WONCA Europe 2002/RCGP 50th Jubilee Conference

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I was fortunate to be able to attend this gathering of more than 2000 general practitioners from 37 nations who congregated in London in June for a conference with the following themes:

International co-operation in primary care research, Core values philosophy and aspirations in family practice, Effective clinical practice in partnership with patients, General practice/family medicine as a career, Informatics and health, Promoting quality in primary care, and *Developments in the organisation and delivery of primary care.*

As a first time visitor to Britain the experience of being in an old city with history and architecture that were familiar from school classes, postcards and travel brochures was a source of great joy! Every corner presented another surprise and although damp at times there were some sunshine hours too, and midsummer meant opportunities to sightsee after programmes were finished at 6pm.

Keynote addresses were delivered by outstanding individuals – on Monday Dr Martyn Evans, with a background in Medical Humanities, joint editor of *Journal of Medical Ethics* and principal of John Snow College, University of Durham, Professor in the Faculty of Health, Medicine and the Environment, who spoke about the relationship of the physical symptom and the experience of that for an individual – and the unique opportunity general practice holds for encounter with an undiagnosed human being – and the value of paying attention to the context of the whole person and the meaning of disease in that context.

The plenary on Tuesday was addressed by Dr Carl Rudeburg, a Swedish general practitioner, researcher and teacher, who resides in a small town by the Baltic Sea. He took as his theme *Imagination and Empathy* in the consultation and was truly inspiring, humorous and wise in his presentation.

'Since heroic diagnostic deeds do not dominate the working day of the GP, he cannot afford that the patient becomes the background of her own consultation. He must make the patient herself the target of his imagination. Who is she? What is her experience like and what does it mean to her? Imagination becomes here more about sharing the experience than dealing with abstract facts. At the core of this experience is the body, which as a theme of life, rather than the laboratory, is where the experienced GP really is a master.'

Dr Carol Herbert, a general practitioner, teacher and research scholar, Dean of the Faculty of Medicine and Dentistry at the University of Western Ontario since 2000, and a visiting professor to New Zealand, Australia, UK, Israel and the USA, spoke about the tasks that need accomplishing for primary care to reach research goals:

Modelling and insisting on positive research attitudes and behaviours in training programmes, developing clinician-researcher career pathways, lobbying for increased funding for primary care research, nurturing and supporting practice-based researchers, sustaining practice-based research networks – and ensuring that the questions we ask are important – studying what matters in primary care as opposed to the interests of academic researchers in university departments. She spoke of the importance of interdisciplinary research teams with a mix of methods – qualitative, quantitative and participatory – where the question warrants those approaches.

The focus of my interest in attending the conference was the sessions relating to domestic violence research and findings, and this took place on Monday morning following the opening plenary session. A general practitioner who has an academic research post at the University of Melbourne, Dr Kelsey Hegarty, chaired the session and contributed some of her findings from a study in Brisbane which surveyed women in 20 random practices. Using a composite abuse scale which took into account severe combined abuse, emotional abuse, physical abuse and harassment (particularly post separation) and with a response rate of 78.5%, (n=1836 women), a lifetime prevalence of 37% was found. She noted that 25% of patients who had suffered current or

past abuse, had clinical depression using a Beck scale: this was consistent with other international experience which had been published. Doctors had inquired about abuse in 13.2% of cases. Women were questioned about factors that facilitated disclosure, and claimed the communication skills of the doctor were of paramount importance. Barriers to disclosure were largely internal, rather than relating to the doctor.

When questioned about her opinion as to whether GPs should be asking women about abuse as part of their health history, Dr Hegarty said she believed this was valuable and would render results in women who were under 40 years of age and separated or divorced. She strongly stated that asking women if they felt afraid of partners was a powerful and sensitive question, as were introductory 'scene-setters' like *'Is there a lot of tension at home – how do you resolve disagreements?'* She cautioned that without training and on-going education for GPs emphasising referral guidelines and care with confidentiality, there was a potential for harm for abused women. It was her opinion that short screening tools were not the whole answer.

Jo Richardson, member of a team from Barts and the London St Mary's School of Medicine and Dentistry, presented findings from a prevalence study undertaken in 13 practices in East London (looking at physical and sexual violence only) in a self administered questionnaire and records review. One thousand two hundred and seven consecutive women were surveyed – but there were many constraining factors including ability to speak English in a high immigrant population, literacy, holding children, being very unwell and understanding consent. Fifty-five per cent of eligible women did not participate. She found a 41% lifetime prevalence and 17% past 12 month prevalence rate. Pregnancy in the past 12 months increased the odds of abuse. Seventeen per cent of events were recorded in notes. This equates to less than 1:5 identification rate. Eighty per cent of women were happy to be asked – but 20% had reservations.

Jean Ramsey, a co-researcher of the above, presented data from a systematic review of studies on domestic violence screening with respect to the classical criteria for screening and found a poor result. Many studies were hard to compare, with various methods, end points and sampling sizes and techniques. She concluded that while classical criteria were not met, the identification and management of domestic violence may require something other than medical or public health models.

Dr Angela Taft, from La Trobe University Melbourne, who with Kelsey Hegarty had presented at the Christchurch WONCA conference in June 2000, addressed the session with her findings from an ethnographic study done as part of her doctoral dissertation, drawing on GPs' interactions with victims, their partners and children, and the stress that this involved for family doctors. She made recommendations about training needs, the dangers of subjective gendered assumptions, and the conflicts in dealing with domestic abuse in a way that at times appears to require a different paradigm to conventional teaching about family medicine to be effective and safe. She stressed the need for careful systems, specific skills and issues requiring addressing in group practice and in referrals to other agencies and in particular from secondary and tertiary health institutions. She recommended inter-disciplinary training and exposure to referral sources and persons in preparation for interventions or referrals and advocated for support for GPs whom she encouraged to undertake CME in this area.

Finally Professor Gene Feder stated that a response was required from medical and nursing sectors given the prevalence and consequences for women and their children. He discussed the methodological difficulties, the challenges and the need for further robust and long-term outcome research, setting women and their stories centre stage and listening carefully to their positive and negative responses to interventions and advocacy in order to refine and improve effectiveness. He had many questions needing answers – what happens to women over time, what mental health sequelae before, during and after intervention, what percentage of women leave, what modifications do they make if they stay, what is the recovery time line after abuse, how can we implement a sustainable and effective primary care training programme, what support and retraining is needed, how can effective intervention in a primary health care setting be reinforced as worthwhile.

The forum was attended by a variety of GPs from Europe, UK, Ireland and USA, including two who are involved in planning WONCA Europe in Amsterdam in 2005 – and who anticipate sessions on general practice and domestic violence will be widely attended.

Domestic violence intervention training is presently being developed by RNZCGP/DSAC and Ministry of Health, so the opportunity to update on current thinking was timely. Sponsorship for attendance to this day of the conference by the Research and Education Charitable Trust (RNZCGP) is gratefully acknowledged.

Further sessions attended included the rest of Monday spent with a group exploring the work at the Tavistock Clinic in London, and the University of Oulu in Finland, on working with patients, families and teams, as an introduction to systemic family medicine, theory and then a practical demonstration session. Again a diverse international group participated, and productive, lively discussion ensued. One reservation that I felt was the difficulty that is likely to be involved in adolescent crises in the family cycle – and the special place that confidentiality has

in that context. However the fact that 10% of patients use 30% of doctors time and resources was a stimulus to consider approaches based on family therapy as worth a second look in particular for complex cases.

Tuesday following the plenary session I attended Tony Fichett's presentation on Journaling as a response to loss and grief. His paper was sympathetically received and the rest of the session on *Gate-keeping in the balance – The dilemmas of family physicians, trust and the gatekeeper*, was equally interesting and thought provoking.

Hamish Wilson presented a workshop that was fully subscribed entitled *'When doctors become patients: Barriers to good medical care'*. The introduction was sharp, the groups interacted well and were hard to stop and the comments afterwards on the content, usefulness and on Hamish's skill in bringing out issues and facilitation were very gratifying.

The afternoon first workshop session entitled *'I don't know how she got pregnant'* was a clever and chilling piece of contrived interactive theatre which unpicked the silence and denial that survivors of sexual abuse all too often meet in maternity care by midwives and clinicians. It was stunning, close to the bone and there were notable 'aha' moments for some participants who were audience members.

A session on refugees and immigrants – *'Unrecognised torture sequelae affects health of many'*- was movingly presented with slides and 16 years experience in the field, by Kathi Antolak (USA). Her assertion that physicians will often find stories hard to envisage and believe and the impact this then also has on the patient was salutary, as was her discussion of the effects of common clinical procedures and scenarios that evoke terrible reliving of memories of victims.

That session developed with another speaker and looked at general practice from the perspective of Northern hemisphere looking South and vice versa – with some enlightening attitudinal and 'stereotypical' differences elucidated.

A Norwegian GP produced data gathered on health in households in Cameroon, during some time he had spent working there, bringing to light the young age group, unidentified illness and infection, and the cost of treatment.

The final presentation of this group which was headed *'Issues of global justice'* addressed the idea of primary care and medicine as a Public Good – taking as an example the use of statins, and asserting that this drug group has been the most successful chemical to come out of the last decade.

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The entire morning session I chose following the keynote address on Wednesday was developed and presented by the Royal College of GPs in Scotland. A variety of impressive speakers expounded ideas about *'What is medicine for'*, challenging assumptions, criticising some attitudes, behaviours and responses, and scanning the history of medicine from Pythagoras onwards – assessing its place and role in society. Much lively discussion and participation ensued, with the speakers being ready to defend their views which were various and considered. A journalist encouraged the audience to heckle her challenges and playing the role of the Devil's Advocate, and robust the challenges were!

The afternoon programme concluded for me with a choice to attend a session on 'My Patient' – three presentations by two GPs of particular case studies which illustrated for the first GP a management point for a long terminal illness and, for the second, two fascinating examples of phenomenological medicine. The second presenter, Anna Luise Kirkengen had studied this approach to physical symptoms not fitting a psychiatric diagnosis and of no physical pathological origin. Her meticulous history taking had uncovered appropriate backgrounds that explained the consequences which were experienced as physical symptoms by her patients. Her approach was originally developed from work with adult incest survivors who were not 'noticed' in traditional medical paradigms, and who had in many cases suffered unneeded investigations and surgery. Her contention was that clinicians need to understand the principles of phenomenological medicine as part of the tools of diagnosis – an added dimension to the biomedical model. The background theory was not hers – but she had undertaken considerable training and then found the skills learned both practical and enlightening for her patients.

Sometimes the 'conference experience' can be disappointing – but meticulous organisation and attention to detail proved to make RCGP/ WONCA Europe extremely enlightening, stimulating and encouraging. Only one frustration – the enormous choice, with up to 20 concurrent sessions at any one time, and always a number relevant to one's interests. The poster sessions were fascinating and time sharing meals with colleagues from regimes very different to ours in NZ was at times humbling. Our working conditions here are light years from those experienced by most in developing countries and even in some wealthy European nations, where GPs struggle to have the value of family medicine recognised, and the discipline accepted by colleagues in other medical areas as well as by governments.