

NATIONAL PRIMARY CARE RESEARCH & DEVELOPMENT CENTRE

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CURRENT AWARENESS BULLETIN

September-October 2008



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These citations have been derived from PubMed.

ACCESS TO CARE

Frosch,D.L., Legare, F., & Mangione,C.M. (2008). Using decision aids in community-based primary care: A theory-driven evaluation with ethnically diverse patients. *Patient Education and Counseling, In Press, Corrected Proof.*

<http://dx.doi.org/10.1016/j.pec.2008.07.040>

<http://pmid.us/18771875>

Objective To assess the effects of informational brochures and video decision aids about cancer screening on patient intention to engage in shared decision-making and its predictors in a racially diverse sample. **Methods** Participants were recruited from 13 community-based primary care practices serving racially and ethnically diverse patients in predominately economically disadvantaged neighborhoods. Participants completed theory-based measures assessing attitudes, perceived social norms, self-efficacy and intentions for working with their physician to make a cancer screening decision after reviewing a brochure or video decision aid, but before seeing the physician. A post-questionnaire assessed screening decisions and participant knowledge. **Results** Participants who reviewed a video decision aid had higher knowledge and were more likely to want to be the primary decision-maker. They reported lower perceived social norms, self-efficacy and intentions to work with their physicians than participants who reviewed a brochure. Participants who decided against cancer screening reported lower intentions to work with their physician in making a decision and were less likely to report having spoken with their physician about screening. **Conclusion** Participants who opted against cancer screening after reviewing a brochure or decision aid were less likely to discuss their decision with their physician. The tendency toward autonomous decision-making was stronger among participants who reviewed a video decision aid.

Kirsh,S., Lawrence,R., & Aron,D. (2008) Tailoring an intervention to the context and system redesign related to the intervention: A case study of implementing shared medical appointments for diabetes. *Implementation Science, 3(1), 34.*

<http://dx.doi.org/10.1186/1748-5908-3-34>

<http://www.implementationscience.com/content/3/1/34>

<http://pmid.us/18533021>

Background Incorporating shared medical appointments (SMAs) or group visits into clinical practice to improve care and increase efficiency has become a popular intervention, but the processes to implement and sustain them have not been well described. The purpose of this study was to describe the process of implementation of SMAs in the local context of a primary care clinic over time. Methods: The setting was a primary care clinic of an urban academic medical center of the Veterans Health Administration. We performed an in-depth case analysis utilizing both an innovations framework and a nested systems framework approach. This analysis helped organize and summarize implementation and sustainability issues, specifically: the pre-SMA local context; the processes of tailoring and implementation of the intervention; and the evolution and sustainability of the intervention and its context .Results: Both the improvement intervention and the local context co-adapted and evolved during implementation, ensuring sustainability. The most important promoting factors were the formation of a core team committed to quality and improvement, and the clinic leadership that was supported strongly by the team members. Tailoring had to also take into account key innovation-hindering factors, including limited resources (such as space), potential to alter longstanding patient-provider relationships, and organizational silos (disconnected groups) with core team members reporting to different supervisors. Conclusion: Although interventions must be designed to meet the needs of the sites in which they are implemented, specific guidance tailored to the practice environment was lacking. SMAs require complex changes that impact on care routines, collaborations, and various organizational levels. Although the SMA was not envisioned originally as a form of system redesign that would alter the context in which it was implemented, it became clear that tailoring the intervention alone would not ensure sustainability, and therefore adjustments to the system were required. The innovation necessitated reconfiguring some aspects of the primary care clinic itself and other services from which the patients and the team were derived. In addition, the relationships among different parts of the system were altered

Lauridsen,S., Norup,M., & Rossel,P. (2008). Bedside rationing by general practitioners: a postal survey in the Danish public healthcare system. *BMC Health Services Research*, 8 (1), 192.

<http://dx.doi.org/10.1186/1472-6963-8-192>

<http://www.biomedcentral.com/1472-6963/8/192>

<http://pmid.us/18808694>

Background It is ethically controversial whether medical doctors are morally permitted to ration the care of their patients at the bedside. To explore whether general practitioners in fact do ration in this manner we conducted a study within primary care in the Danish public healthcare system. The purpose of the study was to measure the extent to which general practitioners (GPs) would be willing to factor in cost-quality trade-offs when prescribing medicine, and to discover whether, and if so to what extent, they believe that patients should be informed about this. Methods :Postal survey of 600 randomly selected Danish GPs, of which 330 responded to the questionnaire. The Statistical Package for the

Social Sciences (SPSS, version 14.0) was used to produce general descriptive statistics. Significance was calculated with the McNemar and the chi-square test. The main outcome measures of the study were twofold: an assessment of the proportion of GPs who, in a mainly hypothetical setting, would consider cost-quality trade-offs relevant to their clinical decision-making given their economic impact on the healthcare system; and a measure of the extent to which they would disclose this information to patients. Results :In the hypothetical setting 95% of GPs considered cost-quality trade-offs relevant to their clinical decision-making given the economic impact of such trade-offs on the healthcare system. In all 90% stated that this consideration had been relevant in clinical decision-making within the last month. In the hypothetical setting 55% would inform their patients that they considered a cost-quality trade-off relevant to their clinical decisions given the economic impact of such trade-offs on the healthcare system. The most common reason (68%) given for not wanting to inform patients about this matter was the belief that the information would not prove useful to patients. In the hypothetical setting cost-quality trade-offs were considered relevant significantly more often in connection with concerns about costs to the patient (86%) than they were in connection with concerns about costs to the healthcare system (55%; $p < 0.001$). Conclusion: Although readiness to consider cost-quality trade-offs relevant to clinical decisions is prevalent among GPs in Denmark, only half of GPs would disclose to patients that they consider this relevant to their clinical decision-making. The results of this study raise two important ethical problems. First, under Danish law physicians are required to inform patients about all equal treatments. The fact that only a few GPs would inform their patients about all of the relevant treatments therefore seems to contravene Danish law. Second, it is ethically controversial that physicians act as economic gatekeepers

Mehrotra,A., et al (2008). Retail clinics, primary care physicians, and emergency departments: a comparison of patients' visits. *Health Affairs (Millwood)*, 27(5), 1272-1282.

<http://dx.doi.org/10.1377/hlthaff.27.5.1272>

<http://pmid.us/18780911>

In this study we compared the demographics of and reasons for visits in national samples of visits to retail clinics, primary care physicians (PCPs), and emergency departments (EDs). We found that retail clinics appear to be serving a patient population that is underserved by PCPs. Ten clinical problems such as sinusitis and immunizations encompass more than 90 percent of retail clinic visits. These same ten clinical problems make up 13 percent of adult PCP visits, 30 percent of pediatric PCP visits, and 12 percent of ED visits. Whether there will be a future shift of care from EDs or PCPs to retail clinics is unknown

Nolan A (2008). The impact of income on private patients' access to GP services in Ireland. *Journal of Health Services Research and Policy*, 13(4), 222-226.

<Http://dx.doi.org/10.1258/jhsrp.2008.008048>

<http://pmid.us/18806180>

Objectives: To examine the extent to which proximity to the income threshold for free GP care results in significant differences in GP visiting. Approximately 30% of the Irish population receives free GP care (medical card patients), while the remaining 70% pays in full (private patients). Medical card eligibility exerts a significant influence on GP visiting, but how do GP visiting rates differ among private patients on differing incomes, and has the differential in visiting among private patients changed over time? Methods: Using micro-data from three nationally representative surveys of the Irish population undertaken in 1987, 1995 and 2001, multivariate models of GP utilization are estimated. Results: There is little evidence that proximity to the income threshold results in significant differences in GP visiting. The most significant difference is between medical card and private patients, rather than between private patients on differing incomes. There is also little evidence that the differential in GP visiting between private patients on different incomes changed over time. Conclusions: While recent commentary has focused on the plight of individuals just above the income threshold for free GP care, these results suggest that the key difference in GP visiting is between those with, and without, eligibility for free care. If private patients are prevented from accessing GP care due to cost, this is as much an issue for those at the top of the income distribution as for those at the bottom.

Nolan, A. (2008). Evaluating the impact of eligibility for free care on the use of general practitioner (GP) services: A difference-in-difference matching approach. *Social Science & Medicine*, 67 (7), 1164-1172.

<http://dx.doi.org/10.1016/j.socscimed.2008.06.021>

<http://pmid.us/18640757>

In Ireland, approximately 30% of the population (medical card patients) are entitled to free general practitioner (GP) care while the remaining 70% (private patients) must pay the full cost of each visit. Previous research has analysed the effect of this system on GP visiting patterns using regression methods, but to date, no attempt has been made to apply techniques from the treatment evaluation literature to this issue. Treatment evaluation techniques are commonly employed when observations are not randomly assigned to treatment and control groups; this is certainly the case here, as the primary criterion for medical card eligibility is an income below a specified income threshold (and individuals may also be granted medical cards for other reasons such as chronic ill-health). In this paper, previous Irish research, which has analysed the effect of medical card eligibility on GP visiting using regression methods, is extended to consider the use of difference-in-difference matching methods, which control for non-random selection into treatment and control groups, as well as differences in time-invariant unobserved characteristics between individuals in both groups. The results are largely consistent with earlier results using pooled cross-sectional and panel data, and confirm that medical card eligibility exerts a significant effect on GP visiting, even after controlling for observed and unobserved differences in characteristics between medical card and private patients

Reed, R.L., et al (2008). Access to general practitioners in South Australia: a population survey. *Medical Journal of Australia.*, 189(2), 95-99.

<http://pmid.us/18637779>

Objective: To determine the timeliness of access to general practitioner appointments in South Australia. Design and setting: Face-to-face interviews with a random and representative sample of South Australians living in metropolitan Adelaide and country towns with a population of 1000 or more in 2007. Participants: 2507 people aged 15 years and over who had seen a GP in the previous 12 months. Main outcome measures: Waiting times for obtaining an appointment with a GP, patients' perceptions about appointment waiting times, and waiting times at the GP's surgery. Results: Most respondents reported that for their last visit with a GP, they were able to be seen on the same day (39%) or within 1 or 2 working days (33%); 20% waited more than 2 working days for their appointment. Nine per cent of respondents (159/1764) reported waiting more than 2 working days because an earlier appointment was not available. Respondents reporting lower levels of household income were more likely to report longer waits for GP appointments. Most respondents (78%) felt that they were able to make a GP appointment as soon as they thought necessary. At the surgery, 46% of respondents were seen within 15 minutes, but 13% waited 45 minutes or longer. Conclusions: In general, access to GPs is timely, and most South Australians reported that for their last GP visit they were able to make an appointment as soon as they thought was necessary

Sampson,F., et al (2008). Impact of same-day appointments on patient satisfaction with general practice appointment systems. *British Journal of General Practice* , 58(554), 641-643.

<http://dx.doi.org/10.3399/bjgp08X330780>

<http://pmid.us/18801282>

Following recent concerns about patients' inability to book appointments in advance, this study examined the relationship between the proportion of GP appointments reserved for same-day booking, and patient satisfaction with appointment systems. In a survey of 12 825 patients in 47 practices, it was found that a 10% increase in the proportion of same-day appointments was associated with an 8% reduction in the proportion of patients satisfied. Practices should be wary of increasing the level of same-day appointments to meet access targets

Wang,L., Rosenberg,M., & Lo,L. (2008). Ethnicity and utilization of family physicians: A case study of Mainland Chinese immigrants in Toronto, Canada. *Social Science & Medicine*, 67(9), 1410-1422.

<http://dx.doi.org/10.1016/j.socscimed.2008.06.012>

<http://pmid.us/18692946>

This paper seeks to examine how immigrants in a multicultural society access and utilize culturally- and linguistically-diverse family physicians. It focuses on Mainland Chinese (MLC) immigrants - the most important source of immigrants to Canada since 1996 - in the Toronto Census Metropolitan Area (CMA), Canada. Specifically, the paper aims to explore the choice between Chinese-speaking and non-Chinese-speaking family physicians by MLC immigrants and to determine the underlying reasons for MLC immigrants use of ethnically- and linguistically-matched family physicians. A wide range of data are analyzed including survey and focus group data, physician data from the College of Physicians and Surgeons of Ontario (CPSO) and geo-referenced 2001 Canadian Census data. A mixed-method approach is employed combining quantitative analysis of survey data and Census data, spatial analysis of patient travel behaviour based on the survey and qualitative analysis based on focus groups. The paper reveals an overwhelming preference among MLC survey respondents for Chinese-speaking family physicians regardless of study areas and socioeconomic and demographic status. The focus groups suggest that language, culture and ethnicity are intertwined in a complex way to influence the choice of health care providers and health management strategies in the host society. The paper yields important policy implications for identifying health professional shortage areas for culturally-diverse populations, addressing issues related to foreign-trained physicians and enhancing primary care delivery relevant for immigrant populations

CHRONIC ILLNESS

Bayliss, E.A., et al . (2008). Processes of care desired by elderly patients with multimorbidities. *Family Practice* , 25(4), 287-293.

<http://dx.doi.org/10.1093/fampra/cmn040>

<http://pmid.us/18628243>

Background: Most recommended care for chronic diseases is based on the research of single conditions. There is limited information on 'best' processes of care for persons with multiple morbidities. Our objective was to explore processes of care desired by elderly patients who have multimorbidities that may present competing demands for patients and providers. MethodS: Qualitative investigation using one-on-one interviews of 26 community-dwelling HMO members aged 65-84 (50% male) who had, at a minimum, the combined conditions of diabetes, depression and osteoarthritis. Participants were chosen from a stratified random sample to have a range of 4-16 chronic medical conditions. Results: Participants' desired processes of care included: the need for convenient access to providers (telephone, internet or in person), clear communication of individualized care plans, support from a single coordinator of care who could help prioritize their competing demands and continuity of relationships. They also desired providers who would listen to and acknowledge their needs, appreciate that these' needs were unique and fluctuating and have a caring attitude. Conclusions: These respondents describe an ideal process of care that is patient centered and individualized and that supports their

unique constellations of problems, shifting priorities and multidimensional decision making. Individual and ongoing care coordination managed by a primary contact person may meet some of these needs. Achieving these goals will require developing efficient methods of assessing patient care needs and flexible care management support systems that can respond to patients' needs for different levels of support at different times

Billett,J., et al (2008). Comorbidity, healthcare utilisation and process of care measures in patients with congenital heart disease in the UK: cross-sectional, population-based study with case-control analysis. *Heart*, 94(9), 1194-1199.

<http://dx.doi.org/10.1136/hrt.2007.122671>

<http://pmid.us/17646191>

Objective: To determine the prevalence of comorbidities, patterns of healthcare utilisation and primary care recording of clinical indicators in patients with congenital heart disease. Patients and methods: A population-based case-control study using data from general practices across the UK contributing data to the QRESEARCH primary care database. The subjects comprised 9952 patients with congenital heart disease and 29,837 matched controls. Outcome measures were prevalence of selected comorbidities; adjusted odds ratios for risk of comorbidities, healthcare utilisation and clinical indicator recording. Results: The overall crude prevalence of congenital heart disease was 3.05 per 1000 patients (95% CI 2.99 to 3.11). Prevalence of key comorbidities in patients with congenital heart disease ranged from 2.4% (95% CI 2.1% to 2.7%) for epilepsy to 9.3% (95% CI 8.8% to 9.9%) for hypertension. After adjusting for smoking and deprivation, cases were significantly more likely than controls to have each of the cardiovascular comorbidities and an increased risk of diabetes, epilepsy and renal disease. Patients with congenital heart disease were more frequent users of primary care than controls. Patients with congenital heart disease were also more likely than controls to have lifestyle and risk factor measurements recorded in primary care, although overall levels of recording were low. Conclusions: There is a significant burden of comorbidity associated with congenital heart disease, and levels of primary care utilisation and referral to secondary care are high in this patient group. The predicted future expansion in the numbers of adults with congenital heart disease owing to improvements in survival will have implications for primary and secondary care, and not just tertiary centres offering specialist care

Bosch,M.,et al (2008). Organizational culture, team climate and diabetes care in small office-based practices. *BMC Health Services Research*, 8(1), 180.

<http://dx.doi.org/10.1186/1472-6963-8-180>

<http://www.biomedcentral.com/1472-6963/8/180>

<http://pmid.us/18717999>

Background: Redesigning care has been proposed as a lever for improving chronic illness care. Within primary care, diabetes care is the most widespread example of restructured integrated care. Our goal was to assess to what extent important aspects of restructured care such as multidisciplinary teamwork and different types of organizational culture are associated with high quality diabetes care in small office-based general practices. Methods: We conducted cross-sectional analyses of data from 83 health care professionals involved in diabetes care from 30 primary care practices in the Netherlands, with a total of 752 diabetes mellitus type II patients participating in an improvement study. We used self-reported measures of team climate (Team Climate Inventory) and organizational culture (Competing Values Framework), and measures of quality of diabetes care and clinical patient characteristics from medical records and self-report. We conducted multivariate analyses of the relationship between culture, climate and HbA1c, total cholesterol, systolic blood pressure and a sum score on process indicators for the quality of diabetes care, adjusting for potential patient- and practice level confounders and practice-level clustering. Results: A strong group culture was negatively associated to the quality of diabetes care provided to patients ($r = -0.04$; $p = 0.04$), whereas a more 'balanced culture' was positively associated to diabetes care quality ($r = 5.97$; $p = 0.03$). No associations were found between organizational culture, team climate and clinical patient outcomes. Conclusion: Although some significant associations were found between high quality diabetes care in general practice and different organizational cultures, relations were rather marginal. Variation in clinical patient outcomes could not be attributed to organizational culture or teamwork. This study therefore contributes to the discussion about the legitimacy of the widespread idea that aspects of redesigning care such as teamwork and culture can contribute to higher quality of care. Future research should preferably combine quantitative and qualitative methods, focus on possible mediating or moderating factors and explore the use of instruments more sensitive to measure such complex constructs in small office-based practices

Chew-Graham, C.A., et al (2008). Using multiple sources of knowledge to reach clinical understanding of chronic fatigue syndrome. *Annals of Family Medicine* 6(4), 340-348.

<http://dx.doi.org/10.1370/afm.867>

<http://pmid.us/18626034>

Purpose: Chronic fatigue syndrome (CFS), or myalgic encephalitis (ME), is a contentious condition and often a diagnosis of exclusion. Current policy in the United Kingdom recommends management in primary care. We explored how patients with CFS/ME and family physicians understand this condition and how their understanding might affect the primary care consultation. Methods: We undertook a qualitative study with patients and family physicians from North West England participating in a primary care-based randomized controlled trial (FINE Trial). Data were collected through purposive sampling and in-depth semistructured interviews with 24 patients and 14 family physicians. We analyzed interview transcripts using constant comparison methods. Results: Family physicians access social and cultural knowledge to reach a clinical understanding of CFS/ME and its management. Patients recognize the difficulties family

physicians encounter in understanding their symptoms and access similar nonclinical sources of information. We suggest that both patients and physicians use biomedical discourse within the consultation: the physician to maintain the position as an expert, the patient to engage the physician. Conclusions: Family physicians obtain information about CFS/ME from their nonprofessional world, which they incorporate into their professional realm. Patients and physicians describe the use of the discourse of science within consultations about CFS/ME. This form of shared understanding could lead to a positive collaborative interaction. Family physicians need a biomedical, evidence-based knowledge about CFS/ME. There is potential to use the rich knowledge base that patients can bring to consultations in training initiatives directed at family physicians

Grimmer-Somers,K., et al (2008). Integrated GP and allied health care for patients with type 2 diabetes *Australian Family Physician* 37(9), 774-779.

<http://pmid.us/18797537>

Background: Integrated general practitioner and allied health chronic disease management (CDM) has been supported by Australian Government Medicare initiatives since 2005. Practical ways of implementing CDM have been slow to develop. Methods: An integrated CDM program for patients with type 2 diabetes was piloted in 2006 by Central Northern Adelaide Health Service (South Australia), in conjunction with four divisions of general practice. Health providers included GPs, practice nurses, credentialed diabetes educators, dietitians and podiatrists. Eligible patients with Medicare approved Team Care Arrangements (TCAs) received allied health care for the Medicare Plus rebate only. This article reports on GP and staff perspectives of the processes, and the effectiveness and sustainability of the pilot. Results: Chronic disease management improved with integrated health care, reflected by appropriate allied health referrals and better quality TCAs, interprofessional communication, and patient satisfaction. Discussion: There are benefits for interested GPs, their staff, co-located allied health providers and diabetic patients if integrated multidisciplinary care is provided in the manner of this Enhanced Primary Care CDM model

McRae,I. (2008). A cost-effectiveness study of integrated care in health services: a diabetes program in Australia. *BMC Health Services Research*, 8(1), 205.

<http://dx.doi.org/10.1186/1472-6963-8-205>

<http://www.biomedcentral.com/1472-6963/8/205>

<http://pmid.us/18834551>

Background: Type 2 diabetes is rapidly growing as a proportion of the disease burden in Australia as elsewhere. This study addresses the cost effectiveness of an integrated approach to assisting general practitioners (GPs) with diabetes management. This approach uses a centralized database of clinical data of an Australian Division of General Practice (a network of GPs) to co-ordinate care according to national guidelines. Methods: Long term outcomes for patients in the program were derived using clinical

parameters after 5 years of program participation, and the United Kingdom Prospective Diabetes Study (UKPDS) Outcomes Model, to project outcomes for 40 years from the time of diagnosis and from 5 years post-diagnosis. Cost information was obtained from a range of sources. While program costs are directly available, and costs of complications can be estimated from the UKPDS model, other costs are estimated by comparing costs in the Division with average costs across the state or the nation. The outcome and cost measures are used derive incremental cost-effectiveness ratios. Results: The clinical data show that the program is effective in the short term, with improvement or no statistical difference in most clinical measures over 5 years. Average HbA1c levels increased by less than expected over the 5 year period. While the program is estimated to generate treatment cost savings, overall net costs are positive. However, the program led to projected improvements in expected life years and Quality Adjusted Life Expectancy (QALE), with incremental cost effectiveness ratios of \$A8,106 per life-year saved and \$A9,730 per year of QALE gained. Conclusions: The combination of an established model of diabetes progression and generally available data has provided an opportunity to establish robust methods of testing the cost effectiveness of a program for which a formal control group was not available. Based on this methodology, integrated health care delivery provided by a network of GPs improved health outcomes of type 2 diabetics with acceptable cost effectiveness, which suggests that similar outcomes may be obtained elsewhere

Wensing, M., et al (2008). The Patients Assessment Chronic Illness Care (PACIC) questionnaire in The Netherlands: a validation study in rural general practice. *BMC Health Services Research*, 8(1), 182.

<http://dx.doi.org/10.1186/1472-6963-8-182>

<http://www.biomedcentral.com/1472-6963/8/182>

<http://pmid.us/18761749>

Background: Many patients with chronic illness receive health care in primary care settings, so a challenge is to provide well-structured chronic care in these settings. Our aim was to develop and test a Dutch version of the PACIC questionnaire, a measure for patient reported structured chronic care. Methods: Observational study in 165 patients with diabetes or COPD from four general practices (72% response rate). Patients completed a written questionnaire, which included instruments for assessing chronic illness care (PACIC), evaluations of general practice (Europep), enablement (PEI), and individual characteristics. Results The patients had a mean age of 68.0 years and 47% comprised of women. Twenty-two to 35% of responding patients did not provide answers to specific items in the PACIC. In 11 items the lowest answering category was used by 30% or more of the responders and in 6 items the highest answering category was used by this number of responders. Principal factor analysis identified the previously defined five domains reasonably well. Cronbach's alpha per domain varied from 0.71 to 0.83, and the intraclass coefficient from 0.66 to 0.91. Diabetes patients reported higher presence of structured chronic care for 14 out of the 20 PACIC items. The effect of patient evaluations of general practice on the PACIC score was positive ($b=0.72$, $p<0.004$), but

the effect of patient enablement on the PACIC score was negative ($b=-1.13$, $p<0.000$).
Conclusions: A translated and validated Dutch version of the PACIC questionnaire is now available. Further research on its validity is recommended

Zwar, N., et al (2008). A cluster randomised controlled trial of nurse and GP partnership for care of chronic obstructive pulmonary disease. *BMC Pulmonary Medicine* 8 8.

<http://dx.doi.org/10.1186/1471-2466-8-8>

<http://www.biomedcentral.com/1471-2466/8/8>

<http://pmid.us/18519003>

Background: Chronic obstructive pulmonary disease (COPD) is a significant health problem worldwide. This randomised controlled trial aims at testing a new approach that involves a registered nurse working in partnership with patients, general practitioners (GPs) and other health professionals to provide care to patients according to the evidence-based clinical practice guidelines. The aim is to determine the impact of this partnership on the quality of care and patient outcomes. Methods: A cluster randomised control trial design was chosen for this study. Randomisation occurred at practice level. GPs practising in South Western Sydney, Australia and their COPD patients were recruited for the study. The intervention was implemented by nurses specifically recruited and trained for this study. Nurses, working in partnership with GPs, developed care plans for patients based on the Australian COPDX guidelines. The aim was to optimise patient management, improve function, prevent deterioration and enhance patient knowledge and skills. Control group patients received 'usual' care from their GPs. Data collection includes patient demographic profiles and their co-morbidities. Spirometry is being performed to assess patients' COPD status and CO analyser to validate their smoking status. Patients' quality of life and overall health status are being measured by St George's Respiratory Questionnaire and SF-12 respectively. Other patient measures being recorded include health service use, immunisation status, and knowledge of COPD. Qualitative methods will be used to explore participants' satisfaction with the intervention and their opinion about the value of the partnership. Analysis: Analysis will be by intention to treat. Intra-cluster (practice) correlation coefficients will be determined and published for all primary outcome variables to assist future research. The effect of the intervention on outcomes measured on a continuous scale will be estimated and tested using mixed model analysis of variance in which time and treatment group will be fixed effects and GP practice and subject nested within practice will be random effects. The effect of the intervention on the dichotomous variables (such as smoking status, patient knowledge) will be analysed using generalised estimating equations with a logistic link and a model structure that is analogous to that described above.

EMPOWERMENT

Lemire,M., Sicotte,C., & Paré,G. (2008). Internet use and the logics of personal empowerment in health. *Health Policy*, 88(1), 130-140.

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

<http://pmid.us/18436330>

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

Mola,E., De Bonis,J.A., & Giancane,R. (2008). Integrating patient empowerment as an essential characteristic of the discipline of general practice/family medicine. *European Journal of General Practice* 1-6. 26th September 2008

<http://dx.doi.org/10.1080/13814780802423463>

<http://pmid.us/18821139>

Background: Efforts to improve the quality of healthcare for patients with chronic conditions have resulted in growing evidence supporting the inclusion of patient empowerment as a key ingredient of care. In 2002, WONCA Europe issued the European Definition of General Practice/Family Medicine, which is currently considered the point of reference for European health institutions and general medical practice. Patient empowerment does not appear among the 11 characteristics of the discipline. **Objectives:** The aim of this study is to show that many characteristics of general practice are already oriented towards patient empowerment. Therefore, promoting patient empowerment and self-management should be included as a characteristic of the discipline. **Methods:** The following investigation was conducted: analysing the concept and approach to empowerment as applied to healthcare in the literature; examining whether aspects of empowerment are already part of general medical practice; and identifying reasons why the European definition of general practice/family medicine should contain empowerment as a characteristic of the discipline. **Results:** General practice/family

medicine is the most suitable setting for promoting patient empowerment, because many of its characteristics are already oriented towards encouraging it and because its widespread presence can ensure the generalization of empowerment promotion and self-management education to the totality of patients and communities. Conclusion: "Promoting patient empowerment and self-management" should be considered one of the essential characteristics of general practice/family medicine and should be included in its definition

Hochwalder,J. (2008). A longitudinal study of the relationship between empowerment and burnout among registered and assistant nurses. *Work*, 30(4), 343-352.

<http://pmid.us/18725697>

The relation between empowerment and burnout was investigated using a two-wave and two-variable panel model. A questionnaire was completed on two occasions, one year apart, by 1,356 nurses. The paths in the model were estimated using regression analyses and the following results were obtained: (a) empowerment is a stable state; (b) higher levels of empowerment are related to lower levels of burnout, when empowerment and burnout are studied at the same point in time; (c) higher prior levels of empowerment can be associated with higher later levels of burnout, when empowerment and burnout are studied at different points in time; (d) for assistant nurses, but not for registered nurses, prior higher levels of burnout resulted in lower later levels of empowerment, indicating a reciprocal relation between the two concepts. The results imply that what is a protective factor from a cross-sectional perspective may be a risk factor from a longitudinal perspective

Rohrer,J.E., et al (2008). Patient-centredness, self-rated health, and patient empowerment: should providers spend more time communicating with their patients? *Journal of Evaluation in Clinical Practice*. 2/5/2008

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

<http://pmid.us/18462285>

Objective Patient-centred communication is often employed as a strategy for empowering patients. The purpose of this study was to investigate the relationship between a direct measure of patient empowerment, feeling that one is in control of one's own health and patient satisfaction with communication. Design A cross-sectional survey of family medicine patients was used to test the theory that, in primary care patients, empowerment is related to satisfaction with several aspects of communication after adjusting for health status, age and gender. Interviews were completed with 680 adult patients for whom complete data were available. Results Multiple logistic regression analysis revealed that being highly satisfied with overall communication [adjusted odds ratio (AOR) = 2.08], explanations (AOR = 2.04), listening (AOR = 2.63), use of understandable words (AOR = 2.41) and involvement in decisions (2.34) were positively associated with empowerment. Self-rated health was more strongly related to empowerment than

satisfaction with communication in every model tested (AORs ranged from 2.8 to 3.0). Conclusions Reliance solely on patient-centred communication to promote empowerment may be insufficient as well as costly. Instead, improved one-to-one communication between patients and providers should be reserved for clinically complex and urgent situations. For other health matters, referral of patients to community health promotion and education programmes should be considered because this may offer a lower-cost approach to empowerment

van Uden-Kraan,C.F., et al (2008). Participation in online patient support groups endorses patients' empowerment. *Patient Education and Counseling* 6th September 2008

<http://dx.doi.org/10.1016/j.pec.2008.07.044>

<http://pmid.us/18778909>

Objective: Although much has been expected of the empowering effect of taking part in online patient support groups, there is no direct evidence thus far for the effects of participation on patient empowerment. Hence our exploring to what extent patients feel empowered by their participation in online support groups, and which processes that occur in these groups are related to the empowering outcomes. MethodS: An online questionnaire was completed by 528 individuals who were active in online groups for patients with breast cancer, fibromyalgia and arthritis. Results: The respondents felt empowered in several ways by their participation. The empowering outcomes that were experienced to the strongest degree were 'being better informed' and 'enhanced social well-being'. No significant differences in empowering outcomes between diagnostic groups were found. The empowering outcomes could only be predicted in a modest way by the processes that took place in the online support groups. Conclusion: This study indicates that participation in online support groups can make a valuable contribution to the empowerment of patients. Practice implications: Health care providers should acquaint their patients with the existence of online support groups and with the benefits that participation in these groups can offer

HEALTH ECONOMICS

Ashworth, M., & Jones, R.H. (2008). Pay for performance systems in general practice: experience in the United Kingdom. *Medical Journal of Australia* , 189(2), 60-61.

http://www.mja.com.au/public/issues/189_02_210708/ash10534_fm.html

<http://pmid.us/18637767>

Pay for performance, or “P4P” as it is often known, is now centre-stage in primary care in the United Kingdom. P4P promotes change in clinical behaviour by offering financial rewards in return for achieving certain predefined targets. Both sides of the P4P “equation” are currently the subject of much debate: how generous should the financial reward be (the first “P”); and which performance indicators (the second “P”) should be used as the basis for calculating eligibility for the reward?

Grant S, & et al (2008). The impact of pay-for-performance on professional boundaries in UK general practice: an ethnographic study . *Sociology of Health and Illness* 2/10/2008

<http://dx.doi.org/10.1111/j.1467-9566.2008.01129.x>

The 2004 new General Medical Services (nGMS) contract exemplifies trends across the public services towards increased definition, measurement and regulation of professional work, with general practice income now largely dependent on the quality of care provided across a range of clinical and organisational indicators known collectively as the 'Quality and Outcomes Framework' (QOF). This paper reports an ethnographically based study of the impact of the new contract and the financial incentives contained within it on professional boundaries in UK general practice. The distribution of clinical and administrative work has changed significantly and there has been a new concentration of authority, with QOF decision making and monitoring being led by an internal QOF team of clinical and managerial staff who make the major practice-level decisions about QOF, monitor progress against targets, and intervene to resolve areas or indicators at risk of missing targets. General practitioners and nurses, however, appear to have accommodated these changes by re-creating long established narratives on professional boundaries and clinical hierarchies. This paper is concerned with the impact of these new arrangements on existing clinical hierarchies.

HEALTH INEQUALITIES

Asthana,S., & Gibson,A. (2008). Deprivation, demography, and the distribution of general practice: challenging the conventional wisdom of inverse care. *Br J Gen Pract*, 58(555), 720-6, 728.

<http://dx.doi.org/10.3399/bjgp08X342372>

<http://pmid.us/18826784>

It is generally believed that the most deprived populations have the worst access to primary care. Lord Darzi's review of the NHS responds to this conventional wisdom and makes a number of proposals for improving the supply of GP services in deprived communities. This paper argues that these proposals are based on an incomplete

understanding of inverse care which underestimates the degree to which, relative to their healthcare needs, older populations experience low availability of primary care. Many deprived practices appear to have a better match between need and supply than practices serving affluent but ageing populations. However, practices serving the oldest and most deprived populations have the worst availability of all

Bauld,L., Day,P., & Judge,K. (2008). Off target: a critical review of setting goals for reducing health inequalities in the United Kingdom. *International Journal of Health Services* 38(3), 439-454.

<http://pmid.us/18724576>

Health policy in the United Kingdom is devolved to the four home countries. Nevertheless, England, Northern Ireland, Scotland, and Wales share a common commitment to reducing health inequalities and have set explicit targets in areas such as life expectancy, cancer mortality, long-standing illness, and smoking prevalence. However, many of the targets leave much to be desired in terms of their limited conceptual scope and their selection of methods and approaches. At one level this might be regarded as relatively unimportant. The mere fact of having health inequalities targets is laudable. But because the United Kingdom has been in the vanguard of research and policy development to reduce health inequalities, a critical appraisal of the strengths and weaknesses of the approaches adopted in the four home countries is timely. Following a description of the health inequalities targets, the article focuses on experiences in England and Scotland as examples of contrasting approaches to target setting and describes progress toward meeting targets in each country. The authors then outline key emerging issues in relation to developing targets and measuring progress, including conceptual dilemmas, biased reporting, implementation failure, and statistical fallacy

Doran,T., et al (2008). Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework. *Lancet*, 372(9640), 728-736.

[http://dx.doi.org/10.1016/S0140-6736\(08\)61123-X](http://dx.doi.org/10.1016/S0140-6736(08)61123-X)

<http://pmid.us/18701159>

Background: The Quality and Outcomes Framework is a financial incentive scheme that remunerates general practices in the UK for their performance against a set of quality indicators. Incentive schemes can increase inequalities in the delivery of care if practices in affluent areas are more able to respond to the incentives than are those in deprived areas. We examined the relation between socioeconomic inequalities and delivered quality of clinical care in the first 3 years of this scheme. Methods: We analysed data extracted automatically from clinical computing systems for 7637 general practices in England, data from the UK census, and data for characteristics of practices and patients from the 2006 general medical statistics database. Practices were grouped into equal-sized quintiles on the basis of area deprivation in their locality. We calculated overall

levels of achievement, defined as the proportion of patients who were deemed eligible by the practices for whom the targets were achieved, for 48 clinical activity indicators during the first 3 years of the incentive scheme (from 2004-05 to 2006-07). Findings: Median overall reported achievement was 85.1% (IQR 79.0-89.1) in year 1, 89.3% (86.0-91.5) in year 2, and 90.8% (88.5-92.6) in year 3. In year 1, area deprivation was associated with lower levels of achievement, with median achievement ranging from 86.8% (82.2-89.6) for quintile 1 (least deprived) to 82.8% (75.2-87.8) for quintile 5 (most deprived). Between years 1 and 3, median achievement increased by 4.4% for quintile 1 and by 7.6% for quintile 5, and the gap in median achievement narrowed from 4.0% to 0.8% during this period. Increase in achievement during this time was inversely associated with practice performance in previous years ($p < 0.0001$), but was not associated with area deprivation ($p = 0.062$). Interpretation: Our results suggest that financial incentive schemes have the potential to make a substantial contribution to the reduction of inequalities in the delivery of clinical care related to area deprivation

Kadam, U.T. (2008) Morbidity severity classifying routine consultations from English and Dutch general practice indicated physical health status. *Journal of Clinical Epidemiology* , 61(4), 386-393.

<http://dx.doi.org/10.1016/j.jclinepi.2007.05.014>

<http://pmid.us/18313564>

Objective: To investigate the construct validity of morbidity severity scales based on routine consultation data by studying their associations with sociodemographic factors and physical health. Study design and setting: Study participants were 11,232 English adults aged 50 years and over and 9,664 Dutch adults aged 18 years and over, and their consulting morbidity data in a 12-month period were linked to their physical health data. Consultants with any of 115 morbidities classified on four ordinal scales of severity ("chronicity," "time course," "health care use," and "patient impact") were compared to all other consultants. Results: As hypothesized, in both countries, morbidity severity was associated with older age, female gender, more deprivation (all comparisons $P < \text{or} = 0.05$), and poor physical health (all trends $P < 0.001$). The estimated strengths of association of poor physical health with the highest severity category expressed as odds ratios, for each of the four scales, were 5.4 for life-threatening on the "chronicity" scale, 1.8 for time course, 2.8 for high health care use, and 3.7 for high patient impact. Conclusions: Four scales of morbidity severity have been validated in English and Dutch settings, and they offer the potential to use simple routine consultation data as an indicator of physical health status in populations from general practice

Mercer, S.W., et al. (2008). General practitioner empathy, patient enablement, and patient-reported outcomes in primary care in an area of high socio-economic deprivation in Scotland-A pilot prospective study using structural equation modeling. *Patient Education and Counseling* 25/8/2008

<http://dx.doi.org/10.1016/j.pec.2008.07.022>

<http://pmid.us/18752916>

Objective: The aim of this pilot prospective study was to investigate the relationships between general practitioners (GPs) empathy, patient enablement, and patient-assessed outcomes in primary care consultations in an area of high socio-economic deprivation in Scotland. Methods: This prospective study was carried out in a five-doctor practice in an area of high socio-economic deprivation in Scotland. Patients' views on the consultation were gathered using the Consultation and Relational Empathy (CARE) Measure and the Patient Enablement Instrument (PEI). Changes in main complaint and well-being 1 month after the contact consultation were gathered from patients by postal questionnaire. The effect of GP empathy on patient enablement and prospective change in outcome was investigated using structural equation modelling. Results: 323 patients completed the initial questionnaire at the contact consultation and of these 136 (42%) completed and returned the follow-up questionnaire at 1 month. Confirmatory factor analysis confirmed the construct validity of the CARE Measure, though omission of two of the six PEI items was required in order to reach an acceptable global data fit. The structural equation model revealed a direct positive relationship between GP empathy and patient enablement at contact consultation and a prospective relationship between patient enablement and changes in main complaint and well-being at 1 month. Conclusion: In a high deprivation setting, GP empathy is associated with patient enablement at consultation, and enablement predicts patient-rated changes 1 month later. Further larger studies are desirable to confirm or refute these findings. Practice Implications: Ways of increasing GP empathy and patient enablement need to be established in order to maximise patient outcomes. Consultation length and relational continuity of care are known factors; the benefit of training and support for GPs needs to be further investigated

Sowden,S.L., Breeze,E., Barber,J., & Raine,R. (2008). Do general practices provide equitable access to physical activity interventions? *British Journal of General Practice* , 58(555), e1-e8.

<http://dx.doi.org/10.3399/bjgp08X342237>

<http://pmid.us/18826774>

Background: Exercise referral schemes are widespread across England. National guidance emphasises the need to engage groups that are disadvantaged. Aim: To examine the influence of socioeconomic deprivation on referral to, and use of, exercise referral schemes. Design of study: Cross-sectional analysis of patients referred by general practices to exercise referral schemes between 2004 and 2006. Setting: Six primary care trusts (PCTs) in Greater London. Method: Routine data about patients who had been referred to exercise referral schemes were used to estimate risk ratios for referral by general practice deprivation quintile, odds ratios (ORs) for uptake, and ORs for completion of exercise referral schemes by patients' deprivation status quintile. Results: All 317 general practices in the six PCTs were included in the referral analysis. Referrals were less likely from general practices serving advantaged socioeconomic areas (adjusted risk ratio for trend across deprivation quintiles 0.84; 95% confidence interval [CI] = 0.76 to 0.93). This study found no association between patients' deprivation status and their

likelihood of taking up (adjusted OR, least versus most deprived quintile 1.05; 95% CI = 0.83 to 1.33) or completing the scheme (adjusted OR 1.23; 95% CI = 0.84 to 1.79). Conclusion: General practices within areas of deprivation were more likely to refer patients to exercise referral schemes than practices in more advantaged areas. Once referred, it was found that patients living in areas of deprivation were as likely to take up and to complete the scheme as those living in more advantaged locations. Research is needed to identify the organisational and contextual factors that allow this pattern of service delivery, which appears to facilitate access to care among patients who live in areas of deprivation

HEALTH POLICY

Buse, K. (2008). Addressing the theoretical, practical and ethical challenges inherent in prospective health policy analysis. *Health Policy and Planning*, 23(5), 351-360.

<http://dx.doi.org/10.1093/heapol/czn026>

As a function of the inherently political nature of health policy, there have long been calls for, as well as guidance on, analysis of its political dimensions to inform practice. Yet there are few accounts in the literature of systematic attention to real-time documentation and analysis of political-economy factors and feedback to engender reform. The dearth of such prospective policy analysis is perhaps understandable given the many intrinsic difficulties in such an enterprise. This paper provides an outline approach of how researchers might work together with advocacy coalitions (or other political actors) to document and analyse the efforts of such coalitions to use policy analysis to influence the policy processes--agenda setting, policy formulation and policy implementation--in which they engage. In so doing, it identifies challenges based on reviews of the theoretical, methodological and empirical literature as well as the experience of the author. The aim of the paper is to generate debate to assist in resolving the myriad challenges inherent in prospective policy analysis. The paper responds to appeals for political research which addresses the problems confronting political actors so as to guide future action-research for evidence-informed, pro-poor health policy

Exworthy, M. (2008). Policy to tackle the social determinants of health: using conceptual models to understand the policy process. *Health Policy and Planning*, 23(5), 318-327.

<http://dx.doi.org/10.1093/heapol/czn022>

Like health equity, the social determinants of health (SDH) are becoming a key focus for policy-makers in many low and middle income countries. Yet despite accumulating evidence on the causes and manifestations of SDH, there is relatively little understanding about how public policy can address such complex and intractable issues. This paper aims to raise awareness of the ways in which the policy processes addressing SDH may be better described, understood and explained. It does so in three main sections. First, it summarizes the typical account of the policy-making process and then adapts this to the specific character of SDH. Second, it examines alternative models of the policy-making process, with a specific application of the policy streams' and networks' models to the SDH policy process. Third, methodological considerations of the preceding two sections are assessed with a view to informing future research strategies. The paper concludes that conceptual models can help policy-makers understand and intervene better, despite significant obstacles

Walt,G., et al (2008). 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy and Planning*, 23(5), 308-317.

<http://dx.doi.org/10.1093/heapol/czn024>

The case for undertaking policy analysis has been made by a number of scholars and practitioners. However, there has been much less attention given to how to do policy analysis, what research designs, theories or methods best inform policy analysis. This paper begins by looking at the health policy environment, and some of the challenges to researching this highly complex phenomenon. It focuses on research in middle and low income countries, drawing on some of the frameworks and theories, methodologies and designs that can be used in health policy analysis, giving examples from recent studies. The implications of case studies and of temporality in research design are explored. Attention is drawn to the roles of the policy researcher and the importance of reflexivity and researcher positionality in the research process. The final section explores ways of advancing the field of health policy analysis with recommendations on theory, methodology and researcher reflexivity

INFORMATION AND COMMUNICATIONS TECHNOLOGY

Bouche,G., & Migeot,V. (2008). Parental use of the Internet to seek health information and primary care utilisation for their child: a cross-sectional study. *BMC Public Health*, 8 (1), 300.

<http://dx.doi.org/10.1186/1471-2458-8-300>

<http://www.biomedcentral.com/1471-2458/8/300>

<http://pmid.us/18755029>

Background: Using the Internet to seek health information is becoming more common. Its consequences on health care utilisation are hardly known in the general population, in particular among children whose parents seek health information on the Internet. Our objective was to investigate the relationship between parental use of the Internet to seek health information and primary care utilisation for their child. Methods: This cross-sectional survey has been carried out in a population of parents of pre-school children in France. The main outcome measure was the self-reported number of primary care consultations for the child, according to parental use of the Internet to seek health information, adjusted for the characteristics of the parents and their child respectively, and parental use of other health information sources. Results: A total of 1 068 out of 2 197 questionnaires were returned (response rate of 49%). No association was found between parental use of the Internet to seek health information and the number of consultations within the last 12 months for their child. Variables related to the number of primary care consultations were characteristics of the child (age, medical conditions, homeopathic treatment), parental characteristics (occupation, income, stress level) and consultation of other health information sources (advice from pharmacist, relatives). Conclusion: We did not find any relationship between parental use of the Internet to seek health information and primary care utilisation for children. The Internet seems to be used as a supplement to health services rather than as a replacement

Davis,P.M., et al (2008). Open access publishing, article downloads, and citations: randomised controlled trial. *British Medical Journal* 337 a568.

<http://dx.doi.org/10.1136/bmj.a568>

<http://pmid.us/18669565>

Objective: To measure the effect of free access to the scientific literature on article downloads and citations. Design: Randomised controlled trial. Setting: 11 journals published by the American Physiological Society. Participants: 1619 research articles and reviews. Main outcome measures: Article readership (measured as downloads of full text, PDFs, and abstracts) and number of unique visitors (internet protocol addresses). Citations to articles were gathered from the Institute for Scientific Information after one year. Interventions: Random assignment on online publication of articles published in 11 scientific journals to open access (treatment) or subscription access (control). Results: Articles assigned to open access were associated with 89% more full text downloads (95% confidence interval 76% to 103%), 42% more PDF downloads (32% to 52%), and 23% more unique visitors (16% to 30%), but 24% fewer abstract downloads (-29% to -19%) than subscription access articles in the first six months after publication. Open access articles were no more likely to be cited than subscription access articles in the first year after publication. Fifty nine per cent of open access articles (146 of 247) were cited nine to 12 months after publication compared with 63% (859 of 1372) of subscription access articles. Logistic and negative binomial regression analysis of article citation counts confirmed no citation advantage for open access articles. Conclusions: Open access publishing may reach more readers than subscription access publishing. No evidence was found of a citation advantage for open access articles in the first year after

publication. The citation advantage from open access reported widely in the literature may be an artefact of other causes

Gaumer, G.L., et al (2007) Use of information technology by advanced practice nurses. *Computers, Informatics and Nursing:CIN* 25(6), 344-352.

<http://dx.doi.org/10.1097/01.NCN.0000299656.59519.06>

<http://pmid.us/18000431>

The purpose of this study is to describe the use of information technology by advance practice nurses. A survey of 519 graduates of the Simmons College nurse practitioner program was conducted. Areas of investigation included the nurse practitioner's use of informatics technology, perception of information technology competence, adequacy of information technology training and support in the workplace, specific information technology health functions used in the workplace, and perceived benefits of using information technology. The data on the 249 usable responses were analyzed using descriptive statistics. These analyses compare the use of information technology by type of job, specialty, years of practice, and setting of work. Results indicate that more than 90% of nurse practitioners utilize computers at work, yet a large fraction of them still have low self-perception of information technology competence, believe initial training at the work site was inadequate, and believe that academic preparation for information technology was also inadequate. There is considerable variation in these measures across nurse practitioner specialties, settings of care, job characteristics, and experience

MEDICINES MANAGEMENT

Bradley,F., (2008) The challenge of integrating community pharmacists into the primary health care team: A case study of local pharmaceutical services (LPS) pilots and interprofessional collaboration. *Journal of Interprofessional Care*, 22(4), 387-398.

<http://dx.doi.org/10.1080/13561820802137005>

<http://pmid.us/18800280>

The aim of this paper is to investigate interprofessional collaboration between general practitioners (GPs) and pharmacists involved in the delivery of enhanced pharmacy services under the local pharmaceutical services (LPS) contract in England. Previous research suggests that a number of interprofessional barriers exist between community pharmacists and GPs which hinders the integration of community pharmacists into the primary health care team (PHCT). One of the aims of the LPS contract, introduced in

England in 2002 as an alternative to national contractual arrangements, was to enable pharmacists to work more closely with other health care professionals. A two-stage survey was distributed to all pharmacists involved in the first wave of LPS and in-depth interviews undertaken with pharmacists and GPs at six of the LPS sites. Overall the level to which the LPS pharmacists felt integrated into the PHCT did not substantially increase with the introduction of LPS, although co-location was reported to have facilitated integration. New relationships were formed with GPs and existing ones strengthened. A good existing working relationship with GPs was found to be an important factor in the successful operation of the pilots as many were dependent on GPs for patient referrals. The findings suggest that establishing interprofessional collaboration between GPs and pharmacists is a piecemeal process, with a reliance on goodwill and trust-based relationships

Cooper R (2008) et al Stakeholders' views of UK nurse and pharmacist supplementary prescribing. *Journal of Health Services Research and Policy*, 13(4), 215-221.

<http://dx.doi.org/10.1258/jhsrp.2008.008004>

Objectives: Supplementary prescribing (SP) by pharmacists and nurses in the UK represents a unique approach to improving patients' access to medicines and better utilizing health care professionals' skills. Study aims were to explore the views of stakeholders involved in SP policy, training and practice, focusing upon issues such as SP benefits, facilitators, challenges, safety and costs, thereby informing future practice and policy. Method: Qualitative, semi-structured interviews were conducted with 43 purposively sampled UK stakeholders, including pharmacist and nurse supplementary prescribers, doctors, patient groups representatives, academics and policy developers. Analysis of transcribed interviews was undertaken using a process of constant comparison and framework analysis, with coding of emergent themes. Results: Stakeholders generally viewed SP positively and perceived benefits in terms of improved access to medicines and fewer delays, along with a range of facilitators and barriers to the implementation of this form of non-medical prescribing. Stakeholders' views on the economic impact of SP varied, but safety concerns were not considered significant. Future challenges and implications for policy included SP being potentially superseded by independent nurse and pharmacist prescribing, and the need to improve awareness of SP. Several potential tensions emerged including nurses' versus pharmacists' existing skills and training needs, supplementary versus independent prescribing, SP theory versus practice and prescribers versus non-prescribing peers. Conclusion: SP appeared to be broadly welcomed by stakeholders and was perceived to offer patient benefits. Several years after its introduction in the UK, stakeholders still perceived several implementation barriers and challenges and these, together with various tensions identified, might affect the success of supplementary and other forms of non-medical prescribing.

Duggan, C (2008) Using evidence-based practice to better manage medicines: Examples of research guiding pharmacy practice and policy *Journal of Communication in Healthcare* 1 (3) 274-284

Kennedy,A.G., Littenberg,B., & Senders,J.W. (2008). Using nurses and office staff to report prescribing errors in primary care. *International Journal for Quality in Health Care*, 20(4), 238-245.

<http://dx.doi.org/10.1093/intqhc/mzn015>.

Objective To implement a prescribing-error reporting system in primary care offices and analyze the reports. **Design** Descriptive analysis of a voluntary prescribing-error-reporting system **Setting** Seven primary care offices in Vermont, USA. **Participants** One hundred and three prescribers, managers, nurses and office staff. **Intervention** Nurses and office staff were asked to report all communications with community pharmacists regarding prescription problems. **Main Outcome Measures** All reports were classified by severity category, setting, error mode, prescription domain and error-producing conditions. **Results** All practices submitted reports, although reporting decreased by 3.6 reports per month (95% CI, -2.7 to -4.4, $P < 0.001$, by linear regression analysis). Two hundred and sixteen reports were submitted. Nearly 90% (142/165) of errors were severity Category B (errors that did not reach the patient) according to the National Coordinating Council for Medication Error Reporting and Prevention Index for Categorizing Medication Errors. Nineteen errors reached the patient without causing harm (Category C); and 4 errors caused temporary harm requiring intervention (Category E). Errors involving strength were found in 30% of reports, including 23 prescriptions written for strengths not commercially available. Antidepressants, narcotics and antihypertensives were the most frequent drug classes reported. Participants completed an exit survey with a response rate of 84.5% (87/103). Nearly 90% (77/87) of respondents were willing to continue reporting after the study ended, however none of the participants currently submit reports. **Conclusions** Nurses and office staff are a valuable resource for reporting prescribing errors. However, without ongoing reminders, the reporting system is not sustainable

Omar,R.Z., et al (2008). A model based on age, sex, and morbidity to explain variation in UK general practice prescribing: cohort study. *British Medical Journal*, 337 a238.

<http://dx.doi.org/10.1136/bmj.a238>.

<http://pmid.us/18625598>

Objective: To examine whether patient level morbidity based measure of clinical case mix explains variations in prescribing in general practice. **Design:** Retrospective study of a cohort of patients followed for one year. **Setting:** UK General Practice Research Database. **Participants:** 129 general practices, with a total list size of 1 032 072. **Main outcome measures:** Each patient was assigned a morbidity group on the bases of diagnoses, age, and sex using the Johns Hopkins adjusted clinical group case mix system.

Multilevel regression models were used to explain variability in prescribing, with age, sex, and morbidity as predictors. Results: The median number of prescriptions issued annually to a patient is 2 (90% range 0 to 18). The number of prescriptions issued to a patient increases with age and morbidity. Age and sex explained only 10% of the total variation in prescribing compared with 80% after including morbidity. When variation in prescribing was split between practices and within practices, most of the variation was at the practice level. Morbidity explained both variations well. Conclusions: Inclusion of a diagnosis based patient morbidity measure in prescribing models can explain a large amount of variability, both between practices and within practices. The use of patient based case mix systems may prove useful in allocation of budgets and therefore should be investigated further when examining prescribing patterns in general practices in the UK, particularly for specific therapeutic areas

Walters,P., Ashworth,M., & Tylee,A. (2008). Ethnic density, physical illness, social deprivation and antidepressant prescribing in primary care: ecological study. *British Journal of J Psychiatry*, 193(3), 235-239.

<http://dx.doi.org/10.1192/bjp.bp.107.038299>

<http://pmid.us/18757984>

Background: Antidepressant prescribing should reflect need. The Quality and Outcomes Framework has provided an opportunity to explore factors affecting antidepressant prescribing in UK general practice. Aims: To explore the relationship between physical illness, social deprivation, ethnicity, practice characteristics and the volume of antidepressants prescribed in primary care. Method: This was an ecological study using data derived from the Quality and Outcomes Framework, the Informatics Collaboratory of the Social Sciences, and Prescribing Analyses and CosT data for 2004-2005. Associations were examined using linear regression modelling. Results: Socio-economic status, ethnic density, asthma, chronic obstructive pulmonary disease and epilepsy explained 44% of the variance in the volume of antidepressants prescribed. Conclusions: Lower volumes of antidepressants are prescribed in areas with high densities of Black or Asian people. This may suggest disparities in provision of care. Chronic respiratory disease and epilepsy may have a more important association with depression in primary care than previously thought

MENTAL HEALTH

Brenes,G.A.,et al (2008). Age and racial differences in the presentation and treatment of Generalized Anxiety Disorder in primary care. *Journal of Anxiety Disorders*, 22(7), 1128-1136.

<http://dx.doi.org/10.1016/j.janxdis.2007.11.011>

Despite the prevalence and impact of Generalized Anxiety Disorder (GAD) in the primary care setting, little is known about its presentation in this setting. The purpose of this study is to examine age and racial differences in the presentation and treatment of GAD in medical patients. Participants were recruited from one family medicine clinic and one internal medicine clinic. The prevalence of GAD was lowest for older adults. Age differences were found in the presentation of GAD, with young adults reporting greater cognitive symptoms of anxiety, negative affect, and depressive symptoms. African-Americans with GAD reported more positive affect and lower rates of treatment. The lower levels of negative affect and depressive symptoms reported among older adults may affect the recognition of GAD by primary care physicians. Further research is needed to better understand the causes of racial differences in treatment.

Cameron, I. M., et al (2008). Assessing the validity of the PHQ-9, HADS, BDI-II and QIDS-SR16 in measuring severity of depression in a UK sample of primary care patients with a diagnosis of depression: study protocol. *Primary Care & Community Psychiatry*, 13(2), 67-71.

<http://dx.doi.org/10.1080/17468840802067486>

[WOS:000257681300004](#)

Background: The 2004 NICE Guidelines and the Quality and Outcomes Framework (QOF) of the new General Medical Services (nGMS) emphasise the importance of measuring the severity of depression in primary care in order to target the condition with an appropriate intervention; however, there is an absence of UK objective psychometric comparisons between the endorsed measures (Patient Health Questionnaire (PHQ-9), Hospital Anxiety and Depression Scale (HADS) and Beck Depression Inventory (BDI-II)). Preliminary investigations on the HADS and PHQ-9 have demonstrated a lack of concordance between the measures' categorisation of severity of depression, leading to a lack of confidence in their validity in this respect. Methods/Design: The present study proposes to assess the validity of the PHQ-9, HADS, BDI-II and Quick Inventory of Depressive Symptomatology (Self Report) (QIDS-SR16) in measuring severity of depression in a sample of primary care patients with a diagnosis of depression and to establish empirically derived severity cut-off scores for these measures. The aim is to recruit 500 patients from general practices across Grampian, Scotland. A full psychometric assessment will be undertaken including investigations of: reliability, factor structure, convergent/discriminant validity, responsiveness to change and empirical derivation of valid severity bandings. Discussion: Presently the best method for measuring severity of depression in primary care is not known. The findings of this research will provide important information to general practitioners when considering how best to assess depression severity

Cordero L, & et al (2008). Accuracy of primary care medical providers' understanding of the FDA black box warning label for antidepressants. *Primary Care & Community Psychiatry*, 13(3), 109-114.

<http://dx.doi.org/10.1080/17468840802213890>

Purpose: To explore the accuracy of primary care providers' understanding of the FDA black box warning label for SSRI antidepressants for children and adolescents. Methods: A total of 115 licensed primary care providers (PCPs) completed an email survey addressing the FDA black box warning label. Results: Despite self-reports of being well informed about the black box warning label, over 91% of PCPs incorrectly reported that the warning label states that patients died by suicide in the aggregated SSRI clinical trials for children and adolescents, in contrast to the actual reported risk for increased frequency of suicidal thinking and suicide-related behaviors (i.e. suicide attempts and deliberate self-harm). The majority of PCPs (90%) also reported providing verbal information to patients regarding the nature of risk. Conclusions: Efforts need to be made to improve PCPs' understanding of the risk communicated in the FDA black box warning label for children and adolescents, specifically that increased risk does not include risk for death by suicide.

Gask,L., et al (2008). Capturing complexity: The case for a new classification system for mental disorders in primary care. *Eur Psychiatry*.

<http://dx.doi.org/10.1016/j.eurpsy.2008.06.006>

<http://pmid.us/18774269>

Primary care differs considerably from specialist mental health settings: problems are presented in undifferentiated forms, with consequent difficulties in distinguishing between distress and disorder, and a complex relationship between psychological, mental and social problems and their temporal variations. Existing psychiatric diagnostic systems, including ICD-10-PHC and DSM-IV-PC, are often difficult to apply in primary care. They do not adequately address co-morbidity, the substantial prevalence of sub-threshold disorders or problems with cross-cultural applications. Their focus on diagnosis may be too restrictive, with a need to consider severity and impairment separately. ICPC-2, a classification system created specifically for use in primary care, provides advantages in that it allows for simple linkage between reason for encounter, diagnosis and intervention. It is both necessary and feasible to develop a classification system for mental health in primary care that can meet four basic criteria: (1) characterized by simplicity; (2) addressing not only diagnosis but also severity, chronicity and disability; (3) feasible for routine data gathering in primary care as well as for training; and (4) enabling efficient communication between primary and specialty mental health care

Gloster,A.T., et al (2008) Psychometric properties of the Depression Anxiety and Stress Scale-21 in older primary care patients. *Journal of Affective Disorders, 110(3), 248-259.*

The Depression Anxiety Stress Scale (DASS) was designed to efficiently measure the

core symptoms of anxiety and depression and has demonstrated positive psychometric properties in adult samples of anxiety and depression patients and student samples. Despite these findings, the psychometric properties of the DASS remain untested in older adults, for whom the identification of efficient measures of these constructs is especially important. To determine the psychometric properties of the DASS 21-item version in older adults, we analyzed data from 222 medical patients seeking treatment to manage worry. Consistent with younger samples, a three-factor structure best fit the data. Results also indicated good internal consistency, excellent convergent validity, and good discriminative validity, especially for the Depression scale. Receiver operating curve analyses indicated that the DASS-21 predicted the diagnostic presence of generalized anxiety disorder and depression as well as other commonly used measures. These data suggest that the DASS may be used with older adults in lieu of multiple scales designed to measure similar constructs, thereby reducing participant burden and facilitating assessment in settings with limited assessment resources.

Knight, D.E., et al (2008). Pharmacist screening for depression among patients with diabetes in an urban primary care setting. *Journal of the American Pharmacists Association* (2003), 48(4), 518-521.

<http://dx.doi.org/10.1331/JAPhA.2008.07048>

<http://pmid.us/18653429>

Objectives: To identify possible undiagnosed and undertreated depression in patients with diabetes in an urban primary care setting using screening by a student pharmacist, to develop a better understanding of the influence of comorbid depression on diabetes control, and to identify predictors of increased risk for comorbid depression. Methods: Patients from an underserved, low-income, inner-city setting who were receiving primary follow-up diabetes care at five Cincinnati Health Department clinics were evaluated for depression using the Zung Self-rating Depression Scale (SDS). A student pharmacist questioned patients on their medical history and documented the information. After the appointment, the student pharmacist also gathered information from patient medical charts, including patient characteristics, age, social history, pertinent laboratory results (glycosylated hemoglobin [A1C], fasting blood glucose, lipid panel information), and documented comorbidities. A positive screen for depression was defined as an SDS score of 50 or more, and the result of the screening was documented as a clinical note in the patient's medical chart. Based on SDS scores, severity of depressive symptoms was categorized as mild (50-59), moderate (60-69), or severe (> or = 70). Results: 45 patients (2 with type 1 diabetes and 43 with type 2 diabetes, 41 aged > 40 years, 35 black, 31 women, and 31 uninsured) were enrolled in the study. Based on the data collected and SDS results, 12 patients (27%) had a current diagnosis of depression from their primary care physician. For this group of 12, the SDS acted as a quality-assurance tool, identifying 3 patients (25%) as adequately treated (SDS scores < 50), 6 (50%) as undertreated (SDS scores > or = 50 with pharmacologic and/or nonpharmacologic therapy), and 3 (25%) as not treated at all (SDS scores > or = 50 without pharmacologic or nonpharmacologic therapy). Of the 33 patients (73%) without a current diagnosis of depression, 16 (48%) screened positive for depression and 17 were not depressed (52%).

No significant differences were observed between nondepressed and depressed participants in mean A1C or fasting blood glucose. Conclusion: Poorly controlled depression in patients with diabetes can be identified by pharmacists in the primary care setting via use of a brief screening tool such as the SDS

Mallen, C.D., & Peat,G. (2008). Screening older people with musculoskeletal pain for depressive symptoms in primary care. *British Journal of General Practice* 58 (555), 688-693.

<http://dx.doi.org/10.3399/bjgp08X342228>

<http://pmid.us/18826780>

Background: Older patients presenting to GPs with musculoskeletal pain are at high risk of having concurrent depression. AIM: To investigate the performance of ultra-short (1-4 items tools) screening questions used during the consultation, and through a patient questionnaire to detect depressive symptoms among older adults presenting with musculoskeletal pain to general practice. Design of study: Cross-sectional survey, linked GP consultation data. Setting: General practices in central Cheshire, UK. Method: Consecutive patients aged > or =50 years presenting with non-inflammatory musculoskeletal pain were eligible to participate. GPs screened all patients in the consultation for the presence of depressive symptoms using two questions. All patients were sent a postal questionnaire within 1 week of consultation containing the Hospital Anxiety and Depression Scale and the written version of the depression screening questions. Results: The total number of patients included in the study was 428. In total, 35.5% of consulters had comorbid depressive symptoms, with 13.5% experiencing moderate or severe symptoms. Just over half of participants (n = 218/242; 51.4%) screened positive on self-administered screening at home compared with only 78 (20.8%) on GP-administered screening in the consultation. There was little difference between GP-administered and self-administered screening in the probability of depressive symptoms among those who screened positive with regard to exhibiting signs of having depressive symptoms. Conclusion: Older patients consulting their GP with musculoskeletal pain frequently have comorbid mental ill health. Ultrashort depression screening questions administered during the consultation miss a large number of those with depressive symptoms, including six out of eight patients with severe symptoms. An improvement in the performance of screening questions in this patient group or narrowing the definition of 'high risk' from all patients aged > or =50 years presenting with musculoskeletal pain could help to improve detection

Naccarella L (2008) et al Managing demand for psychological services within an Australian primary mental healthcare initiative. *Primary Care & Community Psychiatry*, 13(3), 126-133.

<http://dx.doi.org/10.1080/17468840802168227>

Background: The Australian Better Outcomes in Mental Health Care (BOiMHC) program commenced in 2001, with the aim of improving primary mental healthcare

delivery. One component of the BOiMHC program involves 108 Access to Allied Psychological Services (ATAPS) projects which enable GPs to refer patients to allied health professionals for low-cost, evidence-based care. The projects have improved access to psychological care, but referrals are outstripping their capacity to provide psychological services. This study examined the demand management strategies that projects have used, and how well these strategies are working. Method: A survey was emailed to the project officers of the 108 ATAPS projects. Results: The most commonly used demand management strategies were: informing/training GPs; putting in place systems and/or administrative procedures; and monitoring and limiting referrals. Most projects used combined broad demand management strategies, employing many approaches within each strategy. Monitoring and limiting referrals and putting in place systems and/or administrative procedures were ranked as the most useful. Demand strategies were underpinned by strong partnerships and solid infrastructure. Conclusion: The ATAPS projects are using demand management strategies. Strategies tend to be supply-side strategies instituted where the patient makes contact with the GP and/or approaches the GP-allied health professional interface, rather than demand-side strategies aimed at the patient-practice interface. Strategies appear to be working well when supported by collaborations and infrastructure. The need for demand management strategies reflects resourcing issues that impact on providers' morale and patients' satisfaction. Findings are discussed in relation to other recent developments in Australian primary mental healthcare.

Pepper,C.M., Thompson,V.M., & Nieuwsma,J.A. (2008). Providers' perceptions of barriers to the treatment of emotional disorders in non-urban primary care clinics. *Primary Care & Community Psychiatry, 13*(2), 59-65.

<http://dx.doi.org/10.1080/17468840802048973>

[WOS:000257681300003](#)

Context: Primary care providers (PCPs) are often the main source of mental health treatment in rural areas. Greater concerns about income and insurance, negative attitudes to mental illness and help-seeking, limited availability of mental health referrals, and increased travel distances have been suggested as barriers to the treatment of emotional disorders in rural areas. Purpose: The purpose of this study was to investigate PCPs' views on the significance of barriers faced by patients in obtaining treatment for emotional disorders to determine which barriers were most problematic and which barriers were associated with rurality. Methods: PCPs (n = 180) completed the Barriers to Treatment Questionnaire rating the severity of difficulties in various domains of assessment and treatment for mental health problems. Rurality was determined by the population of the city from the PCPs' mailing addresses. Findings: PCPs rated barriers associated with income and insurance as the most severe barriers, followed by attitudes to mental illness and help-seeking. Barriers associated with rurality included concerns about confidentiality and distance to referral facilities. Limitations: PCPs, not patients, reported on perceived barriers. The sample was based on PCPs in small cities and rural areas, but did not include urban areas, and the response rate was relatively low. Conclusions:

Problems associated with financial concerns and patient attitudes are the most severe barriers to the treatment of mental illness in rural areas. Concerns about confidentiality, poor quality of referrals, and travel distance were more severe in more rural areas

Poutanen,O., Koivisto,A.M., & Salokangas,R.K. (2008). The Depression Scale (DEPS) as a case finder for depression in various subgroups of primary care patients. *European Psychiatry*. 7/9/2008

<http://dx.doi.org/10.1016/j.eurpsy.2008.06.007>

<http://pmid.us/18778920>

Purpose: The quick and simple Depression Scale (DEPS) has been a popular self-rating depression scale in Finland for nearly 15 years. The purpose was to assess the validity of the DEPS in various subgroups of patients. Materials and methods: Primary care patients, aged 18-64, completed a postal questionnaire including the DEPS. Of the 1643 patients all screen-positive subjects and every 10th screen-negative subject were invited for interview (the Present State Examination, PSE). Complete DEPS scores were available for 410 patients. They were grouped by gender, age, marital status, perceived physical health, basic education and the Michigan Alcoholism Screening Test (MAST) score. Separately for each subgroup, receiver operating characteristic (ROC) curve analyses were done, sensitivity, specificity, area under the curve (AUC), predictive values and likelihood ratios were calculated, and Cronbach's alpha was estimated. Results: The DEPS was valid in general, but best for patients with basic education longer than 9 years. Discussion: The key statistical figures for the DEPS were comparable to the figures for other short self-rating scales. Conclusion: The DEPS is a valid case finder for primary care patients in the age group 18-64 years, and especially suitable for more highly educated patients. Future studies comparing the DEPS with other simple depression rating scales are needed

van Marwijk,H.W., Ader,H., de,H.M., & Beekman,A. (2008). Primary care management of major depression in patients aged > or =55 years: outcome of a randomised clinical trial. *British Journal of General Practice* , 58(555), 680-6II.

<http://dx.doi.org/10.3399/bjgp08X342165>

<http://pmid.us/18826778>

Background: Late-life depression is associated with chronic illness, disability, and a poor prognosis. Primary care management may be in need of improvement. Aim: To compare the effects of an intervention programme that aims to improve the identification, diagnosis, and treatment of depression in patients aged > or =55 years with the effects of usual care. Design of study: Cluster randomised controlled trial. Setting: General practices in the Netherlands. Method: Trained GPs performed the intervention and their practice assistants conducted the screenings. Patients were screened with the 15-item Geriatric Depression Scale (GDS-15) and given a consultation with the GP who

diagnosed depression with the mood module of the Primary Care Evaluation of Mental Disorders (PRIME-MD). Antidepressant treatment was proposed. Primary outcomes were measured with the Montgomery Asberg Depression Rating Scale (MADRS). Trained independent research assistants performed independent evaluations in both arms. Results: Eighteen practices (23 GPs) were allocated to the intervention and 16 practices (20 GPs) to usual care. From June 2000 to September 2002, 3937 patients were screened; 579 patients had a positive score on the GDS-15, 178 had major depression, of whom 145 participated in the trial. MADRS scores for the intervention group dropped from 21.66 at baseline to 9.23 at 6 months, and the usual care group from 20.94 at baseline to 11.45 at 6 months. MADRS scores decreased during the year in both arms. For the intervention group, these scores increased between 6 and 12 months. Conclusion: The programme resulted in lower MADRS scores in the intervention group than in the usual care group, but only at the end of the intervention, at 6 months after baseline

Walters, K., et al (2008). Help-seeking preferences for psychological distress in primary care: effect of current mental state. *British Journal of General Practice* 58(555), 694-698.

<http://dx.doi.org/10.3399/bjgp08X342174>

<http://pmid.us/18826781>

Background: There is much debate over when it is appropriate to intervene medically for psychological distress, and limited evidence on patients' perspectives about a broad range of possible treatment options. It is currently unclear whether preferences may differ for those patients with milder symptoms compared to those experiencing more severe distress. Aim: To determine patient preferences for professional, informal, and alternative help for psychological distress in primary care, and the impact of their current mental state on these. Design of study: Cross-sectional survey in seven general practices across suburban/urban London. Method: Participants were 1357 consecutive general practice attenders aged 18 years and over. The main outcome measure was the General Health Questionnaire 12-item version and a questionnaire on help-seeking preferences. Results: Overall, only 47% of participants reported wanting 'some help' if feeling stressed, worried, or low and it was affecting their daily life. Those currently experiencing mild-to-moderate distress preferred informal sources of help such as friends/family support, relaxation/yoga, exercise/sport, or massage along with general advice from their GP and talking therapies. Self-help (books/leaflets or computer/internet) was not popular at any level of distress, and less favoured by those with mild-to-moderate distress (odds ratio [OR] = 0.50; 95% confidence interval [CI] = 0.35 to 0.70). Those experiencing severe distress were much more likely to want talking therapies (OR = 3.43, 95% CI = 2.85 to 4.14), tablets (OR = 3.07, 95% CI = 2.00 to 4.71), and support groups (OR = 3.07, 95% CI = 1.72 to 5.47). Conclusion: People with mild-to-moderate distress appear to prefer informal sources of help and those involving human contact, compared to medication or self-help. This has implications for the implementation of potential interventions for psychological distress in primary care

NEED AND DEMAND FOR CARE

Morales-Asencio, J.M., (2008). Effectiveness of a nurse-led case management home care model in Primary Health Care. A quasi-experimental, controlled, multi-centre study. *BMC Health Services Research*, 8(1), 193.

<http://dx.doi.org/10.1186/1472-6963-8-193>

<http://www.biomedcentral.com/1472-6963/8/193>

<http://pmid.us/18811927>

Background: Demand for home care services has increased considerably, along with the growing complexity of cases and variability among resources and providers. Designing services that guarantee coordination and integration for providers and levels of care is of paramount importance. The aim of this study is to determine the effectiveness of a new case-management based, home care delivery model which has been implemented in Andalusia (Spain). Methods: Quasi-experimental, controlled, non-randomised, multi-centre study on the population receiving home care services comparing the outcomes of the new model, which included nurse-led case management, versus the conventional one. Primary endpoints: functional status, satisfaction and use of healthcare resources. Secondary endpoints: recruitment and caregiver burden, mortality, institutionalisation, quality of life and family function. Analyses were performed at base-line, and at two, six and twelve months. A bivariate analysis was conducted with the Student's t-test, Mann-Whitney's U, and the chi squared test. Kaplan-Meier and log-rank tests were performed to compare survival and institutionalisation. A multivariate analysis was performed to pinpoint factors that impact on improvement of functional ability. Results: Base-line differences in functional capacity - significantly lower in the intervention group (RR: 1.52 95%CI: 1.05-2.21; p=0.0016) - disappeared at six months (RR: 1.31 95%CI: 0.87-1.98; p=0.178). At six months, caregiver burden showed a slight reduction in the intervention group, whereas it increased notably in the control group (base-line Zarit Test: 57.06 95%CI: 54.77-59.34 vs. 60.50 95%CI: 53.63-67.37; p=0.264), (Zarit Test at six months: 53.79 95%CI: 49.67-57.92 vs. 66.26 95%CI: 60.66-71.86 p=0.002). Patients in the intervention group received more physiotherapy (7.92 CI95%: 5.22-10.62 vs. 3.24 95%CI: 1.37-5.310; p=0.0001) and, on average, required fewer home care visits (9.40 95%CI: 7.89-10.92 vs. 11.80 95%CI: 9.10-14.54). No differences were found in terms of frequency of visits to A&E or hospital re-admissions. Furthermore, patients in the control group perceived higher levels of satisfaction (16.88; 95%CI: 16.32-17.43; range: 0-21, vs. 14.65 95%CI: 13.61-15.68; p=0,001). CONCLUSIONS: A home care service model that includes nurse-led case management streamlines access to healthcare services and resources, while impacting positively on patients' functional ability and caregiver burden, with increased levels of satisfaction.

ORGANISATIONS

Hogg, W., et al (2008). Framework for primary care organizations: the importance of a structural domain. *International Journal for Quality in Health Care*. 13/6/2008

<http://dx.doi.org/10.1093/intqhc/mzm054>

<http://pmid.us/18055502>

Purpose: Conceptual frameworks for primary care have evolved over the last 40 years, yet little attention has been paid to the environmental, structural and organizational factors that facilitate or moderate service delivery. Since primary care is now of more interest to policy makers, it is important that they have a comprehensive and balanced conceptual framework to facilitate their understanding and appreciation. We present a conceptual framework for primary care originally developed to guide the measurement of the performance of primary care organizations within the context of a large mixed-method evaluation of four types of models of primary care in Ontario, Canada. Methods: The framework was developed following an iterative process that combined expert consultation and group meetings with a narrative review of existing frameworks, as well as trends in health management and organizational theory. Results: Our conceptual framework for primary care has two domains: structural and performance. The structural domain describes the health care system, practice context and organization of the practice in which any primary care organization operates. The performance domain includes features of health care service delivery and technical quality of clinical care. Conclusion: As primary care evolves through demonstration projects and reformed delivery models, it is important to evaluate its structural and organizational features as these are likely to have a significant impact on performance

Maslin-Protheroe SE, Masterson A, & Jones K (2008). Four parts or one whole: The National Health Service (NHS) post-devolution. *Journal of Nursing Management*, 16(6), 662-672.

<http://dx.doi.org/10.1111/j.1365-2834.2008.00909.x>

Aim(s) There is a need for nurse and midwifery managers to have an understanding of devolution and its implications for them and their colleagues. This paper will explain devolution, consider some health and social care policy including similarities and differences, and assess the impact of devolution on the nursing workforce and the regulation of nursing across the four countries of the United Kingdom (UK). Background If managers are to manage effectively it is critical that they remain aware of emerging policy development and outcomes across the UK. It is now more important than ever that nurses maintain a keen eye on the impact divergent policy is having on practice as well as the UK nursing workforce. Evaluation The impact of devolution across the UK will be explored using convergence and divergence as a framework; commencing by providing an overview of devolution and health, moving on to examine health policy in action

across the four countries. Key issues Healthcare is highly political in nature. Devolution has implications for all, and adds to the complexity of health and social care provision. If managers are to manage effectively it is critical that they remain aware of emerging policy development and outcomes across the UK. Conclusion It is equally important that nurses, and nurse managers, develop and draw upon their political leadership skills, actively engaging in policy debates to ensure that when policies are translated into practice their outcomes are optimal in terms of quality, efficiency and sustainability. Implications for nursing management There is a need for nurse and midwifery managers to have an understanding of post-devolution structures and how they operate in order to work effectively, as well as to learn from the experiences of other parts of the UK.

Tsasis,P., & Bruce-Barrett,C. (2008). Organizational change through lean thinking. *Health Services Management Research* 21(3), 192-198.

<http://dx.doi.org/10.1258/hsmr.2007.007023>

<http://pmid.us/18647948>

In production and manufacturing plants, Lean Thinking has been used to improve processes by eliminating waste and thus enhancing efficiency. In health care, Lean Thinking has emerged as a comprehensive approach towards improving processes embedded in the diagnostic, treatment and care activities of health-care organizations with cost containment results. This paper provides a case study example where Lean Thinking is not only used to improve efficiency and cost containment, but also as an approach to effective organizational change

PATIENT AND PUBLIC INVOLVEMENT

Bradshaw PL (2008). Service user involvement in the NHS in England: genuine user participation or a dogma-driven folly. *Journal of Nursing Management*, 16(6), 673-681.

<http://dx.doi.org/10.1111/j.1365-2834.2008.00910.x>

Aim This paper will catalogue and debate the recent policies that seek to extend the role of health Service Users in England. For operational purposes, the term 'Service User' refers collectively to individual patients and also to the public at large. **Background** The provision of principal features of user involvement are twofold. First, it concerns more personalized services to individuals. Second, it represents recognition that the 60 million potential users of health services have a rightful role in determining the design of service development and delivery. **Key issues** The paper will review the conceptual and ideological basis for current policy in relation to users. For a while, involvement policies

began as benign benevolence, users now find themselves as the means to distributing resources in a way that was originally unintended. Conclusions The dilemmas raised by these policies for both users and providers will be explored and analysed. Implication for nursing management The challenge for managers resides in the empirical evidence. This indicates despite undoubted improvements in the service as a whole, data suggests that at the operational level, care is still far from user centred. The task for policy makers and managers as far as user involvement is concerned, is to move from aspiration to reality.

Eldh A, & et al (2008). Considering patient non-participation in health care. *Health Expectations*, 11(3), 263-271.

<http://dx.doi.org/10.1111/j.1369-7625.2008.00488.x>

Objective The aim of this study was to depict patient non-participation as described by a diverse group with recent experiences of being patients. **Background** Patient participation is regarded as a primary condition for optimal quality of care, suggesting that non-participation should be avoided. A common understanding of the concept of patient non-participation is needed. A discrepancy in definitions of patient non-participation has been found in health-care interactions, health-care classifications and health-care research, and little is known of what patient non-participation represents to patients. **Study design** A survey consisting of closed-ended and open-ended questions was administered to persons that had recently been patients to gather respondents' descriptions of what they considered as patient non-participation. Qualitative content analysis was used to analyse free-text descriptions, and descriptive statistics were used for the close-ended alternatives. **Findings** Lacking information (e.g. not being provided with appropriate information) and lacking recognition (e.g. not being listened to and/or lacking recognition as an individual with individual needs and concerns) were significant aspects of patient non-participation. Furthermore, non-participation encompassed facing organization-centred, as opposed to patient-centred, health care as well as feeling insecure in health care interactions. **Conclusion** The findings provide input for a better understanding of what patients experience as non-participation. Organising for the caregivers to be able to thoroughly listen to the patients' illness narratives would easily reduce the risk of patient's experiencing what is described as non-participation and would provide a sound base for patient learning needs.

Martin,G.P. (2008). Representativeness, legitimacy and power in public involvement in health-service management. *Social Science & Medicine*, 14/10/2008

<http://dx.doi.org/10.1016/j.socscimed.2008.09.024>

Public participation in health-service management is an increasingly prominent policy internationally. Frequently, though, academic studies have found it marginalized by health professionals who, keen to retain control over decision-making, undermine the

legitimacy of involved members of the public, in particular by questioning their representativeness. This paper examines this negotiation of representative legitimacy between staff and involved users by drawing on a qualitative study of service-user involvement in pilot cancer-genetics services recently introduced in England, using interviews, participant observation and documentary analysis. In contrast to the findings of much of the literature, health professionals identified some degree of representative legitimacy in the contributions made by users. However, the ways in which staff and users constructed representativeness diverged significantly. Where staff valued the identities of users as biomedical and lay subjects, users themselves described the legitimacy of their contribution in more expansive terms of knowledge and citizenship. My analysis seeks to show how disputes over representativeness relate not just to a struggle for power according to contrasting group interests, but also to a substantive divergence in understanding of the nature of representativeness in the context of state-orchestrated efforts to increase public participation. This divergence might suggest problems with the enactment of such aspirations in practice; alternatively, however, contestation of representative legitimacy might be understood as reflecting ambiguities in policy-level objectives for participation, which secure implementation by accommodating the divergent constructions of those charged with putting initiatives into practice

Perkins,D.,et al . (2008). Engaging participants in a complex intervention trial in Australian General Practice. *BMC Medical Research Methodology*, 8(1), 55.

<http://dx.doi.org/10.1186/1471-2288-8-55>

<http://www.biomedcentral.com/1471-2288/8/55>

<http://pmid.us/18700984>

Background: The paper examines the key issues experienced in recruiting and retaining practice involvement in a large complex intervention trial in Australian General Practice. **Methods:** Reflective notes made by research staff and telephone interviews with staff from general practices which expressed interest, took part or withdrew from a trial of a complex general practice intervention. **Results:** Recruitment and retention difficulties were due to factors inherent in the demands and context of general practice, the degree of engagement of primary care organisations (Divisions of General Practice), perceived benefits by practices, the design of the trial and the timing and complexity of data collection. **Conclusion:** There needs to be clearer articulation to practices of the benefits of the research to participants and streamlining of the design and processes of data collection and intervention to fit in with their work practices. Ultimately deeper engagement may require additional funding and ongoing participation through practice research networks.

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

Abstract: Not yet on Pubmed 30/07/2008

Winblad, U. (2008). Do physicians care about patient choice? *Social Science & Medicine*, 67(10), 1502-1511.

<http://dx.doi.org/10.1016/j.socscimed.2008.07.016>

<http://pmid.us/18786753>

A new policy (patient choice) was introduced in Sweden in the early 1990s to give patients the right to choose their healthcare providers, however, evaluations show that few patients exercise this right. This paper analyses physicians' roles in putting the patient choice policy into effect. To examine attitudes, knowledge and behaviour among physicians, a questionnaire was sent to 960 physicians in one of the most populous counties in Sweden. The results show that the physicians approve of the policy, yet only a minority state that they regularly help patients to choose healthcare providers by giving them information and letting them choose where they will be referred. Instead, referrals are mostly based on medical grounds; the patient's wish to choose a specific provider is considered less important. In summary, we found that more than a decade after the policy was introduced, only a minority of physicians act according to the political intention. This could be one explanation for why many patients still do not exercise their right to choose a hospital

PRIMARY/SECONDARY CARE INTERFACE

Mulder, J. (2008). Is there a need for a GP consultant at a university hospital? *BMC Family Practice*, 9(1), 55.

<http://dx.doi.org/10.1186/1471-2296-9-55>

<http://www.biomedcentral.com/1471-2296/9/55>

<http://pmid.us/18823571>

Background Patients in hospital can develop complaints unrelated to the condition they are admitted for. The treating specialist will then call upon a co-specialist who is specialized in the clinical picture associated with the new complaint. For such a complaint, the GP is usually the first contact, when the patient is not in hospital. Normally specialists only encounter patients GPs have selected for referral. The risk of the specialist overestimating the predictive value of 'unselected' complaints and symptoms of a serious condition is high. This may lead to an overuse of diagnostic treatments. Such treatments weigh more heavily on the patient, cause inadequate use of hospital facilities and, as a consequence, generate higher costs. Because of these considerations, we wished to investigate if there is a need for the GP as a consultant for new complaints during hospital admittance **Method:** The files of a random sample of patients who had an interdisciplinary consultation during their stay in hospital were

judged by an expert panel whether the consultation fitted the expertise of a GP. Results: In 28 out of 84 files the consultation fitted the expertise of a GP; most cases concerned a specific condition that is not part of the specialist's expertise, most frequently dermatological problems. In a minority of cases the specialist is confronted with a clinical problem with symptoms of which the cause is not clear, for example fever. Conclusion: Generally, the consultations concern serious, often very complex conditions, i.e. cases that should be assessed by a specialist. Nevertheless, the expert panel's judgment of the interdisciplinary consultations shows that in more than half of the dermatological cases and in a limited number of consultations by a specialist of internal medicine and geriatrics the problems fit the GP's expertise. Given the morbidity in academic hospitals we suppose that the results of a similar study in a peripheral hospital might even show more perspective for a GP consultant. These results offer sufficient arguments to start a pilotstudy into the role of a GP consultant in hospital

Sibbald,B., & et al (2008). Moving specialist care into the community: an initial evaluation. *Journal of Health Care Research and Policy*, 13(4), 233-239.

<http://dx.doi.org/10.1258/jhsrp.2008.008049>

Abstract: Objectives: To assess the likely impact on patients and local health economies of shifting specialist care from hospitals to the community in 30 demonstration sites in England. Methods: The evaluation comprised: interviews with service providers at 30 sites, supplemented by interviews with commissioners, GPs and hospital doctors at 12 sites; economic case studies in six sites; and patient surveys at 30 sites plus at nine conventional outpatient services. Outcomes comprised: staff views of service organization and development, impact on primary and secondary care, and benefits for patients; cost per consultation and cost per patient in new services compared to estimates of the price of services if undertaken by hospitals; patients' views of waiting time, access, quality (technical and interpersonal), coordination and satisfaction. Results: New services required high initial investment in staff, premises and equipment, and the support of hospital consultants. Most new services were added to existing hospital services so expanded capacity. Patient reported waiting times (6.7 versus 10.1 weeks; $p < 0.001$); technical quality of care (96.2 versus 94.5; $p < 0.001$), overall satisfaction (88.2 versus 85.4; $p < 0.04$); and access (72.2 versus 65.8; $p < 0.001$) were significantly better for new compared to conventional services but there was no significant difference in coordination or interpersonal quality of care. Some service providers expressed concerns about service quality. New services dealt with less complex conditions and undercut the price tariff applied to hospitals, thus providing a cost saving to commissioners. There was some concern that expansion of new services might destabilize hospitals. Conclusions: Moving specialist care into the community can improve patient access, particularly when new services are added to existing hospital services. Wider impacts on health care quality, capacity and cost merit closer scrutiny before rollout.

QUALITY OF CARE

Bonsall, K., & Cheater, F.M. (2008). What is the impact of advanced primary care nursing roles on patients, nurses and their colleagues? A literature review. *International Journal of Nursing Studies* 45(7), 1090-1102.

<http://dx.doi.org/10.1016/j.ijnurstu.2007.07.013>

<http://pmid.us/17905252>

Objectives: To review and draw together the existing research evidence to assess the impact of advanced primary care nursing roles, particularly first contact nursing roles, for patients, nurses themselves and their colleagues in order to highlight salient issues for policy, practice and research. Background: Internationally, nurses' roles continue to expand in response to doctor shortages and policy drives to provide effective and efficient health services. A body of research exists from which to evaluate the impact of advanced nursing roles on various dimensions of healthcare delivery and organisation. Design and data sources: Medline, CINAHL, Applied Social Sciences Index and Abstracts, British Nursing Index, Cochrane Library, EMBASE, National Research Register, and PsycINFO databases were searched, including relevant websites. Studies were included if published in English and relevant to the primary/community care setting. Of a total of 211 papers identified, 88 were of relevance and included in the review. Results: Nurses working in many advanced primary care roles such as acute/minor illness, minor injury and long-term conditions provide safe and effective care, and patient satisfaction is generally high. Many factors influence patient satisfaction with, and access to, such services but are little understood. Evidence on cost-effectiveness, efficiency and impact on other health care professionals is inconclusive though research suggests the introduction of extended roles can create uncertainty and intra-/inter-professional tensions. Conclusions: Evidence is of variable quality, often ignoring potentially important effect mediators such as the experience and educational level of advanced nurses, the effect of service 'maturation', organisational characteristics and differing patient preferences. The complex range of factors that influence patient satisfaction, access and outcomes of care need further investigation. Recent UK developments in nurse prescribing and the introduction of a national post-registration competency framework may improve working relations and patient understanding and experience of advanced nursing roles in primary care

Cinquini, L., & Vainieri, M. (2008). Measuring primary care services performance: issues and opportunities from a home care pilot experience in the Tuscan health system. *Health Services Management Research*, 21(3), 199-210.

<http://dx.doi.org/10.1258/hsmr.2007.007024>

In recent years in Italy, as in other European countries, profound changes have been introduced in health care both at central and regional levels. Most of them were oriented towards a shift from hospital-centred health care to health care based more on primary care services. This transition pursues two objectives: giving more effective responses to citizens' needs and reducing public health expenditure. Changes that involve

organizational structure must also be carried out with the introduction of measurement tools that can help in planning and can control the changes. The paper provides the results obtained through the experience of modelling a measurement system for primary care carried out in 2004 and 2005 by some territorial managers and controllers in the Tuscan Health system, and the main issues in measuring primary care services emerging from this pilot experience focused on integrated home care services

Esch,B.M., et al (2008). Patient satisfaction with primary care: an observational study comparing anthroposophic and conventional care. *Health and Quality of Life Outcomes*, 6(1), 74.

<http://dx.doi.org/10.1186/1477-7525-6-74>

<http://pmid.us/18826582>

Background: This study is part of a cross-sectional evaluation of complementary medicine providers in primary care in Switzerland. It compares patient satisfaction with anthroposophic medicine (AM) and conventional medicine (CON). Methods: We collected baseline data on structural characteristics of the physicians and their practices and health status and demographics of the patients. Four weeks later patients assessed their satisfaction with the received treatment (five items, four point rating scale) and evaluated the praxis care (validated 23-item questionnaire, five point rating scale). 1946 adult patients of 71 CON and 32 AM primary care physicians participated. Results: 1. Baseline characteristics: AM patients were more likely female (75.6% vs. 59.0%, $p < 0.001$) and had higher education (38.6% vs. 24.7%, $p < 0.001$). They suffered more often from chronic illnesses (52.8% vs. 46.2%, $p = 0.015$) and cancer (7.4 % vs. 1.1 %). AM consultations lasted on average 23,3 minutes (CON: 16,8 minutes, $p < 0.001$). 2. Satisfaction: More AM patients expressed a general treatment satisfaction (56.1% vs. 43.4%, $p < 0.001$) and saw their expectations completely fulfilled at follow-up (38.7% vs. 32.6%, $p < 0.001$). AM patients reported significantly fewer adverse side effects (9.3% vs. 15.4%, $p=0.003$), and more other positive effects from treatment (31.7% vs. 17.1%, $p < 0.001$). Europep: AM patients appreciated that their physicians listened to them (80.0% vs. 67.1%, $p < 0.001$), spent more time (76.5% vs. 61.7%, $p < 0.001$), had more interest in their personal situation (74.6% vs. 60.3%, $p < 0.001$), involved them more in decisions about their medical care (67.8% vs. 58.4%, $p = 0.022$), and made it easy to tell the physician about their problems (71.6% vs. 62.9%, $p=0.023$). AM patients gave significantly better rating as to information and support (in 3 of 4 items p [less than or equal to] 0.044) and for thoroughness (70.4% vs. 56.5%, $p < 0.001$). Conclusion: AM patients were significantly more satisfied and rated their physicians as valuable partners in the treatment. This suggests that subject to certain limitations, AM therapy may be beneficial in primary care. To confirm this, more detailed qualitative studies would be necessary

Giesen,P., et al (2008). Rude or aggressive patient behaviour during out-of-hours GP care: Challenges in communication with patients. *Patient Education and Counseling*, 73(2), 205-208.

<http://dx.doi.org/10.1016/j.pec.2008.04.009>

Objective GPs in out-of-hours care report that they feel at risk of rude or aggressive patient behaviour. We tried to get information about the incidence, types and patient characteristics of rude or aggressive behaviour. Methods Retrospective, observational study involving the analysis of medical records of all patients who contacted a Dutch GP cooperative between June 2001 and June 2002. Results Of the 36,259 patient records, 545 (1.5%) reported rude behaviour, 67 (0.2%) reported verbal aggression and physical aggression was not reported. Anxiety, sorrow, or pain was reported by patients in 49.7% of the cases with rude or aggressive behaviour. The conflict topic between patients and professional was mostly the request of a home visit (21.8%), or a centre consultation (17.3%). Patients with mental health problems (OR 2.3 CI 1.8-3.1) were more at risk for rude or aggressive behaviour. Conclusion Rude and aggressive behaviour on GP cooperatives occurs relative seldom and is associated with anxiety, sorrow, and pain. The wish to see a doctor instead getting a telephone advice is a frequent conflict topic between patient and professional. Practice implications The findings suggest that improved communication at the telephone, particularly exploring the expectation, needs and worries of patients, may reduce aggressive behaviour

Hsu, C., et al (2008). Healing in primary care: a vision shared by patients, physicians, nurses, and clinical staff. *Annals of Family Medicine*, 6(4), 307-314.

Purpose We wanted to understand the views of patients and clinicians on the central concept of healing and to identify major facilitators of and barriers to promoting healing in primary care. Methods We undertook a qualitative analysis of focus group discussions. Participants were drawn from primary care clinics of a large, integrated, health care system in Washington State in 2005. Nine focus groups included 84 participants: 28 patients, 23 primary care physicians (19 family physicians), 20 registered nurses, 11 licensed practical nurses, and 2 medical assistants. Randomly sampled established patients were aged from 21 to 65 years; 71% were female. Results We found remarkable concordance across focus groups and among types of participants in the definition of healing: Healing is a dynamic process of recovering from a trauma or illness by working toward realistic goals, restoring function, and regaining a personal sense of balance and peace. Healing is a multidimensional process with physical, emotional, and spiritual dimensions. The key themes are as follows: (1) healing is multidimensional and holistic; (2) healing is a process, a journey; (3) the goal of healing is recovery or restoration; (4) healing requires the person to reach a place of personal balance and acceptance; and (5) relationships are essential to healing. Factors that facilitate healing help build relationships, improve communication, and share responsibility between the patient and clinician. Major barriers are logistical factors that limit high-quality time with healing professionals. Conclusions Patients and health care team members share a vision of healing and agree on ways to enhance the process in primary care

Jabaaij, L. (2008). Familiarity between patient and general practitioner does not influence topics of conversation during consultations. *BMC Family Practice* 9(1), 51.

<http://dx.doi.org/10.1186/1471-2296-9-51>

<http://www.biomedcentral.com/1471-2296/9/51>

<http://pmid.us/18816369>

Background: Personal continuity in general practice is considered to be a prerequisite of high quality patient care based on shared knowledge and mutual understanding. Not much is known about how personal continuity is reflected in the content of GP - patient communication. We explored whether personal continuity of care influences the content of communication during the consultation. Methods: Personal continuity was defined as the degree of familiarity between GP and patient, rated by both the GP and the patient. 394 videotaped consultations between GPs and patients aged 18 years and older were analyzed. GP - patient communication was evaluated with an observation checklist, which rated the following topics of conversation: (1) medical issues, (2) psychological themes, and (3) the social environment of the patient. For each of these topics we coded whether or not it received attention, and was built upon prior knowledge. Data were analyzed using multilevel logistic regression analyses. Results: No relationship was found between GP - patient familiarity and the discussion of medical issues, psychological themes, or the social environment of the patient. But if the patient and the GP knew each other very well, the GP more often displayed prior knowledge with the topic in question. Few patient and GP characteristics were associated with differences in content of communication. Conclusions: Given the relatively small sample size, we carefully conclude that familiarity between a GP and a patient does not influence the content of the communication (medical issues, psychological themes nor topics relating to the social environment). This is remarkable because we expected that familiarity would 'open up the communication' for more psychological and social themes. GPs seem to have the communication skills to put both familiar and non-familiar patients at ease enabling them to freely raise any issue they think necessary

Laurant, M.G., et al (2008). An overview of patients' preference for, and satisfaction with, care provided by general practitioners and nurse practitioners. *Journal of Clinical Nursing*. 17/7/2008

<http://dx.doi.org/10.1111/j.1365-2702.2008.02288.x>

<http://pmid.us/18647199>

Aim and objectives. To assess patients' views on the care provided by nurse practitioners compared with that provided by general practitioners and to determine factors influencing these views. Background. Many countries have sought to shift aspects of primary care provision from doctors to nurses. It is unclear how patients view these skill mix changes. Design. Cross-sectional survey. Method. Patients (n = 235) who received care from both nurse and doctor were sent a self-administered questionnaire. The main outcome measures were patient preferences, satisfaction with the nurses and doctors and factors influencing patients' preference and satisfaction. Results. Patients preferred the doctor for

medical aspects of care, whereas for educational and routine aspects of care half of the patients preferred the nurse or had no preference for either the nurse or doctor. Patients were generally very satisfied with both nurse and doctor. Patients were significantly more satisfied with the nurse for those aspects of care related to the support provided to patients and families and to the time made available to patients. However, variations in preference and satisfaction were mostly attributable to variation in individual patient characteristics, not doctor, nurse or practice characteristics. Conclusion. Patient preference for nurse or doctor and patient satisfaction both vary with the type of care required and reflect usual work demarcations between nurses and doctors. In general, patients are very satisfied with the care they receive. Relevance to clinical practice. In many countries, different aspects of primary care provision have shifted from doctors to nurses. Our study suggests that these skill mix changes meet the needs of patients and that patients are very satisfied with the care they receive. However, to implement skill mix change in general practice it is important to consider usual work demarcations between nurses and doctors

Lester,H., et al (2008). Barriers and facilitators to partnership working between Early Intervention Services and the voluntary and community sector. *Health Soc Care Community*, 16(5), 493-500.

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

<http://pmid.us/18328058>

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

understand where they are, why they are there and the conditions needed to realise the full potential of partnership working

Lewis, J.M., Baeza, J.I., & Alexander, D. (2008). Partnerships in primary care in Australia: Network structure, dynamics and sustainability. *Social Science and Medicine* 67(2), 280-291.

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

<http://pmid.us/18472201>

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

Lutfey, K.E., et al (2008). How are patient characteristics relevant for physicians' clinical decision making in diabetes? An analysis of qualitative results from a cross-national factorial experiment. *Social Science & Medicine*, 67 (9), 1391-1399.

<http://dx.doi.org/10.1016/j.socscimed.2008.07.005>

<http://pmid.us/18703267>

Abstract: Variations in medical practice have been widely documented and are a linchpin in explanations of health disparities. Evidence shows that clinical decision making varies according to patient, provider and health system characteristics. However, less is known about the processes underlying these aggregate associations and how physicians interpret various patient attributes. Verbal protocol analysis (otherwise known as 'think-aloud') techniques were used to analyze open-ended data from 244 physicians to examine which patient characteristics physicians identify as relevant for their decision making. Data are from a vignette-based factorial experiment measuring the effects of: (a) patient attributes (age, gender, race and socioeconomic status); (b) physician characteristics (gender and

years of clinical experience); and (c) features of the healthcare system in two countries (USA, United Kingdom) on clinical decision making for diabetes. We find that physicians used patients' demographic characteristics only as a starting point in their assessments, and proceeded to make detailed assessments about cognitive ability, motivation, social support and other factors they consider predictive of adherence with medical recommendations and therefore relevant to treatment decisions. These non-medical characteristics of patients were mentioned with much greater consistency than traditional biophysiologic markers of risk such as race, gender, and age. Types of explanations identified varied somewhat according to patient characteristics and to the country in which the interview took place. Results show that basic demographic characteristics are inadequate to the task of capturing information physicians draw from doctor-patient encounters, and that in order to fully understand differential clinical decision making there is a need to move beyond documentation of aggregate associations and further explore the mental and social processes at work

McGregor, W., et al (2008). Impact of the 2004 GMS contract on practice nurses: a qualitative study. *British Journal of General Practice* 58(555), 711-719.

<http://dx.doi.org/10.3399/bjgp08X342183>

<http://pmid.us/18826783>

Background: The new GMS contract has led to practice nurses playing an important role in the delivery of the Quality and Outcomes Framework (QOF). Aim: This study investigated how practice nurses perceive the changes in their work since the contract's inception. Design of study: A qualitative approach, sampling practice nurses from practices in areas of high and low deprivation, with a range of QOF scores. Setting: Glasgow, UK. Method: Individual interviews were conducted, audiotaped, transcribed, and analysed using a thematic approach. Results: Three themes emerged: roles and incentives, workload, and patient care. Practice nurses were positive about the development of their professional role since the introduction of the new GMS contract but had mixed views about whether their status had changed. Views on incentives (largely related to financial rewards) also varied, but most felt under-rewarded, irrespective of practice QOF achievement. All reported a substantial increase in workload, related to incentivised QOF domains with greater 'box ticking' and data entry, and less time to spend with patients. Although the structure created by the new contract was generally welcomed, many were unconvinced that it improved patient care and felt other important areas of care were neglected. Concern was also expressed about a negative effect of the QOF on holistic care, including ethical concerns and detrimental effects on the patient-nurse relationship, which were regarded as a core value. Conclusions: The new GMS contract has given practice nurses increased responsibility. However, discontent about how financial gains are distributed and negative impacts on core values may lead to detrimental long-term effects on motivation and morale

McKinlay, J., & Marceau, L. (2008). When there is no doctor: Reasons for the disappearance of primary care physicians in the US during the early 21st century. *Social Science & Medicine*, 67(10), 1481-1491.

<http://dx.doi.org/10.1016/j.socscimed.2008.06.034>

<http://pmid.us/18701201>

Primary care doctoring in the USA today (2007) bears little resemblance to what existed just 25 years ago. We focus on what is likely to unfold in the U.S. over the next several decades and suggest that by about 2025, primary care doctoring in the U.S. could be rare, possibly unrecognizable and even nonexistent. Seven reasons for the probable disappearance of primary care doctoring are identified. The most important reason is medicine's loss of state sponsorship: the U.S. state has shifted from a pluralistic orientation to a New Right approach. With less state protection medicine has become even more attractive for private interests. Six additional reasons include: (1) the epidemiologic transition (chronic diseases reduce doctors to a palliative role and monitoring of incurable conditions); (2) the overcrowded health care playing field (non-physician clinicians are supplanting primary care doctors); (3) the unintended consequences of clinical guidelines (the art of doctoring is reduced to formulaic tasks, easily codified and performed by non-physician clinicians); (4) the demise of the in-person examination (in-person examination is being replaced by impersonal testing); (5) primary care doctoring is becoming unattractive (physicians are dissatisfied, alienated and experiencing income declines. Applications by U.S. graduates to primary care programs continue to decline); (6) patients are not what they used to be (Internet access and Direct to Consumer advertising are changing the doctor-patient relationship). By 2025, many everyday illnesses in the U.S. will be managed via the Internet or by non-physician clinicians working out of retail clinics. Some medical problems will still require a physician's attention, but this will be provided by specialists rather than by primary care doctors (general practitioners)

Marian, F., et al (2008). Patient satisfaction and side effects in primary care: An observational study comparing homeopathy and conventional medicine. *BMC Complementary and Alternative Medicine*, 8(1), 52.

<http://dx.doi.org/10.1186/1472-6882-8-52>

<http://www.biomedcentral.com/1472-6882/8/52>

Background: This study is part of a nationwide evaluation of complementary medicine in Switzerland (Programme Evaluation of Complementary Medicine PEK) and was funded by the Swiss Federal Office of Public Health. The main objective of this study is to investigate patient satisfaction and perception of side effects in homeopathy compared with conventional care in a primary care setting. Methods: We examined data from two cross-sectional studies conducted in 2002-2003. The first study was a physician questionnaire assessing structural characteristics of practices. The second study was conducted on four given days during a 12-month period in 2002/2003 using a physician

and patient questionnaire at consultation and a patient questionnaire mailed to the patient one month later (including Europep questionnaire). The participating physicians were all trained and licensed in conventional medicine. An additional qualification was required for medical doctors providing homeopathy (membership in the Swiss association of homeopathic physicians SVHA). Results A total of 6778 adult patients received the questionnaire and 3126 responded (46.1%). Statistically significant differences were found with respect to health status (higher percentage of chronic and severe conditions in the homeopathic group), perception of side effects (higher percentage of reported side effects in the conventional group) and patient satisfaction (higher percentage of satisfied patients in the homeopathic group). Conclusions: Overall patient satisfaction was significantly higher in homeopathic than in conventional care. Homeopathic treatments were perceived as a low-risk therapy with two to three times fewer side effects than conventional care

Moran, J., Bekker, H., & Latchford, G. (2008). Everyday use of patient-centred, motivational techniques in routine consultations between doctors and patients with diabetes. *Patient Education and Counseling*, 73(2), 224-231.

<http://dx.doi.org/10.1016/j.pec.2008.07.006>

Objective Facilitating lifestyle change and improved self-management are important aspects of diabetes treatment. Previous research shows motivational, patient-centred approaches are more effective at this than traditional, didactic approaches. This study explores the degree to which doctors with no previous training in motivational techniques employ these methods to affect behaviour change in routine consultations. Methods A cross-sectional design was employed. Forty-four routine consultations with nine physicians were tape-recorded, of which nineteen focussed on behaviour change; patient questionnaires assessed patient demographics, intention to self-manage and satisfaction with consultation. Physician behaviour was coded for use of motivational, behaviour change techniques, patient-centeredness and other verbal communication variables; patient communication was also assessed. Results Lifestyle issues were raised in 43% of consultations but few motivational strategies were employed; 10% of physicians' communication was patient-centred. An association was found between physicians' use of patient-centred strategies and patients expressing views ($r = 0.44$, $p < 0.05$). Higher patient satisfaction with the consultation was related to physician partnership-building ($r = 0.37$, $p < 0.05$) and patients asking questions ($r = 0.31$, $p < 0.05$). Familiarity between doctor and patient was associated with more physician recommendations and directives ($r = 0.35$, $p < 0.05$) and information giving ($r = 0.30$, $p < 0.05$), and more assertive responses by the patient ($r = 0.31$, $p < 0.05$). Conclusion Effective communication strategies related to behaviour change were not used routinely in diabetes consultations in the clinic studied. More patient-centred approaches were associated with higher indicators of patient satisfaction. Practice implications Physicians require training and support in employing behaviour change techniques if these are to be integrated into routine care

Platonova,E.A., Kennedy,K.N., & Shewchuk,R.M. (2008). Understanding patient satisfaction, trust, and loyalty to primary care physicians. *Medical Care Research and Review* 2008 Aug 21.

<http://dx.doi.org/10.1177/1077558708322863>

<http://pmid.us/18723450>

The authors developed and empirically tested a model reflecting a system of interrelations among patient loyalty, trust, and satisfaction as they are related to patients' intentions to stay with a primary care physician (PCP) and recommend the doctor to other people. They used a structural equation modeling approach. The fit statistics indicate a well-fitting model: root mean square error of approximation = .022, goodness-of-fit index = .99, adjusted goodness-of-fit index = .96, and comparative fit index = 1.00. The authors found that patient trust and good interpersonal relationships with the PCP are major predictors of patient satisfaction and loyalty to the physician. Patients need to trust the PCP to be satisfied and loyal to the physician. The authors also found that patient trust, satisfaction, and loyalty are strong and significant predictors of patients' intentions to stay with the doctor and to recommend the PCP to others

Plugge,E., Douglas,N., & Fitzpatrick,R. (2008). Patients, prisoners, or people? Women prisoners' experiences of primary care in prison: a qualitative study. *British Journal of General Practice* 58 (554), 1-8.

<http://dx.doi.org/10.3399/bjgp08X33077>

<http://pmid.us/18801272>

Background: The development of primary care services within prisons has been central to improvements in the provision of health care in this setting over the past decade. Despite national imperatives to involve patients in the development of services and numerous policy initiatives, there has been no systematic evaluation of changes in the delivery of primary care and little published evidence of consultation with prisoners. Aim: To explore women prisoners' experiences of primary healthcare provision in prison. Design of study: Qualitative study using focus groups and interviews. Setting: Two women's prisons in southern England. Method: Six focus groups involving 37 women were conducted, as well as 12 semi-structured individual interviews. Focus groups and interviews were recorded, transcribed, and analysed thematically. Results: Women prisoners' perceptions of the quality of prison health care were mixed. There were accounts of good-quality care where practitioners were regarded as knowledgeable and respectful, but many perceived that the quality of care was poor. They complained about difficulties accessing care or medication, disrespectful treatment, and breaches of confidentiality by practitioners. They voiced the belief that staff were less qualified and competent than their counterparts in the community. Conclusion: The prison environment presents unique challenges to those providing health care, and much work has been done recently on modernising prison health care and improving professional standards of

practice. However, the accounts of women prisoners in this study suggest that there is a gap between patient experience and policy aspirations

Potiriadis, M., et al (2008). How do Australian patients rate their general practitioner? A descriptive study using the General Practice Assessment Questionnaire. *Medical Journal of Australia* 189(4), 215-219

<http://pmid.us/18707566>

Objective: To report patient responses to the General Practice Assessment Questionnaire (GPAQ) as a measure of satisfaction with health care received from Australian general practitioners. Design, setting and participants: A clustered cross-sectional study involving general practice patients from 30 randomly selected general practices in Victoria. Between January and December 2005, a screening survey, including a postal version of the GPAQ, was mailed to 17 780 eligible patients. Main outcome measure: Scores on the six GPAQ items. Results: We analysed data from 7130 patients who completed the screening survey and fulfilled our eligibility criteria. Levels of patient satisfaction with general practice care were generally high: mean GPAQ scores ranged from 68.6 (95% CI, 66.1-71.0) for satisfaction with access to the practice to 84.0 (95% CI, 82.2-85.4) for satisfaction with communication. Intracluster correlations for the GPAQ items ranged from 0.016 for overall satisfaction with the practice to 0.163 for satisfaction with access to the practice. Compared with national benchmarks in the United Kingdom, the GPs and practices participating in our study were rated higher on all six GPAQ items. Multivariable mixed effects linear regression showed that patients who were older, rated their health more highly, visited their GP more frequently and saw the same GP each time tended to express greater satisfaction with their care. Conclusion: Generally patients reported high levels of satisfaction with GP care. Greater satisfaction with care was associated with older patients, good health, more frequent contact with the GP, and seeing the one GP consistently

Walshe,C., et al (2008). Implementation and impact of the Gold Standards Framework in community palliative care: a qualitative study of three primary care trusts. *Palliative Medicine* 22(6), 736-743.

<http://dx.doi.org/10.1177/0269216308094103>

<http://pmid.us/18715973>

The Gold Standards Framework (GSF) has been widely adopted within UK general practices, yet there is little understanding of its impact on the provision of community palliative care services. This study presents data on the anticipation and adoption of the GSF within three Primary Care Trusts in North West England. Forty-seven interviews were conducted with generalist and specialist palliative and primary care professionals. Important aspects of the GSF identified were the patient register, communication and out-of-hours protocols. Positive benefits to professionals included improved communication between professionals and appropriate anticipatory prescribing. Negative aspects included increased nursing workload and the possibility of fewer or later visits for

patients. Many respondents believed that the GSF needed local champions to be sustainable. Slow or incomplete adoption was reported. The GSF was recognised as important because it facilitated changes to previously difficult aspects of work between professionals, but few respondents reported direct benefits to patient care

Zebiene,E.,et al . (2008). Agreement in patient-physician communication in primary care: A study from Central and Eastern Europe. *Patient Education and Counseling*, 73(2), 246-250.

<http://dx.doi.org/10.1016/j.pec.2008.07.034>

Objective Efficient patient-physician collaboration is proven to have a direct benefit on health care outcomes through improved compliance, appointment keeping and use of preventive services. The aim of this study was to evaluate the patient-physician agreement on communication during primary care consultations and consider possible discrepancies. Methods A cross-sectional survey using self-administered questionnaires was performed in primary care in four European countries (Lithuania, Slovenia, Serbia and Russia). Post-consultation evaluations of doctor-patient communication were made by patients and physicians and were compared with pre-consultation expectations of the patient. Discrepancies in these evaluations were determined for the entire database, and within groups of expectations, using factor analysis. Results One thousand three hundred and thirty-two sets of questionnaires were collected by the study team. In this sample, in more than 90% of consultations physicians and patients agreed about meeting patient expectations. Discrepancies were more likely to be identified when the patients were consulting the physician for the first time or had not seen that physician for more than 12 months (up to 26.1%). There is a significantly lower correlation between the physician recognising patient's unmet expectations for all factors if the physician had been working in Primary Care for between 6 and 10 years (8.6%). The results demonstrate that physicians working more than 16 years in practice are less likely to recognise that they have failed to meet the expectations of patients who are seeking reassurance (9%). Conclusion Personal continuity of care is associated with a lower discrepancy between the opinions of patients and physicians regarding meeting patient expectations during consultations in primary care. The highest agreement is within first 6 years in practice, which may reflect long-term effects of training. Practice implications Primary care physicians should put more emphasis on identifying and addressing patient expectations in primary care consultation, including agreement with patient. Existing discrepancies may be considered to be indicators of potential opportunities to improve physician's performance and overall quality of care

RESEARCH AND DEVELOPMENT

Gooberman-Hill,R., & et al (2008). Citizens' juries in planning research priorities: process, engagement and outcome. *Health Expectations*, 11(3), 272-281.

<http://dx.doi.org/10.1111/j.1369-7625.2008.00502.x>

<http://pmid.us/18816323>

Background Involving members of the public in setting priorities for health research in becoming increasingly common practice. One method used in public involvement exercises is the citizens' jury. **Objective** This article examines some challenges and benefits of citizens' juries, including issues relating to process, public engagement and outcome. **Design** In Bristol, UK, a citizens' jury was held with the aim of identifying local priorities for research into health and social care. This jury is used as an example through which key issues in public involvement and jury processes are explored. **Setting and Participants** The Bristol Citizens' Jury comprised 20 members of the public ('jurors'), an oversight panel and a steering group. The jurors met at 11 consecutive sessions during 2006 over a period of 16 weeks, which culminated in a written report. All the sessions were audio-recorded, five sessions were observed and video-recorded, and 16 jurors completed written feedback forms at the end of the jury process. **Findings and conclusion** In this article we discuss degree and timing of public involvement in the process of health research; the role of context; representation of communities; processes of deliberation and knowledge production; and how constraints of time and cost may affect public involvement. It was clear that jurors who took part in the Bristol Citizens' Jury were engaged and committed. This engagement may be related to jurors' belief in their ability to shape future research alongside concern about the relevance of the issues under discussion. Opposing emotions of tension and harmony are a crucial part of the deliberation process.

Hopper,L., et al (2008) The views of dentists on their participation in a primary care-based research trial. *British Dental Journal* , 205(2), E4-E7.

<http://dx.doi.org/10.1038/sj.bdj.2008.584>

<http://pmid.us/18596821>

Aims: To determine the attitudes and opinions of dentists undertaking research in primary care dental practices, about the value of research in primary care. **Method:** The data were collected during a face-to-face interview utilising a schedule of open and closed questions, which were used to guide the interview. **Results:** Twenty-seven of the 40 primary care dentists (67.5%) who had participated in a five-year primary care clinical trial completed the interview. All the respondents believed that primary care research was important and should be of relevance to their practice, but only 12 (44%) thought it was important they carried out this research. The majority (96%) of respondents felt it did not pay financially to do research as a primary care practitioner and 12 (44%) thought research in primary care was too time consuming, but 25 (92%) were prepared to get involved in a primary care research group. Five (56%) salaried service (SS) practitioners

and 14 (78%) general dental services (GDS) dentists felt they did not have enough experience, skills or knowledge to conduct their own research. Significantly more salaried dentists compared with GDS dentists felt adequately supported to do primary care research. Conclusion: Future research in primary care should be focused on topics primary care practitioners feel of use to their clinical practice. A method of funding practitioners and providing time for them to complete research away from their clinical duties is necessary. There is a need for collaborative working with an academic institution, which can provide training and academic support for practitioners

Mykhalovskiy,E. (2008). Beyond decision making: class, community organizations, and the healthwork of people living with HIV/AIDS. Contributions from institutional ethnographic research. *Medical Anthropology* 27(2), 136-163.

<http://dx.doi.org/10.1080/01459740802017363>

<http://pmid.us/18464127>

The consolidation of antiretroviral therapy as the primary biomedical response to HIV infection in the global North has occasioned a growing interest in the health decision making of people living with HIV (PHAs). This interest is burdened by the weight of a behaviorist theoretical orientation that limits decision making to individual acts of rational choice. This article offers an alternative way to understand how PHAs come to take (or not take) biomedical treatments. Drawing on institutional ethnographic research conducted in Toronto, Canada, it explores how the "healthwork" of coming to take (or not take) treatments is organized by extended relations of biomedical knowledge. The article focuses on two aspects of the knowledge relations of coming to take pharmaceutical medications that transcend the conceptual and relational terrain of rational decision-making perspectives. First, it explores disjunctures between the everyday healthwork of poor, socially marginalized PHAs and the terms of biomedical decision making. Second, it investigates the knowledge-mediating activities of community-based organizations that help mitigate those disjunctures

Nutbeam,D., & Boxall, A.M. (2008). What influences the transfer of research into health policy and practice? Observations from England and Australia. *Public Health*, 122(8), 747-753.

<http://dx.doi.org/10.1016/j.puhe.2008.04.020>

<http://pmid.us/18561966>

Objectives: To explore the role of evidence in the public health policy-making process, and show how the way in which public health problems are defined and measured influences policy outcomes. Methods: The policy responses of the Blair Labour Government in the UK and the Howard Coalition Government in Australia to persistent health inequalities over the last decade are examined as a case study. Results: Soon after

being elected, the Blair Government commissioned an independent inquiry into health inequalities, signalling the priority it gave to addressing this longstanding challenge. It chose to take a 'whole-of-government' approach, combining actions that addressed both personal risk factors and the social determinants of health. This approach reflects the long-established tradition in England of routinely measuring disparities in health outcomes and correlating them with socio-economic status and underlying social determinants of health. Over the same period, the Howard Government also outlined its 'whole-of-government' approach to addressing the most extreme and persistent health inequalities between indigenous and non-indigenous Australians. In contrast, its approach focused primarily on modifying risk factors and improving service provision. This approach reflects the different historical circumstances in Australia and a different tradition in the collection of health data, focused more on health service access and personal risk factors. Conclusions: This case study offers some insight into the ways in which the production and presentation of evidence can influence and shape governmental responses to public health problems. The usefulness of available evidence is dependent upon the type of data that is produced routinely by government, as well as more deliberate decisions concerning public health research funding. Researchers can maximize the influence of research evidence on the policy process by engaging in the policy-making process, presenting research in ways that fit with the political context of the day, and, where necessary, using research evidence in public health advocacy in order to influence political priorities more directly

Olde, Hartman T et al (2008). Medically unexplained symptoms in family medicine: defining a research agenda. Proceedings from WONCA 2007. *Family Practice* , 25(4), 266-271.

<http://dx.doi.org/10.1093/fampra/cmn041>

<http://pmid.us/18596048>

Background: Medically unexplained symptoms (MUSs) are frequently presented in primary care. Unfortunately, knowledge of these patients and/or symptoms in primary care is still limited. Available research comes mainly from Europe and North America, while the perspectives of cultures such as Africa, Asia and South America are relatively unknown. To bring cultural perspectives together, a symposium and workshop on MUS in primary care was held at the WONCA World Conference 2007 in Singapore. Objective: Main goals of this symposium and workshop-apart from presenting ongoing research and bringing together experts in MUS-were to detect knowledge gaps in MUS and to establish priorities in MUS research. This publication focuses on the proposed research agenda. Methods: Using a nominal group technique, we generated research topics and set priorities. Research topics were grouped into research themes. Results: Participants' (66 researchers and GPs from 29 nationalities) most important research topics were 'formulating a broadly accepted definition of MUS', 'finding a strategy to recognize MUS better and at an earlier stage', 'studying the value of self-management and empowerment in patients with MUS' and 'finding predictors to decide which strategy will best help the individual patient with MUS'. Priorities in research themes of MUS are as follows: (i) therapeutic options for patients with MUS and (ii) problems in consultations

with these patients. Conclusions: More research on MUS in primary care is needed to improve the consultations with and management of these patients. Internationally primary care conferences are excellent for exchanging ideas and formulating central issues of research

Soler, J.K., et al (2008). The coming of age of ICPC: celebrating the 21st birthday of the International Classification of Primary Care. *Family Practice*, 25(4), 312-317.

<http://dx.doi.org/10.1093/fampra/cmn028>

<http://pmid.us/18562335>

The International Classification of Primary Care (ICPC) has, since its introduction in 1987, been quite successful. Now in its second revised version, it has been translated in 22 languages, accepted by the World Health Organization (WHO) as a member of the Family of International Classifications, and is being widely used both in routine daily practice and in research. In this contribution, it is explained that ICPC was designed as a theoretical classification, and that it has especially great potential when used (1) supported by the ICPC2/ICD10 Thesaurus, (2) in sufficiently large studies to allow all classes to be observed often enough to provide reliable data, and (3) in studies based on data on episodes of care, rather than encounter data only. Under these conditions, the likelihood ratios of symptoms given a diagnosis, and of co-morbidity become available, which define the clinical content of family practice

Sussman,A.L., & Rivera,M. (2008). 'Be gentle and be sincere about it': a story about community-based primary care research. *Annals of Family Medicine*, 6(5), 463-465.

<http://dx.doi.org/10.1370/afm.891>

<http://pmid.us/18779552>

Practice-based researchers in primary care have increasingly recognized the need to include community members in research efforts. In this reflective vignette, the importance of community engagement is realized through the researcher's ability to elicit and interpret an alternative story told by a respected local resident in a focus group. The focus group was part of a study examining communication between patients and clinicians about traditional medicine in New Mexico. During this session, yerba mansa, a plant used in traditional medicine, became a powerful cultural metaphor for expressing concerns about the intentions of outside researchers. This story shows how creating opportunities for sustained engagement with the people we serve can lead to more sensitive ways to establish research partnerships

SELF MANAGEMENT

Baldie,D.J., Entwistle,V.A., & Davey,P.G. (2008). The information and support needs of patients discharged after a short hospital stay for treatment of low-risk Community Acquired Pneumonia: implications for treatment without admission. *BMC Pulmonary Medicine* 8 11.

<http://dx.doi.org/10.1186/1471-2466-8-11>

<http://www.biomedcentral.com/1471-2466/8/11>

<http://pmid.us/18664283>

Background: There is increasing evidence that patients with low-risk community acquired pneumonia (CAP) can be effectively treated as outpatients. This study aimed to explore patients' experiences of having pneumonia and seeking health care; their perceptions of the information provided by health professionals; how they self managed at home; their information and support needs; and their beliefs and preferences regarding site of care. Methods: We conducted qualitative, semi-structured interviews with 15 patients who had a confirmed diagnosis of low-risk CAP and had received fewer than 3 days hospital care. Interviews were audio recorded and transcribed, and data were analysed thematically. Results: Most patients left hospital with no clear understanding of pneumonia, its treatment or follow-up and most identified additional-other specific information needs when they got home. Some were unable to independently address their activities of daily living in their first days at home. Main concerns after discharge related to the cause and implications of pneumonia, symptom trajectory and prevention of transmission. Most sought advice from their GP in their first days at home, and indicated they would have appreciated a follow-up phone call or visit to discuss their concerns. Patients' preferences for site of care varied and appeared to be influenced by beliefs about safety (fear of rapid deterioration at home or acquiring an infection in hospital), family burden, access to support, or confidence in home-care services. Those who received intravenous (IV) medication were more likely to state a preference for hospital care. Conclusion: Trends to support community-based treatment of CAP should be accompanied by increased attention to the information and support needs of patients who go home to self-manage. Although some information needs can be anticipated and addressed on diagnosis, specific needs often do not become apparent until patients return home, so some access to information and support in the community is likely to be necessary. Our finding that patients who received IV treatment for low-risk CAP were concerned about the relative safety of home-based care highlights the potential importance of the inferences patients make from treatment modalities, and also the need to ensure that patients' expectations and understandings are managed effectively

Ettner,S.L.,et al . (2008). Investing time in health: do socioeconomically disadvantaged patients spend more or less extra time on diabetes self-care? *Health Economics* 15th August 2008

<http://dx.doi.org/10.1002/hec.1394>

Background: Research on self-care for chronic disease has not examined time requirements. Translating Research into Action for Diabetes (TRIAD), a multi-site study of managed care patients with diabetes, is among the first to assess self-care time. Objective: To examine associations between socioeconomic position and extra time patients spend on foot care, shopping/cooking, and exercise due to diabetes. Data: Eleven thousand nine hundred and twenty-seven patient surveys from 2000 to 2001. Methods: Bayesian two-part models were used to estimate associations of self-reported extra time spent on self-care with race/ethnicity, education, and income, controlling for demographic and clinical characteristics. Results: Proportions of patients spending no extra time on foot care, shopping/cooking, and exercise were, respectively, 37, 52, and 31%. Extra time spent on foot care and shopping/cooking was greater among racial/ethnic minorities, less-educated and lower-income patients. For example, African-Americans were about 10 percentage points more likely to report spending extra time on foot care than whites and extra time spent was about 3 min more per day. Discussion: Extra time spent on self-care was greater for socioeconomically disadvantaged patients than for advantaged patients, perhaps because their perceived opportunity cost of time is lower or they cannot afford substitutes. Our findings suggest that poorly controlled diabetes risk factors among disadvantaged populations may not be attributable to self-care practices. Copyright (c) 2008 John Wiley & Sons, Ltd

Gallagher,R., et al (2008). Self-management in older patients with chronic illness. *International Journal of Nursing Practice* 14(5), 373-382.

<http://dx.doi.org/10.1111/j.1440-172X.2008.00709.x>

<http://pmid.us/18808538>

Chronic illness causes the majority of disease burden and health costs in developed countries; however, this could be substantially reduced by optimal patient self-management. This study examined the levels of self-management in patients (n = 300) with chronic illness (chronic heart failure, chronic respiratory disease, Parkinson's disease and chronic schizophrenia) of moderate severity who had experienced an illness exacerbation in the last month. Patient's perceptions of self-efficacy in relation to their self-management and their sense of coherence were also assessed at baseline and 1 month later. No changes occurred in self-perceptions or self-management from baseline to follow-up. Patients at risk of poor self-management included people with low self-efficacy, poor sense of coherence, older age and a primary diagnosis of chronic schizophrenia. As self-efficacy is the only predictor known to be amenable to intervention, self-efficacy enhancing support should be promoted

Jerant,A., et al (2008). Perceived control moderated the self-efficacy-enhancing effects of a chronic illness self-management intervention. *Chronic Illness* , 4(3), 173-182.

<http://dx.doi.org/10.1177/1742395308089057>

<http://pmid.us/18796506>

Objective: Identifying moderators of the effects of self-efficacy-enhancing interventions could improve their efficiency. We examined the effects of a home-based variant of the Chronic Disease Self-Management Program on self-efficacy, and explored the moderating effects of perceived control over self-management (PCSM). Methods: In a randomized controlled trial, patients (N= 415) aged >40 years with various chronic conditions plus basic activity impairment and/or significant depressive symptoms were randomized to one of three groups: intervention provided in homes or by telephone, v. usual care control. We used mixed effects linear models for repeated measures to examine effects on self-management self-efficacy at 6-month follow-up and explore moderation by PCSM. Results: Only the home intervention had a significant self-efficacy-enhancing effect (Wald test, $\chi^2(2) = 13.8$, $p = 0.008$; effect size = 0.3). The effect was moderated by PCSM, considered as a continuous [effective in subjects with lower PCSM (Wald test, $\chi^2(2) = 13.4$, $p = 0.009$)] or categorical (effective only for subjects in the lowest tercile) variable. Conclusions: People with lower PCSM appear more likely to experience enhanced self-efficacy from chronic illness self-management training than those with higher PCSM. These findings, although preliminary, suggest that office-based measurement of PCSM might identify those chronically ill patients likely to benefit most from self-management training

Partridge, M.R., et al (2008). Can lay people deliver asthma self-management education as effectively as primary care based practice nurses? *Thorax*, 63(9), 778-783.

<http://dx.doi.org/10.1136/thx.2007.084251>

<http://pmid.us/18281394>

Objectives: To determine whether well trained lay people could deliver asthma self-management education with comparable outcomes to that achieved by primary care based practice nurses. Design: Randomised equivalence trial. Setting: 39 general practices in West London and North West England. Participants: 567 patients with asthma who were on regular maintenance therapy. 15 lay educators were recruited and trained to deliver asthma self-management education. Intervention: An initial consultation of up to 45 min offered either by a lay educator or a practice based primary care nurse, followed by a second shorter face to face consultation and telephone follow-up for 1 year. Main outcome measures: Unscheduled need for healthcare. Secondary outcome measures: Patient satisfaction and need for courses of oral steroids. Results: 567 patients were randomised to care by a nurse (n = 287) or a lay educator (n = 280) and 146 and 171, respectively, attended the first face to face educational session. During the first two consultations, management changes were made in 35/146 patients seen by a practice nurse (24.0%) and in 56/171 patients (32.7%) seen by a lay educator. For 418/567 patients (73.7%), we have 1 year data on use of unscheduled healthcare. Under an intention to treat approach, 61/205 patients (29.8%) in the nurse led group required

unscheduled care compared with 65/213 (30.5%) in the lay led group (90% CI for difference -8.1% to 6.6%; 95% CI for difference -9.5% to 8.0%). The 90% CI contained the predetermined equivalence region (-5% to +5%) giving an inconclusive result regarding the equivalence of the two approaches. Despite the fact that all patients had been prescribed regular maintenance therapy, 122/418 patients (29.2%) required courses of steroid tablets during the course of 1 year. Patient satisfaction following the initial face to face consultation was similar in both groups. Conclusions: It is possible to recruit and train lay educators to deliver a discrete area of respiratory care, with comparable outcomes to those seen by nurses

Shah,B.R., & Booth,G.L. (2008). Predictors and effectiveness of diabetes self-management education in clinical practice. *Patient Education and Counseling*

<http://dx.doi.org/10.1016/j.pec.2008.08.005>

<http://pmid.us/18805668>

Objective: To describe the demographic and clinical predictors of attendance at a diabetes education center (DEC) for self-management education, and to compare subsequent quality of care indicators between attendees and non-attendees. Methods: DEC attendance in 2002 was determined from a written questionnaire completed by 781 adults with diabetes across Ontario, Canada. Predictors of attendance and quality of care indicators were defined from the questionnaire and from linkage with health care administrative data. A multivariate logistic regression model was built to find the independent predictors of attendance, while quality of care was evaluated using propensity score methods. Results: 30% of survey participants reported attending a DEC in 2002. Independent predictors of attendance were shorter duration of diabetes, receiving regular primary care, receiving regular diabetes specialist care and single marital status. Attendees were more likely to receive a retinal screening examination in the following 2 years than non-attendees. Conclusion: Receiving regular primary care was the strongest predictor of attending a DEC, suggesting that DEC's are not substitute providers of diabetes care for people without a regular physician. Increased retinal screening among DEC attendees suggests that self-management education improved their self-efficacy to ensure adequate screening was performed. Practice Implications: The findings characterize the types of people who attend DEC's, which may lead to identification and targeting of inequities in access. The findings also highlight the influence diabetes education can have on quality of care in real-world practice

SERVICE ORGANISATION AND DELIVERY

Abbott S, & et al (2008). Clinicians, market players or bureaucrats?: Changing expectations of the general practitioner role in the English and Welsh NHS, 1991-2005. *Journal of Health Organization and Management*, 22(5), 433-445.

<http://dx.doi.org/10.1108/14777260810898679>

Purpose – The purpose of this paper is to explore the variety of mechanisms applied since 1991 to engage English and Welsh general practitioners (GPs) in local health services planning and implementation. Design/methodology/approach – Three qualitative case studies. Findings – The paper identifies three types of mechanism: separation, alliance and integration. "Separation" characterises the relationship between most GPs and health authorities during the 1990s; alliance refers to the cooperative arrangements between groups of GPs and health authorities such as GP commissioning pilots, total purchasing, primary care groups and local health groups; integration refers to the integration of most health authority functions with primary care organisations (primary care trusts – PCTs and local health boards). Alliance models appear to have been most successful in promoting GP engagement in local planning and implementation; the necessarily bureaucratic nature of PCTs and local health board has alienated many. Practical implications – As yet, the National Health Service (NHS) lacks organisational arrangements which permit GPs a primarily clinical focus while ensuring that their knowledge and advice is available to those carrying out administrative functions. Practice-based commissioning may provide a means of improving such arrangements. Originality/value – The paper combines a number of features in health services and policy research. Few studies of primary health care organisations in the mid-2000s have been undertaken; the Welsh NHS is very under-researched; organisational analysis of the NHS is more often based on analysis from the outside rather than grounded in the felt experience of NHS personnel; and the historical perspective is often neglected.

Bosa IM (2008). Innovative doctors in Germany: changes through communities of practice. *Journal of Health Organization and Management*, 22(5), 465-479.

<http://dx.doi.org/10.1108/14777260810898697>

Purpose – The healthcare sector faces new financial and managerial accountability demands, along with their clinical accountability. Various studies show strong opposition by clinicians to new accountability tools, new structures and new ways of working. Less attention is paid to the innovative roles doctors can play in leading changes that use new managerial tools and techniques. The purpose of this paper is to analyse two original case studies illustrating how general practitioners (GPs) in Germany have led radical change. Design/methodology/approach – The paper draws upon original research in Germany to present two case studies using a qualitative method, which are analysed using Glaser and Strauss' conventions of grounded theory, structured by Wenger's communities of practice framework, supporting a comprehensive literature review. Findings – GPs are found to be able to lead radical change in healthcare delivery models and organisation using entrepreneurial talents developed in their practice businesses and to embrace modernising tools and techniques and in the process redefine their identities to include management process in addition to medical competences. Originality/value – The paper presents two original case studies of radical change leading to an integration of healthcare services in Germany. The approach adopted by the German GPs reveals important general lessons for practitioners, as does the analytical framework employed in the paper.

Gunes,E.D., & Yaman,H. (2008). Transition to family practice in Turkey. *Journal of Continuing Education in the Health Professions* 28(2), 106-112.

<http://dx.doi.org/10.1002/chp.167>

<http://pmid.us/18521878>

Introduction: Turkey's primary health care (PHC) system was established in the beginning of the 1960s and provides preventive and curative basic medical services to the population. This article describes the experience of the Turkish health system, as it tries to adapt to the European health system. It describes the current organization of primary health care and the family medicine model that is in the process of implementation and discusses implications of the transition for family physicians and the challenges faced in meeting the needs for health care staff. In Turkey a trend toward urbanization is evident and more staff positions in rural PHC centers are vacant. Shortages of physicians and an ineffective distribution of doctors are seen as a major problem. Family medicine gained popularity at the beginning of the 1990s, as a specialty with a 3-year postgraduate training program. Medical practitioners who are graduates of a 6-year medical training program and are already working in the PHC system are offered retraining courses. Better working conditions and higher salaries may be important incentives for medical practitioners to sign a contract with the social security institution of Turkey. Discussion: The lack of well-trained primary care staff is an ongoing challenge. Attempts to retrain medical practitioners to act as family physicians show promising results. Shortness of physician and health professionals and lack of time and resources in primary health care are problems to overcome during this process

Murray,S.,et al . (2008). Community group practices in Canada: are they ready to reform their practice? *Journal of Continuing Education in the Health Professions.*, 28(2), 73-78.

<http://dx.doi.org/10.1002/chp.160>

<http://pmid.us/18521875>

Introduction: Governments and healthcare organizations in Canada are reforming the clinical practice structures and policies to deliver primary care to the population. A key component of primary healthcare reform is the establishment of an interdisciplinary, community-based team approach to patient care. This study was undertaken to provide in-depth insight regarding primary healthcare providers' beliefs and attitudes in regard to their current group practice, what changes they believe are occurring and those necessary to reform group practice settings, their willingness to embrace changes, and the challenges they face to realize the proposed reform. Methods: This study employed a mixed-method research design (qualitative and quantitative data collection techniques) through day-long focus groups of primary healthcare professionals (eg, family physicians, specialists, dieticians, psychologists) from across Canada. Results: There is considerable variation in the composition of primary care group practices across Canada.

Respondents report that group practices are little more than an economic convenience to facilitate sharing of resources. Even when a practice is composed of several disciplines, there is little to no organized or systematic interaction among healthcare professionals aimed at improving patient care, lack of clarity as to identified leaders/managers of the team, and inconsistencies in the model of care provided to patients. However, there is a perception of value and benefit in working in a cohesive group practice to improve patient care. Discussion: Findings revealed that although healthcare providers report themselves ready to make the necessary changes and willing to move to interdisciplinary team-based practices, there are substantive challenges that impede a movement to truly effective interdisciplinary team practice and functioning. These challenges include the type and allocation of funding, interprofessional healthcare provider education, changing the healthcare provision model, and barriers among healthcare professionals regarding shared and equitable team accountability for patient health outcomes

SOCIAL CAPITAL

Folland ,S.. (2008). An economic model of social capital and health. *Health Economics, Policy and Law*, 3(04), 333-348.

<http://dx.doi.org/10.1017/S1744133108004532>

This paper presents an economic model to connect with the substantial empirical literature on social capital and health that exists largely outside of economics. Representative papers from that literature are reviewed and these show that disagreements exist on the nature and definition of social capital. The paper presents a new line of reasoning to support the view of social capital as a network of interpersonal bonds to include the bonds of family and close friends, not just the community at large. It then adapts and extends the work of Becker and Murphy on social economics to explain the demand for health goods as well as health bads in the presence of increased social capital. It further develops choice under risk to explain the demand for goods that entail a risk of death, such as cigarettes, illegal drugs, or excessive drinking. Empirical examples, including new statistical analyses are presented to illustrate the derivations

Costa-font, J., & Mladovsky,P. (2008). Social capital and the social formation of health-related preferences and behaviours. *Health Economics, Policy and Law*, 3(04), 413-427.

<http://dx.doi.org/10.1017/S1744133108004635>

Social capital appears to be an important determinant of health production and health utilization and demand. However, there is limited evidence on the mechanisms

underlying this relationship. In this article we draw on the evidence and insights reported in this special issue along with findings from the economic and other social science literature to develop a discussion on the explanations of the likely (behavioural) mechanisms that underpin the connection between social capital and health. An important and under-explored influence mediating the relationship between social capital and health (behaviour) lies in the individuals face in determining their life-styles and in using health care. In particular, we point to the interdependence in how individuals in the first place perceive and also respond to common health risks and the role of cultural transmission and social identity as conveyors of this process. We argue that an emerging body of evidence suggesting that interdependent preferences influence health calls for further re-formulation of traditional demand for and production of health models. Additionally, methodological problems are highlighted and possible ways forward suggested

Pronyk, P.M., et al (2008). Can social capital be intentionally generated? A randomized trial from rural South Africa. *Social Science & Medicine*, 67(10), 1559-1570.

<http://dx.doi.org/10.1016/j.socscimed.2008.07.022>

<http://pmid.us/18771833>

While much descriptive research has documented positive associations between social capital and a range of economic, social and health outcomes, there have been few intervention studies to assess whether social capital can be intentionally generated. We conducted an intervention in rural South Africa that combined group-based microfinance with participatory gender and HIV training in an attempt to catalyze changes in solidarity, reciprocity and social group membership as a means to reduce women's vulnerability to intimate partner violence and HIV. A cluster randomized trial was used to assess intervention effects among eight study villages. In this paper, we examined effects on structural and cognitive social capital among 845 participants and age and wealth matched women from households in comparison villages. This was supported by a diverse portfolio of qualitative research. After two years, adjusted effect estimates indicated higher levels of structural and cognitive social capital in the intervention group than the comparison group, although confidence intervals were wide. Qualitative research illustrated the ways in which economic and social gains enhanced participation in social groups, and the positive and negative dynamics that emerged within the program. There were numerous instances where individuals and village loan centres worked to address community concerns, both working through existing social networks, and through the establishment of new partnerships with local leadership structures, police, the health sector and NGOs. This is among the first experimental trials suggesting that social capital can be exogenously strengthened. The implications for community interventions in public health are further explored

Scheffler,R.M., & Brown,T.T. (2008). Social capital, economics, and health: new evidence. *Health Economics, Policy and Law*, 3(04), 321-331.

<http://dx.doi.org/10.1017/S1744133108004593>

In introducing this Special Issue on Social Capital and Health, this article tracks the popularization of the term and sheds light on the controversy surrounding the term and its definitions. It sets out four mechanisms that link social capital with health: making information available to community members, impacting social norms, enhancing the health care services and their accessibility in a community, and offering psychosocial support networks. Approaches to the measurement of social capital include the Social Capital Community Benchmark Survey (SCCBS) developed by Robert Putnam, and the Petris Social Capital Index (PSCI), which looks at community voluntary organizations using public data available for the entire United States. The article defines community social capital (CSC) as the extent and density of trust, cooperation, and associational links and activity within a given population. Four articles on CSC are introduced in two categories: those that address behaviors – particularly utilization of health services and use of tobacco, alcohol, and drugs; and those that look at links between social capital and physical or mental health. Policy implications include: funding and/or tax subsidies that would support the creation of social capital; laws and regulations; and generation of enthusiasm among communities and leaders to develop social capital. The next steps in the research programme are to continue testing the mechanisms; to look for natural experiments; and to find better public policies to foster social capital

Terrior JL, & Lagace M (2008). Communication as precursor and consequence of subjective social capital in older people: a new perspective on the communication predicament model. *Social Theory and Health*, 6(3), 239-249.

<http://dx.doi.org/10.1057/sth.2008.8>

Social capital, or the connections between people that promote the sharing of norms and values, has value in that it can be used to access resources and it creates well-being through a sense of connectedness. Social capital is particularly important to older people, who experience a reduction in personal relationships as they age. Further, it has been demonstrated repeatedly that social capital is associated with positive health outcomes, particularly for older people. There are both objective and subjective dimensions of social capital and, while the benefits of objective social capital have been thoroughly studied, the subjective dimension is less understood. Using the Communication Predicament Model (CPM) as a theoretical framework, the goal of the current paper was to understand the factors that contribute to older people's subjective social capital. The authors propose that communication is central to the process of building social capital for older citizens and that, in turn, elderly people's perception of their social capital influences their communication. This paper proposes a modification to the CPM and identifies potential areas of application.

WORKFORCE

Beaulieu, M.D., et al. (2008). Family practice: Professional identity in transition. A case study of family medicine in Canada. *Social Science & Medicine*, 67 (7), 1153-1163.

<http://dx.doi.org/10.1016/j.socscimed.2008.06.01>

<http://pmid.us/18644668>

With increasingly fewer family physicians in many countries and students less interested in primary care careers, generalists are becoming an endangered species. This situation is a major health care resource management challenge. In a rapidly changing health care environment, family medicine is struggling for a clear identity--a matter which is crucial to health system restructuring because it affects the roles and functioning of other professions in the system. The objective of our study was to explore representations of roles and responsibilities of family physicians held by future family and specialist physicians and their clinical teachers in four Canadian medical school faculties of medicine, using both focus groups and individual interviews. In addition to family medicine, we targeted residency programs in general psychiatry, radiology and internal medicine--three areas that interface significantly between primary care and specialized medicine. In each faculty, respondents included the vice-dean of postgraduate studies; the director of each relevant program; educators in the program; residents in each specialty in their last year of training. Findings are centred around three major themes: (1) the definition of family medicine; (2) family medicine as an endangered species, and (3) the generation gap between young family physicians and their educators. The sustained physician-patient relationship is considered a core characteristic of family medicine that is much valued by patients and physicians--both generalists and specialists--as something to be preserved in any model of collaboration to be developed. Overall, two divergent directions emerge: preserving all the professions' traditional functions while adapting to changing contexts, or concentrating on areas of expertise and moving towards creating "specialist" general practitioners, in response to a rapidly expanding scope of practice, and to the high value attributed to specialization by society and the professional system

Bowman, R.C. (2008). Measuring primary care: the standard primary care year. *Rural Remote Health*, 8 (3), 1009.

<http://pmid.us/18785798>

Introduction: Numerous reports highlight the problem of declining primary care capacity in the USA, especially in rural and remote areas. The reasons for declining primary care capacity are elusive. Little progress is likely without better definitions, tools, and approaches. The author proposes a standard primary care workforce year to adjust each primary care form for losses due to specialization, lower levels of practice activity, lower primary care volume, and shorter career length. Methods: The author reviewed studies to create a standard primary care year estimate representing the total primary care contribution for each of the five training forms of primary care over the career length of the graduate. The standard primary care year was the product of four factors: (1) the

career length in years; (2) the percentage estimated to remain in primary care; (3) the percentage active in practice; and (4) the percentage of primary care volume compared with a family practitioner. A best determination was made regarding the value of each of the four factors for each primary care form. Because specialization rates increased substantially to decrease primary care contributions, the estimate for each form also had to be linked to each class year of graduates. Results: Family practice is the best example of a permanent primary care training form with 29.3 standard primary care years expected over a 35 year career. Other training forms appear to be more flexible with graduates able to choose primary care or specialty care depending on policy and market forces. The 2008 pediatric residency graduates can be expected to serve 17.6 years of primary care. Internal medicine resident primary care contributions have been reduced by 50% in the past decade to 5.3 years with international medical graduate internal medicine contributions decreasing to 2.5 years. Physician assistant estimates have decreased to 6 years, while nurse practitioner estimates have declined below 3 years per graduate. Without changes in policy or training, the USA must graduate 11.7 international medical graduate internal medicine residents, or 10 nurse practitioners, or 5.5 US internal medicine residents, or 4.8 physician assistants, or 1.7 pediatric residents to equal the same primary care contributions as one family physician. With decreasing rural and underserved distribution levels in the flexible forms, the numbers of graduates needed to match the family practice rural primary care year and underserved primary care year contributions are even higher. Conclusions: The primary care year is a versatile tool that can help to estimate primary care contributions across different forms of primary care. Specialization takes a huge toll on primary care capacity. Progressive failure to retain primary care makes expansions of graduates an ineffective and costly intervention. Without graduating more who remain in primary care, the USA can expect consistently lower primary care levels. Primary care contributions of progressively shorter duration could explain the perceived rapid collapse of primary care, particularly when studies of primary care fail to involve the most recent months of changes

Fitzgerald,R.P. (2008). Rural nurse specialists: clinical practice and the politics of care. *Medical Anthropology* , 27(3), 257-282.

<http://dx.doi.org/10.1080/01459740802222757>

<http://pmid.us/18663640>

Doctor flight from rural areas is an international phenomenon that places great pressure on primary health care delivery. In New Zealand, the response to these empty doctors' surgeries has been the introduction of nurse-led rural health clinics that have attracted controversy both in the media and from urban-based doctors over whether such nurse-led care is a direct substitution of medical care. This article analyzes the reflections of nurses working in some of these clinics who suggest that their situation is more complex than a direct substitution of labor. Although the nurses indicate some significant pressures moving them closer to the work of doctoring, they actively police this cross-boundary work and labor simultaneously to shore up their nursing identities. My own conclusions support their assertions. I argue that it is the maintenance of a holistic professional habitus that best secures their professional identity as nurses while they undertake the

cross-boundary tasks of primary rural health care. There are clear professional benefits and disadvantages for the nurses in these situations, which make the positions highly politicized. These recurring divisions of labor within medical care giving and the elaboration of new types of care worker form an appropriate although neglected topic of study for anthropologists. The study of the social organization of clinical medicine is much enriched by paying closer attention to its interaction with allied health professions and their associated understandings of "good" care

Fletcher,J., Gavin,M., Harkness,E., & Gask,L. (2008). A collaborative approach to embedding graduate primary care mental health workers in the UK National Health Service. *Health and Social Care in the Community*, 16(5), 451-459.

<http://dx.doi.org/10.1111/j.1365-2524.2007.00754.x>

<http://pmid.us/18221485>

The UK National Health Service (NHS) workforce has recently seen the arrival of the Graduate Mental Health Worker (GMHW) in primary care. We established a Quality Improvement Collaborative to assist in embedding this new workforce in one Strategic Health Authority Area of England. The intervention utilised 'collaborative' technology which involves bringing together groups of practitioners from different organizations to work in a structured way to improve the quality of their service. The process was evaluated by an action research project in which all stakeholders participated. Data collection was primarily qualitative. During the project, there was an increase in throughput of new patients seen by the GMHWs and increased workforce satisfaction with a sense that the collaborative aided the change process within the organizations. Involvement of managers and commissioners from the Primary Care Trusts where the GMHWs were employed appeared to be important in achieving change. This was not, however, sufficient to combat significant attrition of the first cohort of workers. The project identified several barriers to the successful implementation of a new workforce for mental health problems in primary care, including widespread variation in the level and quality of supervision and in payment and terms of service of workers. A collaborative approach can be used to support the development of new roles in health care; however, full engagement from management is particularly necessary for success in implementation. The problems faced by GMHWs reflect those faced by other new workers in healthcare settings, yet in some ways are even more disturbing given the lack of governance arrangements put in place to oversee these developments and the apparent use of relatively unsupported and inexperienced novices as agents of change in the NHS

Furler,J.,. (2008). Leaders, leadership and future primary care clinical research. *BMC Family Practice*, 9(1), 52.

<http://dx.doi.org/10.1186/1471-2296-9-52>

<http://www.biomedcentral.com/1471-2296/9/52>

<http://pmid.us/18822178>

Background: A strong and self-confident primary care workforce can deliver the highest quality care and outcomes equitably and cost-effectively. To meet the increasing demands being made of it, primary care needs its own thriving research culture and knowledge base. Method: Review of recent developments supporting primary care clinical research. Results: Primary care research has benefited from a small group of passionate leaders and significant investment in recent decades in some countries. Emerging from this has been innovation in research design and focus, although less is known of the effect on research output. Conclusion: Primary care research is now well placed to lead a broad revitalisation of academic medicine, answering questions of relevance to practitioners, patients, communities and Government. Key areas for future primary care research leaders to focus on include exposing undergraduates early to primary care research, integrating this early exposure with doctoral and postdoctoral research career support, further expanding cross-disciplinary approaches, and developing useful measures of output for future primary care research investment.

Nolan E, & Hewison A (2008). Teamwork in primary care mental health: a policy analysis. *Journal of Nursing Management*, 16(6), 649-661.

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

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

Soler, J.K., et al (2008). Burnout in European family doctors: the EGPRN study. *Family Practice*, 25(4), 245-265.

<http://dx.doi.org/10.1093/fampra/cmn038>

<http://pmid.us/18622012>

Introduction: The aim of this study was to determine the prevalence of burnout, and of associated factors, amongst family doctors (FDs) in European countries. **Methodology.** A

cross-sectional survey of FDs was conducted using a custom-designed and validated questionnaire which incorporated the Maslach Burnout Inventory Human Services Survey (MBI-HSS) as well as questions about demographic factors, working experience, health, lifestyle and job satisfaction. MBI-HSS scores were analysed in the three dimensions of emotional exhaustion (EE), depersonalization (DP) and personal accomplishment (PA). Results: Almost 3500 questionnaires were distributed in 12 European countries, and 1393 were returned to give a response rate of 41%. In terms of burnout, 43% of respondents scored high for EE burnout, 35% for DP and 32% for PA, with 12% scoring high burnout in all three dimensions. Just over one-third of doctors did not score high for burnout in any dimension. High burnout was found to be strongly associated with several of the variables under study, especially those relative to respondents' country of residence and European region, job satisfaction, intention to change job, sick leave utilization, the (ab)use of alcohol, tobacco and psychotropic medication, younger age and male sex. Conclusions: Burnout seems to be a common problem in FDs across Europe and is associated with personal and workload indicators, and especially job satisfaction, intention to change job and the (ab)use of alcohol, tobacco and medication. The study questionnaire appears to be a valid tool to measure burnout in FDs. Recommendations for employment conditions of FDs and future research are made, and suggestions for improving the instrument are listed

Wilson, B., et al (2008) Job satisfaction among a multigenerational nursing workforce. *Journal of Nursing Management*, 16(6), 716-723.

<http://dx.doi.org/10.1111/j.1365-2834.2008.00874.x>

<http://pmid.us/18808466>

Aim To explore generational differences in job satisfaction. Background Effective retention strategies are required to mitigate the international nursing shortage. Job satisfaction, a strong and consistent predictor of retention, may differ across generations. Understanding job satisfaction generational differences may lead to increasing clarity about generation-specific retention approaches. Method The Ontario Nurse Survey collected data from 6541 Registered Nurses. Participants were categorized as Baby Boomer, Generation X or Generation Y based on birth year. Multivariate analysis of variance explored generational differences for overall and specific satisfaction components. Results In overall job satisfaction and five specific satisfaction components, Baby Boomers were significantly more satisfied than Generations X and Y. Conclusion It is imperative to improve job satisfaction for younger generations of nurses. Implications for Nursing Management Strategies to improve job satisfaction for younger generations of nurses may include creating a shared governance framework where nurses are empowered to make decisions. Implementing shared governance, through nurse-led unit-based councils, may lead to greater job satisfaction, particularly for younger nurses. Opportunities to self schedule or job share may be other potential approaches to increase job satisfaction, especially for younger generations of nurses. Another potential strategy would be to aggressively provide and support education and career-development opportunities

