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From the President: the Value of Vasco

A recent trip to speak at a meeting in Aveiro, Portugal took me 1000 years. The actual travel time was about 24 hours. The meeting lasted three days. Yet, the journey gave me a chance to reflect back on the life of Vasco da Gama 500 years ago. It also inspired me to look ahead 500 years into the future.

The ostensible purpose of my visit was to attend the 30º Encontro Nacional de MGF (30th National Meeting of General and Family Doctors) of the Associação Portuguesa de Medicina Geral e Familiar (APMGF). Portugal has a population of about 10 million people and 40,000 doctors. APMGF has 4000 members out of the 5700 Portuguese family doctors. Women comprise an estimated 80% of family medicine physicians and trainees. Post-graduate training involves 4 years. There are about 400 new trainees each year; they represent about one quarter of medical school graduates.

A primary care team in Portugal consists typically of a physician, nurse, and administrative assistant. Reforms were adopted in 2005 that provide several options for the organization and payment of primary care. The traditional model (Unidade de Cuidados de Saúde Personalizados or “USCP”) usually has a general doctor who works with a team constituted by the health services. There are three models under the reform program (Unidade de Saúde Familiar or "USF"): models A, B, and C All USF practices are permitted to select their own team members, starting with Model A. In Model B, there are financial rewards if certain performance targets are achieved. Model C has not yet been implemented, but envisions private groups of doctors coming together to contract with government, similar to a cooperative. Depending on the practice setting, family doctors earn anywhere from 1800 (traditional) to 4000 (Model B) Euros per month, compared to the 800 Euros earned monthly by the average Portuguese worker.

Difficult days

The past few years have not been easy for Portugal. The fiscal crisis has prompted a number of austerity measures. Unemployment is at about 15%. Health spending by government has been cut 9%. As civil servants, the relative impact on family doctors has been even greater with some experiencing pay decreases of up to 30%. I expected to find angry and discouraged Portuguese family physicians at the Encontro or in the health centers I visited. I was wrong.

Mini Hippokrates - at the beach. / Mini Hippokrates en la playa

While there was concern and frustration, the general mood was one of confidence and solidarity. The family doctors described their financial stresses as a reflection of the economic pain shared by all Portuguese. They felt an even greater sense of responsibility for the health of their patients and the success of the health system during these trying times. In short, they demonstrated something that is desperately needed, but not always found: leadership.

Watching primary care work

I visited the Aveiro Health Center, which is the main primary care facility in Aveiro. It was surprising to find all three operational models located in the same facility. There were two USCP (traditional) practices and two USF practices (one Model A and one Model B), each occupying its own wing of the building. Each practice consisted of 6-8 doctors and was responsible for about 15,000 patients, who were generally assigned to a practice team. The health center was open every day from 0800 to 2000. Those needing services outside of usual hours were referred to the hospital.

The facility was clean and well equipped. Each of the four wings had its own color, which was reinforced by the color of the trim on the uniforms worn by staff. It was interesting to note that the amenities were slightly nicer in

the Model B wing, followed by the Model A and then the traditional wings. In other words, even under the same primary care health system and working in the same building, it appeared that the practices that were more autonomous and performance-focused received more funds because they presumably delivered better outcomes and higher patient satisfaction. Some concern was expressed about potential inequities resulting from these various models, especially when they were all located under one roof.

Dra Veronica Colaco and Prof Rich Roberts. Notice the purple trim on her coat, which is her unit's color.

La Dra Veronica Colaco y el profesor Rich roberts. Destaca el ribete purpura en su bata, que es el color de su unidad

Dra Veronica with newborn and parents.

La Dra Veronica con un recien nacido y sus padres

In the USF Flor de Sal wing (Model A), Dra Veronica Colaço served as my host. During a typical work day, which consists of seven hours of consultations, she will see 20-30 patients. She showed me the electronic health record system, which facilitates the ready exchange of information between health centers and hospitals. She kindly allowed me to observe her with patients, which included a newborn baby brought in by her parents to establish care. I was pleased to see that Dra Colaço provided care to all age groups for a wide range of problems, including minor surgery. I also spoke about training in Portugal with Dra Joana Cristina Diaz, the director for residency training at the Aveiro Health Center. At the time of my visit, the Center had eight trainees ("internos") six in Family Medicine and two in general residency, as well as two nursing students.

Overall, I came away impressed with the Portuguese primary care system. The family doctors seemed well trained and highly motivated. They appeared to be eager, and more likely, to provide a wider range of services to entire families, while having a reasonable amount of time per consultation (about 15 minutes). Other systems often limit family doctors to certain age groups (e.g., adults only) or limit their consultation time to 3-5 minutes per patient. These limits reduce the positive impact that family doctors can have on the health of their patients and communities

Back to Vasco

Another of my pleasant duties in Aveiro was to speak to the Portuguese arm of the Vasco da Gama Movement (VdGM), named after one of the most celebrated explorers of the Age of Discovery. Founded in 2005, VdGM (www.vdgm.eu) was the first multi-national group in the world formed by and for young family doctors in the European region. VdGM promotes education and training, Hippokrates exchanges, exchanges beyond Europe (especially Canada and Latin America), research, and the image of family doctors and Family Medicine. Like its namesake who discovered a route around Africa from Europe to India, VdGM aims to discover new directions for Family Medicine.

The VdGM meeting in Aveiro brought together 30 young family doctors, 13 of whom had participated recently in an exchange program. One program was Hippokrates, a two week exchange that allows participants to observe the care of patients in primary care, and the other was "mini Hippokrates," which is connected to a meeting such as the Encontro and offers a one week sampling of another health system. Sites are reviewed, approved, and monitored to assure quality learning experiences. The exchange participants who attended the Encontro came from Czech Republic, France, Luxembourg, Portugal, Russia, and Spain. It was inspiring to hear the young doctors describe their exchange experiences and the perspectives they gained from spending time in another health care system. Their enthusiasm for Family Medicine and their commitment to improve the health of those they serve gave me hope for our next generation of family doctor leaders.

More on Vasco

Intrigued by the name selected by VdGM, I did more research on Vasco da Gama. Historians consider his voyage to India to be a seminal moment in human history. His unprecedented 10,000 km sailing across open seas was thought to be impossible. It is regarded as a key step toward globalization. Like most heroic stories however, there is more to the story.

We often think of heroes as solitary figures overcoming considerable odds to accomplish great achievements. Most heroes however, depend on others for inspiration and support. Much of the success of da Gama was the result of others who supported or came before him. King John II was eager to end the monarchy's reliance on the nobility by building up the royal treasury through commerce. India was seen as the financial solution to a political problem. The spice trade out of India was viewed as a golden opportunity, if only an unencumbered path could be found. Until da Gama's expedition, the Venetians controlled much of the European trade with India via a Middle Eastern route. Consequently, the king was willing to bet on a young captain in his twenties to find a way around Africa to India. Previous explorers such as Prince Henry the Navigator and Bartolomeu Dias mapped the African coast and proved it possible to sail around the Cape of Good Hope to the Indian Ocean. Pero da Covilhã and Afonso De Paiva traveled through the Middle East to scope out the spice trade and confirm the potential riches.

On 20 May 1498, da Gama and his ships landed in India, more than 10 months after departing Lisbon in July 1497. It was not until August 1499 that da Gama returned to Portugal. During the 25 months at sea, da Gama's expedition lost more than half its men and two of its four ships. Portugal's purse and power grew after the da Gama expedition, but not for reasons one might expect.

The two ships that made it back were laden with enough spices to yield a 60 fold return on the funds invested in the expedition. Portugal's place as a dominant force on the seas was secured by da Gama's voyage. Yet, da Gama ultimately failed in his quest to secure contracts in India and East Africa for future trade. His ruthless tactics, such as firing cannons on civilians and cutting off the hands of competing merchants, so alienated potential trading partners that they refused to deal with him. For the next 20 years, da Gama was a political outcast. In 1519, after threatening to move to Spain as Magellan had done, da Gama was appointed Count of Vidigueria by King Manuel I and became the first Portuguese count who was not a royal from birth.

The lessons of Vasco

Hopefully without stretching the analogy too far, I believe that da Gama's cautionary tale can teach us some things about Family Medicine. Da Gama's heroic act was in finding inspiration and using knowledge learned from others to take a great risk and accomplish a bold vision. Family doctors have a similarly bold vision: a healthier and more equitable world where every family has a family doctor. We believe this because we know that having a family doctor improves the effectiveness, efficiency, and equity of health care services. We will achieve this vision only by remembering the wisdom of those who preceded us, by responding to changing circumstances as they arise, and by taking necessary risks. As we grow in numbers and influence, we must be mindful that our power is earned through our service to others. It is not a birthright or entitlement. Our challenge is to overcome the obstacles (without cannons or amputations!) while staying true to the vision.

The young VdGM family doctors in Aveiro reminded me of these basic leadership principles and of the vision that guides us. I am certain that their intellect, innovation, enthusiasm, and commitment will lead us to better health care and a better world. I hope that our descendants will look back 500 years from now and conclude that we helped them become the kind of family doctors that we need, and that they can be.

Professor Richard Roberts
President
World Organization of Family Doctors

Closing ceremony - Vasco da Gama meeting participants.

Ceremonia de clausura. Reunión de los participantes del Vasco de Gama

Presidente de WONCA : *El valor de Vasco*

Un viaje reciente para hablar en una reunión celebrada en Aveiro, Portugal, me llevó 1.000 años. El tiempo de viaje real era de aproximadamente 24 horas. La reunión duró 3 días. Sin embargo, el viaje me dio la oportunidad de reflexionar sobre la vida de Vasco da Gama, que vivió hace 500 años. También me inspiró a mirar hacia el futuro 500 años más.

El propósito ostensible de mi visita era asistir al *30 º Encontro Nacional de MGF* (30 ª Reunión Nacional de Médicos Generales y de Familia) de la Associação Portuguesa de Medicina Geral e Familiar (APMGF).

Portugal tiene una población de unos 10 millones de personas y 40.000 médicos. APMGF tiene 4.000 miembros, de un total de 5.700 médicos de familia portugueses. Las mujeres constituyen aproximadamente el 80% del total de los médicos de medicina de familia y de los residentes. La formación de postgrado supone 4 años. Hay alrededor de 400 residentes nuevos cada año, que representan aproximadamente una cuarta parte de los graduados en medicina.

Un equipo de atención primaria en Portugal consta normalmente de un médico, una enfermera y un asistente administrativo. Las reformas aprobadas en 2005 proporcionan varias opciones para la organización y el pago de la atención primaria. El modelo tradicional (Unidade de Cuidados Personalizados de Saúde o "USCP") por lo general, tiene un médico general que trabaja con un equipo de trabajo constituido por los servicios de salud. Hay tres modelos bajo el programa de la reforma (Unidade de Saúde Familiar o "USF"): los modelos A, B y C. El modelo A permite seleccionar a los miembros del equipo. En el modelo B, hay incentivos económicos si se logran determinados objetivos de rendimiento. El modelo C aún no se ha implementado, pero significaría crear grupos de médicos privados que se unen para ser contratados por la administración, suponiendo crear algo similar a una cooperativa. Dependiendo de la configuración de la práctica, los médicos de familia ganan entre 1.800 € (tradicional) a 4.000 € (Modelo B) al mes, frente a los 800 euros obtenidos mensualmente por el trabajador medio portugués.

Días difíciles

Los últimos años no han sido fáciles para Portugal. La crisis fiscal ha impulsado una serie de medidas de austeridad. El desempleo es de aproximadamente un 15%. El gasto en salud ha sido reducido un 9% por parte del gobierno. Como funcionarios públicos, el impacto relativo en los médicos de familia ha sido aún mayor, pues han sufrido algunas disminuciones salariales de hasta el 30%. Esperaba encontrar médicos de familia portugueses enojados y desalentados en el *Encontro* o en los centros de salud que visité. Estaba equivocado.

Si bien existía la preocupación y la frustración, el estado de ánimo general era de confianza y solidaridad. Los médicos de familia describieron sus problemas financieros como un reflejo del dolor económico compartido por todos los portugueses. Mostraban un mayor sentido de responsabilidad por la salud de sus pacientes y el éxito del sistema de salud durante estos tiempos difíciles. En resumen, demostraron algo que se necesita desesperadamente, pero que no se encuentra siempre: liderazgo.

Observando el trabajo de cuidado primario

He visitado el Centro de Salud de Aveiro, que es el principal centro de atención primaria en esa ciudad. Fue sorprendente encontrar los 3 modelos operativos ubicados en el mismo edificio. Había 2 USCP (tradicional) y dos USF (un modelo A y uno B Modelo), ocupando cada uno su propia ala del edificio. Cada consultorio estaba formado por 6-8 médicos y era responsable de alrededor de 15.000 pacientes, que eran asignados generalmente a un equipo de consultas. El centro de salud está abierto desde las 8.00 hasta las 20.00 h. Aquellos servicios que eran requeridos fuera del horario de atención habitual eran remitidos al hospital.

El establecimiento estaba limpio y bien equipado. Cada una de las cuatro alas tenía su propio color, que era reforzado por el color de los uniformes usados por el personal. Fue interesante observar que las instalaciones eran un poco más bonitas en el ala Modelo B, seguido por el Modelo A y luego las alas tradicionales. En otras palabras, incluso trabajando en el mismo sistema de atención primaria de salud en el mismo edificio, se constató que las prácticas que eran más autónomas y más centradas en el rendimiento recibían más dinero, ya que presumiblemente, obtenía mejores resultados y mayor satisfacción del paciente. Se expresó cierta preocupación acerca de las posibles

desigualdades que resultaban de estos modelos, especialmente cuando se encuentra todo bajo un mismo techo.

En la USF del ala Flor de Sal (Modelo A), la Dra. Verónica Colaço fue mi anfitriona. Durante un día normal de trabajo, que supone 7 horas de consulta, ve entre 20 y 30 pacientes. Me mostró el sistema de registro electrónico de salud, que facilita el intercambio de listas de información entre los centros de salud y los hospitales. Amablemente, me permitió observarla con los pacientes, entre los cuales se incluía un bebé recién nacido traído por sus padres para empezar su cuidado. Me complació ver que la Dra. Colaço brinda atención a todos los grupos de edad y en una amplia variedad de problemas, incluyendo la cirugía menor. También me habló de la formación en Portugal con la Dra. Joana Cristina Díaz, directora de la formación de residencia en el Centro de Salud de Aveiro. En el momento de mi visita, el Centro contaba con 8 residentes ("Internos"), seis en Medicina de Familia, y varios estudiantes de enfermería.

APMGF President Joao Carlos and Prof Rich roberts in front of the Aveiro Health Center.

El presidente Joao Carlos y el profesor Richard roberts delante del Centro de salud Aveiro

En general, me quedé impresionado con el sistema de atención primaria portugués. Los médicos de familia parecían estar bien entrenados y altamente motivados. Parecían estar muy dispuestos, y aún más cuando disponen de una cantidad razonable de tiempo por consulta (unos 15 minutos), a proporcionar una gama más amplia de servicios a familias enteras. Otros sistemas limitan a menudo los médicos de familia a ciertos grupos de edad (por ejemplo, sólo para adultos) o limitan su tiempo de consulta a 3-5 minutos por paciente. Estos límites reducen el impacto positivo que los médicos de familia pueden tener en la salud de sus pacientes y comunidades.

Regreso a Vasco

Otro de mis deberes agradables en Aveiro fue hablar con el responsable portugués de Vasco da Gama Movement (VdGM), que toma el nombre de uno de los exploradores más celebrados de la época de los descubrimientos. Fundada en 2005, VdGM (www.vdgm.eu) fue el primer grupo multinacional en el mundo formado por y para médicos de familia jóvenes de la región europea. VdGM promueve la educación y la formación, los intercambios Hipócrates, el intercambio más allá de Europa (especialmente Canadá y América Latina), la investigación, y la imagen de los médicos de familia y de la medicina familiar. Al igual que su homónimo que descubrió una ruta alrededor de África desde Europa a la India, VdGM quiere dar a conocer nuevas orientaciones de la Medicina de Familia.

La reunión de VdGM en Aveiro reunió a 30 médicos de familia jóvenes, 13 de los cuales habían participado recientemente en un programa de intercambio. Uno de los programas de intercambio es Hipócrates, un intercambio de dos semanas que permite a los participantes observar el cuidado de pacientes en atención primaria; y el otro, es "Hippokrates mini", que está conectada a una reunión como el *Encontro* y ofrece una semana de muestra en otro sistema de salud. Los lugares para estos intercambios son revisados, aprobados y supervisados para asegurar experiencias de aprendizaje de calidad. Los participantes del intercambio que asistieron al *Encontro* venían de la República Checa, Francia, Luxemburgo, Portugal, Rusia y España. Fue muy inspirador escuchar a los jóvenes médicos describiendo sus experiencias de intercambio y las perspectivas que adquirieron al pasar un tiempo en otro sistema de atención de salud. Su entusiasmo por la Medicina de Familia y su compromiso de mejorar la salud de aquellos a quienes sirven me dio esperanza para nuestra próxima generación de médicos de familia líderes.

Más sobre Vasco

Intrigado por el nombre elegido por VdGM, hice más investigaciones sobre Vasco da Gama. Los historiadores consideran su viaje a la India como un momento trascendental en la historia de la humanidad. Se creyó imposible

su travesía de 10.000 kms sin precedentes a través de mar abierto, que ha sido considerada un paso clave hacia la globalización. Al igual que las historias más heroicas, sin embargo, hay más en esta narración.

A menudo pensamos en héroes como figuras solitarias superando considerables dificultades para llevar a cabo grandes logros. La mayoría de los héroes, sin embargo, dependen de otros en su búsqueda de inspiración y apoyo. Gran parte del éxito de da Gama fue el resultado de otros que le apoyaron o se presentaron ante él. El rey Juan II estaba dispuesto a poner fin a la dependencia de la monarquía sobre la nobleza mediante la creación de la Real Hacienda a través del comercio. La India fue vista como la solución financiera a un problema político. El comercio de especias con la India fue visto como una oportunidad de oro, si tan solo se lograba encontrar un camino sin trabas. Hasta la expedición de da Gama, los venecianos controlaban gran parte del comercio europeo con la India a través de una ruta con Oriente Medio. En consecuencia, el rey estaba dispuesto a apostar por un joven capitán de unos 20 años para encontrar un camino alrededor de África hasta la India. Algunos exploradores anteriores, como el príncipe Enrique el Navegante y Bartolomeu Dias, elaboraron mapas de la costa africana y demostraron que era posible dar la vuelta al Cabo de Buena Esperanza hasta alcanzar el Océano Índico. Pero da Covilhã y Afonso de Paiva viajaron por Oriente Medio para investigar por su lado sobre el comercio de especias y confirmar las riquezas potenciales.

El 20 de mayo de 1498, da Gama y sus naves llegaron a la India, más de 10 meses después de salir de Lisboa, en julio de 1497. No fue sino hasta agosto 1499 que da Gama regresó a Portugal. Durante los 25 meses en el mar, la expedición de da Gama perdió más de la mitad de sus hombres y dos de sus cuatro barcos. La riqueza de Portugal y su poder creció después de la expedición de da Gama, pero no por las razones que uno podría esperar.

Los dos barcos que llegaron de nuevo estaban cargados de especias suficientes para dar un rendimiento 60 veces mayor que los fondos invertidos en la expedición. El puesto de Portugal como fuerza dominante en el mar fue asegurado por el viaje de da Gama. Sin embargo, da Gama finalmente fracasó en su intento de obtener contratos en la India y en África Oriental para el comercio futuro. Sus tácticas despiadadas, tales como disparar con cañones sobre los civiles o cercenar las manos de los comerciantes que competían entre sí, apartaron a potenciales socios comerciales, que se negaron a tratar con él. Durante los siguientes 20 años, da Gama fue un paria político. En 1519, después de amenazar con trasladarse a España como Magallanes había hecho, da Gama fue nombrado Conde de Vidigueria por el rey Manuel I y se convirtió en el primer conde portugués que no era aristócrata desde su nacimiento.

Las lecciones del Vasco

Tengo la esperanza de que sin estirar la analogía demasiado, pueda contar con que da Gama nos enseñe algunas cosas acerca de la Medicina de Familia. El acto heroico de da Gama fue el encontrar la inspiración y utilizar el conocimiento aprendido de otras personas para asumir un gran riesgo y lograr una visión audaz. Los médicos de familia tienen una visión audaz similar: un mundo más sano y más equitativo, en el que cada familia tiene un médico de cabecera. Creemos esto porque sabemos que tener un médico de familia mejora la efectividad, eficiencia y equidad de los servicios de salud. Vamos a lograr esta visión solo por recordar la sabiduría de aquellos que nos precedieron, al responder a las nuevas circunstancias que vayan surgiendo y al asumir riesgos necesarios. A medida que crecemos en número e influencia, debemos ser conscientes de que nuestro poder se gana a través de nuestro servicio a los demás. No es un derecho de primogenitura o de títulos. Nuestro reto es superar los obstáculos (¡sin cañones o amputaciones!) y mantenernos al tiempo, fieles a la visión.

Los médicos jóvenes de familia del VdGM que estaban en Aveiro me recordaban a esos principios básicos de liderazgo y de la visión que nos guía. Estoy seguro de que su inteligencia, innovación, entusiasmo y compromiso nos llevará a una mejor atención médica y a un mundo mejor. Espero que nuestros descendientes de dentro de 500 años miren hacia atrás y concluyan que les ayudamos a convertirse en el tipo de médicos de familia que necesitamos y que ellos pueden llegar a ser.

Profesor Rich Roberts

Presidente de la Organización Mundial de Médicos de Familia

Traducción: Eva Tudela, Spanish Society of Family and Community Medicine (semFYC) Director

Do Presidente: O valor de Vasco

A recente viagem a Aveiro, Portugal, para falar numa reunião, demorou 1000 anos. O tempo real de viagem foi de cerca de 24 horas. A reunião durou 3 dias. No entanto, a viagem foi uma oportunidade para reflectir sobre a vida de Vasco da Gama há 500 anos. Ele também me inspirou a olhar para o futuro, 500 anos à frente.

O verdadeiro propósito da minha visita foi participar no 30 º Encontro Nacional de Medicina Geral e Familiar da Associação Portuguesa de Medicina Geral e Familiar (APMGF).

Portugal tem uma população de cerca de 10 milhões de habitantes e 40 000 médicos. A APMGF tem como membros 4000 dos 5700 médicos de família portugueses. As mulheres representam cerca de 80% dos médicos e internos de Medicina Geral e Familiar. A formação pós-graduada dura 4 anos. Há cerca de 400 novos internos por ano, que representam cerca de um quarto dos recém-formados das faculdades de medicina.

Em Portugal, uma equipa de Cuidados de Saúde Primários é constituída habitualmente por um um médico, um enfermeiro e um assistente administrativo. A última reforma nos Cuidados de Saúde Primários teve início em 2005 e permite várias opções de organização e financiamento. O modelo tradicional chama-se Unidade de Cuidados de Saúde Personalizados ou “USCP"). Existem ainda três modelos no âmbito do programa de reforma Unidade de Saúde Familiar ou "USF": modelos A, B e C. Em qualquer um destes é da sua responsabilidade a selecção dos seus membros. No Modelo B, há recompensas financeiras, se certas metas de desempenho forem alcançadas. O Modelo C ainda não foi implementado, mas prevê grupos privados de médicos que se juntam para contratualizar com o Governo, semelhante a uma cooperativa.

Dependendo do modelo em que exercem, o vencimento pode variar entre 1800 (tradicional) e 4000 (Modelo B) euros por mês, em comparação com os 800 euros auferidos mensalmente pelo trabalhador médio Português.

Dias difíceis

Os últimos anos não têm sido fáceis para Portugal. A crise fiscal motivou uma série de medidas de austeridade. A taxa de desemprego é de cerca de 15%. Os gastos do Governo na saúde reduziram em 9%. Como funcionários públicos, o impacto relativo sobre os médicos de família tem sido ainda maior, com algumas reduções salariais até 30%. Eu esperava encontrar os médicos de família portugueses irritados e desanimados no Encontro ou nos Centros de Saúde que visitei. Estava errado.

Simultaneamente à preocupação e frustração, o sentimento geral era de confiança e solidariedade. Os médicos de família descreveram as suas tensões financeiras como um reflexo da dor económica compartilhada por todos os portugueses. Referiram uma sensação ainda maior de responsabilidade pela saúde dos seus pacientes e pelo sucesso do sistema de saúde durante estes tempos difíceis. Em suma, eles demonstraram algo que é desesperadamente necessário, mas nem sempre encontrado: liderança.

Visita a uma Unidade de Cuidados de Saúde Primários

Visitei o Centro de Saúde de Aveiro, que é a principal unidade de Cuidados Primários em Aveiro. Foi surpreendente encontrar os três modelos operacionais no mesmo local. Havia duas USCP (tradicional) e duas USF (uma modelo A e uma Modelo B), cada uma na sua própria ala do edifício. Cada unidade é constituída por 6-8 médicos e é responsável por cerca de 15 000 pacientes. O Centro de Saúde está aberto das 08h00 às 20h00 diariamente. Os casos que necessitam de cuidados de saúde fora desse horário são encaminhados para o hospital.

As instalações estavam limpas e bem equipadas. Cada uma das USF tem sua própria cor, o que é reforçado pela cor dos uniformes usados pelos funcionários. No mesmo sistema de saúde e trabalhando no mesmo edifício, aparentemente as unidades mais autónomas e mais focadas no desempenho recebem mais fundos porque presumivelmente obtêm melhores resultados e maior satisfação dos utentes. Alguma

preocupação foi expressa sobre as desigualdades potenciais decorrentes desses vários modelos, especialmente quando estão todos sob o mesmo tecto.

Na USF Flor de Sal (Modelo A), Dra. Verónica Colaço foi a minha anfitriã. Durante um dia de trabalho típico, que consiste em 7 horas de consultas, observa entre 20-30 pacientes. Ela mostrou-me o sistema de registo eletrónico de saúde, que permite a troca imediata de informação entre os Centros de Saúde e Hospitais. Ela gentilmente permitiu-me assistir a uma consulta de vigilância a um bebé recém-nascido trazido pelos seus pais. Fiquei satisfeito ao ver que a Dra. Verónica Colaço presta cuidados a utentes de todas as faixas etárias para uma ampla gama de problemas, incluindo pequena cirurgia. Falei também sobre a formação em Portugal com a Dra. Joana Cristina Dias, Diretora de Internato do Núcleo de Coordenação de Aveiro.

Na altura da minha visita, a USF tinha 8 internas, das quais 6 de Medicina Geral e Familiar e 2 do Ano Comum, e 2 estudantes de enfermagem.

No geral, fiquei impressionado com o sistema português de Cuidados de Saúde Primários. Os médicos de família pareciam bem treinados e altamente motivados. Eles gostam de fornecer uma ampla gama de serviços para as famílias inteiras, apesar de o tempo médio por consulta (cerca de 15 minutos), por vezes não ser o ideal para prestar os cuidados adequados. Outros sistemas, muitas vezes limitam os médicos de família para determinados grupos etários (por exemplo, apenas adultos) ou limitam o tempo de consulta para 3-5 minutos por paciente. Estes limites reduzem o impacto positivo que os médicos de família podem ter sobre a saúde de seus pacientes e comunidades.

Voltar ao Vasco

Outro dos meus deveres agradáveis em Aveiro foi falar com os representantes em Portugal do Movimento Vasco da Gama (VdGM), em homenagem a um dos exploradores mais célebres da era dos Descobrimentos. Fundada em 2005, VdGM (www.vdgm.eu) foi o primeiro grupo internacional no mundo, formado por e para jovens médicos de família da Europa. O VdGM promove a educação e formação, intercâmbios dentro e fora da Europa (especialmente Canadá e América Latina), a pesquisa, e a imagem dos médicos de família e da Medicina Geral e Familiar. Tal como o seu homónimo que descobriu uma rota marítima para a Índia, o VdGM visa descobrir novos rumos para a Medicina Geral e Familiar.

A reunião VdGM em Aveiro reuniu 30 jovens médicos de família, dos quais 13 tinham participado recentemente num programa de intercâmbio. O programa Hippokrates consiste num intercâmbio de 2 semanas, que permite aos participantes tomarem contato com os Cuidados de Saúde Primários de outro país, e o programa "mini-Hippokrates" está associado ao encontro científico de médicos de família do país anfitrião e oferece uma experiência de 1 semana numa unidade de saúde desse país. As unidades que recebem os colegas dos programas de intercambio, são aprovadas e monitorizadas regularmente, para garantir experiências de aprendizagem de qualidade. Os participantes do intercâmbio que participaram no Encontro vinham da República Checa, França, Luxemburgo, Rússia e Espanha. Foi inspirador ouvir os jovens médicos descreverem as suas experiências de intercâmbio e as perspectivas que ganharam ao passar algum tempo noutro sistema de cuidados de saúde. O seu entusiasmo para a Medicina Geral e Familiar e o seu compromisso em melhorar a saúde das pessoas que servem deu-me esperança para a nossa próxima geração de médicos de família.

Mais sobre Vasco

Intrigado com o nome escolhido por VdGM, fiz mais pesquisas sobre o Vasco da Gama. Os historiadores consideram a sua viagem à Índia como um momento preponderante na história humana. A sua viagem à vela por 10 000 km em mar aberto era, até então, impossível. É considerado um passo fundamental para a globalização. Mas assim como nas histórias mais heróicas, há muito mais para contar.

Muitas vezes pensamos em heróis como figuras solitárias que superam grandes desafios. A maioria dos heróis no entanto, dependem de outros para a inspiração e apoio. Grande parte do sucesso do Vasco da Gama foi o resultado de outros que apoiaram ou antecederam.

D. João II estava ansioso por acabar com a dependência da monarquia em relação à nobreza, construindo o tesouro real por meio do comércio. A Índia parecia ser a solução financeira para um problema político. O comércio de especiarias fora da Índia foi visto como uma oportunidade de ouro, desde que se encontrasse uma rota marítima. Até à expedição de Vasco da Gama, os venezianos controlavam grande parte do comércio europeu com a Índia através de uma rota do

Médio Oriente. Consequentemente, o rei estava disposto a apostar num jovem capitão com 20 anos para encontrar uma maneira de contornar a África chegando à Índia. Exploradores anteriores, como o Infante D. Henrique e Bartolomeu Dias mapearam a costa Africana e provaram ser possível contornar o Cabo da Boa Esperança até ao Oceano Índico. Pêro da Covilhã e Afonso de Paiva viajaram por terra pelo Médio Oriente, para confirmar a riqueza potencial do comércio de especiarias.

Em 20 de Maio de 1498, Vasco da Gama e seus navios desembarcaram na Índia, mais de 10 meses após a partida de Lisboa em Julho de 1497. Vasco da Gama só regressou a Portugal em Agosto de 1499. Durante os 25 meses no mar, a expedição de Vasco da Gama perdeu mais de metade dos seus homens e dois dos seus quatro navios. As finanças e o poder de Portugal cresceram após a expedição de Vasco da Gama, mas não pelas razões que se poderia esperar.

Os dois navios que o trouxeram de volta, estavam carregados com especiarias suficientes para produzir um retorno 60 vezes superior aos recursos investidos na expedição.

O lugar de Portugal como uma força dominante nos mares foi garantido por esta viagem. No entanto, Vasco da Gama acabou por fracassar na missão de garantir contratos na Índia e na África Oriental para o comércio futuro. As suas táticas cruéis, como disparar canhões contra civis e cortar as mãos de comerciantes concorrentes, afastaram potenciais parceiros comerciais, que se recusaram a lidar com ele. Nos 20 anos seguintes, Vasco da Gama foi um político. Em 1519, depois de ameaçar emigrar para a Espanha como tinha feito Magalhães, Vasco da Gama foi nomeado conde de Vidigueria pelo rei D. Manuel I e tornou-se o primeiro conde de Portugal sem linhagem real

As lições do Vasco

Não querendo ir longe demais com a analogia, acredito que a história de Vasco da Gama pode ensinar-nos algumas coisas sobre a Medicina Geral e Familiar. O ato heróico Vasco da Gama foi encontrar inspiração e usar o conhecimento aprendido com os outros para enfrentar um grande desafio e fazer uma ousada conquista. Os médicos de família têm uma visão igualmente ousada: um mundo mais saudável e mais justo, onde cada família tem um médico de família. Nós acreditamos nisso porque sabemos que ter um médico de família melhora a eficácia, eficiência e equidade dos serviços de saúde. Vamos atingir esta visão ao lembrar a sabedoria daqueles que nos precederam, respondendo às novas circunstâncias que possam surgir, e correndo riscos necessários. À medida que crescemos em número e influência, devemos estar conscientes de que nosso poder é conquistado através do nosso serviço aos outros. Não é um direito ou uma herança. O nosso desafio é superar os obstáculos (sem canhões ou amputações!) permanecendo fiéis ao sonho.

Os jovens médicos de família VdGM em Aveiro fizeram-me lembrar os princípios básicos de liderança e a visão que nos guia. Estou certo de que o seu intelecto, inovação, entusiasmo e comprometimento nos levará a melhores cuidados de saúde e a um mundo melhor. Espero que os nossos descendentes olhem para trás daqui a 500 anos e cheguem à conclusão que os ajudámos a tornarem-se o tipo de médicos de família que precisamos, e que eles podem ser.

Profesor Richard Roberts

Presidente de WONCA

Muito obrigado a Dra Verónica Colaço por sua assistência com o manuscrito ea tradução Português.

From the CEO - World Family Doctors' day

It's hard to believe that yet another month has slipped by, taking us one month nearer the 20th WONCA World Conference in Prague. We are in regular contact with the Host Organising Committee and they have been doing some really fantastic work to ensure the best World Conference yet. The keynote speakers are all extraordinary people, and the presence at the opening ceremony of Dr Margaret Chan, Director General of WHO, really is the icing on the cake. Our website is now listing a schedule of official WONCA meetings and preconferences.

Family medicine is well established in many countries but others struggle to get acceptance and recognition of our specialism, and one of WONCA's key roles is to highlight and promote the discipline wherever and whenever we can. One of our initiatives was to establish a "World Family Doctors' Day". This was first declared by WONCA in 2010 and the day – 19th May - has become a day to highlight the role and contribution of family doctors in health care systems around the world. The event has gained momentum globally each year and it is a wonderful opportunity to acknowledge the central role of our specialty in the delivery of personal, comprehensive and continuing health care for all of our patients. It's also a chance to celebrate the progress being made in family medicine and the special contributions of family doctors all around the world. Last year many of our colleagues across the globe celebrated the day by organising a variety of events and activities, and we want to encourage even more organisations to celebrate in appropriate style on 19th May 2013.

The June 2012 edition of *WONCA News* highlighted many of the events held, and we would love Member Organisations to tell us in advance of their plans for 2013 – so that we can promote at least some in *WONCA News* – and then we look forward to receiving reports after the events to show and tell. *WONCA News* will publish as many reports as we can, to highlight the really wonderful work done by so many of our great Member Organisations.

So…get your thinking caps on and drop us a mail to tell us of your plans.

In late March Dr Dan Ostergaard and I will be meeting in Prague with our Czech colleagues as the latest Conference Planning Committee, so I hope to bring more news in next month's column.

Until next month.

Garth Manning
CEO
Email activities to editor@wonca.net

FEATURE STORIES

2012 Winners of the VdGM Hippokrates Exchange and Carosino Prizes

The VdGM is happy to announce the winners of this year's Carosino and Hippokrates Exchange Prizes which award the best exchange in a rural and any setting respectively, which took place in 2011 or 2012.

First of all on the behalf of the VdGM, I would like to thank the President of WONCA Europe, Dr Tony Mathie, the Senior Hippokrates Coordinator and creator of the Hippokrates Programme Dr Per Kallestrup and Dr Jaume Banqué Vidiella, executive member of EURIPA, who kindly accepted to take part in the panel who revised and selected this year's applications.

From the passionate and enthusiastic GP trainees who submitted their work, the 2012 winner of the Carosino Prize is Dr Marine Parmentier, a 3rd year GP trainee from France, who visited Dr Angus Gallacher Practice in Buckie, Scotland, UK.

The Hippokrates Exchange Prize goes to Dr Clara Vilavella Lizana, a 3rd year GP trainee from Spain, who was hosted by Dr Brigit Morre Pedersen in Århus, Denmark.

A special thanks also to the entire VdGM Exchange group and all National Exchange Co-ordinators whose work and dedication is essential to the reality and development of the Hippokrates Programme

Sara Rigon

Official WONCA meeting schedule in Prague

Friday 21st June

Meetings: WONCA Regional Councils

Time: all day

Venue: Corinthia Towers Hotel, Prague

Further details: Regional Presidents

Meeting to brief all new Members of World Council

Time: 5pm-6.30pm

Venue: Corinthia Towers Hotel, Prague

Welcome reception hosted by WONCA Executive for all World Council attendees

Time: 7pm–9pm:

Venue: Corinthia Towers Hotel, Prague

Saturday 22nd June

WONCA World Council meeting

Time :all day

Venue: Corinthia Towers Hotel, Prague

Sunday 23rd June

WONCA World Council meeting

Time :all day

Venue: Corinthia Towers Hotel, Prague

Monday 24th June

WONCA World Council meeting

Time : morning only

Venue: Corinthia Towers Hotel, Prague

World Pre-conference meetings of WONCA Young Doctors Groups

Time: all day

Venue: 1st Faculty of Medicine, Charles University, Albertov, Prague

Further details: see news article

WONCA Working Parties, Special Interest Groups and Committees

Time: afternoon

Venue: Corinthia Towers Hotel, Prague

Further details: Contact relevant Chairs

Tuesday 25th June

WONCA Working Parties, Special Interest Groups and Committees

Time: all day

Venue: Corinthia Towers Hotel, Prague

Further details: Contact relevant Chairs

World Pre-conference meetings of WONCA Young Doctors Groups

Time: all day

Venue: 1st Faculty of Medicine, Charles University, Albertov, Prague (the exact place will be specified closer to the date of the Preconference)

Further details: see news article

Preconference of WONCA Special Interest Group on Cancer and Palliative Care

Time: 1.30 – 4.30pm

Venue: Corinthia Towers Hotel, Prague

Further details and registration:

Conference opening ceremony

Time: 5pm

Venue: Prague Congress Centre

Feature: keynote speech by Dr Margaret Chan, Director General World Health Organisation.

Please check the WONCA website regularly for details and more activities of WONCA Working Parties and WONCA Special Interest groups as they come to hand.
http://www.globalfamilydoctor.com/News/OfficialWONCAmeetingscheduleinPrague.aspx

Palliative care preconference in Prague

The WONCA Special Interest Group on Cancer and Palliative Care will hold a preconference at WONCA Prague from 1.30 to 4.30 on Tuesday 25 June 2013 before the official opening ceremony.

This will be a great opportunity to network with GPs interested in cancer and palliative care from throughout the world and to learn of the key challenges and opportunities in clinical practice, teaching and research in these areas. Members of the international primary palliative care network www.uq.edu.au/primarypallcare/ will also update members about their progress over the last year

Preliminary information (Will be updated next month)

Promoting palliative care in primary care: producing a guideline to improve and develop palliative care in the community in different countries.

The SIG meeting will include a workshop to consider how the practice of palliative care may be improved in primary care, so that all people in need of end-of-life care internationally may have access to a general practitioner or nurse who can provide quality palliative care.

To this aim, over 20 countries throughout Europe have already been surveyed and many barriers and facilitating factors have been identified to improved palliative care in the community. Participants will be invited to give perspectives from their own countries from other continents, and mention any examples of successful innovations to make palliative care work well in primary care. These may include national strategies, educational initiatives for GPs and community nurses, integrated care frameworks, and making opioid prescribing more available.

Our output will be a guideline document that can be used by palliative care champions worldwide to advocate for, and guide the development of and training in palliative care in economically developed and resource poor nations. This will be distributed through WONCA and the International Hospice and Palliative Care Association so that national primary care and palliative care organizations can together improve end-of-life care in the community.

Scott A Murray, David Weller (convenor)

Regional News

South Asia research conference a success

Note there is a large photo gallery online
http://www.globalfamilydoctor.com/News/SouthAsiaresearchconferenceasuccess.aspx

WONCA South Asia region president, Dr Preethi Wijegoonewardfene, lights the oil lamp signifying the Lamp of Learning watched by Drs Aloysius, Abeykoon and Sajeeda

The International Research Methodology Conference for Primary Care Physicians was arranged by the South Asian Primary Care Research Network (SAPCRN), WONCA and the College of General Practitioners of Sri Lanka. It was held on January 19–20, 2013 at the National Online Distance Education Services Center, the Open University of Sri Lanka, Nawala, Nugegoda and Colombo, Sri Lanka.

The theme of the conference was *Strengthening Primary Care Research through Family Doctors*.

This event comprised a two days' full-time, hands-on workshop covering all important topics of research methodology; along with research paper presentations and research

proposal discussion before the panel of experts and speakers.

The opening ceremony started with a delectable Sri Lankan breakfast at 0800 hours on Saturday 19 January 2013. After traditional lighting of oil lamp by the chief guest, guest of honour and the faculty, the welcome address was from Dr Preethi Wijegoonewardene, WONCA South Asia Region President. Then Dr Basharat Ali, chairperson of SAPCRN, enlightened the audience on the importance of research in family care in South Asia. He expressed his views and suggested continuing these kinds of workshops in future. Dr Eugene Corea, President College of General Physicians Sri Lanka, expressed his views about the current status of research in Sri Lankan general practice and showed willingness to face the challenge of its promotion.

Research issues unique to each country were discussed in detail by Dr Ruvaiz Haniffa, from Sri Lanka; Professor Waris Qidwai, from Pakistan; and Dr Ramnik Parekh, from India.

Dr Basharat Ali, Chair SAPCRN helping colleagues at the computer

All the participants agreed to take the cause of research in general practice as a challenge in future. Chief guest Dr Palitha Maheepala, Director General Health Services Sri Lanka, addressed the audience about the current status of health services in regard to general practice and research in general practice. He offered his cooperation to promote these activities in future. At the end of opening ceremony guest of honor, Dr Palitha from WHO expressed his views on research in general practice and the way to promote it.

The scientific session was started at 1000 hours, by Dr Basharat Ali, with his presentation on *Introduction to research; how to search for*

a justifiably pleased group

topic and formulate research questions. Then there was a hands-on workshop on literature searching and referencing. Every participant was provided with a computer and internet access to help them understand the roots of the sessions. This was a very interesting session and the participants showed their keen interest. All speakers helped the participants to find the articles of their interest and how to search for references. Dr Seema Bhanji, Chairperson of Pakistan Primary Care Research Network (PPCRN) presented an interactive session on *Introduction to epidemiological study designs*. Participation from the audience was marvelous and Dr Seema presented in an excellent way. Dr Seema also gave talk on how to use SPSS and working with statistics.

Professor Rohini Seneviratne team was marvelous in presenting *the introduction to biostatics and type of data*. Professor Waris Qidwai talked about an important topic, *Research Ethics* and discussed the issues related to ethical problems in different type of studies. Dr Sajida Naseem performed an interactive session on different type of data and their implementation. She also talked about sample collection and way to design questions. The interest of the participants in all these sessions was remarkable.

Dr Noor Ahmad Akhtar presented, *How to write manuscripts and the problems faced by the researcher while writing synopsis, research article and thesis and way to input references*. There were four research papers presented in the conference by Dr Zain Noor, Dr Adnan Nazeer, Dr Sajida Naseesm and Dr Noor Ahmad Akhtar. There were six research proposals presented by Dr K Chandrasekher, Dr RDN Sumanasekera, Dr AHW De Silva, Dr Hiranthini De Silva, Dr Chandima Jeewandara and Dr Shreen Willanthgamuwa. All the

research papers were appreciated well by the experts and the participants. The research proposals were discussed and guidance given by the experts to the presenter. There was a session of reflective process and a detailed session of discussion of the problems family physicians face in research. A primary care research network was made for the Sri Lankan family physicians with its collaboration to SAPCRN.

At the end, concluding remarks were given by presenters and the organisers with recitation of the national anthems of the participant countries. A feedback form was filled in by the participants. The performance of Dr Dinusha Perera as coordinator of the conference was excellent. The participation of Dr Jyoti Parekh, from India, was also memorable.

Research workshops of this kind are a new milestone in family medicine training. These activities should be held frequently in the entire South Asian region to promote research in primary care in South Asia.

Dr Basharat Ali

Chairperson SAPCRN

Dr Tomlin Paul – WONCA North Five Star Doctor

Dr Tomlin Paul, who lives in Jamaica, but was born in Trinidad, was nominated for the WONCA North America five –star doctor award by Dr Winsome Segree-MacKay who stated in her nomination.

Dr Paul addresses the attributes of a five star doctor as follows:

* **a care provider**

For two successive years Dr Paul was one of the top nominees for the Medical Association of Jamaica's "Good Physician Award". The award is for a physician who is nominated by his patients for compassionate, high quality care. Along with a colleague, Dr Paul, in 1993, started Health Plus Associates a Medical Centre based in Kingston and over the years has provided care to patients at this facility. His philosophy brings the patient to the centre of the care process and he has labelled his approach "relationship medicine", writing about it in the Yale Journal of Humanities in Medicine.

In addition to seeing patients at his office he has done home-based care for elderly patients and for a number of years was the physician in charge at Sandhurst Home for Senior Citizens, in Kingston.

For a number of years he was an exemplar and teacher to medical students in primary care medicine in the Department of Community Health and Psychiatry at the University of the West Indies, Jamaica and today remains a part-time lecturer in the graduate programme in Family Medicine in that Department. He has written about his experience with teaching medical students in their final year in the Medical Teacher journal.

He has blended delivery of quality care with serious practice-based enquiry. An example of this is his "review of frequent attenders in clinical practice" published in *General Practice online,* in 2005.

Dr Paul has been recognised in the public media in Jamaica as an outstanding family physician and educator and in May 2006 was recognised as one of WONCA's "Global Family Doctors".

* **a decision maker**

Dr Paul offers primary medical care to patients in Kingston, Jamaica using the mix of technologies available in that setting. With the economic recession hitting Jamaica which is now one of the world's highest indebted countries he has the challenge of treating his patients in a cost-effective manner while maintaining high quality care. He is an advocate of health promotion in medical practice. In 1992 he was appointed a Programme Manager for a Health Promotion project within the University of the West Indies and for five years worked to implement and evaluate programmes in schools and workplaces. In an article published in the *West Indian Medical Journal* (1998 Dec; 47 Suppl 4:49-52) by Dr Paul and Dr Winsome Segree one of his mentors in family medicine, the issues facing the Caribbean in implementing Health Promotion in the region and measuring its impact were discussed.

In a recent publication, along with his colleague Dr Satnarine Maharaj, he spoke of the ethical issues involved in health care financing (West Indian Med J. 2011 Jul;60(4):498-501).

His perspective has always been one of a commitment to service to patient and community with minimal resource consumption and collaboration with local health services. In 2005, he also published a review on the range of clinical procedures conducted by physicians in his general practice with a view to efficient allocation of resources.

* **a communicator**

Dr Paul spends a lot of time with his patients encouraging them to set goals for healthy living and actively following up on their progress. He has also delivered a number of talks to groups in churches and organisations on healthy lifestyle including the Bank of Jamaica and appeared on radio and television programmes. During his stint as a member of the Jamaican National Family Planning Board, he was a frequent guest on the television programme "Teen Scene" promoting healthy sexual behaviour among adolescents.

In 2012, he was invited by the Daily Gleaner one of the national newspapers of Jamaica to write a series of articles targeting persons fifty years and older. The theme of his current series of articles is "Living longer, Living better". He has already published twenty of these articles. A sample can be seen here: http://jamaica-gleaner.com/gleaner/20121107/health/health1.html

His communication skills played a big role in his receiving the Guardian Life Premium teaching award in 2006 and later in 2007 the University of the West Indies, Vice Chancellor's Award for Excellence in Teaching.

In addition to writing for the public media he has published over 50 papers and abstracts and three book chapters on a range of issues. In addition he has produced a Monograph on Health Promotion which is used by Family Medicine Master's students at the University of the West Indies, Jamaica.

* **a community leader**

Dr Paul has had a sound track record of community involvement over his career. Between 1993 and 1997, he was a member of a team working with the Irish Town Citizen's Association to help in the setting up of a local health centre. He also led a team initiating actions among a group of Parents at Oberlin High School geared at improving parenting and consequently the health of children. He was also a founding member of the Hope Estate Educational Partners (HEEP) a local community-based Non-Governmental Organisation which has continued to promote the development of the Hope Estate community in Kingston. One of the outcomes was the Hope Green area – a community environmental project.

He has also been a member of the planning and delivery team for several community-based health fairs organised by churches in Kingston. He held several leadership positions within the medical school at the University of the West Indies and in the past has served on the Board of the Caribbean College of Family Physicians.

In 2010 he took up a major leadership position as Provost/Dean of a newly developing medical school – Global University, Schools of Medicine and Public Health, which will be based in the Turks and Caicos Islands. To date he has been able to lead a team to achieve Initial Provisional Accreditation for the medical school. He has continued to be heavily involved in the delivery of care to his patients while working on the development of this school.

* **a team member**,

There is no doubt about Dr Paul's ability to work as a member of the team and to galvanise the efforts of others towards improving the community and patients' health. During his tenure with the University of the West Indies, he was involved in several committees a number of which fostered the well-being of trainee physicians. He was successful in his advocacy for the establishment of a post in personal and professional development in the Faculty. He also gave service to agencies such as United Way of Jamaica focussing on community health projects. He has been a member of the Board of McCam's Child Development Centre since 2001. He is a founding member of Whole Person Resource Centre which was formed to promote a holistic approach to patient care. In this journey he worked closely with church based groups. He has been a member of several PAHO consultancy teams and currently works as a medical education accreditation consultant with the St.Kitts/Nevis government.

WONCA congratulates Dr Tomlin Paul on his award as WONCA North America region Five-Star doctor

EJGP seeks reviewers

Dear Colleague,

As the Editor-in-Chief of the *European Journal of General Practice*, I would like to invite you to perform peer-reviews for articles submitted by your colleagues to the Journal.

As a Reviewer you have a very important task, and my Editorial Team and I would like to make an appeal on your expertise. We think a Reviewer should have the following profile: (1) experience in research, (2) experience in writing of research articles, (3) the ability to provide critical but constructive feedback to colleagues, and (4) the ability to express him/ herself in the English language.

Your efforts to improve the quality of the Journal will be very much appreciated by the members of our Editorial Team: Prof Manfred Maier, Austria; Prof Christian Mallen, United Kingdom; Dr An De Sutter, Belgium; Prof Igor Švab, Slovenia; Dr José Valderas, United Kingdom; Prof Henk van Weert, the Netherlands, and Prof Adam Windak, Poland.

At the end of each year, we will reward Reviewers who have submitted (an) outstanding report(s) with a three month period of free on-line access to the *European Journal of General Practice*, and a complete printed volume (four issues). All Reviewers will be acknowledged in the March issue of the following year, by publishing their names.

You can create your personal account in our manuscript management system: http://mc.manuscriptcentral.com/ejgp. It is essential that you tick the predefined keywords in the system to facilitate the Editors in selecting the right Reviewer for the right article.

Finally, please e-mail your intention to review for the Journal, to Anneke Germeraad-Uriot, Editorial Assistant (ejgp-agermeraad@maastrichtuniversity.nl).

I thank you in advance and look forward to our collaboration.

Sincerely yours,
Dr Jelle Stoffers
Editor-in-Chief of the European Journal of General Practice
Ejgp-jstoffers@maastrichtuniversity.nl
http://informahealthcare.com/loi/gen

Member Organization news

Unity for Pakistan Family Doctors

History was made at Lahore, Pakistan on Saturday February 16, 2013. Five Family Medicine organizations in the country came under the united banner called “Pakistan Family Doctors Forum”. A united front was and is needed to face and overcome challenges encountered by this newly established specialty in the country. A significant resistance exists in acceptance of Family Medicine as a specialty in general but particularly in relation to other specialty colleagues. This will hopefully further strengthen the earlier initiatives taken to establish and recognize Family Medicine as a specialty in the country. Professor Waris Qidwai, Chair of Family Medicine at Aga Khan University has been selected as its first Chairman.

Prof Waris Qidwai

Addis Ababa University, Ethiopia - Family Medicine launch

On February 4, 2013, Drs Murutse Atsebaha, Netsehet Worku, Assefa Alamir, Assegid Geleta and Assefa Beyene became the first family medicine residents to be trained in Ethiopia.

Dr Ahmed Raja, Dean of the College of Health Sciences, Addis Ababa University, Dr Mahlet Yigeremu, Dean of the School of Medicine, Dr Dawit Wondimagegn, Associate Dean and Director of the Family Medicine Program, and Dr Miliard Derbew, Principal Investigator of the Medical Education Partnership Initiative (MEPI), presided over the program. Drs Lynn Wilson, Jane Philpott, Katherine Rouleau and Sarah Barclay from the Department of Family and Community Medicine, University of Toronto, Drs Brian Cornelson, Mike Cotterill and Anjali Oberai, Canadian faculty based in Addis Ababa, and Drs Cindy Haq and Alida Evans from the University of Wisconsin, celebrated the launch and helped orient the new residents. They were honoured by the presence of the Canadian Ambassador to Ethiopia, representatives from the Ethiopian Federal Ministry of Health, and faculty from George Washington University.

The program is primarily supported by the University of Toronto with additional support from Cuso International, VSO International and the US Dept. of Health and Human Services through the Medical Education Partnership Initiative (MEPI). This was a proud, happy day with many people expressing hopes for a better future:

"We have waited for this day for a very long time. This will revolutionize primary health care in Ethiopia." Dr Dawit, AAU family medicine residency program director.

"This program is important for our people and will link well-trained physicians to communities where they are needed. The program will take the best from the west, and adapt the content to meet the needs of Ethiopia. We are grateful to our partners from Wisconsin and Toronto."

Drs Assegid Gelata, Netsehet Worku, Assefa Alamir, Assefa Beyene and Murutse Atsebaha

Dr Ahmed Reja, Dean, AAU College of Health Sciences.

"This program will prepare physicians to practice in the community and will address the most urgent health care needs of the nation." Dr Girma, Human Resources Director, Ethiopian Ministry of Health.

"This is a discipline without boundaries, community-based and responsive to the needs of the people. Initially I was against the idea, but now that I have seen and understand family medicine, I am convinced it is what our country needs most." Dr Mahlet, Dean, AAU School of Medicine.

We talked about the importance of *thinking big, starting small and acting now*.*

We look forward to continued progress as we celebrate this milestone.

Dawit Wondimagegn, Assistant Professor, Addis Ababa University

Brian Cornelson MD, Assistant Professor, University of Toronto

Cindy Haq MD, Professor, University of Wisconsin

**Quote: Governor Barnabus Sebeu of Papua, Indonesia*

Featured Doctors

Prof Imre Rurik

Hungary – family doctor

Professor Imre RURIK MD, PhD, MSc is Head, Department of Family and Occupational Medicine, University of Debrecen, in Hungary. Here he responds to the WONCA Editor's questions.

What work are you doing currently?

Since 1989, I have been a family doctor in Budapest. In 2008, I was appointed chairman of the Department of Family and Occupational Medicine, in Debrecen. I insisted on keeping my practice, but I can work there only two days a week. Other working days and also the weekend are full with teaching activity and university tasks.

My research activity is wide, with my main topics being nutritional related metabolic diseases (diabetes, obesity) and andrology. The important papers could be checked on http://www.ncbi.nlm.nih.gov/pubmed?term=rurik%20i

Other interesting things you have done previously?

I worked for 10 years as a urologist and during these years spent many shifts in primary care emergency services (at night and weekends). In these years I loved the primary care aspect and thereafter changed my career. I did not give up urology altogether as I run andrology / family planning consultations in my GP office.

(Editor's note: Imre's Curriculum Vitae suggests he is a Lieutenant Colonel in the Army reserves and is a qualified Mediator in Health. He also has a PhD from Semmelweis University, Budapest, Doctoral School (Thesis: *Primary care evaluations on nutrition and health of elderly*) and in 2010 obtained his Dr. habil. from the *University of Debrecen*

What are your interests in work and outside work?

As university teacher, outside work I advertise the importance of primary prevention, and I think physical activity (in an age dependent dosage) is the best way to do this. I usually play tennis, on other days I go jogging or more frequently, swimming in summer and skiing in winter.

What do you like about your interactions in WONCA

The Research Organisation of Hungarian Family Physician (CSAKOSZ) joined to the WONCA group 3 years ago. I have been a regular attender of WONCA meetings, since 1998 (Dublin, World conference), and took part almost all European conferences with posters and presentations, and in recent years as chair of sessions.

There is a wide gap between the primary care systems of the Western and Eastern European countries, and in the East, we have a serious handicap in education and research as well.

I like to try to invite more Hungarian GPs to participate at WONCA conferences, but because of serious financial situation in Hungary they cannot afford to attend.

Asst Prof Sameena Shah

Pakistan – family doctor

Sameena Shah was interviewed about her passion for family medicine. Sameena is a Life Fellow of the College of Family Physicians of Pakistan and a member of the WONCA Working Party on Women in Family Medicine.

Why do you love being a Family Physician?

In short, because I take care of the 'whole person', the patient; and not just the disease or organ system.
I am able to evaluate the disease presentation not just physically, but also its social, psychological impact on the patient and his/her individual response to the disease and as a result I can manage the problems better with the patient.

How did you become a Family Physician?

After getting married in the final year of medical college, I was on a longish break after finishing my House job in 1989. I saw an advertisement in the newspaper inviting graduates to a training programme for Family

Medicine followed by the Membership of the College of Physicians and surgeons, Pakistan. It went on to describe the scope of Family Medicine. They were talking about an opportunity to be a real doctor.

It made so much sense!

Coming from an undergraduate training based in tertiary care hospital where I had, more often than not, seen only the advanced stages of disease or the worst complications it made so much sense to take care of patients before all this. But, best of all, to actually be in a position to prevent all the terrible complications.

Also, again, that opportunity to be a real doctor; where I would be able to look after men and women and children! Absolutely wonderful!

By this time my son, Shehzad, was in school and my daughter, Shahbano, was in Kindergarten, and my parents were delighted to be able to take care of the children. My husband didn't see any reason to prevent me doing it, so I started the Family Medicine Training Programme. I completed it, and got my Membership of the College of Physicians and Surgeons, Pakistan, MCPS, in 1999.

In 2001, I started my residency in Family Medicine at the Aga Khan University, Karachi and got the Fellowship in Family Medicine (FCPS), in 2004.

What work are you doing now?

I am Assistant Professor in the Department of Family Medicine at the Aga Khan University. I do a half day clinic each day; see patients of all age groups presenting with a variety of problems.

My areas of interest are palliative medicine, communication and counselling skills, and domestic violence - although I like seeing patients with all kinds of problems.

As coordinator of Year 5 Family Medicine Clerkship, I teach students a range of family medicine topics using various teaching/learning methodologies. As Chair, Longitudinal Themes, I develop and teach the communication skills sessions across all five years. As Section Head, Palliative Medicine, I am in the process of developing the home based palliative medicine services with my team. I am also working on putting up a multidisciplinary group to address gender violence issues. For my own development I am enrolled in the Masters in Health Professionals Education Program and hope to complete it in 2014.

What else do you like to do?

I love sports, cooking, knitting, reading all kinds of books and watching thrillers, to name a few ...

Resources added this month

Journals

Eurasian Journal of Family Medicine

http://www.ejfm.org/

PEARL 379: Mobile phone-based interventions effective for smoking cessation

Clinical question - How effective are mobile phone-based interventions in helping cigarette smokers to quit?

Bottom line - Mobile phone-based interventions increased the long-term quit rates compared with control programmes, using a definition of abstinence or no smoking at six months since quit day but allowing up to three lapses or up to five cigarettes. Three studies involved a purely text messaging intervention (providing motivation, support and tips for quitting) and one was a multi-arm study of a text messaging intervention and an internet QuitCoach separately and in combination. The final study involved a video messaging intervention delivered via mobile phone.

Caveat - Results were heterogeneous, with findings from three of five studies crossing the line of no effect. There were no published studies on smartphone applications designed to help people stop smoking.

Context - Innovative and effective smoking cessation interventions are required to appeal to those who are not accessing traditional smoking cessation services. Mobile phones are widely used and are now well-integrated into the daily lives of many, particularly young adults. Mobile phones are a potential medium for the delivery of health programmes, such as smoking cessation.

Cochrane Systematic Review

Whittaker R et al. Mobile phone-based interventions for smoking cessation. Cochrane Reviews, 2012, Issue 11. Art. No.: CD006611.DOI: 10.1002/14651858. CD006611.pub3. This review contains 5 studies involving over 9000 participants.

WONCA CONFERENCES 2013-2014

2013

26 – 29 June 2013	20th WONCA WORLD *CONFERENCE*	Prague CZECH REPUBLIC	Family Medicine: Care for Generations www.wonca2013.com

2014

May 21 – 24, 2014	WONCA Asia Pacific Regional Conference	Sarawak MALAYSIA	Nurturing Tomorrow's Family Doctor www.wonca2014kuching.com.my
May 21 – 24, 2014	WONCA World Rural Health Conference	Gramado BRAZIL	Rural health, an emerging need http://www.sbmfc.org.br/woncarural/
July 2 – 5, 2014	WONCA Europe Regional Conference	Lisbon PORTUGAL	New Routes for General Practice and Family Medicine http://www.woncaeurope2014.org/

WONCA Direct Members enjoy *lower* conference registration fees. See WONCA Website **www.globalfamilydoctor.com** for updates & membership information

MEMBER ORGANIZATION MEETINGS

FMPC 2013 India

Date: April 20-21, 2013

Venue: New Delhi, India

Host; Academy of Family Physicians of India

Theme: Preparing multiskilled and competent primary care physicians

Web: www.fmpc2013.com

Email: dr_raman@hotmail.com

City health conference

Host: The Royal College of General Practitioners (England)

Date: April 24-26, 2013

Theme: Tackling inequalities, preventing illness, improving health

Venue: Euston Square, London, UK

Web: www.cityhealthconferences.org.uk

EGPRN spring meeting

Host: European General Practice Research network (EGPRN)

Theme: Risky behaviours and health outcomes in primary care and general practice

Date: May 16-19 2013

Abstracts close: January 15, 2013

Venue: Kusadasi, Turkey

Web: www.egprn.org

12th Brazilian Congress of Family and Community Medicine

Venue: Belem, Brazil

Theme: Family Medicine and community : access to quality

date: May 30-June 2, 2013

Website**:** www.sbmfc.org.br/congresso2013

Email: juliana@oceanoeventos.com.br

XXXIII Congreso de la semFYC

Host**:** SemFYC

Date: June 06-08 2013

Venue: Granada, Spain

Web**:** www.semfyc2013.com

21st Fiji College of General Practitioners conference

Host: Fiji College of General Practitioners

Theme: Holistic medicine

Date: June 22-23, 2013

Venue: Sigatoka, Fiji

Web: http://www.fijigp.org

Email: doctordevika18@yahoo.com

RNZCGP conference for general practice

Host: Royal New Zealand College of General Practitioners

Theme: to be advised

Date: July 11-13, 2013

Venue: Wellington, New Zealand

Web: www.rnzcgp.org.nz

18th Nordic Congress of General Practice

Host**:** Finnish Association for General Practice

Theme: Promoting partnership with our patients - a challenge & a chance ..

Date: August 21-24, 2013

Venue: Tampere, Finland

Web: http://nordicgp2013.fi

European forum for primary care conference

Date: September 9-10, 2013

Venue: Istanbul, Turkey

Host: European forum for Primary care (EFPC)

Theme: Balancing The Primary And Secondary Care Provision For More Integration and Better Health Outcomes

Web: http://nvl007.nivel.nl/euprimarycare/efpc-conference-istanbul-9-10-september-2013

Email: dr_raman@hotmail.com

AAFP annual scientific assembly

Host: The American Academy of Family Physicians

Date: September 24–28, 2013

Venue: San Diego, USA

Web: www.aafp.org

RCGP annual primary care conference

Host: Royal College of General Practitioners

Theme: Progressive Primary Care

Date: October 3–5, 2013

Venue: Harrogate, United Kingdom

Web:www.rcgp.org.uk

RACGP GP '13 conference

Host: The Royal Australian College of General Practitioners

Date: October 17-19, 2012

Venue: Darwin, Northern Territory, Australia

Web: www.gp13.com.au/

2013 Family Medicine Global Health Workshop

Host: American Academy of Family Physicians (AAFP)

Date: October 10-12, 2013

Abstracts close: May 15, 2013

Venue: Baltimore, Maryland, USA

Web: www.aafp.org/intl/workshop

Email: Rebecca Janssen or Alex Ivanov

Family Medicine Forum / Forum en médicine familiale 2012

Host: The College of Family Physicians of Canada.

Le Collège de médecins de famille du Canada

Date: November 7-9, 2012

Venue: Vancouver, Canada

Web: http://fmf.cfpc.ca

The Network: Towards Unity for Health annual conference

Host: TUFH

Theme: Rural and Community Based Health Care: opportunities and challenges for the 21st century

Date: November 16-20, 2013

Venue: Ayutthaya, Thailand

Web: http://www.the-networktufh.org/conferences/upcoming