



NATIONAL PRIMARY CARE RESEARCH  
AND DEVELOPMENT CENTRE



# **CURRENT AWARENESS BULLETIN**

**May – June 2009**

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## ACCESS TO CARE

**Goddard,M. (2009). Access to health care services--an English policy perspective. *Health Economics Policy and Law*, 4 (Pt 2), 195-208.**

<http://dx.doi.org/10.1017/S174413310900485X>

<http://pmid.us/19187570>

The English government has given a commitment to improving access to health care services for particular groups perceived as being under-served, or served inappropriately, by existing services. In this article four examples of policies aimed at improving access are considered: enhancing the supply of services to under-served areas, changing the organization of services, setting targets to improve access, and empowering people to make choices. Policies aimed at improving access will work only if they address the source of inequities, which means identifying the key barriers to access and these barriers are unlikely to be uniform across sectors, services, and groups of people. Evidence on the success of these four types of intervention in terms of influencing access and equity of access is discussed, borrowing some concepts from the sociological literature that enable us to understand the importance of how barriers to access may arise for different services and different population groups. It is clear that some policies may not work as well as we would hope, or may even exacerbate inequities of access, because they fail to recognize the source of the particular barriers faced by some groups

**Gulliford,M. (2009). Modernizing concepts of access and equity. *Health Economics Policy and Law*, 4(Pt 2), 223-230.**

<http://dx.doi.org/10.1017/S1744133109004940>

<http://pmid.us/19250604>

Former UK Prime Minister Tony Blair once observed that ‘the purpose of the twentieth century welfare state was to treat citizens as equals; the purpose of the twenty-first century reforms must be to treat them as individuals as well’ (Blair, 2002). Emphasis on the individual is evident in recent UK health service policy, which identifies the aims of ‘personalizing services [by] making [them] fit for everyone’s needs. That includes those people traditionally less likely to seek help or who find themselves discriminated against in some way’ (p. 9). ‘The National Health Service needs to give patients more rights and control over their own health and care’ (Department of Health, 2008: 33).

**Ignaszak-Szczepaniak,M., et al (2009). Reasons for visiting Polish primary care practices by patients aged 18-44 years: the largest emigrating age group. *Health and Social Care in the Community*, 17(3), 235-243**

<http://dx.doi.org/10.1111/j.1365-2524.2008.00816.x>

<http://pmid.us/19402840>

Over 3% of the entire Polish population migrate for a job within the European Union, most are aged 18-44 years. The main destinations are Germany, the United Kingdom and Ireland. Immigration is connected with the use of many public services, including healthcare services. Assuming Polish immigrants require medical consultations in the countries they reside in, the authors have analysed the reasons for patients' visits to general practitioners (GPs) in Poland in order to predict possible reasons why Polish patients living abroad may make appointments with GPs in other countries. Data from 22 769 visits to GP practices between June 2005 and May 2006 by Polish patients aged 18-44 years were collected electronically. Age was categorised into three groups (18-24, 25-34 and 35-44 years) and the reason for the visit was categorised according to the ICD 10 coding system. Among the 12 535 patients registered with GPs, 73.1% of women and 68.6% of men required consultations during the year the study was conducted. The highest percentage of visits was recorded for women aged 35-44 years, while men of the same age were the least likely to visit a GP. The mean number of visits per patient ranged from 1.89 for men aged 25-34 years to 3.11 for women aged 35-44 years. The means were similar for 18- to 24-year-old men and women. Women aged 35-44 years had a higher mean number of visits compared with women aged 18-24 years, whereas the opposite was true for men. The analysis of reasons for visits within the age groups indicated that the percentage of appointments for respiratory problems and general and unspecified problems dropped by more than half from the 18-24-year-olds to the 35-44-year-olds, while visits for musculoskeletal, cardiovascular, and mental and behavioural problems increased by a factor of four. The presented results intend to enable healthcare services meet Polish immigrants' healthcare needs

**Macfarlane,A., Singleton,C., & Green,E. (2009). Language barriers in health and social care consultations in the community: A comparative study of responses in Ireland and England. *Health Policy*. Online 27/04/2009**

<http://dx.doi.org/10.1016/j.healthpol.2009.03.014>

<http://pmid.us/19403192>

Objective: This paper focuses on the implications of migration for host health and social care systems in terms of linguistic diversity, language barriers and language supports. The objective is to compare Ireland, as a context responding to the new challenge of language barriers in healthcare, and England, as a context in which the management of language barriers is being re-assessed. Methods: Empirical data from two action research studies in Ireland and England are compared. The combined data set is 146 data collection episodes with service users with limited English and their health and social care providers. Results: Key findings are that the same range of formal and informal responses to language barriers occurs in practice in both contexts but proportions of knowledge and use of these responses differ. English service providers have more awareness about the use of formal responses than Irish service providers but uptake of

formal responses remains low in both contexts. Data from service users confirms these findings. Conclusions: There is a need for more attention to the implementation of policies for language barriers in both Ireland and England, further research about the normalization processes associated with these consultations and knowledge transfer networks to facilitate on-going dialogue between all key stakeholders with an emphasis on supporting service users' involvement and participation

**Rennemark, M., et al (2009). Factors related to frequent usage of the primary healthcare services in old age: findings from The Swedish National Study on Aging and Care. *Health and Social Care in the Community*. Online 8/01/2009**

<http://dx.doi.org/10.1111/j.1365-2524.2008.00829.x>

<http://pmid.us/19207603>

People aged 60 or more are the most frequent users of healthcare services. In this age range, however, both frequent and infrequent users can be found. Frequent users have high rates of illnesses. Previous research has found that the frequency may be influenced also by psychological and social factors. The aim of this study was to investigate to what degree such factors add to the explanation of differences in number of visits to a physician. A cross-sectional study was conducted with a random sample consisting of 1017 individuals, aged 60 to 78 years, from the Blekinge part of the Swedish National Study on Aging and Care database. The data were collected during 2001 to 2003. Hierarchical logistic regression analyses were used with frequent (three visits or more during a year) and infrequent use as a dichotomous dependent variable. The final statistical analyses included 643 individuals (63% of the sample). Independent variables were sense of coherence (SOC), internal locus of control, education level and social anchorage. Control variables were age, gender, functional ability and comorbidity. The results showed that comorbidity was most strongly related to frequent use [adjusted odds ratio (OR) = 8.17, 95% confidence interval (CI) 5.54-12.04]. In addition, SOC and internal locus of control had small, but significant effects on the odds of being a frequent user (adjusted OR = 1.03, 95% CI 1.00-1.06 and adjusted OR = 1.14, 95% CI 1.02-1.27, respectively). The lower the SOC and the internal locus of control were, the higher were the odds of frequent use. Education level and social anchorage were unrelated to frequency of use. The results indicate that frequent healthcare services users are more ill than infrequent users. Psychological factors influence the use only marginally, and social factors as well as age and gender are not by themselves reason for frequent healthcare services use

**Strech, D. et al (2009). Are physicians willing to ration health care? Conflicting findings in a systematic review of survey research. *Health Policy*, 90(2-3), 113-124.**

<http://dx.doi.org/10.1016/j.healthpol.2008.10.013>

<http://pmid.us/19070396>

Background: Several quantitative surveys have been conducted internationally to gather

empirical information about physicians' general attitudes towards health care rationing. Are physicians ready to accept and implement rationing, or are they rather reluctant? Do they prefer implicit bedside rationing that allows the physician-patient relationship broad leeway in individual decisions? Or do physicians prefer strategies that apply explicit criteria and rules? Objectives: To analyse the range of survey findings on rationing. To discuss differences in response patterns. To provide recommendations for the enhancement of transparency and systematic conduct in reviewing survey literature. Methods: A systematic search was performed for all English and non-English language references using CINAHL, EMBASE, and MEDLINE. Three blinded experts independently evaluated title and abstract of each reference. Survey items were extracted that match with: (i) willingness to ration health care or (ii) preferences for different rationing strategies. Results: 16 studies were eventually included in the systematic review. Percentages of respondents willing to accept rationing ranged from 94% to 9%. Conclusions: The conflicting findings among studies illustrate important ambivalence in physicians that has several implications for health policy. Moreover, this review highlights the importance to interpret survey findings in context of the results of all previous relevant studies

**Uiters,E. et al (2009). Differences between immigrant and non-immigrant groups in the use of primary medical care; a systematic review. *BMC Health Services Research*, 9(1), 76.**

<http://dx.doi.org/10.1186/1472-6963-9-76>

<http://www.biomedcentral.com/1472-6963/9/76>

<http://pmid.us/19426567>

Background: Studies on differences between immigrant and non-immigrant groups in health care utilization vary with respect to the extent and direction of differences in use. Therefore, our study aimed to provide a systematic overview of the existing research on differences in primary care utilization between immigrant groups and the majority population. Methods: For this review PubMed, PsycInfo, Cinahl, Sociofile, Web of Science and Current Contents were consulted. Study selection and quality assessment was performed using a predefined protocol by 2 reviewers independently of each other. Only original, quantitative, peer-reviewed papers were taken into account. To account for this hierarchical structure, logistic multilevel analyses were performed to examine the extent to which differences are found across countries and immigrant groups. Differences in primary care use were related to study characteristics, strength of the primary care system and methodological quality. Results: A total of 37 studies from 7 countries met all inclusion criteria. Remarkably, studies performed within the US more often reported a significant lower use among immigrant groups as compared to the majority population than the other countries. As studies scored higher on methodological quality, the likelihood of reporting significant differences increased. Adjustment for health status and use of culture-/language-adjusted procedures during the data collection were negatively related to reporting significant differences in the studies. Conclusions: Our review underlined the need for careful design in studies of differences in health care use between

immigrant groups and the majority population. The results from studies concerning differences between immigrant and the majority population in primary health care use performed within the US might be interpreted as a reflection of a weaker primary care system in the US compared to Europe and Canada

## CHRONIC ILLNESS

**Ab,E., Denig,P., van,V.T., & Dekker,J.H. (2009). Reasons of general practitioners for not prescribing lipid-lowering medication to patients with diabetes: a qualitative study. *BMC Family Practice* 10(1), 24.**

<http://dx.doi.org/10.1186/1471-2296-10-24>

<http://www.biomedcentral.com/1471-2296/10/24>

<http://pmid.us/19383116>

Background: Lipid-lowering medication remains underused, even in high-risk populations. The objective of this study was to determine factors underlying general practitioners' decisions not to prescribe such drugs to patients with type 2 diabetes. Methods: A qualitative study with semi-structured interviews using real cases was conducted to explore reasons for not prescribing lipid-lowering medication after a guideline was distributed that recommended the use of statins in most patients with type 2 diabetes. Seven interviews were conducted with general practitioners (GPs) in The Netherlands, and analysed using an analytic inductive approach. Results: Reasons for not prescribing could be divided into patient and physician-attributed factors. According to the GPs, some patients do not follow-up on agreed medication and others object to taking lipid-lowering medication, partly for legitimate reasons such as expected or perceived side effects. Furthermore, the GPs themselves perceived reservations for prescribing lipid-lowering medication in patients with short life expectancy, expected compliance problems or near goal lipid levels. GPs sometimes postponed the start of treatment because of other priorities. Finally, barriers were seen in the GPs' practice organisation, and at the primary-secondary care interface. Conclusions: Some of the barriers mentioned by GPs seem to be valid reasons, showing that guideline non-adherence can be quite rational. On the other hand, treatment quality could improve by addressing issues, such as lack of knowledge or motivation of both the patient and the GP. More structured management in general practice may also lead to better treatment

**Calvert,M. et al (2009). Effect of the quality and outcomes framework on diabetes care in the United Kingdom: retrospective cohort study. *British Medical Journal*, 338 b1870. 26<sup>th</sup> May 2009**

<http://dx.doi.org/10.1136/bmj.b1870>

<http://pmid.us/19474024>

Objectives: To examine the management of diabetes between 2001 and 2007 in the United Kingdom and to assess whether changes in the quality of care reflect existing temporal trends or are a direct result of the implementation of the quality and outcomes framework. Design: Retrospective cohort study. Setting: 147 general practices (annual list size over 1 million) across the UK. Patients People with type 1 or type 2 diabetes. Main outcome measures: Annual prevalence of diabetes and attainment of process and clinical outcomes over the three years before and the three years after the introduction of the quality and outcomes framework. Results: Significant improvements in process and intermediate outcome measures were observed during the six year period, with consecutive annual improvements observed before the introduction of incentives. However, the current diagnostic case definition for the quality and outcomes framework does not capture up to two thirds of people with type 1 diabetes and a third of people with type 2 diabetes. After the introduction of the quality and outcomes framework, existing trends of improvement in glycaemic control, cholesterol levels, and blood pressure were attenuated, particularly in people with diabetes who did not meet the case definition of the quality and outcomes framework. The introduction of the quality and outcomes framework did not lead to improvement in the management of patients with type 1 diabetes, nor to a reduction in the number of patients with type 2 diabetes who had HbA(1c) levels greater than 10%. Introduction of the quality and outcomes framework may have increased the number of patients with type 2 diabetes with HbA(1c) levels of  $\leq 7.5\%$ ; odds ratio 1.05 (95% confidence interval 1.01 to 1.09;  $P=0.02$ ). Conclusions: The management of people with diabetes has improved since the late 1990s, but the impact of the quality and outcomes framework on care is not straightforward; upper thresholds may need to be removed or targets made more challenging if people are to benefit. Many patients in whom care may be suboptimal may not be captured in the quality and outcomes framework assessment

**Crawley, D., et al (2009). Impact of pay for performance on quality of chronic disease management by social class group in England. *Journal of the Royal Society of Medicine* 102(3), 103-107.**

<http://dx.doi.org/10.1258/jrsm.2009.080389>

<http://pmid.us/19297651>

Objective: To examine associations between social class and achievement of selected national audit targets for coronary heart disease (CHD), diabetes and hypertension in England before and after the introduction of a major pay for performance programme in 2004. Design: Secondary analysis of 2003 and 2006 national survey data for respondents with CHD and diabetes and hypertension. Setting: England. MAIN Outcome measure: Achievement of national audit targets for blood pressure, blood glucose and cholesterol control. Results: There were no significant differences in achievement of blood pressure

targets in individuals from manual and non-manual occupational groups with diabetes (2003: 65.9% v 60.3%, 2006: 67.6% v 69.7%) or hypertension (2003: 66.2% v 66.2%, 2006: 72.8% v 71.9%) before or after the introduction of pay for performance. Achievement of the cholesterol target was also similar in individuals from manual and non-manual groups with diabetes (2003: 52.5% v 46.6%, 2006: 68.7% v 70.5%) or CHD (2003: 54.3% v 53.3%, 2006: 68.6% v 71.3%). Differences in achievement of the blood pressure target in CHD [75.8% v 84.5%; AOR 0.44 (0.21-0.90)] were evident between manual and non-manual occupational groups after the introduction of pay for performance. Conclusion: The quality of chronic disease management in England was broadly equitable between socioeconomic groups before this major pay for performance programme and remained so after its introduction

**Cullen,W., et al (2009) Chronic illness and multimorbidity among problem drug users: a comparative cross sectional pilot study in primary care. *BMC Family Practice* 10(1), 25.**

<http://dx.doi.org/10.1186/1471-2296-10-25>

<http://www.biomedcentral.com/1471-2296/10/25>

<http://pmid.us/19383116>

Background: Although multimorbidity has important implications for patient care in general practice, limited research has examined chronic illness and health service utilisation among problem drug users. This study aimed to determine chronic illness prevalence and health service utilisation among problem drug users attending primary care for methadone treatment, to compare these rates with matched 'controls' and to develop and pilot test a valid study instrument. Methods: A cross-sectional study of patients attending three large urban general practices in Dublin, Ireland for methadone treatment was conducted, and this sample was compared with a control group matched by practice, age, gender and General Medical Services (GMS) status. Results: Data were collected on 114 patients. Fifty-seven patients were on methadone treatment, of whom 52(91%) had at least one chronic illness (other than substance use) and 39(68%) were prescribed at least one regular medication. Frequent utilisation of primary care services and secondary care services in the previous six months was observed among patients on methadone treatment and controls, although the former had significantly higher chronic illness prevalence and primary care contact rates. The study instrument facilitated data collection that was feasible and with minimal inter-observer variation. Conclusions: Multimorbidity is common among problem drug users attending general practice for methadone treatment, and primary care may have an important role in primary and secondary prevention of chronic illnesses among this group. Further work on chronic illness and health service utilisation among problem drug users is advocated and this study offers a feasible study instrument

**Dale, J. et al (2009). Telephone peer-delivered intervention for diabetes motivation and support: the telecare exploratory RCT. *Patient Education and Counseling* 75(1), 91-98.**

<http://dx.doi.org/10.1016/j.pec.2008.09.014>

<http://pmid.us/19013741>

Objective: To test trial design issues related to measuring the effectiveness of a peer telephone intervention to enhance self-efficacy in type 2 diabetes; evaluate the impact on self-efficacy and clinical outcome; and describe patient and peer experience. Methods: Eligible patients had raised HbA1c (initial threshold >8%, reduced to >7.4% mid-way through trial). Patients were recruited from 40 general practices and randomised (40:40:20 ratio) to receive routine care alone or, in addition, motivational telephone support from a peer supporter or a diabetes specialist nurse (9 peers and 12 DSNs) for a period of up to 6 months. The primary outcome measure was self-efficacy score, and secondary outcome measures included HbA1c. Patient and telecare supporter satisfaction and experience were evaluated. Results: In all, 231 patients participated. At 6 months there were no statistically significant differences in self-efficacy scores ( $p=0.68$ ), HbA1c ( $p=0.87$ ) or other secondary outcome measures. There was evidence of a high level of acceptability, but peer telecare support was less highly valued than that from a DSN. Some patients stated that they would have valued more information and advice. Conclusions: Further consideration needs to be given to the targeting of the telecare peer support, its intensity, the training and ongoing supervision of peer supporters, and the extent to which information and advice should be incorporated. PRACTICE Implications: While some patients with poorly controlled type 2 diabetes value peer telephone support, this approach appears not to suit all patients. Further intervention development and evaluation is required before widespread adoption can be recommended

**Eccles, M., et al (2009). Improving the delivery of care for patients with diabetes through understanding optimised team work and organisation in primary care. *Implementation Science*, 4(1), 22.**

<http://dx.doi.org/10.1186/1748-5908-4-22>

<http://www.implementationscience.com/content/4/1/22>

<http://pmid.us/19397796>

Background: Type 2 diabetes is an increasingly prevalent chronic illness and is an important cause of avoidable mortality. Patients are managed by the integrated activities of clinical and non-clinical members of the primary care team. Studies of the quality of care for patients with diabetes suggest less than optimum care in a number of areas. Aim The aim of this study is to improve the quality of care for patients with diabetes cared for

in primary care in the UK. by identifying individual, team and organisational factors that predict the implementation of best practice. Design: Participants will be clinical and non-clinical staff within 100 general practices sampled from practices who are members of the MRC General Practice Research Framework. Self-completion questionnaires will be developed to measure the attributes of individual health care professionals, primary care teams (including both clinical and non-clinical staff) and their organisation in primary care. Questionnaires will be administered using postal survey methods. A range of validated theories will be used as a framework for the questionnaire instruments. Data relating to a range of dimensions of the organisational structure of primary care will be collected via a telephone interview at each practice, using a structured interview schedule. We will also collect data relating to the processes of care, markers of biochemical control and relevant indicator scores from the Quality and Outcomes Framework (QOF). Process data (as a proxy indicator of clinical behaviours) will be collected from practice databases and via a postal questionnaire survey of a random selection of patients from each practice. Levels of biochemical control will be extracted from practice databases. A series of analyses will be conducted to relate the individual, team and organisational data to the process, control and QOF data to identify configurations associated with high quality care.

**Gonzalez,E.L., et al (2009). Trends in the prevalence and incidence of diabetes in the UK: 1996-2005. *Journal of Epidemiology and Community Health*, 63(4), 332-336**

<http://dx.doi.org/10.1136/jech.2008.080382>

<http://pmid.us/19240084>

Background: To estimate the incidence and prevalence of type 1 and type 2 diabetes in the UK general population from 1996 to 2005. Methods: Using the Health Improvement Network database, patients with type 1 or type 2 diabetes were identified who were 10-79 years old between 1996 and 2005. Prevalent cases (n = 49 999) were separated from incident cases (n = 42 642; type 1 = 1256, type 2 = 41 386). Data were collected on treatment patterns in incident cases, and on body mass index in prevalent and incident cases. Results: Diabetes prevalence increased from 2.8% in 1996 to 4.3% in 2005. The incidence of diabetes in the UK increased from 2.71 (2.58-2.85)/1000 person-years in 1996 to 4.42 (4.32-4.53)/1000 person-years in 2005. The incidence of type 1 diabetes remained relatively constant throughout the study period; however, the incidence of type 2 diabetes increased from 2.60 (2.47-2.74)/1000 person-years in 1996 to 4.31 (4.21-4.42)/1000 person-years in 2005. Between 1996 and 2005, the proportion of individuals newly diagnosed with type 2 diabetes who were obese increased from 46% to 56%. Treatment with metformin increased across the study period, while treatment with sulphonylureas decreased. Conclusions: The prevalence and incidence of type 2 diabetes have increased in the UK over the past decade. This might be primarily explained by the

changes in obesity prevalence. Also, there was a change in drug treatment pattern from sulphonylureas to metformin

**Goudge, J. et al (2009). Affordability, availability and acceptability barriers to health care for the chronically ill: Longitudinal case studies from South Africa. *BMC Health Services Research*, 9(1), 75.**

<http://dx.doi.org/10.1186/1472-6963-9-75>

<http://www.biomedcentral.com/1472-6963/9/75>

<http://pmid.us/19426533>

Background: There is an increasing burden of chronic illness in low and middle income countries, driven by TB/HIV, as well as non-communicable diseases [1-3]. Few health systems are organized to meet the needs of chronically ill patients [4, 5], and patients' perspectives on the difficulties of accessing care need to be better understood, particularly in poor resourced settings, to achieve this end. This paper describes the experience of poor households attempting to access chronic care in a rural area of South Africa. Methods: A household survey (n=1446 individuals) was combined with qualitative longitudinal research that followed 30 case study households over 10 months. Illness narratives and diaries provided descriptive textual data of household interactions with the health system. Results: In the survey 74% of reported health problems were 'chronic', 48% of which had no treatment action taken in the previous month. Amongst the case study households, of the 34 cases of chronic illness, only 21 (62%) cases had an allopathic diagnosis and only 12 (35%) were receiving regular treatment. Livelihoods exhausted from previous illness and death, low income, and limited social networks, prevented consultation with monthly expenditure for repeated consultations as high as 60% of income. Interrupted drug supplies, insufficient clinical services at the clinic level necessitating referral, and a lack of ambulances further hampered access to care. Poor provider-patient interaction led to inadequate understanding of illness, inappropriate treatment action, 'healer shopping', and at times a break down in cooperation, with the patient 'giving up' on the public health system. However, productive patient-provider interactions not only facilitated appropriate treatment action but enabled patients to justify their need for financial assistance to family and neighbours, and so access care. In addition, patients and their families with understanding of a disease became a community resource drawn on to assist others. Conclusion: In strengthening the public sector it is important not only to improve drug supply chains, ambulance services, referral systems and clinical capacity at public clinics, and to address the financial constraints faced by the socially disadvantaged, but also to think through how providers can engage with patients in a way that strengthens the therapeutic alliance

**Goyder, E. et al (2009). Informed choice and diabetes screening in primary care: Qualitative study of patient and professional views in deprived areas of England. *Primary Care Diabetes*. Epub ahead of print 21/05/2009**

<http://dx.doi.org/10.1016/j.pcd.2009.04.001>

<http://pmid.us/19464976>

**Aims:** To examine perceived need for, and provision of, information prior to participation in a diabetes screening programme in English general practices. **Methods:** Case studies using qualitative semi-structured interviews with patients and practitioners in five participating practices. **Results:** Participating patients generally demonstrated a lack of understanding of issues in relation to the benefits and disadvantages of diabetes screening or the implications of screening test results. Posted invitation letters provided written information but did not necessarily ensure that patients were better informed than those invited by telephone or opportunistically when attending the practice for another reason. Not all patients interviewed wanted the extent of information that would be required to enable them to give fully informed consent to screening. **Conclusions:** The ways in which information is provided to patients requires careful consideration so that a patient has sufficient understanding to make a decision about undergoing a screening test and understands the implications of test results. There is a potential conflict between the ideal of fully informed choice and patient expectations that they can depend on professionals to make the appropriate decision on their behalf

**Guldborg, T. et al (2009). The effect of feedback to general practitioners on quality of care for people with type 2 diabetes. A systematic review of the literature. *BMC Family Practice*, 10(1), 30.**

<http://dx.doi.org/10.1186/1471-2296-10-30>

<http://www.biomedcentral.com/1471-2296/10/30>

<http://pmid.us/19419548>

**Background:** There have been numerous efforts to improve and assure the quality of treatment and follow-up of people with Type 2 diabetes (PT2D) in general practice. Facilitated by the increasing usability and validity of guidelines, indicators and databases, feedback on diabetes care is a promising tool in this aspect. Our goal was to assess the effect of feedback to general practitioners (GPs) on the quality of care for PT2D based on the available literature. **Methods:** Systematic review searches were conducted using October 2008 updates of Medline (Pubmed), Cochrane library and Embase databases. Additional searches in reference lists and related articles were conducted. Papers were included if published in English, performed as randomized controlled trials, studying diabetes, having general practice as setting and using feedback to GPs on diabetes care. The papers were assessed according to predefined criteria. **Results:** Ten studies complied with the inclusion criteria. Feedback improved the care for PT2D, particularly process outcomes such as foot exams, eye exams and HbA1c measurements. Clinical outcomes like lowering of blood pressure, HbA1c and cholesterol levels were seen in few studies. Many process and outcome measures did not improve, while none deteriorated. Meta analysis was unfeasible due to heterogeneity of the studies included. Two studies used electronic feedback. **Conclusions:** Based on this review, feedback seems a promising tool

for quality improvement in diabetes care, but more research is needed, especially of electronic feedback

**Lawton,J., et al (2009). Patients' perceptions and experiences of transitions in diabetes care: a longitudinal qualitative study. *Health Expectations* Online ahead of print 20/03/2009**

<http://dx.doi.org/10.1111/j.1369-7625.2009.00537.x>

<http://pmid.us/19309488>

**Objective** To examine patients' perceptions and experiences over time of the devolvement of diabetes care/reviews from secondary to primary health-care settings. **Design** Repeat in-depth interviews with 20 patients over 4 years. **Participants and setting** Twenty type 2 diabetes patients recruited from primary- and secondary-care settings across Lothian, Scotland. **Results** Patients' views about their current diabetes care were informed by their previous service contact. The devolvement of diabetes care/reviews to general practice was presented as a 'mixed blessing'. Patients gained reassurance from their perception that receiving practice-based care/reviews signified that their diabetes was well-controlled. However, they also expressed resentment that, by achieving good control, they received what they saw as inferior care and/or less-frequent reviews to others with poorer control. While patients tended to regard GPs as having adequate expertise to conduct their practice-based reviews, they were more ambivalent about nurses taking on this role. Opportunities to receive holistic care in general practice were not always realized due to patients seeing health-care professionals for diabetes management to whom they would not normally present for other health issues. **Conclusions** It is important to educate patients about their care pathways, and to reassure them that frequency of reviews depends more on clinical need than location of care and that similar care guidelines are followed in hospital clinics and general practice. A patients' history of service contact may need to be taken into account in future studies of service satisfaction

**van,Lieshout .J., Wensing,M., Campbell,S.M., & Grol,R. (2009). Primary care strength linked to prevention programs for cardiovascular disease. *American Journal of Managed Care*, 15(4), 255-262.**

<http://pmid.us/19355798>

**Objective:** Primary care plays a central role in the prevention and management of cardiovascular disease. We expected that countries with strong primary care systems would have programs to improve management of disease, but wondered how they dealt with lifestyle interventions delivered in primary care. **Study design:** Observational comparative study. **Methods:** Using country coordinators and key informants, we collected information on 42 programs to improve cardiovascular risk management in 11 countries (Austria, Belgium, Finland, France, Germany, Israel, The Netherlands, Spain, Slovenia, Switzerland, the United Kingdom). **Results:** Most (95%) of the improvement programs were targeted at health professionals; 86% of these provided education. Evaluation was part of all programs. In countries with a strong primary care system, 63%

of the programs focused exclusively on disease management, 29% on lifestyle interventions, and 8% on both. In countries with a weak primary care system, 22% of the programs focused on disease management and 78% on lifestyle improvement. Conclusions: Our findings suggest that a strong primary care system is likely to make efforts to improve disease management, but not necessarily efforts to improve delivery of lifestyle interventions. This may be a missed opportunity, given the potential of primary care to influence lifestyle

## CO-MORBIDITY

**Cowie,L., et al (2009). Experience of continuity of care of patients with multiple long-term conditions in England. *Journal of Health Services Research and Policy*, 14(2), 82-87.**

<http://dx.doi.org/10.1258/jhsrp.2009.008111>

<http://pmid.us/19299261>

Objectives: To examine patients' experiences of continuity of care in the context of different long-term conditions and models of care, and to explore implications for the future organization care of long-term conditions. Methods: Qualitative semi-structured interviews were carried out with 33 patients recruited from seven general practices in South London. Patients were selected who had one or more of the following long-term conditions: arthritis, coronary heart disease, stroke, hypercholesterolaemia, hypertension, diabetes mellitus or chronic obstructive pulmonary disease. Results: Multiple morbidity was frequent and experiences of continuity were framed within patients' wider experiences of health care rather than the context of a particular diagnosis. Positive experiences of relational continuity were strongly associated with long-term GP-led or specialist-led care. Management continuity was experienced in the context of shared care in terms of transitions between professionals or organizations. Access and flexibility issues were identified as important barriers or facilitators of continuity. Conclusions: Across a range of long-term conditions, patients' experiences of health care can be understood in terms of nuanced understandings of relational and management continuity. Continuity experiences, meanings and expectations, as well as barriers and facilitators, are influenced by the model of care rather than type of condition

**Koopmans,B., et al (2009). Depressive symptoms are associated with physical inactivity in patients with type 2 diabetes. The DIAZOB Primary Care Diabetes study. *Family Practice* Online 25/03/2009**

<http://dx.doi.org/10.1093/fampra/cmp016>

<http://pmid.us/19321598>

Background. Depression is a common complication of type 2 diabetes, associated with poor disease outcomes such as impaired glycaemic control, cardiovascular disease and increased mortality. The mechanisms behind these associations are unclear. Depression might contribute to poor disease outcomes through decreased physical activity. Objective. To test whether type 2 diabetes patients with elevated depression scores are more often physically inactive. Methods. Demographic features, clinical factors, level of physical inactivity and depressive symptoms were assessed in 2646 primary care patients with type 2 diabetes. Sequential multiple logistic regression analyses [odds ratio, 95% confidence interval (CI)] were performed to test the association between depressive symptoms and physical inactivity. Results. About 48% of the respondents were physically inactive. Elevated depressive symptoms were found in 14% of the respondents. After adjustment for potential confounders, the odds for being physically inactive were almost doubled in depressed patients with type 2 diabetes 1.74 (95% CI 1.32-2.31). Conclusions. Presence of depressive symptoms almost doubles the likelihood of physical inactivity in patients with type 2 diabetes. Longitudinal studies are needed to investigate whether physical inactivity forms the link between depression and poor disease outcomes

**Suija,K., Kalda,R., & Maarros,H.I. (2009). Patients with depressive disorder, their co-morbidity, visiting rate and disability in relation to self-evaluation of physical and mental health: a cross-sectional study in family practice. *BMC Family Practice* 10(1), 38.**

<http://dx.doi.org/10.1186/1471-2296-10-38>

<http://www.biomedcentral.com/1471-2296/10/38>

<http://pmid.us/19486534>

Background: High prevalence of depression among primary care patients has increased the need for more research in this field. The objectives of our study were to analyse how depressed patients evaluate their health; which co-morbid diseases are associated with depression; how depression influences the patients' consultation rate in family practice (FP); how disability is associated with depression; and how depression influences the patients' working ability. Methods: A cross-sectional study, part of the PREDICT study. The study group was formed of 1094 consecutive patients from 23 FPs across Estonia, aged 18-75 years, attending a FP to consult the family doctor (FD). Occurrence of major depression during six months was estimated using the Depression Section of the Composite International Diagnostic Interview. The medical records of all patients were analysed concerning co-morbid diseases, number of visits to the FD, and disability. Every patient filled in questionnaires to assess health-related risk factors for depression, and the SF-12 Health Survey to assess functioning and the perception of health. Results: Depression was found in 230 (21%) of the patients. Depressed patients reported less accomplishment owing to emotional problems (OR 1.80; 95% CI 1.18-2.72), being less careful as usual (OR 1.81; 95% CI 1.26-2.60), and having pain that extremely interfered with their normal work (OR 2.50; 95% CI 1.33-4.70) in comparison with non-depressed patients. Also depressed patients were more days on sick-leave (OR 1.00; 95% CI 1.00-

1.01) than non-depressed patients. However, analysis of the medical records did not indicate that depressed patients consulted the FD more or had more co-morbid diagnoses than the non-depressed patients. Conclusions: Depressed patients may have low self-reported functioning due to emotional problems, pain, and their working ability may have decreased; however, the patients of both groups have an equal number of co-morbid diagnoses and their consultation rate is similar

## EVIDENCE-BASED MEDICINE

**Alonso-Coello,P., et al (2009) Perceptions, attitudes and knowledge of evidence-based medicine in primary care: a study protocol. *BMC Health Services Research*, 9(1), 80.**

<http://dx.doi.org/10.1186/1472-6963-9-80>

<http://www.biomedcentral.com/1472-6963/9/80/abstract>

<http://pmid.us/19445660>

Background: The philosophy of evidence-based medicine (EBM) was introduced in the early 90s as a new approach to the practice of medicine, using the best available evidence to make decisions about health care. Despite ongoing controversy, EBM has developed enormously and physicians' attitude towards it is generally positive. Nevertheless, in Spain little is known about this topic. We will therefore undertake a study to explore perceptions, attitudes and knowledge about EBM among primary care physicians. Design: A mixed-method study combining qualitative and quantitative designs will target family practitioners in Spain with the objective of evaluating current attitudes and perceptions about evidence-based medicine. The project will consist of two phases: a first phase running focus groups to identify perceptions and attitudes of participants, and a second phase assessing their attitudes and knowledge about EBM by means of a survey. Both phases will explore these issues in three different subgroups: family practitioners, with or without previous formal education in EBM; members of working groups that formulate healthcare recommendations; and physicians in charge of training family practice residents. Additionally, we will undertake a systematic review to identify and synthesize the available evidence on this topic. Discussion: The study will identify and gain insight into the perceived problems and barriers to the practice of evidence-based medicine among general practitioners in Spain. The project will also evaluate the main knowledge gaps and training needs, and explore how evidence-based medicine is being taught to family medicine residents, the medical practitioners of the future. Our results will aid researchers and health care planners in developing strategies to improve the practice of evidence-based medicine in our country

## HEALTH ECONOMICS

**Allen,P. (2009). Payment by Results in the English NHS: the continuing challenges. *Public Money & Management*, 29 (3), 161-166.**

<http://dx.doi.org/10.1080/09540960902891681>

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

**Appleby,J., et al (2009). Searching for cost effectiveness thresholds in the NHS. *Health Policy*. Online 23/01/2009**

<http://dx.doi.org/10.1016/j.healthpol.2008.12.010>

<http://pmid.us/19168255>

Objectives: The UK's National Institute of Health and Clinical Excellence (NICE) has an explicit cost-effectiveness threshold for deciding whether or not services are to be provided in the National Health Service (NHS), but there is currently little evidence to support the level at which it is set. This study examines whether it is possible to obtain such evidence by examining decision making elsewhere in the NHS. Its objectives are to set out a conceptual model linking NICE decision making based on explicit thresholds with the thresholds implicit in local decision making and to gauge the feasibility of (a) identifying those implicit local cost effectiveness thresholds and (b) using these to gauge the appropriateness of NICE's explicit threshold. Methods: Structured interviews with senior staff, together with financial and public health information, from six NHS purchasers and 18 providers. A list of health care services introduced or discontinued in 2006/7 was constructed. Those that were in principle amenable to estimation of a cost-effectiveness ratio were examined. Results: It was feasible to identify decisions and to estimate the cost-effectiveness of some. These were not necessarily 'marginal' services. Issues include: services that are dominated (or dominate); decisions about how, rather than what, services should be delivered; the lack of local cost effectiveness evidence; and considerations other than cost-effectiveness. Conclusions: A definitive finding about the consistency or otherwise of NICE and NHS cost effectiveness thresholds would require very many decisions to be observed, combined with a detailed understanding of the local decision making processes

**Benavent,J., et al (2009). Using pay-for-performance to introduce changes in primary healthcare centres in Spain: first year results. *Quality in Primary Care*, 17(2), 123-131.**

<http://pmid.us/19416605>

Introduction: The article describes evaluation of the first year of implementation of a process-management project and a quality-improvement programme linked to economic incentives carried out at CAPSE (Consortium of Primary Healthcare of Eixample, Barcelona City, Catalonia, Spain). Objective: To evaluate the changes and to describe the experience of a variable payment scheme linked to quality objectives in two primary healthcare centres in Spain. Method: Data from a variable payment scheme for professionals, where the variable payment consisted of three parts, were analysed. The three areas included in the variable payment were the results of management by objectives, performance evaluation, and participation in a quality-improvement programme. Parallel to this the actions of continuous quality improvement that had been proposed during 2006 were described and evaluated. Results: Participation among personnel in the quality-improvement programme was high, including 96% of doctors and 100% of nurses. Seventy-two improvement actions were proposed and accepted; 56% of the improvement actions took place within the established period of time, 18% did not finish within the deadline and 26% could not be accomplished for various reasons. Discussion: The following areas needing improving were detected: process-management training for healthcare professionals, process orientation to the patients, the need to develop a communication plan, the selection of process and outcomes indicators, appropriate use of information systems and the time spent in implementation of the quality-improvement programme. Conclusion: Our preliminary results are encouraging. More studies and comparison of similar experiences are required before widespread use of this system can be recommended

**Fabrizi, D., & Monfardini, C. (2009). Rationing the public provision of healthcare in the presence of private supplements: Evidence from the Italian NHS. *Journal of Health Economics* 28(2), 290-304.**

<http://dx.doi.org/10.1016/j.jhealeco.2008.11.004>

<http://pmid.us/19135274>

In this paper we assess the relative effectiveness of user charges and administrative waiting times as a tool for rationing public healthcare in Italy. We measure demand elasticities by estimating a simultaneous equation model of GP primary care visits, public specialist consultations and private specialist consultations, as if they were part of an incomplete system of demand. We find that for public specialist consultations, own price elasticity of demand is about -0.3, while elasticity to administrative waiting time is about -.04. No substitution exists between the demand for public and private specialists, so that user charges act as a net deterrent for over-consumption. The public provision of healthcare does not induce the wealthy to opt out. Moreover our evidence suggests that user charges and waiting lists do not serve redistributive purposes

**Lippi, B.M., Nobilio, L., & Ugolini, C. (2009). Economic incentives in general practice: the impact of pay-for-participation and pay-for-compliance programs on diabetes care. *Health Policy*, 90(2-3), 140-148.**

<http://dx.doi.org/10.1016/j.healthpol.2008.09.008>

<http://pmid.us/18992955>

Objectives: We investigate the impact on quality of care of the introduction of two financial incentives in primary care contracts in the Italian region Emilia Romagna: pay-for-participation and pay-for-compliance with best practices programs. Methods: We concentrate on patients affected by diabetes mellitus type 2, for which the assumption of responsibility and the adoption of clinical guidelines are specifically rewarded. We test the hypothesis that, other things equal, patients under the responsibility of general practitioners (GPs) receiving a higher share of their income through these programs are less likely to experience hospitalisation for hyperglycaemic emergencies. To this end, we examine the combined influence of physician, organisational and patient factors by means of multilevel modelling for the year 2003. Results: Programs aimed at stimulating GP assumption of responsibility in disease management significantly reduce the probability of hyperglycaemic emergencies for their patients. Conclusions: Although it has been recognised that incentive-based remuneration schemes can have an impact on GP behaviour, there is still weak empirical evidence on the extent to which such programs influence healthcare outcomes. Our results support the hypothesis that financial transfers may contribute to improve quality of care, even when they are not based on the ex-post verification of performances

**McDonald,R. (2009). Market reforms in English primary medical care: medicine, habitus and the public sphere. *Sociology of Health and Illness* Online 9/04/2009**

<http://dx.doi.org/10.1111/j.1467-9566.2009.01165.x>

<http://pmid.us/19392936>

Drawing on interviews with English primary care doctors (GPs), this paper examines GP responses to reforms intended to introduce a market in primary health care. GPs' reactions are conceptualised in terms of a GP habitus, which takes for granted the superiority of 'public' providers (i.e. GP partnerships) in the provision of care. GPs are actively involved in the defence of the public sphere, which is neither a neo-liberal minimalist market state, nor a wholly altruistic state, responding to consumers' wants. The public sphere they defend is one in which boundaries are drawn about entitlements and GPs are actively engaged in defining and policing these boundaries. The GP habitus can be seen as shaping responses in ways which serve GP interests. In the context of struggles involving various social actors (e.g. private providers, third-party payers, patients) with different stakes in the field of general medical practice; this public service orientation may enable GPs to reap cultural capital. At the same time, the habitus constrains action in a way which limits resistance to reforms threatening GPs' interests, with GPs responding by coping, rather than downing tools or engaging in active confrontation

**Mooney,G. (2009). Is it not time for health economists to rethink equity and access? *Health Economics, Policy and Law*, 4(Pt 2), 209-221.**

<http://dx.doi.org/10.1017/S1744133109004848>

<http://pmid.us/19192324>

This article considers two key issues in health economics regarding the question of equity. First, why have health economists not resolved better the issue of what are equity and access? Second, the paper draws attention to the relative lack of analyses of equity concerns outside of health care. The question of whose values should prevail in equity is also addressed. On the first issue, there is an obsession with quantification in economics with the result that in analysing equity, in practice often 'use' has been substituted for 'access'. The problem of defining access has thereby been by-passed. This has taken the pressure off trying to research access per se. Second, what is meant by equity and access are in part culturally determined. The continued efforts of health economists to treat equity as some universal construct are misplaced. The lack of effort on the part of health economists to look at equity more broadly than health care equity is concerning. Certainly, to be pursued in practice, equity in both health and health care need a shift in resources, which will be opposed by those who exercise power over decision making in health care and in society more generally. Currently health economists' analyses say all too little about power and property rights in health care and in society. It is argued that the relevant citizens or communities which a health service serves are best placed to judge the access barriers they face and their relative heights. A useful definition of equity established by a citizens' jury in Perth, Australia is used to exemplify this point. It is concluded that the often all too simplistic equity goals adopted in health economics (and sometimes public health discourse) need to be challenged. For health economists, there is a need for more of us to get involved in the issues around inequalities, class and power and the impact of these on health

**Sahn,D.E., & Younger,S.D. (2009). Measuring intra-household health inequality: explorations using the body mass index. *Health Economics 18 Suppl 1* S13-S36.**

<http://dx.doi.org/10.1002/hec.1459>

<http://pmid.us/19294638>

This paper examines the relationship between level of well-being and inequality at inter-country and intra-household levels, using individuals' body mass index (BMI) rather than income as the indicator of well-being. BMI is useful for these purposes because (1) it is measured at the individual rather than household level; (2) it reflects command over food, but also non-food resources that affect health status like sanitary conditions and labour-saving technologies; (3) it accounts for caloric consumption relative to needs; (4) it is easily measured; and (5) any measurement error is likely to be random. We do not find any evidence to support the idea of an intra-household or inter-country Kuznets curve.

We study the correlations between average household well-being, still measured by BMI, and differences in the BMIs of males and females, parents and children. Here, we find a tendency to protect the BMI of young children when living standards are very low. We find no clear patterns by gender. Perhaps the most striking finding in the paper is that about half of total BMI inequality at the country level is within households. Thus, standard measures of inequality that use household-level data may drastically understate true inequality

## HEALTH INEQUALITIES

**Andersen,I., et al (2009). Social inequality in the prevalence of depressive disorders. *Journal of Epidemiology and Community Health*. Online 16<sup>th</sup> March 2009**

<http://dx.doi.org/10.1136/jech.2008.082719>

<http://pmid.us/19293167>

Background: Uncertainties exist about the strength of the relation between socio-economic position and depressive disorders. The aim of this study was to investigate the association between education, occupation, employment and income and depressive disorders measured as minor and major depression as well as antidepressant prescriptions. Methods: Data were collected from a Danish cross sectional study collected year 2000, comprising 9254 subjects, 55% women, and aged 36-56 years. We used register-based information on education, income and prescription. Results: The prevalence of major depression DSM-IV algorithm was 3,3% among men and women, whereas minor depression and prescriptions revealed statistically significant higher prevalence among females. A social gradient was found for all depressive end-points with the strongest estimates related to major depressive disorder (MDD). The associations were as follows: MDD and low education odds ratio (OR) 2.38 (CI 95% 1.7 to 3.4), MDD and non-employment OR 11.67 (CI 95% 8.06 to16.89), MDD and low income OR 9.78 (CI 95% 6.49 to14.74). Education only explained a minor part of the association between non-employment and depressive disorders and no associations were found between education and prescription. This indicates a strong two-way association between depression and non-employment, low-income, respectively. Conclusion: We found a social gradient in depressive disorders regardless of socio-economic position being measured by education, occupation, employment or income. Severe socioeconomic consequences of depression are indicated by the fact, that the associations with non-employment and low income were much stronger than the association with low education

**Boyle,P.J., Norman,P., & Popham,F. Social mobility: Evidence that it can widen health inequalities. *Social Science & Medicine***

<http://dx.doi.org/10.1016/j.socscimed.2009.02.051>

<http://pmid.us/19342136>

Numerous studies consider the role of social, or occupational, mobility on health inequalities. A common conclusion is that social mobility constrains, rather than widens, social class health inequalities. It is argued that such 'gradient constraint' occurs because movers into higher social classes tend to have poorer health than those they join, while movers into lower social classes tend to have better health than those they join. This has led to the suggestion that increasing social mobility may be an effective policy to reduce health inequalities. However, this raises a paradox as many studies also show that health inequalities are widening. We compare class mobility and deprivation mobility between 1971 and 1991 with health in 1991 in England and Wales. In both cases, the health in 1991 of the 'mobile' tended to fall between that of those they left and those they joined. In comparison to the socially stable, the gradient was thus constrained. However, comparing the health in 1991 of everyone by their class/deprivation position in 1991 and 1971, the overall social class health gradient was little different, while the deprivation health gap was considerably wider in 1991. These results show that a reduction in inequalities is not a necessary consequence if the health of 'mobile' people falls between that of those they left and those they joined and this is particularly the case for deprivation mobility

**Kelly-Irving, M., et al (2009). Patient-physician interaction in general practice and health inequalities in a multidisciplinary study: design, methods and feasibility in the French INTERMEDE study. *BMC Health Services Research*, 9(1), 66.**

<http://dx.doi.org/10.1186/1472-6963-9-66>

<http://www.biomedcentral.com/1472-6963/9/66>

<http://pmid.us/19386119>

Background: The way in which patients and their doctors interact is a potentially important factor in optimal communication during consultations as well as treatment, compliance and follow-up care. The aim of this multidisciplinary study is to use both qualitative and quantitative methods to explore the 'black box' that is the interaction between the two parties during a general practice consultation, and to identify factors therein that may contribute to producing health inequalities. This paper outlines the original multidisciplinary methodology used, and the feasibility of this type of study. Methods/ design: The study design combines methodologies on two separate samples in two phases. Firstly, a qualitative phase collected ethnographical and sociological data during consultation, followed by in-depth interviews with both patients and doctors independently. Secondly, a quantitative phase on a different sample of patients and physicians collected data via several questionnaires given to patients and doctors consisting of specific 'mirrored' questions asked post-consultation, as well as collecting information on patient and physician characteristics. Discussion: The design and methodology used in this study were both successfully implemented, and readily

accepted by doctors and patients alike. This type of multidisciplinary study shows great potential in providing further knowledge into the role of patient/ physician interaction and its influence on maintaining or producing health inequalities. The next challenge in this study will be implementing the multidisciplinary approach during the data analysis

## HEALTH POLICY

**Gillies, J.C., et al (2009). Distilling the essence of general practice: a learning journey in progress. *British Journal of General Practice* 59(562), e167-e176.**

<http://dx.doi.org/10.3399/bjgp09X420626>

<http://pmid.us/19401010>

Over the past 5 years, general practice in the UK has undergone major change. Starting with the introduction of the new GMS contract in 2004, it has continued apace with the establishment of Postgraduate Medical Education Training Board, a GP training curriculum, and nMRCGP. The NHS is developing very differently in the four countries of the UK. Regulation of the profession is under review, and a system of relicensing, recertification, and revalidation is being introduced. The Essence project, initiated by RCGP Scotland in conjunction with International Futures Forum 4 years ago is a constructive response to these changes. It has included learning journeys, a discussion day for GPs, and commissioned short pieces of 100 words from GPs and patients. From an analysis of these, some characteristics of the essence of general practice have been defined. These include key roles and core personal qualities for GPs. It is argued that general practice has important and unique advantages - trust, coordination, continuity, flexibility, universal coverage, and leadership - which mean that it should continue to be central to the development of primary care throughout the UK

**Meads, G. (2009). The organisation of primary care in Europe: Part 1 Trends - position paper of the European Forum for Primary Care. *Quality in Primary Care*, 17(2), 133-143.**

<http://pmid.us/19416606>

**Aim:** To describe and classify contemporary organisational developments in primary care across Europe. **Method:** Ten case studies have been undertaken at local sites which are exemplars of organisational practice nominated by national leaders and international experts. The selection is informed by a comprehensive literature and documentary review, with expert advice from members of the European Forum for Primary Care. **Results:** A profile of organisational development trends is indicated, confirming the status of the extended general practice, the growth in managed care enterprises and the omission of service models prominent in other continents. **Conclusion:** The risks as well as the opportunities arising from the enlargement of Europe, with its vulnerable polyclinic and

medical cabinet models, are highlighted, with further discussion and analysis to follow in Part 2 of the position paper

**Mitchell,P et al (2009). Partnerships for knowledge exchange in health services research, policy and practice. *Journal of Health Services Research and Policy*, 14(2), 104-111.**

<http://dx.doi.org/10.1258/jhsrp.2008.008091>

<http://pmid.us/19299264>

Within the health services research community there is a growing strength of feeling that ongoing partnerships between researchers and decision-makers are critically important to effective transfer and exchange of knowledge generated from health services research. A body of literature is emerging around this idea that favours a particular model of partnership based on decision-maker involvement in research. This model is also gaining favour among health research funding bodies internationally. We argue that it is premature for the health services community to privilege any particular model of partnership between researchers and decision-makers. Rather a diversity of models should be conceptualized, explored in theory and practice, and evaluated. We identify seven dimensions that could be used to describe and differentiate models of partnerships for knowledge exchange and illustrate how these dimensions could be applied to analysing partnerships, using three case studies from recent and ongoing health services research partnerships in Australia

## **INFORMATION AND COMMUNICATIONS TECHNOLOGY**

**Davis,K. et al (2009). Health information technology and physician perceptions of quality of care and satisfaction. *Health Policy*, 90(2-3), 239-246.**

<http://dx.doi.org/10.1016/j.healthpol.2008.10.002>

<http://pmid.us/19038472>

Objective: To examine across seven countries the relationship between physician office information system capacity and the quality of care. Design: Multivariate analysis of a cross-sectional 2006 random survey of primary care physicians in seven countries: Australia, Canada, Germany, the Netherlands, New Zealand, United Kingdom, and United States. Main outcome measures: coordination and safety of care, care for chronically ill patients, and satisfaction with practice of medicine. Results: The study finds significant disparities in the quality of health care between practices with low information system capacity and those with high technical capacity after controlling for within country differences and practice size. There were significant physician satisfaction

differences with the overall experience of practicing medicine by information system level. Conclusions: For policy leaders, the seven-nation survey suggests that health systems that promote information system infrastructure are better able to address coordination and safety issues, particularly for patients with multiple chronic conditions, as well as to maintain primary care physician workforce satisfaction

## **MEDICINES MANAGEMENT**

**Lim,D. et al (2009). A systematic review of the literature comparing the practices of dispensing and non-dispensing doctors. *Health Policy* Online 5/03/2009**

<http://dx.doi.org/10.1016/j.healthpol.2009.01.008>

<http://pmid.us/19269055>

Objectives: Some doctors perform the dual roles of prescribing and dispensing pharmaceuticals. The dispensing doctors (DDs) role may give rise to prescribing behaviours that vary from those of non-DDs. The aim of this review was to systematically and comparatively appraise the research evidence related to the practices of DDs. Methods: A systematic search of bibliographic databases and reference lists from selected papers were the sources of the data. Inclusion criteria were papers published in English, between 1970 and 2008 that provided quantitative data comparing the practices of DDs and non-DDs. At least two of the authors abstracted data from all eligible papers using a purpose-made data extraction form. Results: Twenty-one papers were included in this review. Evidence indicated that DDs prescribed more pharmaceutical items and less often generically than non-DDs. There was limited evidence to suggest that DDs prescribed less judiciously and were associated with poor dispensing standards. Patient convenience and access to pharmaceuticals were main reasons for doctors to dispense. Conclusion: DDs can fill an important gap in the provision of pharmaceuticals for their patients especially where health workforce shortages exist. There was evidence the dispensing role influenced prescribing. Patient convenience should be balanced against scarce medical resources, being utilised for dispensing

**Sondergaard,J. et al (2009). Impact of pharmaceutical representative visits on GPs' drug preferences. *Family Practice* Online 8/03/2009**

<http://dx.doi.org/10.1093/fampra/cmp010>

<http://pmid.us/19273463>

Background. Pharmaceutical representative visits are believed to have substantial impact, but the effects on prescribing patterns have not been systematically evaluated. Objective. This study investigates how pharmaceutical sales representative visits influenced physicians' company-specific drug preferences and prevalence of steroid prescribing. Methods. Observational cohort study in Funen County, Denmark, including 165 general

practices visited 832 times by pharmaceutical representatives and 54 080 patients treated with asthma drugs. Visits were conducted from 2001 to 2003. Our main outcome measures were (i) company-specific drug preferences measured as the proportion of dispensings of the promoted drug among all dispensings of fixed combinations of inhaled corticosteroid and long-acting  $\beta$ 2-agonists and (ii) the proportion of patients receiving repeated  $\beta$ 2-agonist dispensings who were treated with inhaled steroids. Results. The first visit had a statistically significant effect on the GPs' drug preference in favour of the marketed drug [odds ratio (OR), 2.39; 95% confidence interval (CI), 1.72-3.32]. The effect on drug preference increased further after the second visit (OR, 1.51; 95% CI, 1.19-1.93), while there was no significant change after the third visit (OR, 1.06; 95% CI, 0.94-1.20). Pharmaceutical sales representative visits did not influence the overall treatment pattern with inhaled steroids (OR, 1.01; 95% CI, 0.97-1.06). Conclusions. Pharmaceutical sales representative visits markedly increased the market share of the promoted drug, but only the two first visits had significant impact. Visits had no significant impact on GPs' overall prescribing of inhaled steroids

## MENTAL HEALTH

**Beattie,A., et al (2009). Primary-care patients' expectations and experiences of online cognitive behavioural therapy for depression: a qualitative study. *Health Expectations*, 12(1), 45-59.**

<http://dx.doi.org/10.1111/j.1369-7625.2008.00531.x>

<http://pmid.us/19250152>

Objective: To explore expectations and experiences of online cognitive behavioural therapy (CBT) among primary-care patients with depression, focusing on how this mode of delivery impacts upon the therapeutic experience. Design: Qualitative study, using repeat semi-structured interviews with patients before and after therapy. The study was conducted in parallel with a randomized controlled trial examining the effectiveness and cost-effectiveness of online CBT for patients with depression. Participants: Twenty-four patients with depression recruited from five general practices in southwest England, who were offered up to 10 sessions of CBT, delivered via the internet by a psychologist. Results: Most participants accessed the therapy from their home computer and found this to be a major advantage, in terms of convenience and fitting therapy into their daily routine, with any technical problems quickly resolved. Two key themes regarding expectations and experiences of online CBT were: developing a virtual relationship with a therapist, and the process of communicating thoughts and emotions via an online medium. Online CBT seems to be acceptable to, and experienced as helpful by, certain subgroups of patients with depression, particularly those who are familiar with computers, feel comfortable with writing their feelings down, enjoy the opportunities to review and reflect that written (or typed) communication offers are attracted to the 'anonymity' of an online therapeutic relationship and are open to the proactive requirements of CBT itself. However, on-line CBT may feed into the vulnerability of

depressed people to negative thoughts, given the absence of visual cues and the immediate response of face-to-face interaction. Conclusions: Online CBT has the potential to enhance care for patients with depression who are open to engaging in 'talking' (or typing) therapies as part of their treatment. If online CBT is to be provided via the NHS, it is important to establish patient preferences regarding this mode of delivery and ensure that referral practices are appropriately targeted. The results of our main trial will provide evidence regarding the effectiveness and cost-effectiveness of receiving therapy via this modality

**Cronin,E., et al (2009). A tale of two systems: perceptions of primary care for depression in London and Melbourne. *Family Practice Online* 5/03/2009**

<http://dx.doi.org/10.1093/fampra/cmp017>

<http://pmid.us/19264839>

Background: Depression represents a major and growing disease burden. About 90% of depressed patients are treated solely in primary care, yet there are system-related barriers to primary care for people with depression in the UK and Australia, countries which have different health care arrangements. Objectives: The aim was to explore the views of GPs and patients in London and Melbourne about primary care system features which support or hinder best care for mild-to-moderate depression. The study differentiated between policy and reality 'on the ground'. Methods: Two round Delphi technique methodology with four panels: GPs and patients in London and GPs and patients in Melbourne, to elicit views on the extent to which system features were reflected in policy, reflected in reality and were of value for best care. Results: Four themes were generated: system and financing, responsibility and continuity, consultations and primary care team. Patient-centred care, having sufficient time during a consultation, and the GP-patient relationship extending over time were rated highly by all panels. Panellists differentiated between policy and reality on a number of features. Conclusions: The Australian system does not guarantee continuity of care with practitioner or practice but patients took steps to see the same doctor for depression. There was a difference in the way London and Melbourne panels responded to finance-related statements. There was a tendency for panellists to value aspects of their own system and to fail to see possibilities of other systems

**Cunningham,P.J. (2009). Beyond parity: primary care physicians' perspectives on access to mental health care. *Health Affairs (Millwood)*. 28 (3) Online 14/04/2009**

<http://dx.doi.org/10.1377/hlthaff.28.3.w490>

<http://pmid.us/19366722>

About two-thirds of primary care physicians (PCPs) reported in 2004-05 that they could not get outpatient mental health services for patients--a rate that was at least twice as high as that for other services. Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage were all cited by PCPs as important barriers to mental health care access. The probability of having mental health access problems for patients varied by physician practice, health system, and policy factors. The results

suggest that implementing mental health parity nationally will reduce some but not all of the barriers to mental health care.

**Fleury M-J, & et al (2009). Variables associated with general practitioners taking on patients with common mental disorders. *Mental Health in Family Medicine*, 5(3), 149-160.**

Objective: The article assesses variables associated with general practitioners (GPs) taking on patients suffering from common mental disorders (CMD). Method: The study is based on a sample of 398 GPs, representative of the 7199 equivalent full-time GPs practising in Quebec, the second-largest province of Canada. GPs were asked to answer a 143-item questionnaire related to their socio-demographic profile, clinical practice, patient characteristics, perceived interprofessional relationships, quality of care, and support strategies for improving continuity of care. Descriptive, bivariate, and multivariate analyses were performed. Results: This study demonstrates that the following dimensions are associated with GPs taking on patients with CMD: (1) their interest and knowledge in dealing with such patients; (2) the relative simplicity of treating CMD cases; (3) the quality of, and interest in, mental healthcare collaboration; and (4) the availability of diversified services. The main enabling variable in GPs taking on CMD patients is their interest in mental disorders. Conversely, the principal impeding variable is their positive perception of relationships with psychiatric teams. Conclusions: In accordance with current healthcare reforms, this study reinforces the need to promote GP interest and training in mental health care. Increasing GP co-ordination with psychosocial services, along with developing integrated care models including specialised care, is strongly recommended.

**Hegarty, K., et al (2009). How could depression guidelines be made more relevant and applicable to primary care? A quantitative and qualitative review of national guidelines. *British Journal of General Practice* 59(562), e149-e156.**

<http://dx.doi.org/10.3399/bjgp09X420581>

<http://pmid.us/19401008>

Background: Many guidelines have been developed in the area of depression but there has been no systematic assessment of their relevance to general practice. Aim: To assess national guidelines on general practice management of depression using two complementary approaches to identify specific ways in which guidance could be made more relevant and applicable to the nature of general practice and the patients who seek help in this context. Design of study: Review of national guidelines. Setting: Seven English speaking countries: UK, US, Australia, New Zealand, Ireland, Canada, and Singapore. Method: Seven guidelines were independently reviewed quantitatively using the Appraisal of Guidelines for Research and Evaluation (AGREE) scores and qualitatively using thematic coding. Results: The quantitative assessment highlights that most of the guidelines fail to meet the criteria on rigour of development, applicability, and editorial independence. The qualitative assessment shows that the majority of

guidelines do not address associated risk factors sufficiently and the dilemma of diagnostic uncertainty flows over into management recommendations. Management strategies for depression (antidepressants and psychological strategies) are supported by all of the guidelines, with several listing drugs before psychological therapies; there is limited attention paid to the different types of psychological therapies. Moreover, the guidelines in the main fail to acknowledge individual patient circumstances, in particular the influence on response to treatment of social issues such as adverse life events or social support. Conclusion: Assessments of current national guidelines on depression management in general practice suggest significant limitations in their relevance to general practice

**Holle,R. (2009). Dementia care initiative in primary practice - study protocol of a cluster randomized trial on dementia management in a general practice setting. *BMC Health Services Research*, 9(1), 91**

<http://dx.doi.org/10.1186/1472-6963-9-91>

<http://www.biomedcentral.com/1472-6963/9/91>

<http://pmid.us/19500383>

Background: Current guidelines for dementia care recommend the combination of drug therapy with non-pharmaceutical measures like counselling and social support. However, the scientific evidence concerning non-pharmaceutical interventions for dementia patients and their informal caregivers remains inconclusive. Targets of modern comprehensive dementia care are to enable patients to live at home as long and as independent as possible and to reduce the burden of caregivers. The objective of the study is to compare a complex intervention including caregiver support groups and counselling against usual care in terms of time to nursing home placement. In this paper the study protocol is described. Methods: The IDA (Initiative Demenzversorgung in der Allgemeinmedizin) project is designed as a three armed cluster-randomized trial where dementia patients and their informal caregivers are recruited by general practitioners. Patients in the study region of Middle Franconia, Germany, are included if they have mild or moderate dementia, are at least 65 years old, and are members of the German AOK (Allgemeine Ortskrankenkasse) sickness fund. In the control group patients receive regular treatment, whereas in the two intervention groups general practitioners participate in a training in evidence based dementia treatment, recommend support groups and offer counseling to the family caregivers either beginning at baseline or after the 1-year follow-up. The study recruitment and follow-up took place from July 2005 to January 2009. 303 general practitioners were randomized of which 129 recruited a total of 390 patients. Time to nursing home admission within the two year intervention and follow-up period is the primary endpoint. Secondary endpoints are cognitive status, activities of daily living, burden of caregiving as well as healthcare costs. For an economic analysis from the societal perspective, data are collected from caregivers as well as by the use of routine data from statutory health insurance and long-term care insurance. Discussion: From a public health perspective, the IDA trial is expected to lead to evidence based results on the community effectiveness of non-pharmaceutical support measures for dementia

patients and their caregivers in the primary care sector. For health policy makers it is necessary to make their decisions about financing new services based on strong knowledge about the acceptance of measures in the population and their cost-effectiveness.

**Korner H, & et al (2009). 'It's really a myriad of different signals, not just the textbook': the complexities of diagnosing depression in gay men in general practice. *Mental Health in Family Medicine*, 5(3), 167-176.**

This paper reports on in-depth interviews with general practitioners (GPs) about their views and experiences of diagnosing depression in gay men - some of whom are living with HIV - and the broader social contexts in which such a diagnosis is located. This analysis is a key outcome of a collaboration between social researchers, primary healthcare researchers, GPs and community partners, to investigate the management of depression in gay men in primary care settings. As the qualitative component of this project, semi-structured in-depth interviews were conducted with 16 GPs with high caseloads of gay men, in three geographical settings in Australia: Sydney, Adelaide and a rural-coastal town. GPs considered the diagnosis and management of depression to be an integral part of primary care, especially in gay male patients. They had a heightened sense of awareness that depression was common in the group of patients they were seeing. Central to diagnosing depression was the ongoing, long-term relationship GPs had with their gay male patients. GPs were vigilant and proactively inquired about depression, taking into account somatic, social and psychological indicators. In their approach to diagnosing depression, GPs considered not only the life circumstances of individual patients but also the broader social context of stigma related to homosexuality, and the effects that the HIV epidemic has had on individuals, especially on gay men who have been living with HIV for a long time.

**Lester,H., et al (2009). Development and implementation of early intervention services for young people with psychosis: case study. *British Journal of Psychiatry* , 194(5), 446-450.**

<http://dx.doi.org/10.1192/bjp.bp.108.053587>

<http://pmid.us/19407276>

Background: The development of early intervention services for young people with first-episode psychosis is a priority internationally. Aims: To evaluate the development, implementation and impact of existing and newly formed early intervention services in England. Method: Multiple-case study involving staff, users, carers and commissioners of 14 early intervention services. Results: Service numbers increased in response to national policy directives. They were still actively working with 90.6% of service users 12 months after inception. They were highly valued by users and carers as providing a personal service that contrasted with previous experiences of care. Tensions between providing a quality service and meeting case-load targets linked to future funding led teams to adopt a series of survival strategies with some unintended consequences. Conclusions: Early

intervention services are highly valued by consumers and engage users effectively after 12 months. Implementation of these services is threatened unless sufficient consistent funding is made available

**Lester H (2009) et al REDIRECT: cluster randomised controlled trial of GP training in first-episode psychosis. *British Journal of General Practice*. Advance online publication 20/04/2009**

<http://dx.doi.org/10.3399/bjgp09X420851>

Background Delays in accessing care for young people with a first episode of psychosis are significantly associated with poorer treatment response and higher relapse rates. Aim To assess the effect of an educational intervention for GPs on referral rates to early-intervention services and the duration of untreated psychosis for young people with first-episode psychosis. Design of study Stratified cluster randomised controlled trial, clustered at practice level. Setting Birmingham, England. Method Practices with access to the three early-intervention services in three inner-city primary care trusts in Birmingham were eligible for inclusion. Intervention practices received an educational intervention addressing GP knowledge, skills, and attitudes about first-episode psychosis. The primary outcome was the difference in the number of referrals to early-intervention services between practices. Secondary outcomes were duration of untreated psychosis, time to recovery, use of the Mental Health Act, and GP consultation rate during the developing illness. Results A total of 110 of 135 eligible practices (81%) were recruited; 179 young people were referred, 97 from intervention and 82 from control practices. The relative risk of referral was not significant: 1.20 (95% confidence interval [CI] = 0.74 to 1.95; P = 0.48). No effect was observed on secondary outcomes except for 'delay in reaching early-intervention services', which was statistically significantly shorter in patients registered in intervention practices (95% CI = 83.5 to 360.5; P = 0.002). Conclusion GP training on first-episode psychosis is insufficient to alter referral rates to early-intervention services or reduce the duration of untreated psychosis; however, there is a suggestion that training facilitates access to the new specialist teams for early psychosis.

**Lucassen P, & et al (2009). Making fewer depression diagnoses: beneficial for patients? *Mental Health in Family Medicine*, 5(3), 161-166.**

Currently, general practitioners actively search for depressive disorders in their patients. When they diagnose 'depressive disorder', they tell their patients that they have a disease and can be treated accordingly. This is probably an important reason for the huge prescription rates of antidepressants. In doing so, general practitioners implement specialised, psychiatric diagnostic methods in a setting characterised by patients with symptoms that superficially may resemble those of depressive disorder but in reality mainly arise from normal problems in everyday life due to losses of valued relations or failure to achieve desired goals. We argue that it might be beneficial for patients if general practitioners, in a stepped care approach, hold back on specialised methods of psychiatry and instead use a more generalist approach as first step, in which patients'

problems are formulated in their own words, and efforts are directed in helping patients regain their self-confidence to solve them. Our arguments for directing attention away from diagnosing depressive disorder are: depressive disorder is a diagnosis by agreement and therefore relative, so there are other ways to look at problems than through psychiatric glasses; depression has unclear boundaries with other mental disorders and with normality; depression is often not an adequate summary of the real problems of the patient; the patient often has a very different conception about what is wrong and often does not agree with the proposed presence of a mental disorder; to diagnose depressive disorder may have more disadvantages than advantages for the patient; the efficacy of antidepressants is very modest.

**Mavaddat,N., Lester,H.E., & Tait,L. (2009). Development of a patient experience questionnaire for primary care mental health. *Quality and Safety in Health Care*, 18(2), 147-152.**

<http://dx.doi.org/10.1136/qshc.2007.023143>

<http://pmid.us/19342531>

Introduction: There are no validated measures available for use in assessing patients' views of the quality of primary care mental healthcare at practice level. Methods: The Patient Experience Questionnaire was developed through an initial information-gathering phase with focus groups followed by questionnaire development and validation with patients in nine general practices in the West Midlands. Statistical analyses were performed to test the internal consistency, validity and reliability of the questionnaire. Results: Fifty-six patients participated in focus groups, and 241 patients completed the questionnaire. The 20-item questionnaire had good internal consistency (Cronbach alpha = 0.94) and test-retest reliability ( $r = 0.859$ ;  $p = 0.01$ ). Discussion: The Patient Experience Questionnaire appears to be a valid and reliable instrument, able to assess patients' views of the quality of primary care mental healthcare at practice level

**Noiseux,S., et al . (2009). Developing a model of recovery in mental health. *BMC Health Services Research*, 9(1), 73.**

<http://dx.doi.org/10.1186/1472-6963-9-73>

<http://www.biomedcentral.com/1472-6963/9/73>

<http://pmid.us/19409092>

Background: The recovery process is characterized by the interaction of a set of individual, environmental and organizational conditions common to different people suffering with a mental health problem. The fact that most of the studies have been working with schizophrenic patients we cannot extend what has been learned about the process of recovery to other types of mental problem. In the meantime, the prevalence of anxiety, affective and borderline personality disorders continues to increase, imposing a significant socioeconomic burden on the Canadian healthcare system and on the patients,

their family and significant other. The aim of this study is to put forward a theoretical model of the recovery process for people with mental health problem schizophrenic, affective, anxiety and borderline personality disorders, family members and a significant care provider. Method/Design: To operationalize the study, a qualitative, inductive design was chosen. Qualitative research open the way to learning - the inside - about different perspectives and issues people face in their process of recovery. The study proposal is involving a multisite study that will be conducted in three different cities of the Province of Quebec in Canada: Montreal, Quebec and Trois-Rivieres. The plan is to select 108 participants, divided into four comparison groups representing four types of mental health problem. Each comparison group (n=27) will be made up of 9 units. Each unit will comprise one person with a mental health problem (schizophrenia, affective anxiety, and borderline personality disorders). Data will be collected through semi-structured open-ended interview. The in-depth qualitative analysis inspired from the grounded theory approach will permit the illustration of the recovery process. Discussion: The transformation of our Health Care System and the importance being put on the people well-being and autonomy development of the person who are suffering with mental problem. This study protocol follows-up on earlier theory-building process that begun with the work of Noiseux. The contribution of the present study is to increase the comprehension of the concept of recovery and to enhance the body of knowledge in that domain. Very few studies have examined recovery and the one that did used a descriptive approach which did not take into account the perspective of the family members and the caregivers of the recovery process

**Oud,M., et al (2009). Care for patients with severe mental illness: the general practitioner's role perspective. *BMC Family Practice*, 10(1), 29.**

<http://dx.doi.org/10.1186/1471-2296-10-29>

<http://www.biomedcentral.com/1471-2296/10/29>

<http://pmid.us/19419547>

Background: Patients with severe mental illness (SMI) experience distress and disabilities in several aspects of life, and they have a higher risk of somatic co-morbidity. Both patients and their family members need the support of an easily accessible primary care system. The willingness of general practitioners and the impeding factors for them to participate in providing care for patients with severe mental illness in the acute and the chronic or residual phase were explored. Methods: A questionnaire survey of a sample of Dutch general practitioners spread over the Netherlands was carried out. This comprised 20 questions on the GP's 'Opinion and Task Perspective', 19 questions on 'Treatment and Experiences', and 27 questions on 'Characteristics of the General Practitioner and the Practice Organisation'. Results: 186 general practitioners distributed over urban areas (49%), urbanised rural areas (38%) and rural areas (15%) of the Netherlands participated. The findings were as follows: GPs currently considered themselves as the first contact in the acute psychotic phase. In the chronic or residual phase GPs saw their core task as to diagnose and treat somatic co-morbidity. A majority would be willing to monitor the general health of these patients as well. It appeared that GP trainers and GPs with a

smaller practice setting made follow-up appointments and were willing to monitor the self-care of patients with SMI more often than GPs with larger practices. GPs also saw their role as giving support and information to the patient's family. However, they felt a need for recognition of their competencies when working with mental health care specialists. Conclusions: GPs were willing to participate in providing care for patients with SMI. They considered themselves responsible for psychotic emergency cases, for monitoring physical health in the chronic phase, and for supporting the relatives of psychotic patients

**Pilgrim,D., & Rogers,A. (2009). Survival and its discontents: the case of British psychiatry. *Sociology of Health and Illness* Online 10/04/2009**

<http://dx.doi.org/10.1111/j.1467-9566.2009.01166.x>

<http://pmid.us/19392934>

Sub-divisions of labour in health settings are common and medical dominance and encroachment from competitors are well known. This article considers this general picture but in specific relation to mental health work in Britain and its particular features of recent contestation. British psychiatric orthodoxy has faced challenges to its legitimacy for over a century. However, since the 1980s, in the wake of de-institutionalisation and a new shared service commitment to 'recovery', these challenges have taken new shape. They are explored by considering: the current ambit of mental health care; the subdivision of labour in specialist mental services; recent governmental expectations of the mental health workforce; and the contested legacy of theory and practice in mental health work. The conclusion is that the profession is not under immediate threat of collapse but that its fate may now rest on whether a biomedical or a biopsychosocial model of practice predominates in routine service delivery

**Schroer,S., MacPherson,H., & Adamson,J. (2009). Designing an RCT of acupuncture for depression--identifying appropriate patient groups: a qualitative study. *Family Practice* Online 7/04/2009**

<http://dx.doi.org/10.1093/fampra/cmp021>

<http://pmid.us/19351703>

Background. Acupuncture is a popular complementary therapy choice for depression in the UK but the evidence base lags behind its usage. Further effectiveness trials are required; however, these need based on appropriate design for a complex intervention on a heterogeneous group of people. Aim. To identify subgroups of patients with depression who could be the focus of effectiveness trials. Methods. Qualitative research using in-depth interviews in UK primary care. In-depth interviews with 30 participants from three stakeholder groups: 10 acupuncture patients and 10 acupuncturists--to examine the reasons why acupuncture is used for depression and 10 physicians--to elicit who would be acceptable to refer into a trial of acupuncture for depression. Interviews were transcribed and analysed using a Framework approach. Results. The data have highlighted that the acceptability of particular treatments for depression is influenced by

the individuals' illness career within their social context. In addition, the plausibility and associated acceptability of depression treatments are also closely tied to an individuals' explanatory model of their condition. Seven patient subgroups were identified who could potentially find acupuncture of particular interest and on which effectiveness trials could be focused. Conclusions. We have identified the main reasons why people seek acupuncture for depression and the circumstances in which physicians would be willing to refer for depression were it to prove effective. We have also set out a number of potential patient subgroups who may be particularly interested participating in a randomized controlled trial of acupuncture for depression

**Seekles,W. et al (2009). Stepped care for depression and anxiety: a randomised controlled trial testing the effectiveness of a stepped care program among primary care patients with mood or anxiety disorders. *BMC Health Services Research* 9(1), 90.**

<http://dx.doi.org/10.1186/1472-6963-9-90>

<http://www.biomedcentral.com/content/pdf/1472-6963-9-90.pdf>

<http://pmid.us/19500346>

Background: Mood and anxiety disorders are highly prevalent and have a large impact on the lives of the affected individuals. Therefore, optimal treatment of these disorders is highly important. In this study we will examine the effectiveness of a stepped care program for primary care patients with mood and anxiety disorders. A stepped care program is characterized by different treatment steps that are arranged in order of increasing intensity. MethodS: This study is a randomised controlled trial with two conditions: stepped care and care as usual, whereby the latter forms the control group. The stepped care program consists of four evidence based interventions: (1) Watchful waiting, (2) Guided self-help, (3) Problem Solving Treatment and (4) Medication and/or specialized mental health care. The study population consists of primary care attendees aged 18-65 years. Screeners are sent to all patients of the participating general practitioners. Individuals with a Diagnostic and Statistical Manual of mental disorders (DSM) diagnosis of major depression, dysthymia, panic disorder (with or without agoraphobia), generalized anxiety disorder, or social phobia are included as well as individuals with minor depression and anxiety disorders. Primary focus is the reduction of depressive and anxiety symptoms. Both conditions are monitored at 8, 16 and 24 weeks. Discussion: This study evaluates the effectiveness of a stepped care program for patients with depressive and anxiety disorder. If effective, a stepped care program can form a worthwhile alternative for care as usual. Strengths and limitations of this study are discussed.

**Townley,G., Kloos,B., & Wright,P.A. (2009). Understanding the experience of place: expanding methods to conceptualize and measure community integration of persons with serious mental illness. *Health and Place.*, 15(2), 520-531.**

<http://dx.doi.org/10.1016/j.healthplace.2008.08.011>

<http://pmid.us/19062326>

Community integration research explores community contexts and factors that encourage or hinder individuals with serious mental illness (SMI) from actively participating in community life. This research agenda can be advanced by using mixed-methods that better document the relationships between contextual factors and individual experience. Two such methods were applied to a mixed-methods study of 40 adults with SMI living in independent housing in the Southeastern United States. Their contextualized experiences of community integration were measured by applying innovative participatory mapping and Geographic Information Systems (GIS) mapping techniques. Use of these methods in conjunction with one another facilitated the creation of activity spaces, which can measure geographic accessibility and help to represent an individual's experience of place and degree of mobility. The utility of these newly applied methods for better understanding community integration for persons with SMI is explored and implications for using these measures in research and practice are discussed

## **PATIENT AND PUBLIC INVOLVEMENT**

**Mitton, C. et al (2009). Public participation in health care priority setting: A scoping review. *Health Policy*. Online 2/03/2009**

<http://dx.doi.org/10.1016/j.healthpol.2009.01.005>

<http://pmid.us/19261347>

Objective: While much literature has debated public engagement in health care decision-making, there is no consensus on when public engagement should be sought and how it should be obtained. We conducted a scoping review to examine public engagement in one specific area: priority setting and resource allocation. Method: The review drew upon a broad range of health and non-health literature in an attempt to elicit what is known and not known on this topic, and through this to outline any guidance to assist decision-makers and identify where efforts for future research should be directed. Results: Governments appear to recognize benefits in consulting multiple publics using a range of methods, though more traditional approaches to engagement continue to predominate. There appears to be growing interest in deliberative approaches to public engagement, which are more commonly on-going rather than one-off and more apt to involve face-to-face contact. However, formal evaluation of public engagement efforts is rare. Also absent is any real effort to demonstrate how public views might be integrated with other decision inputs when allocating social resources. Conclusion: While some strands can be taken to inform current priority setting activity, this scoping review identified many gaps and highlights numerous areas for further research

**Smith,E., et al (2009). Getting ready for user involvement in a systematic review. *Health Expectations* Online ahead of print 20/2/2009**

<http://dx.doi.org/10.1111/j.1369-7625.2009.00535.x>

<http://pmid.us/19236632>

**Objective** This paper aims to support the critical development of user involvement in systematic reviews by explaining some of the theoretical, ethical and practical issues entailed in 'getting ready' for user involvement. **Background** Relatively few health or social care systematic reviews have actively involved service users. Evidence from other research contexts shows that user involvement can have benefits in terms of improved quality and outcomes, hence there is a need to test out different approaches in order to realize the benefits of user involvement and gain a greater understanding of any negative outcomes. **Design** Setting up a service-user reference group for a review of user involvement in nursing, midwifery and health visiting research involved conceptualizing user involvement, developing a representation framework, identifying and targeting service users and creating a sense of mutuality and reciprocity. **Setting and participants** Recruitment was undertaken across England by two researchers. Members from 24 national consumer organizations were selected to participate in the review. **Main variables studied** Learning was gained about finding ways of navigating consumer networks and organizations, how best to communicate our goals and intentions and how to manage selection and 'rejection' in circumstances where we had stimulated enthusiasm. **Results and conclusions** Involving service users helped us to access information, locate the findings in issues that are important to service users and to disseminate findings. User involvement is about relationships in social contexts: decisions made at the early conceptual level of research design affect service users and researchers in complex and personal ways

**Thompson,J., et al (2009). Health researchers' attitudes towards public involvement in health research. *Health Expectations* Online ahead of print 22/4/2009**

<http://dx.doi.org/10.1111/j.1369-7625.2009.00532.x>

<http://pmid.us/19392833>

**Objective** To investigate health researchers' attitudes to involving the public in research. **Background** Public involvement in research is encouraged by the Department of Health in the UK. Despite this, the number of health researchers actively involving the public in research appears to be limited. There is little research specifically addressing the attitudes of health researchers towards involving the public: how they interpret the policy, what motivates and de-motivates them and what their experiences have been to date. **Design** A qualitative research design, using semi-structured telephone interviews. **Setting and**

participants Fifteen purposively sampled UK-based University health researchers were the participants. Interviews were conducted over the telephone. Findings The participants suggested varying constructions of public involvement in research. Arguments based on moral and political principles and consequentialist arguments for involving the public in research were offered and most participants highlighted the potential benefits of involving the public. However, feelings of apprehension expressed by some participants imply that a number of researchers may still be uncomfortable with involving the public, as it presents a different way of working

## PRIMARY/SECONDARY CARE INTERFACE

**Berendsen,A.J., et al (2009). Assessment of patient's experiences across the interface between primary and secondary care: Consumer Quality Index Continuum of Care. *Patient Education and Counseling* Published online 15/4/2009**

<http://dx.doi.org/10.1016/j.pec.2009.01.011>

<http://pmid.us/19375266>

Objective: Development and validation of a questionnaire that measures patients' experiences of collaboration between general practitioners (GPs) and specialists. Methods: A questionnaire was developed using the method of the consumer quality index and validated in a cross-sectional study among a random sample of patients referred to medical specialists in the Netherlands. Validation included factor analysis, ascertain internal consistency, and the discriminative ability. Results: The response rate was 65% (1404 patients). Exploratory factor analysis indicated that four domains could be distinguished (i.e. GP Approach; GP Referral; Specialist; Collaboration). Cronbach's alpha coefficients ranged from 0.51 to 0.93 indicating sufficient internal consistency to make comparison of groups of respondents possible. The Pearson correlation coefficients between the domains were <0.4, except between the domains GP Approach and GP Referral. All domains clearly produced discriminating scores for groups with different characteristics. Conclusions: The Consumer Quality Index (CQ-index) Continuum of Care can be a useful instrument to assess aspects of the collaboration between GPs and specialists from patients' perspective. Practice Implications: It can be used to give feedback to both medical professionals and policy makers. Such feedback creates an opportunity for implementing specific improvements and evaluating quality improvement projects

**Berendsen,A., et al (2009). Transition of care: experiences and preferences of patients across the primary / secondary interface - a qualitative study. *BMC Health Services Research*, 9 (1), 62.**

<http://dx.doi.org/10.1186/1472-6963-9-62>

<http://www.biomedcentral.com/1472-6963/9/62>

<http://pmid.us/19351407>

Background: Coordination between care providers of different disciplines is essential to improve the quality of care, in particular for patients with chronic diseases. The way in which general practitioners (GP's) and medical specialists interact has important implications for any healthcare system in which the GP plays the role of gatekeeper to specialist care. Patient experiences and preferences have proven to be increasingly important in discussing healthcare policy. The Dutch government initiated the development of a special website with information for patients on performance indicators of hospitals as well as information on illness or treatment. In the present study we focus on the transition of care at the primary - secondary interface with reference to the impact of patients' ability to make choices about their secondary care providers. The purpose of this study is to (a) explore experiences and preferences of patients regarding the transition between primary and secondary care, (b) study informational resources on illness/treatment desired by patients and (c) determine how information supplied could make it easier for the patient to choose between different options for care (hospital or specialist). Methods: We conducted a qualitative study using semi-structured focus group interviews among 71 patients referred for various indications in the north and west of The Netherlands. Results :Patients find it important that they do not have to wait, that they are taken seriously, and receive adequate and individually relevant information. A lack of continuity from secondary to primary care was experienced. The patient's desire for free choice of type of care did not arise in any of the focus groups. Conclusion :Hospital discharge information needs to be improved. The interval between discharge from specialist care and the report of the specialist to the GP might be a suitable performance indicator in healthcare. Patients want to receive information, tailored to their own situation. The need for information, however, is quite variable. Patients do not feel strongly about self-chosen healthcare, contrary to what administrators presently believe

**Brez,S., et al (2009). Transition from specialist to primary diabetes care: A qualitative study of perspectives of primary care physicians. *BMC Family Practice* 10(1), 39.**

<http://dx.doi.org/10.1186/1471-2296-10-39>

<http://www.biomedcentral.com/1471-2296/10/39/abstract>

<http://pmid.us/19500397>

Background: The growing prevalence of diabetes and heightened awareness of the benefits of early and intensive disease management have increased service demands and expectations not only of primary care physicians but also of diabetes specialists. While research has addressed issues related to referral into specialist care, much less has been published about the transition from diabetes specialists back to primary care. Understanding the concerns of family physicians related to discharge of diabetes care

from specialist centers can support the development of strategies that facilitate this transition and result in broader access to limited specialist services. This study was undertaken to explore primary care physician (PCP) perspectives and concerns related to reassuming responsibility for diabetes care after referral to a specialized diabetes centre. Methods: Qualitative data were collected through three focus groups. Sessions were audio-taped and transcribed verbatim. Data were coded and sorted with themes identified using a constant comparison method. The study was undertaken through the regional academic referral center for adult diabetes care in Ottawa, Canada. Participants included 22 primary care physicians representing a variety of referral frequencies, practice types and settings. Results: Participants described facilitators and barriers to successful transition of diabetes care at the provider, patient and systems level. Major facilitators included clear communication of a detailed, structured plan of care, easy ongoing access to specialist services for advice or re-referral, continuing education and mentoring for PCPs. Identified provider barriers were gaps in PCP knowledge and confidence related to diabetes treatment, excessive workload and competing time demands. Systems deterrents included reimbursement policies for health professionals and inadequate funding for diabetes medications and supplies. At the PCP-patient interface, insufficient patient confidence or trust in PCP's ability to manage diabetes, poor motivation and "non-compliance" emerged as potential patient barriers to transition. Incongruence between PCP attitudes and expectations related to diabetes self-management and those of patients who had attended a multidisciplinary specialist center was also observed. Conclusions: This study underlines the breadth of PCP concerns related to transition of diabetes care and the importance of this topic to them. While tools that promote timely information flow and care planning are cornerstones to successful transition, and may be sufficient for some practitioners, appropriately resourced decision support and education strategies should also be available to enhance PCP capacity and readiness to resume diabetes care after referral to a specialist centre. Characteristics of the patient-care provider relationship that impact discharge were identified and are worthy of further research

**Pickard,S. (2009). Governing old age: the 'case managed' older person. *Sociology*, 43(1), 67-84.**

<http://dx.doi.org/10.1177/0038038508099098>

This article applies a Foucauldian approach to an examination of contemporary policy and practice towards older people, specifically a model of case management designed to manage older people 'at risk' of hospital admission. The article proceeds by reviewing old age policy over three historical time periods, emphasizing discontinuities and mutations, in an attempt to problematize the principles underlying case management. It then draws on empirical data from a study of the micro-practices of case management, focusing on the construction of expertise, the subjectification of the 'at risk' older person and the interplay between expert and patient. The productive and repressive aspects of this interaction are both discussed and resistances to it by the older people are seen to take the nuanced form of imposing family values upon the professional encounter

**Sheaff,R. (2009). Impacts of case management for frail elderly people: a qualitative study. *Journal of Health Services Research Policy*, 14(2), 88-95**

<http://dx.doi.org/10.1258/jhsrp.2008.007142>

<http://pmid.us/19299262>

**Objective**To assess the impacts of different forms of case management for people aged over 65 years at risk of unplanned hospital admission, in particular the impacts upon patients, carers and health service organization in English primary care; and, in these respects, compare the Evercare model with alternatives. **Methods** Multiple qualitative case studies comparing case management in nine English Primary Care Trusts which piloted the Evercare model of case management and four sites which implemented alternative forms of case management between 2003 and 2005. Data were obtained from 231 interviews with patients, carers and other key informants, and from content analysis of documents and observation of meetings. **Results**All the projects established functioning case management services, but none led to major service reorganization or savings elsewhere in the health care system. Many informants reported examples of admissions which case management had prevented, but overall hospital admissions did not significantly change, possibly due to increased case-finding. Patients and carers valued case management for improving access to health care, increasing psychosocial support and improving communication with health professionals. **Conclusion**Case management was highly valued by patients and their carers, but there were few major differences in outcomes between Evercare and other models

**Sorensen,T.H., Olsen,K.R., & Vedsted,P. (2009). Association between general practice referral rates and patients' socioeconomic status and access to specialised health care. A population-based nationwide study. *Health Policy*. Online 23/04/2009**

<http://dx.doi.org/10.1016/j.healthpol.2009.03.011>

<http://pmid.us/19394106>

**Objectives:** To explore the association between patients' socioeconomic status and their referral from general practice to specialised health care. **Methods:** Multiple regression analysis was used on cross-sectional data on general practice referral rates for all Danish general practices in year 2006. **Results:** Our models explained between 26% and 45% of the variation in general practice referral to specialised care. Adjusting for access to specialised care (local supply of hospitals and practicing specialists) reduced the association between socioeconomic factors and referral rates. The results suggest that persons with high socioeconomic status are referred more to practicing specialist than persons with low socioeconomic status and that the latter are referred more to hospital care than the former. **Conclusions:** Our results indicate that the influence of socioeconomic factors may be overstated failing to control for access to specialised care. Still, a socioeconomic gradient was observed in GPs' referral pattern to different sorts of health care after adjusting for access. The association between socioeconomic status and referral pattern can both be rooted in morbidity variation and to the ability of persons with high socioeconomic status to influence general practitioners' (GPs') decision making

## QUALITY

**Cox,S.J., & Holden,J.D. (2009). Presentation and outcome of clinical poor performance in one health district over a 5-year period: 2002-2007. *British Journal of General Practice*, 59(562), 344-348.**

<http://dx.doi.org/10.3399/bjgp09X420527>

<http://pmid.us/19401017>

Background: The detection, assessment, and management of primary care poor performance raise difficult issues for all those involved. Guidance has largely focused on managing the most serious cases where patient safety is severely compromised. The management of primary care poor performance has become an increasingly important part of primary care trust (PCT) work, but its modes of presentation and prevalence are not well known. AIM: To report the prevalence, presentation modes, and management of primary care poor performance cases presenting to one PCT over a 5-year period. Design of study: A retrospective review of primary care poor performance cases in one district. Setting: St Helens PCT administered 35 practices with 130 GPs on the performers list, caring for 190 110 patients in North West England, UK. Method: Cases presenting during 2002-2007 were initially reviewed by the chair of the PCT clinical executive committee. Anonymised data were then jointly reviewed by the assessor and another experienced GP advisor. Results: There were 102 individual presentations (20 per year or one every 2-3 weeks) where clinician performance raised significant cause for concern occurred over the 5-year period. These concerns related to 37 individual clinicians, a range of 1-14 per clinician (mean 2.7). Whistleblowing by professional colleagues on 43 occasions was the most common presentation, of which 26 were from GPs about GPs. Patient complaints (18) were the second most common presentation. Twenty-seven clinicians were GPs, of whom the General Medical Council (GMC) were notified or involved in 13 cases. Clinicians were supported locally, and remedying was exclusively locally managed in 14 cases, and shared with an external organisation (such as the GMC or deanery) in another 12. Conclusion: Professional whistleblowing and patient complaints were the most common sources of presentation. Effective PCT teams are needed to manage clinicians whose performance gives cause for concern. Sufficient resources and both formal and informal ways of reporting concerns are essential

**Goodyear-Smith,F., Arroll,B., & Coupe,N. (2009). Asking For help is helpful: validation of a brief lifestyle and mood assessment tool in primary health care. *Annals of Family Medicine*, 7(3), 239-244.**

<http://dx.doi.org/10.1370/afm.962>

<http://pmid.us/19433841>

**Purpose** The short, validated, self-administered, Case-finding and Help Assessment Tool (CHAT) for lifestyle and mental health assessment of adult patients in primary health care addresses inactivity, tobacco use, alcohol and other drug misuse, problem gambling, depression, anxiety and stress, abuse, and anger problems. For each issue patients are asked whether they would like help, either during the consultation or at a later date. This study aims to assess the value of the help question. **Methods** Validation of the CHAT was conducted according to the Standards for Reporting of Diagnostic accuracy studies statement for diagnostic tests. The setting was Auckland primary care practices with populations ranging from socioeconomically advantaged to deprived. Participants were 755 consecutive primary care patients who completed the CHAT plus the help question and reference standards. Sensitivity, specificity, and likelihood ratios with and without the addition of help the question were calculated. **Results** Sensitivity ranged from 80% to 98% for the more-common conditions (depression, nicotine dependency, anxiety, problematic drinking). For each condition, specificity increased with the addition of the help question: depression increased from 73% to 98%; anxiety 77% to 99%; drinking 85% to 99%; verbal anger 92% to 99%; verbal abuse 97% to 99%; problematic drinking and gambling 98% to 99%. **Conclusions** The help question increased specificity without compromising sensitivity and reduced false positives, thereby increasing the positive predictive value. It allowed patients with comorbidities to prioritize issues they wished to address, indicate their readiness to change, promote self-determination, and give the clinician an indication of which topics to pursue

**Kepros,J., & Opreanu,R. (2009). A new model for health care delivery. *BMC Health Services Research*, 9(1), 57.**

<http://dx.doi.org/10.1186/1472-6963-9-57>

<http://www.biomedcentral.com/1472-6963/9/57>

<http://pmid.us/19335920>

**Background:** The health care delivery system in the United States is facing cost and quality pressures that will require fundamental changes to remain viable. The optimal structures of the relationships between the hospital, medical school, and physicians have not been determined but are likely to have a large impact on the future of healthcare delivery. Because it is generally agreed that academic medical centers will play a role in the sustainability of this future system, a fundamental understanding of the relative contributions of the stakeholders is important as well as creativity in developing novel strategies to achieve a shared vision. **Discussion:** Core competencies of each of the stakeholders (the hospital, the medical school and the physicians) must complement the others and should act synergistically. At the same time, the stakeholders should determine the common core values and should be able to make a meaningful contribution to the delivery of health care. **Summary:** Health care needs to achieve higher quality and lower cost. Therefore, in order for physicians, medical schools, and hospitals to serve the needs of society in a gratifying way, there will need to be change. There needs to be more scientific and social advances. It is obvious that there is a real and urgent need for relationship building among the professionals whose duty it is to provide these services

**McDonald,R., Checkland,K., Harrison,S., & Coleman,A. (2009). Rethinking collegiality: Restratisation in English general medical practice 2004-2008. *Social Science and Medicine*, 68(7), 1199-1205.**

<http://dx.doi.org/10.1016/j.socscimed.2009.01.042>

<http://pmid.us/19232453>

For Freidson [(1985). The reorganisation of the medical profession. *Medical Care Review*, 42(1), 11-35], collegiality, or ostensible equal status amongst members of the medical profession, serves a dual purpose. It socialises members into an attitude of loyalty to colleagues and presents an image to those outside the profession that all its members are competent and trustworthy. However, Freidson saw the use of formal standards developed by one (knowledge) elite within medicine and enforced by another (administrative) elite as threatening collegiality and professional unity. Drawing on two studies in English primary medical care this paper reports the emergence of new strata or elites, with groups of doctors involved in surveillance of others and action to improve compliance in deficient individuals and organizations. Early indications are that these developments have not led to the consequences which Freidson predicted. The increasing acceptance of the legitimacy of professional scrutiny and accountability that we identify suggests that new norms are emerging in English primary medical care, the possibility of which Freidson's analysis fails to take account

**Marcinowicz,L., Chlabicz,S., & Grebowski,R. (2009) Patient satisfaction with healthcare provided by family doctors: primary dimensions and an attempt at typology. *BMC Health Services Research*, 9(1), 63.**

<http://dx.doi.org/10.1186/1472-6963-9-63>

<http://www.biomedcentral.com/1472-6963/9/63>

<http://pmid.us/19371417>

Background: Patient satisfaction is a complex and difficult concept and use of exclusively quantitative methods for they measure is inadequate The purpose of this survey was firstly to identify particular healthcare dimensions that determine a patient's satisfaction or dissatisfaction; and secondly to attempt to typologise the patients' responses based on their evaluation of healthcare. Methods: Using a qualitative research design approach, thirty-six in-depth interviews with patients of family physicians were conducted; four patients from each of 9 family practices in different regions of Poland, were interviewed. The main outcome measure was factors associated with patient satisfaction/dissatisfaction. Results: In their evaluations of their contacts with the family doctor, the patients mentioned mostly issues connected with interpersonal relations with the doctor. Almost 40% of the statements referred to this very aspect of healthcare, with nearly equal proportions of positive and negative comments. The second most frequently mentioned were contextual factors (21%) which related to conditions of medical service, with two-thirds of the evaluations being negative. Statements concerning the doctor's competencies (12.9%) and personal qualities (10.5%) were less common. Conclusion: Because

dimensions that decide a patient's satisfaction or dissatisfaction differently, assessments of quality should focus on their components, whereas questions about satisfaction itself should be avoided

**olde Harman TC, & van Ravesteign HJ (2009). 'Well doctor, it is all about how life is lived': cues as a tool in the medical consultation. *Mental Health in Family Medicine*, 5(3), 183-188.**

Introduction: During consultations, the perspective of the patient and the family physician come together. In order to reach a shared view about the symptoms it is important to know the agenda of the patient. Cues (i.e. non-explicit remarks that can enclose a special meaning) can serve as a tool to clarify the agenda. Case report: In this article, we describe a patient with unexplained palpitations during vacuuming. During one of the following consultations she provided an important psychosocial cue which changed my perspective on her palpitations, resulting in a deeper understanding of her symptoms. Discussion: Recognition and exploration of cues is important for reaching mutual understanding of doctors and patients about the symptoms. Moreover, it enhances the therapeutic relationship and improves illness outcomes and patient satisfaction. Conclusion: Noticing cues in the medical consultation helps the doctor to understand the patient's real worries. It gives us, as doctors, a better understanding of the patient's perspective

**Osteras,N., et al . (2009). Implementing structured functional assessments in general practice for persons with long-term sick leave: a cluster randomised controlled trial. *BMC Family Practice*, 10(1), 31.**

<http://dx.doi.org/10.1186/1471-2296-10-31>

<http://www.biomedcentral.com/1471-2296/10/31>

<http://pmid.us/19419575>

Background: The increasing attention on functional assessments in medical and vocational rehabilitation requires a focus change for the general practitioners (GP) into paying attention to patient resources, possibilities and coping instead of symptoms, problems and limitations. The GPs report difficulties in performing the requested explicit functional assessments. The purpose of this study was to implement a structured method in general practice for assessing functional ability in persons with long-term sick leave. The study aim was to evaluate intervention effects on important GP parameters; knowledge, attitudes, self-efficacy towards functional assessments and knowledge about patient work factors. Methods: Fifty-seven GPs were randomly assigned to an intervention or a control group. The intervention group GPs attended an introductory one-day workshop and implemented structured functional assessments during an eight months intervention period. GP knowledge, GP attitudes, and GP self-efficacy towards functional assessments, as well as GP knowledge of patient work factors, were collected before, after and six months after the intervention period started. Evaluation score-sheets were filled in by both the intervention GPs and their patients immediately after the consultation

to evaluate the GPs' knowledge of patient work factors. Results: The intervention GPs reported increased knowledge (B: 0.56, 95% CI (0.19, 0.91)) and self-efficacy (B: 0.90, 95% CI (0.53, 1.26)) towards functional assessments, and increased knowledge about their patients' workplace (B: 0.75, 95% CI (0.35, 1.15)) and perceived stressors (B: 0.55, 95% CI (0.23, 0.88)) with lasting effects at the second follow-up. No intervention effect was seen in relation to GP attitudes. Both before and after the intervention, the GPs were most informed about physical stressors, and less about mental and work organisational stressors (Guttman's reproducibility coefficient: 0.95 and 1.00). After the consultation, both the intervention GPs and their patients reported that the GPs' knowledge about patient work factors had increased (GP B: 0.60 (95% CI: 0.42, 0.78); patient B: 0.50 (95% CI: 0.34, 0.66)). Conclusions: Introducing and implementing structured functional assessments in general practice made the GPs capable to assess functional ability of their patients in a structured manner. Intervention effects of increased GP knowledge and GP self-efficacy sustained at the second follow-up

**Porzolt,F., Ghosh,A., & Kaplan,R. (2009). Qualitative assessment of innovations in healthcare provision. *BMC Health Services Research*, 9(1), 50.**

<http://dx.doi.org/10.1186/1472-6963-9-50>

<http://www.biomedcentral.com/1472-6963/9/50>

<http://pmid.us/19298658>

Background: The triad of quality, innovation and economic restraint is as important in health care as it is in the business world. There are many proposals for the assessment of quality and of economic restraints in health care but only a few address assessment of innovations. We propose a strategy and new structures to standardize the description of health care innovations and to quantify them. Discussion: Strategy and structure are based on the assumption that in the early phase of an innovation only data on the feasibility and possibly on the efficacy or effectiveness of an innovation can be expected. From the patient's perspective, benefit resulting from an innovation can be confirmed only in a later phase of development. Early indicators of patient's benefit will be surrogate parameters which correlate only weakly with the desired endpoints. After the innovation has been in use, there will be more evidence on correlations between surrogate parameters and the desired endpoints to provide evidence of the patient benefit. From an administrative perspective, this evidence can be considered in decisions about public financing. Different criteria are proposed for the assessment of innovations in prevention, diagnosis and therapy. For decisions on public financing a public fund for innovations may be helpful. Depending on the phase of innovation risk sharing models are proposed between manufacturers, private insurers and public funding. Summary: Potential for patient benefit is always uncertain during early stages of innovations. This uncertainty decreases with increasing information on the effects of the innovation. Information about an innovation can be quantified, categorized and integrated into rational economic decisions

**Reeve, J. et al (2006). Insights into the impact of clinical encounters gained from personal accounts of living with advanced cancer. *Primary Health Care Research & Development*, 1-11. Online 6/03/2009**

<http://dx.doi.org/10.1017/S1463423609001121>

**Aim** To describe the impact of interactions with health care professionals revealed by people's accounts of living and dying with cancer; to explore reasons for the observed effects; and thus, to consider the implications for practice. **Background** The importance of practitioner-patient interactions is enshrined within professional values. However, our understanding of how and why the consultation impacts on outcomes remains underdeveloped. Stories recounted by people living and dying with cancer offer important insights into illness experience, including the impact of contact with health services, framed within the context of the wider social setting in which people live their lives. From our recent study of distress in primary palliative care patients, we describe how people's accounts revealed both therapeutic and noxious effects of such encounters, and discuss reasons for the observed effects. **Method** A qualitative study with a purposive sample of 19 primary palliative care patients: (8 men, 11 at high risk of depression). In-depth interviews were analysed using the iterative thematic analysis described by Lieblich. **Findings** Living with cancer can be an exhausting process. Maintaining continuity of everyday life was the norm, and dependent on a dynamic process of balancing threats and supports to people's emotional well-being. Interactions with health care professionals were therapeutic when they provided emotional, or narrative, support. Threats arose when the patient's perception of the professional's account of their illness experience was at odds with the person's own sense of their core self and what was important to them. Our findings highlight the need for a framework in which clinicians may legitimately utilize different illness models to deliver a personalized, patient-centred assessment of need and care. The work provides testable hypotheses supporting development of understanding of therapeutic impact of the consultation.

**Shackelton, R., et al (2009). Does the culture of a medical practice affect the clinical management of diabetes by primary care providers? *Journal of Health Services Research and Policy*, 14(2), 96-103.**

<http://dx.doi.org/10.1258/jhsrp.2009.008124>

<http://pmid.us/19299263>

**Objectives:** The financing and organization of primary care in the United States has changed dramatically in recent decades. Primary care physicians have shifted from solo practice to larger group practices. The culture of a medical practice is thought to have an important influence on physician behavior. This study examines the effects of practice culture and organizational structure (while controlling for patient and physician characteristics) on the quality of physician decision-making. **Methods:** Data were obtained from a balanced factorial experiment which employed a clinically authentic

video-taped scenario of diabetes with emerging peripheral neuropathy. Results: Our findings show that several key practice culture variables significantly influence clinical decision-making with respect to diabetes. Practice culture may contribute more to whether essential examinations are performed than patient or physician variables or the structural characteristics of clinical organizations. Conclusions: Attention is beginning to focus on physician behavior in the context of different organizational environments. This study provides additional support for the suggestion that organization-level interventions (especially focused on practice culture) may offer an opportunity to reduce health care disparities and improve the quality of care

**de Stampa, M., et al (2009). Fostering participation of general practitioners in integrated health services networks: incentives, barriers, and guidelines. *BMC Health Services Research*, 9(1), 48.**

<http://dx.doi.org/10.1186/1472-6963-9-48>

<http://www.biomedcentral.com/1472-6963/9/48>

<http://pmid.us/19292905>

Background: While the active participation of general practitioners (GPs) in integrated health services networks (IHSNs) plays a critical role in their success, little is known about the incentives and barriers to their actual participation. Methods: Data were gathered through semi-structured interviews and a mail survey with GPs enrolled in SIPA (system of integrated care for older persons) at 2 sites in Montreal. A total of 61 GPs completed the questionnaire, from which 22 were randomly selected for the qualitative study, with active and non-active participation in the IHSN. Results: The key themes associated with GP participation were clinician characteristics, consequences perceived at the outset, the SIPA implementation process, relationships with the SIPA team and professional consequences. The incentive factors reported were collaborative practices, high rates of elderly and SIPA patients in their clienteles, concerns about SIPA, the selection of frail elderly patients, close relationships with the case manager, the perceived efficacy of SIPA, and improved professional practices. Barriers to GP participation included high expectations, GP recruitment, lack of information on SIPA, difficult relationships with SIPA geriatricians and deterioration of physician-patient relationships. Four profiles of participation were identified: 2 groups of participants active in SIPA and 2 groups of participants not active in SIPA. The active GPs were familiar with collaborative practices, had higher IHSN patient rates, expressed more concerns than expectations, reported satisfactory relationships with case managers and perceived the efficacy of SIPA. Both active and non-active GPs reported quality care in the IHSN and improved professional practice. Conclusion: Throughout the implementation process, the participation of GPs in an IHSN depends on numerous professional (clinician characteristics) and organizational factors (GP recruitment, relationships with case managers). Our study provides guiding principles for establishing future integrated models of care. It suggests practical guidelines to support the active participation of GPs in these networks such as physicians with collaborative practices, recruitment of

significant number of patients per physicians, the information provided and the accompaniment by geriatricians

**Tung, Y.C., & Chang, G.M. (2009). Patient satisfaction with and recommendation of a primary care provider: associations of perceived quality and patient education. *International Journal for Quality in Health Care*, 21(3), 206-213.**

<http://dx.doi.org/10.1093/intqhc/mzp006>

<http://pmid.us/19258342>

**Objective** To identify whether attributes of perceived clinic quality and patient education are associated with patient satisfaction and recommendation of a primary care provider. **Design** Data used in this study were obtained through a national telephone survey by random sampling. **Setting** Clinics throughout Taiwan. **Participants** A total of 1910 patients. **Main outcome measures** Overall patient satisfaction and recommendation were measured by single item questions. Attributes of clinic quality were measured using 11 items: doctor's technical skill (four items), doctor's interpersonal skill (three items), staff care and access (four items). Patient education was measured on the basis of education provided on disease prevention and control during the visit. **Results** With regard to clinic quality, doctor's technical skill was most related to overall satisfaction and recommendation, followed by doctor's interpersonal skill. Staff care and access were associated with overall satisfaction but were not associated with recommendation. Patient education was related to both overall satisfaction and recommendation. **Conclusion** Doctor's technical skill is the most critical attribute of primary care quality for both overall satisfaction and recommendation, followed by doctor's interpersonal skill. Staff care and access are associated with improved overall satisfaction but not related to increasing the likelihood of recommending a clinic to relatives and friends. Doctor's technical and interpersonal skills rather than staff care and access can be the essence of quality competition in the primary care market. Providing patient education during the visit on how to prevent or control diseases may also relate to improved patient satisfaction and recommendation

**Walshe, K. (2009). Pseudoinnovation: the development and spread of healthcare quality improvement methodologies. *International Journal for Quality in Health Care*, 21(3), 153-159.**

<http://dx.doi.org/10.1093/intqhc/mzp012>

<http://pmid.us/19383716>

**Background** Over the last two decades, we have seen the successive rise and fall of a number of concepts, ideas or methods in healthcare quality improvement (QI). Paradoxically, the content of many of these QI methodologies is very similar, though their presentation often seeks to differentiate or distinguish them. **Methods** This paper sets out to explore the processes by which new QI methodologies are developed and disseminated and the impact this has on the effectiveness of QI programmes in healthcare organizations. It draws on both a bibliometric analysis of the QI literature over the period

from 1988 to 2007 and a review of the literature on the effectiveness of QI programmes and their evaluation. Results The repeated presentation of an essentially similar set of QI ideas and methods under different names and terminologies is a process of 'pseudoinnovation', which may be driven by both the incentives for QI methodology developers and the demands and expectations of those responsible for QI in healthcare organizations. We argue that this process has important disbenefits because QI programmes need sustained and long-term investment and support in order to bring about significant improvements. The repeated redesign of QI programmes may have damaged or limited their effectiveness in many healthcare organizations. Conclusions A more sceptical and scientifically rigorous approach to the development, evaluation and dissemination of QI methodologies is needed, in which a combination of theoretical, empirical and experiential evidence is used to guide and plan their uptake. Our expectations of the evidence base for QI methodologies should be on a par with our expectations in relation to other forms of healthcare interventions

## RESEARCH AND DEVELOPMENT

**Dixon-Woods,M., & Tarrant,C. Why do people cooperate with medical research? Findings from three studies. *Social Science & Medicine*, Online 24/04/2009**

<http://dx.doi.org/10.1016/j.socscimed.2009.03>.

<http://pmid.us/19394741>

In this paper, we distinguish decisions about cooperation with medical research from decisions research participation. We offer an empirical and theoretical exploration of why people in three different UK-based medical research projects chose to cooperate. Data analysis of the accounts of 128 participants across the three studies was based on the constant comparative method. Participants' cooperation was engaged by a perception that they would be contributing to the 'public good', but they also wanted to justify their decision as sensible and safe. Critical to their cooperation was their belief that researchers would fulfil their side of the cooperative bargain, by not exposing participants to risks of harm or exploitation. Although participants were generally unaware of the details of the regulatory regime for research, they demonstrated a generalised reliance on regulation as a feature of everyday life that would provide a safe context for cooperation. In their assessment of particular projects, participants made judgements about whether to cooperate based on more specific cues, which acted as signs to assure them that researchers shared their cooperative intentions. These cues included organisational and professional credentials, the role identities and perceived trustworthiness of those involved in recruiting to research, and visible signs of reasonable practice mandated by regulatory systems. Thus participants drew on their understandings of an institutional field that was much broader than that of research alone. We propose that the social organisation of research is fundamental to the judgements people make about cooperation with research. Cooperation may be a more useful way of thinking about how people come to engage in collaboratively oriented actions such as research participation, rather

than currently dominant individualistic models. Attention to the institutional context of research is critical to understanding what makes cooperation possible, and has important implications for the design of regulatory regimes for research

**Draper, H., et al (2009). Offering payments, reimbursement and incentives to patients and family doctors to encourage participation in research. *Family Practice Online* 3/03/2009**

<http://dx.doi.org/10.1093/fampra/cmp011>

<http://pmid.us/19261621>

Sometimes researchers fail to meet their recruitment targets, and sometimes it is predicted that recruitment may prove difficult but it is not obvious what ethical latitude researchers have to boost participation by, for instance, paying participants to take part or by paying family doctors to recruit patients to participate. In this paper, we distinguish between payment, reimbursement and inducement. We look first at the ethics of paying research participants. We conclude that payment raises all kinds of ethical difficulties, but that reimbursement--whilst not completely unproblematic--is an ethical requirement. We then look at whether some inducement to participate is acceptable and conclude that it is. We continue by asking whether the same arguments can be applied to encouraging family doctors to recruit patients. We conclude that it is right for family doctors to be reimbursed for the costs of recruiting research participants and also argue that there are fewer problems with paying family doctors to recruit patients than there are with paying research participants. Given, however, that there is a fine line between reimbursement and payment, given the potential for conflicts of interests to arise, and given that even suspicion of such a conflict might undermine trust in doctors, systems of both payment and reimbursement need to be transparent

**Eccles, M.P., et al (2009). An implementation research agenda. *Implementation Science* 4 18**

<http://dx.doi.org/10.1186/1748-5908-4-18>

<http://www.implementationscience.com/content/4/1/18>

<http://pmid.us/19351400>

In October 2006, the Chief Medical Officer (CMO) of England asked Professor Sir John Tooke to chair a High Level Group on Clinical Effectiveness in response to the chapter 'Waste not, want not' in the CMOs 2005 annual report 'On the State of the Public Health'. The high level group made recommendations to the CMO to address possible ways forward to improve clinical effectiveness in the UK National Health Service (NHS) and promote clinical engagement to deliver this. The report contained a short section on research needs that emerged from the process of writing the report, but in order to more fully identify the relevant research agenda Professor Sir John Tooke asked Professor Martin Eccles to convene an expert group - the Clinical Effectiveness Research Agenda Group (CERAG) - to define the research agenda. The CERAG's terms of reference were

'to further elaborate the research agenda in relation to pursuing clinically effective practice within the (UK) National Health Service'. This editorial presents the summary of the CERAG report and recommendations

**Fattore,G. et al (2009). Social network analysis in primary care: The impact of interactions on prescribing behaviour. *Health Policy*.**

<http://dx.doi.org/10.1016/j.healthpol.2009.03.005>

<http://pmid.us/19356822>

Objectives: In many healthcare systems of affluent countries, general practitioners (GPs) are encouraged to work in collaborative arrangements to increase patients' accessibility and the quality of care. There are two lines of thought regarding the ways in which belonging to a network can affect GP behaviour: (1) the social capital framework posits that, through relationships, individuals acquire resources, such as information, that allow them to perform better; and (2) the social influence framework sees relationships as avenues through which individual actors influence other individuals and through which behavioural norms are developed and enforced. The objective of this study is to provide an evaluation of the effects of GP network organisation on their prescribing behaviour. Methods: We used administrative data from a Local Health Authority (LHA) in Italy concerning GPs organisation and prescriptions. Results: We found that GPs working in a collaborative arrangement have a similar prescribing behaviour while we did not find a significant relationship between the centrality of a GP and her capability to meet LHA's targets. Conclusions: Our data support the conclusion that, in the case of GP collaboration initiatives, the social influence mechanism is more relevant than the social capital mechanism

**Glynn,L., et al (2009). Research activity and capacity in primary healthcare: The REACH study: A survey. *BMC Family Practice*, 10(1), 33.**

<http://dx.doi.org/10.1186/1471-2296-10-33>

<http://www.biomedcentral.com/1471-2296/10/33>

<http://pmid.us/19432990>

Background :Despite increased investment in primary care research and development (R&D), the level of engagement of primary healthcare professionals with research remains poor. The aim of this study is to assess the level of research activity and capacity for research among primary healthcare professionals in a health authority of over one million people in a mixed urban/rural setting in the West of Ireland. Methods:A questionnaire, incorporating the R+D Culture Index, was sent to primary healthcare professionals in the HSE Western Region. Baseline characteristics were analysed with the use of one-way ANOVA and Chi-square test and the dependence of R&D Culture Index score on all sixteen available covariates was examined using multiple regression and regression tree modelling. Results: There was a 54% response rate to the questionnaire. Primary healthcare professionals appeared to have an interest in and awareness of the

importance of research in primary care but just 15% were found to be research active in this study. A more positive attitude towards an R&D culture was associated with having had previous research training, being currently involved in research and with not being a general practitioner (GP) ( $p < 0.001$ ), but much variability in the R&D culture index score remained unexplained. Conclusion: Despite awareness of the importance of R&D in primary care and investment therein, primary healthcare professionals remain largely unengaged with the R&D process. This study highlights the issues that need to be addressed in order to encourage a shift towards a culture of R&D in primary care: lack of research training particularly in basic research skills and increased opportunities for research involvement. The use of the R&D Culture Index may enable groups to be identified that may be more research interested and can therefore be targeted in any future R&D strategy

**Morris,Z.S., & Clarkson,P.J. (2009). Does social marketing provide a framework for changing healthcare practice? *Health Policy*. Online 13/01/2009**

<http://dx.doi.org/10.1016/j.healthpol.2008.11.009>

<http://pmid.us/19147249>

Objectives: We argue that social marketing can be used as a generic framework for analysing barriers to the take-up of clinical guidelines, and planning interventions which seek to enable this change. Methods: We reviewed the literature on take-up of clinical guidelines, in particular barriers and enablers to change; social marketing principles and social marketing applied to healthcare. We then applied the social marketing framework to analyse the literature and to consider implications for future guideline policy to assess its feasibility and accessibility. Results: There is sizeable extant literature on healthcare practitioners' non-compliance with clinical guidelines. This is an international problem common to a number of settings. The reasons for poor levels of take up appear to be well understood, but not addressed adequately in practice. Applying a social marketing framework brings new insights to the problem." Conclusions: We show that a social marketing framework provides a useful solution-focused framework for systematically understanding barriers to individual behaviour change and designing interventions accordingly. Whether the social marketing framework provides an effective means of bringing about behaviour change remains an empirical question which has still to be tested in practice. The analysis presented here provides strong motivation to begin such testing

**Padgett,D.K., & Henwood,B.F. (2009). Obtaining large-scale funding for empowerment-oriented qualitative research: a report from personal experience. *Qualitative Health Research* , 19(6), 868-874.**

<http://dx.doi.org/10.1177/1049732308327815>

<http://pmid.us/19429771>

Obtaining funding for qualitative research remains a challenge despite greater openness to methodological pluralism. Such hurdles are presumably compounded when the proposed study employs empowerment theory, rendering it susceptible to charges of elevating ideology over rigor. This article draws on the authors' experience in securing large-scale funding for an empowerment-oriented qualitative study of homeless mentally ill adults. Lessons learned include the importance of weaving empowerment theory into the proposal's "argument," and infusing empowerment values into study protocols while simultaneously paying close attention to rigorous and transparent methods. Additional benefits accrue from having prior relationships with study sites and being willing to revise and resubmit proposals whenever possible. Though representing a fraction of all externally funded projects in the United States, qualitative research has tremendous untapped potential for success in this competitive arena-success that need not entail surrendering a commitment to empowerment values

**Quinlan,E. (2009). The 'actualities' of knowledge work: an institutional ethnography of multi-disciplinary primary health care teams. *Sociology of Health and Illness* Online 8/04/2009**

<http://dx.doi.org/10.1111/j.1467-9566.2009.01167.x>

<http://pmid.us/19392938>

This study is set against the backdrop of the evolving order of a health care system in a province implementing a set of concurrent reforms. The study investigates how 'knowledge work' of multi-disciplinary health care teams is actually done and how it is co-ordinated across sites. Knowledge work involves three processes: the creation of new knowledge during the transfer of knowledge, in the context of the application of knowledge to their collective clinical decision-making. Institutional ethnography is used to explore the social and institutional forces that shape the knowledge work of health care providers in and across multi-disciplinary teams by way of examining how the texts trans-locally organise the formation and functioning of multi-disciplinary teams. The study confirms that in the course of their collective clinical decision-making, teams' dialogical exchange facilitates the articulation of tacit knowledge and opens up the communicative space for the creation of new knowledge. In addition to this confirmatory finding, the study contributes to the existing health-related knowledge management by illustrating the importance of the social, communicative aspects of the knowledge processes, and in particular, the relationship between knowledge and the social organisation of power

**Sarre,G., & Cooke,J. (2008). Developing indicators for measuring Research Capacity Development in primary care organizations: a consensus approach using a nominal group technique. *Health and Social Care in the Community*. 17 (3) 244-253**

<http://dx.doi.org/10.1111/j.1365-2524.2008.00821.x>

<http://pmid.us/19040697>

Research Capacity Development (RCD) in the National Health Service supports the production of evidence for decision-making in policy and practice. This study aimed to establish a level of consensus on a range of indicators to measure research capacity in primary care organizations. Indicators were developed in a two-stage process using workshops and modified nominal group technique. In 2005, workshops were used to generate possible indicators from a wide range of research active and research-interested people. A theoretical framework of six principles of RCD was used to explore and identify indicators. Data were thematically coded, and a 129-item, 9-point Likert scale questionnaire was developed. A purposive sample of nine experts in developing research capacity in primary care agreed to take part in a nominal group in April 2006. The questionnaire was circulated prior to the meeting, and analysis of the responses formed the basis for structured discussion. Participants were then asked to rescore the questionnaire. Only seven participants were able to take part in the discussion and rescore stages. Data were analysed in two ways: level of relevance attributed to each indicator as a measure of organizational RCD, represented by median responses (medians of 7-9 defined strong support, 4-6 indicated moderate support and 1-3 indicated weak support), and level of consensus reached by the group. Consensus was reached if 85% of the group rated an indicator within the same band. Eighty-nine (68%) indicators were ranked as strongly relevant, and for seventy-three of these indicators, a consensus was reached. The study was successful in generating a set of agreed indicators considered relevant for measuring RCD in primary care organizations. These will form the basis of a pilot tool kit to assist primary care organizations to develop research capacity. Further work will explore the applicability of the indicators in practice

## RESEARCH METHODS

Ibanez, B, et al . (2009). Is there much variation in variation? Revisiting statistics of small area variation in health services research. *BMC Health Services Research*, 9(1), 60.

<http://dx.doi.org/10.1186/1472-6963-9-60>

<http://www.biomedcentral.com/1472-6963/9/60>

<http://pmid.us/19341469>

Background: The importance of Small Area Variation Analysis for policy-making contrasts with the scarcity of work on the validity of the statistics used in these studies. Our study aims at 1) determining whether variation in utilization rates between health areas is higher than would be expected by chance, 2) estimating the statistical power of

the variation statistics; and 3) evaluating the ability of different statistics to compare the variability among different procedures regardless of their rates. Methods: Parametric bootstrap techniques were used to derive the empirical distribution for each statistic under the hypothesis of homogeneity across areas. Non-parametric procedures were used to analyze the empirical distribution for the observed statistics and compare the results in six situations (low/medium/high utilization rates and low/high variability). A small scale simulation study was conducted to assess the capacity of each statistic to discriminate between different scenarios with different degrees of variation. Results: Bootstrap techniques proved to be good at quantifying the difference between the null hypothesis and the variation observed in each situation, and to construct reliable tests and confidence intervals for each of the variation statistics analyzed. Although the good performance of Systematic Component of Variation (SCV), Empirical Bayes (EB) statistic shows better behaviour under the null hypothesis, it is able to detect variability if present, it is not influenced by the procedure rate and it is best able to discriminate between different degrees of heterogeneity. Conclusion: The EB statistics seems to be a good alternative to more conventional statistics used in small-area variation analysis in health service research because of its robustness

**May,C., et al (2009). Development of a theory of implementation and integration: Normalization Process Theory. *Implementation Science*, 4(1), 29.**

<http://dx.doi.org/10.1186/1748-5908-4-29>

<http://www.implementationscience.com/content/4/1/29>

<http://pmid.us/19460163>

Background: Theories are important tools in the social and clinical sciences. The methods by which they are derived are rarely described and discussed. Normalization Process Theory explains how new technologies, ways of acting, and ways of working become routinely embedded in everyday practice and has applications in the study of implementation processes. This paper describes the process by which it was built. Methods: Between 1998 and 2008, we undertook three tasks. (i) We derived a set of empirical generalizations from analysis of data collected in qualitative studies of healthcare work and organization. (ii) We developed an applied theoretical model through summative analysis of empirical generalizations. (iii) We built a formal theory through a process of extension and implication analysis of the applied theoretical model. Results: Each phase of theory development showed that the constructs of the theory did not conflict with each other, had explanatory power, and possessed sufficient robustness for formal testing. As the theory developed its scope expanded from a set of observed regularities in data with procedural explanations, to an applied theoretical model, to a formal middle-range theory. Conclusion: Normalization Process Theory has been developed through procedures that were properly sceptical and critical, and which were opened to review at each stage of development. The theory has been shown to be sufficiently robust to merit formal testing

**Noble,S., et al (2009). Feasibility and cost of obtaining informed consent for essential review of medical records in large-scale health services research. *Journal of Health Services Research and Policy*, 14(2), 77-81**

<http://dx.doi.org/10.1258/jhsrp.2008.008085>

<http://pmid.us/19299260>

Objective: To evaluate the effectiveness and cost of obtaining consent for review of medical records within the passively observed non-intervention arm of a cluster randomized controlled trial, 'Comparison Arm for ProtecT'. Methods: Two hundred and thirty men, who had been notified to the trial by cancer registries as having prostate cancer, were sent a consent form from their general practitioner or secondary care clinician. The consent rate of participants to the review of their medical records and the estimated costs of the process were evaluated. Results: One hundred and seventy-nine men (84%: 95% CI = 78%, 89%) consented to have their medical notes reviewed at an estimated cost of pound123 (euro172, \$248) per person. Conclusions: A high consent rate for review of medical notes is achievable but at a cost. There needs to be renewed debate about the automatic need for consent to review medical records where the chance of personal harm is negligible and the purpose of the review is to provide robust evidence to save lives, prevent needless suffering, and improve the effectiveness and efficiency of health care delivery

**Ryan,R., Kaufman,C., & Hill,S. (2009). Building blocks for meta-synthesis: data integration tables for summarising, mapping, and synthesising evidence on interventions for communicating with health consumers. *BMC Medical Research Methodology*, 9(1), 16.**

<http://dx.doi.org/10.1186/1471-2288-9-16>

<http://www.biomedcentral.com/1471-2288/9/16>

<http://pmid.us/19261177>

Background: Systematic reviews have developed into a powerful method for summarising and synthesising evidence. The rise in systematic reviews creates a methodological opportunity and associated challenges and this is seen in the development of overviews, or reviews of systematic reviews. One of these challenges is how to summarise evidence from systematic reviews of complex interventions for inclusion in an overview. Interventions for communicating with and involving consumers in their care are frequently complex. In this article we outline a method for preparing data integration tables to enable review-level synthesis of the evidence on interventions for communication and participation in health. Methods and Results Systematic reviews published by the Cochrane Consumers and Communication Review Group were utilised

as the basis from which to develop linked steps for data extraction, evidence assessment and synthesis. The resulting output is called a data integration table. Four steps were undertaken in designing the data integration tables: first, relevant information for a comprehensive picture of the characteristics of the review was identified from each review, extracted and summarised. Second, results for the outcomes of the review were assessed and translated to standardised evidence statements. Third, outcomes and evidence statements were mapped into an outcome taxonomy that we developed, using language specific to the field of interventions for communication and participation. Fourth, the implications of the review were assessed after the mapping step clarified the level of evidence available for each intervention. Conclusion: The data integration tables represent building blocks for constructing overviews of review-level evidence and for the conduct of meta-synthesis. Individually, each table aims to improve the consistency of reporting on the features and effects of interventions for communication and participation; provides a broad assessment of the strength of evidence derived from different methods of analysis; indicates a degree of certainty with results; and reports outcomes and gaps in the evidence in a consistent and coherent way. In addition, individual tables can serve as a valuable tool for accurate dissemination of large amounts of complex information on communication and participation to professionals as well as to members of the public

**Song,F., et al . (2009) Methodological problems in the use of indirect comparisons for evaluating healthcare interventions: survey of published systematic reviews. *British Medical Journal*, 338 b1147.**

<http://dx.doi.org/10.1136/bmj.b1147>

<http://pmid.us/19346285>

Objective: To investigate basic assumptions and other methodological problems in the application of indirect comparison in systematic reviews of competing healthcare interventions. Design: Survey of published systematic reviews. Inclusion criteria Systematic reviews published between 2000 and 2007 in which an indirect approach had been explicitly used. Data extraction: Identified reviews were assessed for comprehensiveness of the literature search, method for indirect comparison, and whether assumptions about similarity and consistency were explicitly mentioned. Results: The survey included 88 review reports. In 13 reviews, indirect comparison was informal. Results from different trials were naively compared without using a common control in six reviews. Adjusted indirect comparison was usually done using classic frequentist methods (n=49) or more complex methods (n=18). The key assumption of trial similarity was explicitly mentioned in only 40 of the 88 reviews. The consistency assumption was not explicit in most cases where direct and indirect evidence were compared or combined (18/30). Evidence from head to head comparison trials was not systematically searched for or not included in nine cases. Conclusions: Identified methodological problems were an unclear understanding of underlying assumptions, inappropriate search and selection of relevant trials, use of inappropriate or flawed methods, lack of objective and validated methods to assess or improve trial similarity, and inadequate comparison or inappropriate combination of direct and indirect evidence. Adequate understanding of basic

assumptions underlying indirect and mixed treatment comparison is crucial to resolve these methodological problems. Appendix 1: PubMed search strategy. Appendix 2: Characteristics of identified reports. Appendix 3: Identified studies. References of included studies

**Wade,J., et al** It's not just what you say, it's also how you say it: Opening the “black box” of informed consent appointments in randomised controlled trials. *Social Science & Medicine*, Online 11/04/2009

<http://dx.doi.org/10.1016/j.socscimed.2009.02.023>

<http://pmid.us/19364625>

Randomised controlled trials (RCTs) represent the gold standard methodology for determining effectiveness of healthcare interventions. Poor recruitment to RCTs can threaten external validity and waste resources. An inherent tension exists between safeguarding informed decision-making by participants and maximising numbers enrolled. This study investigated what occurs during informed consent appointments in an ongoing multi-centre RCT in the UK. Objectives were to investigate: 1] how study staff presented study information to participants; 2] what evidence emerged as to how well-informed participants were when proceeding to randomisation or treatment selection; and 3] what aspects of the communication process may facilitate improvements in providing evidence of informed consent. Qualitative analysis of a purposive sample of 23 recruitment appointments from three study centres and involving several recruitment staff applied techniques of thematic, content and conversation analysis (CA). Thematic analysis and CA revealed variation in appointment content and structure. Appointments were mostly recruiter-led or participant-led, and this structure was associated with what evidence emerged as to how participants understood information provided and whether they were in equipoise. Participant-led appointments provided this evidence more consistently. Detailed CA identified communication techniques which, when employed by recruiters, provided evidence as to how participants understood the choices before them. Strategic use of open questions, pauses and ceding the floor in the interaction facilitated detailed and systematic exploration of each participant's concerns and position regarding equipoise. We conclude that the current focus on content to be provided to achieve informed consent should be broadened to encompass consideration of how information is best conveyed to potential participants. A model of tailored information provision using the communication techniques identified and centred on eliciting and addressing participants' concerns is proposed. Use of these techniques is necessary to make potential participants' understanding of key issues and their position regarding equipoise explicit in order to facilitate truly informed consent

## SELF MANAGEMENT

**Baksi,A.K. (2009). Experiences in peer-to-peer training in diabetes mellitus: challenges and implications. *Family Practice***

<http://dx.doi.org/10.1093/fampra/cmp014>

<http://pmid.us/19258442>

This paper briefly describes the functions of peer advisers in diabetes (PADs) and their training. The formal process used in the assessment of the peer advisers at the completion of the training courses is also stated. The findings of a recent randomized controlled trial to study the effectiveness of peer advisers in delivering a programme of education on self-management are also described. The experience gained after the completion of four courses for the training of peer advisers, in addition to a review of the literature, forms the basis for discussion of the subject of peer-to-peer support activities in diabetes. PADs are effective in the provision of one-to-one psychosocial support and advice on self-management. They are also effective as committee members and advocates for diabetes. More recently, they have been shown to be effective as teachers on self-management to their peers with diabetes. With the imminent explosion in the number of people with diabetes, there will be increased need for psychosocial support and in the requirement for the provision of education on self-management. It is unlikely that health services would be given sufficient resources to cope with this. Society should identify alternative resources. People with diabetes and their close carers are the obvious choice, and we need to commence their training now. The implications for primary care are discussed

**Blenkinsopp,A., et al Joining Up Self-Care: evaluation of a PCT-wide programme of support for self-care. *Primary Health Care Research & Development, 10(02), 83-97.***

<http://dx.doi.org/10.1017/S1463423608000984>

**Background and Aim** Although there is existing activity within the NHS and local communities to support self-care there has been no previous attempt at integration across a Primary Care Trust (PCT). The Joining Up Self-Care (JUSC) study aimed to implement and evaluate such a programme. **Methods** Three self-care support modules for members of the public, together with a training course for primary care teams, were developed with, and implemented in, one PCT. The modules related to disease prevention (community-based coronary heart disease (CHD) prevention), care of people with long-term conditions (a disease-specific self-care skills training course for asthma) and the management of minor ailments aimed at mothers of children aged 3 months to 12 years (the service plus information booklets and campaigns). Postal questionnaires were completed by participants in CHD prevention (178), management of asthma (76) and minor ailments management (92), and by controls. A general population survey (n = 540) provided a comparison group for the CHD module and assessed general awareness of local self-care support. Four focus groups were held with mothers of young children. An audit of general practitioner (GP) records was conducted for consultations for minor

ailments. Structured telephone interviews were conducted with 51 local health professionals and nine members of staff from the PCT. Results Participants in the CHD module reported significantly more risk-reducing behaviours. Participants in a disease-specific Expert Patient Programme (EPP) for people with asthma rated the course positively, were subsequently more confident about discussing asthma with their doctor and had fewer concerns about their asthma medicines. Most users of the minor ailments scheme reported positive feedback and an intent to use the service again in the future. There were no significant differences in numbers of GP consultations for minor ailments between intervention and control groups. Health professionals were generally positive about encouraging self-care. Many felt they were already doing this but had insufficient time to implement it. A Local Enhanced Service (LES) was successful in engaging local general practices with self-care. Some organizational development relating to self-care occurred within the PCT but integration across different directorates was not achieved. Conclusions The JUSC programme was associated with changes in self-reported CHD risk reduction behaviours, in confidence to manage asthma and fewer concerns about medication, and with more positive attitudes towards consulting a pharmacist for minor ailments. Key principles for future PCT self-care strategies were identified. Further work is needed to embed support for self-care across the PCT as an organization

**Catalano,T. et al (2009). The experiences of leaders of self-management courses in Queensland: exploring Health Professional and Peer Leaders' perceptions of working together. *Health and Social Care in the Community*, 17(2), 105-115.**

<http://dx.doi.org/10.1111/j.1365-2524.2008.00801.x>

<http://pmid.us/19040700>

This paper describes the experiences of volunteers who have been trained to deliver the Stanford Chronic Disease Self-Management Program course. In Queensland, Australia, Leaders usually work in pairs (a Health Professional Leader (HPL) and a Peer Leader (PL)). Qualitative data were collected to explore volunteers' experiences as Leaders and their opinions about working together to deliver self-management courses. The data were collected from September 2005 to December 2005. In-depth, semistructured telephone interviews were conducted with a purposive sample of 34 Leaders (17 PL, 17 HPLs). Thematic analysis revealed two core themes that described Leaders' perceptions and experiences of working relationships between HPLs and PLs: (1) The Value of Working Together and (2) Relationship Tensions. Both HPLs and PLs believed that working together represented 'the best of both worlds' and that the combination of peers and health professionals enhanced the sustainability of the approach. However, a number of tensions were revealed that undermined the development and sustainability of these working relationships. From HPLs' perspective, the benefits of working with volunteer PLs did not always justify the 'burden'. Finding the 'right person' for the PL role was difficult and a higher value was often placed on the contribution of professionals. The tensions that were most prominent for PLs were grounded in the disparity between their status and that of HPLs, their lack of ownership over courses coupled with lack of a strong voice in the co-Leader relationship, and the absence of connection and engagement among Leaders.

Working relationships between HPLs and PLs have potential to deliver positive outcomes for people with chronic disease, but the current study has highlighted the necessity of developing a culture of mutual respect and a system that values both forms of knowledge and expertise (i.e. experiential and professional)

**Fisher,E.B., et al (2009). Cross-cultural and international adaptation of peer support for diabetes management. *Family Practice* Online 10/03/2009**

<http://dx.doi.org/10.1093/fampra/cmp013>

<http://pmid.us/19276176>

Peer support may improve self-management among the millions of people with diabetes around the world. A major challenge to international promotion of peer support is allowing for tailoring to population, cultural, health system and other features of specific settings, while also ensuring congruence with standards for what peer support entails. One strategy to address this challenge was used in the Robert Wood Johnson Foundation Diabetes Initiative. Key functions of self-management--Resources and Supports for Self-Management--were identified. Individual programmes were then encouraged to implement these resources and support in ways that were feasible in their settings and responsive to the needs and perspectives of those they serve. Extending this to peer support, three Key functions are (i) assistance in managing and living with diabetes in daily life; (ii) social and emotional support and (iii) linkage to clinical care. International promotion may be advanced by emphasizing these key functions and then encouraging local variation in the specific ways they are addressed. Similarly, evaluation of the general benefits of peer support across several individual programmes may rest on measurement of implementation of the key functions, participants' reports of receipt of them and common end points. Challenges to promoting peer support include integrating peers amidst others in the health care system, harmonizing peers with family and other social networks, maintaining the engagement of peer supporters and those they assist and preventing training, quality improvement and professionalism from distorting the fundamental benefits of support from a peer

**Graffy,J. et al Personalized care planning for diabetes: policy lessons from systematic reviews of consultation and self-management interventions. *Primary Health Care Research & Development* Online 3/06/2009**

<http://dx.doi.org/10.1017/S1463423609001157>

Aim To determine whether a process of care planning for people with diabetes, combining a patient-centred approach by practitioners with measures to promote self-management by patients, improve health outcomes. Background Health policy, in many countries, seeks to engage people with long-term conditions in protecting their health. This review was conducted by members of a working group established by the Department of Health and Diabetes, UK to consider the potential for personalized care planning in UK diabetes services. Methods Review of systematic reviews. The Cochrane Library and Database of Reviews of Effectiveness were searched to identify reviews

concerned with components of care planning. Reviews conducted before 1990, and those involving education outside the consultation were excluded. s were reviewed and data extraction undertaken by reviewers working independently in pairs .Results In all, 86 reviews were identified as potentially relevant and 22 included. Patient-focused interventions, such as pre-consultation prompts, enhanced the role patients played in consultations. Personalized approaches using tailored information influenced health behaviour more than uniform approaches. Decision aids and computerized knowledge management improved the process of decision-making. Although effective communication was important, focusing solely on changing practitioner behaviour appeared inadequate. Taken together, there was good evidence that the processes involved in personalized care planning would engage patients more effectively in managing their care, but little robust research on the impact on health outcomes of doing so. Conclusions The present review identifies effective interventions that are available for clinicians to use in diabetes consultations, but engaging patients requires more than this. Mechanisms to share information and decision-making need further development and evaluation to assess their impact on health outcomes. Narrowly targeted interventions focused on practitioner behaviour appear less effective than whole-system approaches. Personalized care planning offers a mechanism to integrate patient-centred medicine and support for self-management to improve diabetes care

**Heisler,M. (2009). Different models to mobilize peer support to improve diabetes self-management and clinical outcomes: evidence, logistics, evaluation considerations and needs for future research. *Family Practice* Online 17/03/2009**

<http://dx.doi.org/10.1093/fampra/cmp003>

<http://pmid.us/19293400>

Much of diabetes care needs to be carried out by patients between office visits with their health care providers. Yet, many patients face difficulties carrying out these tasks. In addition, many adults with diabetes cannot count on effective support from their families and friends to help them with their self-management. Peer support programmes are a promising approach to enhance social and emotional support, assist patients in daily management and living with diabetes and promote linkages to clinical care. This background paper provides a brief overview of different approaches to mobilize peer support for diabetes self-management support, discusses evidence to date on the effectiveness of each of these models, highlights logistical and evaluation issues for each model and concludes with a discussion of directions for future research in this area

**Jackson,C., et al (2006). Facilitating partnership working in public health: evaluation of a clinical service development approach. *Primary Health Care Research & Development*, published online 6/4/2009**

<http://dx.doi.org/10.1017/S146342360900108X>

Background UK health policy identifies partnership working as fundamental to tackling health inequalities. Related to this is the development of a multi-disciplinary public health workforce, including an increase in the public health role of primary care nurses. Within this policy context, a primary care trust in the north of England established a community health team (CHT) in September 2005 to improve intra- and inter-agency working for public health. The Clinical Microsystems (CMS) framework informed the process of development, an approach not previously applied to public health. Aim This paper describes an evaluation of the CHT and presents the key lessons learnt in terms of what worked and did not work in the context of the CMS framework. Methods Participants were members and wider stakeholders of the CHT from three professional groups: individuals holding relevant strategic posts in the Public Health and Nursing Directorates within the Primary Care Trust, health visitors and school nurses, and voluntary sector staff. Focus group (n = 9 focus groups) and postal questionnaire (n = 21) data were collected at baseline, 6 and 12 months post-implementation. Participants views on the implementation of the CHT were explored with the “five Ps”: (purpose, population, people, processes and patterns) of the CMS framework. Findings Six themes emerged from the focus group data that illustrated key issues for the implementation of the CHT: agreeing the focus, strong leadership, the challenge of communication, managing workloads and new ways of working, success of the CHT outside influences.; Communication and heavy workloads were identified as key barriers to the success of the CHT in the questionnaire data. These data highlight the complex and evolving nature of public health partnership working and identify important issues that might usefully be considered in future initiatives of this kind

**Kennedy,A., et al (2009). Creating 'good' self-managers?: Facilitating and governing an online self care skills training course. *BMC Health Services Research*, 9(1), 93.**

<http://dx.doi.org/10.1186/1472-6963-9-93>

<http://www.biomedcentral.com/1472-6963/9/93>

Background: In chronic disease management, patients are increasingly called upon to undertake a new role as lay tutors within self-management training programmes. The internet constitutes an increasingly significant healthcare setting and a key arena for self-management support and communication. This study evaluates how a new quasi-professional health workforce - volunteer tutors - engage, guide and attempt to manage people with long-term conditions in the ways of 'good' self-management within the context of an online self-management course. Methods: A qualitative analysis of postings to the discussion centre of 11 online classes (purposively selected from 27) run as part of the Expert Patients Programme. Facilitators (term for tutors online) and participants posted questions, comments and solutions related to self-management of long-term conditions; these were subjected to a textual and discursive analysis to explore: a) how facilitators, through the internet, engaged participants in issues related to self-management; b) how participants responded to and interacted with facilitators. Results: Emergent themes included: techniques and mechanisms used to engage people with self-management; the process facilitators followed - 'sharing', 'modelling' and 'confirming';

and the emergence of a policing role regarding online disclosure. Whilst exchanging medical advice was discouraged, facilitators often professed to understand and give advice on psychological aspects of behaviour. Conclusions: The study gave an insight into the roles tutors adopt - one being their ability to 'police' subjective management of long-term conditions and another being to attempt to enhance the psychological capabilities of participants

**McFadden,E., et al (2009). Self-rated health does not explain the socioeconomic differential in mortality: a prospective study in the EPIC-Norfolk cohort. *Journal of Epidemiology and Community Health*, 63(4), 329-331.**

<http://dx.doi.org/10.1136/jech.2008.078139>

<http://pmid.us/19147634>

Background: Self-rated health (SRH), a subjective measure of health, is strongly predictive of mortality, independently of objective measures of health status and existing known disease. There is a strong social gradient in SRH. An investigation was carried to determine whether SRH can explain the well-known socioeconomic gradient in mortality. Methods: The effect of adjusting for SRH on the socioeconomic differential in mortality was examined in a prospective study of 20 754 men and women aged 39-79 years, without prevalent disease, living in the general community in Norfolk, UK, recruited using general practice age-sex registers for 1993-1997 and followed up for an average of 10 years. Results: Mortality risk increased with decreasing social class in men and women. There was some attenuation after adjustment for covariates age, body mass index, smoking, history of diabetes, systolic blood pressure, cholesterol level, alcohol consumption, physical activity and educational level, but a gradient remained. Further adjustment for SRH attenuated the association slightly more, but there was still some evidence of a socioeconomic differential in mortality, particularly in class V compared with class I (age- and sex-adjusted hazard ratio 1.57; 95% CI 1.19 to 2.06). Conclusions: SRH does not substantially explain the socioeconomic differential in mortality beyond that explained by health-related covariates

**McFadden,E., et al (2009). Does the association between self-rated health and mortality vary by social class? *Social Science and Medicine* 68(2), 275-280.**

<http://dx.doi.org/10.1016/j.socscimed.2008.10.012>

<http://pmid.us/19028414>

Self-rated health (SRH) predicts future mortality. Individuals in different social classes with similar physical health status may have different reference levels and criteria against which they judge their health, therefore the SRH-mortality relationship may vary according to social class. We examine the relationship between SRH and mortality by occupational social class in a prospective study of 22,457 men and women aged 39-79 years, without prevalent disease, living in the general community in Norfolk, United Kingdom, recruited using general practice age-sex registers in 1993-1997 and followed up for an average of 10 years. As expected, SRH was related to subsequent mortality. The

age and sex adjusted hazard ratio for mortality for those with poor compared to those with excellent SRH was 4.35 (95% confidence interval 3.38-5.59, P<0.001). The prevalence of poor or moderate SRH was higher in manual than in non-manual classes. However, SRH was similarly related to mortality in manual and non-manual classes: when non-manual classes are compared with manual classes for each category of SRH, the 95% confidence intervals for the mortality hazard ratios overlap. There was no evidence of an interaction between social class and SRH in either men or women. Thus in this population, SRH appears to predict mortality in a similar manner in non-manual and manual classes

**Nettles,A., & Belton,A. (2009). An overview of training curricula for diabetes peer educators. *Family Practice* Online 8<sup>th</sup> January 2009**

<http://dx.doi.org/10.1093/fampra/cmn102>

<http://pmid.us/19131580>

Global community members who experience similar health problems gravitate to each other for information and support. Peers may be more approachable and can relate to the particular living circumstances one experiences. In well-resourced countries, people have opportunities for learning diabetes self-management; however, empathy may be more helpful when practical barriers arise. Little is published in medical literature about how to foster diabetes peer support and what is published is often limited to English language. Among those programs available, commonalities are readily seen. There is significant evidence that well-informed people cope better with adapting their lifestyle to medical regimens. Professionally delivered diabetes education has been well defined, but there may be additional benefit from learning from those who are living the experience everyday regarding how to navigate health care systems, handle finances, deal with natural emotions or family relations. Diabetes is epidemic and worldwide. There will never be sufficient traditional health care services to meet all future patients needs. While we persist in training health care professionals to deliver better diabetes care, we can explore how to mobilize willing volunteers to provide additional ongoing support to people with diabetes, where they live and work. While the characteristics of a peer educator have been defined slightly differently by several programs, there is agreement across programs that they need to be able to communicate clearly, they need to be willing to learn, they need to have confidence and they need to be flexible and dependable

**Pratt,R., Halliday,E., & Maxwell,M. (2009). Professional and service-user perceptions of self-help in primary care mental health services. *Health and Social Care in the Community*, 17(2), 209-215.**

<http://dx.doi.org/10.1111/j.1365-2524.2008.00819.x>

<http://pmid.us/19040698>

Self-help is becoming an increasingly accessible option for addressing mental health problems. Despite this, self-help is subject to a variety of interpretations, little is known about how professionals and service-users conceptualise self-help, or how service-users

engage in self-help activities. This study aimed to explore the views of self-help by service-users and health professionals in one area of Scotland, including the perceptions of what constitutes self-help and how it might be used to address mental health problems in primary care. The research involved semistructured interviews with 31 primary care mental health professionals, and in-depth interviews with 34 service-users. We found that professionals and service-users describe self-help in different ways, which has great implications for referral to and implementation of self-help in primary care settings. It also emerged that self-help was not necessarily perceived to be able to address the causes of mental distress, which could leave some professionals defaulting to offering no interventions despite the fairly positive attitude service-users show to self-help strategies. Finally, professionals need to be convinced that interventions are useful, effective and accessible as there are significant barriers in professionals using self-help; if they are not convinced, such approaches will support their therapeutic approach. The research supports the need to develop methods of delivery that offer self-help as part of a broad package of care that also considers social causes of distress

**Rogers,A. (2006). Advancing the Expert Patient? *Primary Health Care Research & Development* Online 3/06/2009**

<http://dx.doi.org/10.1017/S1463423609001194>

The self-management of long-term conditions undertaken by people in their own homes has been attributed with increasing importance in health care policy. Interventions based on self-skills training have been introduced as a means of promoting and increasing levels of self-care practises in the population which have been informed by psychological models and concepts of change such as in the case of the national policy of the Expert Patients Programme (EPP) self-efficacy. Evidence to date suggests modest or equivocal effectiveness and there may be a number of reasons for this. One of the reasons is a failure to give due attention to the perspectives and work that patients themselves undertake in self-management interventions. Whilst the notion of an Expert Patient conveys a sense of what a new health policy centred on long-term condition management hopes to achieve, an important corollary is understanding the conditions necessary to accommodate and embed new techniques in the routine elements of illness undertaken by patients living with a long-term condition. This paper explores the health policy context of self-management, including the evidence and adequacy of the organizing concepts and outcomes associated with the EPP, and suggests that a greater focus on illness work and the social and domestic contexts is required in future innovation and research in the area of long-term condition management

**Ryan,A., et al (2009). Factors associated with self-care activities among adults in the United Kingdom: a systematic review. *BMC Public Health*, 9(1), 96.**

<http://dx.doi.org/10.1186/1471-2458-9-96>

<http://www.biomedcentral.com/1471-2458/9/96>

<http://pmid.us/19344526>

**Background** :The Government has promoted self-care. Our aim was to review evidence about who uses self-tests and other self-care activities (over-the-counter medicine, private sector, complementary and alternative medicine (CAM), home blood pressure monitors).**Methods** :During April 2007, relevant bibliographic databases (Medline, Embase, Cumulative Index to Nursing and Allied Health Literature, Applied Social Sciences Index and Abstracts, PsycINFO, British Nursing Index, Allied and Complementary Medicine Database, Sociological Abstracts, International Bibliography of the Social Sciences, Arthritis and Complementary Medicine Database, Complementary and Alternative Medicine and Pain Database) were searched, and potentially relevant studies were reviewed against eligibility criteria. Studies were included if they were published during the last 15 years and identified factors, reasons or characteristics associated with a relevant activity among UK adults. Two independent reviewers used proformas to assess the quality of eligible studies. **Results**: 206 potentially relevant papers were identified, 157 were excluded, and 49 papers related to 46 studies were included: 37 studies were, or used data from questionnaire surveys, 36 had quality scores of five or more out of 10, and 27 were about CAM. Available evidence suggests that users of CAM and over-the-counter medicine are female, middle-aged, affluent and/or educated with some measure of poor health, and that people who use the private sector are affluent and/or educated. **Conclusion**: People who engage in these activities are likely to be affluent. Targeted promotion may, therefore, be needed to ensure that use is equitable. People who use some activities also appear to have poorer measures of health than non-users or people attending conventional services. It is, therefore, also important to ensure that self-care is not used as a second choice for people who have not had their needs met by conventional services

**Simmons,D., et al (2009). The New Zealand experience in peer support interventions among people with diabetes. *Family Practice* Online 2/03/2009**

<http://dx.doi.org/10.1093/fampra/cmp012>

<http://pmid.us/19254967>

**Background.** Peer-to-peer support has the potential to assist people with diabetes, or at risk of diabetes. **Objective.** To review the development of diabetes peer support initiatives in New Zealand. **Methods.** A systematic review of diabetes peer support publications from New Zealand, supplemented by unpublished records from Diabetes New Zealand (DNZ, the national diabetes patient organization) and the two major regional initiatives in South Auckland and Waikato. **Results.** DNZ, which has 40 societies and 71 diabetes support groups, delivers a range of services to members and non-members. The membership is mainly older European New Zealanders with diabetes, with some Maori and associated societies for Pacific and Youth. While demand exists, no quantitative evaluation of health impact by these organizations has been undertaken. Other peer support groups have developed in South Auckland and Northland. Common themes that emerge relate to leadership, organization and balancing the different needs of people with diabetes at different stages (e.g. newly diagnosed versus others) and with different personal needs. In South Auckland and the Waikato, lay educators have been trained to

provide 1:1 and group sessions for people with, or at high risk of, diabetes. A range of training, management, funding and organizational barriers existed in the implementation of these lay educator programmes. Conclusions. Peer-to-peer support and education programmes in diabetes have been considered useful in New Zealand. Knowledge regarding training, management and organization is nearing a level, which would allow formal evaluation of a strategy for both the prevention of diabetes and in supporting people with diabetes

**Sousa, V.D. et al (2009). New measures of diabetes self-care agency, diabetes self-efficacy, and diabetes self-management for insulin-treated individuals with type 2 diabetes. *Journal of Clinical Nursing* 18(9), 1305-1312.**

<http://dx.doi.org/10.1111/j.1365-2702.2008.02729.x>

<http://pmid.us/19413558>

Aims and objectives: To develop and refine three new scales that measure diabetes self-care agency, diabetes self-efficacy and diabetes self-management to reflect the American Diabetes Association current standards of diabetes care and the American Association of Diabetes Educators self-care behaviours. And, to establish the clarity, consistency and content validity of the scales. Background: There is a need to have valid and reliable instruments or scales to assess an individual's diabetes self-care agency, self-efficacy and self-management to plan appropriate interventions that can be effective in improving glycaemic control and delaying or preventing diabetes-related complications. Design: A methodological design was used to conduct this study. MethodS: Ten clinicians and 10 insulin-treated individuals with type 2 diabetes (T2DM) from a diabetes care center in the southern USA participated in this study. Analysis consisted of inter-rater agreement to determine clarity and consistency with standards of diabetes care and content validity of individual items on the scales (I-CVI) and the overall scales (S-CVI/Ave) to determine relevance for current diabetes care practice. Results: All I-CVI and S-CVI/Ave of the DSES exceeded the minimum acceptable criteria. All I-CVI and the S-CVI of the DSMS also exceeded the minimum accepted criteria, except for one item that had I-CVI = 0.70. Evaluation of the items and the directions of the scales by the sample of insulin-treated individuals with T2DM exceeded the minimum criteria of 80% inter-rater agreement. Relevance to research and clinical practice: Further psychometric testing of the scales with samples of insulin-treated individuals with diabetes is warranted and will lay the groundwork for further research and clinical practice to enhance the capability, confidence and actual performance of diabetes self-management activities among insulin-treated individuals with T2DM. Conclusions: The scales can be used by diabetes care providers to assess and follow-up individuals with diabetes who need intense case management. They also can be the measures of choice to conduct future research to test the effects of interventions among insulin-treated individuals with T2DM

## **SOCIAL CAPITAL**

**Snelgrove,J.W., Pikhart,H., & Stafford,M. (2009). A multilevel analysis of social capital and self-rated health: Evidence from the British Household Panel Survey. *Social Science & Medicine*, 68(11), 1993-2001.**

<http://dx.doi.org/10.1016/j.socscimed.2009.03.011>

<http://pmid.us/19345465>

Social capital is often described as a collective benefit engendered by generalised trust, civic participation, and mutual reciprocity. This feature of communities has been shown to associate with an assortment of health outcomes at several levels of analysis. The current study assesses the evidence for an association between area-level social capital and individual-level subjective health. Respondents participating in waves 8 (1998) and 9 (1999) of the British Household Panel Survey were identified and followed-up 5 years later in wave 13 (2003). Area social capital was measured by two aggregated survey items: social trust and civic participation. Multilevel logistic regression models were fitted to examine the association between area social capital indicators and individual poor self-rated health. Evidence for a protective association with current self-rated health was found for area social trust after controlling for individual characteristics, baseline self-rated health and individual social trust. There was no evidence for an association between area civic participation and self-rated health after adjustment. The findings of this study expand the literature on social capital and health through the use of longitudinal data and multilevel modelling techniques

## **WORKFORCE**

**Alexis,O., & Vydelingum,V. (2009). Experiences in the UK National Health Service: The overseas nurses' workforce. *Health Policy*, 90(2-3), 320-328.**

<http://dx.doi.org/10.1016/j.healthpol.2008.10.014>

<http://pmid.us/19081650>

Background: This paper presents an analysis based on the recently recruited overseas nurses in the NHS in the United Kingdom [UK]. Objectives: The aims of the study were

to determine how overseas nurses perceive equal opportunity as well as the opportunities for skill development and training to be in the National Health Service [NHS] in the UK. Methods: A survey approach was adopted to investigate the aims of the study. There were 900 questionnaires distributed of which 188 were suitable for the study, thus giving rise to 21% success rate. Results: The findings revealed many statistical differences between the different ethnic groups used in the study. Overall, overseas nurses from Africa perceived equal opportunity and their prospect for skills development and training to be different to that of their overseas counterparts. In addition the results showed that African nurses were less likely to view their experiences positively particularly if they were not working in any of the NHS trust hospitals in London. Conclusion: It is important to say that equal opportunity as well as opportunities for skills development and training should be universal within the NHS as this could improve the inequitable treatment that is apparent throughout the UK. There is a need for NHS trust hospitals in the UK to review their equal opportunity and skills development and training policies in the light of these findings

**Buchan,J., et al (2009). Does a code make a difference - assessing the English code of practice on international recruitment. *Human Resources for Health*, 7(1), 33.**

<http://dx.doi.org/10.1186/1478-4491-7-33>

<http://www.human-resources-health.com/content/7/1/33>

<http://pmid.us/19358727>

Background: This paper draws from research completed in 2007 to assess the effect of the Department of Health, England, Code of Practice for the international recruitment of health professionals. The Department of Health in England introduced a Code of Practice for international recruitment for National Health Service employers in 2001. The Code required National Health Service employers not to actively recruit from low-income countries, unless there was government-to-government agreement. The Code was updated in 2004. Methods: The paper examines trends in inflow of health professionals to the United Kingdom from other countries, using professional registration data and data on applications for work permits. The paper also provides more detailed information from two country case studies in Ghana and Kenya. Results: Available data show a considerable reduction in inflow of health professionals, from the peak years up to 2002 (for nurses) and 2004 (for doctors). There are multiple causes for this decline, including declining demand in the United Kingdom. In Ghana and Kenya it was found that active recruitment was perceived to have reduced significantly from the United Kingdom, but it is not clear the extent to which the Code was influential in this, or whether other factors such as a lack of vacancies in the United Kingdom explains it. Conclusions: Active international recruitment of health professionals was an explicit policy intervention by the Department of Health in England, as one key element in achieving rapid staffing growth, particularly in the period 2000 to 2005, but the level of international recruitment has dropped significantly since early 2006. Regulatory and education changes in the United Kingdom in recent years have also made international entry more difficult. The

potential to assess the effect of the Code in England is constrained by the limitations in available databases. This is a crucial lesson for those considering a global code: without a clear link between explicit objectives of a code, and relevant monitoring capacity, it is not possible to judge the actual impact of a code. A second message for policy-makers is that attempts to use a single country code in other countries where there are a multiplicity of independent, private-sector health care employers, or where there is a federated political and regulatory structure, will be a much more challenging and complex issue than in England, which has one major public sector health care employer and one national point of entry for regulated health professionals. Finally, there is a message about the importance of the "visibility" of any recruitment code - for policy-makers, employers and potential recruits. The Department of Health Code has a good level of recognition in the National Health Service, but would benefit from better dissemination in low-income countries, particularly in Africa, together with further consultation on the appropriateness of its provisions in specific countries. To achieve high visibility and recognition of any global code will be a much bigger challenge

**Chapman,L et al (2009). Community matrons: primary care professionals' views and experiences. *Journal of Advanced Nursing* . Online 25/04/2009**

<http://dx.doi.org/10.1111/j.1365-2648.2009.05002.x>

<http://pmid.us/19456996>

Community matrons: primary care professionals' views and experiences. Aim. This article is a report of a study exploring how the role of the community matron is progressing and any barriers or facilitators to performing the role. Background. Long-term conditions are distressing for patients and costly for healthcare services. Government policy in western countries has increasingly focussed on more integrated and pro-active management of patients with multiple long-term conditions to maintain the ability of the aging population to function independently. The role of community matrons has been introduced in England in an attempt to address these issues. Method. A purposive sample of 31 health and social care professionals participated in five focus group discussions. Reported experiences of the community matron role by community matrons, district nurses, social workers and general practitioners were analysed according to the principles of grounded theory. Data were collected in 2007. Findings. The community matron role was seen as effective in meeting the medical and social needs of patients. This was achieved through patient education, developing patients' self-management of their health conditions and monitoring their social needs. Potential barriers to success of the role were associated with lack of role definition prior to its introduction. Conclusion. It is unclear whether the role is financially viable in its current form. Further research is required to examine differing models for implementing the role and judging its effectiveness in bridging the primary-secondary care interface

**Goldacre,M.J., Davidson,J.M., & Lambert,T.W. (2009). Retention in the British National Health Service of medical graduates trained in Britain: cohort studies. *British Medical Journal* 2009;338:b1977**

<http://dx.doi.org/10.1136/bmj.b1977>

<http://pmid.us/19493940>

**Objective** To report the percentage of graduates from British medical schools who eventually practise medicine in the British NHS. **Design** Cohort studies using postal questionnaires, employment data, and capture-recapture analysis. **Setting** Great Britain. **Subjects** 32 430 graduates from all British medical schools in nine graduation cohorts from 1974 to 2002, subdivided into home based medical students (those whose homes were in Great Britain when they entered medical school) and those from overseas (whose homes were outside Great Britain when they entered medical school). **Main outcome measures** Working in the NHS at seven census points from two to 27 years after qualification. **Results** Of home based doctors, 88% of men (6807 of 7754) and 88% of women (7909 of 8985) worked as doctors in the NHS two years after qualification. The corresponding values were 87% of men (7483 of 8646) and 86% of women (7364 of 8594) at five years; 86% (6803 of 7872) and 86% (5407 of 6321) at 10 years; 85% (5404 of 6331) and 84% (3206 of 3820) at 15 years; and 82% (2534 of 3089) and 81% (1132 of 1395) at 20 years. Attrition from the NHS had not increased in recent cohorts compared with older ones at similar times after graduation. Of overseas students, 76% (776 of 1020) were in the NHS at two years, 72% (700 of 972) at five years, 63% (448 of 717) at ten years, and 52% (128 of 248) at 20 years. **Conclusions** The majority of British medical graduates from British medical schools practise in the NHS in both the short and long term. Differences between men and women in this respect are negligible. A majority of doctors from overseas homes remain in Britain for their years as junior doctors, but eventually about half leave the NHS

**Lakhan,S., & Laird,C. (2009). Addressing the primary care physician shortage in an evolving medical workforce. *International Archives of Medicine*, 2(1), 14.**

<http://dx.doi.org/10.1186/1755-7682-2-14>

<http://www.intarchmed.com/content/2/1/14>

<http://pmid.us/19416533>

**Background:** Primary care physicians have been shown to play an important role in the general health of the communities in which they serve. In spite of their importance, however, there has been a decrease in the number of physicians interested in pursuing primary care fields, while the proportion of specialists continues to increase. The prediction of an overall physician shortage only augments this issue in the US, where this uneven distribution is particularly evident. As such, serious effort to increase the number of practicing primary care physicians is both necessary and beneficial for meeting this country's health care needs. **Discussion:** There are several factors at play which contribute to the decrease in the number of practicing physicians in primary specialties. Lifestyle concerns, such as schedule and income, as well as the lack of prestige associated with this field seem to be among the most prevalent reasons cited for the

diminishing interest. Multifaceted concerns such as these, however, are difficult to adequately invalidate; doing so would not only require a great deal research, but also a good deal of time -- a resource which is in short supply given the current physician shortage being faced. Thus, a more immediate solution may lie in the increased recruitment and continued support of those individuals who are already associated with primary care service. This is particularly relevant given the Association of American Medical College's goal of increasing medical school enrollment by 15% over the next 10 years. Several groups have been shown to be large contributors to primary care in the US. Here, we focus on three such groups: minority students, international medical graduates, and osteopathic physicians. Although these groups are highly diverse individually, they all share the distinction of being underutilized in regard to the current primary care shortages faced. Thus, through more fully accentuating these resources, some of the problems being faced by this nation's healthcare industry may be ameliorated. Summary: To improve our nation's health and healthcare, it is our opinion in this commentary that we must determine a comprehensive approach to increase the number of practicing physicians in primary care which may include minority and underserved medical student recruitment, and acceptance of international medical graduates and osteopathic physicians. Although overtime some of the more underlying causes of primary care under-representation must be addressed, these previous options may offer more immediate aid, while recognizing and augmenting populations who already contribute greatly to our nation's medical system

**Leonard,C., Stordeur,S., & Roberfroid,D. (2009). Association between physician density and health care consumption: A systematic review of the evidence. *Health Policy*. Online 15/01/2009**

<http://dx.doi.org/10.1016/j.healthpol.2008.11.013>

<http://pmid.us/19150579>

Background: Supplier-induced demand (SID) for health care could be a crucial factor of rising health expenditures. However, there is thus far no consensus on the topic. Objective: To assess how physician density (physician-to-population ratio) and health care consumption correlate. Methods: A systematic review of studies retrieved through electronic databases: Medline, Econlit, PsychINFO and Embase. Search, inclusion and quality appraisal were based on standard procedures and applied independently by two researchers. Results: Twenty-five studies, generally of moderate quality, were included. Despite a substantial heterogeneity in study design and data modelling, a significant association between physician density and health care consumption was consistently observed. However, estimates varied according to a number of method parameters such as the definition of the dependent variable (physician volume or care intensity), the geographical entity or the medical specialty under consideration, and the adjustment for confounding factors. Conclusions: The exact importance of SID and the underlying motivations remain poorly understood. We discuss technical issues for better SID assessment. In the absence of more accurate information, limiting physician supply as a measure of cost containment should also be considered cautiously

**Oandasan,I.F., et al (2009). The impact of space and time on interprofessional teamwork in Canadian primary health care settings: implications for health care reform. *Primary Health Care Research & Development*, 10(02), 151-162.**

<http://dx.doi.org/10.1017/S1463423609001091>

**Aim** This paper explores the impact of space and time on interprofessional teamwork in three primary health care centres and the implications for Canadian and other primary health care reform. **Background** Primary health care reform in Canada has emphasized the creation of interprofessional teams for the delivery of collaborative patient-centred care. This involves the expansion and transformation of existing primary health care centres into interprofessional family health teams (FHT) promising to provide patients better access, more comprehensive care, and improved utilization of individual health professionals. Benefits for providers include improved workplace satisfaction and organizational efficiencies. Currently, there is little evidence for how effective interprofessional teamwork happens and little is known about how to create high-functioning teams in the primary health care setting. **Methods** We used ethnographic observations and interviews to gain a deep understanding of the nature of interprofessional teamwork. Three academic family health centres participated in a total of 139 h of observation and 37 interviews. Team members in all three centres from the disciplines of medicine, nursing, physiotherapy, occupational therapy, social work, dietetics, pharmacy, and office administration participated in this study. **Findings** We found that both the quantity and quality of interprofessional communication and collaboration in primary health care is significantly impacted by space and time. Across our research sites, the physical layout of clinical space and the temporal organization of clinical practice led to different approaches to, and degrees of success with, interprofessional teamwork. Varied models of interprofessional collaboration resulted when these factors came together in different ways. These findings have important implications for the transition to interprofessional family health teams in Canada and beyond

**Spence Laschinger,H.K. et al (2009). Workplace empowerment, incivility, and burnout: impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management* , 17(3) (This issue: Discussions on Job Satisfaction, Work Environment and Burnout), 302-311.**

<http://dx.doi.org/10.1111/j.1365-2834.2009.00999.x>

<http://pmid.us/19426367>

**Aim** The aim of this study was to examine the influence of empowering work conditions and workplace incivility on nurses' experiences of burnout and important nurse retention factors identified in the literature. **Background** A major cause of turnover among nurses is related to unsatisfying workplaces. Recently, there have been numerous anecdotal reports of uncivil behaviour in health care settings. **Method** We examined the impact of workplace empowerment, supervisor and coworker incivility, and burnout on three

employee retention outcomes: job satisfaction, organizational commitment, and turnover intentions in a sample of 612 Canadian staff nurses. Results Hierarchical multiple linear regression analyses revealed that empowerment, workplace incivility, and burnout explained significant variance in all three retention factors: job satisfaction ( $R(2) = 0.46$ ), organizational commitment ( $R(2) = 0.29$ ) and turnover intentions ( $R(2) = 0.28$ ). Empowerment, supervisor incivility, and cynicism most strongly predicted job dissatisfaction and low commitment ( $P < 0.001$ ), whereas emotional exhaustion, cynicism, and supervisor incivility most strongly predicted turnover intentions. Conclusions In our study, nurses' perceptions of empowerment, supervisor incivility, and cynicism were strongly related to job satisfaction, organizational commitment, and turnover intentions. Implications for nursing management Managerial strategies that empower nurses for professional practice may be helpful in preventing workplace incivility, and ultimately, burnout

**Taylor, K.S., Lambert, T.W., & Goldacre, M.J. (2009). Career progression and destinations, comparing men and women in the NHS: postal questionnaire surveys. *British Medical Journal*, 2009; 338:b1735**

<http://dx.doi.org/10.1136/bmj.b1735>

<http://pmid.us/19493938>

Objective To study the career progression of NHS doctors, comparing men and women. Design Postal questionnaire surveys. Participants and setting Graduates of 1977, 1988, and 1993 from all UK medical schools. Results The response rate was 68% (7012/10344). Within general practice, 97% (1208/1243) of men, 99% (264/267) of women who had always worked full time throughout their career, and 87% (1083/1248) of all women were principals. Median times from qualification to principal status were 5.8 (95% confidence interval 5.6 to 6.0) years for men, 5.6 (5.4 to 5.8) years for women who had worked full time during training, and 6.8 (6.5 to 7.0) years for all women. Of the 1977 and 1988 graduates in hospital practice, 96% (1293/1347) of men were consultants, compared with 92% (276/299) of women who had always worked full time throughout their career and 67% (277/416) of women who had not. Median time to first consultant post was 11.7 (11.5 to 11.9) years for men, 11.3 (11.0 to 11.6) years for women who worked full time during training, and 12.3 (12.0 to 12.6) years for all women. Women who had not always worked full time throughout their career were over-represented in general practice and under-represented in most hospital specialties, substantially so in the surgical specialties and anaesthetics. Women who had always worked full time were under-represented not only in the surgical specialties but also in general practice. Conclusions Women not progressing as far and as fast as men was, generally, a reflection of not having always worked full time rather than their sex. The findings suggest that women do not generally encounter direct discrimination; however, the possibility that indirect discrimination, such as lack of opportunities for part time work, has influenced choice of specialty cannot be ruled out

**Tomblin Murphy, G., et al (2009). Planning for what? Challenging the assumptions of health human resources planning. *Health Policy* Online 12/5/2009**

<http://dx.doi.org/10.1016/j.healthpol.2009.04.001>

<http://pmid.us/19443074>

Objectives: Health human resource planning has traditionally been based on simple models of demographic changes applied to observed levels of service utilization or provider supply. No consideration has been given to the implications of changing levels of need within populations over time. Recently, needs based resource planning models have been suggested that incorporate changes in needs for care explicitly as a determinant of health care needs. Methods: In this paper, population indicators of morbidity, mortality and self-assessed health are analyzed to determine if health care needs have changed across birth cohorts in Canada from 1994 to 2005 among older age groups. Multivariate regression analysis was used to estimate the age pattern of health by birth year with interaction terms included to examine whether the association of age with health was conditional on the birth year. Results: Results indicate that while the probability of mortality, mobility problems and pain rises with age, the rate of change is greater for those born earlier. The probability of self-assessed poor health increases with age but the rate of change with age is constant across birth years. Conclusions: Even in the short time period covered, our analysis shows that health care needs by age are changing over time in Canada

**Wakefield,A., et al (2009). Assistant or substitute: exploring the fit between national policy vision and local practice realities of assistant practitioner job descriptions. *Health Policy*, 90(2-3), 286-295.**

<http://dx.doi.org/10.1016/j.healthpol.2008.10.011>

<http://pmid.us/19056142>

Objectives: To understand the extent to which the assistant practitioner role is described as 'assistive' in formal job descriptions and analyse whether the term 'assistive' has been stretched to encompass more 'substitutive' or 'autonomous' characteristics. Methods: Sixteen AP job descriptions representing all clinical divisions across one UK acute NHS Hospital Trust were both macro- and micro-analysed for broad similarities and differences in line with Hammersley and Atkinson's analytical framework. The analysis specifically focused on how clinical tasks were related to clinical responsibility, from this the job descriptors were then indexed as belonging to one of five discrete categories. Results: Our analysis revealed the following categories: fully assistive (n=1), supportive/assistive (n=7), supportive/substitutive (n=4), substitutive/autonomous (n=3) and fully autonomous (n=1). From this, a number of anomalies manifest in the form of divergent organisational expectations regarding the AP role. ConclusionS: This study highlights a series of tensions extant between policy vision and implementation of the AP role in practice. Introduction of new healthcare roles requires compromise and negotiation, to shape and define what social space incumbents of these and existing roles will occupy. However the way in which new roles are defined will determine how they become embraced and embedded within future healthcare services

**Zurmeahly,J., Martin,P.A., & Fitzpatrick,J.J. (2009). Registered nurse empowerment and intent to leave current position and/or profession. *Journal of Nursing Management* 17(3) (This issue: Discussions on Job Satisfaction, Work Environment and Burnout), 383-391**

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<http://pmid.us/19426372>

**Aim** This study explored the relationship between Registered Nurses' (RN) empowerment and intent to leave their current position and/or profession. **Background** While there is documentation of the relationship between job satisfaction and retention, little is known about the relationship between empowerment and intent to leave either the current position and/or profession. **Methods** A web-based survey was conducted in which 1355 respondents completed measures of personal demographics, empowerment, intent to leave their current position and the profession. **Results** Relationships were found between empowerment and intent to leave the current position ( $F = 80.08, P < 0.001$ ) and intent to leave the profession ( $F = 75.99, P < 0.001$ ). **Implications for nursing management** The results of this study contribute to the limited body of knowledge in this area. It is suggested that nursing leaders utilize empowerment and intent to leave the position and/or profession as new concepts to measure future retention within the nursing workforce. **Conclusion** Retention strategies need to focus on strategies for nurse empowerment

