



The Grapevine

SUMMER 2014

Its high summer and if you've been on your summer holidays I hope they were fantastic and if you haven't yet been here is some summer holiday reading for you!

This edition of *Grapevine* has an update on the 5th EURIPA Rural Health Forum, being held in Latvia in September – we hope to see you there - and a report from the successful WONCA Europe conference in Lisbon last July, at which EURIPA held several workshops.

At the 12th WONCA World Rural Health Conference, Gramado, Brazil, in April 2014 the WONCA *Rural Medical Education Guidebook* was launched and a short summary is included here as well as reports from EURIPA members from across Europe.

Jane Randall-Smith

Executive Secretary EURIPA

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Message from the President of EURIPA

Extending the scope of EURIPA to the world.

Europe has led other world continents in achieving to unite its medical workforce and in particular its rural practitioners since, in 1995, a group of rural general practitioners led by Dr John Wynn-Jones held a meeting that resulted, two years later, in the foundation of the European Rural and Isolated Practitioners Association (EURIPA). This has been a difficult task, in a continent that represents 12% of the world's population which speaks 200 different languages, in 50 different nations, of which only half share a solid political link (the European Union), countries that show great differences, like at their nominal GDP that ranges from some of the richest in the world to those as far down as 125th, and for the amount of a 200 million rural population (the 23% of its total population), in countries which some are predominantly rural (up to 85% of the population) whereas others are almost entirely urban.

Despite these huge cultural, financial and geographical differences, Europe, with the help of EURIPA, is beginning to be the first world continent that is becoming successful (with more or less good fortune) in the endeavour, and is becoming a mirror for all the remaining world continents. Europeans are now leading the world WONCA Working Party on Rural Practice, will next year lead the WONCA World Rural Health conference, and are extending their influence at other world regions, such as South America, defining the rural health needs and counseling their colleagues outside the European borders. We have to congratulate that, for example, at the Montevideo International Declaration (the link to this Declaration is available at the EURIPA website), the EURIPA ideological input has been strongly appreciated and has resulted key for the agreement.

Up to now, the leaders in world rural practice and policies came from distant regions like North America or AUSTRALASIA, with a poor consideration towards other world regions. Now Europe, due to EURIPA's involvement, is becoming more and more protagonist, and receives the call from other world regions. We have to congratulate ourselves in our task, which seems to confirm that we are following the right path.

Jose Lopez-Abuin
President of EURIPA

EURIPA 5th Rural Health Forum

Riga, Latvia September 26th – 28th, 2014
Rural Family medicine – today and tomorrow

It is now little more than a month to the 5th EURIPA Rural Health Forum which is taking place in Riga, Latvia. The International Organising Committee has been working hard with the Local Committee to put together an exciting programme and to make sure that delegates have the opportunity to enjoy Riga, which is this year's European Capital of Culture.

The programme begins on the Friday afternoon with the “**poster walk**” and will be followed by a series of workshops:

Friday 26th : Practical Workshops

- Rural Proofing for health
- How to use Social Media (joint session with the Vasco de Gama Movement)

Saturday 27th

Plenary: Designing a pan-European Rural Health Policy strategy

Workshops:

- Policy making: primary health care actualities in European countries
- Prioritising issues in rural health/practice
- Collecting and using evidence to inform policy
- Structure of primary healthcare in rural locations – is there a universal model?
- How can rural GPs influence healthcare politics?
- Building partnerships across sectors
- Training in Rural Medicine in Europe: Graduates and Undergraduates. What political and academic actions are needed?
- Health-related behaviours and quality of life- Rural vs urban patients.

Sunday 28th

Workshops: “Learning from the Experts”

- Education
- Occupational Health

More information is available at the web site www.euripaforum2014.eu

We hope to see you in Riga!!

EURIPA at Lisbon at the WONCA Europe conference

Jose Lopez-Abuin
President of EURIPA

EURIPA actively participated by running four workshops at the WONCA Europe conference in Lisbon in July. Over 3,500 delegates attended the conference which had the title:

New Routes for General Practice and Family Medicine

On the next pages are a summary of EURIPA’s workshops:

“If telemedicine is the answer to rural health, what are the questions?” (Leaders: Janko Kersnik and Zalika Klemenc-Ketis).

In the past years we have seen major expansion in the development of telemedicine and an even larger growth in expectations for the future of health care, especially in terms of rural family medicine. Namely, rural family doctors face unique challenges in delivering health care, i.e. isolation, problems in communication, problems in accessibility, lack of infrastructure, lack of equipment of surgeries and problems in accessing current medical information or peer opinion exchange. Therefore, telemedicine is increasingly perceived as the uniform answer to all problems in rural family medicine practice. To understand the advantages and the disadvantages of telemedicine as a part of patient management and develop attitudes towards the use of telemedicine in their practice has been the main aim of the discussion, and participants have learned to develop a critical attitude towards its use in the delivery of their patients.

“Developing practice-based research networks in rural Europe: the joint work between EURIPA/EGPRN” (Leader: Christos Lionis; Speakers: Nicola Buono, Jean-Pierre Jacquet, Zalika Klemenc-Ketiš, Donata Kurpas, Jose Lopez-Abuin, Ferdinando Petrazzuoli)

Although practice-based research presents a realistic vehicle to study, explore and measure effectiveness and cost of research in primary care as well as to highlight barriers that impede its implementation, the subject has received little attention in Europe. A joint workshop has recently been organized by EURIPA and EGPRN in Malta and its key message was that practice-based research network seems to be an effective strategy and urgent priority within the European rural setting. This workshop has been the second step of these joint efforts. The goal was to highlight further possibilities that the PBRNs to be developed in rural Europe. Attempts to determine what capacity is needed and the barriers to be anticipated have been made while selected best practices from rural Europe have been presented. The participants have been informed about needs and solutions for rural practice research as well as a practical proposal on how to improve research skills via research courses tailored for rural researchers and PBR networks. They have also learned from examples of PBR in a rural primary care setting that have been presented in the session. Finally, the next steps of cooperation between EURIPA and EGPRN have been discussed and will be developed.

“ Defining the extended-scope practitioner (ESP) for rural remote communities” (Leader: Jose Lopez-Abuin; Speakers: Oleg Kravtchenko, Gunta Ticmane, Ioanna Tsiligianni, Jean-Pierre Jacquet, Donata Kurpas, Zalika Klemenc-Ketis, Roger Strasser, Diederik Aarendonk).

Within the world, and also in Europe, the definition of the rural practitioner's profile has been discussed without achieving a global agreement. The complexity of the different contexts, together with the concepts of patient-centered care and of social accountability towards the community where they are serving, seems to determine the need of (as the president of EURIPA has denominated) a more extended-scope practitioner (ESP) able to cope with the different issues related to health care that may arise within remote, underserved and isolated communities. EURIPA has committed itself to reach an agreement re this definition of the Extended-Scope Practitioner (ESP) for Remote Rural Communities, and this workshop was designed to fit for the purpose in order to be able to determine the influence of the context at remote and isolated communities in the needs of their health care, and be able to identify their problems and solutions. Some brief presentations were performed by several members of the EURIPA Executive and IAB Boards, as well as by other invited members from different networks. Definitions of rural practice and of the rural practitioner from different world regions were described, running a short discussion over the most innovative world statements: the Montevideo Declaration (available at the EURIPA website), as well as the draft version of the

Gramado Statement (from the last WONCA World Rural Health conference) and the recent Cairns Consensus (an Australian-based initiative). The Montevideo Declaration achieved the major grade of agreement within the participants, and the discussion will still keep running in the next future.

“EURIPA-VdGM Workshop: How to develop leadership” (Leader: Raquel Gomez-Bravo; Speakers: Sara Rigon, Maija Kozlovska, Noreen Lineen Curtis, Liga Kozlovska, Sandra Gintere, Sara Belinchon Moyano, Tanja Pekez-Pavliko, Jose Lopez-Abuin, Paloma Rodríguez Turégano, Belisa Tarazona Chocano).

This session has showed that leadership training has a direct impact on the ability of physicians to make continual system improvements and family medicine organizations have the responsibility and commitment to promote and achieve the best possible outcomes possible. New programs are needed to develop this health workforce and EURIPA made it one of its top priorities by engaging and supporting most of all the now prevalent female doctors and also junior doctors in leadership and management activities: Primary Care physicians are often considered to be leaders in Primary Care even if they are inadequately and differently trained across Europe and our commitment to our social accountability task requires leadership. This session has encouraged participants to develop and improve leadership skills.

The EURIPA president met with the WONCA-Europe Executive, and in a very positive discussion requested a greater involvement at WONCA’s activities and offering our collaboration for rural issues. The WONCA-Europe president, Job Metzmakers, will be keen to participate at our next Rural Health Forum in Riga.

The EURIPA booth was also very active: an opportunity to meet the EURIPA Board and also the Latvian delegation who introduced the 2014 Rural Health Forum. We must also not forget that the 2015 WONCA-World Dubrovnik conference, in which EURIPA will be a strong partner, has also run its own booth at the conference. Both booths received many visits of our members and also from rural colleagues from around Europe who wished to join our network: more than 100 new members have signed up with us there!

Not all at the conference was scientific and business. Many EURIPA members and also colleagues from other networks joined us for fun at our Rural Dinner, enjoying the Portuguese Fado music. Special thanks to Tina Eriksson and her Equip colleagues, who brought a strong delegation!.

If you visit the conference website you will be able to link to the WONCA-World’s president presentation, to the Lisbon Declaration, and to many other interesting conference news.



Left to right are: Oleg Kravtchenko, Jose Lopez-Abuin, Jean-Pierre Jacquet

Reports from EURIPA members

Rural Connectivity is no trivial matter – David Hogg, Scotland

Rural Practice in Northern Sweden – Peter Berggren, Sweden

Family and Community Medicine in Catalonia - José Luis Pérez Vallina, Spain

Clinical case of a child with “running nose” – Pavlo Kolesnyk, Ukraine

Rural connectivity is no trivial matter

by [David Hogg](#) on March 12, 2014 in [Innovation](#), [Rural Deprivation](#), [Rural-Proofing](#)

The availability of good medical care tends to vary inversely with the need for the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.

Dr Julian Tudor Hart, 1971

Tudor Hart’s analysis remains a pertinent reflection on the difference between demand and need, and the tendency to inequality when healthcare provision is left to supply/demand (market) forces. Yet health & wellbeing inequalities have been allowed to worsen due to [market forces dictating access to digital connectivity](#). Access to a mobile phone network and the internet is increasingly being [viewed as a ‘basic need’](#), and yet there is a wide variation in this access across Scotland. We are now at a point where unless the issue is taken more seriously, this [digital divide](#) between the ‘most and least connected’ threatens to create a very real inequality within Scotland.

Ten years ago, it may have been assumed that those living in rural and remote areas should not be surprised to miss out on the opportunity to use their mobile phone for calls and texts, never mind email and internet video. ***However, now the poverty of connectivity in rural Scotland is no longer an acceptable fact of rural life.***

The threat that poor coverage now poses to rural areas, is such that this deserves to be a high priority issue at corporate and government levels. The [‘digital divide’](#) – the difference between those who have access to fast broadband, 3G/4G cellular coverage and ‘always on’ technology; and those who don’t, has become a driver of numerous subsequent inequalities – access to information, business development, freedom of speech, the [right to be heard](#) and interaction with services essential to everyday living. It is now commonplace for certain services – from both commercial and public organisations – to offer only online ways of interacting, with the assumption that this is universally available across Scotland.

Even on stripping the necessities for communication right down to functions commonly viewed as ‘vital’ – such as summoning and co-ordinating emergency care – there is a paucity of acceptable network coverage. For example on the Isle of Arran, we see the following examples of the difficulties presented by poor mobile phone coverage:

- Difficulty in contacting on-call staff including medical and midwifery staff. Our system is as safe as we can get it – we carry radiopagers which have improved coverage, but this offers no means to respond to the one-way message that this can send, nor any confirmation that the message has been received.
- Difficulty for our ambulance First Responder teams – both in missing calls and subsequently volunteers naturally losing interest as they are either tied to their home phone, or have to relinquish their commitment to volunteer on a regular basis
- The great benefits offered by SMS callout of our [Mountain Rescue Team](#) (allowing rapid assessment of who is immediately available) are overshadowed by poor coverage throughout the island – and in particular for the volunteers who live in Lamlash which is a particular blackspot. This is dependent on 2G only, in an area that includes hospital, ambulance, lifeboat, coastguard, medical, local authority and other centres, including Arran High School.
- The [Emergency Medical Retrieval Service](#) from Glasgow have invested heavily in making the most of iPads and iPhones to achieve and maintain gold standards in critical and transfer care of patients. However, as our community hospital in Lamlash has no mobile phone coverage, it is impossible to access these unless sticking to offline content. In addition, this also makes it very difficult for the EMRS team to stay in touch with their base, and maintain phone availability to other rural centres who may also have critically ill patients to discuss with them. This example is detailed more fully in the [NoBars section of this website](#), and is replicated across rural hospital sites across Scotland.

Position-finding

A number of emergency teams on Arran can make use of a basic 2G signal to find the position of a phone during emergency situations. For example, [ambulance service resource tracking](#) (including availability of [BASICS](#) GPs) is reliant on GPS-units which continue to send a GPS position over the 2G network. When a medical emergency arises, ambulance control can quickly pinpoint who is available, and where they are. Without 2G, this function is lost, and this is the case throughout much of Arran and other rural areas in Scotland.

Another example is in the case of finding a missing person, for example lost walkers on the hills of Arran. In certain circumstances, Police Scotland can trace the signal from a mobile call, and work out its location. This information allows emergency teams, for example the mountain rescue team, to rapidly reach the missing person or casualty, saving vital time in preventing ongoing injury or hypothermia.

Without any mobile coverage, these functions are simply impossible.

Smartphones are smart

Smartphones are now so commonplace that they bring an almost-universal access to their other key functions. Email, maps and key documents whilst on the move can all be facilitated by 3G access, and the vast majority of phone customers are already on 3G contracts. In being prevented the use of 3G functions whilst away from home wifi, this simply causes an even greater void between what is now currently possible, and what is available to folk living in rural areas.

Access to social media is also increasingly important to form and maintain professional networks, as well as keep up to date with medical news and advances. In my own experience, much of this is possible through Twitter – our colleagues in Australia have been particularly active on this front – and yet, during a typical 8am-7pm day at work it is not possible to engage with social media due to having no connection.

The situation is further exacerbated by the barring of social media sites by many employers (in my case, our NHS IT team) for fear of activating virus activity from online contacts. With professional and social isolation being a considerable risk and concern in rural practice, this lack of appropriate phone connectivity does nothing to improve social contacts with colleagues elsewhere in the country and further afield.

What about wired broadband?

In addition, we have seen a similar divide develop with access to hard-wired internet connections. With urban areas now seeing access to rapid fibre-optic connections, many rural areas still lumber on with fixed copper-wire, offering no more than 6Mb/s – and often the connection is as low as 2 Mb/s. So on both accounts (mobile and fixed networking), we are seeing the digital divide widen at an exponential rate.

Hotels now rely on online bookings and customer review sites. GP practices rely on networked access to results, records and reporting systems. Commercial and charitable organisations rely on cloud-based document storage. Schools rely on adequate IT access to ensure that students are IT-savvy for the wider world.

Scotland, as a forward-looking country, needs to realise the widening disparities being created by differences in digital connectivity.

The double-whammy of 4G

For many of us working and living in rural Scotland, we will look to Germany with some degree of envy. When 4G technology came along – promising broadband-speed mobile connectivity – mobile network providers were keen to bid for licences, in order to rollout of this service to urban areas where the money was easiest to make (no problem with that in the context of business).

Germany, at this point, [realised the prospect of widening inequalities](#) in access to digital connectivity. The German Government therefore began their 4G licensing process [by prioritising rural areas for 4G licences first](#). Only after providing 4G to these areas, could mobile providers then move on to obtaining licences for more urban areas. This, I understand, has been successful in closing the digital divide, but without significant penalty to those in cities, as high-speed fibre-broadband was generally already available.

In addition, 4G could rapidly become a surrogate for hard-wired broadband access. The increased costs in laying fibre-optic cable across rural geography is a prohibitive and costly factor for bringing faster broadband to rural communities. [There is some realisation even within the industry](#), that implementation of decent 4G roll-out to rural areas would improve internet connectivity – **as well as** the advantages in mobile phone coverage.

Why the concern now?

If this has long been the case, why the concern now? Until relatively recently, mobile applications were new, and most folk living in rural areas have come to expect (justifiably) that digital rollout tends to happen in more urban areas first. That is where the larger consumer-base is likely to be found, and so it makes sense on many levels, including for profit.

However, the last five years have seen a rapid expansion of the opportunities to network at professional, personal and social levels by having access to 3G coverage or more. Along with this we have seen it become increasingly important to have an internet connection in order to engage with systems – road tax, online shopping, news and media, and especially professional networks. The loss of local post office services has exacerbated this dependence on online public services. Videoconferencing is commonplace, and virtual collaboration is essential for progressing with initiatives and projects. **Poor connectivity simply stifles this productivity.**

In 1971, Dr Julian Tudor Hart's work on describing the '[Inverse Care Law](#)' raised awareness of the fact that in order to benefit those who need it most, healthcare should not blindly follow market forces, and that demand does not equal need. Whilst the telecommunications industry is rightly a highly competitive and demand-led consumer business, it must be realised that telecommunications *per se* are an essential component to successful, healthy and productive communities. Scotland needs more effective action to tackle this inequality if it is to benefit from the vibrancy, innovation and productivity available from more rural areas of the country. **It is vital to close this digital divide.**

David Hogg

Rural Practice in northern Sweden

Peter Berggren

With an ageing population, medical centres in the rural and remote regions of northern Sweden are trialling new ways of providing care. To be able to deliver high quality care at a reasonable cost in the future, the development of distance bridging solutions and innovative methods of bringing care closer to the patient is high on the agenda. The overall goal is to be world leaders in the development of innovative medical practices for rural and remote medicine within an old population.

In many ways, a visit to Storuman's Medical Centre, placed in the middle of southern Lapland, portrays how care is provided by Medical Centres across rural and remote Sweden. The average age of patients within this region is high, and the nature of living in a small community is that most people are acquainted with one another. It is considered good manners to taking the time to talk and joke with patients before investigation.

Somewhat unexpectedly, or is it just that the author is prejudiced? - is that even when considering the peripheral position of Storuman's Medical Centre, the facility drives a practice which in many respects is at the forefront, both technical and organizationally.

The Swedish medical journal visited Storuman's Medical Centre late one September's day 2013 to meet one of the driving characters, specialised doctor Peter Berggren. Born in Storuman, Peter had planned to carry out a career as a surgeon in Örnsköldsvik. However 20 years ago, he was requested to come home by colleague Gunnar Hjernerstam, who despite being 82 years, continues to work within Storuman's Medical Centre a few days per week.

"Gunnar rang me once a week wondering when the hell I would be coming home, until finally we became so sick of him that we moved back", explained Peter Berggren.

To provide an example of the challenges faced by the more rural medical centres, Peter Berggren describes that when he is on call, he is the only available doctor within an area almost as large as Wales or twice the island of Creete, serving 12 000 inhabitants. The nearest hospital, located in Lycksele, is 100 km away. For patients living in the western parts of this region, this distance to the hospital, is an additional two or three times as long.

To be able to provide care which achieves both quality and cost effectiveness under such extreme conditions requires use of creativity and innovation. One such example is the use of the community hospital, (in swedish Sjukstuga) a model for provision of care, which has origins dating back to the 1800's. This model provides, besides being a Gp surgery, a kind of miniature emergency medical facility inclusive of an ambulance and an emergency room which is manned 24 hours a day by a nurse. For patients requiring ongoing care, there are also a small number of inpatient care beds. There is also Doctor on call 24 hours 7 days a week.

Since the establishment of the community hospital, this kind of care has saved lives and provided security for people within the region. However since the start of telemedicine, an entire new range of opportunities have become possible. Medical Centres in southern Lapland were the first to provide telemedicine specialist consultation in Sweden 1995, and today telemedicine is a corner stone in which work is conducted. To illustrate, Peter Berggren taped a button on the keyboard in the emergency room, where a live-broadcasting screen showing the emergency room in Tärnaby, then appeared. In this way, he can support nurses both in Storuman, as well as in any of the other Community hospitals within the district.

“You can zoom in a lot and I can easily assess for instance injuries this way and if the patient needs a few stitches the nurse can do that locally, which then saves the patient having to travel 250 km back and forth to receive treatment for a simple injury.”

Similarly, x-rays of a fracture can be done on site and these images can then be sent digitally to the doctor on call. If the injury simply requires a cast, then this can be done by the nurse thereby saving the patient a trip to the hospital. An electronic stethoscope is similarly utilised to listen to a patient’s heartbeat via distance, and a fiberscope is also utilised to check patient’s ears and throat.

At the ward in Storuman there are 8 available places for short time treatment. We treat a lot of older patients with infections, heart failure, different types of cancer and COPD. We also provide palliative care and rehabilitation after stroke and fractures. In the same corridor, there is also a nursery home with 8 short term beds available.

“We have the same treatment time in our ward as in a hospital and also the same patients, however at a cost of only two thirds of the price.”

Centre of Rural Medicine in Storuman

Currently, we are facing new challenges. We have to offer high quality care to an ageing population with increasingly complex medical needs. To meet these challenges, the county council has created a new research and development department in Storuman, Centre of Rural Medicine, where Peter Berggren is manager. It is within this department new methods are developed and researched.

Peter Berggren’s goal is to become world’s leading in developing and delivering care to an ageing population in rural and remote areas. It may sound like hubris but according to Peter, no more remarkable than the small mountain settlement of Tärnaby being able to successfully mass-produce world stars in down-hill skiing.

“In Tärnaby they have steep hills, lots of snow and not much else to do, which is excellent conditions for being good at skiing”, says Peter meaning that personnel within northern Sweden also have some unique conditions which allow for development of innovative care models.

“To begin with, it is good to have an old population, which we have. A change towards older populations will occur in many countries and in this aspect we are 25 years ahead. This is an advantage we have to use. Secondly we have a very well developed broadband network with fibre connections also in remote areas, which give opportunities to develop distance bridging care close to patients. The third is that we have well educated personnel used to work with telemedicine. At last, which also concerns the whole of Sweden, is that we have a trust in our institutions. It is easy get help from our inhabitants when we want their opinion on how

to develop our working or if we want to test new technology.

A number of projects are already under way. One of them are remote controlled cardiac ultrasound. Peter Berggren shows one of the rooms within the Medical Centre which is home to a small industry robot. The robot is steered with a joystick, controlled by a biomedical analyst located in Skellefteå Hospital, 260 km away. The idea is that heart ultrasounds conducted at distance will become an alternative to sending patients with, for example murmurs or suspected cardiac failure, to a heart clinic in nearest hospital. It is difficult to have heart ultrasound performed within the local area by Gp:s.

“There are many other ultrasounds that can be performed by Gp:s with low volume and still good quality, but not heart ultrasounds”.

After the ultrasound examination is completed, the Gp sits with the patient and via video link, consults with the cardiologist so as to form an appropriate treatment plan. For me as a Gp, this is an attractive way of working, states Peter Berggren.

“If I send a patient to hospital, in best case, I receive an abstract answer which I do not learn much from”, says Peter Berggren, who means that even if the concept is developed for use in the more rural and remote areas, it can also be applied on a larger scale.

“There are a number of smaller hospitals in Sweden which find it difficult to maintain right competence among personnel to administer heart ultrasounds 24 hour every day. There could be an organisational centre which acts to service the whole of Sweden, or at least the northern parts.”

Another project which we currently have started is the Virtual Health Room, which is established in Slussfors, a small remote settlement located between Storuman and Tärnaby.

“There is a considerably old population in this area and the alternative for these people is to come here. We will see how much people manage to do by themselves, by helping each other, or utilising the home care personnel”, says Peter Berggren.

In this unmanned health room, there will be equipment available for residents to monitor for instance blood pressure, blood count, b-glucose or PK/INR. These samples are analysed as they are taken, and the results sent digitally to the medical centre in Storuman. If an individual requires consultation with a doctor or nurse, they are also provided with the opportunity of connecting via video link to the Medical Centre in Storuman.

An important consideration when planning for the future, is determining what should be done where? It is obvious that telemedicine can be used much more, but just because it can be used, does not mean that it should be. What can be performed via distance or even by patients themselves, without being a negative effect on quality of practice? When is it beneficial to live in the same social and cultural context as your patients? Which procedures should be carried out within a hospital, and not in primary care or community hospitals? Within this area a scientific base is missing, and therefore personnel in Storuman are working in collaboration with a

number of university institutions and some other countries, in a larger overall study to illustrate these questions from different perspectives.

But large areas and small populations are not the only challenges within rural and remote medicine in Sweden. There are difficulties in recruit and retention of personnel, especially doctors. Temporarily rostered staff has been the traditional solution for this, which has also come with well known downfalls. In a partially EU funded project, Centre of Rural Medicine are working in collaboration with partners from Norway, Finland, Greenland, Iceland, Scotland, Canada and Ireland to develop strategies around recruiting and retaining staff.

Here in Storuman however, this previous pattern has already begun to change.

“We have always had trouble with recruitment, and about 10 years ago we became so sick of having doctors that were left over, because the work up here is so difficult that we need the best. So we agreed to offer a resident physician training program which is so hard, difficult and complicated, that only the best doctors bother to try it”.

Together with the Swedish Association for Rural and Remote Medicine and the four northernmost counties, a resident medical training program was created and designed specifically for medical practice in rural and remote areas. Given that a rural and remote doctor meets a broader base of patients including larger number of acute medical cases, this program includes training which is additional to ordinary specialist training program for family medicine. To facilitate in the collaboration of new ideas, this training also offers exchange with other countries that similarly have large rural and remote areas, such as Canada and Norway.

This program can be described as nothing less than a success. The number of residents has markedly increased, from 3 to 12.

Above all however, Peter Berggren is most appreciative of the number of competent applications received.

“The goal is that it will be Sweden’s best specialist training program within family medicine, and whilst this is hard to measure, I am damn sure that we’ve got it right”.

Family and Community Medicine in Catalonia.

José Luis Pérez Vallina

I do not remember exactly when I first thought to be a doctor but I think it's clear when the first time was. I heard about what a medical doctor is as a Platonic idea. His name was Fidel. I had no many dealings with him but my mother always spoke of him with admiration and reverence. He was the doctor of his little village, a small town in Castilla la Vieja (Spain) in the Sierra de Gredos, just 500 inhabitants. The place where I spent all summers with my grandmother Micaela, every year for three long and fruitful months.

Once, when I was six years old I had a bicycle accident with the front fender which gave me a gap in my forehead. There are two things that I recall: the first one is a scar on my right eye; the second is a memory of the doctor who treated me: Don Fidel. I guess he sewed my head and some more. Seeing my little scar I think it wasn't so much as a wound but I remember the peace I felt. I don't know how he did it but the feeling I had it couldn't be anything wrong. My eye would not fall out and I did not become blind. The scar remains on my soul and I hope to be worthy for it. That day I had unwittingly discovered what a doctor is. A Rural Doctor.

Now I am a 43 year old doctor and I work in a little village in Catalonia, in the Garraf area, its name is Olivella . I have a specialization in Family and Community Medicine, which is the precise degree to work in the Primary Care Spanish health system. I was trained in Asturias where my soul comes from and where I spent my adolescence, youth and studied my career. In this happy period my contact with rural medicine was rather limited. Only personal relationship as a patient or helping some relative who lived in a village. I was focused on important things: learning how to be a good doctor but no one taught me things like that I lived as a child. I had the opportunity to finish my residency period in Catalonia where I came to work. I did not think it twice. First I worked in Palamos and later in Sant Pere de Ribes at the same time I was growing up, learning and acquiring more knowledge and skills. During this years I changed from being a "chick" to be a person with the connivance of my medical colleagues, nurses, secretaries and my patients.

In the Garraf area we give health care to several large towns like Sitges. It has about 30,000 inhabitants but in the periphery there is a little village of about 3500 inhabitants. It's called Olivella and I've been working here for 4 years.



It is located in the Garraf Natural Park and it has many farms and tourist routes of great interest, as the Plana Novella route, where, by the way, we have a Buddhist monastery.

When I started working on this team, Olivella was called "Siberia " for me. Under my point of view, it was a far 6 km endless route, on a full of dangerous and menacing bends where you worked "alone" as a doctor, only " yourself " in front of your destiny. The place where the local doctor worked was a windowless room like a dungeon that it had been temporarily authorized to make an office .

But one day my mate in Olivella became deeply ill and he could no longer work alone in that local office, anymore . So I got the call from our boss who explained the situation and giving me to understand that I could be his permanent replacement if it seemed appropriate. I was bedridden recovering from an appendicitis episode which I had suffered two days earlier. I was very sore, dazed and it did not sound great at all.

I told him that I was not interested in Olivella and he need to look for another solution. I was fine in my office, with my five fellow family physicians in the Health Center of Ribes, the main Health Center in the area. It has two gynecologists , a midwife , two pediaticians and six nurses , and six secretaries. Without a winding road and my patients known since I was working there for seven years. What would my poor patients do without me? In addition I was responsible for training residents in the team. I was responsible for coordinating all the work and teaching programmes between resident and tutors. What would make my poor residents and tutors without me? How could I go to the mountain!jj Definitely I was not interested in any change. But just how huge and exciting challenge it was jji

After almost 4 years I can only say that everything remains the same, more or less. Because, after a long chat with my wife, finally I called my boss an hour later of telling him that I was not interested in any change. I explained that I had changed my mind so when I recover from my appendicitis I'll go to Olivella to stay if his offer was standing.

I still have the same partners, 6 miles away, but frankly I feel that if I need it I have them. Management work has been ruled by another partner to the delight of all the team and I have gained with the change not to do some tasks that were rather bureaucratic (as I write this word in my gesture becomes grin) but I'm still doing the training tasks. The road, without changing has become a delightful ride that you just regret not having a convertible car to fully enjoy it.



I have new challenges, of course. The distances are not the same as before. Olivella is one of the largest municipalities in Catalonia, with a scattered population. But curiously I perform less not scheduled home care than when I was in Ribes. The office, a new one, is located in Mas Mila which is an urbanization annex to the little village where most of the municipality's population lives. It is located 5 km from Olivella , 13 km from Plana Novella which is the farthest

urbanization. The Hospital de Sant Camil in Sant Pere de Ribes is located to 8 Km from the office and the main Health Center in Sant Pere de Ribes, where the rest of my team is, at 6 km.

I work alone, but I'm very well accompanied by a nurse and a secretary. In the Main Center of Ribes the medical / nurse / secretary ratio was not one to one , of course. Cinta, Eli and Jose perform a very nice little team , no doubt . We also have the only pharmacy in the village at 20 meters from my office . I usually take occasional coffee with Enric the pharmacist with whom I have a smooth and fair working relationship. More than once we've helped to solve a problem with a patient in front of us.

Now I have to be in church of everything in the office. I have a quota of more than 2000 adult patients habitually they live in the village, in addition I have to attend to the displaced people who come to visit their relative or friends. In Ribes I had a quota of 1,500 patients but I had to visit to patients from other doctors that there weren't in the Centre at that time.

Nowadays I attend about 30 adult patients every day , from Monday to Friday in the morning . My patients make an appointment in advance and come to see me for a consultation, with the nurse we give health care dealing both healing and prevention. Appointments have been established about 10 minutes for each visit. Obviously service time depends on the number of visits a day, but people know that everything flows at a different pace . Here " I cook it and I eat it".

At 14 hours the office is closed and I go to meetings and teaching sessions with the rest of my team in Sant Pere de Ribes. Patients who need health care in the evenings have to go to Sant Pere de Ribes main centre which closes at 21 pm . The same happens when they have to get an X-ray or blood tests. The same goes for children or women who have some obstetric or gynaecological problem. In Catalonia patients under 15 years and women have to attend paediatricians and gynaecologists directly since these services are integrated in Primary Care in the Public Health System. Patients who need health care at night must go to the county hospital in Sant Pere de Ribes. Finally patients who cannot travel and need health care are assessed via a telephone triage system, which sorts out what is the most suitable advice for them: either a doctor (from the main Health Centre of Ribes, in the morning or in the afternoon or from the Hospital if it is at night) or a medicalized or conventional ambulance, which is based in the county Hospital with an isochrone of 20 minutes.

To these new challenges I have learned to put other resources on the table which it already had and perhaps I did not pay due attention before. I've learned to give value to other things, other dimensions and other perceptions of the same reality we all share. I learned about organization, management , clinical medicine with the right and necessary additional tests, humanism, communication, ethics , health education and teaching andalthough I knew it, now I have a new point of view about that which helped me to complete a holistic point of view of practicing medicine and life .

Surely rural life in a little villages is something else and things flow here otherwise.

José Luis Pérez Vallina
Olivella March 2014

Clinical case of a child with “running nose”

By **Kolesnyk Pavlo** Docent, MD PhD.

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Evidence based medicine is not widely used in Ukraine yet. Many doctors still use old fashioned methods of diagnostics and treatment in our primary care. As a family doctor’s trainer I try to promote the idea of evidence based approach in the primary medical care. The following case may be a good example of how useful it might be in the everyday medical activity of a Family doctor.

A 56-year old lady who was my patient for 10 years brought her 3 years old grandson who was not my patient before. She complained that her grandson had a **permanent “running nose”** during several former months. He has been treated by long courses of nasal decongestants and antibiotics which was not evidence-based and not effective either.

From his medical history I realized that the boy had also a night **cough** which was caused, according to his grandmother, by the drip syndrome. I figured out that the boy had **colds** more than 6 times a year. During the last 2,5 years the boy had **atopic dermatitis and stomach problems** starting from his babyhood. Moreover, the grandmother remembered that her grandson had **bronchial obstructions 6 times** per year which were considered as an acute bronchitis during his cold. This gave the grandmother reasons to suspect that the boy had a “poor immunity” and needed special treatment (that is not evidence-based but very often causes prescriptions of vitamins and immune-stimulators in the Ukrainian family doctor’s routine practice). The boy was often prescribed antibiotics (which was a common routine practice in the primary medical care in Ukraine because doctors used to start antibiotic therapy just after the start of bronchitis. This practice is not evidence based also but still widespread in our country.) After adding bronchodilators to his treatment the symptoms of obstruction first disappeared but appeared again soon.

Summing up all the observed child’s symptoms I understood that I had a case of the **“atopic march”**: atopic dermatitis – digestive disorders probably caused by allergens – atopic rhinitis – bronchial asthma.

Coming to this conclusion I was not satisfied with the boy’s previous treatment and started to investigate the possible reasons of atopic disease. It happened that the child and his parents were living together with the grandmother who was my old patient and who had been suffering from **bronchial asthma** during the last 20 years. The **atopic family history** was also present in this case. The apartment they were living in was on the ground floor and the walls were damp and moldy that could be one of the reasons for the atopic diseases in the child (and probably in his grandmother on the start of her atopic disease). While **rhinoscopy** I found pale edema of concha’s nasale on both sides, pure exudation, and postnasal drip – signs of atopic rhinitis. **Auscultation** revealed light expiratory crepitating from both sides which approved the bronchial obstruction.

I had to approve the clinical diagnosis by some other investigation but:

- Skin prick tests were impossible because of the atopic dermatitis in this child.
- Spirography was impossible because the child was only 5.

- Total level of IgE was 5 times higher than the normal rate but it could also be normal even in the case of atopy, according to the evidence).
- Specific IgE level for mold was also high (that has been accurate to prove the diagnosis of atopic disease) .

Finally, the child had an atopic rhinitis, atopic dermatitis and atopic bronchial asthma. He was prescribed inhaled steroids, bronchodilators and oral montelukast and his symptoms were gone for a long time.

It's interesting to mention that as soon as the boy's family moved from our town to San Francisco the symptoms of atopic diseases had **gone for 1 year** even without any treatment that time (I believe because of changing his living place and absence of allergens). But coming back to Uzhgorod to the same apartment he lived before with his grandmother provoked the next exacerbation of the boy's asthma in a year.

Education News !!!

At the 12th WONCA World Rural Health Conference, Gramado, Brazil, in April 2014 the

WONCA *Rural Medical Education Guidebook*

was launched

The project has been proudly supported by WONCA through the WONCA Working Party on Rural Practice, the Northern Ontario School of Medicine, Memorial University of Newfoundland (MUN), and the Rockefeller Foundation.

It consists of 71 chapters written by 74 authors, under 5 themes:

- Theme 1 Overview: Framing and Resourcing of Rural Medical Education and Practice
- Theme 2 Medical Education in Rural Settings
- Theme 3 Professional and Technical Support for Rural Medical Educators
- Theme 4 Undergraduate Medical Education
- Theme 5 Postgraduate Medical Education

It represents a unique collaboration, with contributions from every continent. It is intended to be a free resource for doctors, educators and others wanting to obtain practical ideas on implementing aspects of rural medical education and to learn from the experience of colleagues in different contexts.

You can download the content at: <http://www.globalfamilydoctor.com/RMEG>

Taken from the WONCA web site

Rural Medical Education in Sweden



The Swedish Society of Rural Medicine has taken the initiative to complementary requirements for what a doctor specializing today in Family Medicine needs to get "extra" to be prepared to work in rural areas. The situation is that there is a lack of GP:s in Sweden and especially in remote areas. The only way of recruiting and retaining is to offer an even better education.

Sweden has 9,5 million inhabitants and has an area of 500,000 square kilometers. The northern counties cover nearly half of the nation's area. The number of inhabitants here are around 550,000, most of them living in the cities along the east coast. Half of the 9,5 million people in Sweden live in or close to the three bigger urban areas around Stockholm, Gothenburg and Malmö. The largest geographical area of Sweden can thus be said to be rural, especially the northern parts.

The Swedish Society of Rural Medicine was founded in 2002. Its primary task is to develop healthcare in rural areas of Sweden. The society is open for all medical personnel with interest in the field of rural medicine.

The society will support and develop education of medical students in the field of rural medicine both during basic and postgraduate education. During our annual meetings we had several invited speakers and often a thrilling program, that draw interest to our goal, that is to define rural medicine in Sweden, to enhance education and research in rural and remote areas.

Education in rural medicine has been on the agenda at every annual conference since the start. In April 2007 representatives from the four northern county councils (the country is divided into 21 more or less independent counties, with a local political government and administration, responsible for the health care within the county) gave the society the mission to formulate a specialist education- a GP with profiled rural medicine training

In Sweden it takes five years to be a specialist, same amount of time for all including family medicine. In 2008 there was a new description from The Swedish National Board of Health and Welfare, for all doctor's specialist training. In Family Medicine there are 21 objectives: Twelve concerning medical qualifications, three about leadership, tutoring, regulations, four objectives concerning scientific methods and research, EBM and public health and six mandatory courses.

The Swedish society of rural medicine proposed in addition:

A GP in rural/remote areas need specific training. The residents (Called ST-doctors) has to be employed at a primary care unit in the rural area and their specialist training is carried out in close cooperation with specialists in the different hospital clinics, to meet our specific demands. We defined the differences against working in general practice situated near a hospital, and made a description and a check-list for the resident, their mentor's and their employers to use in the extended, individual educational plan that every ST has to have. It consists of specific education while the residents work in hospital clinics such as ER, cardiology, gyn/obstetrics,

orthopedics, surgery, advanced palliative care, ophthalmology, ENT, as well as additional courses e.g. ATLS/PHTLS, emergency medicine, palliative care, training to lead work in the field with accident/other emergency situations and of course most of all their main education at their rural health care center, that often also have some beds for inpatients.

From 2008 the first residents in Family Medicine with a Rural Medicine profile started. So from this year, 2013, we are having our first “graduates”. For the rural health care centers in the northern inland of Sweden this has been encouraging. Several new residents, keeping in contact with each other, proud of their rural medicine education and contributing to its development.

The Society is now helping ST doctors from urban areas to come for a shorter rural rotation. In that way we want to get more young doctors to have some experience of the rural work – and life. Some of them might stay or spread the word to others that working in general practice far from the city and the larger hospitals could be something they always dreamt of.

The last couple of years we have noticed, during our annual meetings and when taking part in other national meetings regarding education and research, that the interest in rural medicine has grown in Sweden, especially among young doctors.

Anna Falk anna.falk@lvn.se

Board member of the Swedish Society of Rural Medicine

Director of studies in Family Medicine for AT (interns) and ST (residents) in county of Västernorrland

GP at Ånge Health Care Center

Update on EURIPA activities

EURIPA’s Executive Committee and the Organising Committee for the Rural Health Forum have been meeting regularly during the year. The Executive Committee will meet jointly with the International Advisory Board on Friday 26th September in Riga. New members of the IAB will be confirmed. The Annual General Meeting will also be held in Riga.

Hot Topics continue and we would like as many people as possible to contribute as it helps develop the evidence base about rural practice and rural health in Europe. The current Hot Topic focusses on **Occupational Health** and there is still time to complete the questionnaire which is available on the web site at <http://euripa.woncaeurope.org/content/hot-topics> It is becoming an important issue for rural GPs so please respond!

If you are involved in research or training initiatives in rural health we would welcome a contribution to the International **Electronic Journal of Rural and Remote Health Research Education Practice and Policy**.

The Journal contains a European section and we would like to encourage EURIPA members to contribute to the Journal. Original research is always welcomed but there is also the opportunity to send in letters, project reports or personal perspectives.

There is support available to help you get published – new authors are actively encouraged!

Publications

Below are some publications from across Europe in the international Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy (<http://www.rrh.org.au/euro/defaultnew.aspof>) that may be of interest to other rural practitioners:

Stress and wellbeing among Turkish and German adolescents living in rural and urban areas

Published: 8 July 2014

Author(s) : [Yeresyan I](#), Lohaus A.

Citation: Yeresyan I, Lohaus A. Stress and wellbeing among Turkish and German adolescents living in rural and urban areas. *Rural and Remote Health* **14: 2695**. (Online) 2014. Available: <http://www.rrh.org.au>

Rural and urban disparities in quality of life and health-related behaviors among chronically ill patients

Published: 10 June 2014

Author(s) : [Kurpas D](#), Mroczek B, Bielska D

Citation: Kurpas D, Mroczek B, Bielska D. Rural and urban disparities in quality of life and health-related behaviors among chronically ill patients. *Rural and Remote Health* **14: 2485**. (Online) 2014. Available: <http://www.rrh.org.au>

Relationship between COPD and lower socioeconomic status in farmers from south-eastern Poland (Lublin region)

Published: 3 March 2014

Author(s) : [Golec M](#), Skórska C, Mackiewicz B, Dutkiewicz J, Góra A, Lemieszek M, Milanowski J.

Citation: Golec M, Skórska C, Mackiewicz B, Dutkiewicz J, Góra A, Lemieszek M, Milanowski J. Relationship between COPD and lower socioeconomic status in farmers from south-eastern Poland (Lublin region). *Rural and Remote Health* **14: 2531**. (Online) 2014. Available: <http://www.rrh.org.au>

Investigating factors of self-care orientation and self-medication use in a Greek rural area

Published: 8 April 2014

Author(s) : [Papakosta M](#), Zavras D, [Niakas D](#).

Citation: Papakosta M, Zavras D, Niakas D. Investigating factors of self-care orientation and self-medication use in a Greek rural area. *Rural and Remote Health* **14: 2349**. (Online) 2014. Available: <http://www.rrh.org.au>

WONCA News

WONCA News has published a report on the 12th World Rural Health Conference, Gramado, Brazil which can be read at:

<http://www.globalfamilydoctor.com/News/Reporton12thWorldRuralHealthConferenceGramadoBrazil.aspx>

This edition also contains a paper on the importance of training in rural areas by Jo Scott-Jones from New Zealand. You can read it at:

<http://www.globalfamilydoctor.com/News/RuralRounduptheimportanceoftraininginruralareas.a>
cnv

Forthcoming Events

Below are a selection of events for the remainder of 2014 onwards that may be of interest to EURIPA members. Please send in your events for future editions of *Grapevine* so that we can make this section more comprehensive. Please send to the editor at jane@montgomery-powys.co.uk

Annual Rural Primary Care Conference

1st – 3rd October 2014, Gregynog, nr Newtown, Wales

Organised on behalf of Montgomery medical Society by Ann Whale at annw@irh.ac.uk

Economic Crisis and Research in Primary Care

79th EGPRN meeting

23rd – 26th October 2014, Heraklion, Crete

For more information please go to: <http://meeting.egprn.org/home>

The Muster - Global Community Engaged Medical Education

27th - 30th October 2014, Uluru Northern Territory Australia

For more information please go to www.flinders.edu.au/muster2014

Or email muster2014@flinders.edu.au

WONCA Rural Working Party Conference

Breaking down barriers, bringing people together

15th – 18th April 2015 Dubrovnik, Croatia

Abstract submission will open in September 2014

More information: <http://woncarural2015.com/>

WONCA Europe 2015

Future of Family Medicine..... being young, staying young

October 22nd – 25th 2015 in Istanbul, Turkey

For more information go to: <http://www.woncaeurope2015.org/>

Future Contributions to *Grapevine*

The next issue of the *Grapevine* will be Autumn 2014 and contributions are welcome by

Sunday 26th October 2014

If you are interested in contributing to the next edition of *Grapevine* please get in touch with me at Jane@montgomery-powys.co.uk. Please think about what you do in your practice and if you would like to contribute to the new clinical case section, or send us a piece about your practice, tell us about research you are doing or have published, an event that is being held in your country please do get in touch.

Grapevine is YOUR Newsletter and we always welcome new contributors.