploration of primary care research using discourse analysis. *Social Science & Medicine* 2008 66 (12) 2506-19.

<http://dx.doi.org/10.1016/j.socscimed.2008.02.014>

<http://pmid.us/18378371>

Health research is fundamental to the development of improved health and healthcare. Despite its importance, and the role of policy in guiding the kind of research that gets addressed, there are very few empirical studies of health research policy. This paper redresses this, exploring the means by which one area of health research policy is shaped, enabled and constrained. We ask: what are the historical, social and political origins of research policy in primary care in England? What are the key discourses that have dominated debate; and what are the tensions between discourses and the implications this raises for practitioners and policymakers? To answer these questions we employed a Foucauldian approach to discourse analysis to explicitly recognise the historical, social and ideological origins of policy texts; and the role of power and knowledge in policy development. We adapted Parker's framework for distinguishing discourses as a means of selecting and analysing 29 key policy documents; 16 narrative interviews with historical and contemporary policy stakeholders; and additional contextual documents. Our analysis involved detailed deconstruction and linking across texts to reveal prevailing storylines, ideologies, power relations, and tensions. Findings show how powerful policy discourses shaped by historical and social forces influence the type of research undertaken, by whom and how. For instance, recent policy has been shaped by discourse associated with the knowledge-based economy that emphasises microscopic [^]discovery', exploitation of information and the contribution of highly technological activities to [^]UK plc' and has re-positioned primary care research as a strategic resource and [^]population laboratory'

for clinical research. Such insights challenge apolitical accounts of health research and reveal how health research serves particular interests

Shergold M, Grant J. Freedom and need: The evolution of public strategy for biomedical and health research in England. *Health Research Policy and Systems* 2008 6:2.

<http://dx.doi.org/10.1186/1478-4505-6-2>

<http://pmid.us/18230124>

The optimal support of health-related research and development with public money is a complex challenge. Over the last century, policy makers in England have conceived and implemented a variety of models, ranging from independent, curiosity driven research to needs-based state commissions, and promoting different bodies to oversee scientific work. This paper traces these approaches, identifies the principles that drove them, and discusses their role in shaping policy for publicly funded health research, up to the recent launch of a new research strategy by the Department of Health

RESEARCH METHODS

Bailey J. First steps in qualitative data analysis: transcribing. *Family Practice* . 2008; 25 (2) :127-31.

<http://dx.doi.org/10.1093/fampra/cmn003>

<http://pmid.us/18304975>

Qualitative research in primary care deepens understanding of phenomena such as health, illness and health care encounters. Many qualitative studies collect audio or video data (e.g. recordings of interviews, focus groups or talk in consultation), and these are usually transcribed into written form for closer study. Transcribing appears to be a straightforward technical task, but in fact involves judgements about what level of detail to choose (e.g. omitting non-verbal dimensions of interaction), data interpretation (e.g. distinguishing I don't, no' from I don't know') and data representation (e.g. representing the verbalization hwarryuhh' as How are you?'). Representation of audible and visual data into written form is an interpretive process which is therefore the first step in analysing data. Different levels of detail and different representations of data will be required for projects with differing aims and methodological approaches. This article is a guide to

practical and theoretical considerations for researchers new to qualitative data analysis. Data examples are given to illustrate decisions to be made when transcribing or assigning the task to others

Eldridge S, et al . Internal and external validity of cluster randomised trials: systematic review of recent trials. *British Medical Journal* 2008; 336 (7649) :876-80.

<http://dx.doi.org/10.1136/bmj.39517.495764.25>

<http://pmid.us/18364360>

Objectives: To assess aspects of the internal validity of recently published cluster randomised trials and explore the reporting of information useful in assessing the external validity of these trials. DESIGN: Review of 34 cluster randomised trials in primary care published in 2004 and 2005 in seven journals (British Medical Journal, British Journal of General Practice, Family Practice, Preventive Medicine, Annals of Internal Medicine, Journal of General Internal Medicine, Pediatrics). Data sources: National Library of Medicine (Medline) via PubMed. Data extraction: To assess aspects of internal validity we extracted data on appropriateness of sample size calculations and analyses, methods of identifying and recruiting individual participants, and blinding. To explore reporting of information useful in assessing external validity we extracted data on cluster eligibility, cluster inclusion and retention, cluster generalisability, and the feasibility and acceptability of the intervention to health providers in clusters. Results: 21 (62%) trials accounted for clustering in sample size calculations and 30 (88%) in the analysis; about a quarter were potentially biased because of procedures surrounding recruitment and identification of patients; individual participants were blind to allocation status in 19 (56%) and outcome assessors were blind in 15 (44%). In almost half the reports, information relating to generalisability of clusters was poorly reported, and in two fifths there was no information about the feasibility and acceptability of the intervention. Conclusions: Cluster randomised trials are essential for evaluating certain types of interventions. Issues affecting their internal validity, such as appropriate sample size calculations and analysis, have been widely disseminated and are now better addressed by researchers. Blinding of those identifying and recruiting patients to allocation status is recommended but is not always carried out. There may be fewer barriers to internal validity in trials in which individual participants are not recruited. External validity seems poorly addressed in many trials, yet is arguably as important as internal validity in judging quality as a basis for healthcare intervention

Kuramoto L, Sobolev B, Donaldson M. On reporting results from randomized controlled trials with recurrent events. *BMC Medical Research Methodology* 2008 8:35.

<http://dx.doi.org/10.1186/1471-2288-8-35>

<http://pmid.us/18513418>

Background: Evidence-based medicine has been advanced by the use of standards for reporting the design and methodology of randomized controlled trials (RCT). Indeed, without this information it is difficult to assess the quality of evidence from an RCT. Although a variety of statistical methods are available for the analysis of recurrent events, reporting the effect of an intervention on outcomes that recur is an area that remains poorly understood in clinical research. The purpose of this paper is to outline guidelines for reporting results from RCTs where the outcome of interest is a recurrent event. **Methods:** We used a simulation study to relate an event process and results from analyses of the gamma-Poisson, independent-increment, conditional, and marginal Cox models. We reviewed the utility of regression models for the rate of a recurrent event by articulating the associated study questions, presenting the risk sets, and interpreting the regression coefficients. **Results:** Based on a single data set produced by simulation, we reported and contrasted results from statistical methods for evaluating treatment effect from an RCT with a recurrent outcome. We showed that each model has different study questions, assumptions, risk sets, and rate ratio interpretation, and so inferences should consider the appropriateness of the model for the RCT. **Conclusion:** Our guidelines for reporting results from an RCT involving a recurrent event suggest that the study question and the objectives of the trial, such as assessing comparable groups and estimating effect size, should determine the statistical methods. The guidelines should allow clinical researchers to report appropriate measures from an RCT for understanding the effect of intervention on the occurrence of a recurrent event

O'Cathain A, Murphy E, Nicholl J. The quality of mixed methods studies in health services research. *Journal of Health Services Research and Policy* 2008 13 (2) 92-8.

<http://dx.doi.org/10.1258/jhsrp.2007.007074>

<http://pmid.us/18416914>

Objectives: To assess the quality of mixed methods studies in health services research (HSR). **Methods:** We identified 118 mixed methods studies funded by the Department of Health in England between 1994 and 2004, and obtained proposals and/or final reports for 75. We applied a set of quality questions to both the proposal and report of each study, addressing the success of the study, the mixed methods design, the individual qualitative and quantitative components, the integration between methods and the inferences drawn from completed studies. **Results:** Most studies were completed successfully. Researchers mainly ignored the mixed methods design and described only the separate components of a study. There was a lack of justification for, and transparency of, the mixed methods design in both proposals and reports, and this had implications for making judgements about the quality of individual components in the context of the design used. There was also a lack of transparency of the individual methods in terms of clear exposition of data collection and analysis, and this was more a problem for the qualitative than the quantitative component: 42% (19/45) versus 18% (8/45) of proposals ($p = 0.011$). Judgements about integration could rarely be made due to the absence of an attempt at integration of data and findings from different components

within a study. Conclusions: The HSR community could improve mixed methods studies by giving more consideration to describing and justifying the design, being transparent about the qualitative component, and attempting to integrate data and findings from the individual components

Rapley T. Distributed decision making: the anatomy of decisions-in-action. *Sociology of Health and Illness* 2008 30 (3) 429-44.

<http://dx.doi.org/10.1111/j.1467-9566.2007.01064.x>

<http://pmid.us/18194358>

Conceptualising the doctor-patient relationship has been a central project for both medicine and medical sociology. This paper seeks to show how an understanding of the distributed nature of medical practice can help us research the decision-making process in doctor-patient encounters. I draw on a range of empirical studies of medical interaction, knowledge, technology and work in primary and secondary care. I describe the 'ethno-methods' (Garfinkel 1967) of patient-orientated medical decision making in order to highlight some of the fundamental facets of distributed decision making. Initially, I outline how decision making is an ongoing event that often evolves over multiple encounters. I then show how decision making is never just a solo, cognitive activity but rather distributed over a range of people. Finally, I outline how decision making is initiated, sustained and transformed over a range of encounters with both people and technologies. I argue that recognising the distributed nature of decision making shifts the focus from overly prescriptive visions of decision making to more plausible, albeit, more mundane sets of ideals. Centrally, a focus on distribution offers new opportunities actively to engage with, support and research decision-making-in-action

Ried K,et al General practice research training: impact of the Australian Registrar Research Workshop on research skills, confidence, interest and involvement of participants, 2002-2006. *Family Practice* 2008 25 (2)19-26.

<http://dx.doi.org/10.1093/fampra/cmn010>.

<http://pmid.us/18304969>

Background. An intensive 3-day training programme, the Registrar Research Workshop' (RRW), has aimed to build research capacity among Australian general practice registrars since 1994. Objectives. To investigate the impact of the RRW on participants' skills, confidence, interest in research and research activity. Methods. Cross-sectional postal survey in 2006 of five groups of registrars who participated in the annual workshop in 2002-2006 (response rate: 64%; 77 of 121). Outcome measures included research experience and skills prior to and after the workshop; impact of the workshop on capacity, confidence, attitude and interest in research; and research involvement as measured by publications and grant funding. Results. Self-reported research skills increased over time for the whole group (two-way analysis of variance: $P = 0.047$), most significantly for registrars with little or no research experience ($P < 0.001$) and research

project participants ($P = 0.003$). The impact of the workshop on capacity, confidence and interest in research was rated highly (mean 3.5-4.0 $\{\pm\}$ 0.1 on a five-point scale). Two-thirds of the survey respondents had been research active, 34% presented their findings at conferences, 25% published in peer-reviewed journals and 31% received research funding. Eighty-four per cent of respondents indicated a high interest in undertaking research in the future. All survey respondents recommended the workshop to other registrars. Conclusions. The RRW provides a useful model for effective research training for interested general practice trainees. Such training has the potential to increase knowledge of research methods, which might augment future research activity in general practice

Themessl-Huber M, et al Audio-visual recording of patient-GP consultations for research purposes: A literature review on recruiting rates and strategies. *Patient Education and Counseling* 2008 71 (2) 157-68.

<http://dx.doi.org/10.1016/j.pec.2008.01.015>

<http://pmid.us/18356003>

Objective To identify ethical processes and recruitment strategies, participation rates of studies using audio or video recording of primary health care consultations for research purposes, and the effect of recording on the behaviour, attitudes and feelings of participants. **Methods** A structured literature review using Medline, Embase, Cochrane Library, and Psychinfo. This was followed by extensive hand search. **Results** Recording consultations were regarded as ethically acceptable with some additional safeguards recommended. A range of sampling and recruitment strategies were identified although specific detail was often lacking. Non-participation rates in audio-recording studies ranged from 3 to 83% for patients and 7 to 84% for GPs; in video-recording studies they ranged from 0 to 83% for patients and 0 to 93% for GPs. There was little evidence to suggest that recording significantly affects patient or practitioner behaviour. **Conclusions** Research involving audio or video recording of consultations is both feasible and acceptable. More detailed reporting of the methodical characteristics of recruitment in the published literature is needed. **Practice implications** Researchers should consider the impact of diverse sampling and recruitment strategies on participation levels. Participants should be informed that there is little evidence that recording consultations negatively affects their content or the decisions made. Researchers should increase reporting of ethical and recruitment processes in order to facilitate future reviews and meta-analyses

SOCIAL CAPITAL

Chen X, et al Personal Social Capital Scale: an instrument for health and behavioral research. *Health Education Research* Advance Access 9/5/2008.

<http://dx.doi.org/10.1093/her/cvn020>

<http://pmid.us/18469318>

The concept of social capital has drawn much attention in social and behavioral epidemiology and health education research. The purpose of this study is to develop the 'Personal Social Capital Scale' for quantitative survey studies of social factors that are related to health and behavior. The instrument contained 10 composite items based on 42 items for assessing personally owned social capital, including bonding and bridging capitals. The instrument was assessed using cross-sectional survey data collected among 128 participants (64 women) with a participation rate of 95%. Results from correlation and confirmatory factor analysis indicated adequate reliability and internal consistency. The mean score of the scale was 25.9 (SD = 5.2) for total social capital, 15.2 (SD = 3.0) for bonding social capital and 10.8 (SD = 3.4) for bridging social capital. The scale scores significantly predicted a number of theoretically related factors, including people skills, being sociable, social capital investment, informational support, instrumental support, emotional support and collective efficacy. This instrument provides a new tool for cross-cultural research to assess personally owned social capital

Engstrom K, et al Contextual social capital as a risk factor for poor self-rated health: A multilevel analysis. *Social Science & Medicine* 2008 66 (11) :2268-80.

<http://dx.doi.org/10.1016/j.socscimed.2008.01.019>

<http://pmid.us/18314238>

In this study, we critically examine whether contextual social capital (CSC) is associated with self-rated health, with an emphasis on the problem of confounding. We also examine different components of CSC and their association with self-rated health. Finally, we look at differences in susceptibility between different socio-demographic groups. We use the cross-sectional base line study of the Stockholm Public Health Cohort, conducted in 2002. A postal questionnaire was answered by 31,182 randomly selected citizens, 18-84 years old, in Stockholm County. We used four measures of social capital: horizontal (civic trust and participation), vertical (political trust and participation), cognitive (civic and political trust) and structural (civic and political participation). CSC was measured at parish level from aggregated individual data, and multilevel regression procedures were employed. We show a twofold greater risk of poor self-rated health in areas with very low CSC compared with areas with very high CSC. Adjustments for individual socio-demographic factors, contextual economic factors and individual social capital lowered the excess risk. Simultaneous adjustment for all three forms of confounding further weakened the association and rendered it insignificant.

Cognitive and structural social capital show relatively similar associations with self-rated health, while horizontal CSC seems to be more strongly related to self-rated health than vertical CSC. In conclusion, whether there is none or a moderate association between CSC and self-rated health, depends on the extent to which individual social capital is seen as a mediator or confounder. The association with self-rated health is similar independent of the measure of CSC used. It is also similar in different socio-demographic groups

Stafford M, et al Neighbourhood social capital and common mental disorder: Testing the link in a general population sample. *Health & Place* 2008 14 (3) 394-405.

<http://dx.doi.org/10.1016/j.healthplace.2007.08.006>

<http://pmid.us/17919964>

General population multilevel studies of social capital and mental health are few in number. This multilevel study examined external measures of neighbourhood social capital and common mental disorders (CMD). Main effects and stress buffering models were tested. Based on data from over 9000 residents in 239 neighbourhoods in England and Scotland, there was no evidence of a main effect of social capital. For people living in deprived circumstances only, associations between neighbourhood social capital and CMD were seen. Elements of bridging social capital (contact amongst local friends) were associated with lower reporting of CMD. Elements of bonding social capital (attachment to neighbourhood) were associated with higher reporting of CMD. Findings provide some support for the hypothesis that social capital may protect against CMD, but indicate that initiatives should be targeted to deprived groups, focus on specific elements of social capital and not neglect the important relationship between personal socioeconomic disadvantage and CMD

Stephens C. Social capital in its place: using social theory to understand social capital and inequalities in health. *Social Science and Medicine* 2008 66 (5) 1174-84.

<http://dx.doi.org/10.1016/j.socscimed.2007.11.026>

<http://pmid.us/18155335>

Social capital has been controversially linked to public health benefits, particularly as an explanation for the relationship between economic inequalities and health. This paper focuses on social capital in this context, particularly a recent emphasis on social capital in neighbourhoods and growing use of Bourdieu's social theory in empirical investigations. A review of some of this work is used to suggest the need for a more coherent theoretical approach to using Bourdieu and to introduce an ethnographic study of social connections in New Zealand. Forty-six residents of, a rural town, a deprived city suburb, or an affluent suburb, volunteered to be interviewed about their social connections. Their talk was transcribed and analysed in terms of everyday practice. The results of this study suggest that social connections are not necessarily located in neighbourhoods, and that social capital will be better understood in a broader social context which includes

competition for resources between deprived and non-deprived groups, and the practices of all citizens across neighbourhoods. When considering social capital, an exclusive focus on deprived neighbourhoods as sites for research and intervention is not helpful

WORKFORCE

Caers R, et al Measuring community nurses' job satisfaction: literature review. *Journal of Advanced Nursing* 2008; 62 (5) 521-9.

<http://dx.doi.org/10.1111/j.1365-2648.2008.04620.x>

<http://pmid.us/18355229>

This paper is a report of a review of the literature on community nurses' job satisfaction, including research using different scales and settings, what is known to date and directions for future research. Background. Job satisfaction is one of the strongest predictors of intent to stay and retention of nurses. An adequate understanding of the sources of job satisfaction and their importance can aid policymakers in the community nursing setting to cope with the growing demand for its services. Data sources. A database of papers was established using ISI Web of Knowledge. Cited references were used to expand the database. Journals adding to the database were scanned for related research. This technique was repeated until no additional papers could be found. Findings. Twelve job satisfaction scales were found, with striking differences in methodology, settings and sample characteristics of the studies concerned. A wide variety of job satisfaction and dissatisfaction sources is identified, but little is known on their relative importance. The Measure of Job Satisfaction and the Home Healthcare Nurses' Job Satisfaction Scale prove highly reliable and applicable. Conclusion. Findings on the level and sources of community nurses' job satisfaction are ambiguous. Of all the scales reviewed, the Home Healthcare Nurses' Job Satisfaction Scale seems most promising for use in future research, based on its strong psychometric properties and its specificity for the community nursing setting

Downing, A Predicting the future supply of doctors . . . why is it so difficult? *Health Policy Review* 2007 2 (1): 9-20

[http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFHPRwin07/\\$FILE/49294HealthPolicyReview.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFHPRwin07/$FILE/49294HealthPolicyReview.pdf)

The NHS workforce has been one of the hottest topics in the health service over the last year and the medical workforce has had its share of attention. The plight of junior doctors and the Modernising Medical Careers (MMC) training programme, the cost implications

of the GP and consultant contracts, the stalemate of the contract for staff grade and associate specialist doctors, and attempts to limit the level of medical immigration are a few of the workforce issues that have faced the medical profession over the last year.

Eley D, Young L, Shrapnel M. Rural temperament and character: a new perspective on retention of rural doctors. *Australian Journal of Rural Health* 2008;16: (1) 12-22.

<http://dx.doi.org/10.1111/j.1440-1584.2007.00946.x>

<http://pmid.us/18186717>

Objective: This exploratory study serves as a starting point to establish a psychobiological profile for rural GPs. The overall aim is to describe how individual levels and combinations of temperament (mildly heritable) and character (influenced by sociocultural learning) traits allow GPs to flourish or fail in rural medicine. DESIGN: In a mixed-method study, 13 rural GPs (rural and remote metropolitan areas 5-7, minimum 7 years of experience) from Central/Southern Queensland, Australia completed the Temperament and Character Inventory-R140 to identify the intensity of the seven basic dimensions of temperament and character. These are novelty seeking, harm avoidance, reward dependence, persistence, self-directedness, cooperativeness and self-transcendence. Semistructured interviews provided in-depth information on what brought them to and kept them in rural practice. Results: Preliminary results show that our sample of rural GPs are highly self directed, caring, cooperative, objective and persistent. Individual variations occur in the temperament dimensions of harm avoidance, novelty seeking and reward dependence. In particular, GPs who intended to leave rural practice due to dissatisfaction had significantly higher harm avoidance ($F = 23.74$; $P < 0.01$) than those GPs intent on staying. Conclusion: Although preliminary, triangulation of the data sources provides insight into individual GP profiles regarding which particular combination of traits is most conducive to maintaining a rural career, and might provide a greater understanding of rural doctors. This information could provide a basis for counselling of students with an interest in rural medicine and for informing policy on appropriate initiatives for rural GPs and the communities they serve

Ford, John Needs versus demand based medical workforce planning. *Health Policy Review* 2007; 2 (1): 42-47 (Winter 2007)

[http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFHPRwin07/\\$FILE/49294HealthPolicyReview.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFHPRwin07/$FILE/49294HealthPolicyReview.pdf)

To a free market economist, the need to plan the medical workforce would be an artificial construct deriving from the socialised nature of the National Health Service [NHS] in the UK. Seen in this light, it is a normative, value-driven process assessing healthcare needs and their associated requirements for health resources including doctors rather than a positive one whereby the supply of doctors reflects the revealed demand of patients/consumers as in the market for any other good or service. In short, the difference

between a needs-based and a demand-based approach. So why do we embark on medical workforce planning when in theory the market could take care of it for us? First, as the monopoly employer of doctors in the UK, the NHS has an obvious interest in ensuring that sufficient doctors are available and that these are trained to the requisite standard, something which is also recognised by the major participants in market based systems, eg Medicare in the United States. Furthermore, there being no mechanism for linking the cost of doctors directly to demand (as in fee for service systems) the consequences of getting the balance wrong are delays in treatment (under supply) or medical unemployment/ underemployment (over supply). Neither of these is acceptable in the UK, the latter if only because the state has involved itself in underwriting considerable elements of the cost of undergraduate and postgraduate education. The adverse consequences of a market driven medical workforce might also be felt in relation to (a) quality, by regulating the size of the potential workforce, we can ensure that training opportunities conform to uniform standards and (b) distribution, the market seeming unable to achieve the social equity goal of distributing doctors to the specialties and geographical areas where they are needed, though it clearly has the tools to do so.

Goodyear-Smith F, Janes R. New Zealand rural primary health care workforce in 2005: more than just a doctor shortage. *Australian Journal of Rural Health* 2008 16 (1) 40-6.

<http://dx.doi.org/10.1111/j.1440-1584.2007.00949.x>

<http://pmid.us/18186721>

Objective: To obtain a 2005 snapshot of New Zealand (NZ) rural primary health care workforce, specifically GPs, general practice nurses and community pharmacists. Design: Postal questionnaires, November 2005. Setting: NZ-wide rural general practices and community pharmacies. Participants: Rural general practice managers, GPs, nurses, community pharmacy managers and pharmacists. MAIN Outcome measures: Self-reported data: demographics, country of training, years in practice, business ownership, hours worked including on-call, intention to leave rural practice. Results: General practices: response rate 95% (206/217); 70% GP-owned, practice size ranged from one GP/one nurse to 12 GPs/nine nurses. Pharmacies: Response rate 90% (147/163). Majority had one (33%) or two (32%) pharmacists; <10% had more than three pharmacists. GPs: response rate 64% (358/559), 71% male, 73% aged >40, 61% full-time, 79% provide on-call, 57% overseas-trained, 78% male and 57% female GPs aged >40; more full-time male GPs (76%) than female (37%). Nurses: response rate 65% (445/685), 97% female, 72% aged >40, 31% full-time, 28% provide on-call, 84% NZ-trained, 45% consulted independently in 'nurse-clinics' within practice setting. Pharmacists: response rate 96% (248/258), 52% male, 66% aged >40, 71% full-time, 33% provide on-call, 92% NZ-trained, 55% sole/partner pharmacy owners. Many intend to leave NZ rural practice within 5 years: GPs (34%), nurses (25%) and pharmacists (47%). Conclusion: This is the first NZ-wide rural workforce survey to include a range of rural primary health care providers (GPs, nurses and pharmacists). Ageing rural primary health care workforce and intentions to leave herald worsening workforce shortages

Grey E, The role of the non medically qualified practitioner - a medical workforce solution? Health Policy Review 2007 2 (1) 34-41

[http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFHPRwin07/\\$FILE/49294HealthPolicyReview.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFHPRwin07/$FILE/49294HealthPolicyReview.pdf)

Extended roles for non-medically qualified practitioners is not a new concept, however such roles have only become topical in the UK since the proposals in 2005 for a new type of healthcare professional; the medical care practitioner. The supply and demand for the future medical workforce has been scrutinised not only by those responsible for the NHS and the services it provides but also many others including international commentators. There is a great body of literature about changes to the medical workforce and new ways working following implementation of new contractual arrangements for consultants and GPs, the increased number of medical school places, changes to working hours under the European Working Time Directive, and more recently Modernising Medical Careers. Each has implications on the way the medical profession practises in the UK and how healthcare is delivered. In order to meet the workforce requirements set out in the NHS Plan (2000) there has been a concerted effort by the Department of Health to develop and extend the roles of some non medically qualified practitioners.

Hann M, Sibbald B, Young R. Workforce participation among international medical graduates in the National Health Service of England: a retrospective longitudinal study. *Human Resources for Health* 2008 6:9.

<http://dx.doi.org/10.1186/1478-4491-6-9>

<http://pmid.us/18513401>

Background: Balancing medical workforce supply with demand requires good information about factors affecting retention. Overseas qualified doctors comprise 30% of the National Health Service (NHS) workforce in England yet little is known about the impact of country of qualification on length of stay. We aimed to address this need. **Methods:** Using NHS annual census data, we calculated the duration of 'episodes of work' for doctors entering the workforce between 1992 and 2003. Survival analysis was used to examine variations in retention by country of qualification. The extent to which differences in retention could be explained by differences in doctors' age, sex and medical specialty was examined by logistic regression. **Results:** Countries supplying doctors to the NHS could be divided into those with better or worse long-term retention than domestically trained doctors. Countries in the former category were generally located in the Middle East, non-European Economic Area Europe, Northern Africa and Asia, and tended to be poorer with fewer doctors per head of population, but stronger economic growth. A doctor's age and medical specialty, but not sex, influenced patterns of retention. **Conclusions:** Adjusting workforce participation by country of qualification can improve estimates of the number of medical school places needed to balance supply with demand. Developing countries undergoing strong economic growth are likely to be the most important suppliers of long stay medical migrants

Humphries N, Brughha R, McGee H. Overseas nurse recruitment: Ireland as an illustration of the dynamic nature of nurse migration. *Health Policy* 2008 In Press

<http://dx.doi.org/10.1016/j.healthpol.2007.12.014>

<http://pmid.us/18304684>

This paper presents an analysis of Ireland's recent experience of overseas nurse recruitment. Ireland began actively recruiting nurses from overseas in 2000 and has recruited almost 10,000 nurses, primarily from India and the Philippines since that time. This paper takes a timely look at the Irish experience to date. It reviews the literature on the supply and demand factors that determine the need for, and the international migration of, nurses and presents working visa and nurse registration statistics. This enables the authors to quantify and discuss the trends and scale of recent nurse migration to Ireland from outside the European Union (EU). The paper discusses the data essential for national workforce planning and highlights the deficiencies in the Irish data currently available for that purpose. The paper concludes with a discussion of the implications of Ireland's heavy reliance on overseas nurse recruitment

Lewis JM, Baeza JI, Alexander D. Partnerships in primary care in Australia: network structure, dynamics and sustainability. *Social Science and Medicine* 2008.

<http://dx.doi.org/10.1016/j.socscimed.2008.03.046>

<http://pmid.us/18472201>

Partnerships represent a prescriptive form of network governance, based on the idea of cooperation. This article has four aims. The first is to describe why network governance and partnerships are important now, and what one particular example - Primary Care Partnerships - is addressing. The second is to analyse the network structure of two of these partnerships, and the third is to examine network dynamics. The fourth aim is to explore relationships and sustainability over the longer term. Two government-funded and steered partnerships, which were established to increase coordination between primary care services in Victoria, Australia, were examined. Annual interviews at three points in time between 2002 and 2005 were used to explore relationships between organizations within these two partnerships. The structure of two different communication networks, based on contacts for work and contacts for strategic information, were examined using social network analysis. Tracing network structures over time highlighted partnership dynamics. The network structures changed over the three years of the study, but an important constant was the continuing centrality of the independent staff employed to manage the partnerships. Over the longer term, it seems to be more important to fund independent partnership staff, rather than people who connect partnerships to the funding agency. If partnerships are seen as valuable in improving

service coordination and health outcomes, then long term rather than just start-up funding support is required

McComb ED. Which psycho-demographic factors predict a doctor's intention to leave New Zealand general practice? *New Zealand Medical Journal* 2008 121 (1273) 25-36.

<http://pmid.us/18480883>

Aim: To assess the predictive ability of various demographic and psychological variables in respect of New Zealand general practitioners' (GPs') intention to leave general practice. Methods: 1000 GPs were surveyed. Demographic variables measured were gender, age, life status, income, hours worked, and work arrangements. Psychological variables measured were satisfaction with general practice (measured by a single item), and commitment to general practice (measured by the Meyer and Allen^{1,2} three-component model questionnaire). Intention to leave general practice was measured at two time intervals: within 6 months and within 5 years. Results: The response rate was 58%. Twelve percent of GPs indicated an intention to leave general practice within 6 months, and nearly 30% indicated an intention to leave within 5 years. Despite these intentions, the reported level of satisfaction was reasonably high (mean score 3.67/5) as was the level of commitment (overall 72% reported being committed to general practice). While some demographic variables exhibited statistically significant relationships with intended withdrawal from the occupation, their predictive ability was very poor. Satisfaction with and commitment to general practice were both significantly negatively related to intention to leave and had much higher predictive value than demographic variables. The relationship between satisfaction and intention to leave was mediated by commitment. Conclusion: For those interested in the maintenance of an adequate GP workforce, these results suggest some attention should be paid to commitment. Further work is necessary to establish how commitment develops and is maintained

Morris S, Gravelle H. GP supply and obesity. *Journal of Health Economics*. 2008 article in press

<http://dx.doi.org/10.1016/j.jhealeco.2008.02.012>

<http://pmid.us/18420294>

We investigate the relationship between area general practitioner (GP) supply and individual body mass index (BMI) in England. Individual level BMI is regressed against area whole time equivalent GPs per 1000 population plus a large number of individual and area level covariates. We use instrumental variables (area house prices and age weighted capitation) to allow for the endogeneity of GP supply. We find that that a 10% increase in GP supply is associated with a mean reduction in BMI of around 1kg/m² (around 4% of mean BMI). The results suggest that reduced list sizes per GP can improve the management of obesity

O'Toole K, et al Rethinking policies for the retention of allied health professionals in rural areas: A social relations approach. *Health Policy* 2008 In press

<http://dx.doi.org/10.1016/j.healthpol.2008.01.012>

<http://pmid.us/18336949>

Objective Retaining allied health professionals in rural areas is a recognised problem. Generally the literature has concentrated on three elements: practitioner needs, community needs and organisational needs. There has been little attempt to focus other types of social relations in which health practitioner retention and recruitment takes place. The aim of this paper is to question the present dominant hierarchical approach taken in relation to the retention of allied health professionals in rural localities. Methods The data derives from a survey in Southwest Victoria, Australia. The sample was purposive rather than representative as it was intended to be exploratory in nature rather than definitive. Results The data indicates that there is a greater tendency for allied health professionals in private practice to be retained in rural areas than those in the public sector. Conclusion The paper concludes by raising some questions about the pertinence of present models for regional health initiatives since they are locked into a bureaucratic model where relationships are hierarchical and asymmetrically controlled

Sarma S, Peddigrew C. The relationship between family physician density and health related outcomes: the Canadian evidence. *Cahiers de Sociologie et de Demographie Medicales* 2008 48 (1) 61-105.

<http://pmid.us/18447066>

This paper analyzes if and to what extent the density of family physicians influences health related outcomes in Canada. The density of family physicians in a given region is assumed to serve as proxy for the access to and availability of desirable primary care services. We use self-reported general and mental health status as our overall health outcome measures. We also use several quality of care indicators reflecting whether or not an individual received influenza immunization, mammography, pap smear, and colorectal cancer screening if at high-risk. The empirical results of this study suggest that an additional family physician per 10,000 population has a statistically significant impact in the order of 2% to 4% on self-reported general health status, as well as, other quality of care outcomes. We also find important socioeconomic and demographic factors, such as income, education and immigrant status, influencing health related outcomes considered in this study. Understanding the influence of physician density and socioeconomic factors on health related outcomes are important considerations for health policy and planning

Twellaar M, Winants Y, Houkes I. How healthy are Dutch general practitioners? Self-reported (mental) health among Dutch general practitioners. *The European Journal of General Practice* 2008 14 (1) 4-9.

<http://dx.doi.org/10.1080/13814780701814911>

<http://pmid.us/18464166>

Objective: To investigate the level of burnout and health status of male and female Dutch general practitioners (GPs), and to compare this with former samples of GPs and with the Dutch general population. Methods: A postal survey of 350 male and 350 female practising GPs in the Netherlands. Results: Although levels of emotional exhaustion of Dutch GPs were lower than those of national samples of GPs in the 1990s, the prevalence of burnout was still almost twice that of the general population. In contradiction with this, GPs reported better general health and fewer diseases than their fellow countrymen. Another remarkable finding was that female GPs were as healthy as their male colleagues, while in the general population, males report better health than females. Conclusion: The positive self-reported health status of general practitioners might reflect the high standards of the medical profession, which make physicians reluctant to show their own vulnerability. This might result in fewer, but more serious cases of (mental) illness among GPs as compared to the general population

Unsworth J, Danskin J, Taylor M. Non-elective demand management: the renaissance of district nursing? *British Journal of Community Nursing* 2008 13 (2) :76-82.

<http://pmid.us/18414242>

Abstract: Despite the fact that the majority of district nurses are grasping opportunities to provide care to increasingly complex patients at home there have been concerns expressed recently that district nursing as a discipline is in decline. This is partly attributed to a lack of leadership and focus (Lowe, 2006). This alleged decline is set against a backdrop of rising rates of emergency admissions with associated cost pressures for many primary care organizations. This paper presents an overview of a programme which targets district nursing services at the avoidance of non-elective (emergency) admissions. The programme used a model to match staff capacity with demand to free up capacity within teams to tackle admissions from a range of client groups. Using care pathways staff were able to provide structured care for individuals at home. Teams were set targets for the number of admissions they needed to try and avoid. Within the first five months staff reduced non-elective admissions by 17% and achieved savings of 668,000 UK pounds. At a time when community services are being opened up to competition as a result of the changes proposed by "Commissioning a patient-led NHS," district nursing is capable of playing a key role in demonstrating the value of the services to commissioners

Virtanen P, et al Work stress and health in primary health care physicians and hospital physicians. *Occupational and Environmental Medicine* 2008 65 (5) :364-6.

<http://dx.doi.org/10.1136/oem.2007.034793>

<http://pmid.us/18045846>

Objective: In order to understand the reasons for the low priority given to work in primary health care among physicians, we studied differences in work stress, health and health related lifestyles between general practitioners (GPs) and hospital physicians. **Method:** A cohort of 226 GPs and 523 consultants from Finland responded to a questionnaire survey. The responses were linked to data on registered sickness absence. **Results:** Compared with consultants, GPs reported higher job strain (OR 1.76, 95% CI 1.23 to 2.53) and perceived work overload (OR 2.29, 95% CI 1.65 to 3.16) but were less likely to report poor team climate (OR 0.65, 95% CI 0.46 to 0.91), procedural injustice (OR 0.49, 95% CI 0.34 to 0.72) and interactional injustice (OR 0.62, 95% CI 0.44 to 0.88). There were only small differences in lifestyle, perceived health, psychological distress and long sick leaves between GPs and consultants. Short sick leaves were more common among GPs, but this difference disappeared after controlling for work characteristics. **Conclusion:** In relation to the current recruitment crisis in primary health care and the studied working conditions, job strain and heavy workload outweigh the attractiveness of a good working climate and low organisational injustice. The non-significant differences in health may indicate that there are no differences in total work stress between GPs and consultants. In tackling the recruitment problems in the field of health care, it is of particular importance to be aware of the sector specific difficulties in working conditions

