Vol.7 n 2

Periodico Trimestrale di Ricerca e VRQ in Medicina Generale fondato nel 1996 Da S.I.V.R.Q. (area Cure Primarie) e SIMG sezione di Verona.
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Sito Web: http://www.rivistaqg.it

La Qualità e le Qualità in Medicina Generale

Anno VII n.2 - Maggio 2002
Iscrizione Tribunale di Verona n. 1187 del 12/12/95

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EDITORIAL

M.Baruchello

Qualitative research represents a peculiar field of the General Practice.

Recently J.D. Maeseneer and C.V. Weel have mentioned that "Quantitative research methods certainly have their place. But sometime, when explanatory model are unclear,quantitative research may contribute a lot to the understanding of what really happens in our daily practice".

(European Journal of General Practice, Vol. 7, September 2001)

To give us a proof of this is the starting point made by Franco Del Zotti, which illustrates sophisticated clinical-diagnostical tools available and consultable on line in the daily practice.

It is our purpose to send us your contributions regarding this topic.

We will also insert in the following editions of QQ photographs of some offices that have distinctive layout elements and that can affect the quality of the services through the organizing model.

Audit, descriptive researches, reports, working tools used with a severe methodological aim lead to a daily practice that we consider to be more adherent to reality.

A recent Cochrane review (www.update/software.com/abstract/it/it00259.htm) confirms that the feedback and audit interventions have the potentiality of modifying the professional practice of the doctors.

The results of trend researches by some important academics from Northern Europe appears to be sometimes depersonalized with respect to the individual doctor and his relationship with the patient.

All the researches that take place in QQ have the doctors as protagonists and participants.

Andrea Gardini, President of the Italian Society Quality Assurance writes

"In order to follow the doctors in the complex world of the "significance" of their work (because this is the fundamental experience of the evaluation of the quality) and in the effort to make it better, you need a different approach from the Cartesian model of science. The science that comes from mechanicalism leaves out the study of the weak and not measurable relations (because it lacks of specific tools that are suitable for the purpose of the study), the relationships between the people and the institutions".

INDEX

The general practice that you are going to read in the following pages of QQ demonstrates this variety of approaches.

It is the subjectivity that the citizens look for in the access to the Emergency Room of each hospital (Falasca), the objective to educate to a correct use of the important drugs (Campanini), the focus group as a tool for the methodological and organizing analysis (Mazzi), all these go alongside with the important and nowadays completed Italian Audit, which confirms the existence of a correct adhesion to the guide lines in the use of ASA in the post cardiac heart-attack (Grassi).

The prevention of the cardio-vasculary risk has a high cost and its economic impact is devastating, in these months, the budget of the ASL: Laurora makes a previsional model and we will see the future development.

The experience by Corteleone confirms also that the intervention of an individual community doctor can obtain tangible health outcomes.

In short, this month QQ presents the caleidoscopic aspect of the Quality and Qualities in GP, that years ago had inspired the title of the magazine itself.

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PARMA Conference 2002

(http://www.parmaconference.3000.it)

Morning:

moderatore: Dott. G. Visentin

- Prof. F. Dobbs: "*La ricerca in MG in Gran Bretagna ed in Europa"*
- Dott. F. Del Zotti: "*L'esperienza italiana di Netaudit"*
- Prof. R. Grol: "*La verifica di qualità in MG in Olanda e in Europa"*

moderatore Dott. M. Baruchello

- Dott. F. Carelli: "*L'esperienza di Euract, gruppo europeo dei docenti di MG*"
- Dott. A. Campanini, Dott. G. Passerini: "*L'esperienza in EQuiP, gruppo europeo per la verifica di qualità*"
- Dott. G. Boldrocchi: "*La sperimentazione clinica controllata in MG (DM 10.5.01)"* DISCUSSIONE

Afternoon:

- Dott. P. Falasca: "*Studio dell'appropriatezza degli accessi al PS da parte dei medici generali*"
- Tirocinanti del Biennio di formazione in MG: "*Stato di compenso del paziente in trattamento cronico con anticoagulanti orali e consapevolezza della terapia: è possibile migliorarli con un intervento educativo nello studio del mmg?*"
- Dott. N.R. Laurora: "*Dall'audit alla clinica. Impatto dei trials sulla pratica del mmg*"
- Dott. M. Grassi: "*Audit sul trattamento con ASA nei pazienti infartuati in MG*"
- Dott. E. Brizio: "*Audit sul trattamento dell'asma*"
- Dott. P. Quattrocchi: "*Corteolona 2000 - Progetto cittadella della salute*"
- Dott. P. Pavone: "*Esperienza di una metodologia di ricerca e formazione in MG*" (*)
- Dott. M. Bolognesi: "*L'impatto del counselling di attività fisica attraverso il programma P.A.C.E. sullo stile e qualità di vita di pazienti obesi e in sovrappeso nell'ambito delle cure primarie*" (*)
- Dott. M.P. Mazzi: "*Focus group fra otto mmg sull'utilizzo di un opuscolo sulla prevenzione*"

(*) these interventions are online (QQ of march 2002) at: http://www.rivistaqq.it/index_ita.html

There is no doubt that the partcipants in the Congress "Research in General Practice in Italy and in Europe" held in Parma on the 20th of April 2002, had many subjects to ponder and evaluate.

The opening addresses made by eminent members of the University, of the National College of Italian Physicians and of the supporting Authorities were significant, passionate and sincere.

The Congress examined carefully two main thematic areas that are separated but at the same time, strictly connected: tradition and up-to-dateness of research in General Practice in Italy and in Europe, and the new perspectives of controlled clinical experimentation of drugs directly in the GPs'surgeries. Experimentation made possible in Italy by the May 10, 2001 decree.

The research theme was extended up to the point of including a complete overall view of the European Promotion of QA and QI, and of the educational training in General Practice: two themes strictly connected to research.

For this reason we invited two famous representatives of the European Academic General Practice: Prof. Frank Dobbs, University lecturer in Plymouth, past vice-president of EGPRW and Prof. Richard Grol, University lecturer in Njimegen and Maastricht, President of EQuiP; together with the national representatives of the European networks: Francesco Carelli (EURACT), Franco Del Zotti (EGPRW), Angelo Campanini and Gianluigi Passerini (EQuiP).
The moderator was Giorgio Visentin, representative in WONCA of CSeRMEG.

Prof. Dobbs traced a wide panorama of the present situation of research in GP in several European

countries, underlying the strategic choices needed to make reserach progress in areas, such as ours, where it is less organized. The necessity to learn with patience "on the field" the right techniques and methodologies; the effort to find co-operation, mainly with the University, as technical and organizational support and finally the need for funds.

In the morning, Franco Del Zotti presented in a crucial lecture, the story, the philosophy and the data of the NetAudit experience: a net-work of researchers he created and with which many of us have been cooperating for more than one year.
The posters hung in the Congress Hall, the afternoon communications and this lecture showed that research can be carried out also in Italy, even if with many problems and with a few pragmatic, conscious and simplified choices of traditional academic procedures.
Participants truly "breathed" the experience of every-day practice, the urgency of health care, the lack of time. Factors that cannot be forgotten when research is carried out in the setting of GP.

Professor Grol explained the techniques and the most recent experiences in the field of QA and QI telling the story of a true patient whose care and treatment were actually improved. He reminded us the importance and the limits of Guide-Lines, (the Netherlands have in this field, all over the world, the most important experience in General Practice) the usefulness of Audit techniques - simple information feed-back is not sufficient - and the most advanced experiences of "visits to the surgeries made by either a trained physician or a nurse", to give GPs a picture of the performances and the efficiency of their work from an organizational and relational point of view. Not certainly with a "punitive" aim, but with the intention of helping and supporting improvement. This lecture was an injection of methodological preciseness, of moral tension, of sincere passion for a profession that can give the most to the health of patients.

The European situation was outlined, completing the general picture, by the lectures of: Francesco Carelli (EURACT) on the teaching of GP, with the compulsory necessity of an academic Department, a place where research generates new knowledge to be taught; and of Angelo Campanini (EQuiP) on the connectione between QI and CME.

At this point the "topical" theme of the Congress was faced: the new opportunities created by the May 10, 2001 decree that recognizes that possibility of carrying out a clinical controlled experimentation of drugs in phase III and IV in the surgeries of GPs.

Under the careful moderation of Mario Baruchello (national secretary of SIQuAS - VRQ), Gianluigi Passerini underlined the benefits and the risks of this new available activity of GPs: the benefits could lead to an improvement of knowledge and of critical capabilities of the research methodologies of the future experimeters. The risks could be tied to mere market interests: development of not really innovative "copy" drugs to the disadvantage of care and epidemiological priorities. Gianluca Boldrocchi, education responsible of Parmàs Local Health Unit (AUSL) explained in details the decree and the applying regulations, underlying uncertainties and interpretative difficulties of some lines. The risk is that these "details" could be delegated to pharmaceutical firms, creating conflicting interests capable to diminish the credibility and transparence of research.

The second part of the Congress was characterized by the discussion of original research papers presented by Italian GPs. This QQ number is the summary of what happened.

We are convinced that the amount of up-to-date information and of highly qualified stimuli will lead us, in the future, to significant results. All those who love research have the duty to develop these themes involving, as much as possible, our Colleagues, as we believe that research in GP is not a sterile pass-time for idealists or dreamers, but a fundamental activity for a discipline that wishes to show and state its autonomy and uniqueness.

Claudio Carosino - SIMG - Parma
Paolo Schianchi - SIMG - Parma

STUDY OF APPROPRIATENESS OF THE USE TO EMERGENCY SERVICE FROM THE GENERAL PRACTITIONERS

Pasquale Falasca°, M. Teresa Di Fiore *, Mengolini Barbara *
° Epidemiology Service Asl of Ravenna
* District of Faenza

The recording and the transfer of clinical information are a essential prerequisite in order to guarantee the continuity of health care (1)
European countries experience underlines on the benefits of the recent IT development in the communication to guarantee that clinical information follows the patient through all the episodes of cure (2).
To promote the diffusion of the good prescribed behaviors of general practitioners is necessary the correct use and interpretation of the clinical data (3).

In Health Local Authority of Ravenna the team of physician's emergency service has write out an introductory document where are considered the use of appropriateness outpatient facilities to improve the performances of 19 potentially improper medical DRG (which the indications of the Region Autority).

Beginning from this job we want to start a mechanism to transfer the clinical information across the interface between primary and secondary care.
This mechanism is evaluative trials based, admission policies focused, appropriateness and quality of information provided and clinical audit shared.

Preliminary elaborations in order to support the discussion, to enhance the search of the critical factors and to promote clinical local ownership of the communication process between health care professionals are: 74.7% of the access are white or green code, 52.5% happen between the 8:00 a.m. and the 15:00 p.m. and 289 patients have carried out in 1 year from 6 to 20 repeated access.

1) Jick H, Jick S, Derby L (1991) *Validation of information recorded on general practitioner based on computerised data resource in the U.K.* BMJ 1991; 302: 766-768
2) Ryan M, Corbett M G, Clark I R, Peters M (1991*) Clinical decision support: devolution of expertise across the GP hospital interface.* Health Care Computing; 332-338.
3) O'Brien MA Thomson; AD Oxman; DA Davis; RB Haynes; N Freemantle; EL Harvey *Audit and feedback versus alternative strategies: effects on professional practice and health care outcomes* The Cochrane Library, Issue 1, 2001. Oxford: Update Software

AUDIT ON ASPIRIN TREATMENT IN PATIENTS WITH PREVIOUS MYOCARDIAL INFARCTION IN GENERAL PRACTICE

Marco Grassi GP Santarcangelo di Romagna (Rimini) SIMG Rimini
Galante Roberto GP SIMG Padova
Balestrazzi Marina GP SIMG Bari
Bagagli Franco GP SIMG Torino

Background and reasons for choice

Survivors of a myocardial infarction are at greatly increased risk of reinfarction, cardiovascular morbility and death (1). There is convincing evidence that some strategies, including drugs and life-style changes, prevent such events. (2) (see table 1)

Table 1

Interventions for secondary prevention of MI for five years*	**Number needed to treat (NNT)**
Mediterranean diet	**9**
Eating oily fish	**19**
Stopping smoking	**21**
Statins	**26**
Beta-blockers	**30**
Aspirin	**37**

NHS Centre for Reviews and Dissemination. Cholesterol and coronary heart disease: screening and treatment. Effective Heath Care Bulletin 1998; 4(1): 1-16

The potential importance of antiplatelet therapy for patients with raised vascular risk was first highlighted in 1994 by Anti Platelet Trialist Collaboration (APT): its meta-analysis presented strong evidence that treatment with aspirine or other antilplatelet agents in various categories of patients could prevent cardiovascular events. (3) APT's last meta-analysis (4), published in 2002, confirms these data.

So, a group of GPs (collaborative group of GPs called Netaudit) has decided to review the care of these patients to improve the quality of medical care they receive. The purpose of this audit was to investigate how well doctors were managing these high risk patients and rate of aspirin prescription.

Methodology

Aims

Aim: to reduce the risk of reinfarction or other cardiovascular events in patients with previous MI with an antiplatelet therapy based on aspirin (level of evidence Ia)
Criteria: patients who have previously had a myocardial infarction should be treated with aspirin 75 mg. daily for 3 years (strenght of raccomandation A) after 3 years aspirin shouuld be continued long term at a dose of 75 mg. daily (D)
Standard 100% in patients without any contraindications for aspirin and recent MI (onset <3 years), 80% in patients without any contraindications and MI older than 3 years from onset**.**

Baseline data collection

1. Using the computer we have looked at the records of every patient registered in the practice with diagnosis of MI and ave looked at the following data (age, sex, date of IM, other pathologies)

2. We have registered if patients take aspirin or other antiplatelet drugs following this scheme:
   - no therapy
   - aspirin
   - ticlopidine or clopidogrel
   - others antiplatelet drugs (indobufene)
   - Oral anticoagulants
   - aspirin in association
3. We have registered any contraindications to the use of aspirin

Inclusion and exclusion criteria

1. Diagnosis: diagnosis of MI was accepted only if it was based on documented clinical/instrumental criteria (hospital discharge with diagnosis of MI, ECGraphical signs of previous MI and recall of hospital admission for MI. We excluded patients with ECGraphical signs of previous MI without recall of hospital admission or tipical sintomatology and patients suffering stable/instable angina who had received by-pass or CAGB)
2. Therapy: from the repeat prescribing system we have ascertained the drug assumption for at least 6 month in the last year.
3. Contraindication: we considered
   - absolute: major allergy, active peptic ulcer and
   - relative: previous peptic ulcer, gastric intolerance, esophagitis, minor allergy)

Results

The GPs involved in audit

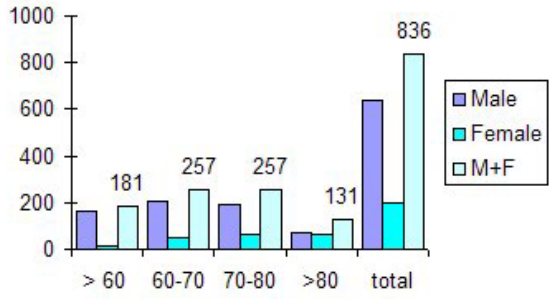
This audit was carried on by 53 General Practitioners coming from various Italian regions: 32 (60,4%) from Northern Italy, 11 (20,8%) fron Central Italy and 10 (18,9%) from Southern Italy, 85% of these GPs were male doctors. (Graph 1)

Graph 1 Geographical distribution of GPs

The patients screened

These 53 GPs assist 74.143 patients (1398 patients/GP) Among the total population we have detected 836 patients with previous MI (prevalence=1,12%). The prevalence detected in this sample is lower (0,5%) than the known prevalence of MI in Italy.

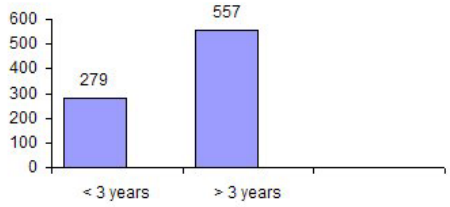
Prevalence of MI in Italy is 2,5% for men and 0,5% for women but it was calculated with different criteria of diagnosis.
MI is far more prevalent in the male gender than in the female one in every range of ages (only in older patients, male and female prevalence is equal). (Graph 2)



Graph 2 The patients: age and sex

MI is three times more frequent in males than females, according to statistical data in literature.

Trials about aspirin for secondary prevention report limited follow-up (about three years), so we divided patients in two groups: more recent MI (< 3 years from onset) where there is direct evidence that antiplatelet therapy reduces adverse outcomes and older than three years MI. (see graph 3)

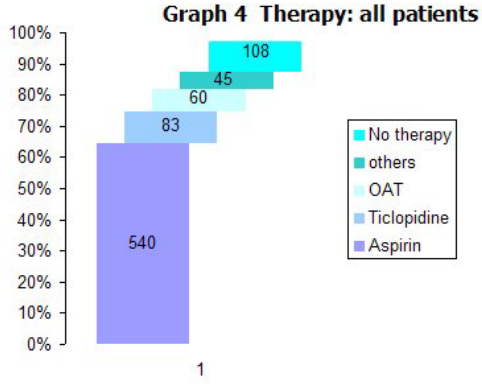


Graph3 The patients: onset of myocardial infarction

Therapy

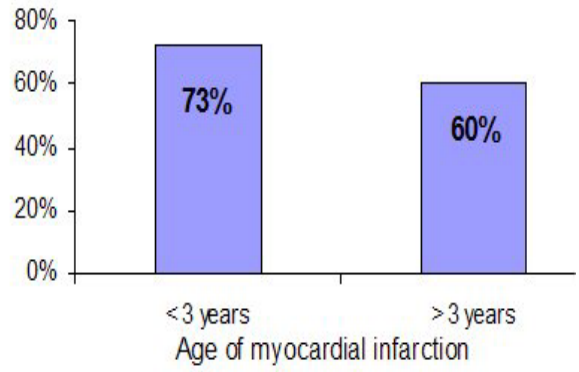
A high percentage of patients (87,1) takes antiplatelet therapy (aspirin, ticlopidine, clopidogrel, indobufene) or oral anticoagulants. (see graph 4)

Graph 4 Therapy: all patients



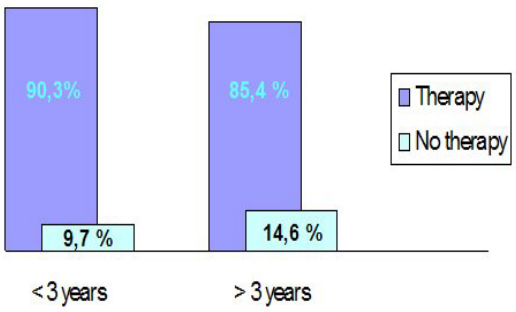
Only 12,9% of patients with previous MI doesn't take any profilactic antiplatelet medication. About 64% of the total sample takes aspirin, the drug with the most cost/effective ratio. (graph 5)

Graph 5 Percentage of patients taking aspirin as antiplatelet agent



A high percentage (90%) of the patients with more recent MI (< 3 years from onset) takes medication while a smaller percentage (85%) goes on taking antiplatelet medications after three years from the MI onset.(graph 6)

Graph 6 Therapy with antiplatelet agents and age of myocardial infarction

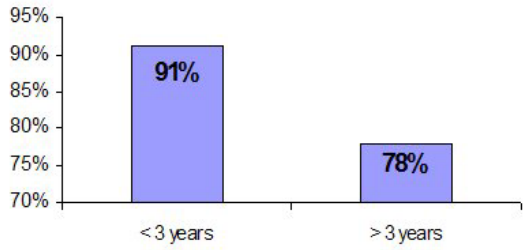


According to guidelines patients who have previously had a MI should be treated with aspirin daily for three years with a strength of grade A raccomandation while strength of raccomandation is minor (D) after three years. For this reason we graded standards to achieve. So we have also tried to explain why patients don't take any antiplatelet medication and to verify if patients without aspirin therapy had any contraindications for aspirin assumption.
We have found that 40% of patients with recent onset of MI and without any antiplatelet therapy have strong contraindications for aspirin assumption. (11 of 27 patients who don't take any antiplatelet drugs).

Similar situation we found in patients with older MI.

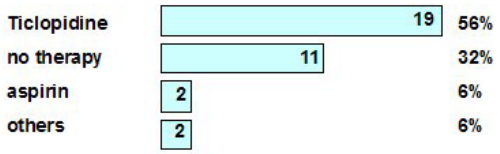
If we consider only patients without any contraindications for aspirin assumption we have a higher rate of patients taking aspirin. (see graph 7.)

Graph 7 Patient without contraindications taking aspirin



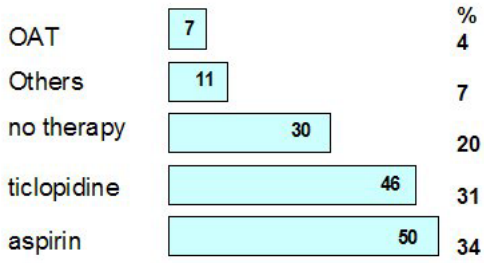
Patients with some contraindications to aspirin received alternative therapies.
Those with absolute contraindications (34 patients) received ticlopidine as favourite alternative, only 1/3 didn't receive any antiplatelet therapy. (see graph 8.)

Graph 8 Therapeutic alternatives in patients with absolute contraindication to aspirin (34 patients)



Patients with some relative contraindications received a more aggressive therapeuthic intervention because only 20% of patients hadn't any therapeuthic alternatives to aspirin. (see Graph 9.)

Graph 9 Therapeutic alternatives in patients with minor contraindication to aspirin (146 patients)



Conclusions

This audit has met the suggested standards: 95% of patients with recent MI and 90% of patients with older MI take preventive antiplatelet medications (aspirin or other drugs equally effective).
Because the high rate of compliant patients to the antiplatet therapy only a marginal improvement is possible, so we think it isn't necessary to plan an action to improve the results and we reccomand only to maintain the suggested and achieved standards.

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GP involved from Netaudit list:
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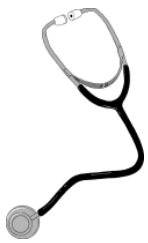

FROM AUDIT TO CLINIC
Trials impact on GPs practice

N. Renzo Laurora - Socio SIQuAS e SIMG/Area Cardiovascolare - Venezia
Massimo Fusello - Socio SIMG/Area Management - Venezia

INTRODUCTION: The cardiovascular diseases and the diabetes are in continuous increase, like cause of died like economic impact on the sanitary expense of the industrialized countries. Therefore it's necessary to place attention to all those drugs that demonstrate the ability to reduce complications like infarct, ictus or diabetic nephropathy.

OBJECTIVES: To search second between the own ones assisted the considered subjects a risk the international criteria of enlistment in two trials like the study HOPE and study HPS, to verify if they have been subjected to drugs object of the trial in period 1997-2000 and to confront these data with the half year October 2001-March 2002 in order to evidence differences in the prescription.

DESIGN: Self Audit

MATERIALS AND METHODS: Search from part of two General Practitioner in the data-base of just the program of office data processing General Medicine management (*Millenet-Datamat*), using *MilleUtilità program* for the selections of search on the catalogued problems, prescribed drugs and the pertinent examinations of laboratory. They have been therefore identified, second the cardiovascular criteria of the study HOPE, the enlisting patients for age, diseases or complicated diabetes and has been verified the percentage of subject to which they had been prescribed ACE-I and, more just, Ramipril. These data have been subsequently confronted with accredit it of last the six months. And be moreover verified the cause of died of the patients to risk and their belongings or less to the group under treatment. With the same methodology, the criteria of verified HPS study have been identified the enlisting people about the HPS rules and, in the same way, the prescription of the Simvastatin and the eventual influenced of prescription changes from the data gradually emerging.

RESULTS: They have been characterized, selecting quinquennial 1997-2001, 24 subjects (12.3%) on a total of 195 selecting for ages and pathology, second the criteria HOPE, that they second assumed Ramipril and 16 (3.6%) criteria HPS, that they assumed Simvastatin. In nobody of the two groups to the selected end the dosage was equal to that one of the trials. The comparison with the last half year made to find unmodified data as far as Ramipril and Simvastatin.

CONCLUSIONS: The percentage of the patients with Ramipril and Simvastin is still low regarding the

number that the could attend after the conclusions of both the studies and the indiscriminate treatment of all the enlisting patients could take to a senseless increment of the sanitary expense. Anyway we notice in the prescriptions of both Practitioners a meaningful increment of use both Ramipril and Simvastatin in the subjects that could have more benefit (subgroup of the diabetic subjects with cardiovascular diseases). From the aforesaid data cross, it seems possible, as well as useful, to extract a subgroup of patients that could be not ethical not to deal in way arranged with both drugs.

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A PREVENTION PROJECT IN A COMMUNITY OF 1800 INHABITANTS FROM 1994 TO 2001

Performed in collaboration with

- Policlinico S. Matteo Div. Cardiologia
- Azienda Sanitaria Locale 12 – Pavia
- Università di Pavia – Facoltà di Medicina Dipartimento di Medicina Preventiva, I Cattedra di Chimica Biologica
- Fondazione Salvatore Maugeri – Servizio oncologico di prevenzione- Pavia
- Ordine dei Medici di Pavia

Project Coordin. prof. **Italo Richichi**
Local Coordin. dr. **Pietro Quattrocchi**, GP
Corteolona is a little small town of about 2000 inhabitants, with the features of the typical population of the modern society and contemporary, with biorhythms and like habits to those of thousands of north and central Italy towns. The choice of this town to do the Cittadella of the Health was based on the following criteria:
· Social Features fellows to those of many Italy towns
· Very higth citizens compliance
· Whole availability of the local government
· Whole collaboration with local GP
Already in past Corteolona citizens were having demonstrated the greatest interest to the Prevention Cardio-vascular, with excellent adherence to the Project Policentrico Lombardo. These premises and the contribution of private sponsor, like Fertilvita, Galbani, commercial Credit, have determined the interest to organize a city model to arrest and to invert the trend of the main illnesses of the Pavia Lombard and Italian society.

The general pourpose of the project are:

- Growth of the health culture
- Reduction of the cardiovascular risk factors
- Decreasing cardiovascular mortality
- Decreasing mortality for cancer
- Decreasing general mortality
- Enhancement of the quality of the life.

The protocol was started in 1994 and is finished in 2001
Every adults from 20 to 65 years was convened in the surgery Corteolona District ASL 12 surgery and submitted to the following inquiry:
1) Medical examination with familiar, oncological, pathological anamnesis
2) ECG
3) Ematic withdrawal for: hemocrom, lipid, azotemia, glycemia, VES, AST, ALT, GGT, markers of the epatite, if enzymes altered, Na+,K+ , fibrinogeno.
From **20 to 39** years monitoring expected after **5** years. From **40 to 65** years monitoring repeated annually. After the **65** years monitoring were established from time to time by the GP. After the **40** years performed every **2** years Hemoccoult test and for the women Pap test.
All citizens were reserved for letter to perform the visits and the withdrawals in the days and in the hourly established.
In wait to elaborate all of the data concentrated on the database, were elaborated alone the relevant data to the citizens between the **40** and the **65** years presented to at least four of six controls carried out. These the data pointed out (we speak always of citizens that we will call "**COSTANTI**" between 40 and 65 age) · The number of the "**COSTANTI**" it is maintained in five controls appraised between 339 and 342

- The average age goes from 55 years of 1996 to 58 years of 2000
- Diabetics appraised for glicemia superior to 126 mg/dl are decreased from 7% to 6%
- The alcoholic consumption of drinks has seen decrease the drinkers adequate but has seen to increase the astemi for that in general is decreased the alcoholic consumption of drinks
- Unchanged the percentage of ipertension
- Increased is the percentage of subjects with BMI included between 26 and 29, while is remained unchanged percentage of BMI> to 30, this data could be associate to the fall of smokers, and the increase of average age above all for the women.
- The ipercolesterolemie with total cholesterol beyond the 250 mg/dl are decreased from 26% to 15%
- The ipertrigliceridemia for trigliceridi superior to 160 are decreased from 27% to 18% · In general the Dislipidemic are decreased from 56% to 41%
- There were taken in consideration three main factors of risk BMI> 30 Hypertension and Dislipidemia: the subjects with factors of risk are decreased from a percentage of 83% to 75%
- The General mortality is decreased in absolute from 187 dead in seven previous years the project to 147 dead in seven years in which the project were performed. · Particularly the mortality for 1000

inhabitants is decreased from 15,3 to 11,6 and particularly the mortality for cardiovascolar-disease is come down from 31 to 15 and for IMA from 12 to 8, for ICTUS from 11 to 8 nearly unchanged that for TUMORS.

Conclusions
Most finalities of the project were respected, particularly the mortality cardiovascolar is deeply decreased to demonstration of the fact that such a model of prevention carried out on a population is of easy accomplishment and gives considerable qualitative and quantitative results:

- Importance of the GP in the good one success of this kind of projects
- Adequate scientific knowledge in GP
- Recognition of the engagement lavished
- Health education should be parallel to the accomplishment of prevention projects

STATE OF PATIENTS ON LONG-TERM ORAL ANTICOAGULANT THERAPY, IN OR OUT OF THE THERAPEUTICAL RANGE, AND PATIENTS' THERAPY AWARENESS.

Trainees in 2000/2002 General Practice vocational training course – Modena – Emilia Romagna
Teachers of the Seminar: "Research in General Practice". A. Campanini and C. Carosino

Background
Many Authors think that what is most important for the success of the long-term Oral Anticaogulant Therapy (OAT) is the degree of patient's compliance. There are no studies on the factors influencing the therapeutical range of the therapy within General Practice and on the efficacy of educational training within GP.

Objectives
1. To test if there is a correlation between the therapeutical range of the therapy and patients' therapy awareness.
2. To test the efficacy of an aimed educational intervention, carried out within GP, on the regularity of anticoagulation.

Methods
The trainees of Modena's course, intend to carry out this research during the training period in their tutors' surgery with their tutors' agreement and collaboration. This research is divided in four parts:
1. Enrolment and questionnaire
2. Retrospective phase
3. Educational intervention
4. Perspective phase

- Enrolment and questionnaire

We think of enrolling all the tutor's patients on long-term OAT (started at least two years previously); calculating a range of 20/25 patients for each GP with 1,500 patients, we should easily enroll 200/250 subjects. All these patients will be asked to fill in a questionnaire to verify their therapy awareness, the quality and quantity of correct information to face unforseen circumstances during treatment .

- Retrospective phase

We intend to verify the state of the therapeutical range of each patient during the previuos year and through a correct anamnesis to look for possible haemorrhagic episodes or thromboembolic events and using two parameters (Prothrombin time and INR) to assess the quality of the treatment.

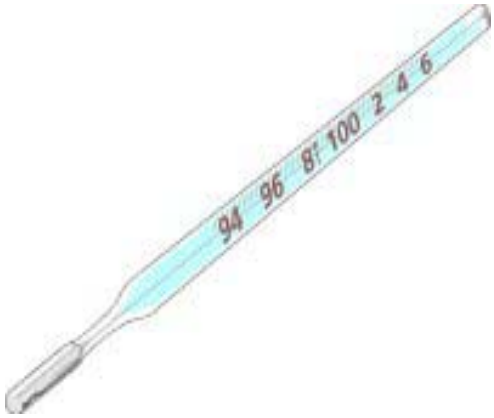
- Educational intervention

We wish to give all patients an educational programme divided in two parts: information followed by checked therapy awareness and reinforcement.

- Perspective phase

An observational phase will follow. We will control the state of the therapeutical range of each patient in the following 4-5 months. At the end of this observational period we intend to compare this with the same period of the previous year, trying to identify the possible confounding factors.

Reasons to present this project
We wish to discuss the usefulness and value of this research and the validity of the instruments we singled out to reach the established objectives.



FOCUS GROUP AMONG EIGHT GENERAL PRACTITIONERS ON THE USE OF A PREVENTIVE BOOKLET.

AUTHORS: Mazzi Marco Pietro, Del Zotti Franco, Cressoni M. Chiara, Fioretta Anna, Losi Serena, Varaschin Mariella, Casalaina Domenico, Maurelli Innocenzo (GPs, SIMG Verona - Italy)

BACKGROUND: Under the aegis of SIMG (Italian Society of General Medicine) we've created a laboratory for the experimentation and the self-audit of the activity for health education. Besides sharing the guidelines of Evidence Based Medicine both for objective and anamnestic preventive exams, the general practitioners (GPs) of seven local practices tested a pocket-booklet on health-education, which was addressed to their patients and which was called "Personal Guide to Health". The handing out of this pocket-booklet was financed by the municipal administration of Valeggio sul Mincio, Verona. Two years after the beginning of this experience, we organized a first focus group (FS) with all doctors involved in this medical research in order to evaluate the points of resistance and the strategies of the changes occured by making tests about logistic and cognitive-involving impact.

OBJECTIVES:

1. To evaluate problems and pratical solutions which ever medical doctor has been adopting while improving the use of the booklet in practice.
2. To identify all positive or negative feelings which have been preduced in the GP's behaviour by the use of this health educational instrument.

METHOD: In the two years before the first FG eight general prectitioners distributed individually the booklet to over 15 years old patients in a quite opportunistic way. Then GPs (4 men and 4 women) attended a focus group for about 3 hours, in which several interesting points aroused from discussion and where the most frequent themes connected with this experience where clearly pointed out both on a paper board and on a tape recorder. Further more it was made a double reading analysis which was absolutely indipendent and which focused the most frequent categories and themes occurred during the experimentation.

RESULTS/ DISCUSSION:

COGNITIVE ANAYSIS: Frustrating feelings.

1. "**Patients receive too many messages from massmedia that they do little attention to the booklet or they are not curious about it or they don't feel like changing their habits**." The attitude of delegation and lack of responsibility is not modified by the use of the guide book. They continue considering it as an instrument for the doctor, more than the means of management for their health.
2. **"We where not ready to run the emotiotional involvement of the relation betweeen doctor and patient" , " while I was explaning the booklet, i could early perceive a sort of frustration which derived from the fact that the patient did not show any particular interest or was not motivated…"** For this reason the GP must be prepared and be able to face and deal with stress and frustration during the educational work.
3. **"I feel embarassed when i talk about aims or way of life which I do not follow"** Some feelings of embarassement must be taken into serious consideration (2 GP of the Focus Group where smokers).

COGNITIVE ANALYSIS: Positive feelings.

1. **"… this booklet enables me to give a better consideration of my role as doctor."** The instrument has been unanimously evaluated as a concrete presentation for health promotion in GP's setting.
2. **"… it does meet peoples's expectations towards their medical officer."** The fact that the guidebook was been approved by international medical institutions give more prestige to educational action of GPs.
3. **"… I can personalize the educational message"** The personalization of some pages of the booklet is extremely useful because it helps to separate the education by GP from medical information.
4. **"… I think that the use of this booklet can be more effective on low attender patients"** It is a further device for the relation that gives a strong non verbal message that means: " I do respect your lack of interest but as your medical consultant I help you in order to enable you to self manage or talk with me about important problems, whenever you think it is useful**"**
5. **"… I have spontaneously changed my way of working, sitting next to the patient so that he could see the booklet and what I was writing on it …"**The guidebook stimulates some modification of setting, of verbal and not verbal situation connected to relationship in order to diverge from paternalistic traditional model and to set the contest on a new organized preventive consultation.

DISHOMOGENEITY AMONG MEDICAL PRACTITIONERS

The quantity of booklets delivered is quite acceptable with a rate of 42 per cent of patient who received the booklet. There are different styles of use of guide book in the experience of each GP. These are also influenced by logistic of the office and by the inner motivation of GP. Different manners of partial or total illustration of the arguments of the booklet have been evidentiated. Some GPs prefer to draw their attention only on the "principal theme" of prevention. The parts of the booklet, studied to be personally filled out by the patient and the doctor, often remain blank or not completed. It was also noticed the problem of patient's

compliance **"These seldom come to the following visit with their own booklet "**.

CONCLUSIONS
The result of the Focus Group underlines that the use of the Booklet is a real opportunity in General Practice, that is connected with the important issue of instruments and methods of health education in our setting. We are convinced that they be deserve to be discussed in our European forum.

AN UNDERESTIMATED VARIABLE: SOCIAL PROBLEMS IN GENERAL PRACTICE - A CASE AND A MINISTATISTIC OF A GP

Franco Del Zotti – GP – Verona

A young asthmatic patient arrived in my office at the beginning of March because his cough had worsened, for dyspnoea and whizzes. I know he is subject to asthma attacks and I also know he is a smoker.

Pat. Yes Doc, I know I shouldn't smoke, but maybe these attacks are also due to my motorbike ….. I go to work with my motorbike even when it is cold.

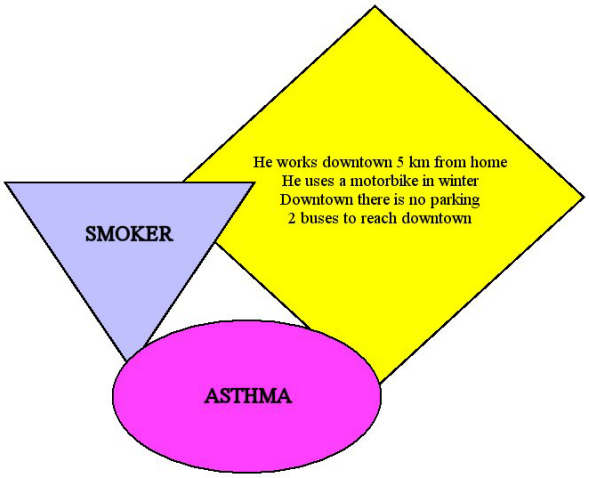
Doc. Don't you have money to buy a car?

Pat. Doc, I do have a car, but I can't use it because I work in the downtown area where there are no parking spaces.

Doc. Well, why don't you catch a bus?

Pat. I would have to take two buses and it would take me double the time to get there.

At this point I give up and I ask myself: why did his condition worsen? Does it depend on his smoking habit or from the social circumstances that make him use his motorbike even in the colder months? After our talk it seems clear that the patient is claiming his right to keep at least one explanation of his illness at choice (…….. smoke), respect to social causes, that come from the outside. Here we can see a logical analysis of the problem, which is yet unproductive and absolutely difficult to change by simply being paternalistic.
In the following FIGURE 1 you can try to determine the game of the different casual levels of illness, with graphical solutions that suit the bio-psycho-social model.



Dimensions and intersections of bio-psycho-social models:
Triangle = relational –behavioural variable
Ellipsis = clinical variable
Rhomb = (double triangle) = social variable

From the same surface of the various figures you can understand how the discussion with the patient is important to analyse the social determinants and the eventual strategies to determine micro-solutions or adequate "alliances" or "references" in the social field. Beyond the possibility of truly affecting these processes, the GP's "sympathetic" participation can be a pre-condition for the next formulation of the motivational approach regarding the behavioural problem (smoking). You are slowly discovering that the story I told you at the beginning, wanted to introduce more general aspects of the working methods of GPs, who shouldn't nor mustn't limit themselves to the sole consideration of clinical data. As a matter of fact, the quantitative dimension of the extra-clinical variables in our job is often scotomized by the GPs. The following mini-statistic can illustrate the problem better.

During a months period (April 2002) I recorded all the visits in my office in which I found the following (TABLE 1-2):

a) a **Diagnostic Clinical Dilemma**, which caused me to consult in my PC the following sources: 1) the Griffith-5 Minute Consultation manual; software 2) the DiagnosisPro expert software system; 3) the Gideon software for infectious diseases 4) Netter- Atlas of clinical Anatomy; 5) phone call to an expert

b) a **Social Dilemma** in which the social component wasn't presented by the patient and represented a fundamental part of the "pathogenesis" or "aetiology" of the case

The two following tables briefly indicate the characteristics of the various cases.

Patients with Clinical Dilemmas

PROBLEM	Question/s	Fonti Consultate
Gynaecomastia in a 68 year old male who takes medication drugs	Which medication drugs are the cause? Which lab tests should be done ?	1; 2
Sciatica or meralgia paresthetica?	The pain follows the dermatomers or areas of particular nerves?	4
Intollerance to Glucides; I have 3 values>115	glucose test?	1; 2; 5
High Calcium and Parathormone	Takes mini-doses of cortisone for PMR: Primary or secondary Hyperparathyroidism	1; 2
Red spots in the underarm region	Psoriasis? Fungus? Lichen? Which disease comes in the underarm region?	1; 2
Pain in cheek and pus inside the cheek	Dental Abscess? Abscess/stones of the parotid?	4; 5
Referred of tick PUNCTURE 3 days and erythematous area	Was it a tick? What tests must be suggested?	1; 5
Lung Fibrosis; the patient wants to undergo "special" tests	Is CAT useful for Precocious Diagnosis Of complications?	1;2; 5
Fever for over 1 month to be determined	All the routine tests are negative: Other tests? Hospitalisation?	1; 2; 3; 5

Patients with Social Dilemmas

PROBLEM	Social Cause
Herpes Zoster in healthy 45 year old	Recent new software in the office that gives problems and a new way of working
Pelvic and thigh pain (M – 22yrs)	Sportsman; he cannot stop – he has an important race
Colitis and Gastralgia (27 yrs)	Foreigner :works as an assistant to elderly 24 hours a day 6 days a week at 40 km from her home
Allergic conjunctivitis from dust (F – 53 yrs)	Wall-to-wall carpeting at work
Insomnia (F - 43 yrs)	The neighbour uses a noisy air conditioner
Migraine headache (F – 38yrs)	Conflict with a new colleague
Insomnia (F - 44 yrs)	Little time; she works in a company with her husband
Videogame addiction financial loss (M - 62 yrs. Retiree)	He has an alternative: playing cards, but the only bar nearby just has a few tables available
Asthenia from some time (F - 38 yrs)	For social reasons she is dividing a home in a "working-class building" with a "depressing" alcoholic
Muscular pain (not during the week-end) (M - 41 yrs)	stress da super-lavoro
Onicomicosis Big toe nail (M - 32 yrs)	He uses safety shoes
Epi-condilitis in worker (M - 42 yrs)	Recent increase of hard work (road repairs)
Insomnia (F - 50 yrs)	Works from 5 to 8 in a shop with her husband; until 11 housework
Insomnia (F- 66 yrs)	The house is small- if she gets up at night she disturbs – she stays in bed and feels nervous
Night perspiration (F – 30yrs)	She works very much in a Restaurant with less personnel than usual
Hives never seen before (F-38 yrs)	A colleague is sick and now she is working much more

Conclusions

If we draw the conclusions regarding these cases, we can observe 25 cases in which 9 have a Diagnostic Dilemma and 16 having a Social Dilemma. Due to the limited number of cases, we can't speak of significative differences, yet certainly the data suggests the usefulness of making deeper studies, and the need of additional updates in such a neglected field: social problems such as causes or concomitant causes of disease. Not many could raise objections at this point such as: "But what can a single GP do when he has made the "diagnosis" of a social problem? Not much….." I would answer to these people that even if the GPs carry out many clinical diagnoses "he will not be able to do much". I would also eventually answer that, often we underestimate our micro-social role (certifications, exemptions, web of social acquaintances of the GP; the GP as a problem-solver; the GP as a model citizen, etc.), and our important "human therapy and comprehension" role, in all the personal problems of our patients-citizens, which are embedded in the identification of the social dynamics of each single case.

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