WONCA News

An International Forum for Family Doctors/

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WONCA condolences to French colleagues

WONCA President, Michael Kidd and WONCA Europe President, Prof Job FM Metsemakers have sent messages of condolence to our colleagues in France on behalf of the greater WONCA family.

I was very saddened to hear about the terrorist attacks in Paris and the terrible loss of life. My thoughts are with you and with all our family medicine colleagues in Paris and across France at this very distressing time, and especially with those who have lost loved ones in these attacks.

Professor Kidd has sent the message to our colleagues in France at La Société Française Médecine Générale (SFMG), and the Collège National des Généralistes Enseignants (CNGE) Collège Académique about yesterday's devastating attacks in Paris. He has also sent a similar message to the president of the Lebanese Society of Family Medicine, about the loss of life in the terrorist attacks in Beirut on Thursday evening.

WONCA Europe President, Prof Job FM Metsemakers has sent the following message to our colleagues in France, via Professor Pierre-Louis Druais, President of the Collège de la Médecine Générale.

Dear Pierre-Louis
The WONCA family is shocked by the brutality of the terrorist acts in Paris, killing and wounding so many people. Our hearts feel the pain you and all French people must feel. We offer our condolences and emotional support.

However much people may differ in culture and beliefs, there is no justification for these kinds of acts. Understandably, but unfortunately, they already succeed in putting fear into our lives. Museums, theatres, shops, Disneyland Paris have been closed, disrupting the normal day to day pattern of life.

The spontaneous joint singing of the Marseillaise which I saw on the news, shows the strength the French People have to stay united. We all have to stay united and we all will have to learn how to cope with this new Europe. A region on high alert for terrorists - while refugees still look at it as a safe haven. The world has become a strange place.

Our condolences and support on behalf of the WONCA family.
Prof Job FM Metsemakers

Condoléances à nos collègues en France

Le président de WONCA et le président de WONCA Europe ont tous deux adressé des messages de condoléances concernant les attentats dévastateurs de Paris à nos collègues en France au nom de la famille WONCA.

Veuillez lire ci-dessous le message envoyé par le Président de WONCA, Professeur Michael Kidd, à nos collègues en France à la Société Française de Médecine Générale (SFMG) et au Collège National des Généralistes Enseignants (CNGE) Collège Académique. Professeur Kidd a aussi adressé un message similaire au président de la Lebanese Society of Family Medicine concernant les victimes des attentats terroristes de Beyrouth jeudi soir.

J'ai été attristé par la nouvelle des attentats terroristes de Paris et les pertes de vies humaines terribles. Toutes mes pensées sont avec vous et avec tous les collègues de médecine familiale à Paris et dans toute la France en ces temps de détresse, et particulièrement avec ceux qui ont perdu des proches dans ces attentats.

Veuillez lire ci-dessous le message envoyé par le Président de WONCA Europe, Professeur Job FM Metsemakers à Professeur Pierre-Louis Druais, Président du Collège de Médecine Générale.

Cher Pierre-Louis
La famille WONCA est sous le choc de la brutalité des actes terroristes de Paris, ayant causé tant de victimes. Nous partageons la douleur de tous les Français et vous offrons nos condoléances et notre soutien moral.

Quelles que soient les différences de cultures et de croyances, il n'y a guère de justification pour ce type d'actes. Nous comprenons que malheureusement leurs auteurs ont déjà réussi à semer la terreur dans nos vies. Les musées, les théâtres, les magasins et Disneyland Paris sont restés fermés, interrompant ainsi les habitudes de la vie quotidienne.

L'improvisation jointe et spontanée de la Marseillaise que j'ai entendue aux nouvelles démontre la détermination des Français à rester unis. Nous devons maintenir cette unité et il nous faudra maintenant apprendre à survivre dans cette nouvelle Europe. Une région en état d'alerte élevée en ce qui concerne les terroristes –alors que les réfugiés continuent à la voir comme terre d'asile sûre. Le monde est devenu un endroit bien étrange.

Toutes nos condoléances de la part de la famille WONCA.
Prof Job FM Metsemakers
Traduit par Josette Liebeck, traduction Anglais-Français accréditée NAATI No 75800

From the President: Lessons from a great family doctor

Photo: WONCA President with members of Ian McWhinney's family, young family doctors from Western University and Dr Francine Lemire, Chief Executive Officer of the College of Family Physicians of Canada

Ian McWhinney was a family doctor from the UK who moved to Canada in 1967 to establish the Department of Family Medicine at Western University in Ontario. Ian influenced the careers and the attitudes of family doctors in many parts of the world, and he was one of the pioneer leaders of the development of the academic basis of our professional discipline. Ian died in 2012 at the age of 85. *Photo : Dr Ian McWhinney OC (1926-2012)*

In September I was invited to deliver the inaugural Ian McWhinney lecture named in his honour at Western University.

Like many people in family medicine around the world, I knew and admired Ian from a distance, through his influential writing and from the privilege of being in the audience when he spoke at a WONCA conference.

My own introduction to Ian's work was in 1988, shortly after I joined the Department of General Practice and Community Medicine at Monash University in Melbourne, Australia, as a junior academic family doctor. The following year, my boss, Professor Neil Carson, another pioneer leader in academic family medicine, handed me a book he had been sent by a publisher to review to see if it might be suitable for teaching our medical students. Neil asked me to read the book and let him know what I thought. The book was the first edition of Ian McWhinney's now famous Textbook of Family Medicine.

The first chapter was about the Origins of Family Medicine and I found Ian's brief history of our discipline very interesting, but it was the next chapter, about the Principles of Family Medicine, that opened my eyes to a new way of looking at my chosen career. The nine principles of family medicine, outlined by Ian, articulated in clear terms the work that we do as family doctors, no matter where in the world we live and work. I have shared these nine principles with many groups of medical students and family medicine residents over the years. Here they are:

1. Family physicians are committed to the person rather than to a particular body of knowledge, group of diseases, or special technique. In this simple sentence, Ian captured the humanity of the work we do and our commitment to person-centred care, long before that term became fashionable.

Photo: WONCA President with young family doctors in rural Ontario, Canada

2. The family physician seeks to understand the context of the illness. Ian asked us to consider how the experience of illness impacts on each individual, again part of the person-centred focus of our work.

3. The family physician sees every contact with his or her patients as an opportunity for prevention of disease or promotion of health. Prevention has been neglected in recent years in some parts of the world, but its importance is coming back to the fore with the understanding about the global impact of so-called non-communicable diseases and the importance of prevention and health promotion in avoiding or delaying the onset of

heart disease, diabetes, and many cancers and other chronic conditions.

Photo: Dr Jo-Anne Hammond, family doctor at London Health Science Centre, London, Ontario, Canada

4. The family physician views his or her practice as a "population at risk". I like this principle because it captures the work we do in primary care to improve population health. Each of us has the opportunity to observe the illnesses that affected our patient population and look at ways to prevent further morbidity and mortality.

5. The family physician sees himself or herself as part of a community-wide network of supportive and health-care agencies. In some parts of the world, team-based care and the gatekeeper and referral roles of family doctors, are seen as something newly discovered, but they are of course part of our rich tradition.

6. Ideally, the family physician should share the same habitat as their patients. This one is my personal favourite, sounding like something from David Attenborough, but also very true. Ian believed that you can't truly understand the health needs and concerns of a community, unless you are a part of that community. Being a member of a community allows us to understand the social context of our patients' lives.

7. The family physician sees patients in their homes. Again a very important part of the work we do, and providing both an extraordinary privilege and the opportunity to understand the context of our patients' lives better and the challenges that they face each day. Although home visits have become less common in some parts of the world, they are making a resurgence through the development of family health teams in some countries, and even through telehealth, which at least allows us to catch a glimpse of our patients in their home surroundings.

Photo: Dr Vikram Dalal, rural family doctor at Thames Valley Family Health Centre, Mount Brydges, Ontario, Canada meeting with Professor Stephen Wetmore

8. The family physician attaches importance to the subjective aspects of medicine. Again one of the important lessons we learn as family doctors. Trust your instincts. Listen to your patients. And especially listen to the carers of your patients. Never ignore a parent's concerns about their young child. Or a child's concerns about their ageing parent.

9. The family physician is a manager of resources. At the time I thought this final principle was a bit dry, but I now realise it is one of the major contributions family doctors make to our nations. Through judicious use of expensive investigations and through appropriate management of referrals to other clinicians and services, we ensure that our nations have the finances available to provide health care to all people, rather than just to an entitled subgroup.

These are nine seemingly simple principles that encapsulate our role and our contribution as family doctors. For me, this is part of Ian's great legacy, his ability to describe with such clarity the important work we do.

A few days later, my boss, Neil Carson, asked me what I thought about the book. I said we should be using it as part of our teaching. He said he would think about that. He then asked if he could have the book back. I said no, I'm keeping it. He got the message.

As family doctors, we are indebted to our teachers; our family doctor colleagues, like Ian, who have taught us how to practise medicine in our communities using a combination of "scientific knowledge and tender loving care".
Michael Kidd
WONCA President
Read the full text of the oration

Del Presidente:
Lecciones de un gran médico de familia

Imagen: El Presidente de WONCA con miembros de la familia de Ian McWhinney, jóvenes médicos de familia de la Universidad de Western y la Dra. Francine Lemire, Directora Ejecutiva del Colegio de Médicos de Familia de Canadá.

Ian McWhinney era un médico de familia en el Reino Unido que se trasladó a Canadá en 1967 para establecer el Departamento de Medicina Familiar de la Universidad de Western, Ontario. Ian influyó en las carreras y las actitudes de los médicos de familia en muchas partes del mundo, y fue uno de los líderes pioneros del desarrollo de la base académica de nuestra disciplina profesional. Ian murió en 2012 a la edad de 85 años.

Imagen : Dr Ian McWhinney OC (1926-2012)

En septiembre fui invitado para impartir la conferencia inaugural en honor a Ian McWhinney en la Universidad de Western.

De la misma forma que mucha gente de la Medicina de Familia en todo el mundo, yo conocí y admiré a Ian desde la distancia, a través de su escritura influyente y desde el privilegio de poder estar entre el público cuando habló en una conferencia de WONCA.

Mi iniciación a la obra de Ian fue en 1988, poco después de haberme unido al Departamento de Práctica General y Medicina Comunitaria de la Universidad de Monash en Melbourne, Australia, como un académico junior en Medicina de Familia. Al año siguiente, mi jefe, el profesor Neil Carson, otro líder pionero en la medicina familiar académica, me entregó un libro que había sido enviado por un editor para que lo revisase y viera si podía ser adecuado para enseñar a nuestros estudiantes de medicina. Neil me pidió que leyera el libro y le hiciera saber lo que pensaba. Se trataba de la primera edición del ya famoso Libro de texto de Medicina de Familia de Ian McWhinney.

Imagen: Presidente de WONCA con jóvenes médicos de familia en la zona rural de Ontario, Canada.

El primer capítulo trataba los Orígenes de la Medicina de Familia y me pareció que la breve historia de Ian sobre nuestra disciplina era muy interesante, pero fue el siguiente capítulo, acerca de los Principios de la Medicina de Familia, el que me abrió los ojos a una nueva forma de mirar mi carrera. Los nueve principios de la Medicina de Familia, esbozados por Ian, articulaban en términos claros el trabajo que hacemos como médicos de familia, sin importar el lugar del mundo en el que vivimos y trabajamos. He compartido estos nueve principios con muchos grupos de estudiantes de medicina y residentes de Medicina de Familiar en los últimos años. Son los siguientes:

1. Los médicos de familia están comprometidos con la persona más que con un campo particular de conocimiento, o un grupo de enfermedades, o una técnica especial. En esta simple frase, Ian capturó la humanidad del trabajo que hacemos y nuestro compromiso con la atención centrada en la persona, mucho antes de que ese término se pusiera de moda.

2. El médico de familia busca entender el contexto de la enfermedad. Ian nos pidió que considerásemos hasta qué punto la experiencia de la enfermedad afecta a cada individuo, de nuevo partiendo del enfoque de nuestro trabajo centrado en la persona.

3. El médico de familia considera que cada contacto con sus pacientes es una oportunidad

para la prevención de la enfermedad o la promoción de la salud. La prevención se ha descuidado en los últimos años en algunas partes del mundo, pero su importancia está volviendo al frente con el entendimiento del impacto global de las llamadas enfermedades no transmisibles y la importancia de la prevención y promoción de la salud para evitar o retrasar la aparición de enfermedades del corazón, diabetes y muchos tipos de cáncer y otras patologías crónicas.

Imagen: Dr. Jo-Anne Hammond, médico de familia en el Centro de Salud de Londres en Ontario, Canada.

4. El médico de familia ve su práctica como una "población en riesgo". Me gusta este principio porque recoge el trabajo que hacemos en la Atención Primaria para mejorar la salud de la población. Cada uno de nosotros tiene la oportunidad de observar las enfermedades que afectan a nuestra población de pacientes y buscar las maneras de evitar una mayor morbilidad y mortalidad.

5. El médico de familia se ve a sí mismo o a sí misma como parte de una gran red comunitaria de agencias de apoyo y de atención a la salud. En algunas partes del mundo, la atención en equipo y el controlador de acceso y la forma de referirse a los roles de los médicos de familia, son vistos como algo recién descubierto, pero son, por supuesto, parte de nuestra rica tradición.

6. Lo ideal sería que el médico de familia compartiese el mismo hábitat que sus pacientes. Éste punto es, personalmente, mi favorito, sonando un poco como David Attenborough, pero que es muy cierto también. Ian creía que no se pueden verdaderamente comprender las necesidades de salud y preocupaciones de una comunidad, a menos que se forme parte de esa comunidad. Ser miembro de una comunidad nos permite entender el contexto social de la vida de nuestros pacientes.

Imagen: Dr. Vikram Dalal, médico de familia rural en el Centro de Salud de Familia del Valle de Thames, Monte Brydges, Ontario, Canada, encuentro con el Profesor Stephen Wetmore.

7. El médico de familia ve a los pacientes en sus hogares. Una vez más una parte muy importante del trabajo que hacemos, y que nos proporciona un privilegio extraordinario a la vez que una oportunidad de entender mejor el contexto de la vida de nuestros pacientes y los retos a los que se enfrentan cada día. Aunque las visitas al domicilio se han vuelto menos comunes en algunas partes del mundo, en otros países están resurgiendo gracias al desarrollo de los equipos de salud de la familia e incluso a través de telesalud, que nos permite, al menos, echar un vistazo a nuestros pacientes en los alrededores de su hogar.

8. El médico de familia otorga importancia a los aspectos subjetivos de la medicina. Una vez más una de las importantes lecciones que aprendemos como médicos de familia. Confía en tus instintos. Escucha a tus pacientes. Y, sobre todo, escucha a los cuidadores de tus pacientes. Nunca ignores las preocupaciones de los padres acerca de su niño pequeño. O las preocupaciones de un niño acerca del envejecimiento de su padre.

9. El médico de familia es un gestor de recursos. En un primer momento pensé que este último principio era un poco inexacto, pero ahora me doy cuenta que es una de las principales contribuciones que los médicos de familia hacen a nuestras países. Mediante el uso juicioso de las investigaciones costosas y de una adecuada gestión de derivaciones a otros médicos y servicios, nos aseguramos de que nuestros países tengan las finanzas disponibles para proporcionar servicios de salud a todas las personas, en lugar de sólo a un subgrupo privilegiado.

Estos son nueve principios aparentemente simples que encapsulan nuestro papel y nuestra contribución como médicos de familia. Para mí,

esto es parte del gran legado de Ian, su capacidad para describir con tanta claridad el importante trabajo que hacemos.

Unos días más tarde, mi jefe, Neil Carson, me preguntó qué pensaba sobre el libro. Le dije que deberíamos estar usándolo como parte de nuestra enseñanza. Él dijo que iba a pensar en eso. Luego me preguntó si podía devolverle el libro. Le dije que no, que me lo quedaba. Recibió el mensaje.

Como médicos de familia, estamos en deuda con nuestros maestros; nuestros colegas médicos de familia, como Ian, que nos han enseñado cómo practicar la medicina en nuestras comunidades utilizando una combinación de "conocimiento científico y de cariño".

Michael Kidd
Presidente de WONCA

Traducción: Pere Vilanova, Spanish Society of Family and Community Medicine (semFYC) - Periodismo y comunicación

Lee el texto completo del discurso del Presidente en inglés
Compartimos un fragmento de la conferencia en español

Du président:

Leçons d'un grand médecin de famille

Image: Président de WONCA avec des membres de la famille d'Ian McWhinney, de jeunes médecins de famille de l'université de Western Ontario et Dr Francine Lemire, directrice générale du Collège des Médecins de Famille du Canada

Ian McWhinney était un médecin de famille du Royaume-Uni, émigré au Canada en 1967 pour établir le Département de Médecine Familiale à l'Université de Western Ontario. Ian a influencé les carrières et les attitudes des médecins de famille dans beaucoup de régions du monde, et il fut l'un des pionniers du développement de la base universitaire de notre discipline professionnelle. Ian est décédé en 2012 à l'âge de 85 ans.

Image : Dr Ian McWhinney OC (1926-2012)

En septembre, j'ai été invité à présenter le discours inaugural dédié à Ian McWhinney à l'Université de Western Ontario.

Comme beaucoup d'autres en médecine familiale autour du monde, j'ai connu et admiré Ian à distance, à travers ses écrits influents et grâce au privilège d'avoir été présent dans l'auditoire lors de son discours à une conférence de WONCA.

Ma propre introduction aux travaux d'Ian eut lieu en 1988, peu de temps après mon entrée au Département de Médecine Générale et de Médecine Communautaire à l'Université Monash de Melbourne, en Australie, comme jeune universitaire en médecine familiale. L'année suivante, mon supérieur, le professeur Neil Carson, autre pionnier en médecine familiale universitaire, me remit un livre qui lui avait été envoyé par un éditeur pour révision afin d'en déterminer la pertinence pour l'enseignement de nos étudiants en médecine. Neil m'a demandé de lire ce livre et de lui faire connaître mon opinion. Il s'agissait de la première édition du désormais célèbre Manuel de Médecine Familiale par Ian McWhinney.

Image : Président de WONCA auprès des jeunes médecins de famille en Ontario rural, Canada

Le premier chapitre était consacré aux Origines de la Médecine Familiale et la brève histoire de notre discipline racontée par Ian me parut très intéressante. Cependant, ce fut le chapitre

suivant, au sujet des Principes de Médecine Familiale, qui me donnèrent un nouveau regard sur la carrière que j'avais choisie. Les neuf principes de médecine familiale décrits par Ian articulaient en termes clairs le travail que nous effectuons en tant que médecins de famille, quel que soit l'endroit au monde où nous vivons et travaillons. J'ai partagé ces neuf principes avec beaucoup de groupes d'étudiants en médecine et de résidents de médecine familiale au fil des années.
Les voici :

1. "Family physicians are committed to the person rather than to a particular body of knowledge, group of diseases, or special technique". Dans cette phrase simple, Ian a capturé l'humanité du travail que nous effectuons et notre engagement aux soins centrés sur la personne, bien avant que cette expression ne devienne à la mode.

2. Le médecin de famille cherche à comprendre le contexte de la maladie. Ian nous a demandé de prendre en compte l'impact de l'expérience de la maladie sur chaque individu, ceci faisant partie de notre travail centré sur la personne.

Image : Dr Jo-Anne Hammond, médecin de famille au Centre de Santé de Londres, Londres, Ontario, Canada

3. Le médecin de famille voit chaque contact avec ses patients comme une occasion de prévenir la maladie ou de promouvoir la santé. La prévention a été négligée ces dernières années dans certaines régions du monde, mais reprend de l'importance du fait de la compréhension de l'impact global des maladies prétendument non-communicables et de l'importance de la prévention et de la promotion de la santé en évitant ou en retardant le début des maladies cardiaques, du diabète, de beaucoup de cancers et d'autres conditions chroniques.

4. Le médecin de famille voit sa clientèle comme « population à risque ». J'aime ce principe parce qu'il capture le travail que nous faisons au niveau des soins primaires pour améliorer la santé publique. Chacun de nous a l'occasion d'observer les maladies qui affectent nos patients et cherche des solutions afin de réduire toujours davantage la morbidité et la mortalité.

5. Le médecin de famille se voit lui-même ou elle-même comme élément d'un réseau à l'échelle communautaire des agences de soutien et de services de santé. Dans certaines régions du monde, les rôles en matière de soins dispensés en équipe, de protection et de recommandation des médecins de famille, sont vus comme une découverte récente, mais ils font bien évidemment partie de notre riche tradition.

6. Dans le meilleur des cas, le médecin de famille devrait partager le même environnement que ses patients. Ceci est mon concept préféré bien qu'il ressemble à une idée du style de David Attenborough mais il est tout à fait correct. Ian croyait qu'il est impossible de vraiment comprendre les besoins de santé et les soucis d'une communauté sans en faire partie soi-même. L'appartenance à la communauté nous permet de comprendre le contexte de la vie de nos patients et de leurs difficultés'.

7. Le médecin de famille voit des patients à domicile. Encore un aspect très important de notre travail qui nous confère un privilège extraordinaire et l'occasion de mieux comprendre le contexte de la vie de nos patients et les défis auxquels ils se confrontent chaque jour. Bien que les visites à domicile soient devenues moins courantes dans certaines régions du monde, elles ont réapparu par le développement des équipes de santé familiale dans quelques pays, et même par les services de télésanté, qui nous permettent au moins d'avoir un aperçu de nos patients dans leur propre environnement.

8. Le médecin de famille attache de l'importance aux aspects subjectifs de la médecine. Encore une des leçons importantes que nous apprenons comme médecins de famille. Faites confiance à vos instincts. Écoutez vos patients. Et écoutez particulièrement les personnes qui s'occupent de vos patients. N'ignorez jamais les soucis d'un parent concernant son enfant en bas âge. Ou les soucis d'un enfant en ce qui concerne un parent âgé.

Image : Dr Vikram Dalal, médecin de famille rural au centre de santé familiale de Thames Valley, Mount Brydges, Ontario, Canada

9. Le médecin de famille est un gestionnaire de ressources. Au début, je pensais que ce principe final était un peu aride, mais je réalise maintenant qu'il s'agit de l'une des contributions principales des médecins de famille aux nations. Par la limite judicieuse d'examens coûteux et par la gestion appropriée des ordonnances vers d'autres cliniciens et services, nous nous assurons que nos nations ont les finances disponibles pour donner à tous accès à la santé plutôt qu'à un seul sous-groupe privilégié.

Ces neuf principes d'apparence simple encapsulent notre rôle et notre contribution comme médecins de famille. Pour moi, ils constituent une partie de l'héritage considérable laissé par Ian, sa capacité à décrire avec une telle clarté le travail important que nous effectuons.

Quelques jours plus tard, mon supérieur, Neil Carson, me demanda ce que j'avais pensé du livre. Je lui dis que nous devrions l'utiliser pour l'enseignement. Il répondit qu'il y réfléchirait. Il demanda alors s'il pouvait récupérer le livre. Je le lui refusai et dis que je le gardais. Il comprit le message.

Comme médecins de famille, nous avons une dette envers nos professeurs, nos collègues médecins de famille, comme Ian, qui nous ont enseigné la pratique de la médecine dans nos communautés en employant une combinaison « de connaissance scientifique et de soins individualisés».

Michael Kidd
Président de WONCA

Article traduit de l'anglais par Josette Liebeck
Traductrice accréditée NAATI No 75800

Voir le texte complet du discours du Président en anglais

From the CEO's desk: recent and future meetings, and season's greetings

The end of yet another year! I'm sure Einstein's theory of relativity must offer an explanation, but time definitely goes faster as you get older!

The past few weeks have been extraordinarily hectic ones for WONCA, and many of us are looking forward very much to a quiet time with family and friends over the forthcoming break. Of course for many it is not a holiday time – including for the Secretariat staff – but I'm sure they won't begrudge us the chance to rest and to re-charge our batteries in preparation for a very busy 2016.

Last month I reported on the latest face-to-face meeting of the WONCA Executive, held in Istanbul just prior to the WONCA Europe conference. After Istanbul I travelled to Geneva to take part in two meetings at WHO HQ. The first was on cardiovascular disease and the second was on ageing and health.

Cardiovascular disease

We were reminded at the meeting that cardiovascular disease (CVD) is the 'Number 1' cause of death globally, and that over three quarters of CVD deaths take place in low- and middle-income countries. Of course people in low- and middle-income countries often do not have the benefit of integrated primary health care programmes for early detection and treatment, so they are often detected later in the course of the disease and die younger. The poorest people in low-and middle-income countries are affected most, and CVD is a key cause of poverty in these people due to catastrophic out-of-pocket expenditure.

There was considerable discussion about how best to reduce the burden of CVD. "Best buys" – very cost effective interventions which can be implemented even in low resource settings – have already been identified. These include such issues as comprehensive tobacco control policies; taxation to reduce the intake of foods high in fat, sugar and salt; building facilities such as walking

and cycle tracks to encourage physical activity; strategies to reduce the consumption of alcohol; and providing healthy school meals to school children.

I was heartened by the explicit recognition among all the experts present that primary health care had a really pivotal role to play in detection and management of these conditions, though I also pleaded for greater consensus among the many different organizations represented about clearer guidelines and protocols.

Ageing and Health
The second meeting was on ageing and health, and was timed to coincide with the launch of the first "*World report on ageing and health",* produced by Dr John Beard and his colleagues from the Ageing and Life Course Division of WHO.

Populations around the world are ageing rapidly, but there is actually very little evidence to suggest that increasing longevity is being accompanied by extended periods of good health. The report is built around a re-definition of healthy ageing that centres on the notion of functional ability, and it makes clear that this will not be achieved simply by doing more of what is already being done. What is needed is to redevelop systems to ensure coverage of integrated services without financial burden, that are centred on the needs and rights of older people, and to deliver care built around a common goal of functional ability.

Of course primary health care has a key role to play in delivery of these more person centered and integrated models of care, and – as in the CVD meeting – there was clear recognition of the importance of primary health care / family medicine in achieving the goals of the report. WONCA had contributed comments to the original drafts of the report, so has been involved in the development from a fairly early stage, and it was good to be mentioned on several occasions, with John Beard explicitly stating the importance of ever-closer collaboration with WONCA on issues of ageing and health.

The report is available on the WHO website and I encourage you to read through it http://www.who.int/ageing/publications/world-report-2015/en/

Conferences
We now look forward to the many events planned for 2016. The world conference in Rio de Janeiro is the "must-attend" event of the year, but there are also a number of regional conferences and events which deserve our support. I want to finish by highlighting four events in particular:

South Asia Region conference
in Colombo, Sri Lanka, from 11th to 14th February
www.woncasar2016.org

Eastern Mediterranean Region conference
in Dubai, 17th to 19th March
www.woncaemr2016.com

WONCA CIMF Summit and Mesoamerican conference
in San Jose, Costa Rica from 12th to 17th April

Europe Region conference
in Copenhagen from 15th to 18th June.
www.woncaeurope2016.com

May I finish by sending greetings from all of us at the WONCA Secretariat to all our members across the globe. We wish you all a Happy New Year for 2016 and look forward to meeting as many of you as possible at the various events throughout the year.

Dr Garth Manning, CEO

Policy Bite: Early years – the importance of family doctors in intervention and advocacy.

With Amanda Howe

One of the most heart wrenching aspects of the photos of refugees is the sight of small children trailing across deserts, being dragged into boats, or through police lines. Any family can be the victim of a tragedy, but the odds are stacked against children from lower income families: in the U.K., "*the most prevalent risk factors for psychological (and physical) ill health in children are low income (around 30% of children), linked directly to being a lone parent (24% of families), and living in social housing (27% of families). Factors relating to ethnicity (minority ethnic 7.9%), child factors (such as low birth weight 7-10%) and maternal factors (such as maternal age and smoking in pregnancy (17%) are less prevalent: and being of low income/socioeconomic status does further increase these additional risk factors.*" 1

As family doctors, we know we cannot generalise – that each child and family are different, and some can be wonderfully resilient in the face of considerable adversity. Many children from lower income families will have happy and nourishing upbringings – caring and protecting adults in family networks and communities can compensate for material challenges. Some of the biggest risks are to those whose families have to migrate for economic or safety reasons, and end up in big cities without social support. But these children, if identified early and supported in their use of education and health services, can grow and thrive. And this is where the role of strong primary health care teams who are local to communities and offer comprehensive services over time can play a crucial role.

One of the contributors in the rural track (*Clinical morbidity profile in Rural Chattisgarh* Dr Raman Kataria) of the recent highly successful and enjoyable Family Medicine Conference in Delhi, India, gave several case studies where the location of a community team enabled significant preventive and diagnostic work to be carried out in families who would otherwise probably have missed out on relevant care. Examples included diagnosis of TB in family members of a pregnant woman; children who were malnourished noticed by a health worker when visiting a relative; and the offer of rehabilitation to a young father with a previous spinal injury, which led to him being able to greatly improve his mobility. Contrast the situation of many people in India, which, in spite of its global status as an emerging economy, has low government spend on health care - and where innovations in health care development and financing have not yet achieved equitable access to good services2. Many have to pay out of pocket for health care, often also travelling long distances, and this means they are less likely to take up preventive care or present early to doctors.

Other barriers are that some health systems send child patients direct to paediatricians, which both undermines the status of family doctors and can decrease access to relevant knowledge of other family members. If the team caring for the child is outside the community, then local intelligence about emerging problems in households (such as job losses, alcohol abuse, or domestic violence) is lost to the clinicians, and the kinds of 'incidental' finding of problems illustrated above is also lost.

The new W.H.O. Sustainable Development Goals show that much of what is needed for excellent outcomes in child health goes beyond health care.

The U.K. has laid great emphasis on early years engagement with families who are 'socially' at risk3, and much of this is about education and economic facilitation. Nevertheless, the role of a local doctor and primary care team can do crucial work with individual families, to encourage engagement with services and manage risk4; collect data on health needs and ensure uptake by marginalised groups; and also to speak as advocates when services are inadequate or failing to meet the needs of their populations.

The subject for this policy bite appealed to me because I have a new grandchild – so the health of young children and the needs of their parents is vivid for me at present. It is also approaching Christmas in the U.K. – a public holiday which is linked with the story of the birth of Jesus when he was far from home and his parents had to rely for shelter on an innkeeper who allowed them to sleep in the stable. I know many of you will be doing your hard work for families and children's wellbeing every day; some of you are working with those taking temporary shelter in a foreign land; and all of you want your own families to thrive and flourish. Time spent on good care for children is a particular part of our mission as family doctors; they are our future. I know your patients will benefit, and hopefully be grateful, for all the help you can give.

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3. https://www.gov.uk/government/publications/2010-to-2015-government-policy-childcare-and-early-education/2010-to-2015-government-policy-childcare-and-early-education

4. http://www.rcgp.org.uk/~/media/Files/CIRC/Child-and-Adolescent-Health/NSPCC-child-maltreatment-report-July-2014.ashx

Fragmentos de política: Primeros años – la importancia de la intervención y la promoción para los médicos de familia

Uno de los aspectos más desgarradores de las fotos de los refugiados es el hecho de ver a niños pequeños arrastrándose a través de los desiertos, empujados a los botes o a través de las líneas de control policial. Cualquier familia puede ser víctima de una tragedia, pero los niños de las familias más humildes siempre tienen un mayor número de factores en contra: en el Reino Unido, "los factores de riesgo más predominantes para la salud psicológica (y física) de los niños son los ingresos bajos (entorno al 30% de los niños), relacionados directamente con el hecho de estar en una familia mono parental (24% de las familias), y vivir en un centro social (27% de las familias). Otros factores que tienen menos prevalencia son los factores relativos al origen étnico (las minorías étnicas representan el 7,9%), los factores propios de la infancia (tales como el infra peso en el nacimiento, 7-10% de los casos) y los factores maternos (como los de la edad o el hecho de fumar durante el embarazo, 17%): y el hecho de formar parte de un estatus socioeconómico bajo/con ingresos bajos lo que hace es aumentar estos factores de riesgo adicionales." [1]

Como médicos de familia, sabemos que no podemos generalizar – que cada niño y cada familia son diferentes, y que algunos pueden mostrar una capacidad de resistencia extraordinaria al hacer frente a adversidades considerables. Muchos niños provenientes de familias con ingresos bajos tienen una educación estimulante y feliz – el cuidado y la protección de los adultos en el seno de las redes familiares y comunitarias puede compensar las necesidades materiales. Alguno de los mayores riesgos son para los niños cuyas familias tienen que emigrar por razones económicas o de seguridad, y terminan en las grandes ciudades, sin apoyo social. Pero estos niños, si son identificados tempranamente y se les inculca la utilidad de la educación y de los servicios sanitarios, pueden crecer y prosperar. Y es aquí donde el rol de los equipos de una Atención Primaria fuerte que sean próximos a sus comunidades y ofrezcan servicios integrales en un tiempo sostenido puede ser crucial.

Uno de los colaboradores en el ámbito rural de la altamente exitosa y agradable Conferencia de Medicina Familiar en Nueva Delhi (India), mostró diversos estudios de casos en los que la ubicación de un equipo comunitario posibilitó un significativo trabajo preventivo y de diagnóstico realizado hacia familias que de otro modo no hubieran recibido ninguna asistencia significativa. Entre los ejemplos encontramos el diagnóstico de tuberculosis en la familia de una mujer embarazada; niños con malnutrición detectados por un trabajador de la salud al visitar a un familiar cercano; y el ofrecimiento de rehabilitación a un joven padre con una anterior lesión de columna, hecho que le permitió mejorar en gran medida su movilidad. Estos ejemplos se encuentran en contraste con la situación de mucha gente en la India, que, a pesar de ser una economía emergente tiene un gasto público muy bajo en el sistema sanitario – y dentro de la cual las innovaciones en la asistencia sanitaria y de financiación no han logrado aún conseguir un acceso equitativo a buenos servicios[2]. Mucha gente tiene que pagar la asistencia sanitaria de su propio bolsillo, a menudo tienen que desplazarse largas distancias, y esto significa que probablemente no tomen medidas preventivas o no se presenten a los médicos con suficiente antelación.

Otros obstáculos son que en algunos de los sistemas sanitarios se manda a los niños directamente a los pediatras, lo cual debilita el estatus de los médicos de familia y disminuye el acceso a un conocimiento relevante por parte de otros miembros de la familia. Si el equipo que se ocupa del niño es externo a la comunidad, entonces la habilidad para afrontar los problemas que surjan en los hogares (como por ejemplo la pérdida de trabajo, el abuso del alcohol o la violencia de género) se pierde por parte de los profesionales médicos, así como las problemáticas aparecidas "incidentalmente" que hemos ilustrado más arriba.

Los nuevos Objetivos de Desarrollo Sostenible de las Naciones Unidas (W.H.O. Sustainable Development Goals) muestran los elementos que son necesarios para la obtención de resultados excelentes en la salud infantil que van más allá de la asistencia en salud.

El Reino Unido ha puesto mucho énfasis en el compromiso durante los primeros años con las familias que se encuentran "socialmente" en riesgo[3], y gran parte de ello es a causa de la educación y las posibilidades económicas. A pesar de eso, el papel del médico local y del equipo de Atención Primaria puede desempeñar un trabajo

crucial con las familias a nivel individual, para estimularlas a comprometerse con los servicios y a saber gestionar los riesgos[4]; recoger datos de las necesidades sanitarias y asegurar el uso de la AP por parte de los grupos marginados; y también hablar como sus defensores cuando los servicios son inadecuados o no responden a las necesidades de la población.

La temática de este Fragmentos de política me atrae de una manera especial porque tengo un nuevo nieto – por eso la salud de la infancia y las necesidades de sus padres están muy vivas en mí en este momento. También se acercan las navidades en el Reino Unido – celebraciones populares relacionadas con la historia del nacimiento de Jesús cuando se encontraba lejos de casa y sus padres tuvieron que pedir refugio a una persona que les permitió dormir en un establo. Sé que muchos de vosotros estáis llevando a cabo un duro trabajo por el bienestar de los niños y las niñas y de sus familias todos los días; algunos de vosotros trabajáis con aquellos que se encuentran en un refugio provisional en una tierra extranjera; y todos vosotros queréis que vuestras propias familias prosperen y crezcan. El tiempo invertido en el buen cuidado de la infancia es una misión particular de nuestra tarea como médicos de familia; ellos son nuestro futuro. Sé que vuestros pacientes saldrán beneficiados, y espero que agradecidos, por toda la ayudo que podéis darles.

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Drs Ramnik and Jyoti Parekh – Lifetime Achievement Award

Last year we were delighted to feature Drs Ramnik and Jyoti Parekh of Mumbai, who had each taken out WONCA Life Direct Membership. We are even more delighted to announce that at the recent conference of AFPI (Academy of Family Physicians of India) Ramnik and Jyoti were awarded the first AFPI Lifetime Achievement Award in recognition of their enormous contribution to family medicine development in the South Asia Region. The award was made to the couple by the Union Health Minister of the Government of India, Mr JP Nadda.

AFPI has established this award, to be made annually, to acknowledge the contribution of senior family medicine leaders from India and the South Asia Region, and Ramnik and Jyoti were hailed as very worthy first winners.

But in turn Ramnik and Jyoti have displayed enormous generosity to young family doctors in the region. Firstly they have established an annual bursary of 100,000 Indian rupees, to enable young family doctors in the Spice Route Movement to attend regional conferences. They have followed this up by establishing a grant to pay for one young doctor leader, in each year that a suitable candidate is identified, to be given WONCA Life Direct Membership in recognition of their leadership in the region. The first recipient of this is Dr Sonia Mehra(Chery) who, with Ramnik, was instrumental in establishing the Spice Route Movement for South Asia young doctors in 2010. The second winner, for 2016, is Dr Raman Kumar, President of AFPI and the young doctor movement representative on the WONCA Executive.

We congratulate the two winners and thank Ramnik and Jyoti for these generous awards, which greatly help to motivate and recognise our young doctor leaders.

Read more about Ramnik
Read more about Jyoti

WHO call to protect health from climate change

Dear readers,
With less than two weeks away from the climate change negotiations in Paris (COP-21), please take a moment, if you haven't done so, and sign the WHO Call to Action on health and climate change and encourage your wider networks, friends, colleagues and other organizations to also sign.

Climate change has the potential to do serious harm to the health of individuals around the world. But tackling climate change could substantially reduce the risks while also improving human health by, for example, delivering cleaner air and healthier cities.
That's why WHO is asking you to support our call to action, with the aim at raising awareness of the health opportunities we can realise by tackling climate change now.

WHO call to action will be presented at the Paris COP and will demand a climate deal that delivers:
• Strong and effective action to limit climate change, and avoid unacceptable risks to global health.
• Scaling up of financing for adaptation to climate change: including public health measures to reduce the risks from extreme weather events, infectious disease, diminishing water supplies, and food insecurity, and
• Actions that both reduce climate change and improve health, including reducing the number of deaths from cancer, respiratory and cardiovascular diseases that are caused by air pollution (currently over 7 million per annum).

You can take action today by:
1. Signing the WHO Call to Action. Click here and sign.
2. Sharing it with your professional networks, friends and family.
3. Learning more about how acting on climate change could improve human health.

Read the WHO statement calling on countries to protect health from climate change.
View the WHO/UNFCCC climate and health country profiles and read the release.
Read the feature story from Bangladesh
Read the WHO commentary Our climate, our health: It's time for all health professionals to take action

I count on you and encourage you to join forces with us in the journey leading up to COP-21.

Best wishes,
Dr Maria Neira
Director
Department of Public Health, Environmental and Social Determinants of Health WHO

WONCA Working Parties and Groups

Rural Round-up: new elective for undergraduates in Germany

Jens Holst MD, from Germany is this month's Rural Round-up author. Jens specialised in internal medicine, and has a doctorate of Public Health. He is a consultant in health sciences and international cooperation and researcher on health policy, social health protection and health services research at various institutes, most recently at the Institute of General Practice and Family Medicine (until September 2015). He has longstanding experience as a university lecturer, and is currently deputising professor at the University of Applied Sciences Fulda / Germany. He writes about a new elective, undergraduate rural practice course at the University of Magdeburg.

The Institute of General and Family Medicine at the University of Magdeburg in Germany has recently implemented an elective short-term rural-practice programme for creating interest in general medicine and encouraging students to work in rural practice. The two-weekend-programme started in the summer semester 2014. The objective is to teach skills of rural medical practice, make students reflect their professional and personal goals and immerse or even engage students in rural life.

The two weekends comprise a full programme developed according to participants' expectations and applies a series of didactic tools such as presentations, interviews and discussions for bringing students closer to rural medical practice. Moderated discussions with various practitioners running different forms of rural practice in the region provided positive role models. The experience of different rural doctors´ life and work concept gave the students an idea of the social importance of their action in contrast to the technical rationality, which governs systems of instrumentality like the medical industrial complex in the context of tertiary and quaternary care of the university clinic.

Moreover, students had excellent opportunities to train specific communication skills for patient management and long-term care of patients or their families in the community. Discussions about structural issues of rural medical offices, necessary skills, workload and possible coping strategies of rural healthcare professionals accomplished the programme. Likewise students had the opportunity to get into practical skills such as manual therapy and yoga offered by a physiotherapist. The assessment performed directly after the second weekend showed that the likelihood of future rural practice had substantially increased. In the final evaluation, students appreciated particularly the diversity of topics and the seminar-like structure of the two weekend courses outside the faculty structure and rhythm.

Despite irrefutable shortage of rural practitioners, however, general practice and particularly rural health needs are still far away from being priority of the Magdeburg medical school, which is still dominated by tertiary and quaternary hospital care and largely overwhelmed by highly specialised basic research. The Institute of General Practice itself is still balancing priority setting between preparing students for overall general practice and a particular focus on the rural-practice track. And in general the interest of medical students in rural practice still offers much room for improvement. Regardless of existing obstacles, the two-weekend rural elective of the medical school in Magdeburg is promising to positively influence students' motivation to go for rural practice.

Jens Holst

Related publication:
Citation: Holst J, Normann O, Herrmann M. Strengthening training in rural practice in Germany: new approach for undergraduate medical curriculum towards sustaining rural health care. *Rural and Remote Health* 15: 3563. (Online) 2015. Available: http://www.rrh.org.au/

The VdGM Compass: Navigating the Sea of Soci@l Media

In the last five years we have become very familiar with the term “social media”. While many of us may find it difficult to remember a time before Facebook, Twitter, LinkedIn or WhatsApp, not all family doctors are engaged in social media.

Despite widespread use of “social media”, it remains in its infancy and many of us have a lot to learn. What is also true is that social media is here to stay, is almost certain to become increasingly used including amongst our patients, and like it or loathe it, we cannot afford to ignore it!

In delivering social media workshops over the last few years, it became patently obvious to the Vasco da Gama Movement (VdGM) that there were very few robust resources for family doctors that provide an overview of social media, how it should and can be used, the etiquette, the pros and cons, and the dos and donts.

In 2013, the a VdGM social media workshop at the 2013 WONCA Prague conference led a small group of enthusiastic VdGM social media users to have the idea of creating a social media resource for fellow Vasco da Gamians. Driven by the enthusiasm and passion of Ulrik Bak Kirk and Luís Pinho-Costa, with support from Harris Lygidakis, Raluca Zoitanu, Raquel Gomez-Bravo and others, the concept has now finally become a reality in the form of our VdGM ePDF Social Media Guide.

Our aims in creating this ePDF, through using actual case studies in peer-to-peer social media usage, were to empower family doctors, GP trainees and medical students, enabling them to make good use of social media, and to develop professional social media strategies that support the maintenance of a healthy work/life balance. Areas which are covered in the guide include social media myths, professional use of social media, social media trends and codes of conduct.

Our knowledge and understanding of social media has grown during a process which for those involved was a labour of love. Their journey has resulted in the creation of what we believe to be a very special ePDF guide, the process itself having been the actual product.

Finally, huge thanks are due to all authors of the chapters and all those who contributed their stories, to the multi-media designer Peter Lübben (visual & layout artist), who generously provided his expertise and time to craft the graphic content and layout, to Harris Lygidakis, Raluca Zoitanu, and Raquel Gomez-Bravo, and particularly to the main protagonists in this endeavour, Ulrik Bak Kirk (editor & vision/concept) and Luís Pinho-Costa.

We hereby invite you to download the ePDF The Vasco da Gama Movement Compass: Navigating the Sea of Soci@l Media (PDF, 5MB) launched during the 20th WONCA Europe Conference in Istanbul at the end of the "Social Media: An Exercise in Time Wasting for Young People?" VdGM-EQuiP panel.

Direct link to ePDF
Download small file for printing
Read more here

Peter A Sloane
President VdGM

Ulrik Bak Kirk
EQuiP Manager

Research Workshop at WONCA Istanbul

A one-day workshop on Research in Primary Health Care was organised by a joint collaboration between the European General Practice Research Network (EGPRN) and the Vasco da Gama Movement (VdGM) during the VdGM preconference (Istanbul, 21st October).

The main aim was to provide young family doctors and residents with the knowledge, skills and attitudes necessary to perform clinical research in a Primary Care setting. The specific objectives included to help participants formulate research questions, to provide a basic understanding of epidemiological methods and biostatistics, and to develop critical faculties for critical appraisal of the literature. The workshop was designed to achieve a balance between theoretical and practical learning, and between conceptual and factual material.

There were 30 participants from a number of European countries including Italy, Portugal, Ireland, United Kingdom, Belgium, Finland, Estonia, France and Germany, with an average age of 30 years. 53% were General Practice / Family Medicine (GP/FM) residents with the remainder being young family doctors.

The workshop contained about eight hours of teaching with regular breaks and adequate discussion time after each didactic session. The contents included 1) formulation of a research question, 2) consideration about writing and publishing, 3) quantitative methods, 4) qualitative methods, and, 5) literature research and critical appraisal of the literature.

At the end of the day, the participants were divided into four groups and challenged to design a research question inspired by a humorous question arising from their experience as VdGM preconference participants, and to suggest a suitable methodological approach. The next day, all groups shared their questions with all VdGM participants in the “Discussion Groups” session. Using their “humorous” questions as a starting point, all groups identified, outlined and discussed key concepts in research, including such factors as the importance of proper definition of the variables, awareness of bias and adjustment for confounding factors, and assessment of statistical significance.

A survey was conducted to understand the perspectives of young family doctors towards research and how prepared they feel to engage with research activity. Although 17.6% had previous research training during their medical degree, only 6% mentioned having had specific research training during FM/GP residency. Regarding publishing activity, 23.5% of the participants had already authored papers in the field of primary care. All participants considered that research training was a core competence of a family doctor, pointing out its relevance for personal development (76.5%), clinical decision making (76.5%), critical appraisal of the literature (64.7%) and for personal curricula improvement (47.1%).

Facilitators of the course were: Ferdinando Petrazzuoli, Nicola Buono, Laurence Coblentz-Baumann, Michael Harris and Hans Thulesius from the EGPRN Educational Committee, Ana Luisa Neves from the EGPRN Public Relations and Communications Committee and VdGM/EGPRN Liaison, and Jelle Stoffers, Editor-in-Chief of the European Journal of General Practice (EJGP). The course was made possible by collaboration between Jean Karl Soler (former EGPRN chair), Mehmet Ungan (former EGPRN vice-chair and new EGPRN chair), and Peter Sloane (VdGM President).

This seminal experience brought us closer to the needs of young GP/FMs regarding research. It highlighted the need for specific studies aimed at clarifying the differences and similarities between research training within Europe. Identifying existing strengths and weaknesses is a crucial first step in identifying key opportunities for further improvement in research within European family medicine, particularly for young family doctors.

Ana Luisa Neves (EGPRN Educational Committee), Ferdinando Petrazzuoli (EGPRN Public Relations and Communications Committee and VdGM/EGPRN Liaison), Peter Sloane (VdGM President).



Member Organization news

Report: 8th Spanish conference on patient safety in primary care

The eighth annual conference on patient safety in primary care took place on May 29, 2015 in Cruces Hospital in Baracaldo, Bilbao (Spain).

More than 300 primary care professionals met together to share patient safety activities, and to discuss and make new proposals to enhance patient safety in primary care.

This annual conference had the theme was "*Second victims: impact of adverse events on healthcare professionals*".

This conference was organised with the collaboration of four healthcare professional societies, Spanish Society of Family and Community Medicine (SEMFYC), Spanish Society of Healthcare Quality (SECA), Primary care and community Nursing Federation of Regional Associations (FAECAP), and Spanish Society of Primary Care Pharmacists (SEFAP); as well as the Basque Country Health Department and Osakidetza (Basque Health Service) and the Spanish Health Ministry.

The Opening lecture was delivered by Susan Scott, Missouri University, with the title *Nine years experience on giving support to second victims related to adverse effects.*
Scott SD, Hirschinger LE, Cox KR, McCoig M, et al. Caring for our own: deploying a system wide second victim rapid response team. *Jt Comm J Qual Patient Saf*. 2010;36 (5):233-240.

A round table to present different perspectives concerning patient safety in primary care took place afterwards. D Enrique Peiro introduced the Basque Country Strategy on Patient Safety. Dr Jose-Joaquin Mira (University Miguel Hernandez, Elche, Alicante) presented the first results of a national project which measures the impact of adverse events on health professionals and healthcare institutions. The final lecture was delivered by Dr Asier Urruela (University of Zaragoza) with a reflection about legal concerns on open disclosure to patients, reporting and learning systems and a proposal for improvement of patient safety culture on Spanish legislation.

A total of 40 scientific abstracts were received from different primary care teams all over Spain. Main topics were: safe use of medications, hand hygiene, reporting and learning systems and other safe clinical practices.

At the end, the "Fernando Palacio awards" for improvement of patient safety in primary care were awarded to the following projects: *"an*

experience of save use of high risk medication in primary care", "process management to support a safer immunization", and "an analysis of an safety incident in a practice".

Four workshops took place in the afternoon: Susan Scott ran a workshop on their institutional program to support second victims "For You Team". Lena Ferrus ran a workshop on role-playing for healthcare professionals to cope with an adverse event in the very initial moments. Sheila Sanchez ran a workshop on the management of FEMA (Failures and Effects Modal Analysis) to improve patient safety in a health centre. Elena Valverde gave a workshop on "*Wise prescription and de-prescription strategy for medications"*

You may find the scientific abstracts of this conference as well as the eight previous ones are in the following site: www.seguridadpaciente.com

Some of the lectures videos are available in the Spanish Society for Healthcare Quality (SECA) web site : www.calidadasistencial.com

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VIII jornadas españolas de seguridad del paciente en atención primaria

El pasado 29 de mayo de 2015 tuvieron lugar las VIII Jornadas de Seguridad del Paciente en Atención Primaria en el aulario docente del Hospital de Cruces en Baracaldo (Bilbao. España)

Más de 150 profesionales de la atención primaria para Atención Primaria para nos reunimos para analizar, debatir y hacer propuestas de mejora en relación con la seguridad del paciente en nuestro medio.

El objetivo de la jornada es el de mantener un foro de debate específico para abordar experiencias relacionadas con la seguridad del paciente en Atención Primaria. Esta vez analizando más en profundidad la atención a las segundas víctimas, los profesionales implicados en los eventos adversos tema que dio nombre a su: "*Segundas víctimas: El impacto de los efectos adversos en los profesionales*"

Como en ediciones anteriores las jornadas se organizan conjuntamente entre la Sociedad Española de Calidad Asistencial (SECA), la Sociedad Española de Medicina Familiar y Comunitaria (SEMFYC), la Federación de Asociaciones de Enfermería Comunitaria y de Atención Primaria (FAECAP) y la Sociedad Española de Farmacéuticos de Atención Primaria (SECAP). Además, este año se suman a la organización la Asociación Vasca para la Calidad Asistencial (AKEB), Osatzen (Sociedad Vasca de Medicina Familiar y Comunitaria) y la Consejería de Salud del Gobierno Vasco junto a Osakidetza (Servicio Vasco de Salud) y la Gerencia del Hospital de Cruces que nos facilita las instalaciones de su aulario docente para la celebración de la Jornada. Por último, también contamos con la colaboración del Ministerio de Sanidad, Política Social e Igualdad a través de la Dirección General de Salud Pública, Calidad e Innovación.

El tándem Seguridad del Paciente-Atención Primaria ya tiene un importante recorrido desde que celebramos nuestra primera jornada en San Sebastián en 2008 y, como cada año, será una

oportunidad para volver a vernos y aprender, compartiendo experiencias.

En esta edición, hemos contado con la participación de una de las investigadoras mundiales más destacadas en soporte a segundas víctimas: Doña Susan Scott, de la Universidad de Missouri que dio la conferencia inaugural con el título "*Experiencia de nueve años dando apoyo a las segundas victimas relacionadas con los efectos adversos*". Debemos destacar su artículo Scott SD, Hirschinger LE, Cox KR, McCoig M, et al. Caring for our own: deploying a system wide second victim rapid response team. *Jt Comm J Qual Patient Saf.* 2010; 36 (5):233-240.

En la mesa de ponencias hemos contado con la ponencia que narraba el despliegue de la Estrategia de Seguridad del Paciente en Osakidetza que nos ha presentado Don Enrique Peiró. En una segunda ponencia se ha presentado la experiencia investigadora en Segundas Víctimas del grupo liderado por el Profesor Mira y la Dra Lorenzo en España. Y para cerrar la mesa contamos con las aportaciones desde la perspectiva del derecho, en cuanto a la situación jurídica actual de la notificación de incidentes de seguridad del paciente de forma anónima, por parte del Profesor Asier Urruela Mora, de la Cátedra Interuniversitaria de Derecho y Genoma Humano de la Universidad de Zaragoza, Universidad del País Vasco y Universidad de Deusto.

Estas actividades unidas a todas las aportaciones que en forma de 40 comunicaciones sobre experiencias de equipos de atención primaria se han presentado han permitido conocer la situación de la seguridad del paciente en nuestro país.

En el acto de clausura del final de la mañana se entregaron los reconocimientos "Fernando Palacio a la mejora de la Seguridad del Paciente en Atención Primaria": 1. Premio a la mejor comunicación oral estándar: Vigilando de cerca a MARC. Primera autora: Leyre Remirez Simón. CS Huarte. Pamplona. Osasunbidea. 2. Premio a la mejor comunicación oral breve: La gestión de procesos, una herramienta útil para abordar la seguridad de la inmunización en Atención Primaria. Primera autora: *Asunción Cañada Dorado. Dirección de Calidad y Procesos asistenciales. Dirección de Atención Primaria. Servicio Madrileño de Salud. 3. Premio al mejor incidente que enseña: A propósito de un incidente de seguridad en un Equipo de Atención Primaria (EAP). Primera autora: M. Asunción Ibarra Carcamo. osi ezkerraldea-enkarterri-h.cruces.*

Por la tarde tuvieron lugar los talleres, todos ellos trataron temas interesantes y no fueron sesiones magistrales de los ponentes, sino que pudieron practicar sobre Análisis Modal de Fallos y Efectos (AMFE), role-playing en la atención a las segundas víctimas, etc. Uno de los talleres se desarrolló en inglés Taller 1: "*Taller práctico de soporte de segundas víctimas*" por la propia Susan Scott, Universidad de Missouri que compartió los aspectos prácticos de su programa de soporte a segundas víctimas: "*For you team".* Siguiendo con el lema de segundas víctimas, las investigadoras del grupo del Dr Mira, desarrollaron un taller sobre la confección de videos comparando cómo debe darse una noticia de un evento adverso y cómo no, de tal forma que sirva de aprendizaje. Fue el taller 2: "*Role playing sobre segundas víctimas*" impartido por Lena Ferrus-Estopa, enfermera consultora de la Univ Pompeu Fabra y su equipo de actrices y psicologa.

El Taller 3: "*Uso del AMFE como herramienta prospectiva y sistemática para la identificación y prevención de problemas de seguridad clínica en los procesos clínicos*" impartido por Sheila Sanchez Gomez propuso el AMFE como herramienta que permite hacer cambios en la organización para reducir la probabilidad de nuevos eventos adversos.

Finalmente el Taller 4: *"Prescripción prudente y deprescripción de medicamentos*" impartido por Elena Valverde Bilbao. Amaia Mendizábal-Olaizola. Farmacéuticas de OSI Bidasoa-Osakidetza aportó propuestas para mejorar la prescripción de medicamentos en atención primaria.

Tras la jornada se ha creado un repositorio de comunicaciones en la página web: www.seguridadpaciente.com
Las videograbaciones de las ponencias están accesibles en la página web de SECA: www.calidadasistencial.com gracias a la grabación y edición del servicio de audiovisuales del Hospital de Cruces, Osakidetza.

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twitter: @sanoysalvoblog

Canadian College's new governance structure and board.

Français

CFPC Membership Approves New National Governance Structure

(Toronto, ON, November 12, 2015) – At the Annual Meeting of Members (AMM) of the College of Family Physicians of Canada (CFPC), members voted to approve a new governance structure for the College that will see a transition to a smaller skills-based Board of Directors.

"We are very excited to have the new governance structure approved by our members," says CFPC President, Garey Mazowita, MD, CCFP, FCFP. "Commitments to follow best governance practices created the opportunity for change in order to ensure continued accountability as well as timely and effective governance, enhance responsiveness, and increase opportunities for member engagement."

"We want to thank the members of the CFPC's Governance Advisory Committee for their tremendous work to research and develop a proposal to best meet the governance requirements of our College," adds Executive Director and CEO, Francine Lemire, MD CM, CCFP, FCFP, CAE. "We also appreciate the insightful contributions received from CFPC members, Chapters and stakeholders through the extensive communications that were held over the past year. We are moving to a structure and process that will both result in effective governance, and maximize the rich input from our volunteers by engaging them strategically."

The new Board membership will reflect the breadth of experiences of Canadian physicians based on: geographic differences; health system differences; practice models; stages of practice (there is a requirement is for an individual in his/her early years of practice or residency); and demographics.

The new governance structure will be evaluated on an ongoing basis to assess its effectiveness with input from a variety of stakeholders.

The 2015-2016 Board of Directors:
Tom Bailey, MD, CCFP, FCFP, Director-at-Large
Guillaume Charbonneau, MD, CCFP, Secretary-Treasurer
Cathy Faulds, MD, CCFP, FCFP, Director-at-Large
Jennifer Hall, MD, CCFP, FCFP, President
Stephen Hawrylyshyn, MD, CCFP, Director-at-Large
Yordan Karaivanov, MD, CCFP, FCFP, Director-at-Large
Nadia Knarr, MD, CCFP, Director-at-Large
John Maxted, MD, CCFP, FCFP, Director-at-Large
Garey Mazowita, MD, CCFP, FCFP, Past-President
Paul Sawchuk, MD, CCFP, FCFP, Director-at-Large
David White, MD, CCFP, FCFP, President-Elect
Francine Lemire, MD CM, CCFP, FCFP, Executive Director and Chief Executive Officer (non-voting)

Brief biographies of the new CFPC Board members are available on the CFPC website.
To view the governance proposal that was approved please see this page.

The AMM was held at the Metro Toronto Convention Centre as part the CFPC's annual Family Medicine Forum held November 11-15, 2015.

The CFPC represents more than 35,000 members across the country. It is the professional organization responsible for establishing standards for the training and certification of family physicians. The CFPC reviews and accredits continuing professional development programs and materials that enable family physicians to meet certification and licencing requirements and lifelong learning interests. It also accredits postgraduate family medicine training in Canada's 17 medical schools. The College provides quality services, supports family medicine teaching and research, and advocates on behalf of family physicians and the specialty of family medicine.

If further information is required about the new CFPC Board, please contact Sarah Scott, Director, Governance and Strategic Planning at sscott@cfpc.ca

Jayne Johnston,
Director, Communications
College of Family Physicians of Canada
jjohnston@cfpc.ca
www.cfpc.ca

semFYC : la Asamblea de WONCA Europa en Estambul

La Sociedad Española de Medicina de Familia y Comunitaria (semFYC) participó en la Asamblea y en el Congreso anuales celebrado en Estambul de WONCA Europa como miembro de las 45 organizaciones representadas por WONCA en toda Europa. La semFYC es la única sociedad científica de Medicina de Familia y Comunitaria española con representación en los organismos y comités mundiales de WONCA y sus miembros se encuentran en todos los grupos de trabajo de la entidad internacional. Además, la semFYC, es uno de sus activos más valiosos.

En este sentido, este año ha sido un socio de la Sociedad, Josep Maria Vilaseca, quien ha sido elegido nuevo miembro del WONCA Europe Finance Committe y la semFYC mostró su compromiso y su voluntad de colaboración erigiéndose como la primera sociedad científica del Congreso en cuanto a número de congresistas, volumen de actividad y comunicaciones.

Entre las propuestas que se presentaron y que se debatieron en el WONCA Europe Council por parte de la semFYC destacamos la del Easy English, que defendió José Miguel Bueno, para evitar las barreras lingüísticas de la lengua inglesa, única lengua oficial, solicitando que "se hable despacio, sencillo y claro para que los congresistas puedan entender y participar en el Congreso más fácilmente, realizando por parte del moderador resúmenes periódicos de los contenidos que faciliten la participación activa de los delegados no anglo parlantes."La propuesta fue aprobada por unanimidad por la asamblea del órgano de gobierno y también se presentará en la Asamblea Mundial del próximo noviembre del 2016 en el seno del WONCA World Council que tendrá lugar en Río de Janeiro.

Otra de las propuestas presentadas fue la de Penosidad laboral, en que se denunciaban las precarias condiciones de trabajo a las que tienen que someterse los profesionales de la especialidad.

Manifiesto de Estambul

Por otro lado, el manifiesto redactado en Estambul por parte de WONCA Europa y de la semFYC, expone la necesidad de:

• **Reconocer** la crisis de los refugiados actuales como la mayor crisis humanitaria del continente europeo desde la Segunda Guerra Mundial.

• **Reconocer** sus efectos devastadores en la salud de los refugiados.

• **Mostrar** nuestra preocupación ante las nuevas prioridades en materia de salud pública y ante los retos que el personal de Atención Primaria debe afrontar.

Por esta razón, la semFYC, el presidente de WONCA Europa, el profesor Job Metsemakers, y el presidente de la Asociación Turca de Médicos de Familia (TAHUD), el profesor Okay Basak, como máximo representante del país anfitrión, hacen un llamamiento a todas las organizaciones miembros para:

1. Urgir a los gobiernos a tomar medidas con el fin de que todas las personas que viven de forma permanente o temporal en Europa tengan acceso a servicios equitativos, asequibles y de salud de alta calidad.

2. Reafirmar el compromiso de que el apoyo y el asesoramiento de WONCA Europa deben ser necesarios para la toma de decisiones.

3. Promover la estrecha colaboración con los gobiernos, responsables políticos y organizaciones no gubernamentales para un mayor desarrollo y fortalecimiento de los recursos humanos e institucionales para la Medicina de Familia, con el fin de que el suministro sostenible y ininterrumpido de la atención sanitaria esté garantizado;

4. Recomendar, cuando pueda practicarse, la realización del examen médico previo a la salida, la adecuada comunicación, protocolos de coordinación y presentación de informes posteriores a la llegada y durante el seguimiento para garantizar el desplazamiento seguro y la reasentamiento de los refugiados;

5. Reconocer el riesgo de violencia, con sus muchas formas y sus efectos en esta población vulnerable;

6. Invitar a los médicos de familia a proteger e identificar rápidamente los casos de violencia y abuso, y a prevenir e intervenir en colaboración con las autoridades pertinentes y los recursos de la comunidad;

7. Enfatizar la importancia de la educación médica reconociendo la epidemiología cambiante de Europa y de sus países vecinos, y los determinantes sociales en salud.

8. Recomendar la capacitación adecuada de los médicos de familia sobre las diferencias culturales, las tendencias de las enfermedades infecciosas en evolución, los problemas de salud mental de los refugiados, y las necesidades especiales de los niños huérfanos y otros inmigrantes menores de edad que viajan sin la compañía de sus familiares;

9. Dar forma al estudio, a la formación y al desarrollo profesional continuo necesarios para atender las necesidades inmediatas del personal sanitario mientras la crisis aumente;

En 2015, TAHUD, la asociación turca de los médicos de familia, celebra su 25 aniversario y WONCA Europa cumple 20 años. Durante este tiempo hemos estado fomentando la asistencia en Medicina de Familia a todas las familias y comunidades de Turquía y en Europa como un conjunto. Dado que la posición de los médicos de familia se reconoce cada vez más en muchos países, somos conscientes de que más ciudadanos están recibiendo la atención de calidad que necesitan cerca de sus casas. Los médicos de familia ofrecen servicios a las personas y a las sociedades sin condiciones y sobre la base de un conjunto de valores fundamentales, independientemente de su sexo, edad, etnia, nacionalidad, orientación sexual o religión.
Sin embargo, aún se puede lograr mucho más.

Tanto WONCA Europa como la semFYC se reafirman en que los médicos de familia europeos están dispuestos a desempeñar un papel importante en la prestación de servicios de alta calidad y de salud al alcance de toda la población europea actual y futura.

En este sentido, el presidente de la semFYC Josep Basora quiere remarcar que: "Creemos firmemente que cada ser humano tiene el derecho a la paz y abogamos por acciones para su logro en nuestra región y en el mundo entero."

Manifiesto de EstanbulIstanbul Statement (English)
Traducción: Pere Vilanova, Spanish Society of Family and Community Medicine (semFYC) - Periodismo y comunicación

Featured Doctors

Dr Jennifer HALL: Canada

Dr Jennifer Hall has recently taken over as president of the College of Family Physicians of Canada (CFPC).

What work do you do currently?

In addition to my role as CFPC president, I practice part time family medicine in a comprehensive group practice in Saint John, NB. In addition I am Associate Dean Dalhousie Medicine New Brunswick (DMNB) . DMNB is the distributed medical education campus for Dalhousie University for undergraduate, postgraduate and research.

What other interesting activities that you have been involved in?

I am a teacher for Dalhousie Family Medicine.

What are your interests as a family physician and also outside work?

I have a strong interest in palliative care and making housecalls. Outside of work, I enjoy hiking, biking, snowshoeing and travelling with my husband.

What are your aspirations as the new President of the CFPC?

I am looking forward to meeting with members across Canada including students and residents, and working hard to ensure that the educational goals of the CFPC align with the practice needs of family doctors and the needs of our patients in the community.

Announcement from the CFPC

The CFPC welcomes Dr Jennifer Hall as its 2015-2016 President

Dr Jennifer Hall of Rothesay, New Brunswick, was welcomed as the 62nd President of the College of Family Physicians of Canada (CFPC) on November 13, 2015 during the annual Family Medicine Forum in Toronto, Ontario.

Moved by the deep compassion and care shown by a Saint John family physician to his patients during difficult times, Dr Hall was inspired to pursue a career in family medicine. She set a goal for herself: to emulate that same compassion with her patients, and hold herself to the same high standard of care.

Dr Hall received her Masters of Science in Toxicology from Memorial University of Newfoundland in 1987 and her medical degree in 1992. In 1994, she earned Certification in Family Medicine (CCFP) and became a Fellow (FCFP) of the College in 2005.

Dr Hall's passion for family medicine has translated into her extensive work with academia. After beginning her career at Memorial University, she moved to New Brunswick and soon took on the role of Residency Program Director with Dalhousie University. Dr Hall continues her work there as Associate Dean Dalhousie Medicine New Brunswick, a position Dr Hall began in January 2015. She is also a preceptor to undergraduate medical students and residents at Dalhousie and Memorial.

Since 2002, Dr Hall has provided comprehensive family medicine–including palliative care–with the Horizon Health Network, Saint John Zone. In the 1990's she also practised with the Memorial University Department of Family Medicine and worked as Clinical Chief of Palliative Medicine at the Health Care Corporation in St. John's, Newfoundland.

In 2004, Dr Hall began working with other educators to transform the family medicine rounds format at the Saint John Regional Hospital. Her work led to the creation of a continuing professional development program that uses evidence-based exercises to answer questions that arise from everyday practice. This activity brought family medicine residents and community family physicians together to learn.

In 2010, she collaborated with family medicine program leaders and educators to support the development of the Dalhousie University Family Medicine Residency Site on Prince Edward Island. Dr Hall worked with local clinical educators on the development of the university's first three-year integrated family medicine-emergency medicine program based in Saint John.

Dr. Hall served as the Saint John Site Director of the Dalhousie Family Medicine Program from 2004 to 2009. From 2000 to 2004, she participated as a board member of the Canadian Society of Palliative Care Physicians. She continues to be actively involved as a member of several committees with the Faculty of Medicine at Dalhousie University.

For the past 10 years, Dr Hall has held many leadership roles with the CFPC which have enhanced her knowledge and experience with College programs and services. She has participated with numerous CFPC committees including the Accreditation Committee, the Red Book Accreditation Standards Revision Committee, and a number of residency program accreditation surveys. For five years, she served on the Board of the New Brunswick Chapter representing continuing professional development interests. Dr Hall became a member of the CFPC's National Executive Committee in 2012 as Member-at-Large and subsequently served as Honorary Secretary-Treasurer. In 2014-2015, she served as Chair and President-Elect.

"It's a tremendous honour to have the opportunity to serve as CFPC President during this exciting time of change," says Dr. Hall. "The proposed changes to the College's governance as well as the major enhancements to programs and services will take the value of membership to a new level– a level that will provide an enhanced level of support for a stronger family medicine presence across the country."

In 2010, Dr Hall was acknowledged by the CFPC as the Family Physician of the Year for New Brunswick with the Reg L. Perkin Award. She received the Gus Rowe Teaching Award for Family Medicine Discipline from Memorial University of Newfoundland in 1998 and 2002, and a CFPC Award of Excellence in 2008.

Dr Hall grew up in Saint John, New Brunswick and has one younger brother, Richard. In her spare time, she enjoys cycling, travelling, playing Bridge (poorly), and hiking with her husband, David Methven–a fish ecologist whom she has been married to for 26 years–and their two dogs, River and Brook.

Dr Shastri MOTILAL: Trinidad

Dr Shastri Motilal MBBS (Hons), DM Fam-Med, from Trinidad, is the WONCA North America region (Caribbean College of Family Physicians) Montegut Scholar for 2015 and represented the College at the WONCA Polaris preconference in Denver, Colorado in October 2015. He is also the coordinator chosen by the CCFP for our Caribbean Polaris Group, the group of young and new family doctors that practice in the non-Spanish speaking Caribbean. He is an Honours graduate of the University of the West Indies, having completed the DM in Family Medicine.

What has your path been in Family Medicine?

I grew up in Spring Village, Valsayn, Trinidad where I started UWI, St Augustine Campus in 1998 after winning a scholarship from Fatima College. I completed M.B,B.S. with Honours in 2003 and started internship at Port of Spain General Hospital in July 2003.

After 1½ years internship I joined the North Central Regional Health Authority as a house officer in Emergency room where I spent almost two years before being accepted for the training Family Medicine. I worked thereafter in the St Joseph Health Centre where I received most of my primary care experience and training. During this time I interacted with clinical medical students and started teaching final year medical students as an Associate Lecturer (part time) with University West Indies (UWI) which I really enjoyed.

Finally I took up a post of lecturing full time in Family Medicine. As a UWI staff member my duties involve teaching at both the undergraduate and postgraduate levels in family medicine. What also comes with the position are responsibilities for correcting and attending examinations both locally and regionally. I am also involved in research.

Although I resigned from the public service I still practice clinical medicine. I had started my private practice in October 2009 in Kelly Village, Caroni, Trinidad. It is a rural community that has been gradually developing over the last couple of years. I work there part time (roughly 20 hours a week) and see a range of patients with the common ailments that would present to any general practice service. I have a keen interest in procedures (intra-articular/ intra-lesional injections, ECG's, electro-cautery skin lesions) and minor surgery (removal of lumps and bumps) which I do every week.

What are your special interests outside of work ?

Music Keyboard (Piano), Meditation.

I love musical instruments like the piano and guitar and I play as a novice. Meditation has gained my greatest interest over the past decade and I see it as the secret to true happiness and enlightenment. I grew up in a Hindu home and celebrate the major festivals however when asked my religion I prefer to describe myself as Spiritual. Another area of interest has been where medicine and spirituality meet in form of Regression Therapy. This is something I aspire to do and I read books on the topic. I think it has huge potential for curing lots of symptoms that traditionally we as physicians cannot explain after using the biomedical approach we were taught in medical school. I hope someday to practice this..

What does being a family doctor mean to you, especially in the context of family medicine in your country?

Being a Family Doctor is more than just delivering a service where I try to aspire to best practice in caring for a wide range of patients. Having served both in the public setting (past nine years) and private setting (past 3 years) my wealth of experience has come from dealing with people from the different cultural and socio-economic groups.

Primary care to me has been about making a difference in patients' lives. I look at it as not only a Medical Science but an art form where the human touch can be introduced into every patient encounter. In this regard I believe together all of us are capable of transforming our patients for better and by extension our nation.

Read news item on Shastri's Montegut Scholar experience

Conferences 2016

WONCA SAR - Sri Lanka heading for a big bang in February

The WONCA South Asia Region conference organisers are planning an exciting conference in Colombo from 12 to 14 February, 2016. (preconference workshops 11- 12 February).

It will be a interesting programme highlighting current issues in the South Asian region and focussing the role of the family physician in primary health care and the way forward in keeping with the theme "*Reaching Across the shores to Strengthen Primary Care*" .

Many key speakers are invited to conduct workshops, symposia and guest lectures on vital topics to sensitise and create awareness amongst the GPs in South Asia on such topics as Global Health, Universal Health Coverage, SDG's, NCD and CKD in South Asia, Research in Primary Care etc.

There will be many events on the social programme -the Inauguration Ceremony followed by a cultural programme and cocktail party (All international delegates are requested to bring along their national costumes for the opening ceremony); the Grand Banquet (optional), the Conference Banquet (tickets available at registration desk) and sightseeing tours within and outside the city.

In addition the official conference tour organisers Jetwing Travels have planned many exciting tours to see beautiful Sri Lanka at special package prices for registrants. The interest shown by many WONCA members from the region and all over the world to attend and participate in this conference is encouraging. Please visit our website http://www.woncasar2016.org for more details.

If you have not already registered, now is the time to catch the 'Early Bird"!! (EARLY BIRD REGISTRATION UNTIL JANUARY 1)

Looking forward to see you in sunny Sri Lanka!!

Preethi Wijegoonewardene,
Chair-HOC

Visit us in Copenhagen 15 - 18 June 2016

WONCA Europe Conference 2016

Dear family medicine colleagues,

Many GPs are already looking very much forward to the WONCA Europe Conference in June 2016 in Copenhagen. Several groups and individuals have expressed their positive interest in contributing to the themes and the issues addressed by the keynote speakers; high quality expertise within important aspects of future family medicine (www.woncaeurope2016.com).

We have already received a promisingly high number of abstract submissions and we hope you are considering submitting your abstract to the congress. The deadline for abstract submission is 15 January 2016, so there is still time – But suddenly it is Christmas and then New Year.

Submit your abstract

Would you like to become part of our team of reviewers? Join the acknowledged reviewer panel and contribute with your valuable input the content we are going to present in Copenhagen in June 2016.
Use this link to sign up for the reviewer panel

For all Special Interest Groups, networks or other specific groups, please see WONCA Europe 2016 themes for contributing to the WONCA Europe 2016 in Copenhagen.

(If you have not already signed up directly for our WONCA Europe 2016 newsletter this can be done here)

Peter Vedsted
President of Scientific Committee

Roar Maagaard
President of Host Organising Committee

Contact the secretariat:
secretariat@woncaeurope2016.com

FAMILY DOCTORS
with heads and hearts
WONCA EUROPE CONFERENCE 15-18 JUNE 2016 • Copenhagen • Denmark

17-19 MARCH 2016
DUBAI | UNITED ARAB EMIRATES

WONCA EMR Submit your abstract

Be part of the Scientific Program at WONCA EMR 2016

The scientific committee of 3rd WONCA East Mediterranean Region Family Medicine Congress 2016 invites presenters worldwide to submit abstracts to be presented as an oral or poster presentation at WONCA EMR 2016 being held from 17 – 19 March 2016 in Dubai, United Arab Emirates.

Important Deadlines:
Abstract submission: December 30, 2015
Early bird Registration: January 31, 2016

Abstract Topics:
- Health Policies and Management
- Ethical Issues
- Continuous Medical Education
- Research in family Medicine
- Quality and Accreditation
- Nursing in PHC
- Non-Communicable Diseases
- Communicable Diseases
- Mother and Child Care
- Geriatric Care
- Preventative Care and Health Promotion
- Women and Men's Health
- Palliative Care
- Abuse and Violence
- Musculoskeletal Health
- Clinical Audit
- Evidence Based Medicine
- Age Related Screening
- Undifferentiated Illness

Conference Website

WONCA Rio workshop abstracts close Feb 1

Abstracts for workshops, panels and symposia for the WONCA World conference coming to Rio next year close on February 1, 2016. (New extension of time announced 24 October).
Submit abstract
For posters and oral presentations the deadline for abstracts is February 1, 2016
Submit abstract
The Host Organizing committee is also accepting abstracts for cultural activities, deadline February 1, 2016
Submit activity

Definition of panels, symposia and workshops.
- **Panel** (1-2 hours)
A panel discussion is a situation in which a group of people are gathered together to discuss an issue, often to provide feedback on something, to brainstorm solutions to a problem or to discuss an issue of public concern in front of an audience.

- **Symposium** (20-30 minutes)
A Symposium is a formal meeting at which experts discuss a particular topic. Information about different aspects of the topic considering the best evidence and state of art should be provided within the symposium. The speakers should prepare proper slides to assist their presentation within the specified time limits.

- **Workshop** (2-4 hours)
A meeting at which a group of people engage in intensive discussion and activity on a particular subject or project, by emphasizing on exchange of ideas and the demonstration, and application of techniques, skills, etc. Workshops may have a small presentation but most of the time should be used for group discussions.
Conference website

WONCA CONFERENCES 2016

February 13-14, 2016	WONCA South Asia region conference	Colombo, SRI LANKA	http://woncasar2016.org/
March 17-19, 2016	WONCA East Mediterranean region conference	Dubai UAE	woncaemr2016.com
April 11-17, 2016	WONCA Iberoamericana-CIMF summit & Mesoamerican conference	San Jose COSTA RICA	Save the dates!
June 15-18, 2016 June 14-15,2016	WONCA Europe Region conference and VdGM preconference	Copenhagen, DENMARK	www.woncaeurope2016.com
September 14-16, 2016	3rd Vasco da Gama forum	Jerusalem, ISRAEL	3rdforumvdgm
November 2-6, 2016	WONCA WORLD CONFERENCE	Rio de Janeiro, BRAZIL	www.wonca2016.com

- WONCA Direct Members enjoy *lower* conference registration fees.
- To join WONCA go to: http://www.globalfamilydoctor.com/AboutWONCA/Membership1.aspx

WONCA CONFERENCES 2017

April 30 – May 3, 2017	WONCA World Rural Health conference	Cairns, AUSTRALIA	Save the dates!
June 28 – July 1, 2017	WONCA Europe Region conference	Prague, CZECH REPUBLIC	Save the dates!
November 1-4, 2017	WONCA Asia Pacific Region conference	Pattaya City, THAILAND	Save the dates!

WONCA ENDORSED EVENTS 2016

10 Apr - 13 Apr 2016

9th Geneva conference on person-centred medicine

Geneva, Switzerland

MEMBER ORGANIZATION EVENTS

For more information on Member Organization events go to
http://www.globalfamilydoctor.com/Conferences/MemberOrganizationEvents.aspx

31 Mar - 02 Apr 2016	10th Congress of General Practice France Paris, France
22 Apr - 23 Apr 2016	49th EQuiP assmbly meeting Prague, Czech Republic
30 Apr - 04 May 2016	STFM Annual Spring Conference Minneapolis, Minnesota, USA
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20 May - 24 May 2016	EGPRN meeting Tel Aviv, Israel
09 Jun - 11 Jun 2016	36 CONGRESO SEMFYC La Coruña, Spain
26 Jul - 30 Jul 2016	The Network: Towards Unity for Health conference Shenyang, China
28 Jul - 31 Jul 2016	RNZCGP conference for general practice Auckland, New Zealand
04 Sep - 06 Sep 2016	European Forum for Primary Care conference Riga, Latvia
20 Sep - 24 Sep 2016	AAFP Family Medicine Experience Orlando, Florida, USA
29 Sep - 01 Oct 2016	RACGP GP 16 conference Perth, Australia
06 Oct - 08 Oct 2016	RCGP annual primary care conference Harrogate, United Kingdom
20 Oct - 22 Oct 2016	Rural Medicine Australia 2016 Canberra, Australia