



NATIONAL PRIMARY CARE RESEARCH
AND DEVELOPMENT CENTRE



CURRENT AWARENESS BULLETIN

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ACCESS TO HEALTH CARE

den Boer-Wolters, D et al **Frequent attendance of primary care out-of-hours services in The Netherlands: characteristics of patients and presented morbidity.** *Family Practice* Epub ahead of publication 23-12-2009.

<http://dx.doi.org/10.1093/fampra/cmp103>.

<http://pmid.us/20032165>

Background. Over the last years, a system of regional general practices was developed in The Netherlands, responsible for the primary care out-of-hours services (OHS). As in daytime, frequent attendance of the OHS increases workload and the health care; detailed description of the background of frequent attendance is required to develop interventions aiming at reduction. Objectives. To assess the characteristics of the frequent attenders (FAs) and the presented morbidity during their consultations and to study the persistence of frequent attendance. Methods. We performed a retrospective descriptive 1-year database investigation of all patient contacts (n = 44 953) made in 2007 with the OHS de Gelderse Vallei'. We analysed characteristics of normal attender, FA and very frequent attender (VFA) and compared the reason for encounter, GP diagnoses, psychiatric co-morbidities and management during their 2007 consultations. Results. VFAs, constituting 1% of the attenders and 7.7% of the total number of contacts, more often reported agitation as reason for encounter. The prevalence of psychiatric diagnosis in the VFA group (15.3%) was significantly higher than in other groups. Reassurance was the most frequent prevalent management action in each group. The prevalence of chronic diseases and psychological problems was higher in the VFA groups. Conclusions. Frequent attendance puts severe pressure on OHS resources. Much of the frequent attendance can be explained by the increased incidence of chronic diseases and psychiatric co-morbidity

Deb, P. and Trivedi, P. K. 2009 **Provider networks and primary-care signups: do they restrict the use of medical services?** *Health Economics* 18(12), 1361-1380.

<http://dx.doi.org/10.1002/hec.1432>

<http://pmid.us/19097145>

This article analyzes the effect of gatekeeper and network restrictions on use of health-care services using simulation-based estimation methods. Data from the Community Tracking Survey (1996-1997) show significant evidence of selection into plans with gatekeeper and/or network restrictions. Enrollees in plans with networks of physicians have fewer office-based visits to non-physician medical professionals, but more emergency room visits and hospital stays. Individuals in plans that require signups with a primary-care provider have more visits to non-physician providers of care, more surgeries and hospital stays but substantially fewer emergency room visits. Enrollees of plans that

do not pay for out-of-network services have more office-based and emergency room visits, but less surgeries and hospitalizations

McGrail, Matthew and Humphreys, John. 2009 The index of rural access: an innovative integrated approach for measuring primary care access. *BMC Health Services Research* 9(1), 124.

<http://dx.doi.org/10.1186/1472-6963-9-124>

<http://www.biomedcentral.com/1472-6963/9/124>

<http://pmid.us/19624859>

Background: The problem of access to health care is of growing concern for rural and remote populations. Many Australian rural health funding programs currently use simplistic rurality or remoteness classifications as proxy measures of access. This paper outlines the development of an alternative method for the measurement of access to primary care, based on combining the three key access elements of spatial accessibility (availability and proximity), population health needs and mobility. Methods: The recently developed two-step floating catchment area (2SFCA) method provides a basis for measuring primary care access in rural populations. In this paper, a number of improvements are added to the 2SFCA method in order to overcome limitations associated with its current restriction to a single catchment size and the omission of any distance decay function. Additionally, small-area measures for the two additional elements, health needs and mobility are developed. By utilising this improved 2SFCA method, the three access elements are integrated into a single measure of access. This index has been developed within the state of Victoria, Australia. Results: The resultant index, the Index of Rural Access, provides a more sensitive and appropriate measure of access compared to existing classifications which currently underpin policy measures designed to overcome problems of limited access to health services. The most powerful aspect of this new index is its ability to identify access differences within rural populations at a much finer geographical scale. This index highlights that many rural areas of Victoria have been incorrectly classified by existing measures as homogenous in regards to their access. Conclusion: The Index of Rural Access provides the first truly integrated index of access to primary care. This new index can be used to better target the distribution of limited government health care funding allocated to address problems of poor access to primary health care services in rural areas

Rees, Philip et al 2009 The estimation of mortality for ethnic groups at local scale within the United Kingdom. *Social Science & Medicine* 69(11), 1592-1607. 2009.

<http://dx.doi.org/10.1016/j.socscimed.2009.08.015>

<http://pmid.us/19781840>

As an input to projections of sub-national populations by ethnicity, this paper develops the first estimates of the mortality risks experienced by the UK ethnic groups. Two estimates were developed using alternative methods. In the first, UK 2001 Census data on limiting long-term illness to predict mortality levels and regression equations between local Standardized Illness and Mortality Ratios for all ethnicities are assumed to apply to individual ethnic groups. In the second, the geographical distribution of ethnic groups by local areas is combined with local mortality for all ethnicities to estimate national mortality rates by ethnicity, which are then employed to estimate local ethnic mortality. A comparison of the two estimates indicates that the method based on illness rates produces more plausible outcomes. The local SMRs produced for each ethnic group were used to generate ethnic group life tables for 432 UK local authority areas in 2001, which included estimates of survivorship probabilities by single year of age, gender and ethnic group for each local area for use in a projection model

Wallace, L et al Digging deeper: quality of patient-provider communication across Hispanic subgroups. *BMC Health Services Research* 9(1), 240. 2009.

<http://dx.doi.org/10.1186/1472-6963-9-240>

<http://www.biomedcentral.com/1472-6963/9/240>

<http://pmid.us/20025725>

Background: Recent research suggests that ethnic subgroup designation plays an important role in health-related disparities among Hispanics. Our objective was to examine the influence of Hispanics' self-reported ethnic subgroup designation on perceptions of their health care providers' communication behaviors. Methods: Cross-sectional analysis of the 2005 Medical Expenditure Panel Survey (MEPS). Participants included non-institutionalized Hispanics (n = 5197; US population estimate = 27,070,906), aged ≥18 years, reporting visiting a health care provider within the past 12 months. Six (n = 6) items were used to capture respondents' perceptions of their health care providers' communication behaviors. Results: After controlling for socio-demographic covariates, compared to Other Hispanics (reference group), very few differences in perceptions of health care providers communication emerged across ethnic subgroups. Puerto Ricans were more likely to report that their health care provider "always" showed respect for what they had to say (OR = 2.16, 95% CI 1.16-4.03). Both Puerto Ricans (OR = 2.28, 95% CI 1.06-4.92) and Mexicans (OR = 1.88, 95% CI 1.02-3.46) were more likely to indicate that their health care provider "always" spent enough time with them as compared to Other Hispanics. Conclusions: We observed very few differences among Hispanics respondents in their perceived quality of interactions with health care providers as a function of their ethnic subgroup designation. While our findings somewhat contradict previous research, they do suggest that other underlying factors may influence the quality of perceived interactions with health care providers

CHRONIC ILLNESS

Coole, C., Watson, P. J., and Drummond, A. Work problems due to low back pain: what do GPs do? A questionnaire survey. *Family Practice* Epub ahead of publication 26-10-2009.

<http://dx.doi.org/10.1093/fampra/cmp074>

<http://pmid.us/19858125>

Background: Low back pain can affect work ability and remains a main cause of sickness absence. In the UK the GP is usually the first contact for patients seeking health care. The UK government intends that the GP will continue to be responsible for sickness certification and work advice. This role requires a considerable level of understanding of work rehabilitation, and effective communication between GPs, patients, employers and therapists. Objectives: The aim of this study was to identify GPs' current practice in managing patients whose ability to work is affected by low back pain, and their perception of the support services required. Method: A postal questionnaire of 441 GPs in the South Nottinghamshire area of the UK was carried out. Areas covered included referral patterns, sickness certification, and communication with therapists and employers. Results: There was a 54.6% response rate. The majority of GPs (76.8%) reported that they did not take overall responsibility for managing the work problems of patients arising from low back pain. Few 'mainly agreed' that they initiated communication with employers (2.5%) and/or therapists (10.4%) regarding their patients' work. Conclusion: The results of this study demonstrate that most GPs do not readily engage in vocational rehabilitation and do not initiate contact with employers or other health care practitioners regarding patients' work problems. Thus the current government expectation that GPs are able to successfully manage this role may be unrealistic; considerable training and a change in the GPs' perception of their role will be required

Crosson, J. C., et al A comparison of chronic illness care quality in US and UK family medicine practices prior to pay-for-performance initiatives. *Family Practice* 26(6), 510-516. 2009.

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

<http://pmid.us/19748914>

Background: The Quality and Outcomes Framework (QOF) has contributed to modest improvements in chronic illness care in the UK. US policymakers have proposed similar pay-for-performance (P4P) approaches to improve care. Since previous studies have not compared chronic illness care quality in US and UK primary care practices prior to the QOF, the relative preparedness of practices to respond to P4P incentives is unknown. Objective: To compare US and UK practices on P4P measures prior to program

implementation. Methods: We analysed medical record data collected before QOF implementation from randomly selected patients with diabetes or coronary artery disease (CAD) in 42 UK and 55 US family medicine practices. We compared care processes and intermediate outcomes using hierarchical logistic regression. RESULTS: While we found gaps in chronic illness care quality across both samples, variation was lower in UK practices. UK patients were more likely to receive recommended care processes for diabetes [odds ratio (OR), 8.94; 95% confidence interval (CI), 4.26-18.74] and CAD (OR, 9.18; 95% CI, 5.22-16.17) but less likely to achieve intermediate diabetes outcome targets (OR, 0.50; 95% CI, 0.39-0.64). Conclusions: Following National Health Service (NHS) investment in primary care preparedness, but prior to the QOF, UK practices provided more standardized care but did not achieve better intermediate outcomes than a sample of typical US practices. US policymakers should focus on reducing variation in care documentation to ensure the effectiveness of P4P efforts while the NHS should focus on moving from process documentation to better patient outcomes

Gambling, Tina and Long, Andrew. 2009 Tailoring advice and optimizing response: a case study of a telephone-based support for patients with type 2 diabetes. *Family Practice* . Epub ahead of publication 23-12-2009.

<http://dx.doi.org/10.1093/fampra/cmp097>.

<http://pmid.us/20032169>

Background and aims. Health care increasingly incorporates telephone counselling, but the dynamics of interactions supporting its delivery are not well understood. This paper explores how advice was packaged and received by participants with type 2 diabetes within the context of a Pro-Active Call-Centre Treatment Support (PACCTS) system delivered to provide diabetes self-care training over the telephone. Methods. The data relate to nine participants who formed part of the qualitative evaluation within the intervention arm of a randomized controlled trial (n = 591) of PACCTS. One consultation call between the tele-carer and the participant was tape recorded towards the end of the 3-year study and each participant was interviewed by telephone within 24 hours of the consultation. The nine calls and interviews were transcribed and analysed using the constant comparative method. Results. The type of advice the participants received was packaged in six forms: advice as explanation, general information-giving, generic advice, advice in the form of practitioner self-disclosure, personalized advice and responsive advice. Variation was evident in terms of the nature of advice provided, level of generality, form and context. Conclusions. As the participants had to make multiple behavioural changes over time, advice needed to be delivered, reiterated and reinforced to achieve understanding and uptake. The more specific and personalized the information and advice, the more likely it was for the participant to give a positive and engaged response. Seizing every opportunity to deliver good quality personalized and/or responsive advice is essential in order to facilitate effective behavioural change

Gialamas, A., et al 2009 Point-of-care testing for patients with diabetes, hyperlipidaemia or coagulation disorders in the general practice setting: a systematic review. *Family Practice* Epub ahead of publication 6-12-2009.

<http://dx.doi.org/10.1093/fampra/cmp084>

<http://pmid.us/19969524>

Background: Point-of-care testing (PoCT) is increasingly being used in the general practice setting and has the potential to provide improved health outcomes for patients. Objectives: The aim of the study was to systematically assess the literature relating to the analytical performance, clinical effectiveness, cost and satisfaction of patients and health professionals with PoCT for monitoring patients with diabetes, with hyperlipidaemia or requiring anticoagulant therapy in general practice. METHODS: Systematic review and synthesis of randomized and quasi-randomized trials during 1966-2007 was performed. PubMed, EMBASE, CINAHL, Current Contents, BIDS and the Cochrane Library databases were searched using key terms relating to PoCT for diabetes (glycosylated haemoglobin, urine albumin creatinine ratio), hyperlipidaemia (total cholesterol, triglycerides and high-density lipoprotein) and anticoagulant therapy (international normalized ratio) in the general practice setting. Results: Nine papers from six randomized or quasi-randomized trials were included in the review. Large between-study heterogeneity made pooling of the data inappropriate. In terms of clinical effectiveness, no study found a significant difference between PoCT and pathology laboratory testing. There was a similar lack of data in relation to the analytical performance of PoCT, to cost outcomes and to patient and health professional satisfaction, making conclusions difficult to infer. Conclusions: This systematic review does not provide robust evidence that PoCT in general practice improves patient health outcomes, that it has comparable analytical quality to pathology laboratory testing, that it is cost-effective compared to usual care or that patients and health professionals find PoCT satisfactory. The number of trials is low, the follow-up of patients is short and many of the trials did not investigate PoCT as a separate intervention

Godwin, Marshall, et al 2009 A primary care pragmatic cluster randomized trial of the use of home blood pressure monitoring on blood pressure levels in hypertensive patients with above target blood pressure. . *Family Practice* Epub ahead of publication 23-12-2009.

<http://dx.doi.org/10.1093/fampra/cmp094>.

<http://pmid.us/20032170>

Background. The measurement of blood pressure (BP) at home by patients with hypertension is increasingly used to assess and monitor BP. Evidence for its effectiveness in improving BP control is mixed. Methods. To determine if home BP monitoring improves BP a pragmatic cluster randomized controlled trial was carried out in family practices in southeastern Ontario, Canada. Family practice patients with uncontrolled hypertension were recruited to the trial. Patients were divided into two groups: one with

at least weekly measurements of BP at home, recording those measurements and showing those to the family physician during office visits for hypertension and the control group were given usual care. The primary outcome was mean awake BP on ambulatory monitoring at 6- and 12-month follow-up and the secondary outcomes were mean BP on full 24-hour ambulatory blood pressure monitoring (ABPM), mean sleep BP on ABPM and BP on the BpTRU device, all at 6- and 12-month follow-up. Results. Home BP monitoring did not improve BP compared to usual care at 12-month follow-up: mean awake systolic BP on ABPM [141.1 versus 142.8 mmHg, mean difference 1.7 mmHg; 95% confidence interval (CI) -0.6 to 4.0, P = 0.314] and mean awake diastolic BP on ABPM (78.7 versus 79.4 mmHg, mean difference 0.7 mmHg; 95% CI -7.7 to 9.1, P = 0.398). Similar negative results were obtained for men and women separately. However, outcomes using the full 24-hour ABPM and the BpTRU device showed a significantly lower diastolic BP at 12 months. When analysis was done by sex, this effect was shown to be only in men. Conclusion. Home BP monitoring may improve BP control in men with hypertension

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

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

<http://pmid.us/19675116>

Objectives: In participatory decision-making (PDM), physicians actively engage patients in treatment and other care decisions. Patients who report that their physicians engage in PDM have better disease self-management and health outcomes. We examined whether physicians' diabetes-specific treatment PDM preferences as well as their self-reported practices are associated with the quality of diabetes care their patients receive. Methods: 2003 cross-sectional survey and medical record review of a random sample of diabetes patients (n=4198) in 10 US health plans across the country and their physicians (n=1217). We characterized physicians' diabetes care PDM preferences and practices as 'no patient involvement,' 'physician-dominant,' 'shared,' or 'patient-dominant' and conducted multivariate analyses examining their effects on the following: (1) three diabetes care processes (annual hemoglobin A1c test; lipid test; and dilated retinal exam); (2) patients' satisfaction with physician communication; and (3) whether patients' A1c, systolic blood pressure (SBP), and low-density lipoprotein cholesterol (LDL) were in control. Results: Most physicians preferred 'shared' PDM (58%) rather than 'no patient involvement' (9%), 'physician-dominant' (28%) or 'patient dominant' PDM (5%). However, most reported practicing 'physician-dominant' PDM (43%) with most of their patients, rather than 'no patient involvement' (13%), 'shared' (37%) or 'patient-dominant' PDM (7%). After adjusting for patient and physician-level characteristics and clustering by health plan, patients of physicians who preferred 'shared' PDM were more likely to receive A1c tests [90% vs. 82%, AOR: 2.05, 95% CI: 1.03-3.07] and patients of physicians who preferred 'patient-dominant' treatment decision-making were more likely to receive lipid tests [60% vs. 50%, AOR: 1.58, 95% CI: 1.04-2.39] than those of

providers who preferred 'no patient involvement' in treatment decision-making. There were no differences in patients' satisfaction with their doctor's communication or control of A1c, SBP or LDL depending on their physicians' PDM preferences. Physicians' self-reported PDM practices were not associated with any of the examined aspects of diabetes care in multivariate analyses. Conclusions: Patients whose physicians prefer more patient involvement in decision-making are more likely than patients whose physicians prefer more physician-directed styles to receive some recommended risk factor screening tests, an important first step toward improved diabetes outcomes. Involving patients in treatment decision-making alone, however, appears not to be sufficient to improve biomedical outcomes

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

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

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

<http://pmid.us/19772639>

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

Koch, H., et al 2009 The course of newly presented unexplained complaints in general practice patients: a prospective cohort study. *Family Practice* 26(6), 455-465. 2009.

<http://dx.doi.org/10.1093/fampra/cmp067>

<http://pmid.us/19825865>

Objective: Newly presented unexplained complaints (UCs) are common in general practice. Factors influencing the transition of newly presented into persistent UCs have been scarcely investigated. We studied the number and the nature of diagnoses made over time, as well as factors associated with UCs becoming persistent. Finally, we longitudinally studied factors associated with quality of life (QoL). Methods: Prospective cohort study in general practice of patients presenting with a new UC. Data sources were case record forms, patient questionnaires and electronic medical registries at inclusion, 1, 6 and 12 months. Presence of complaints and diagnoses made over time were documented. Potential risk factors were assessed in mixed-effect logistic and linear regression models. Results: Sixty-three GPs included 444 patients (73% women; median age 42) with unexplained fatigue (70%), abdominal complaints (14%) and musculoskeletal complaints (16%). At 12 months, 43% of the patients suffered from their initial complaints. Fifty-seven percent of the UCs remained unexplained. UCs had (non-life-threatening) somatic origins in 18% of the patients. QoL was often poor at presentation and tended to remain poor. Being a male [odds ratio (OR) 0.6; 95% confidence interval (CI) 0.4-0.8] and GPs' being more certain about the absence of serious disease (OR 0.9; 95% CI 0.8-0.9) were the strongest predictors of a diminished probability that the complaints would still be present and unexplained after 12 months. The strongest determinants of complaint persistence [regardless of (un)explicability] were duration of complaints >4 weeks before presentation (OR 2.6; 95% CI 1.6-4.3), musculoskeletal complaint at baseline (OR 2.3; 1.2-4.5), while the passage of time acted positively (OR 0.8 per month; 95% CI 0.78-0.84). Musculoskeletal complaints, compared to fatigue, decreased QoL on the physical domain (4.6 points; 2.6-6.7), while presence of psychosocial factors decreased mental QoL (5.0; 3.1-6.9). Conclusion: One year after initial presentation, a large proportion of newly presented UCs remained unexplained and unresolved. We identified determinants that GPs might want to consider in the early detection of patients at risk of UC persistence and/or low QoL

Lemmens, K., et al 2009 Professional commitment to changing chronic illness care: results from disease management programmes. *International Journal of Quality in Health Care* 21(4), 233-242.

<http://dx.doi.org/10.1093/intqhc/mzp017>

<http://pmid.us/19389724>

Objective: The aim of this exploratory study was to investigate to what extent primary care professionals are able to change their systems for delivering care to chronic obstructive pulmonary disease (COPD) patients and what professional and organizational

factors are associated with the degree of process implementation. Design: Quasi-experimental design with 1 year follow-up after intervention. Setting: Three regional COPD management programmes in the Netherlands, in which general practices cooperated with regional hospitals. Participants: All participating primary care professionals (n = 52). Intervention: COPD management programme. Main outcome measures: Professional commitment, organizational context and degree of process implementation. Results: Professionals significantly changed their systems for delivering care to COPD patients, namely self-management support, decision support, delivery system design and clinical information systems. Associations were found between organizational factors, professional commitment and changes in processes of care. Group culture and professional commitment appeared to be, to a moderate degree, predictors of process implementation. Conclusions: COPD management was effective; all processes improved significantly. Moreover, theoretically expected associations between organizational context and professional factors with the implementation of COPD management were indeed confirmed to some extent. Group culture and professional commitment are important facilitators

Less, L. A., et al A preliminary report on an assessment of a community-based intervention for diabetes control in adults with type 2 diabetes. *Family Practice* Epub ahead of publication 4-12-2009.

<http://dx.doi.org/10.1093/fampra/cmp085>

<http://pmid.us/19965903>

Objective: The aim of this study was to evaluate the effectiveness of lay diabetes facilitators (LDFs) to increase knowledge and improve control among persons with diabetes. Methodology. A prospective cohort study was conducted among persons with diabetes in 16 health care centres in Jamaica to evaluate the effect of LDFs on glycaemia [haemoglobin A1c (HbA1c)] and body mass index (BMI). One hundred and fifty-nine persons with diabetes were recruited for the intervention from eight clinical settings in which LDFs had been recruited and trained. A matched group of 159 were recruited as a comparison sample from eight clinical settings without LDFs. HbA1c and BMI were measured at baseline and 6 months. Results: Mean HbA1c at baseline for the intervention and comparison groups were 7.9% and 8%, respectively. After 6 months, the intervention group showed a mean decrease of 0.6% while the comparison group showed an increase of 0.6%, significant after control for potential confounders ($P < 0.05$). There was no statistically significant change in BMI between groups. Conclusion: Patients educated by LDFs showed improved metabolic control over the first 6 months of observation

Mishali, Moshe, et al 2009 Reducing resistance to diabetes treatment using short narrative interventions. *Family Practice* , Epub ahead of publication 23-12-2009.

<http://dx.doi.org/10.1093/fampra/cmp091>

<http://pmid.us/20032167>

Objective. This article presents a narrative-based technique, which allows medical personnel to empower patients with diabetes and improve adherence. Methods. The study was undertaken in Maccabi Healthcare Services, among 123 patients diagnosed with diabetes. Four empathic narratives were constructed, referring to different factors influencing resistance to treatment, as were identified by the Resistance to Treatment Questionnaire. Each narrative contains statements typical for patients whose resistance to treatment is influenced by a particular factor. An Empathic Narratives Evaluation Questionnaire was designed for this study. It contained three items, assessing the correlation of a specific empathic narrative with the patient's attitude and their reasons for resistance to treatment. The patients were asked to indicate whether they recognize these narratives as describing their reasons for resistance. Three empathic narratives were read to each patient: two narratives were matched for the two major categories of resistance for each patient and one narrative related to a category of resistance that received the lowest score. Results. The narratives were found to correspond to the core reasons for resistance to diabetes treatment. Significant difference was found also between the scores of the empathic narrative related to the second strongest reason for resistance to treatment and the empathic narrative related to the weakest reason for resistance to treatment. This finding supports testimonial validity of the narratives. Conclusion. Short narrative interventions demonstrated in this study can be used by health care professionals as a working tool that provides the possibility reducing the patient's reasons for resistance to treatment

Moreau, A., et al 2009 Patient versus general practitioner perception of problems with treatment adherence in type 2 diabetes: From adherence to concordance. *European Journal of General Practice* Epub ahead of publication 2-11-2009.

<http://dx.doi.org/10.3109/13814780903329510>

<http://pmid.us/19883146>

Objectives: To determine the prevalence of problems with treatment adherence among type-2 diabetic patients with regards to medication, dietary advice, and physical activity; to identify the associated clinical and psychosocial factors; and to investigate the degree of agreement between patient-perceived and GP-perceived adherence. Methods: Consecutive patients were solicited during visits to 39 GPs. In total, 521 patients self-reported on treatment adherence, anxiety and depression, and disease perception. The GPs reported clinical and laboratory data and patients' adherence. A multivariate analysis identified the factors associated with adherence problems. Results: Problems of adherence to medication, dietary advice, and physical activity recommendations were reported by 17%, 62%, and 47% of the patients, respectively. Six independent factors were found associated with adherence problems: young age, body-mass index (BMI) > 30 kg/m², glycosylated haemoglobin (HbA_{1c}) > 8%, single life, depression, and perception of medication as a constraint. Agreement between patients' and GPs' assessments of treatment problems reached 70%. Conclusion: In type 2 diabetes, problems with dietary advice or physical activity are far more frequent than problems

with medication, and not all physicians are fully aware of patients' problems. More active listening and shared decision-making should enhance adherence and improve outcomes

Murphy, A. W., et al 2009 Effect of tailored practice and patient care plans on secondary prevention of heart disease in general practice: cluster randomised controlled trial. *British Medical Journal* 339:b4220 29/10/2009

<http://dx.doi.org/10.1136/bmj.b4220>

<http://pmid.us/19875426>

Objective To test the effectiveness of a complex intervention designed, within a theoretical framework, to improve outcomes for patients with coronary heart disease. **Design** Cluster randomised controlled multicentre trial. **Setting** General practices in Northern Ireland and the Republic of Ireland, regions with different healthcare systems. **Participants** 903 patients with established coronary heart disease registered with one of 48 practices. **Intervention** Tailored care plans for practices (practice based training in prescribing and behaviour change, administrative support, quarterly newsletter), and tailored care plans for patients (motivational interviewing, goal identification, and target setting for lifestyle change) with reviews every four months at the practices. **Control** practices provided usual care. **Main outcome measures** The proportion of patients at 18 month follow-up above target levels for blood pressure and total cholesterol concentration, and those admitted to hospital, and changes in physical and mental health status (SF-12). **Results** At baseline the numbers (proportions) of patients above the recommended limits were: systolic blood pressure greater than 140 mm Hg (305/899; 33.9%, 95% confidence interval 30.8% to 33.9%), diastolic blood pressure greater than 90 mm Hg (111/901; 12.3%, 10.2% to 14.5%), and total cholesterol concentration greater than 5 mmol/l (188/860; 20.8%, 19.1% to 24.6%). At the 18 month follow-up there were no significant differences between intervention and control groups in the numbers (proportions) of patients above the recommended limits: systolic blood pressure, intervention 98/360 (27.2%) v control, 133/405 (32.8%), odds ratio 1.51 (95% confidence interval 0.99 to 2.30; P=0.06); diastolic blood pressure, intervention 32/360 (8.9%) v control, 40/405 (9.9%), 1.40 (0.75 to 2.64; P=0.29); and total cholesterol concentration, intervention 52/342 (15.2%) v control, 64/391 (16.4%), 1.13 (0.63 to 2.03; P=0.65). The number of patients admitted to hospital over the 18 month study period significantly decreased in the intervention group compared with the control group: 107/415 (25.8%) v 148/435 (34.0%), 1.56 (1.53 to 2.60; P=0.03). **Conclusions** Admissions to hospital were significantly reduced after an intensive 18 month intervention to improve outcomes for patients with coronary heart disease, but no other clinical benefits were shown, possibly because of a ceiling effect related to improved management of the disease.

Paddison, Charlotte A. M., et al Are people with negative diabetes screening tests falsely reassured? Parallel group cohort study embedded in the ADDITION (Cambridge) randomised controlled trial. *British Medical Journal* 339b4535. Epub ahead of publication 30-11-2009.

<http://dx.doi.org/10.1136/bmj.b4535>

<http://pmid.us/19948642>

Objective To assess whether receiving a negative test result at primary care based stepwise diabetes screening results in false reassurance. **Design** Parallel group cohort study embedded in a randomised controlled trial. **Setting** 15 practices (10 screening, 5 control) in the ADDITION (Cambridge) trial. **Participants** 5334 adults (aged 40-69) in the top quarter for risk of having undiagnosed type 2 diabetes (964 controls and 4370 screening attenders). **Main outcome measures** Perceived personal and comparative risk of diabetes, intentions for behavioural change, and self rated health measured after an initial random blood glucose test and at 3-6 and 12-15 months later (equivalent time points for controls). **Results** A linear mixed effects model with control for clustering by practice found no significant differences between controls and people who screened negative for diabetes in perceived personal risk, behavioural intentions, or self rated health after the first appointment or at 3-6 months or 12-15 months later. After the initial test, people who screened negative reported significantly (but slightly) lower perceived comparative risk (mean difference -0.16, 95% confidence interval -0.30 to -0.02; P=0.04) than the control group at the equivalent time point; no differences were evident at 3-6 and 12-15 months. **Conclusions** A negative test result at diabetes screening does not seem to promote false reassurance, whether this is expressed as lower perceived risk, lower intentions for health related behavioural change, or higher self rated health. Implementing a widespread programme of primary care based stepwise screening for type 2 diabetes is unlikely to cause an adverse shift in the population distribution of plasma glucose and cardiovascular risk resulting from an increase in unhealthy behaviours arising from false reassurance among people who screen negative.

van, Bruggen R., et al 2009 Clinical inertia in general practice: widespread and related to the outcome of diabetes care. *Family Practice* 26(6), 428-436. 2009

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

<http://pmid.us/19729401>

Background and aims: Clinical inertia is considered a major barrier to better care. We assessed its prevalence, predictors and associations with the intermediate outcomes of diabetes care. **Materials and methodS:** Baseline and follow-up data of a Dutch randomized controlled trial on the implementation of a locally adapted guideline were used. The study involved 30 general practices and 1283 patients. Treatment targets differed between study groups [HbA1c \leq 8.0% and blood pressure (BP) $<$ 140/85% versus HbA1c \leq 8.5% and BP $<$ 150/85]. Clinical inertia was defined as the failure to intensify therapy when indicated. A complete medication profile of all participating

patients was obtained. Results: In the intervention and control group, the percentages of patients with poor diabetes or lipid control who did not receive treatment intensification were 45% and 90%, approximately. More control group patients with BP levels above target were confronted with inertia (72.7% versus 63.3%, $P < 0.05$). In poorly controlled hypertensive patients, inertia was associated with the height of systolic BP at baseline [adjusted odds ratio (OR) 0.98, 95% confidence interval (CI) 0.98-0.99] and the frequency of BP control (adjusted OR 0.89, 95% CI 0.81-0.99). If a practice nurse managed these patients, clinical inertia was less common (adjusted OR 0.12, 95% CI 0.02-0.91). In both study groups, cholesterol decreased significantly more in patients who received proper treatment intensification. Conclusion: GPs were more inclined to control blood glucose levels than BP or cholesterol levels. Inertia in response to poorly controlled high BP was less common if nurses assisted GPs

van Lieshout, Jan, Wensing, Michel, and Grol, Richard. Improvement of primary care for patients with chronic heart failure: a pilot study. *BMC Health Services Research* 10(1), 8. 2010.

<http://dx.doi.org/10.1186/1472-6963-10-8>

<http://www.biomedcentral.com/1472-6963/10/8>

Background: Many patients with chronic heart failure (CHF) receive treatment in primary care, but data have shown that the quality of care for these patients needs to be improved. We aimed to evaluate the impact and feasibility of a programme for improving primary care for patients with CHF. Methods: An observational study was performed in 19 general practices in the south-eastern part of the Netherlands, evaluation involving 15 general practitioners and 77 CHF patients. The programme for improvement comprised educational and organizational components and was delivered by a trained practice visitor to the practices. The evaluation was based on case registration forms completed by health professionals and telephone interviews. Results: Management relating to diet and physical exercise seemed to have improved as eight patients were referred to dietitians and five to physiotherapists. The seasonal influenza vaccination rate increased from 94% to 97% (75/77). No impact on smoking was observed. Pharmaceutical treatment was adjusted according to guideline recommendations in 12% of the patients (9/77); 7 patients started recommended medication and 2 patients received dosage adjustments. General practitioners perceived the programme to be feasible. Clinical task delegation to nurses and assistants increased in some practices, but collaboration with other healthcare providers remained limited. Conclusions: The improvement programme proved to have moderate impact on patient care. Its effectiveness should be tested in a larger rigorous evaluation study using modifications based on the pilot experiences

COMORBIDITY

Barber, J., et al 2009 Measuring morbidity: self-report or health care records? *Family Practice* Epub ahead of publication 17-12-2009.

<http://dx.doi.org/10.1093/fampra/cmp098>

<http://pmid.us/20019091>

Background: Epidemiological surveys often rely on self-report as a measure of morbidity in a population. However, these data can also be extracted from primary care records. Objective: To compare morbidity estimates based on self-report with those obtained from primary care records. Methods: A cross-sectional survey and accompanying medical record review were carried out in all consenting adults aged ≥ 50 years in three general practices in North Staffordshire, UK. Self-reported morbidity was compared with computerized general practice consultation records for the 2 years prior to the survey. Results: Of the 7878 survey responders, 5889 consented to medical record review. Agreement between self-reported and consultation data was excellent for diabetes. Agreement between the two sources of data was lower for hypertension, heart problems, chest problems and eyesight problems. It was poor for deafness and falls. Conclusions: Self-report and consultation data provide comparable estimates of the prevalence of specific diagnoses such as diabetes. For other conditions, self-report and consultation records provide different measures of prevalence, and the choice of measure will depend on the morbidity being studied

Caughey, G et al 2009 Comorbid chronic diseases, discordant impact on mortality in the elderly; a 14 year longitudinal population study. *Journal of Epidemiology and Community Health* Epub ahead of publication 23-10-2009.

<http://dx.doi.org/10.1136/jech.2009.088260>

<http://pmid.us/19854745>

To determine the impact of comorbid chronic diseases on mortality in the elderly. Prospective cohort study, (1992-2006). Associations between numbers of chronic diseases or mutually exclusive comorbid chronic diseases on mortality over 14 years, by Cox-proportional hazards model adjusting for socio-demographic variables or kaplan-meier analyses, respectively. Population based, Australia. 2087 randomly selected participants aged ≥ 65 years old, living in the community or institutions. Participants with 3-4 diseases or ≥ 5 had a 25% (95% CI 1.05-1.5, $p=0.01$) and 80% (95% CI 1.5-2.2, $p<0.0001$) increased risk of mortality, respectively, by comparison with no chronic disease, after adjusting for age, sex and residential status. When cardiovascular disease (CVD), mental health problem or diabetes were comorbid with arthritis there was a trend toward increased survival (range 8.2-9.5 years) by comparison with CVD, mental health problem or diabetes alone (survival 5.8-6.9 years). This increase in survival with arthritis as a comorbidity was negated when CVD and mental health problems or CVD and diabetes were present in disease combinations together. Elderly persons with ≥ 3 chronic diseases have increased risk of mortality, but discordant effects on survival dependant on specific disease combinations. These results raise the hypothesis that patients who have an increased likelihood of opportunity for care from their physician are

more likely to have comorbid diseases detected and managed

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

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

<http://pmid.us/19884124>

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

GOVERNANCE

Sheaff, Rod, et al Network resilience in the face of health system reform. *Social Science & Medicine* Epub ahead of print 5/1/2010

<http://dx.doi.org/10.1016/j.socscimed.2009.11.011>

<http://pmid.us/20056304>

Many health systems now use networks as governance structures. Network 'macroculture' is the complex of artefacts, espoused values and unarticulated assumptions through which network members coordinate network activities. Knowledge of how network macroculture during 2006-2008 develops is therefore of value for understanding how health networks operate, how health system reforms affect them, and how networks function (and can be used) as governance structures. To examine how quasi-market

reforms impact upon health networks' macrocultures we systematically compared longitudinal case studies of these impacts across two care networks, a programme network and a user-experience network in the English NHS. We conducted interviews with key informants, focus groups, non-participant observations of meetings and analyses of key documents. We found that in these networks, artefacts adapted to health system reform faster than espoused values did, and the latter adapted faster than basic underlying assumptions. These findings contribute to knowledge by providing empirical support for theories which hold that changes in networks' core practical activity are what stimulate changes in other aspects of network macroculture. The most powerful way of using network macroculture to manage the formation and operation of health networks therefore appears to be by focusing managerial activity on the ways in which networks produce their core artefacts

HEALTH ECONOMICS

Chung S et al 2009 Does the Frequency of Pay-for-Performance Payment Matter?- Experience from a Randomized Trial. *Health Services Research* Epublication ahead of print 31/12/2009

Objective. To examine the effects of incentive payment frequency on quality measures in a physician-specific pay-for-performance (P4P) experiment. Study Setting. A multispecialty physician group practice. Study Design. In 2007, all primary care physicians (n=179) were randomized into two study arms differing by the frequency of incentive payment, either four quarterly bonus checks or a single year-end bonus (maximum of U.S.\$5,000/year for both arms). Data Collection/Extraction Methods. Data were extracted from electronic health records. Quality measure scores between the two arms over four quarters were compared. Principal Findings. There was no difference between the two arms in average quality measure score or in total bonus amount earned. Conclusions. Physicians' responses to a P4P program with a small maximum bonus do not differ by frequency of bonus payment.

Elliott, R, et al 2009 The role of the staff MFF in distributing NHS funding: taking account of differences in local labour market conditions. *Health Economics* Epub ahead of publication 4-8-2009.

<http://dx.doi.org/10.1002/hec.1489>

<http://pmid.us/19653330>

The National Health Service (NHS) in England distributes substantial funds to health-care providers in different geographical areas to pay for the health care required by the populations they serve. The formulae that determine this distribution reflect populations' health needs and local differences in the prices of inputs. Labour is the most important

input and area differences in the price of labour are measured by the Staff Market Forces Factor (MFF). This Staff MFF has been the subject of much debate. Though the Staff MFF has operated for almost 30 years this is the first academic paper to evaluate and test the theory and method that underpin the MFF. The theory underpinning the Staff MFF is the General Labour Market method. The analysis reported here reveals empirical support for this theory in the case of nursing staff employed by NHS hospitals, but fails to identify similar support for its application to medical staff. The paper demonstrates the extent of spatial variation in private sector and NHS wages, considers the choice of comparators and spatial geography, incorporates vacancy modelling and illustrates the effect of spatial smoothing.

Martin-Fernandez, J., et al 2009 Perception of the economic value of primary care services: A willingness to pay study. *Health Policy* Epub ahead of publication 27-11-2009.

<http://dx.doi.org/10.1016/j.healthpol.2009.11.001>

<http://pmid.us/19945763>

Objective: Identify the economic value the user attributes to the visit to the family physician, in a setting of a National Health System, by the Willingness to Pay (WTP) expressed. Methods: Economic evaluation study, by the contingent valuation method. Questions were asked about WTP using a payment card format. Interviews were conducted with 451 subjects, in areas with different socioeconomic characteristics. An ordered probit was used to evaluate model's validity. RESULTS: Median WTP expressed was euro18 (interquartile range euro8-28), not including "zero-answers" of thirty-four subjects (7.5%). This value represents 2% of average adjusted family incomes. Patients with higher incomes or with chronic illnesses presented a probability of 5-14 percentage points of expressing a high WTP. For every point of increase of patient satisfaction, the probability of presenting a WTP in the lowest range decreases 7.0 percentage points. Subjects with a low education level and those older than 65 expressed a lower WTP. Accessibility, risk perception, nationality and having private insurance were not related to the WTP expressed. Conclusions: Users of primary care have a clear perception of the economic value of care received from the family physician, even in a framework of providing services financed by taxes and without cost at the moment of use. This value increases in subjects with higher incomes, with greater need for care, or more satisfied:

HEALTH INEQUALITIES

Bambra, Clare, et al 2009 Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. *Journal of Epidemiology and Community Health* Epub ahead of print 19-8-2009.

<http://dx.doi.org/10.1136/jech.2008.082743>

<http://pmid.us/19692738>

There is increasing pressure to tackle the wider social determinants of health, through the implementation of appropriate interventions. However, turning these demands for better evidence about interventions around the social determinants of health into action requires identifying what we already know and highlighting the evidence gaps. Systematic review methodology was used to identify systematic reviews (from 2000-2007, developed countries only) that described the health effects of any intervention based on the wider social determinants of health: water and sanitation, agriculture and food, access to health and social care services, unemployment and welfare, work conditions, housing and living environment, education, and transport. Thirty systematic reviews were identified. Certain categories of intervention may impact positively on health, in particular interventions in the fields of housing and work. However, there were clear gaps in the evidence, and the effects of interventions on health inequalities were unclear. Intervention studies which address inequalities in health are a priority area for future public health research

Kondo, Naoki, et al 2009 Income inequality, mortality, and self rated health: meta-analysis of multilevel studies. *British Medical Journal* 339:b4471. 10/11/2009

<http://dx.doi.org/10.1136/bmj.b4471>.

<http://pmid.us/19903981>

Objective To provide quantitative evaluations on the association between income inequality and health. **Design** Random effects meta-analyses, calculating the overall relative risk for subsequent mortality among prospective cohort studies and the overall odds ratio for poor self rated health among cross sectional studies. **Data sources** PubMed, the ISI Web of Science, and the National Bureau for Economic Research database. **Review methods** Peer reviewed papers with multilevel data. **Results** The meta-analysis included 59 509 857 subjects in nine cohort studies and 1 280 211 subjects in 19 cross sectional studies. The overall cohort relative risk and cross sectional odds ratio (95% confidence intervals) per 0.05 unit increase in Gini coefficient, a measure of income inequality, was 1.08 (1.06 to 1.10) and 1.04 (1.02 to 1.06), respectively. Meta-regressions showed stronger associations between income inequality and the health outcomes among studies with higher Gini (≥ 0.3), conducted with data after 1990, with longer duration of follow-up (>7 years), and incorporating time lags between income inequality and outcomes. By contrast, analyses accounting for unmeasured regional characteristics showed a weaker association between income inequality and health. **Conclusions** The results suggest a modest adverse effect of income inequality on health, although the population impact might be larger if the association is truly causal. The results also support the threshold effect hypothesis, which posits the existence of a threshold of income inequality beyond which adverse impacts on health begin to emerge. The findings need to be interpreted with caution given the heterogeneity between studies, as well as

the attenuation of the risk estimates in analyses that attempted to control for the unmeasured characteristics of areas with high levels of income inequality

Rosa, Dias P. 2009 Inequality of opportunity in health: evidence from a UK cohort study. *Health Economics* 18(9), 1057-1074.

<http://dx.doi.org/10.1002/hec.1535>

<http://pmid.us/19644964>

This paper proposes an empirical implementation of the concept of inequality of opportunity in health and applies this to data from the UK National Child Development Study. Drawing on the distinction between circumstance and effort variables in John Roemer's work on equality of opportunity, circumstances are proxied by parental socio-economic status and childhood health; effort is proxied by health-related lifestyles and educational attainment. Stochastic dominance tests are used to detect inequality of opportunity in the conditional distributions of self-assessed health in adulthood. Two alternative approaches are used to measure inequality of opportunity. Econometric models are estimated to illuminate and quantify the triangular relationship between circumstances, effort and health. The results indicate the existence of a considerable and persistent inequality of opportunity in health. Circumstances affect health in adulthood both directly and through effort factors such as educational attainment. This indicates that, while the influence of some unjust circumstances can only be tackled during childhood, the implementation of complementary educational policies may be of paramount importance

INFORMATION AND COMMUNICATION TECHNOLOGIES

Advocat, Jenny and Lindsay, Jo. Internet-based trials and the creation of health consumers. *Social Science & Medicine* 70(3), 485-492. 2010.

<http://dx.doi.org/10.1016/j.socscimed.2009.10.051>

<http://pmid.us/19926185>

In this paper we document the experience of participating in novel randomised controlled trials for panic disorder - where face-to-face and Internet delivery of cognitive behavioural therapy are compared. Our analysis is based on 18 months of observation and in-depth interviews with 10 trial participants and 8 trialists in Victoria, Australia. We argue that the participants are positioned as active health consumers and approach the trial as they would other self-help practices. High levels of individual responsibility are assumed of participants in these trials, which they accept by approaching the trials reflexively and searching for information and strategies they can employ while building their health literacy on panic disorder. Although the researchers set the parameters of the

treatment and interaction, increasingly the participants choose the extent to which they will comply with their defined role. For the participants the trial is one of the 'pick and mix' options of available treatment and we suggest it is a compelling example of contemporary health consumption

Crowe, S., Tully, M. P., and Cantrill, J. A. Information in general medical practices: the information processing model. *Family Practice* Epub ahead of publication 18-12-2009.

<http://dx.doi.org/10.1093/fampra/cmp102>

<http://pmid.us/20022907>

Background: The need for effective communication and handling of secondary care information in general practices is paramount. Objective: To explore practice processes on receiving secondary care correspondence in a way that integrates the information needs and perceptions of practice staff both clinical and administrative. Methods: Qualitative study using semi-structured interviews with a wide range of practice staff (n = 36) in nine practices in the Northwest of England. Analysis was based on the framework approach using N-Vivo software and involved transcription, familiarization, coding, charting, mapping and interpretation. Results: The 'information processing model' was developed to describe the six stages involved in practice processing of secondary care information. These included the amendment or updating of practice records whilst simultaneously or separately actioning secondary care recommendations, using either a 'one-step' or 'two-step' approach, respectively. Many factors were found to influence each stage and impact on the continuum of patient care. Conclusion: The primary purpose of processing secondary care information is to support patient care; this study raises the profile of information flow and usage within practices as an issue requiring further consideration

Williams, Brian, et al 2010 Developing a longitudinal database of routinely recorded primary care consultations linked to service use and outcome data. *Social Science & Medicine* 70(3), 473-478. 2010.

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

<http://pmid.us/19896255>

The primary care consultation provides access to the majority of health care services and is central to obtaining diagnoses, treatment and ongoing management of long-term conditions. This paper reports the findings of an interdisciplinary feasibility study to explore the benefits and practical, technical and ethical challenges (and solutions) of creating a longitudinal database of recorded GP consultations in Tayside, Scotland which could be linked to existing routine data on intermediate and long-term health outcomes. After consultation we attempted to recruit and audio-record the consultations of all patients attending three general practices over a two week period. Background patient data, and patient and staff experiences of participation were also collected. Eventually,

two practices participated with 77% of patients approached agreeing to participate. The findings suggest that the perceived integrity of the consultation was preserved. The overwhelming majority of patients believed that recording was worthwhile and did not feel it impacted on communication or the treatment they received; 93% indicated they would be willing to have subsequent consultations recorded and 81% would recommend participation to a friend. Staff had similar beliefs but raised concerns about potential increases in workload, confidentiality issues and ease of software use. We conclude that practice participation could be increased by providing safeguards on data use, financial reward, integrated recording software, and procedures to lessen the impact on workload. The resulting Scottish Clinical Interactions Project (SCIP) would provide the largest and most detailed longitudinal insight into real world medical consultations in the world, permitting the linking of consultation events and practices to subsequent outcomes and behaviours

MEDICINES MANAGEMENT

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

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

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

<http://pmid.us/19772551>

Background: The UK, USA and the World Health Organization have identified improved patient safety in healthcare as a priority. Medication error has been identified as one of the most frequent forms of medical error and is associated with significant medical harm. Errors are the result of the systems that produce them. In industrial settings, a range of systematic techniques have been designed to reduce error and waste. The first stage of these processes is to map out the whole system and its reliability at each stage. However, to date, studies of medication error and solutions have concentrated on individual parts of the whole system. In this paper we wished to conduct a systematic review of the literature, in order to map out the medication system with its associated errors and failures in quality, to assess the strength of the evidence and to use approaches from quality management to identify ways in which the system could be made safer. Methods: We mapped out the medicines management system in primary care in the UK. We conducted a systematic literature review in order to refine our map of the system and to establish the quality of the research and reliability of the system. Results: The map demonstrated that the proportion of errors in the management system for medicines in primary care is very high. Several stages of the process had error rates of 50% or more: repeat prescribing reviews, interface prescribing and communication and patient adherence. When including the efficacy of the medicine in the system, the available evidence suggested that only between 4% and 21% of patients achieved the optimum benefit from their medication. Whilst there were some limitations in the evidence base,

including the error rate measurement and the sampling strategies employed, there was sufficient information to indicate the ways in which the system could be improved, using management approaches. The first step to improving the overall quality would be routine monitoring of adherence, clinical effectiveness and hospital admissions. Conclusion: By adopting the whole system approach from a management perspective we have found where failures in quality occur in medication use in primary care in the UK, and where weaknesses occur in the associated evidence base. Quality management approaches have allowed us to develop a coherent change and research agenda in order to tackle these, so far, fairly intractable problems

Granlund, David. Are private physicians more likely to veto generic substitution of prescribed pharmaceuticals? *Social Science & Medicine* 69(11), 1643-1650. 2009.

<http://dx.doi.org/10.1016/j.socscimed.2009.09.016>

<http://pmid.us/19815322>

Physicians' decisions whether or not to veto generic substitution were analyzed using a sample of 350,000 pharmaceutical prescriptions from the county of VΣsterbotten, Sweden. Although generic substitution reforms have been introduced in many European countries and American states, this is to my knowledge the first study on this topic. The topic is important since physicians' decisions regarding generic substitution not only directly affect patients' and insurers' costs for pharmaceuticals, but also indirectly since more bans against substitution reduces price-competition between pharmaceutical firms. The primary purpose was to test if physicians working at private practices were more likely to oppose substitution than county-employed physicians working on salary. It was found that private physicians were 50-80% more likely to veto substitution. Also, the probability of a veto was found to increase as patients' copayments decreased. This might indicate moral hazard in insurance, though other explanations are plausible

Hobson, R. J., Scott, J., and Sutton, J. 2009 Pharmacists and nurses as independent prescribers: exploring the patient's perspective. *Family Practice Epub ahead of publication* 26-10-2009.

<http://dx.doi.org/10.1093/fampra/cmp070>

<http://pmid.us/19858124>

Background: Little is known about patients' opinions upon the development of non-medical prescribing (NMP). Objective: To explore the opinions of patients on the development of NMP. Method: In-depth interviews using qualitative methodology (Interpretative Phenomenological Analysis). Eighteen interviews were undertaken in Bristol (Sites 1 and 3), Swindon (Site 2) and Brighton (Site 4). [Site 1 = primary care, GP prescriber (n = 5), Site 2 = secondary care, consultant prescriber (n = 5), Site 3 = primary care (n = 5) and Site 4 = secondary care (n = 3) (both pharmacist supplementary prescribers.) Participants (n = 18) were randomly sampled from patients under the care of

the participating prescriber. Participants were aged between 42 and 81 years of age (n = 11 male and n = 7 female). Interviews took place between January and August 2006. Results: Participants expressed concerns about clinical governance, privacy and whether sufficient space were available to provide the service in community pharmacies. Participants acknowledged the expert drug knowledge of pharmacists and their accessibility. These factors enhanced acceptability of this role for pharmacists. Nurses were highly regarded, accepted and preferred as prescribers with few concerns. Conclusions: The results indicate support for pharmacists and nurses as prescribers, which aid successful implementation. Further research may be needed to evaluate the level of understanding that the public has of NMP and their views of the service once NMP is more widely established. Stakeholders should be mindful that the public may be hesitant regarding the professionalism, quality and clinical governance standards of clinics in community pharmacies in particular

Prados-Torres, Alexandra, et al 2009 Pharmaceutical cost control in primary care: opinion and contributions by healthcare professionals. *BMC Health Services Research* 9(1), 209.

<http://dx.doi.org/10.1186/1472-6963-9-209>

<http://www.biomedcentral.com/1472-6963/9/209>

<http://pmid.us/19922620>

Background: Strategies adopted by health administrations and directed towards drug cost control in primary care (PC) can, according to earlier studies, generate tension between health administrators and healthcare professionals. This study collects and analyzes the opinions of general practitioners (GPs) regarding current cost control measures as well as their proposals for improving the effectiveness of these measures. Methods: A qualitative exploratory study was carried out using 11 focus groups composed of GPs from the Spanish regions of Aragon, Catalonia and the Balearic Islands. A semi-structured guide was applied in obtaining the GPs' opinions. The transcripts of the dialogues were analyzed by two investigators who independently considered categorical and thematic content. The results were supervised by other members of the team, with overall responsibility assigned to the team leader. RESULTS: GPs are conscious of their public responsibility with respect to pharmaceutical cost, but highlight the need to spread responsibility for cost control among the different actors of the health system. They insist on implementing measures to improve the quality of prescriptions, avoiding mere quantitative evaluations of prescription costs. They also suggest moving towards the self-management of the pharmaceutical budget by each health centre itself, as a means to design personalized incentives to improve their outcomes. These proposals need to be considered by the health administration in order to pre-empt the feelings of injustice, impotence, frustration and lack of motivation that currently exist among GPs as a result of the implemented measures. ConclusionS: Future investigations should be oriented toward strategies that involve GPs in the planning and management of drug cost control mechanisms. The proposals in this study may be considered by the health administration as a means to move toward the rational use of drugs while avoiding concerns about

injustice and feelings of impotence on the part of the GPs, which can lead to lack of interest in and disaffection with the current measures

Sayers, Y. M., Armstrong, P., and Hanley, K. 2009 Prescribing errors in general practice: a prospective study. *European Journal of General Practice* 15(2), 81-83..

<http://dx.doi.org/10.1080/13814780802705984>

<http://pmid.us/19169911>

Prescribing is one of the commonest tasks in daily general practice. Surprisingly there is little published research on errors that occur in this area. The aim of this study was to estimate the seriousness and level of prescribing errors that occurred in general practice. This prospective survey documented errors in prescriptions from 28 general practitioners as they occurred over a 3-day period in 12 community pharmacies. From a total of 3,948 prescriptions, 491 (12.4%) contained one or more errors. From a total of 8,686 drug items, 546 (6.2%) contained one or more errors. Of the errors the majority were minor (398, 72.9%), a smaller number (135, 24.7%) were major nuisance errors, and there were 13 (2.4%) potentially serious errors. The most common errors related to drug directions and dosage

Vegda, K., et al Trends in health services utilization, medication use, and morbidity among older adults: a 2-year retrospective chart review in a primary care practice. *BMC Health Services Research* 9(1), 217. 30-11-2009.

<http://dx.doi.org/10.1186/1472-6963-9-217>

<http://www.biomedcentral.com/1472-6963/9/217>

<http://pmid.us/19948033>

Background: Population aging poses significant challenges to primary care providers and healthcare policy makers. Primary care reform can alleviate the pressures, but these initiatives require clinical benchmarks and evidence regarding utilization patterns. The objectives of this study is to measure older patients' use of health services, number of health conditions, and use of medications at the level of a primary care practice, and to investigate age- and gender-related utilization trends. Methods: A cross-sectional chart audit over a 2-year study period was conducted in the academic family practice clinic of Sunnybrook Health Sciences Centre in Toronto, Ontario, Canada. All patients 65 years and older (n=2450) were included. Main outcome measures included the number of family physician visits, specialist visits, emergency room visits, surgical admissions, diagnostic test days, inpatient hospital admissions, health conditions, and medications. Results: Older patients (80-84 and 85+ age-group) had significantly more family physician visits (average of 4.4 visits per person per year), emergency room visits (average of 0.22 ER visits per year per patient), diagnostic days (average of 5.1 test days per person per year), health conditions (average of 7.7 per patient), and medications average of 8.2 medications per person). Gender differences were also observed: females had significantly more family physician visits and number of medications, while men had

more specialist visits, emergency room visits, and surgical admissions. There were no gender differences for inpatient hospital admissions and number of health conditions. With the exception of the 85+ age group, we found greater intra-group variability with advancing age. Conclusions: The data present a map of greater interaction with and dependency on the health care system with advancing age. The magnitudes are substantial and indicate high demands on patients and families, on professional health care providers, and on the health care system itself. There is the need to create and evaluate innovative models of care of multiple chronic conditions in the late life course

Watson, M. C., Cleland, J. A., and Bond, C. M. Simulated patient visits with immediate feedback to improve the supply of over-the-counter medicines: a feasibility study. *Family Practice* 26(6), 532-542. 2009.

<http://dx.doi.org/10.1093/fampra/cmp061>

<http://pmid.us/19828574>

Background: The supply of over-the-counter (OTC) medicines from community pharmacies should be safe and effective, but there is evidence that appropriate practice is not always achieved. The primary objective of this study was to assess the acceptability of simulated patient (SP) visits combined with feedback, delivered by either SPs or pharmacy educators (PEs), as a method for improving the supply of OTC medicines in community pharmacies. Methods: This feasibility study used a randomized controlled trial design where participating pharmacies were randomized into two groups (SP or PE, feedback). SP visits were audiotaped and questionnaire data collected from participants post-intervention. Each pharmacy received three covert visits from SPs. Feedback was provided immediately after the first and second visits. Data were collected on information gathering and advice provision. The visits were assessed for minimum standards of practice and appropriateness of outcome. Results: Twenty-two pharmacists and 34 medicine counter assistants (MCAs) from 20 community pharmacies in Grampian, Scotland, participated. Sixty SP visits were completed (three per pharmacy) and were well received, particularly by the pharmacists. Similar results were shown across both study groups in terms of information gathering and information/advice provision during consultations. Few SP consultations achieved the minimum standard of practice although most resulted in an appropriate outcome. Conclusions: SP visits with feedback were acceptable to pharmacists as a method of improving the quality of consultations for OTC medicines, irrespective of the person giving feedback (SP or PE). The process by which pharmacists and their staff derived their recommendations, in terms of information gathering, could be improved. A large-scale study is needed to assess the effectiveness and cost-effectiveness of SP visits with feedback

MENTAL HEALTH

Dowrick, Christopher, et al 2009 Researching the mental health needs of hard-to-reach groups: managing multiple sources of evidence. *BMC Health Services Research* 9(1), 226. 2009.

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

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

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

England, E., Lester, H., and Birchwood, M. 2009 Collaborating to provide early-intervention services to persons in England with first-episode psychosis. *Psychiatric Services* 60(11), 1484-1488.

<http://dx.doi.org/10.1176/appi.ps.60.11.1484>

<http://pmid.us/19880466>

Objective: This qualitative study explores the experiences of stakeholders in implementing the guidance for early-intervention services (EIS) for first-episode psychosis in England. One important challenge in implementing early-intervention policy

is to develop workable, integrated partnership across a number of diverse organizational boundaries, particularly with child and adolescent mental health services (CAMHS). Methods: A series of 142 semistructured interviews and six focus groups involving 31 people were undertaken between February 2004 and September 2007. A broad range of individuals were interviewed from different strategic, managerial, and operational levels of the health service. Results: A main finding was the challenge experienced by a majority of EIS agencies in developing partnerships with CAMHS. Elements that led to more successful partnership development included joint learning and training, senior-level "champions" of the partnership, joint operational policy or protocol development, and use of specific CAMHS-EIS link workers. The most successful approach was to develop a separate youth-focused service that placed multiple teams and organizations responsive to younger people's needs (including education, employment guidance, social activities, pregnancy services, and peer support) under one roof. Conclusions: This study highlights that traditional hierarchical models of policy implementation may be less successful in achieving the goal of collaborative partnerships at the interface between CAMHS and EIS. The most successful model of working between CAMHS and EIS required an innovative approach to commissioning, policy implementation, and service development. The findings from this study may help determine the best model of partnership development for EIS and CAMHS in England

Giron, M., et al Self-reported chronic mental health problems and mental health service use in Spain. *Chronic Illness*. 5(3), 197-208. 2009

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

<http://pmid.us/19666955>

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

Landstedt, E., Asplund, K., and Gillander, Gadin K. Understanding adolescent mental health: the influence of social processes, doing gender and gendered power relations. *Sociology of Health and Illness* 31(7), 962-978. 2009.

<http://dx.doi.org/10.1111/j.1467-9566.2009.01170.x>

<http://pmid.us/19659740>

Despite a well-documented gender pattern in adolescent mental health, research investigating possible explanatory factors from a gender-theoretical approach is scarce. This paper reports a grounded theory study based on 29 focus groups. The aim was to explore 16- to 19-year-old students' perceptions of what is significant for mental health, and to apply a gender analysis to the findings in order to advance understanding of the gender pattern in adolescent mental health. Significant factors were identified in three social processes categories, including both positive and negative aspects: (1) social interactions, (2) performance and (3) responsibility. Girls more often experienced negative aspects of these processes, placing them at greater risk for mental health problems. Boys' more positive mental health appeared to be associated with their low degree of responsibility-taking and beneficial positions relative to girls. Negotiating cultural norms of femininity and masculinity seemed to be more strenuous for girls, which could place them at a disadvantage with regard to mental health. Social factors and processes (particularly responsibility), gendered power relations and constructions of masculinities and femininities should be acknowledged as important for adolescent mental health.

Munthugh, Anna, et al Collaborative stepped care for anxiety disorders in primary care: aims and design of a randomized controlled trial. *BMC Health Services Research* 9(1), 159. 2009.

<http://dx.doi.org/10.1186/1472-6963-9-159>

<http://www.biomedcentral.com/1472-6963/9/159>

<http://pmid.us/19737403>

Background: Panic disorder (PD) and generalized anxiety disorder (GAD) are two of the most disabling and costly anxiety disorders seen in primary care. However, treatment quality of these disorders in primary care generally falls beneath the standard of international guidelines. Collaborative stepped care is recommended for improving treatment of anxiety disorders, but cost-effectiveness of such an intervention has not yet been assessed in primary care. This article describes the aims and design of a study that is currently underway. The aim of this study is to evaluate effects and costs of a collaborative stepped care approach in the primary care setting for patients with PD and GAD compared with care as usual. Methods/Design: The study is a two armed, cluster randomized controlled trial. Care managers and their primary care practices will be randomized to deliver either collaborative stepped care (CSC) or care as usual (CAU). In the CSC group a general practitioner, care manager and psychiatrist work together in a collaborative care framework. Stepped care is provided in three steps: 1) guided self-help,

2) cognitive behavioral therapy and 3) antidepressant medication. Primary care patients with a DSM-IV diagnosis of PD and/or GAD will be included. 134 completers are needed to attain sufficient power to show a clinically significant effect of 1/2 SD on the primary outcome measure, the Beck Anxiety Inventory (BAI). Data on anxiety symptoms, mental and physical health, quality of life, health resource use and productivity will be collected at baseline and after three, six, nine and twelve months. Discussion: It is hypothesized that the collaborative stepped care intervention will be more cost-effective than care as usual. The pragmatic design of this study will enable the researchers to evaluate what is possible in real clinical practice, rather than under ideal circumstances. Many requirements for a high quality trial are being met. Results of this study will contribute to treatment options for GAD and PD in the primary care setting. Results will become available in 2011

O'Connor, E. A., et al 2009 Screening for depression in adult patients in primary care settings: a systematic evidence review. *Annals of Internal Medicine* 151(11), 793-803. 1-12-2009

<http://dx.doi.org/10.1059/0003-4819-151-11-200912010-00007>

<http://pmid.us/19949145>

Background: In primary care settings, prevalence estimates of major depressive disorder range from 5% to 13% in all adults, with lower estimates in those older than 55 years (6% to 9%). In 2002, the U.S. Preventive Services Task Force (USPSTF) recommended screening adults for depression in clinical practices that have systems to ensure accurate diagnosis, effective treatment, and follow-up. Purpose: To conduct a targeted, updated systematic review for the U.S. Preventive Services Task Force about the benefits and harms of screening adult patients for depression in a primary care setting, the benefits of depression treatment in older adults, and the harms of depression treatment with antidepressant medications. Data sources: MEDLINE, the Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effects, PsycINFO (1998 to 2007), expert suggestions, and bibliographies of recent systematic reviews. Study selection: Fair- to good-quality randomized clinical trials or controlled clinical trials; systematic reviews; meta-analyses; and large observational studies of serious adverse events and early discontinuation due to adverse effects. All studies were published in English. Data extraction: Two investigators abstracted, critically appraised, and synthesized 33 articles that met inclusion criteria. Data synthesis: Nine fair- or good-quality trials indicate that primary care depression screening and care management programs with staff assistance, such as case management or mental health specialist involvement, can increase depression response and remission. Benefit was not evident in screening programs without staff assistance in depression care. Seven regulatory reviews or meta-analyses and 3 large cohort studies indicate no increased risk for completed suicide deaths with antidepressant treatment. Risk for suicidal behaviors was increased in young adults (aged 18 to 29 years) who received antidepressants, particularly those who received paroxetine, but was reduced in older adults. Limitation: Examination of harms was limited to serious adverse events, and existing systematic reviews were primarily used. Additional studies published from 2007

to 2008 extend this review. Conclusion: Depression screening programs without substantial staff-assisted depression care supports are unlikely to improve depression outcomes. Close monitoring of all adult patients who initiate antidepressant treatment, particularly those younger than 30 years, is important both for safety and to ensure optimal treatment

Pierce, R. 2009 A changing landscape for advance directives in dementia research. *Social Science and Medicine* Epub ahead of print 22-11-2009.

<http://dx.doi.org/10.1016/j.socscimed.2009.10.037>

<http://pmid.us/19932546>

The number of persons afflicted by dementia has increased steadily. The need for research leading to diagnostic and therapeutic interventions is widely recognized. However, dementia patients eventually lose the capacity to consent to the very research that could lead to discoveries of effective interventions. Worldwide, surrogate decision-making remains the primary means of consent for this population. This significantly restricts the autonomy of competent patients who wish to prospectively consent to research and do not wish to relinquish this decision to a third party. Advance research directives (ARDs) have been proposed as a mechanism for prospective consent for persons who anticipate cognitive impairment, as in the case of prodromal or early stage dementia patients. Currently, few guidelines specifically address the use of ARDs despite calls for official recognition. This absence of official guidelines regarding ARDs renders this mechanism susceptible to misuse, under-use, or non-use in instances where it could be advantageous for individuals, their families/caregivers, and progress in dementia research and treatment. This paper explores the changing landscape of ARDs, identifying relevant scientific, social, and policy developments, and queries whether, under these circumstances, reticence to use, recognize, or regulate ARDs is justified. It addresses some of the persistent issues related to vulnerability, the role of surrogates, and scope of prospective consent, and concludes that ARDs can serve as an important mechanism of autonomy and empowerment, and that protections should be crafted such that the availability of this option is not limited to those who also appoint a surrogate

Poutanen O et al 2009 Gender differences in the symptoms of major depression and in the level of social functioning in public primary care patients. *European Journal of General Practice* Epub ahead of print August 2009

<http://dx.doi.org/10.1080/13814780903186423>

<http://pmid.us/19685381>

Background: There are no great differences in the symptom profiles of depression between the genders in observer rating scales, but women self-report more symptoms. Objective: To compare gender differences in symptom profiles of clinical depression in

primary care with a short self-report depression scale and an observer-rated scale for social functioning. Methods: A sample of 436 primary care patients aged 18-64 years were screened using the Depression Scale (DEPS) and interviewed using the Present State Examination (PSE). Level of social functioning was also assessed. Sum scores and single items of DEPS were compared between men and women in the groups of both depressive and non-depressive patients, and the interactions between gender and depression were analysed. Results: Depressive men scored poorer on both instruments. Feeling that everything is an effort and feeling worthless were typical for depressive men. Feeling blue was more typical for non-depressive women than for non-depressive men. Conclusion: In this sample of primary care patients, there were differences in the symptom profiles of depression between men and women. Depressive men more commonly had serious symptoms than depressive women. Clinically, male depression deserves more attention. The psychosocial profile of public primary care patients in Finland warrants further research.

Rait, G., et al Recent trends in the incidence of recorded depression in primary care. *British Journal of Psychiatry* 195(6), 520-524. 2009.

<http://dx.doi.org/10.1192/bjp.bp.108.058636>

<http://pmid.us/19949202>

Background: There is a paucity of data describing how general practitioners (GPs) label or record depression. Aims: To determine incidence and sociodemographic variation in GP-recorded depression diagnoses and depressive symptoms. Method: Annual incidence rates calculated using data from 298 UK general practices between 1996 and 2006, adjusted for year of diagnosis, gender, age and deprivation. Results: Incidence of diagnosed depression fell from 22.5 to 14.0 per 1000 person-years at risk (PYAR) from 1996 to 2006. The incidence of depressive symptoms rose threefold from 5.1 to 15.5 per 1000 PYAR. Combined incidence of diagnoses and symptoms remained stable. Diagnosed depression and symptoms were more common in women and in more deprived areas. Conclusions: Depression recorded by general practitioners has lower incidence rates than depression recorded in epidemiological studies, although there are similar associations with gender and deprivation. General practitioners increasingly use symptoms rather than diagnostic labels to categorize people's illnesses. Studies using standardised diagnostic instruments may not be easily comparable with clinical practice:

Rajmil, Luis, et al 2009 Effect on health-related quality of life of changes in mental health in children and adolescents. *Health and Quality of Life Outcomes* 7(1), 103. 2009.

<http://dx.doi.org/10.1186/1477-7525-7-103>

<http://www.hqlo.com/content/7/1/103>

<http://pmid.us/20030835>

Background: The objective of the study was to assess the effect of changes in mental health status on health-related quality of life (HRQOL) in children and adolescents aged 8 - 18 years. Methods: A representative sample of Spanish children and adolescents aged 8-18 years completed the self-administered KIDSCREEN-52 questionnaire at baseline and after 3 years. Mental health status was measured using the Strengths and Difficulties Questionnaire (SDQ). Changes on SDQ scores over time were used to classify respondents in one of 3 categories (improved, stable, worsened). Data was also collected on gender, undesirable life events, and family socio-economic status. Changes in HRQOL were evaluated using effect sizes (ES). A multivariate analysis was performed to identify predictors of poor HRQOL at follow-up. Results: Response rate at follow-up was 54% (n = 454). HRQOL deteriorated in all groups on most KIDSCREEN dimensions. Respondents who worsened on the SDQ showed the greatest deterioration, particularly on Psychological well-being (ES = -0.81). Factors most strongly associated with a decrease in HRQOL scores were undesirable life events and worsening SDQ score. Conclusions: Changes in mental health status affect children and adolescents' HRQOL. Improvements in mental health status protect against poorer HRQOL while a worsening in mental health status is a risk factor for poorer HRQOL.

Richards DA et al 2009 Collaborative Depression Trial (CADET): multi-centre randomised controlled trial of collaborative care for depression--study protocol. *BMC Health Services Research* 2009 Oct 16;9:188.

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

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

<http://pmid.us/19832996>

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

van der Zwet J., et al . Lonely patients in general practice: a call for revealing GPs' emotions? A qualitative study. *Family Practice* 26(6), 501-509. 2009.

<http://dx.doi.org/10.1093/fampra/cmp059>

<http://pmid.us/19770218>

Background: Loneliness is a universal phenomenon that influences one's health and health perception. GPs are confronted with lonely people quite often. Yet, what GPs think of this phenomenon and how they deal with emotions lonely patients evoke is not known. Objective: We aimed to explore GPs' experiences with lonely patients. We wanted to gain insight in GPs' feelings regarding consultations with lonely patients and potential resulting behaviour from these feelings. Methods: We performed a qualitative study based on semi-structured interviews. We interviewed 20 Dutch GPs. Transcripts were analysed according to a grounded theory-like method in order to bring to surface key concepts and relations between them. Results: GPs considered loneliness as something subjective, a feeling. They found it relevant to know whether their patients were lonely. However, they had difficulty defining their task and experienced a lack of therapeutic options. Beside feelings of pity and interest, lonely patients could evoke feelings of frustration and powerlessness. These feelings were more pronounced when patients were chronically lonely and could cause GPs to spend less time on these patients or refer them more often. GPs did not constructively use their own emotions during consultation. Conclusions: When confronted with lonely patients, a helpful distinction could be made between transitory and chronic loneliness. Chronically lonely patients are more likely to evoke negative feelings and behaviour in their GPs. GPs should try to recognize these emotions and make sure they do not harmfully influence consultation

Waldorff, F. B., et al The effect of reminder letters on the uptake of an e-learning programme on dementia: a randomized trial in general practice. *Family Practice* 26(6), 466-471. 2009.

<http://dx.doi.org/10.1093/fampra/cmp072>

<http://pmid.us/19858123>

Background and aims: The aim of the present study was to evaluate whether three reminder letters mailed to GPs after dissemination of a Dementia Guideline increased the GPs' use of the corresponding e-learning programme (ELP). Methods: Single-blinded randomized trial among all GPs in Copenhagen Municipality from 1 November 2006 to 1 May 2007. Results: A total of 15 of 320 GPs (4.7%) had a web-based logon during the study period. The intervention group had a significantly increased frequency of web-based logons ($P = 0.0192$) equivalent to a hazard ratio of 8.0 (95% CI: 1.03-66.1; $P = 0.047$). NNT was calculated to 22.2. We could not detect any significant differences in any of the secondary outcomes. Conclusions: Three reminder letters added to a nationwide dissemination increased the probability for a GP logon in the ELP by a Factor 8. However, in total, only a small proportion used the ELP. Thus, further research is needed

in order to consider future implementation strategies for Internet-based Continuous Medical Education activities among not primed GPs

PATIENT AND PUBLIC INVOLVEMENT

Ishikawa, H., et al Patient health literacy and patient-physician information exchange during a visit. *Family Practice* 26(6), 517-523. 2009.

<http://dx.doi.org/10.1093/fampra/cmp060>

<http://pmid.us/19812242>

Background: Health literacy (HL), the capacity of individuals to access, understand and use health information to make informed and appropriate health-related decisions, is recognized as an important concept in patient education and disease management. Objective: To examine the relation of three levels of HL (i.e. functional, communicative and critical HL) to patient-physician information exchange during a visit. Methods: Participants were 134 outpatients with type 2 diabetes who were under continuous care by four attending physicians at a university-affiliated hospital. The visit communication was recorded and analysed using the Roter Interaction Analysis System. Patient HL was measured through a self-reported questionnaire using newly developed self-rated scales of functional, communicative and critical HL. Sociodemographic and clinical characteristics and patient's perception of the information exchange were assessed for each patient through self-reported questionnaires and review of electronic medical records. Results: Patient HL levels were related to the information exchange process during the visit. Among the three HL scales, communicative HL (the capacity to extract information, derive meaning from different forms of communication and apply new information to changing circumstances) was related to patient's perceptions of the information exchange. Further, patient communicative HL had a modifying effect on the relationship between physician's information giving and patient's perception of it, suggesting that physician's communication may be perceived differently depending on the patient's HL. CONCLUSION: The exploration of patient HL may provide a better understanding of potential barriers to patient-physician communication and patient's self-management of disease

Jones, A. Creating history: documents and patient participation in nurse-patient interviews. *Sociology of Health and Illness* 31(6), 907-923. 2009.

<http://dx.doi.org/10.1111/j.1467-9566.2009.01190.x>

<http://pmid.us/19843273>

Strongly worded directives regarding the need for increased patient participation during nursing interaction with patients have recently appeared in a range of 'best-practice' documents. This paper focuses on one area of nurse-patient communication, the hospital admission interview, which has been put forward as an ideal arena for increased patient participation. It uses data from a total of 27 admission interviews, extensive periods of participant observation and analysis of nursing records to examine how hospital admission interviews are performed by nurses and patients. Analysis shows that topics discussed during admission closely follow the layout of the admission document which nurses complete during the interview. Whilst it is tempting to describe the admission document as a 'super technological power' in influencing the interaction and restricting patient participation, this analysis attempts a more rounded reading of the data. Findings demonstrate that, whilst opportunities for patient participation were rare, admission interviews are complex interactional episodes that often belie simplistic or prescriptive guidance regarding interaction between nurses and patients. In particular, issue is taken with the lack of contextual and conceptual clarity with which best-practice guidelines are written

PRIMARY/SECONDARY CARE INTERFACE

Valderas, Jose, et al Routine care provided by specialists to children and adolescents in the United States: 2002-2006. *BMC Health Services Research* 9(1), 221. 2009

<http://dx.doi.org/10.1186/1472-6963/9/221>

<http://www.biomedcentral.com/1472-6963/9/221>

Background : Specialist physicians provide a large share of outpatient health care for children and adolescents in the United States, but little is known about the nature and content of these services in the ambulatory setting. Our objective was to quantify and characterize routine and co-managed pediatric healthcare as provided by specialists in community settings. Methods: Nationally representative data were obtained from the National Ambulatory Medical Care Survey for the years 2002-2006. We included office based physicians (excluding family physicians, general internists and general pediatricians), and a representative sample of their patients aged 18 or less. Visits were classified into mutually exclusive categories based on major reason for the visit, previous knowledge of the health problem, and whether the visit was the result of a referral. Primary diagnoses were classified using Expanded Diagnostic Clusters. Physician report of sharing care for the patient with another physician and frequency of reappointments were also collected. Results: Overall, 41.3% out of about 174 million visits were for routine follow up and preventive care of patients already known to the specialist. Psychiatry, immunology and allergy, and dermatology accounted for 54.5% of all routine and preventive care visits, and three conditions (attention deficit disorder, allergic rhinitis and disorders of the sebaceous glands) accounted for 28.1% of these visits. Overall, 73.2

% of all visits resulted in a return appointment with the same physician, in half of all cases as a result of a routine or preventive care visit. Conclusions: Ambulatory office-based pediatric care provided by specialists includes a large share of non-referred routine and preventive care for common problems for patients already known to the physician. It is likely that many of these services could be managed in primary care settings, lessening demand for specialists and improving coordination of care.

Yang, S. C., et al 2009 . Factors influencing general practice follow-up attendances of patients with complex medical problems after hospitalization. *Family Practice* epub ahead of publication 4-11-2009.

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

<http://pmid.us/19889711>

Background: Supported discharge care of patients with complex medical problems is associated with improved health outcomes. GPs are ideally placed to provide post-discharge care in the community. Knowledge of factors that influence patients' decisions to attend such follow-up is thus important to improve health care outcomes of these patients. Objectives: To explore factors that influence complex medical patients' decision to attend GP follow-up after discharge and factors affecting their level of satisfaction with such follow-up. Methods: Qualitative investigation using semi-structured telephone interviews of 26 patients with complex medical issues conducted 2 weeks after hospital discharge. Results: Complex medical patients experienced varying degrees of concern and information needs after discharge from hospital. Patients' understanding of the role of the GP and experiences of continuity of care also influence patients' decisions to attend follow-up with their GP. In addition, practical factors such as GP availability, presence of discharge instructions, access to transport and level of social support also affect patients' ability to attend early GP follow-up after hospital discharge. Patients' satisfaction with GP follow-up was influenced by perceived competence and personal continuity with the GP. Conclusions: Patients' decisions to attend GP follow-up after hospitalization are influenced by a number of factors. Interventions to support post-hospital care that address these issues need to be developed and tested. Key issues are patients' understanding of their condition, understanding of the role of the GP in follow-up and continuity of care.

QUALITY

Adler, R et al The relationship between continuity and patient satisfaction: a systematic review. *Family Practice* , epub ahead of publication 6-1-2010.

<http://dx.doi.org/10.1093/fampra/cmp099>.

<http://pmid.us/20053674>

Background. Continuity between doctors and patients likely affects patient satisfaction. Objective. To assess the current evidence on the relationship between continuity and patient satisfaction. Methods. Systematic review of studies of adults in general, family, or internal medicine practices with ongoing, direct, face-to-face contact with their physician. Measures of the relationship between continuity and patient satisfaction were examined. Results. A MEDLINE search covering 1984-2007 and a Cumulative Index to Nursing and Allied Health Literature search covering 1981-2007 identified 263 relevant studies and 12 studies met inclusion criteria. There were 12 different continuity measures and 9 different satisfaction measures. Conclusions. Continuity has a variable effect on patient satisfaction

Conboy, L et al 2010 Which patients improve: Characteristics increasing sensitivity to a supportive patient-practitioner relationship. *Social Science & Medicine* 70(3), 479-484. 2010.

<http://dx.doi.org/10.1016/j.socscimed.2009.10.024>

<http://pmiid.us/19900742>

Supportive social relationships, including a positive patient-practitioner relationship, have been associated with positive health outcomes. Using the data from a randomized controlled trial (RCT) undertaken in the Boston area of the United States, this study sought to identify baseline factors predictive of patients' response to an experimentally applied supportive patient-practitioner relationship. To sort through the hundreds of potential attributes affecting the patient-practitioner relationship, we applied a false discovery rate method borrowed from the field of genomics and bioinformatics. To our knowledge such a method has not previously been applied to generate hypotheses from clinical trial data. In a previous RCT, our team investigated the effect of the patient-practitioner relationship on symptom improvement in patients with irritable Bowel syndrome (IBS). Data were collected on a sample of 289 individuals with IBS using a three-week, single blind, three arm, randomized controlled design. We found that a supportive patient-practitioner relationship significantly improved symptomatology and quality of life. A complex, multi-level measurement package was used to prospectively measure change and identify factors associated with improvement. Using a local false discovery rate procedure, we examined the association of 452 baseline subject variables with sensitivity to treatment. Out of 452 variables, only two baseline factors, reclusiveness, and previous trial experience increased sensitivity to the supportive patient-practitioner relationship. A third variable, additional opportunity during the study for subjects to discuss their illness through experiential interview, was associated with improved outcomes among subjects who did not receive the supportive patient-practitioner relationship. The few variables associated with differential benefit suggest that a patient-centered supportive patient-practitioner relationship may be beneficial for most patients. This may be especially important for reclusive individuals. Within the context of our study, additional study attention in the form of repeated experiential

interviews compensated for a lack of positive patient-practitioner support. A supportive patient-practitioner relationship may also help overcome low provider expectations for subjects with previous trial experience. These results converge with the results of the parent trial, implicating the importance of the social world in healing

Nyweide, D. J., et al 2009 Relationship of primary care physicians' patient caseload with measurement of quality and cost performance. *JAMA* 302(22), 2444-2450. 9-12-2009.

<http://dx.doi.org/10.1001/jama.2009.1810>

<http://pmid.us/19996399>

Context: Sufficient numbers of patients are necessary to generate statistically reliable measurements of physicians' quality and cost performance. Objective: To determine whether primary care physicians in the same physician practice collectively see enough Medicare patients annually to detect meaningful differences between practices in ambulatory quality and cost measures. Design, setting, and patients: Primary care physicians in the United States were linked to their physician practices using the Healthcare Organization Services database maintained by IMS Health. Patients who visited primary care physicians in the 2005 Medicare Part B 20% sample were used to estimate Medicare caseloads per practice. Caseloads necessary to detect 10% relative differences in costs and quality were calculated using national mean ambulatory Medicare spending, rates of mammography for women 66 to 69 years, and hemoglobin A(1c) testing for 66- to 75-year-olds with diabetes, preventable hospitalization rate, and 30-day readmission rate after discharge for congestive heart failure (CHF). MAIN Outcome measureS: Percentage of primary care physician practices with a sufficient number of eligible patients to detect a 10% relative difference in each performance measure. Results: Primary care physician practices had annual median caseloads of 260 Medicare patients (interquartile range [IQR], 135-500), 25 women eligible for mammography (IQR, 10-50), 30 patients with diabetes eligible for hemoglobin A(1c) testing (IQR, 15-55), and 0 patients hospitalized for CHF. For ambulatory costs, mammography rate, and hemoglobin A(1c) testing rate, the percentage of primary care physician practices with sufficient caseloads to detect 10% relative differences in performance ranged from less than 10% of practices with fewer than 11 primary care physicians to 100% of practices with more than 50 primary care physicians. None of the primary care physician practices had sufficient caseloads to detect 10% relative differences in preventable hospitalization or 30-day readmission after discharge for CHF. Conclusion: Relatively few primary care physician practices are large enough to reliably measure 10% relative differences in common measures of quality and cost performance among fee-for-service Medicare patients

Shuval, K., et al 2009 Association between primary care physicians' evidence-based medicine knowledge and quality of care. *International Journal of Quality in Health Care* Epub ahead of print 1-12-2009.

<http://dx.doi.org/10.1093/intqhc/mzp054>

<http://pmid.us/19951965>

Ample research has examined physicians' evidence-based medicine (EBM) knowledge and skills; however, previous research has not linked EBM knowledge to objective measures of process of care. Design: A cross-sectional study of quality of care measures extracted from electronic medical records and EBM knowledge assessed via a validated questionnaire. Setting: One region of the largest Health Maintenance Organization in Israel. Participants: Seventy-four physicians and their 8334 diabetic patients, 7092 coronary heart disease patients and 17 132 hypertensive patients. MAIN Outcome measures: Outcome measures were four diabetes quality of care indicators (LDL tests, microalbumin tests, hemoglobin A1C tests, eye examination referrals), and two drug prescription indicators (statin prescription for coronary heart disease patients, and thiazide prescription for hypertensive patients). Independent variables were total EBM knowledge and its components: critical appraisal and information retrieval. RESULTS: Total EBM knowledge was independently and significantly associated with LDL testing (b = 0.13; P = 0.036), microalbumin testing (b = 0.33; P = 0.001), hemoglobin A1C testing (b = 0.17; P = 0.036), eye examination referrals (b = 0.16; P = 0.021) and statin prescriptions (b = 0.18; P = 0.025). Critical appraisal was independently associated with microalbumin tests (b = 0.46; P = 0.002) and eye examination referrals (b = 0.20; P = 0.048). Information retrieval was only independently associated with hemoglobin A1C testing (b = 0.43; P = 0.004). Thiazide prescription was not associated with EBM knowledge scores. Conclusions: Physicians' higher total EBM knowledge primarily correlates with better quality of care; however, correlations were modest and explained only a small portion in the variance of clinical performance. Results indicate that there might be a need to focus on teaching all the components of EBM rather than EBM microskills

Wallace, J. E., Lemaire, J. B., Ghali, W. A. 2009 Physician wellness: a missing quality indicator. *Lancet* 374(9702), 1714-1721. Epub ahead of print 14-11-2009.

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

<http://pmid.us/19914516>

When physicians are unwell, the performance of health-care systems can be suboptimum. Physician wellness might not only benefit the individual physician, it could also be vital to the delivery of high-quality health care. We review the work stresses faced by physicians, the barriers to attending to wellness, and the consequences of unwell physicians to the individual and to health-care systems. We show that health systems should routinely measure physician wellness, and discuss the challenges associated with

implementation

Weingarten, M. A. et al 2009 An anatomy of conflicts in primary care encounters: a multi-method study. *Family Practice* Epub ahead of print 30-11-2009.

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

<http://pmid.us/19948564>

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

Wynne-Jones, G., Mallen, C. D., Main, C. J., and Dunn, K. M. Sickness certification and the GP: what really happens in practice? *Family Practice* Epub ahead of publication 24-12-2009.

<http://dx.doi.org/10.1093/fampra/cmp096>.

<http://pmid.us/20034995>

Background. GPs typically sanction absence from work by issuing sickness certificates. There has been some debate recently about changing the way sickness certificates are issued and by whom. However, without understanding GPs' certification practices, their requirements in terms of training and education and how they feel the certification process should or should not be changed, measures aimed at improving the system are unlikely to succeed. Objective. To investigate and describe British GPs' sickness certification practices. Methods. A cross-sectional nationwide postal survey of 2154 UK GPs was conducted. GPs were asked about perceived certification practices, training in sickness certification, their opinions about the certification process and potential to improve the system. Results. Adjusted response was 42% (n = 878). GPs do ask about a

patient's work situation but lack training in sickness certification. GPs would like to maintain their role in sickness certification but felt there was scope for other health professionals to issue some sickness certificates. GPs report more frequent sickness certification for mental health and musculoskeletal conditions compared to any other condition. Conclusions. This study has highlighted the main issues that GPs face during a consultation where sickness certification is a possible outcome. Lack of training in certification was a recurrent theme. However, GPs felt there was scope to improve training and recommendations were made as to how this might be achieved. The survey has highlighted that GPs feel there are opportunities to improve the system and that other health professionals may play a role in the certification process

RESEARCH AND DEVELOPMENT

Blaxter, M. The case of the vanishing patient? Image and experience. *Sociology of Health and Illness*. 31(5), 762-778. 2009.

<http://dx.doi.org/10.1111/j.0141-9889.2009.01178.x>

<http://pmid.us/19659735>

It has been argued that the new technologies of medicine privilege the image over the actual body and its experience, so that the patients themselves may 'vanish' behind the images. A case study is used to explore this from the patient's point of view. What evidence is there that alienation or other dysfunctional effects can actually happen? In this example of the high-tech medicine of lung cancer treatment, it was demonstrable that the process of diagnosis was not only dependent on, but also in some ways distorted by, the reliance on technologies. It was not necessarily true, however, that the machines and the images themselves proved alienating to the patient, or produced a feeling of disembodiment. It was the system in which they were used, their translation into records and decisions, which was deeply alienating, with only lip-service paid to the principles of patient-centredness or the inclusion of the patient as a partner in decision making. Features of the contemporary British health service which seem to foster this are discussed

Colligan, L et al 2010 Does the process map influence the outcome of quality improvement work? A comparison of a sequential flow diagram and a hierarchical task analysis diagram. *BMC Health Services Research* 10(1), 7. 2010.

<http://dx.doi.org/10.1186/1472-6963-10-7>

<http://www.biomedcentral.com/1472-6963/10/7>

<http://pmid.us/20056005>

Background: Many quality and safety improvement methods in healthcare rely on a complete and accurate map of the process. Process mapping in healthcare is often achieved using a sequential flow diagram, but there is little guidance available in the literature about the most effective type of process map to use. Moreover there is evidence that the organisation of information in an external representation affects reasoning and decision making. This exploratory study examined whether the type of process map - sequential or hierarchical - affects healthcare practitioners' judgments. Methods: A sequential and a hierarchical process map of a community-based anti coagulation clinic were produced based on data obtained from interviews, talk-throughs, attendance at a training session and examination of protocols and policies. Clinic practitioners were asked to specify the parts of the process that they judged to contain quality and safety concerns. The process maps were then shown to them in counter-balanced order and they were asked to circle on the diagrams the parts of the process where they had the greatest quality and safety concerns. A structured interview was then conducted, in which they were asked about various aspects of the diagrams. Results: Quality and safety concerns cited by practitioners differed depending on whether they were or were not looking at a process map, and whether they were looking at a sequential diagram or a hierarchical diagram. More concerns were identified using the hierarchical diagram compared with the sequential diagram and more concerns were identified in relation to clinical work than administrative work. Participants' preference for the sequential or hierarchical diagram depended on the context in which they would be using it. The difficulties of determining the boundaries for the analysis and the granularity required were highlighted. Conclusions: The results indicated that the layout of a process map does influence perceptions of quality and safety problems in a process. In quality improvement work it is important to carefully consider the type of process map to be used and to consider using more than one map to ensure that different aspects of the process are captured

Jung, T and et al. Instruments for exploring organizational culture: a review of the literature. *Public Administration Review* 69(6), 1087-1096. 2009.

<http://dx.doi.org/10.1111/j.1540-6210.2009.02066.x>

Organizational culture is widely considered to be one of the most significant factors in reforming and modernizing public administration and service delivery. This article documents the findings of a literature review of existing qualitative and quantitative instruments for the exploration of organizational culture. Seventy instruments are identified, of which 48 could be submitted to psychometric assessment. The majority of these are at a preliminary stage of development. The study's conclusion is that there is no ideal instrument for cultural exploration. The degree to which any measure is seen as "fit for purpose" depends on the particular reason for which it is to be used and the context within which it is to be applied.

Kelly, M. 2009 The role of theory in qualitative health research. *Family Practice* . Epub ahead of publication 29-10-2009.

<http://dx.doi.org/10.1093/fampra/cmp077>

<http://pmid.us/19875746>

The role of theory in qualitative research is often underplayed but it is relevant to the quality of such research in three main ways. Theory influences research design, including decisions about what to research and the development of research questions. Theory underpins methodology and has implications for how data are analyzed and interpreted. Finally, theory about a particular health issue may be developed, contributing to what is already known about the topic that is the focus of the study. This paper will critically consider the role of theory in qualitative primary care research in relation to these three areas. Different approaches to qualitative research will be drawn upon in order to illustrate the ways in which theory might variably inform qualitative research, namely generic qualitative research, grounded theory and discourse analysis. The aim is to describe and discuss key issues and provide practical guidance so that researchers are more aware of the role theory has to play and the importance of being explicit about how theory affects design, analysis and the quality of qualitative research

Loegstrup, L. et al GP and staff evaluation of the maturity matrix as a tool to assess and improve organisational development in primary care. *International Journal of Health Care Quality Assurance* 22(7), 686-700. 2009.

<http://dx.doi.org/10.1108/09526860910995029>

<http://pmid.us/19957823>

Purpose: This paper aims to evaluate the maturity matrix (MM) a facilitated formative self-assessment tool for organisational development in primary care) on satisfaction, differences between GP and staff, the extent to which practice teams worked on goals set, and to identify suggestions for change to MM. Design/methodology/approach: The approach taken was a cross-sectional survey administered to all participants by mail in 57 family practices, 278 participants, (143 GPs; 135 staff) in Denmark, one year after participating in the MM project. Findings: At practice level 44 returned at least one questionnaire. At participant level, 144 returned the questionnaire: 82 GPs; 62 staff. A total of 93 gave positive statements on satisfaction with MM, 16 stated initial expectations were not met, 79 would recommend MM to colleagues. Differences between GPs and staff were only statistically significant regarding "increased insight into organisation of work after participation in the MM project". There was a tendency that GPs were more positive and likely to give an opinion. A total of 22 planned how to meet the goals set at the first MM meeting and 18 felt that they achieved them. In 24 out of 44 practices MM was stated to contribute new ways of working. A total of 12 of 144 stated that they needed more follow-up support. Practical implications: The results indicate that MM is a workable method to assess and gain insight into practice organisation with no major differences between GPs and staff. Originality/value: The paper examines participants views' on MM one year after introduction

Monteserin, Rosa, et al 2009 Effectiveness of a geriatric intervention in primary care: a randomized clinical trial. *Family Practice* Epub ahead of publication 6-1-2010.

<http://dx.doi.org/10.1093/fampra/cmp101>.

<http://pmid.us/19828574>

Objective. To assess the effectiveness of an intervention after comprehensive geriatric assessment (CGA) in reducing morbidity and mortality in patients over 74 years in primary care. Methods. Randomized controlled trial with 18 months of follow-up. Patients in the control group (CG) followed usual care. Patients in the intervention group (IG) were classified as at risk or non-risk of frailty based on the CGA. Patients at non-risk of frailty in the IG were provided with recommendations about healthy habits and adherence to treatment in group sessions, while patients at risk of frailty were visited individually by a geriatrician. Results. Six hundred and twenty patients were randomized to the IG (49.7%) or to the CG (50.3%), 83.2% completed follow-up. Cox's proportional hazards model showed as covariates the study group (hazard ratio [HR] 0.58; 95% confidence interval [CI] 0.28-1.22), risk of frailty (HR 1.33; 95% CI 0.71-2.51) and the interaction between both (HR 3.08; 95% CI 1.22-7.78). Forty-nine percent of the patients in the IG and 43% in the CG were at risk of frailty at baseline. At the end of the study, 27.9% of the IG and 13.5% of the CG had reversed their initial at risk of frailty status ($P = 0.027$). Multivariate predictors of reversible risk of frailty were younger age, not being at risk of depression, low consumption of medications and the intervention itself. Conclusions. A specific intervention in patients over 74 years attended in primary care reduces morbidity and mortality in patients at risk of frailty and increases the proportion of patients that reversed their initial status at risk of frailty

Pilnick, A., Hindmarsh, J., and Gill, V. T. Beyond 'doctor and patient': developments in the study of healthcare interactions. *Sociology of Health and Illness* 31(6), 787-802. 2009.

<http://dx.doi.org/10.1111/j.1467-9566.2009.01194.x>

<http://pmid.us/19843267>

Three decades of conversation analytic investigations of medical interaction have produced a rich collection of findings of sociological interest, from a diverse array of encounters. This paper briefly outlines the development of this field to provide a context for the special issue. The paper discusses how studies of doctor-patient interaction have revealed the ways in which participants organise the medical visit to accomplish tasks such as diagnosing and recommending treatment for illness, and how doctors and patients address various interactional issues and dilemmas that arise as they undertake these tasks. It then highlights a growing number of CA studies that explore medical settings and activities beyond the doctor-patient encounter. In doing so, it charts the distinctive interactional practices that emerge, for example, where participants are engaging in

hands-on treatment, medical practitioners are interacting with one another, or various technologies are employed during the encounter. Finally, papers in this special issue are introduced and shown to build upon this latter tradition. The papers address distinctive practical problems and institutional dilemmas that arise in healthcare encounters and medical settings beyond dyadic doctor-patient interaction, with a focus on the participants' orientations to policy, their distinctive modes of participation, and the use of technology

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

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

<http://pmid.us/19896255>

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

SELF CARE

Bai, Y. L., Chiou, C. P., and Chang, Y. Y. **Self-care behaviour and related factors in older people with Type 2 diabetes.** *Journal of Clinical Nursing* **18(23), 3308-3315. 2009.**

<http://dx.doi.org/10.1111/j.1365-2702.2009.02992.x>

<http://pmid.us/19930088>

Aim: The present study examined the factors related to self-care behaviour in type 2 diabetic patients aged > or =65 years. In addition, this study tested the effect of the important explanatory factors on self-care behaviour. **Background:** Along with the development of an ageing society, diabetes occurs frequently among older people. Diabetes requires continual medical treatment, with patients responsible for self-care. Although the relationships among social support, depression and self-care have been widely studied, little is known about older diabetic patients, especially in Taiwan. **Design:** A correlational design was adopted. In total, 165 patients recruited using convenience sampling were diabetic outpatients at three hospitals in southern Taiwan from January-March 2005. **Methods:** The participants were interviewed using the Personal Resource Questionnaire 2000 (PRQ 2000), Diabetes Self-Care Scale and Taiwan Geriatric Depression Scale (TGDS). Data were analysed using descriptive statistics and multiple regression analysis. **Result:** Self-care behaviour scores were significantly influenced by different gender, education level, economic status and religious beliefs of older diabetic patients. Depression and self-care behaviour were negatively correlated. Social support, education and duration of diabetes significantly affected self-care behaviour, accounting for 35.6% of total variance. **Conclusions.** Social support plays a vital factor in contributing to the facilitation of self-care behaviour. These analytical findings demonstrate the importance of social support, education and duration of diabetes in determining self-care behaviour for diabetic older diabetic patients and serve as references for future studies of self-care behaviour in type 2 older diabetic patients. **Relevance to clinical practice:** Implication for nurses highlights the significance of providing patients with social support that will enable them to have good support systems during their disease treatment to enhance self-care abilities and improve quality of life:

Lancee, B. and Ter Hoeven, C. L. Self-rated health and sickness-related absence: The modifying role of civic participation. *Social Science and Medicine* Epub ahead of print . 23-11-2009.

<http://dx.doi.org/10.1016/j.socscimed.2009.10.032>

<http://pmid.us/19939531>

In this study, we examined civic participation as an effect modifier between self-rated health and absence from work. Building on the theoretical framework of social exchange, we use German data to test a conceptual model relating self-rated health to sickness-related absence, as well as the interaction between self-rated health and civic participation. We used the 1996 wave of the German Socio-Economic Panel Study. Since sickness-related absence is a censored variable, we used a tobit regression model. The results confirmed the hypotheses: the effect between self-rated health and sickness-related absence was modified by civic participation, indicating that the effect of self-rated health on sickness-related absence is less pronounced for people who participate more as opposed to those who report less civic participation. In other words, those who are

unhealthy and participate more, are fewer days absent from work. We argue that civic participation buffers the relationship between self-rated health and sickness-related absence because those who participate more have more resources to fulfill self-regulatory needs. Our findings emphasize the importance of civic participation outside the workplace for people at work when they do not feel physically well

Minet, L., et al 2009 Mediating the effect of self-care management intervention in type 2 diabetes: A meta-analysis of 47 randomised controlled trials. *Patient Education and Counseling* Epub ahead of print 9-11-2009.

<http://dx.doi.org/10.1016/j.pec.2009.09.033>

<http://pmid.us/19906503>

Objective: To perform a meta-analysis assessing the effects of self-care management interventions in improving glycaemic control in type 2 diabetes by analysing the impact of different study characteristics on the effect size. Methods: A literature search in eight scientific databases up to November 2007 included original studies of randomised controlled trials involving adult patients diagnosed with type 2 diabetes and evaluating a self-care management intervention. Results: The 47 included studies yielded 7677 participants. The analysis showed a 0.36% (95% CI 0.21-0.51) improvement in glycaemic control in people who received self-care management treatment. In the univariate meta-regression sample size (effect size 0.42%, $p=0.007$) and follow-up period (effect size 0.49%, $p=0.017$) were identified to have significant effect on the effect size in favour of small studies and short follow-up. For type of intervention and duration of intervention there was a non-significant effect on effect size in favour of educational techniques and short interventions. Conclusion: In type 2 diabetes, there are improvements in glycaemic control in people who receive self-care management treatment with a small advantage to intervention with an educational approach. Practice implications: Further research on frequency and duration of intervention may provide useful information to identify the most effective regime

SERVICE ORGANISATION AND DELIVERY

Frosch, D. L., Singer, K. J., and Timmermans, S. Conducting implementation research in community-based primary care: a qualitative study on integrating patient decision support interventions for cancer screening into routine practice. *Health Expectations* 10-11-2009.

<http://dx.doi.org/10.1111/j.1369-7625.2009.00579.x>

<http://pmid.us/19906215>

Background Despite a growing body of evidence supporting the efficacy of patient decision support interventions (DESI), little is known about their implementation in community-based primary care practices. Objective The goal of this study was to explore the feasibility of integrating the use of DESIs for cancer screening in primary care practices serving patients from diverse backgrounds and learn more about the potential barriers and facilitators of integration. Setting 12 community-based primary care practices in metropolitan Los Angeles. Main variables studied Qualitative field notes documented the roles played by staff and physicians in accomplishing project goals, the impact of the programmes on the clinical work-flow in the practices and other noteworthy observations. Results Practices that were better able to integrate the project had adequate clinic infrastructure, a relatively well-matched patient pool, and positive work and patient care environments. The remaining identified components, including staff facilitation and the physician's role accounted for higher level differences between the clinics, acting as barriers and facilitators that distinguished practices that were able to work independently from those that required more assistance and, to a lesser extent, those clinics that did and those that did not meet the project goals. Discussion and conclusions This study suggests that implementation of DESIs to be used immediately before a consultation is feasible if the practice infrastructure can provide sufficient basic accommodation and physician and staff are dedicated to patient care goals that are implicit in the use of these tools. Overall, the physician's role appeared to be the most important factor in determining whether project integration was successful

PM

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

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

<http://pmid.us/19843414>

Background: Alternative provider of medical services (APMS) legislation enables private commercial firms to provide NHS primary care. There is no central monitoring of APMS adoption by primary care trusts (PCTs), the new providers, or market competition. Aim: The aims were to: examine APMS contract data on bidders and providers, patient numbers, contract value, duration, and services; present a typology of primary care providers; establish the extent of competition; and identify which commercial providers have entered the English primary care market. Design of study: Cross-sectional study. Setting: All PCTs in England. Method: A survey was carried out in March 2008 gathering information on the number of APMS contracts, their value and duration, patient numbers, the successful tender, and other bidders. RESULTS: A total of 141 out of 152 PCTs provided information on 71 APMS contracts that had been awarded and 66 contracts that were out to tender. Of those contracts awarded, 36 went to 14 different commercial companies, 28 to independent GP contractors, seven to social enterprises, and two to a PCT-managed service; one contract is shared by three different provider types. In more than half of the responses information on competition was not disclosed. In a fifth of those contracts awarded to the commercial sector, for which there is

information on other bidders, there was no competition. Contracts varied widely, covering from one to several hundred thousand patients, with a value of pound6000-12 million, and lasting from 1 year to being open-ended. Most contracts offered standard, essential, additional, and enhanced services; only a few were for specialist services. Conclusion: The lack of data on cost, patient services, and staff makes it impossible to evaluate value for money or quality, and the absence of competition is a further concern. There needs to be a proper evaluation of the APMS policy from the perspective of value for money and quality of care, as well as patient access and coverage

SOCIAL CAPITAL

Oksanen, Tuula, et al **Prospective study of workplace social capital and depression: Are vertical and horizontal components equally important?** *Journal of Epidemiology and Community Health*. 19-8-2009.

<http://dx.doi.org/10.1136/jech.2008.086074>

<http://pmid.us/19692720>

Recent studies have emphasised the multidimensional nature of the social capital concept, but it is not known whether the health effects of social capital vary by dimension. The objective of this study was to examine the vertical component (i.e., respectful and trusting relationships across power differentials at work) and the horizontal component of workplace social capital (trust and reciprocity between employees at the same hierarchical level) as risk factors for subsequent depression. A cohort of 25 763 Finnish public sector employees who were initially free from depression was followed up on average 3.5 years for new self-reported physician-diagnosed depression and recorded antidepressant prescriptions derived from national registers. Factor analysis confirmed the existence of vertical and horizontal components of workplace social capital. The odds for new physician-diagnosed depression and antidepressant treatment were 30-50% higher for employees with low vertical or horizontal workplace social capital than for their counterparts with high social capital at work. In mutually adjusted models, vertical and horizontal social capital remained independent predictors of physician-diagnosed depression and antidepressant treatment. These results highlight the importance of both vertical and horizontal components of workplace social capital as predictors of employee mental health

WORKFORCE

Laurant, M., et al 2009 The impact of nonphysician clinicians: do they improve the quality and cost-effectiveness of health care services? *Medical Care Research and Review MCRR*. 66(6 Suppl), 36S-89S.

<http://dx.doi.org/10.1177/1077558709346277>

<http://pmid.us/19880672>

Health care is changing rapidly. Unacceptable variations in service access and quality of health care and pressures to contain costs have led to the redefinition of professional roles. The roles of nonphysician clinicians (nurses, physician assistants, and pharmacists) have been extended to the medical domain. It is expected that such revision of roles will improve health care effectiveness and efficiency. The evidence suggests that nonphysician clinicians working as substitutes or supplements for physicians in defined areas of care can maintain and often improve the quality of care and outcomes for patients. The effect on health care costs is mixed, with savings dependent on the context of care and specific nature of role revision. The evidence base underpinning these conclusions is strongest for nurses with a marked paucity of research into pharmacists and physician assistants. More robust evaluative studies into role revision are needed, particularly with regard to economic impacts, before definitive conclusions can be drawn

Rakovski, C. C. and Price-Glynn, K. Caring labour, intersectionality and worker satisfaction: an analysis of the National Nursing Assistant Study (NNAS). *Sociology of Health and Illness* Epub ahead of print 4-11-2009.

<http://dx.doi.org/10.1111/j.1467-9566.2009.01204.x>

<http://pmid.us/19891615>

Caring labour in long-term care settings is increasingly important as the US population ages. Ethnographic research on nursing assistants (NAs) portrays nursing home care as routine and fast paced in facilities that emphasise life maintenance more than care. Recent interview-based and small quantitative studies describe a mix of positive and negative aspects of NA work, including the rewards of caring, despite shortcomings in working conditions and pay. The current study continues this research but, for the first time, using national data. The 2004 Centers for Disease Control and Prevention's National Nursing Assistant Study (NNAS) provides survey data from 3,017 NAs working in long-term care facilities across the US. The NNAS results confirm the importance and centrality of caring to NAs' work. NAs motivated by caring for others were significantly more satisfied with their jobs than those motivated by other reasons, such as convenience or salary. Overall, NAs report surprisingly high job satisfaction, particularly with learning new skills, doing challenging work, and organisational support for caring labour. Areas of dissatisfaction were salary, time for reproductive labour, and turnover. Intersectional

analysis revealed race and citizenship played a stronger role than gender in worker satisfaction