WONCANews

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From the President: New Zealand, Singapore and Quality

Photo: Singhealth clinic visit

In early August I returned from a very enjoyable trip to the Royal New Zealand College of GPs (RNZCGP) who invited me to their annual conference (see photo below) and on the way home I also visited our colleagues in Singapore.

This is the third time I have been to New Zealand (NZ) and the second time to the RNZCGP (thanks!). I was struck by the major developments in 'upscaling' of general practice there over the last five years. Much of the country now has GPs linked into primary health organisations, with some direct funding for their activities in planning and developing services. I saw the same in my visit to Singapore, and indeed am seeing parallel developments - though less mature – in the UK. I debate these models further in my policy bite this month.

A key theme at the NZ conference was 'Quality' and how to achieve it. The RNZCGP have had a practice accreditation system for a number of years; this is currently being reviewed, in order to balance the goal of robust measures of achievement with an efficient process of assessment. Many family doctors want a benchmark of standards achieved, and recognition for their work – it is for this reason that WONCA itself is now running options for practice accreditation and academic accreditation, which may be of interest to those who do not have this opportunity at a national level.

WONCA Practice accreditation

WONCA Standards for Postgraduate FM education

The NZ debate centred around how to motivate primary care teams towards continuing improvements and innovation, while ensuring that all patients receive a good enough package of care – so setting the 'bottom line' but encouraging movement upwards from it ! There is always a risk that some patients will get wonderful care while others get poor care – so checks for both are needed. How our member organizations lead on these issues will vary, but the RNZCGP has a lot of experience to share. You can see my keynotes for this trip on the WONCA website.

I was also impressed by the work being done to improve the health and care of New Zealand's indigenous communities – Maori and Pacific Islanders. The RNZCGP have staff leading on these issues, and there were traditional welcomes for both meetings. The number of GPs from these backgrounds is low, but numbers are increasing both at medical school and in graduate training. WONCA has active leaders in a number of our Working Parties (WPs) and Special Interest Groups (SIGs) – including Prof Felicity Goodyear-Smith leading the WP on Research WP, Dr Tane Taylor convenor of the WP on Indigenous and Minority Health, and Dr Jo Scott-Jones WP on Rural Practice Executive: it was great to see all of them.

I did manage a clinic visit, and am grateful to the Island Bay Medical Centre team and Dr Richard Medlicott for welcoming me to their

friendly neighbourhood practice, in Wellington. (photo below)

In Singapore, I was a guest of the Duke National University of Singapore, and met members of our member organization, the College of Family Physicians of Singapore, there as well. I did a Faculty seminar on teaching, and contributed to a medical student workshop about family medicine and research, as well as visiting the College of Family Physicians and one of the Singhealth polyclinics (see photos and talks). Singapore also has strong development of large scale primary healthcare organisations, but GPs are less dominant in these than NZ – however, the voice of family medicine is definitely growing, including having a family doctor in a leading position in their ministry. There is a significant divide between the public and private sector GPs, and speciality postgraduate training is not a mandatory requirement in Singapore. These are both issues that the academic community and professional leadership are actively addressing. The academic community are also busy developing primary care research networks, which are enabling practitioner engagement in research and also facilitating community based research projects.

Photo: Signing the Singapore College guest book with left to right Prof Lee Kheng Hock, President Tan Tze Lee, Dr Suraj Kumar

So in summary, the issues for NZ and Singapore mirror many around the world – still a need to get more people into speciality training and into the workforce, especially to serve rural and vulnerable communities; a need for stable resourcing and support, and also for visibility and influence. But the family doctors of both countries are definitely striving for excellence, and it was a privilege to see their work up close. My thanks to all involved.

The rest of the work for WONCA has been a continuing stream of activities from WHO, around the Alma Ata 40th anniversary, and preparation for our World conference in Seoul. I have trips coming up to the Towards Unity for Health conference and with whom we are in official collaboration), to Indonesia as a keynote speaker for an International Public Health conference and to meet our leaders there; then to the World Psychiatric Association conference, in Mexico, at the end of September, which will be my final keynote as President to an external partner! I will update you about all this in October, as well as saying a kind of farewell.

Till then, all best wishes for your work as family doctors, and your lives as people. Go well and thanks.

Amanda Howe
President

The RNZCGP will host the WONCA Asia Pacific region conference in 2020 – from 26-31 May in Auckland, New Zealand

De la presidenta – Nueva Zelanda y Singapur.

Foto: Visita en la clínica Singhealth

A principios de agosto volví de un viaje que disfruté mucho durante el cual pude visitar el Real Colegio de Médicos de Familia de Nueva Zelanda (Royal New Zealand College of GPs, RNZCGP), tras aceptar su invitación para asistir al Congreso anual y, de vuelta a casa, también pasé a visitar a nuestros colegas en Singapur.

foto: Centro Médico de Island Bay, Wellington NZ, con Doctor Richard Medlicott y personal

Esta ha sido la tercera ocasión en la que he visitado Nueva Zelanda (NZ) y la segunda vez que he estado en el Colegio Real de Médicos de Familia de Nueva Zelanda (RNZCGP) (¡muchas gracias!). Me quedé atónita al ver los crecientes y grandes progresos de la práctica de medicina de familia y comunitaria en el país durante los últimos cinco años. La mayor parte de Nueva Zelanda tiene médicos y médicas de familia que mantienen estrechas relaciones con organizaciones y sociedades de Atención Primaria, mediante una financiación directa para sus actividades en la planificación y en el desarrollo de los servicios. Percibí lo mismo durante mi estancia en Singapur y, sin duda, veo avances que van en paralelo – aunque con menos intensidad y madurez – en el Reino Unido. En mi artículo de Fragmentos de política de este mes, pongo el foco de debate en estos modelos con más profundidad.

Un tema clave en el Congreso de Nueva Zelanda fue la “Calidad” y el cómo conseguirla. El Real Colegio de Médicos de Familia de Nueva Zelanda (RNZCGP) ha puesto en práctica un sistema determinado en el fomento de la calidad a lo largo de varios años y sus consecuencias están siendo revisadas, con el fin de equilibrar el objetivo tanto por lo que respecta a las medidas robustas en la financiación como en el proceso eficiente del asesoramiento. Muchos médicos y muchas médicas de familia quieren poder contar con un punto de referencia y con estándares claros, y que se reconozca su trabajo – es por esa razón que la misma WONCA está poniendo sobre la mesa las opciones para la acreditación de la práctica y académica, que pueden resultar interesantes para todas aquellas personas que no han conseguido lograr su oportunidad a nivel nacional.

>Acreditación práctica de la WONCA

>Estándares de la WONCA para el posgrado de Medicina de Familia en Educación

Foto: Amanda Howe en el Colegio Real de Nueva Zelanda de Médicos de Familia

En Nueva Zelanda, en estos momentos, el debate se está centrando en torno a cómo motivar los equipos de Atención Primaria hacia una mejora continuada basada en la innovación, mientras se garantiza que los

pacientes reciben un paquete asistencial lo suficientemente adecuado y de calidad, ¡así que antes de implementar el "resultado final" avancemos hacia este punto! Siempre existe el riesgo de que algunos pacientes reciban una asistencia magnífica mientras otros gozan de una asistencia más precaria – así que los controles de calidad son necesarios en ambos casos. La forma mediante la cual nuestras organizaciones miembro pueden gestionar y liderar este tipo de cuestiones será diferente en cada caso, pero el Colegio Real de Médicos de Familia de Nueva Zelanda tiene mucha experiencia y puede compartir la suya. Podéis ver mis comentarios clave acerca de este viaje en la página web.

Yo también me sentí impresionada por el trabajo que se ha hecho para mejorar la salud y la asistencia de las comunidades indígenas de Nueva Zelanda – los Maori y los isleños del Pacífico. El Real Colegio de Médicos de Familia de Nueva Zelanda cuenta con personal cuya labora está especialmente dirigida a estos ámbitos, y ahí hubo bienvenidas tradicionales para todos los encuentros. El número de médicos de familia con estos antecedentes es francamente bajo, sin embargo, las cifras están creciendo tanto a nivel de escuelas médicas como en la formación de graduados. WONCA tiene líderes activos en buena parte de nuestros Grupos de Trabajo (Working Parties, WPS) y Grupos de Interés Especial (Special Interest Groups, SIGs) – incluyendo la profesora Felicity Goodyear-Smith que lidera el Grupo de Trabajo en Investigación, la Doctora Tane Taylor, coordinadora del Grupo de Trabajo en Salud de los Indígenas y Minorías, y el Doctor Jo Scott-Jones del Grupo de Trabajo en Práctica Rural Ejecutiva: fue fantástico verlos a todos juntos.

Tuve la ocasión de poder gestionar una vistia clínica, y estoy muy agradecida al equipo del Centro de Salud de Island Bay y al Doctor Richard Medlicott por darme la bienvenida e invitarme formar parte de su amistoso vecindario en Wellington.

Foto: Firmando el libro de invitados en el Colegio de Singapur con izquierda hacia la derecha Profesor Lee Kheng Hock, Presidente Tan Tze Lee, el Doctor Suraj Kumar.

En Singapur, fui invitada a la Universidad Nacional Duke, y conocí a miembros de nuestra organización miembro, el Colegio de Médicos de Familia de Singapur. Participé en un seminario en la Facultad acerca de la enseñanza, y contribuí en los talleres de estudiantes médicos acerca de la Medicina de Familia y la investigación, así como visité el Colegio de Médicos de Familia y una de las policlínicas Singhealth (ved fotos y conversaciones). Singapur también goza de un fuerte desarrollo dentro de la gran gama de variedad de las organizaciones miembro de Atención Primaria, pero los médicos de familia tienen menos peso que en Nueva Zelanda – a pesar de ello, la voz de la Medicina de Familia está, sin duda, en crecimiento, con un ministro de sanidad que es médico de familia. En Singapur, existe una división muy significativa entre el sector público y el privado en lo que respecta a la Medicina de Familia, y, sobre todo, en lo que afecta a la formación especializada de postgrado, que no es una condición obligatoria en Singapur. Estas son cuestiones para las que se está buscando una solución, tanto por lo que respeta a la comunidad académica como en lo referente al ámbito del liderazgo profesional. La comunidad académica también está ocupada desarrollando las redes de investigación de la Atención Primaria, que están permitiendo que más médicos de familia se comprometan con la investigación. así como facilitando aquellos proyectos basados en la actividad comunitaria.

De modo que, en resumen, las cuestiones que afectan a Nueva Zelanda y Singapur son comunes en todo el mundo – sigue la necesidad de conseguir que más gente se involucre en la formación especializada y de aumentar el personal sanitario, especialmente para dar servicio a las comunidades rurales y vulnerables; una necesidad para conseguir una fuente de recursos y de apoyos estable, que aumenten su visibilidad y su influencia. Pero los médicos de familia de ambos países se están esforzando de forma determinante para conseguir la excelencia, y poder ver su trabajo desde cerca fue un auténtico privilegio. Os agradezco mucho a todas las personas que os involucrasteis.

El resto del trabajo por parte de la WONCA ha sido un continuo flujo de actividades desde la Organización Mundial de la Salud, alrededor

del 40 Aniversario de Alma Ata, hasta la preparación de nuestro Congreso mundial en Seúl. ¡Tengo diversos viajes en el horizonte desde el Towards Unity for Health conference y con quienes somos colaboradores a nivel oficial), hasta una parada en Indonesia donde seré oradora principal como Presidenta de una organización colaboradora externa! Os daré más actualizaciones al respecto en octubre, y también aprovecharé para mandaros una especie de despedida.

Hasta entonces, recibid mis mejores deseos por vuestro trabajo como médicos y médicas de familia, y también en vuestra vida personal. ¡Cuidaos y muchas gracias!

Amanda Howe
Presidenta de la WONCA

De la présidente : Nouvelle Zélande et Singapour

Photo: Visite de la clinique Singhealth

Je suis rentrée début août d'un agréable voyage au Royal New Zealand College of GPs (RNZCGP) où j'avais été invitée à la conférence annuelle et, en chemin, j'ai également rendu visite à nos collègues de Singapour.

C'était la troisième fois que je me rendais en Nouvelle Zélande et la deuxième fois au RNZCGP (merci!). J'ai été surprise par les grandes améliorations du pays en matière de médecine générale au cours des cinq dernières années. Dans la majorité du pays, les généralistes sont intégrés dans des organisations de santé primaire et reçoivent un financement direct de leurs activités dans le domaine des services de planification et de développement. J'ai constaté la même chose durant ma visite à Singapour et, en effet, il existe des développements parallèles -bien que de maturité moindre- au Royaume Uni. Je débats ces modèles plus en détail dans ma note politique du mois.


Photo: Amanda Howe a la conférence de RNZCGP

La 'qualité' et comment y parvenir était un thème clé de la conférence de Nouvelle Zélande. Le RNZCGP a un système d'accréditation des pratiques depuis de nombreuses années. Ce système est maintenant le sujet d'une révision afin d'équilibrer l'objectif de mesure robuste des résultats et une procédure efficace d'évaluation. De nombreux médecins de famille souhaitent l'adoption de standards et la reconnaissance de leur travail -c'est la raison pour laquelle WONCA offre désormais des options pour l'accréditation pratique et l'accréditation académique, ce qui pourrait intéresser ceux qui n'ont pas eu cette occasion au niveau national.

>Accréditation pratique WONCA

>Standards WONCA pour l'éducation postuniversitaire en médecine familiale

Le débat de Nouvelle Zélande était centré sur la motivation des équipes de soins primaires pour la continuation des améliorations et de l'innovation tout en s'assurant que tous les patients reçoivent des soins adéquats -donc l'établissement d'une ligne de base limite et l'encouragement d'un mouvement vers le haut ! Le risque que certains patients recevront des soins de qualité alors que d'autres auront une mauvaise expérience est toujours présent -des contrôles sont donc nécessaires dans les deux cas. La façon dont nos organisations membres approchent ces questions variera mais le RNZCGP a une grande expérience à partager. Vous pouvez consulter les discours donnés au cours de ce voyage sur le site web.

J'ai aussi beaucoup apprécié le travail résultant en une amélioration de la santé et des soins dans les communautés indigènes de Nouvelle Zélande -Maori et Polynésiens. Le RNZCGP dispose de personnel spécialisé dans ces questions et des cérémonies traditionnelles de bienvenue ont pris place lors des deux réunions. Le nombre de médecins généralistes issus de ces

cultures est bas mais il croît à la fois à la faculté de médecine et dans la formation des diplômés. WONCA a des leaders actifs au sein de nombre de nos groupes de travail et de nos groupes d'intérêts spéciaux -y compris Prof Felicity Goodyear-Smith leader du groupe de travail sur la recherche, Dr Tane Taylor coordinatrice du groupe de travail sur la santé des Indigènes et des Minorités, et Dr Jo Scott-Jones du groupe de travail sur la direction de pratique rurale. J'ai eu le plaisir de tous les rencontrer.

J'ai également pu visiter une clinique et je remercie l'équipe du Centre médical d'Island Bay et Dr Richard Medlicott pour leur accueil dans leur sympathique cabinet local à Wellington. (photo à droit)

A Singapour, j'étais l'invitée de l'Université Duke National et j'y ai aussi rencontré quelques membres de notre organisation du Collège des médecins de famille de Singapour. J'ai dirigé un séminaire universitaire sur l'enseignement et contribué à un atelier pour étudiants en médecine sur la médecine de famille et la recherche. J'ai aussi visité le Collège des médecins de famille ainsi que la polyclinique Singhealth (Voir les photos et les discours). Singapour connaît aussi de grands développements dans le domaine des organisations de soins de santé primaire, mais la présence de médecins généralistes y est moins dominante qu'en Nouvelle Zélande - cependant, la voix de la médecine familiale grossit résolument et il y a même un médecin de famille dans un poste clé au ministère. Il y a un fossé significatif entre la médecine générale du secteur public et celle du secteur privé et la formation postuniversitaire des spécialistes n'est pas une condition obligatoire à Singapour. La communauté universitaire et le leadership professionnel traitent activement ces deux questions. La communauté universitaire s'acharne à développer des réseaux de recherche sur les soins de santé primaire, réseaux qui permettent l'engagement des praticiens dans la recherche et facilitent aussi les projets communautaires de recherche.

Photo: Signature du registre de visiteurs du Collège de Singapour avec, de gauche à droite, Prof Lee Kheng Hock, President Tan Tze Lee, Dr Suraj Kumar

Donc en résumé, les questions présentes en Nouvelle Zélande et à Singapour reflètent celles de beaucoup d'autres pays dans le monde -le besoin constant d'encourager plus de gens dans la formation de spécialistes pour joindre le monde du travail, en particulier dans le but de servir les communautés rurales et vulnérables ; le besoin de ressources et de soutien stables et aussi dans le but de développer visibilité et influence. Les médecins de famille des deux pays travaillent certainement avec comme objectif l'excellence et j'ai eu le privilège de voir leur travail de près. Mes remerciements à tous.

Le reste de mon travail pour WONCA a consisté en un flot continu d'activités de l'OMS, autour du 40e anniversaire de l'Alma Ata et la préparation de notre conférence mondiale à Seoul. Mes voyages à venir à la conférence Towards Unity for Health, avec laquelle nous collaborons officiellement), en Indonésie comme conférencière principale pour la conférence internationale sur la santé publique et pour y rencontrer nos leaders ; puis à la conférence mondiale de l'Association de Psychiatrie au Mexique fin septembre. Ce sera là ma prestation finale pour un partenaire externe en tant que Présidente ! Je vous tiendrai au courant de tout cela en octobre et je vous ferai alors mes adieux.
En attendant, tous mes meilleurs souhaits dans votre travail de médecins de famille et dans vos vies privées. Au revoir et merci.

Amanda Howe
Présidente

From the CEO's desk: WONCA membership explained

Garth Manning writes:

In a World Conference (and Council) year, the period in the weeks before the event is quite quiet in terms of visits and events. This is because there is a moratorium on official WONCA events for the four months prior to a world meeting. However it's a very busy period for the Secretariat, as we finalise the Annual Report and prepare for the meetings of Executive and Council.

A couple of years ago I wrote on WONCA membership, and thought that I would return to this, to update members on which organizations have been admitted to WONCA membership in this biennium. Year on year the organization continues to grow, and we remain delighted that applications for membership remain buoyant. WONCA now boasts over 130 Member Organizations in around 150 countries and territories and represents some 600,000 family doctors globally – and with more potential applications in the pipeline.

WONCA has a number of membership categories. These are detailed in the Bylaws, as outlined below, and I have listed those organizations which have been admitted in each category in this biennium:

Full Membership

is open to national organizations or a group of national organizations which are representative of general practitioners/family physicians of that country or those countries and a majority of whose constituent voting membership consists of general practitioners/family physicians who are legally registered to practise within that country or those countries.

Full members have the right to vote at regional and world level.

Full Membership 2016-18
1. College of Indonesian Primary Care Physicians
2. Pakistan Society of Family Physicians (previously an Associate Member)
3. Society of Family Physicians of Ghana
4. Public Organization National Association of Family Medicine Workers of Tajikistan.

Academic Membership

is open to Academic Departments or training programs of general practice/family medicine which are actively involved in teaching and research, support the Mission of the Organization, and desire affiliation with the Organization.

Academic Membership 2016-18
1. Department of Family Medicine, University of Malawi College of Medicine.
2. Division of Family Medicine, University of Cape Town, South Africa.
3. Department of General Practice, Faculty of Postgraduate Medicine, Khesar Gyalpo University of Medical Sciences of Bhutan (KGUMSB), Thimphu, Bhutan
4. Department of Family Medicine at Queen's University, Kingston, Ontario, Canada
5. Department of Family Medicine (DFM) of Faculty of Medicine and Community Health (FMCH), Queensland University, Haïti.
6. Aswan Family Medicine Residency Programme, Egypt

Organization in Collaborative Relationship status

is open to international organizations whose missions and objectives are consistent with those of WONCA and who are not eligible for, or who do not seek, Full or Associate Membership.

Organization in Collaborative Relationship (OCR) 2016-18
1. World Federation of Public Health Associations (WFPHA)
2. International Primary Care Cardiovascular Society (IPCCS)
In turn, WONCA has been admitted as a partner (OCR equivalent) with WFPHA.

Direct Individual Member.

These are individual persons who are members of a recognized health profession and who support the vision, mission and goals of WONCA, and who wish to belong to a worldwide network of family medicine/general

practice professionals, educators, caregivers and advocates. Membership can be for a limited period, but since 2013 we have also offered Life Direct Membership to those individuals who wish to make a special gift to the World Organization of Family Doctors in return for waiver of annual direct membership renewal requirements. Note that this category of membership is open to all health professionals and not just family doctors.

There are simply too many Individual Direct Members to list, but in recognition of those who have very generously taken out Life Direct Membership we have included them on a roll on the WONCA website.

Congratulations to all

This great boost in membership numbers is a great tribute to the hard work of the WONCA Executive – especially regional presidents – together with the Secretariat staff and the WONCA Membership Committee who have worked hard to process all these applications.

To all our new members – a very warm welcome to the WONCA family.

Until next month.

Dr Garth Manning
CEO

Policy Bite - 'Working at scale' – issues for family doctors

Family doctors define our discipline in part by our relationship with, and active knowledge of, our patients as people: also recommending an ongoing relationship with both individuals and their communities, so that we can be proactive about health needs and risks identified for the different populations within our reach.

Systems where care is anonymous, and where the next available appointment is randomly allocated to any doctor available, are less acceptable to patients, and also less effective – because prior knowledge and ongoing trust helps both the doctor and the patient to make good decisions, and to act on the advice given. Even within a primary health care team, efforts are made to keep some continuity where the patient wants or needs it, while a shared record allows 'knowledge' to travel between the clinic staff, and to be efficiently used for team care.

But there may be advantages to joining up some functions. A well run clinic will need administrative, human resource, financial and IT expertise, as well as clinical competence. Primary care services must interact with the hospital and social care sectors, as well as with the agencies who fund their work. If the clinic is owned by the doctors, they will need to make decisions about who to employ, how to organise the team, and infrastructure services such as cleaning and medical supplies. A serious commitment to community engagement needs staff to spend time in discussions with local stakeholders to create healthier environments. Leadership roles in teaching, research and service management will take staff time away from clinical services. And even the most centralised health systems benefit from some involvement of the family doctors in service development initiatives.

So there are discussions to be had about how to do this 'at scale' – that is, finding new ways of working that enable us to meet the increasing challenges and demands placed on our clinics, by working collaboratively with other practices and healthcare providers to achieve economies of scale and improve overall services; but still retaining local autonomy and ownership of the doctor-patient-community relationship.

This is a journey I have seen in the UK, New Zealand, Singapore, and Brazil – to name only a few.

Let me start with the UK When I was a child, I went to the GP's house, where his wife checked the patients into the waiting room in the downstairs of their house, and he was the only clinician in the team. When I first went to work as a GP, my senior partner was still working from his family home with his children's nanny as one receptionist - but the

house had been extended into a small clinic, and we were four GPs, three receptionists, and two nurses. Soon we expanded all three parts of the team, became computerised, and also started to share some work and initiatives with eight other practices. We compared data on referrals and admissions, co-funded some innovative services for mental and occupational health problems, and shared out-of-hours cover.

Various experiments – including government-driven policies around funding and commissioning, plus the increasing needs for high calibre business and personnel expertise - have now led to many UK general practices merging their 'back office functions', in order to improve their purchasing power and market opportunities. The Nuffield Trust policy unit reported in 2017 that almost 75% of GPs were now linked into some kind of collaborative or federated network. This does not usually mean selling their businesses, but may take the form of a 'not for profit' organisation, or a network who have agreed to co-employ some staff and run some shared services. The 'local face' of the clinic remains unchanged in many of these models, but GPs can band together to negotiate with other service providers for improved models of care for patients. And leading for teaching, research, or clinical quality initiatives, can be done across practices - with more opportunities because of the larger patient base.

In New Zealand, these linkages have been driven in part by government policies to address quality and population health needs through setting up primary health organisations (PHOs). GPs were already moving to collaborative models – one of the most mature, Pegasus Health, in Canterbury, https://www.pegasus.health.nz/ has been in development for 25 years, and most GPs are now linked into PHOs. Cooperation for staffing and professional development has led into major service redevelopment and citywide cooperation – while keeping identifiable local practice teams. The national voice of GPs is also strong, with clear leadership and inputs to policy making through our WONCA member, the Royal New Zealand College of GPs.

Singapore has a different challenge – the public sector GPs and academic family medicine units are linked into three major clusters of health care providers and are often hospital based, running specific services (see for example singhealth https://www.singhealth.com.sg/Pages/home.aspx). The need here is to ensure services are community oriented, and that some continuity of clinician contact is made possible. There are new 'polyclinics' being opened under GP leadership, and family medicine is making major impacts on care pathways - for example, an integrated care approach to older people's care, to minimise hospital admissions and length of stay, and to increase home support. Another challenge is that there is a large private GP sector, with very different service models – the question of how to include these doctors in both service and professional development networks is also one of attaining 'scale'.

So, key messages – while small is beautiful, and the personal relationship between patient and doctor one to be treasured for its therapeutic potential, most of us cannot survive economically or psychologically as a single person service.

Most patients value access to a modern team and a range of services, with reliable care available when needed, especially if their 'own' GP is away from frontline service. And we need capacity for nonclinical services – in a network of clinics, named individuals (both clinical and others) can play lead roles to develop teaching, research, extended services, and also act as advocates and managers for collaboration with other service providers. I personally recall the amateurish attempts we made as young GPs to secure a good practice manager – and how much more successful and enjoyable our practice became when we got a very experienced person. We had to offer a higher salary scale, but managed this by appointing them with another clinic, and the individual was more than skilful enough to run both practices – in fact, we ended up 'lending' her to some others!

So as family doctors we need to think both small and big – and not always feel we must 'go it alone'. Some of the modern models of care offer effective support and capacity, while keeping the human face of family medicine.

Amanda Howe
WONCA President

Fragmentos de política –Trabajando a escala – problemas para los médicos de familia

Los médicos de familia definimos nuestra disciplina en parte por nuestras relaciones con la gente y por nuestro conocimiento activo de alguna cuestión, bien sea de nuestros pacientes como personas o recomendando la relación en curso tanto con pacientes a nivel particular como con sus comunidades, de modo que podemos ser proactivos y proactivas acerca de nuestras necesidades en salud y con respecto a los riesgos identificados para diferentes tipos de poblaciones a nuestro alcance.

Aquellos sistemas en los que la asistencia es anónima, y en los que nuestra siguiente cita disponible se selecciona de forma aleatoria y se elige así a cualquier médico o médica que esté disponible, son menos aceptados por parte de los pacientes y también se ha demostrado que son menos efectivos – porque una vez se pone en marcha la primera toma de contacto y se genera la confianza suficiente, esto ayuda tanto al médico como al paciente a la hora de tomar decisiones correctas y a la hora de actuar de acuerdo a los consejos recibidos. Incluso dentro del equipo de Atención Primaria, se hacen muchos esfuerzos por mantener una cierta continuidad en aquellos puntos en los que el paciente la quiere o la necesita, mientras que el registro compartido permite el "conocimiento" necesario para poder ser transferido y tratado por diversos miembros del personal clínico y para que sea utilizado eficientemente por parte de la asistencia en equipo.

Pero puede que haya muchas ventajas para que algunas funciones se lleven a cabo de forma unitaria. Una clínica bien gestionada necesita recursos administrativos, humanos, financieros y experiencia en tecnología de la información, así como una buena competencia clínica. Los servicios de Atención Primaria deben interactuar con los sectores hospitalarios y sociales, así como con las agencias que financian sus trabajos. En el caso de que la clínica o la consulta sean propiedad de los médicos, estos necesitarán tomar decisiones de gestión, como por ejemplo a quien contratar, como organizar el equipo, o los servicios de infraestructura como por ejemplo la limpieza o los proveedores. Un serio cometido con este compromiso necesita el personal para invertir tiempo en debates con políticos locales para que creen entornos más saludables. Hay que tener claros los roles del liderazgo a la hora de enseñar, de investigar y de gestionar los servicios que se tomarán en parte de las asistencias clínicas, y a pesar de que los sistemas sanitarios más centralizados se benefician de una gran implicación de los médicos de familia al servicio de las iniciativas de desarrollo.

Así que hay diversos debates que hay que tener en cuenta acerca de cómo actuar a "este nivel" – esto significa, encontrando nuevos caminos de trabajar que nos permitan afrontar los retos crecientes y las demandas de nuestras clínicas, por medio de un trabajo colaborativo con otras especialidades y profesionales sanitarios para conseguir ahorrar de forma significativa y mejorar el conjunto de los servicios; pero manteniendo la autonomía local y la propiedad de la relación doctor-paciente-comunidad.

Esta es una evolución que he visto en el Reino Unido, en Nueva Zelanda, en Singapur y en Brasil – por nombrar simplemente algunos sitios.

Dejadme empezar con el caso del Reino Unido. Cuando yo era una niña fui a casa del Médico de Familia, donde su mujer inspeccionaba a los pacientes en la sala de espera bajo las escaleras de su casa, y él era el único profesional clínico en el equipo. Cuando por primera vez empecé trabajando como médica de familia, mi compañero seguía trabajando desde su casa con su niñera como recepcionista – pero la casa había sido engrandecida hasta llegar a ser una pequeña clínica, y éramos cuatro médicos de familia, tres recepcionistas y 2 enfermeras. Pronto decidimos expandir todavía más las tres partes del equipo, nos informatizamos y también empezamos a compartir parte de nuestro trabajo y de nuestras iniciativas con ocho especialidades distintas más. Comparamos datos a partir de derivaciones y admisiones, fundamos conjuntamente algunos servicios innovadores para diferentes problemas de salud mental, y compartíamos las horas extra.

Algunos experimentos – incluyendo las políticas gubernamentales entorno a la financiación y las comisiones, además de las necesidades crecientes para negocios de envergadura y especialidad del personal – han llevado ahora a muchas consultas (como esta) de médicos del Reino Unido a incorporarse a "funciones de trasfondo", con el fin de mejorar el poder de adquisición y las oportunidades del mercado. La unidad de análisis político del Nuffield Trust indica que en 2017 prácticamente un 75% se encontraban vinculados con algún tipo de relación con alguna red colaborativa o federada. Esto no significa que estén "vendiendo" sus negocios, si no que muchos de estos toman la forma de organizaciones "sin ánimo de lucro", o de redes que han aceptado el co-empleo de parte de su personal y ofrecer algunos servicios compartidos. La "cara local" de la clínica se mantiene sin cambios en muchos de estos modelos, pero los médicos de familia pueden juntarse para negociar con otros proveedores de servicios en aquellos modelos de servicios mejorados de asistencia para pacientes. Y seguir siendo líderes para la docencia, la investigación o las iniciativas clínicas de calidad, puede hacerse a través de las prácticas – mediante un mayor número de oportunidades a causa de una base mayor de pacientes.

En Nueva Zelanda, estas relaciones se han ido viendo alejadas en parte a causa de las políticas gubernamentales a la hora de buscar dar una respuesta a las necesidades con respecto a la calidad sanitaria y a la salud de la población (PHOs). En aquellos momentos, los médicos y las médicas de familia estaban ya evolucionando hacia modelos colaborativos – uno de los más maduros (Pegasus Health, en Canterbury, consultad www.pegasus.health.nz) ha sido desarrollador durante 25 años, y la mayor parte de los médicos de familia se encuentran en estos momentos conectados al PHOs-Coperación con el fin de dotar de desarrollo profesional y de recursos humanos y que ha tenido como consecuencia un mayor servicio de renovación y cooperación por toda la ciudad. Mientras, se siguen haciendo prácticas identificables con equipos locales. La voz nacional de los médicos de familia también se oye fuertemente, con un liderazgo claro y buenas aportaciones a la hora de diseñar políticas a través a de nuestra organización miembro, el Real Colegio de Nueva Zelanda de Médicos de Familia.

Singapur tiene un reto distinto – el sector público de médicos de familia y las unidades académicas de Medicina de Familia están conectadas a través de tres grupos de profesionales de la salud y a menudo están basados en el contexto hospitalario, ofreciendo servicios específicos (ved por ejemplo https://www.singhealth.com.sg/Pages/home.aspx). La necesidad aquí es la de garantizar que los servicios que se presentan están orientados a la comunidad, y que el contacto clínico es posible en la comunidad. Hay nuevas "policlínicas" que han sido inauguradas con el liderazgo de médicos de familia y la Medicina de Familia está logrando tener un gran impacto en las diversas vías de la asistencia – por ejemplo, una aproximación a la asistencia integrada para la gente mayor, para minimizar la hospitalización y la duración de las estancias hospitalarias, así como para aumentar el apoyo en casa. Otro de los retos a los que hay que hacer frente es el gran sector privado existente en Medicina de Familia con modelos de servicio muy diferentes – la cuestión sobre cómo incluir este personal médico tanto en el servicio asistencial como en las redes de desarrollo profesional es otro de los elementos que tiene que ver con la "dimensión".

Así que, como mensajes clave – si bien es cierto que lo pequeño es bonito, y la relación personal entre pacientes y los médicos es, sin duda, un elemento que hay que atesorar por su gran potencial terapéutico, la mayor parte de nosotros no puede sobrevivir económicamente o psicológicamente ofreciendo un servicio totalmente y solamente individualizado. La mayor parte de los pacientes valoran el acceso a un equipo moderno y a una gama de servicios diversa, con una asistencia en la que se pueda confiar en cuando sea necesario, especialmente si su "propia" Medicina de Familia se encuentra lejos del servicio de primera línea. Y necesitamos la capacidad para los servicios no-clínicos – dentro de una red de policlínicas, llamadas individuales (tanto centros de salud como otros tipos de clínica) que pueden jugar diferentes roles a la hora de desarrollar la docencia, la investigación, los servicios ampliados, y actuar igualmente como defensores y gestores de colaboración con otros proveedores de servicios. Personalmente, me acuerdo mucho de los intentos amateurs que hicimos como jóvenes médicas de familia para asegurar una buena

gestión práctica – y cómo nuestra práctica llegó a ser mucho más exitosa y agradable y mejoró cuando tuvimos una persona muy experimentada. Nosotros tuvimos que ofrecer un salario más alto que el de la media, pero una vez gestionada esta cuestión, con la ayuda de otros profesionales clínicos, y personal individualizado, tuvimos habilidades suficientes para realizar ambas prácticas – ¡de hecho, incluso dejamos un poco de experiencia para los otros!

Así que como médicos y médicas de familia necesitamos pensar tanto a nivel pequeño como a nivel más grande – y no siempre debemos sentir que debemos avanzar nosotros solos. Algunos de los modelos en asistencia moderna ofrecen un apoyo efectivo y una mayor capacitación, mientras mantenemos como prioridad la cara humana de la Medicina de Familia.

Amanda Howe
WONCA President

Working Party Annual reports

Working Party on eHealth Annual Report

Ilkka Kunnamo (Finland), chair of the Working Party on eHealth reports:

The WONCA Policy Statement on eHealth bit.ly/1WLQiAy published in 2016 has guided the topics raised at WONCA conferences. It has stimulated many discussions about the active role of patients in recording and managing their own health data, about the benefits but also confidentiality risks of national data repositories holding both primary and secondary care data, data capture for big data repositories and for quality measurement. Most importantly, the long-waited opportunity for the general practitioner to take the role of coordinator in both health promotion and in the care of patients with multiple morbidities could finally come true as all health data and an integrated care plan will soon be available both to the GP and to his or her patients.

The WONCA Working Party on eHealth collaborated with EQuiP in organizing two workshops at WONCA Europe in Krakow with eHealth as one focus. The topics were quality measurement (presentation) and integrated care plans (presentation). eHealth was a keynote topic at the EQuiP Conference in Bratislava (presentation).

We have received more than 20 requests to join the Working Party during the last year. The number of requests is steadily increasing. All new members are welcome, and they will be contacted personally.

There has been a lot of hype about artificial intelligence (AI) in medicine, but few clinical applications so far. The Working Party should actively follow new developments, keep the key principles of general practice in focus, and promote ethical discussion on who controls AI implementation.

Merging together the Working Party on eHealth and WONCA International Classification Committee has been discussed, because the implementation of eHealth is very much dependent on structured health data, and discussing how to utilize coded data together with emerging technology of natural language processing in clinical practice may be even more important than promoting a specific coding systems.

Time has come for me to retire from the position as convenor of the Working Party and thank all colleagues who have been involved in its activities. We wish to elect a new convenor by the end of this year.

Join our working party

International Classification committee (WICC) annual report

The annual WONCA International Classification Committee (WICC) meeting in 2017 was held from 26 August to 1 September in Lyon/France. There were 23 members and six observers participating. The main topics were the international ICPC-3 Consortium founded for the development of a new version of the International Classification of Primary Care (ICPC-3) under the lead of Kees van Boven at the University of Nijmegen/Netherlands and its relationship to WICC. Furthermore the WICC directly worked on the content of the future ICPC-3. Another important topic was the development of a primary care version (linearization) of ICD-11 in collaboration with WHO.

In the meantime the ICPC-3 Consortium took up its work which can be followed at the Consortium website. Another website to keep informed about the work of WICC is the PH3C-website.

At the midyear meeting of the WHO-Family of International Classifications (WHO-FIC) Network in Geneva at the 14./15. April 2018 there were discussions about the current state of the primary care version of ICD-11. The main change from ICD-10 to ICD-11 will be a switch from the former big book to a software based version published as a searchable database to be incorporated in other software systems. Another change will be that a so called foundation layer has been created, containing all concepts of the domain of medicine in a defined manner with semantic linkages (is part of…, relates to…)

in all possible directions (so called multi-parenting). The classifications are built on this foundation layer which is why they are called linearizations. One of these linearizations is the Joint Linearization for Morbidity and Mortality Statistics (JLMMS) which recently has been released as a version for preparing implementation in member states, including translations, on 18 June 2018. In the beginning an independent primary care linearization both for the high and a low resource setting in a telescopic structure, based directly on the foundation layer was planned. Up to now only a simple pick-list from JLMMS as a short version for primary care has been achieved in a preliminary version. This is disappointing but was to be expected as nobody was willing or capable of investing into sufficient work force to achieve the former goal.

This years WHO-FIC annual conference will be held in Seoul/South-Korea. Due to the anniversary of the declaration of Alma-Ata the overarching topic of the conference will be primary health care. We hope this will bring the needs of primary care to the center. This year's meeting of WICC will be held in Lviv in Ukraine from 24 -29. August 2018. Again, the main topic will be the collaboration with the Consortium and common work on content of ICPC-3. Vivid discussions are to be expected. Anybody interested in the work of WICC will be welcome.

Prof Thomas Kühlein
Chair, WICC
thomas.kuehlein@uk-erlangen.de

Rural Round Up: WP on Rural Practice annual report

John Wynn-Jones reports: on progress on the 2016-2019 work plan

Equity, Diversity and Relevance

Progress continues to be made on all fronts. We have developed a scoring system to help provide us with an equitably balanced and diverse council. This will

mean positively discriminating with regard to gender, age and geography. We have excellent representation from South Asia and more contacts are being established in Africa and Asia Pacific. Although we work with colleagues in Brazil, it has been difficult to build contacts in the Spanish speaking parts of South America. This will become a priority for 2018. Rural Seeds has helped us connect successfully with young doctors and students

around the world.

Conferences
Plans for our next conference in 2019 in New Mexico are well underway. Our partners will be the University of New Mexico and The National Rural Health Association. New Mexico has its own unique rural health challenges and the NRHA has been the main advocate for the health of America's rural population for decades. New Mexico has a major Spanish speaking population and we hope that this link will help connect more with the Spanish speaking countries of Central and South America.
https://www.ruralhealthweb.org/events/event-details?eventId=1031

Report on 15th WONCA World Rural Health Conference 2018
Special thanks must go to our Indian hosts, who have worked tirelessly to organise one of our most successful conferences to date. It was uniquely a very Indian conference but at the same time international with over a thousand delegates form over 40 countries.

Our enduring memory will be the engagement with so many young doctors and students from around the world. The conference was a testament to the next generation and their ability to fight for what they believe in and their commitment to change the world around them. Special thanks must go to my good friends Raman Kumar and Pratyush Kumar who have worked so hard over the last 12 months to make it a success.

The timing of the conference was perfect as a result of two important events:

1. The Prime Minister of India, Mr Narendra Modi had just announced the plan to establish 150,000 Wellness Centres around India (yes - the figures are correct!). There is a hope now that those 60% of the rural population of India who have no access to health care will now have some justice.

2. It is 40 years since the declaration of Alma Ata was signed. This was probably the most important statement on the value of Primary Care in the last century. It also acknowledged that health and wellbeing are also dependent on economic and social issues. WHO are currently working on a new declaration and we were asked to comment. We saw an opportunity to view Alma Ata from a rural perspective, and our contribution can be found via the Delhi Declaration.

I always hope that our conferences leave a lasting legacy in every country that we visit and I have no doubt that this one will. It attracted wide political, professional and media support. We were honoured to welcome the Vice-President of India, the Honourable Venkaiah Naidu and 2 Health Ministers. The Vice-President's passionate address was the best speech that I have heard at any of our previous conferences from a politician. A national consultation on primary care was held in parallel with the main conference.

The conference produced a number of deliverables in addition to the determination to make a difference by bringing accessible health care to the rural millions of India. These included:
• The Delhi Declaration.
• New policy on Digital Health
• Project SETU A new Indian Student & Young Doctor Group dedicated to reducing the inequity between the rich and the poor in India. They see this initially as an Indian initiative but hope that working with IFMSA and RuralSeeds, it will become an international student project.
• National Consultation on Primary Care in India
• AFPI Rural: A new section of the Indian Academy of Family Physicians of India dedicated to rural health

WONCA World conference, Korea 2018

Despite the fact that we already had our council meeting, we intend to have a significant presence in Seoul, Korea. We are committed to at least 10 workshops (either our own or in a joint capacity with other groups). Our final plans will be discussed at council but we intend to use the time to link in and work with other WPs and SIGs.

Working in Partnership
Current collaboration with: Working parties (Education, Environment, Women & Family Medicine and Mental Health); Special Interest Groups (Point of care testing, Emergency Medicine, Family Violence); Young Doctor Movements (VdGM, Spice Route, Polaris). We have also developed valuable links with NGOs and Organisations outside WONCA. These include: WHO, The Network Towards Unity for Health, Darwin International Institute on Compassion, National Rural Health Association (USA)

Portfolios
All executive members have their own portfolios. They are responsible for developing their specific areas within the WP. These include: Research: Dr Zakiur Rahman (Bangladesh); Developing World: Pratyush Kumar (India); Students and young doctors: Mayara Floss (Brazil) + Veronika Rasic (Croatia and UK); Clinical Practice: Bikash Gauchan (Nepal)
Education + Training: Barb Doty (USA); Publications: Dave Schmitz (USA); Communication: Jo Scott Jones (New Zealand); Policy Development: Role of Past Chairs

Rural Seeds
The Rural Seeds network was established to link aspiring rural health professionals who were students or in the early stages of their training. This growing network links with YDMs and IFMSA but is an integral part of Rural WONCA. The future of Rural Practice lies in their hands. I must take the opportunity to show my gratitude to a number of dedicated individuals who have made this a success. A brief outline of their work includes
• Rural Family Medicine Café:
• Rural Success Stories:
• Mentor Mentee Programme:

Policies, Statements and Publications

Our policies and statements, including a Values Statement, can be found on the WONCA website.

Communication

The main avenue for discussion remains the Google Group. We have approximately 900 members worldwide. Our reach increases greatly when we add the EURIPA and WoRSA groups. We also run a Facebook page and a Twitter page. The past Rural Family Medicine Café can be viewed on YouTube along with some wonderful videos produced by Dr Mayara Floss

Special initiatives
-Rural Heroes
-Rural Medical Education Guidebook: We are again taking this forward once more. Expressions of interest are being sought to fill some of the gaps currently present in this remarkable resource.
-The WHO link : Following Jim Campbell's visit to the 14th Conference in Cairns, we were asked to contribute to the 4th Global Forum on Human Resources for Health in Dublin in November 2017. We ran a panel workshop where the response was so good that there was standing room only and we made new valuable contacts (especially from Africa). Through our participation, there was a significant rural presence at the conference and this was reflected in the final Dublin Declaration.

Looking Forward
Coming to the end of our triennium, we must look to the future. A new Chair will take over in 2019 and a fresh work plan will be developed. Possible ideas for the future could include:

• Expand the regional network: Asia Pacific; North America?
• Attend the Africa Region Conference 2019 and promote the WP.
• Promote rural research in LMICs to reduce the 90/10 gap globally in health-related research
• Develop a Multidisciplinary/Cross sectoral focus (+ Community Health Workers)
• Linking student groups/Global health
• Expand the global voice of the WP
• Work with the rural generalist movement to adapt their model to the needs of LMICs
• Compassion in Rural health care

Editor's note: this is an edited report - a complete version was circulated to all google group members

WP on Indigenous & Minority Groups Health Issues annual report

Dr Tane A Taylor, Chair, WP on Indigenous & Minority Groups Health Issues (WWPI&MGHI) chair reports:

The activities outlined in this plan have been bubbling along, but can and should be enhanced.

As an organisation WONCA covers the full breadth of general practice which faces multiple challenges across the globe. We have many knowledgeable and willing experts across multiple WG and SIG. Every one of these groups and we as individuals (including myself) are very protective of our 'area of interest/expertise' – however we might consider how we can be more efficient and successful if we develop a more principle based patient/family outcome focus, coordinated and fluid collaboration framework. Meaning measuring our success on a quality patient/family health/wellness outcome. Understanding and implementing the notion that there is no quality without equity.

Our Working Party workplan for 2017 to 2019 highlights key activities to support the group's previously stated objectives:

• To serve as a focus to stimulate and promote standards of excellence in the primary care management of cultural competency, consistent with patient and professional values and with reference to evidence based health care
• To promote the concept of indigenous and minority groups health issues
• To promote and develop indigenous and minority groups health research activities in primary care and the primary care interface
• To hold scientific meetings, which may include sessions and workshops, during WONCA regional and world conferences, to present original papers and to address broader educational issues through discussion, training and debate
• To develop and promote appropriate literature for primary care professionals using a variety of resources, including WONCA Online
• To promote cultural competency world-wide through collaborative working within WONCA, NGOs, government organisations, patient groups and other medical colleges
• To address the issue of stigma associated with indigenous and minority groups health issues.

Key issues include:

1. Enhance WWPI&MGHI structures
-Expand membership
-Foster and encourage an 'All of WONCA Governance Ownership' approach to these issues by requiring representation and participation across all WONCA constituencies - Regional Presidents; WONCA Young Doctors Movements; Working Parties Chairs; Special Interest Groups Chairs.
-Enhance communication between WWPI&MGHI members

2. Provide leadership
-Advise Executive and Council of relevant indigenous & minority groups health issues.
-Ensure all WONCA sponsored/associated conferences have appropriate content addressing Indigenous & Minority Groups Health issues.
-Ensure all WONCA sponsored/associated conferences abstracts are reviewed through an equity lens.
-Encourage WONCA to actively seek and engage with Indigenous & Minority groups across the globe either directly or through their membership organisations.
-Facilitate discussions within WONCA on how to prioritise the importance of Cultural Competency not only in the training of our new family physicians but also in the delivery of healthcare within our communities across the globe.

I am looking forward to meeting up with as many as possible during our Seoul conference gathering.

Join our working party

Special Interest Groups Annual reports

SIG on Emergency Medicine annual report

Dr Victor Ng, (Canada), convenor, WONCA SIG Emergency Medicine writes:

Since the conception of our Special Interest Group (SIG) on Emergency Medicine (EM) in 2016, the number of members of the SIG has grown significantly. We have over 75 members who have indicated an interest to help with our work to advance the clinical domain of emergency medicine within the discipline of family medicine. One key area of work is ensuring that we have strong workshops at WONCA conferences.

In WONCA Europe, Dr Elena Klusova and her colleagues at Spanish Society of Family and Community Medicine (SemFYC) have been working diligently to offer workshops. At both WONCA Europe conferences in Prague (2017) and Krakow (2018), we held emergency medicine workshops. Topics presented have included toxicology, basic and advanced life support, palliative care in the emergency department and the emergency gymkhana which is a popular multi-station learning activity first pioneered in Spain.

Recently at the WONCA Rural conference in New Delhi, Dr Nisanth Menon from India, along with his colleagues, delivered a set of Rectify workshops. These interactive workshops are designed to teach basic emergency skills to family doctors from a rural and resource constrained perspective. These sessions were well attended and very well received. We are looking to Dr Menon's leadership as we scale up these sessions for the upcoming WONCA world conference in Seoul.

From an advocacy perspective, our SIG on emergency medicine has been working with the WONCA leadership and the SIG on Conflict and Catastrophe medicine, on how to best assist family doctors in responding to disasters. We have engaged with key stakeholders from around the world including the World Health Organization and the World Association of Disaster and Emergency Medicine to plan next steps. We look forward to ensuring that the family medicine voice is included in both the planning of the disaster response and also during acute and sub-acute disaster events.

Below are a few examples of the great work of our WONCA SIG EM members in various WONCA regions. While this is far from an exhaustive list, it shows the commitment of our members to promote acute and emergency medicine to the rest of our family medicine colleagues. We appreciate and are thankful for their service to our discipline.

Individual Member Highlights

Dr Will Leung (Hong Kong) – Topic: Shortness of Breath (Hong Kong Primary Care Conference, June 2018)
Dr Pramendra Prasad (Nepal) – Topic: Disaster and Rural EM (First National Emergency Medicine conference, Kochi, 2018)
Dr Elena Klusova (Spain) – Topic Toxicology of Recreational Drugs (VdGM Forum, Porto, 2018)
Dr Ayose Perez Miranda (Spain) and SemFyC colleagues - Atlas gráfico de Urgencias Manual launched in 2017.
Dr Eleni Politi (Greece) – Published "Proposing a three-dimensional, holistic approach to lead the assessment of CPD needs" (Education for Primary Care, 2018)

Join our SIG

SIG on Workers' Health annual report

Photo: SIG Participation during ICOH2018 World Congress held in Dublín.

Join our SIG

The joint statement of WONCA and the International Commission on Occupational Health (ICOH) – the first one ever made together – was released on July 3, 2014, during the WONCA Europe conference in Lisbon, Portugal. It included the pledge that follows.

The World Organization of Family Doctors (WONCA) and the International Commission on Occupational Health (ICOH) pledge to work with our partner organizations (including WHO and ILO) to address the gaps in services, research, and policies for the health and safety of workers and to better integrate occupational health in the primary care setting, to the benefit of all workers and their families.

As a new SIG we have set course in order to take this pledge into practice.

Photo: SIG Participants during WONCA Europe Congress in Prague.

Main activities undertaken have included aiming to provide resources and support and promote research through presentations and workshops at WONCA conferences.

In this sense, this first year has been a very productive one.

During 2017 Peter Buijs and Frank van Dijk represented our SIG during WONCA Europe Congress held in Prague, developing a Workshop on Workers Health. Meanwhile Garth Manning, Viviana Martinez Bianchi, Carolina Jara and Ezequiel Lopez assisted WONCA CIMF Conference in Perú, where they presented the Workshop on Primary Care and Workers Health.

Finally, our SIG's outstanding participation during the ICOH World Congress that was held in Dublin in May 2018 deserves special mention. Garth Manning, Frank van Dijk, Peter Buijs and Ezequiel Lopez participated in a Workshop on PHC and Workers Health, with the participation of Dr. Jukka Takala, ICOH President among other distinguished participants.

We renewed our commitment to work together with ICOH and other organizations with the decision to generate a specific agenda and meetings for the discussion of Workers Health.

We continue to have as goals to organize a work conference on basic workers' health care in PHC settings, trying to continue the work done by WONCA, ICOH, WHO and many other organizations during The Hague Conference in 2011.

We have developed an SIG email Group for enhancing communication between members which can be accessed through our web page. This group already comprises 25 family and occupational health specialists from different regions

We are also present on Twitter at @PCWorkersHealth and also in Linkedin at WONCA Special Interest Group on Workers Health. WONCA Salud de los Trabajadores.

We continue to develop SIG meetings during WONCA- and ICOH Congresses

Conclusion
We continue to recruit and welcome new members from all WONCA regions who wish to work together to strengthen the discipline of Family Medicine with a special interest on Workers Health. On the occasion of the 40th anniversary of the Alma Declaration, Family Doctors must emphasize our passion for Primary Care, reinstalling in that Declaration our renewed commitment to bring medical care as close as possible to where our patients live and work.

Ezequiel Lopez
convenor

SIG on Migrant Care, Int Health & Travel Medicine annual report

Prof Maria van den Muijsenbergh, convenor, WONCA SIG on Migrant Care, International Health and Travel Medicine writes

This SIG, founded in 2008, aims to improve the knowledge and skills of general practitioners as well as the organizational and financial conditions to deliver culturally competent, equitable and good quality of primary care to migrants of all kinds: travellers, economic migrants, as well as refugees, including the undocumented. The SIG has steadily grown over the years and now consists of a group of 64 members, from 18 different nations in Australia, South- Africa, USA, South-America, Middle-East and Europe. Members are involved in international research, medical (postgraduate) education and health care delivery related to refugees

and other migrants.

In 2018, Guus Busser, GP, international officer and Primary Lecturer at Radboud University Medical Centre in Nijmegen, the Netherlands will take over as convenor of the SIG as the current convenor has been in place since the start of the SIG in 2008. Maria, current chair and Guus, future chair, pictured in Rio in 2016.

Activities in 2017 - 2018
1. We continued our collaboration with Euract and WONCA WP on Education to exchange and develop educational programs and materials related to culturally sensitive care for immigrants. We exchanged information on curricula and educational materials for GP training. We are seeking opportunities to publish about educational programs on migration.

2. We continued our collaboration with the WONCA WP for Mental Health. The joint guidance for mental health care and migrants will be finished by autumn 2018.

3. The European book on migrant care with contributions from several SIG members is expected to be published by autumn 2018.

4. In March 2018, at the request of one of our Syrian members, we supported the issuing of a WONCA statement on the dramatic situation in Ghouta, Syria pleading against destruction of medical facilities and for access to medical care.

5. We started to collaborate with the newly founded Vasco da Gama working party on migrant care. In Krakow, during WONCA Europe 2018 we participated in each other's workshops on migrant care, and discussed further collaboration.

6. We organized a workshop on migration related violence (human trafficking and other violence and abuse) in Krakow and collaborated with the Health Equity group in the workshop on implicit bias. At the migration conference in Edinburgh, in May 2018, we participated in a workshop on international collaboration on migrant care and migration health networks, and the development/implementation of guidelines on migrant care.

Join our SIG

SIG on Point of Care Testing annual report

As of 24 April 2018, there are 113 members in the Special Interest Group (SIG) on Global Point-of- Care Testing (POCT), comprising 11 Executive Members and 102 General Members; these members represent 44 different countries and all seven WONCA regions.

In July 2017, the SIG published a summary of the workshop titled 'Point-of-Care Testing for Today's Family Doctor: Innovations and Application' presented by Professor Mark Shephard, Lara Motta, Tessa McCormack and Brooke Spaeth on behalf of the WONCA Special Interest Group on Global Point-of-Care Testing for *WONCA News*

Across November 2017 to March 2018, members of the SIG collaborated to prepare and lodge two abstracts for the upcoming 22nd WONCA World Conference in Seoul, Korea in October 2018. The first being for a 90-minute workshop titled 'Point-of-Care Testing in Daily Practice: a worldwide hit?' to be presented by Dr Rogier Hopstaken, a GP and member of the SIG from the Netherlands. And the second, a poster presentation titled 'World Health Organization Multi-Country Evaluation of Molecular-Based Point-of-Care Testing for Chlamydia, Gonorrhoea and Trichomonas', co-authored by SIG members Professor Mark Shephard, Lara Motta and Dr Igor Toskin (WHO Observer).

The SIG is preparing a paper on the results of our online survey on the use of POCT by WONCA members for publication in a peer-reviewed journal.

In May 2018, an email will be delivered to the members of the SIG to notify them that the three-year period that Professor Mark Shephard and Lara Motta can act as Secretariat for the SIG is coming to an end, and requesting members to nominate to take over the positions of Chair and Secretary.

Professor Mark Shephard & Lara Motta
Chair & Secretary Special Interest Group on Global Point-of-Care Testing

SIG on Family Violence annual report

Hagit Dascal-Weichhendler (Israel) at left, and Kelsey Hegarty (Australia) at right, co-convenors of the SIG on Family Violence report:

The Special Interest Group on Family Violence (SIG FV), active since 2014, has focused in 2017/18 on continuing our global connections and supporting family doctors to undertake identification and care of families affected by family violence.

The group continues to grow, connecting with other professionals who are interested in contributing their knowledge and ideas to the SIG FV. Our Call to Action statement of recommendations was approved by the executive group in March of 2018, focusing on exchange and dissemination of training curricula and new knowledge from research. The statement called for colleges and academies in WONCA to address family violence policy, training and procedures as a matter of urgent priority in order to have their members supported and resourced to manage this common problem effectively and in an evidence-based manner.

SIG FV has provided support, resources and education through presentations and workshops, including at the WONCA Rural Health Conference in Cairns (May 2017) the WONCA Europe conference in Prague (June 2017) and the WONCA Asia Pacific Regional Conference in Pattaya (November 2017). We have also contributed to a number of other conferences, such as the VdGM Family Violence Group in Strasbourg (April 2017) and

the AfriWon Renaissance in South Africa (August 2017). Further to this, we are connecting with other groups such as the VdGM and Equally Different, with a successful workshop that had the objective to raise awareness of the characteristics and specific needs of the LGBTQ community related to partner violence presented at the 5th VdGM Forum held in Porto in January 2018.

An extremely productive meeting was held by the SIG FV (led by ex-chair Leo Pas) collaborating with the Europrev Working Group on Mental Health and Family Violence & the European Family Justice Centres Association in Brussels (December 2017) that gathered together an enthusiastic group of 130 representatives from multidisciplinary collaboration projects on domestic violence, sexual violence and child abuse. The discussion centred around areas relating to family-oriented care, and to exchange information and risk management assessment in family violence, and the result aims to better promote a mutual understanding and collaboration of these issues amongst workers in the health care sector.

In 2018, we committed to several more conferences with abstracts accepted to hold workshops in WONCA Rural conference in India (April 2018), and WONCA Europe in Krakow (May 2018), and collaborated with both VdGM and WWPWFM for these conferences.

We will continue to emphasize the needs for both training and research on FV. As a group we are collaborating with Dr. Raquel Gomez Bravo who is currently undertaking a PhD project related to training on Family Violence. SIG FV former Chair, Leo Pas, is currently working on training material with Young Doctors and Family Justice to combine their knowledge into a usable training package that eventually will be translated into English. We are continuing our efforts to strengthen young doctors' interest and involvement addressing family violence. We are also in the process of considering adding working consultancies to our group, to enable us to reach out, connect and support GPs and other health professionals, and to equip them with the tools and knowledge to better respond to cases of family and domestic violence.

At the international level we are exploring the idea of offering consultancies to regional areas, to help strengthen knowledge, education and training. We continue to cooperate with organizations such as the World Health Organisation and United Nations to support our goals of making Family Violence a global health priority.

Finally, we are continuing to connect and network through communications, and have started this by updating our website, and sending through a regular newsletter to our members.

For more information email convenor

SIG on Ageing and Health Annual Report

Professor Dimity Pond (Australia), Convenor, SIG on Ageing and Health writes:

The WONCA Special Interest Group on Ageing and Health has been reconvened in this 12 months. It currently has 17 members from a number of countries including Australia, Bulgaria, Canada, Hong Kong China, the Netherlands, the UK, the USA, and Zambia

The group has been busy producing a consensus statement about the importance of strengthening family medicine in the face of the increasing numbers of elderly people throughout the countries of the world. The group recognises however, that this is not possible in every country, and that a range of workforce responses to aged care – largely around primary care - may need to be considered.
While emphasising that policy responses should emphasise primary care, the group has also raised other issues for policy consideration, including the need for standards in aged care and the integration of health and social care.

The group is also compiling resources around aged care best practice and also around teaching in aged care for family doctors. The group is considering collaborations both within and beyond WONCA to pursue matters of interest to family medicine in the area of aged care.
>Join the SIG Ageing and Health

About Dimity Pond

Dimity Pond is Professor of General Practice, School of Medicine and Public Health, University of Newcastle, Australia. She is also a GP in clinical practice. She conducts research in the areas of mental health and particularly dementia, focusing mainly on GP identification and management. Projects have included GP guidelines for management of dementia (currently being revised), a randomised controlled trial of GP education in dementia identification, a nurse practitioner project, and several studies exploring the role of the GP practice nurse in dementia identification and management. She has had over $20 million in research funds, and has published over 150 papers in peer reviewed journals.

SIG on Health Equity annual report

Dr William Wong, convenor for the Special Interest Group (SIG) on Health Equity reports:

Over the last year, the group has been devoted to its core agenda of promoting Health Equity in primary care. It serves as an effective platform connecting representatives from different regions through emails, newsletters, committee meetings, and workshops, thereby facilitating better sharing and exchange of up-to-date information of Health Equity. Through the joint efforts of our representatives, the group has made major achievements in the past year.

First, the EQuiP Dublin Declaration "*Patients should have access to safe, equitable, affordable and high-quality health care services in Europe"* has been accepted and endorsed. One of our regional representatives has also presented the declaration at WONCA Europe and has received very positive feedback. The group is going to present the declaration again at WONCA Seoul. In the workshop, attendees will be invited to share situations in their own countries and apply the Statement in their cases.

Second, the group is planning to produce a special issue on Homelessness around the world for a future newsletter. Every regional representative of the group will contribute to a column and report the situation of homelessness in their home countries.

Third, the group is devoted in attracting more members to join and participate in future activities. Various promotional strategies are planned and will be executed accordingly. Copies of newsletter and flyers introducing the group will be circulated at WONCA Seoul. Interactive communication will also be facilitated with the use of Facebook groups, Tweet Chat and other social media tactics to engage members around the globe. The website of the group will also be updated regularly and circulated among members.

With the support of all committee members and the rising number of registered members, the WONCA SIG on Health Equity has gained a more sophisticated understanding of the gaps in Health Equity. The brilliant ideas and projects contributed by our regional representatives and other members have added strong impetus to the group's power and impact in exploring and reducing health inequalities in the community worldwide. We are confident that the group will continue to produce excellent works and significant outcomes in the coming year.

Join our SIG

SIG on Quaternary Prevention & Overmedicalization annual report

Miguel Pizzanelli, (Uruguay), convenor, SIG on Quaternary Prevention & Overmedicalization (QP&O), writes

Leadership and Team Building

It was possible to have active groups in the Europe and Iberoaméricana regions. We are promoting leadership in the other regions. It is still too early to establish a QP&O Executive Team with leaders of all WONCA Regions. We are working to establish more knowledge exchange with Asia and Africa.

Collaborative Networks

Activities supported in Iberoaméricana Región included -Iberoamerican Conference Lima, August 2017; sponsorship and academic collaboration to Peruvian Quaternary Prevention Academic training; coordination of Quaternary Prevention group in Uruguay. Support to Iberoamerican on-line networks.

WONCA QP&O sponsorship: Lecce Oct 2017 1st Italian conference on overdiagnosis

WONCA QP&O sponsorship in Peruvian First National Course; “Quaternary Prevention in Primary Care / “I Curso Nacional de Prevención Cuaternaria en Atención Primaria”. Lima Perú, 1 y 2 de junio de 2018. (Sopemfyc) Sociedad Peruana de Medicina Familiar y Comunitaria.

First contact with WONCA (EUROPREV) Europe Working Group on Overdiagnosis. Discussing how QP&O could support the Position Paper on Overdiagnosis and Action to Be Taken.

Innumerable activities in Iberoamerica impossible to systematize; working groups meetings, networking, colleagues’ collaborations.

Communication Level

Ongoing projects and activities:
More than 100 topics in the Collaborative Database on Quaternary Prevention Resources and References. Pizzanelli M, Lavalle R, Jamoulle M. Quaternary prevention library and resources (QP library). 2017 Apr 10 [cited 2017 Apr 22]; Available from: http://orbi.ulg.ac.be/handle/2268/209390

Iberoamericana Region has very active on line interactive forums.

Posting in the SIG space on WONCA web page.

Posting in Quaternary Prevention web blog.

Exchange Level

Preparing a working meeting of the group in the WONCA World Conference in Seoul. Coordination team: Monica Nivelo, Daniel Widmer, Myon Bae.

See all publications, workshops, courses content in conferences etc

Join our SIG

Featured Doctors

Dr Andrei BROVCHIN - Ireland /Romania

Andrei is a young doctor who trained in Romania but now works in rural Ireland.

- What work to do now?
I work as a general practitioner in a busy practice in Listowel, Co Kerry, Ireland. The town has about 5000 inhabitants, and the surgery I work for has about 12,000 registered patients (town and surroundings). I am currently in a GP assistantship role with the view to becoming partner at the end of this year.
As one could expect, rural general practice would be more challenging than an urban role. This is partly due to the long waiting lists of the county hospital and also because of the historical role of GPs in the rural communities, where most of the patient's health problems would be sorted out locally.

- Other interesting things you have done?
I have engaged with a charity that has provided me with the tools (and within the next month, a car) in order for me to provide prehospital emergency services alongside the national ambulance service. I thoroughly enjoy that role and in our part of the county the national ambulance resources are scarce. I am called for cardiac arrests in a radius of 30 km outside the surgery, and within the next two months I would be tasked directly by the ambulance service to various medical, surgical, and trauma emergencies.

- What are the differences and similarities of working as a GP in Ireland in Romania?
I was exposed to general practice in Romania for part of my training (this was a few years ago). While I can't be absolutely certain, I think at this point in time, working as a GP in Romania is quite restrictive - in terms of adhering to quite strict "guidelines" and budget restraints. I know for a fact that most Romanian surgeries would not have access to diagnostics and for public patients a referral for bloods would take quite a long time. In this aspect, I am quite happy to report that in Ireland I am able to see a patient, draw the bloods and have a working diagnosis within a day. The problem in Ireland comes next, when I need to refer a public patient for specialist consult and/or treatment. It does depend on which hospital and what specialty you do refer the patient to, but as a rule, there is a significant waiting time in Ireland. In this aspect Romania is much faster. You would likely get seen as an out-patient the following week, and (imaging) investigations and treatment plan would be arranged within a month for most conditions.

For myself, the working arrangements and liberties regarding my practice in Ireland are far superior to those in Romania. You do have to use all your expertise and experience in Ireland, especially rural Ireland, where you work as an internist, cardiologist, rheumatologist, paediatrician, geriatrician, community health officer, emergency medicine provider, palliative care provider, and so on. I can safely say that, for me, the denomination of "family doctor" actually finds its true meaning in rural Ireland.

- Your interests at work and privately?
At work, I can say that I find it more rewarding when consulting and treating patients with cardiology issues, and also when I manage "emergency" presentations (both in the surgery and out in the field). I also aim to engage in quality projects, to further streamline certain processes at work and hopefully introduce a plan for the surgery to go as "paper free" as possible. My other near-term goal is to engage with the University College Dublin in their advance paramedic training scheme - I was briefly involved in teaching before and I did find it quite rewarding.

Privately, I thoroughly enjoy going on short or long holidays, city breaks, and generally exploring new places. I guess this wouldn't be a surprise, as most of my working week is spent being quite static

Dr Tom O'CALLAHAN - Ireland

Tom O'Callahan has been around to be part of family medicine change in Ireland.

What work do you do now?
Keeping close to patients and daily practice I work part time as a family doctor in Dublin providing family medicine to Google staff in their Dublin HQ. I get to hear of their excitement to be working in digital marketing and disruptive technology and their various personal stories and ambitions to improve the world we live in using technology.

Why did you become a doctor?
It was my good fortune to have a wonderful father who was the family doctor for over 50 years to our small rural community. He was full of compassion, humanity and good humour. Witnessing first-hand the trust and friendship he had with his patients, the respect in which they held him, and the joy and pleasure he took in helping them and sharing in their lives shaped my ambition to follow in his footsteps and be part of our great profession.

My parents made many personal and financial sacrifices to ensure we had a good education and the Jesuits who taught me very definitely instilled in me the importance of social justice and our personal responsibility to support those less fortunate than ourselves. Where better to help those in need than as a family doctor and have a challenging, impactful and rewarding career?

I studied medicine at the Royal College of Surgeons in Dublin where I had my first exposure to fellow medical students from various exotic and far flung parts of the Middle East, Asia and Africa. This provided the opportunity to start to understand their different cultures and health systems and how patients are cared for in other parts of the world. This sparked in me the desire to be part of a wider global medical community that could advance healthcare and particularly family medicine in areas of the world where it was needed most. Summer student electives to Africa and Latin America, where I was exposed to medicine in remote rural communities, helped me understand this more. Having completed family medicine residency training I returned to join my father in practice and we had very many happy years working together, caring for our patients and community, and sharing much fun and many stories.

How have you seen Family medicine change in Ireland?
Family medicine has changed and grown in professional status very significantly in Ireland in the last twenty years. There has been a big move towards group practices working from purpose-built primary care centres. Of all the specialties, family medicine was first in Ireland to embrace computerisation and now interprofessional team based care for chronic disease management and task shifting of many hospital based activities to primary care have made family medicine the specialty to be in. There is now clear recognition of the key role family medicine plays in Ireland, not only amongst the community and patients at large but politically and across the medical profession. Our present Taoiseach (Prime Minister) is a young family doctor and we have had a Minister for Primary Care at Government level which has given us a very strong voice when decisions are being made.

Other interesting things you have done?
I have been lucky to be part of this journey over the last 20 years and, with colleagues, have been involved in various national and regional initiatives to improve family medicine and primary care. I've worked with the Irish College of General Practitioners, the Health Research Board and University College Cork, the Royal College of Surgeons in Ireland and with Trinity College, Dublin. Specifically I have been involved in various initiatives such as out of hours family medicine co-operative services, building national electronic referral pathways to secondary care, and bringing colleagues together to practice in and establish new purpose-built primary care centres. It has been very exciting to have worked with the Irish College Of General Practitioners on various projects to support colleagues in the Middle East and Asia. Recently I have been part of WHO's Eastern Mediterranean Region Expert Advisory Group to support family medicine capacity building in the Gulf Co-operation Council (GCC) countries and the wider Middle Eastern Region.

At policy level I have been involved in shaping family medicine and primary care development

in Ireland by providing advice to a number of health Ministers on rolling out primary care centres and have represented family medicine research capacity building on the national health research agenda.

A number of years ago I set up an online medical education organisation, supported by the Irish Government, to design develop and deliver online and blended education programmes for Ministries and Governments around the world. Our ambition in iheed is to help build primary care capacity where it is needed most by delivering programmes in partnership with leading medical universities and postgraduate training bodies around the world. We are now a growing team of passionate and committed professionals across various disciplines of technology, medical education, instructional design, digital marketing and research, based in Dublin, and we are having an impact in many countries with our various postgraduate programmes. It is wonderful to hear the feedback from family doctors in various countries who have successfully completed a programme we helped design, develop, and deliver which allowed them to gain new skills and a university qualification, while staying in the workplace caring for their patients and not having to travel abroad.

And your personal interests?
My interest in the outdoors and mountaineering has taken me on expeditions to many remote parts of the world to climb with friends and to meet many remote mountain communities. I have been involved in mountain rescue groups here in Ireland and in teaching expedition and high altitude medicine at Irish Universities.

Liz, my wife, is a sports physio and we have three children - Anna, George and Patrick. We live on a farm in rural Tipperary which, as the song says, is a long way from many of my WONCA colleagues!!

WONCA CONFERENCES

WONCA Conferences 2018

October 17-21, 2018	WONCA World conference	Seoul, SOUTH KOREA	http://www.wonca2018.com/

WONCA Conferences 2019

WONCA in Kyoto, Japan, in 2019

This is the first announcement in *WONCA News* about the WONCA Asia Pacific region conference coming in 2019 to Kyoto, Japan.

The conference will be held from May 15-18, 2019, at the Kyoto International Conference Center, and is hosted by the Japan Primary Care Association (JPCA). Keynote speakers include Prof Felicity Goodyear-Smith (University of Auckland and chair of the WONCA Working Party on Research) Ms Natsuko Iino (Senior commentator, NHK), Prof. David Haslam (Chair of the National Institute for Healthcare Excellence - NICE, UK).

The closing date for abstract submission for the symposia and workshops is November 30, 2018. The call for papers and early bird registration will open on October 1, 2018.

Please keep your eye on our website for the update information:
conference website
I will also keep up-dating the information of the WONCA APR 2019 Kyoto in most issues of WONCA News. Please mark your calendar and save the date for the WONCA APR 2019 in Kyoto.

Kindly yours,
Prof Nobutaro Ban
Representing the Japan Primary Care Association
Chair, Organizing Committee, WONCA APR 2019 Japan

Professor and Director, Medical Education Center, Aichi Medical University School of Medicine

South Asia region conference 2019

Theme: Primary Care- complete health care

Venue: Lahore, Karachi, Pakistan

Host: Pakistan Society of Family Physicians.

Dates: November 22-24, 2019

Email: dr_tariq_aziz@hotmail.com

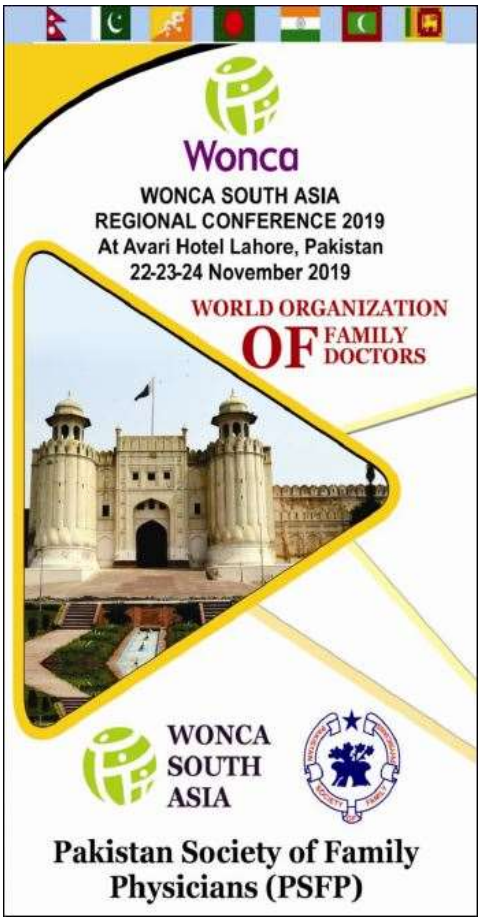
Conference brochure

>Abstract submission details

>Abstract submission form

>Registration and costs information

>Registration form



WONCA Direct Members enjoy *lower* conference registration fees.

To join WONCA go to: http://www.globalfamilydoctor.com/AboutWONCA/Membership1.aspx

WONCA Conferences 2019

March 20-23, 2019	WONCA East Mediterranean region conference	Beirut, LEBANON	Save the dates.
May 1-3, 2019	Congreso Iberoamericano de Medicina Familiar	Tijuana, MEXICO	http://cimfwonca.org/eventos/proximos-regionales/
May 15-18, 2019	WONCA Asia Pacific region conference	Kyoto, JAPAN	www.c-linkage.co.jp/woncaaprc2019kyoto
June 5-8, 2019	WONCA Africa region conference	Kampala, UGANDA	Save the dates.
June 26-29 2019	WONCA Europe región conference	Bratislava, SLOVAK REPUBLIC	www.woncaeurope2019.com
October 11-15, 2019	WONCA World Rural Health conference	Albuquerque USA	www.ruralhealthweb.org/wrhc
November 22-24, 2019	WONCA South Asia región conference	Lahore, PAKISTAN	www.globalfamilydoctor.com/SAR19

WONCA Conferences 2020

April 21-22, 2020	VIII Cumbre Iberoamericana de Medicina Familiar	San Juan, PUERTO RICO	Save the dates.
May 26-31, 2020	WONCA Asia Pacific region conference	Auckland, NEW ZEALAND	Save the dates
June 24-27, 2020	WONCA Europe región conference	Berlin, GERMANY	Save the dates
November 26-29, 2020	WONCA World conference	Abu Dhabi, UAE	Save the dates

Member Organization Events 2018

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

21 Sep - 22 Sep 2018	**EURACT Medical Education conference**	Leuven, Belgium
27 Sep - 30 Sep 2018	**VIII Congreso internacional de Medicina Familiar**	Bayahibe, La Romana. República Dominicana
04 Oct - 06 Oct 2018	**RCGP annual primary care conference**	Glasgow, United Kingdom
04 Oct - 07 Oct 2018	**87th EGPRN Meeting**	Sarajevo, Bosnia and Herzegovina
09 Oct - 13 Oct 2018	**AAFP Family Medicine Experience**	New Orleans, USA
11 Oct - 13 Oct 2018	**RACGP GP18**	Gold Coast, Queensland, Australia
14 Nov - 17 Nov 2018	**Family Medicine Forum / Forum en médicine familiale**	Toronto, Canada
14 Nov - 16 Nov 2018	**EURIPA Rural Health Forum**	Maale Hachamisha, Israel
15 Nov - 18 Nov 2018	**17th International Conference of Iraqi Family Physicians Society (IFPS)**	Baghdad, Iraq