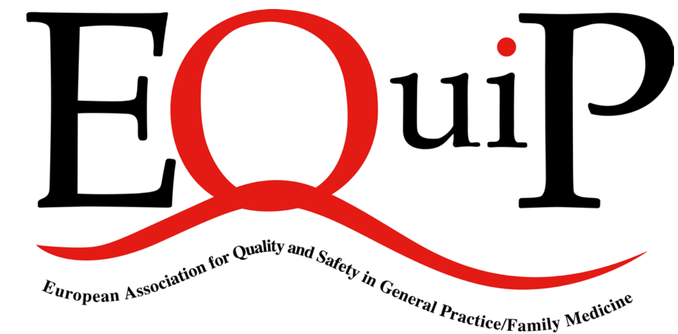

Newsletter
December 2018

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HOLIDAY GREETINGS

Dear EQuiP/WONCA Members & Delegates, Dear Colleagues & Friends,
On behalf of the EQuiP Secretariate and the Executive Board we wish you a Merry Christmas, Happy Holidays and a Happy New Year.

For the EQuiP Network, 2018 has been very successful:

• We networked with other organisations, which recently resulted in very good VdGM collaboration.

• We organised a very successful European conference in Bratislava.

• The EQuiP participation at the WONCA Europe conference in Krakow was very visible and highly recognised by many participants.

• EQuiP produced two powerful position papers:

- Measuring Quality in Primary Health Care

- EQuiP Position Paper on Equity - a core dimension of Quality in Primary Care.

Both were very well accepted among the WONCA Europe Council delegates.

• Again, an EQuiP Summer School has been very successfully organized in France.

• We had a very fruitful meeting in Zagreb in November, which resulted in many new ideas for the work in 2019. This will mainly be based on the work in EQuiP Working Groups.

I am positive that also in 2019, EQuiP will have a variety of activities, which will result in workshops, presentation, publications, policy papers, and decision support to stakeholders.

We are very thankful to all the delegates, individual and organizational members for all the work they have done in the field of quality and safety in 2018.

We are looking forward to meeting you at EQuiP Conference in Thessaloniki 29-30 March, at WONCA Europe Conference in Bratislava and at the EQuiP Council Meeting in Zagreb in November 2019.

Zalika Klemenc Ketiš
EQuiP President

Michael Balint 2.0 [2]

By Helena Galina Nielsen, GP (Denmark)* [1]

From Hungarian refugee to patient-centered medicine

Michael Balint's approach to the doctor-patient relationship and his seminal group work for GPs together with his wife Enid in the 1950s England, which he described in The Doctor, his Patient and the Illness [3], is still relevant today.

It greatly influenced the development of the profession of General Practice in England. He was born Jewish and his father was a GP. However, he converted to Unitarism.

Although he started his medical career in biochemistry, he was drawn by psychoanalysis and was an educated psychoanalyst under the influence of Sandor Ferenczi.

In the early 1920s he worked psycho therapeutically with patients who were somatically ill. From the beginning his main project was how psychotherapy could be integrated into medicine. He criticized 'the medical model' with increasing medicalization.

In 1939 he and his wife Alice emigrated to England from Hungary. Unfortunately, she died later that year of an aorta aneurysm He started to work with child psychology and developed an early interest in the mother-infant relationship.

In the beginning of the 1950s he and his third wife, Enid, introduced seminars with general practitioners. Enid was a psychotherapist who was training social workers and family therapists at the Tavistock Clinic in London. He was inspired by the English paediatrician and psychoanalyst D. Winnicott, as well as the psychoanalyst W. Bion, who developed theories about group dynamics and group processes.

He and Enid developed the group model (the Balint group) in cooperation with the GPs to be feasible in general practice and took departure in the narratives of the GPs from their daily work presented in cases.

In the 1960s he and Enid introduced the concept of patient-centered medicine as a holistic way of understanding the doctor-patient relationship.

In 1969 the Balint Society (The British Society) was founded. At that time many countries had shown interest in the method already, and Balint had contact with psychoanalysts in France and US.

In 1972 The International Balint Federation (IBF) was founded. IBF arrange international congresses every second year, and since 2011 international conferences for group leaders with group leader training and supervision of group leader work take place every other second year.

A Balint group

Michael Balint's described the groups he formed with Enid as 'research-cum-training-seminars'. They should be different from the traditional teaching situation characterized by a hierarchic 'teacher-pupil' relationship, where the teacher (the specialist) as the smartest and in the most active role would teach the passive pupil - and the teacher would define program and content of the sessions.

On the other side, Balint believed that effective learning would only arise if the doctors were active participating and took departure from their own experiences.

In the 'research-cum-training-seminars' the GPs and the psychiatrists should form a research team, which in collaboration study psychological parts of the doctor-patient relationship, how to discover and understand the problems and how the insight could be used with the patients in a psychotherapeutic way.

A basic assumption is that psychological factors influence the doctor-patient relationship unconsciously, and patient's psychological problems can be manifested somatically.

Thus, psychological knowledge and awareness is crucial in the diagnostic process in general practice. If the doctor understands the patient as a whole person and has got an empathetic approach, it may benefit the patient in a therapeutically way.

The first groups [4] consisted of 6-12 general practitioners who met once a week.
The doctors had long interviews with the patients they would present in the group. However, this model did not fit into everyday work of the most GPs and encounters from everyday surgeries could be used as cases in the discussions.

Balint considered equality, confidence and continuity to be essential for the groups to work. The Balint groups may be considered as the first supervision groups for GPs.

In Denmark one third of GPs using group supervision in 2008 had used the Balint method.

Michael Balint 2.0 [2]

By Helena Galina Nielsen, GP (Denmark)* [1]

The dissemination of Balint Groups.
In 2017 The International Balint Confederation consists of 24 countries and some individual members from all over the world. In Germany a course Psychosomatische Grundversorgung is mandatory in several medical specialties and has a base in the Balint method.

At the International Balint Congress 2017, Balint theory and Practice: Exploring diversities [5], contributions from all over the world showed some of the Diversities. Report from an aboriginal community in the north of Australia and from a French colony (Guadeloupe) were some of the examples. Recently Balint's book has been translated to Chinese.
In a workshop young doctors from Young Doctor's Movement, WONCA showed how Balint groups from distant and different countries met on the Internet and formed group meetings through Skype (Balint 2.0).

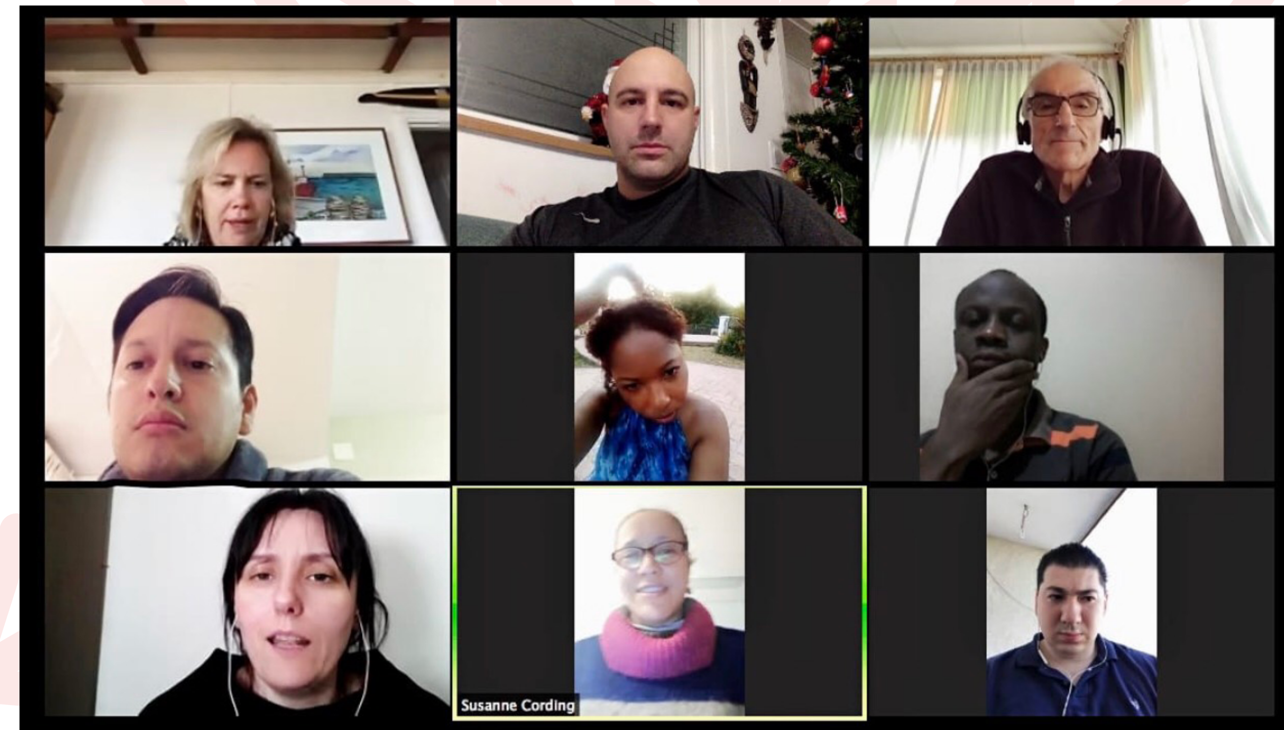
In several countries Balint groups are introduced in medical education. In England the groups are part of psychotherapeutic training in vocational training in psychiatry and will be part of the curriculum for under- as well as postgraduate training.

In Denmark group supervision is mandatory in the last year of vocational training for GPs. The method to use however is not specified.

Research in Balint groups
In "A Study of Doctors" [6] Michael Balint et al. made a research study on the first groups in a fourteen-year period. The study aimed to examine the impact of a mutual selection interview before entering a group and the characteristics for the doctors who stayed and the doctors who would leave the group, and to examine the results of the training scheme.

Lots of articles have been written over the years about the use of Balint groups in medical education under- and postgraduate. Most research has examined the outcome for the participants, and in a literature review 2015 van Roy found indications of the value of BGwork.

The research, however, was diverse, scarce and often methodologically weak and further research was asked for focusing on the benefit for patients. In recent years, more research is emerging i.e. about the value of the model, how to rate success of the training and how the effectiveness of the person of the Balint group leader was the most predictive factor for learning effects.



Balint 2.0 :-) awesome collaboration!! — sammen med **Shakera Carroll** og **6 andre** Se mere

Du, Kim Yu og 46 andre 3 kommentarer

Synes godt om Kommenter Del

Michael Balint 2.0 [2]

By Helena Galina Nielsen, GP (Denmark)* [1]

Relevance today

In Denmark there is a long tradition for group supervision in general practice and some of the first groups were Balint groups [7–9]. The dilemmas in 'the medical model' Balint criticized in the 1930ies still exist.

In the Danish College for General Practitioners the doctor-patient relationship has the highest priority. Medical practice and research worldwide strive to achieve a more patient- or person-centered approach. The concept of 'the drug doctor' which was introduced by Balint has been acknowledged in the placebo research, which shows how an empathetic and understanding doctor influences the patient's compliance and response on the treatment.

In the first groups focus was on the doctor-patient relationship. In the groups today relation to staff, colleagues and the health system may be discussed as well. Wilke who led supervision groups for GPs in London, experienced how the doctors became traumatized by continually change of structure, higher demands of accreditation and effectiveness on the system's premises without involving the GPs in the decision process. Therefore, he found it important for the doctors to have protected space in the groups which would allow reflection and discussion of frustrations about the health system.

This may have a beneficial impact on the patients as well.As a counterbalance to increasing specialization, Balint groups are still most relevant.

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*This article is a slightly revised version of an article published in Danish [1]: Nielsen HG, Davidsen AS. Michael Balint anno 2017. Ugeskr Læger 2018;180:V01180028

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"Training in understanding of the doctor-patient relationship is relevant for all doctors. The benefits of the groups have shown to be develop more empathetic and patient-centered doctors, and to prevent burnout."

Offering patients a choice for colorectal cancer screening:
A quality improvement pilot study in a quality circle of primary care physicians

By Yonas Martin [1], Alexander Leonhard Braun [1] Kali Tal [1], Reto Auer [1] and Adrian Rohrbasser [1,2]

[1] Institute of primary health care (BIHAM), University of Bern, Switzerland
[2] Medbase, Wil, Switzerland

Background
Guidelines recommend physicians offer patients a choice of colonoscopy and faecal immunochemical test for colorectal cancer screening so patients can choose the test they prefer.

In Switzerland, almost all patients are tested with colonoscopy and screening rates are low.

The heavy skew towards colonoscopy likely reflects physician preference, so the imbalance might decrease if we train primary care physicians in shared decision making.

An ideal site for training is a quality circle, where a group of primary care physicians discuss and implement step-based quality improvement interventions aimed at changing their own behaviour.

This study was a pilot of a step wedge designed randomized controlled trial that is on the way now.

Objective
Increase the number of physicians who use shared decision making to elicit the colorectal cancer screening preferences of eligible 50-75-year old patients and raise overall screening rates.

Methods
Working through 4 Plan-Do-Study-Act (PDSA) cycles, a QC of primary care physicians from one practice adapted tools to shared decision making, implemented them in their practices, and addressed organizational barriers.

On 20 and then 40 consecutive 50-75-year old. patients, they repeatedly measured the proportion of eligible patients with whom they discussed colorectal cancer screening and the patient's decision.

Study timeline

CYCLE PHASE	Jan-Feb 2017	Mar-Apr 2017	May-Jun 2017	Jul-Aug 2017	Sep-Oct 2017	Nov-Dec 2017	Jan-Feb 2018	Mar-Apr 2018	Sept 2018
(meeting dates)	*18.1 1.2 15.2*		*31.5*	*16.8*		*22.11*	*18.2*	*28.3*	

CYCLE PHASE	Activity
PDSA Cycle 1	
Plan	Presented QC with materials in support of SDM and presented the data collection form
Do	Materials tested internally
Study	Decided how the materials needed to be adapted
Act	Adapted the materials
PDSA Cycle 2	
Plan	Discussed the literature and the acceptability of improvements
Do	Integrated SDM material into daily routine and collected data
Study	Presented results of data collection
Act	Decided to adopt SDM and overcome organizational barriers by involving PAs and adapting EMRs.
PDSA Cycle 3	
Plan	Planned to involve and train PAs and simplify referal.
Do	2 week pilot trial with 2 PAs and QC-facilitator
Study	Determined feasiblity and identified possible improvements
Act	Implemented the collaboration between PCPs-PAs) and organizational aspects.
PDSA Cycle 4	
Plan	The team planned to implement CRC discussions and collect data with the assistance of PAs, which required training
Do	Implement SDM for CRC screening with the help/assistance of PAs into daily routine, adapt EMR, and collect 2nd round of data
Study	Presented the results of the data collection
Act	Decided to discuss CRC screening on the long run and as part of everyday practice

Results
The 9 participating primary care physicians found shared decision making for colorectal cancer screening was easier than they anticipated, that practice assistants reduced organizational barriers, and that they needed electronic medical records to track patients' colorectal cancer status.

Over a year, colorectal cancer screening rates trended upwards, from 37% to 40% ($p=0.46$) and FIT use increased from 2% to 7% ($p=0.008$). Initially, 7/9 primary care physicians had no patient ever tested with FIT; after the intervention only 2/8 recorded no FIT tests.

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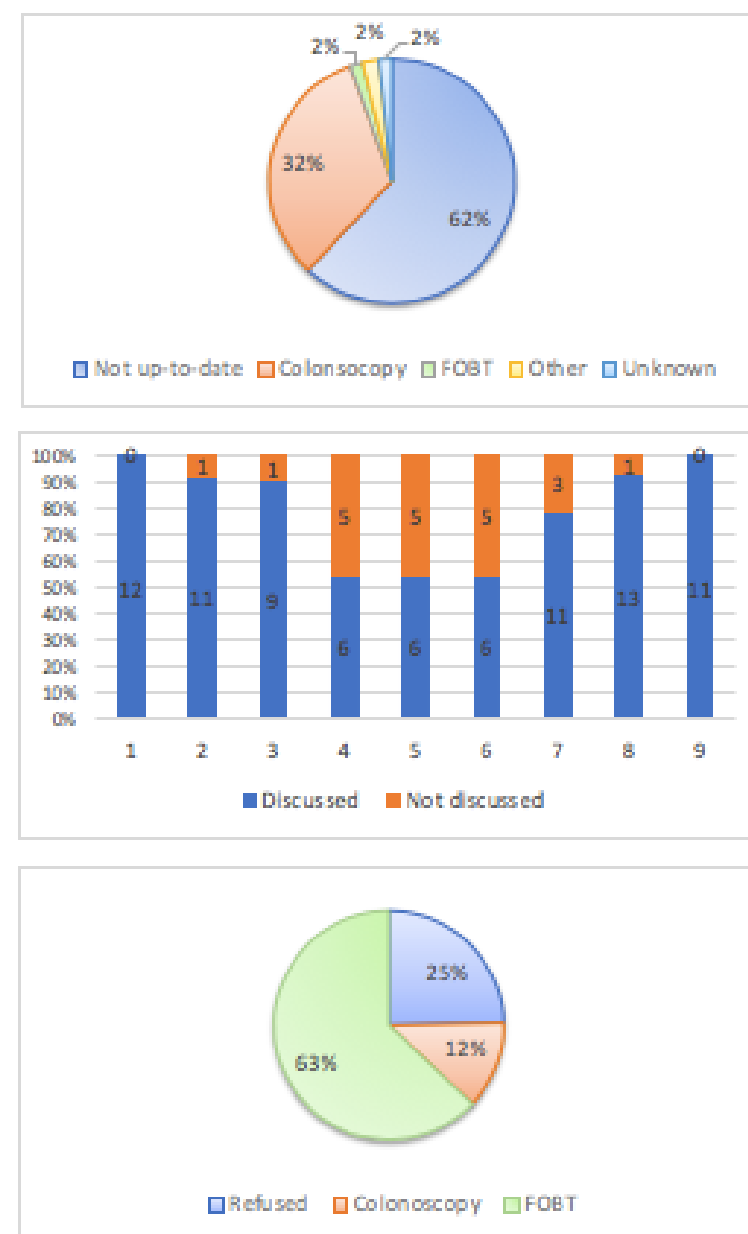
Figure 2

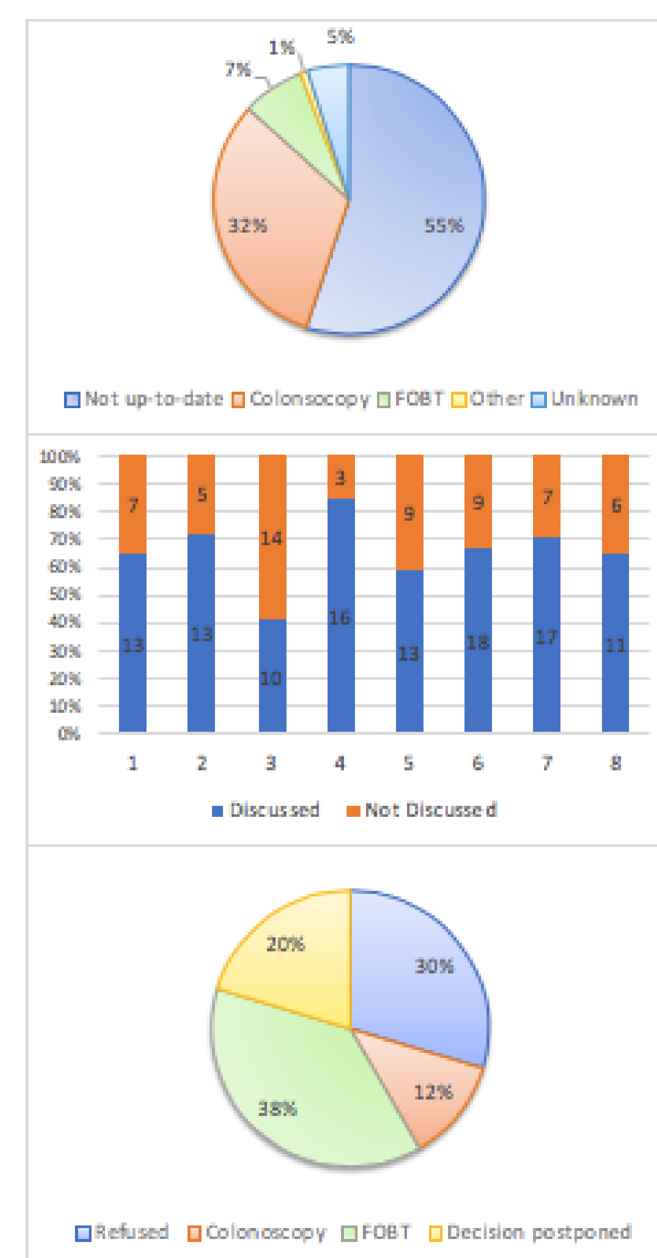


Panel A:
Colorectal cancer screening status at baseline in 2017 (n=176)

Panel B:
Discussion rates for each primary care physicians in 2017 (n=106)

Panel C:
Decisions after discussion in 2017 (n=85)

Figure 3



Panel A:
Colorectal cancer screening Status at baseline in 2018 (n=320)

Panel B:
Discussion rates conducted by practice assistants and primary care physicians for each primary care physician in 2018 (n=171)

Panel C:
Decisions after discussion in 2018 (n=111)

Conclusions

Through data-driven Plan-Do-Study-Act cycles and significant organizational changes, a QC of primary care physicians implemented shared decision making about colorectal cancer screening options in their daily routine, increasing the proportion of patients who took a decision.

The more balanced use of FIT and colonoscopy suggests that patients' values and preferences were better respected.

Acknowledgments

The authors would like to acknowledge all practice assistants and all primary care physicians in Wil who participated to this study.

Funding

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Target Journal

BMJ Open Quality

WONCA's Award of Excellence in Health Care (Five Star Doctor Award):

Dr Verónica Casado from Spain

Dear colleagues,

It is our pleasure to announce that Dr Verónica Casado from Spain has been awarded WONCA's Award of Excellence in Health Care, also known as the Five Star Doctor Award.

Congratulations Verónica on behalf of the WONCA World Working Party on Quality and Patient Safety. It is an honour to have such an excellent doctor among us. **Read more**

She already won the **WONCA Europe Award of Excellence in Health Care** (Five Star Doctor) back in 2017 at the WONCA Europe Prague conference.

Kind regards to all,

Maria Pilar Astier Peña and
Jose Miguel Bueno Ortiz

EQuiP delegates from Spain.

New individual member: Ana Belen Espinosa

I am a general practitioner qualified in Spain. I am interested in health services research, particularly on how the regulation and financing aspects of PHC influence providers' performance and organisation of PHC delivery at regional and national levels.

Currently, I am completing a PhD in the Centre for Health Policy, Imperial College London. My PhD project is a Europe-based cross-country comparison on the impact of financing and regulation in providers' use of resources and accessibility and comprehensiveness of PHC, with a particular focus on equity and distribution of services and outcomes.

I am also interested in local or regional public health initiatives, led by PHC teams, for primary prevention of non-communicable diseases.

I am very pleased to have joined EQuiP since I think it provides the ideal platform to:

- Share and learn about different PHC organisations (local, regional and national level)
- Discuss the health policy contexts in which they are embedded
- Identify challenges and elaborate potential solutions

I also believe this will be a positive and enjoyable way to explore gaps in knowledge together and stimulate research collaborations.

Ana Belen Espinosa
PhD fellow at Centre for Health Policy
Institute of Global Health Innovation
Imperial College London

Change of thinking about quality management and policy by Dutch GPs

By Stijn van den Broek, the Dutch College of General Practitioners

Social trends, new insights and developments in healthcare also change the approach to quality in GP care. Patients increasingly demand tailor-made care that suits their needs, personal goals and life situation. Under influence of extramuralization and other trends the complexity of the demand for care is increasing.

The pas two years, Dutch GPs indicate that quality means more than just applying guidelines and focusing on measurements and outcomes. They want to provide the most appropriate care that meets the wishes and needs of patients. The (technological) possibilities to deliver more patient centered care increase.

At the same time, GPs are struggling with work pressure and (threatening) capacity shortages. The discomfort among Dutch GPs about accountability requirements and associated administrative burdens has increased. In addition to patients and GPs, other stakeholders also have interest in the quality of GP care.

For example health insurance companies that are expected to purchase good quality care for their clients and national supervisors who approach GPs for their responsibility for delivering good quality. These developments together are the reason to adjust the vision on quality of GP care in the Netherlands. The quality policy in GP care - the way in which GPs work on quality - has become a complicated playing field. The different players have more and higher expectations.

This requires customization when applying the professional standard, interpreting guidelines and quality indicators. From this perspective the Dutch GPs believe that they should look for a new balance between evidence- and practice-based working by professionals that is more suitable to the increased complexity and expectations of patients.

Don Berwick speaks in this context about a new era of ‘learning and improving together’ in which a justified trust is being worked on. *The New Quality Thinking* of the Dutch Quality Council of the Care Institute illustrates this change in thinking by indicating that quality of care can be understood as a learning process that takes place in practice: “The quality of care is the result from the opinion of caregivers and patients together and working on quality is then learning together.”

Due to the changing definition of and view about quality of GP care a transition is taking place with a shift from ‘verification of accountability to trust in responsibility’.

The intrinsic motivation of GPs to do the right thing in the interests of patients seems to be an excellent starting point for the quality policy of GP care. On the basis of current knowledge, experiences of colleagues and with the patient as a discussion partner, the central focus is on learning and improving together.

Increasingly, GPs will appeal to their self-learning ability and learn from other available sources of quantitative and qualitative mirror information, such as experiences and feedback from patients and colleagues, care usage, care provider satisfaction, stories and casuistry, benchmarks of quality indicators.

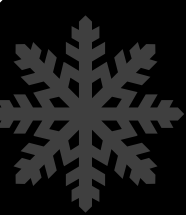
The collected knowledge and mirror information and especially discussions about these give input to short-term improvement plans (according to the steps of the PDCA quality cycle), in which general practitioners further develop themselves and their practice. GPs mainly work with aspects of care and practice that fit their situation (including the patient population and practice organization), and in which they see added value, or which are valuable to the development of quality.

GPs can help each other with this learning process through peer review. Differences between general practitioners and practices (practice variation) provide starting points for learning from each other.

Joining patients, other stakeholders like health insurance companies and national supervisors on a practical, regional and national level enriches the learning process. By talking to each other, more insight is gained into the learning process and creates a realistic picture of what one can expect from the other.

Working on quality is more satisfying when it succeeds in triggering meaningful changes, meeting satisfied patients and give more working pleasure. Only then GPs and their employees can be proud of the achieved successes and like to show them, as well as experienced obstacles to working on quality.

A simple way to provide this insight is to use a quality annual report. This is also a useful way to engage with employees, colleagues, patients and other stakeholders. In this way justified trust in the quality of general practice care and supervision in a different manner can be fulfilled.



New 2-day Course on Quality Improvement (Portugal)

Quality Improvement and Patient Safety Education in Azores

By David Rodrigues, New University of Lisbon - NOVA

Last September, David Rodrigues - GP and national representative of Portuguese National Family Medicine in EQuiP - made a 2-day workshop on Quality Improvement in Ponta Delgada, Azores (Portugal).

Family Medicine residents had the opportunity to learn and discuss quality improvement methods, patient safety, leadership and team building.

They ended up planning a quality improvement project that they will carry out during 2019.

Program

Day 1
Intro and welcoming
What is quality in health care?

- A quality culture
- Defining a problem
- Appraising the evidence

Day 2
Defining a solution
The improvement cycle (PDCA)
Spreading quality (squire)

3 Improvement Projects

#1
Data confidentiality on referrals to secondary care specialist.

- Students discussed and identified the main problems concerning the referral letters from primary to secondary care.
- They came out with a defined plan (specific changes to implement and measures) to guarantee the confidentiality of patient data.

#2
The problem is common in many health units: No one answers the phone.

- Students used fishbone diagrams and focus groups to elaborate on potential solutions.
- They came out with a plan to improve patient accessibility by telephone calls.
- This improved access through telephone calls in a primary care health unit.

#3
Adhesion to a quality culture in three primary care health units

- Students felt that the health units they worked in lacked quality culture.
- They planned an intervention about promotion of quality circles (PDCA).
- This raised awareness, solved problems and stimulated collaboration.