



The Grapevine



Greetings

Our EURIPA President is just returning from Borneo (speaking on provision for those with learning disabilities in rural areas) but we have his report on the WONCA Europe conference in Warsaw (see below). We also have further comments on the Sinaia meeting, from Richard Roberts, WONCA President, and a report on the Conference of the Hungarian Scientific Association of Rural Health. 'My Practice' this time comes from Anna Pawelec, MD, in Nowy Wiśnicz, Poland, and the suitably wintry photo above is the view out of their window. In addition we congratulate Elizabeth Swensen (this year's 'Dandelion'); there is a moving tribute to Claudio Carosino and more on the Hippocrates programme; and we have received some wonderful Christmas recipes! We hope it is not too early to wish you all a very happy Christmas and a peaceful and productive New Year.

Jane Randall-Smith, Executive Secretary

Reporting back

Romania

Although we reported on the conference in Sinaia, Romania, in our summer issue, we are very pleased to be able to include a further analysis from **Richard G. Roberts**, President, World Organization of Family Doctors (WONCA) 2010-2013 and Professor of Family Medicine, University of Wisconsin School of Medicine & Public Health:

Rural Family Doctors: The Future of Better Health and Health Care

My visit to Sinaia, Romania to attend the EURIPA meeting reinforced my belief that rural family doctors are the key to the future of healthier societies and successful health care systems. Rural family physicians promote equity. They provide medical access to rural people who are more often poor when compared to urban people. Rural family doctors are an important source of development. They generate considerable economic benefit to their local communities. Yet, these positive attributes are not unique to rural family physicians. Urban family doctors are also important contributors to equity and economic development. The reasons for my belief are more fundamental and reflect the tension between generalism and specialism.

A brief review of rural and urban realities is in order. It was reported recently that there are now more people residing in urban than rural areas, for the first time in human history. In many developed countries, the rural to urban ratio may be 1:4 or less. The move to cities is often a move to better educational and employment opportunities. The shift to an urban setting also

means greater specialism, as people compete for economic primacy by focusing on ever narrower occupational pursuits. In health and health care however, this narrowing focus can cause harm.

Specialism limits and fragments care by disease, age group, gender, or other considerations. Consequently, specialism requires hand offs from one specialist to another when a patient has additional issues beyond the scope of the individual specialist. Hand offs are major sources of error in the care continuum with vital information not always transmitted between professionals, necessary interventions sometimes overlooked, and patient values not always understood. Specialism also breeds increasing use of health services, as each specialist feels compelled to address symptoms or findings that may be self-limited. A major problem in some countries is the excess use of health services, with iatrogenic harm to patients and fiscal harm to society.

Starfield and others have shown that people have better health outcomes when their care is centered in a relationship with a primary care professional who attends to the whole person, not a part of a person. Starfield concluded that family doctors are the premier primary care professionals because of their commitment to continuity relationships and comprehensive services. Among family physicians, rural family doctors are most likely to demonstrate continuity and comprehensiveness.

Rural people may not always choose greater continuity and comprehensiveness as a deliberate decision. Rural patients may have little choice of professional, with continuity forced upon them. Rural family doctors often must provide a wide range of services because there is no one else to supply those essential services. It may be that limited choice compels continuity, and limited resources demand clear priorities and force comprehensiveness. Intended or not, the increased continuity and comprehensiveness in rural settings translate into greater equity, effectiveness, and efficiency of health care services.

My belief in the value of rural family doctors goes beyond health care services. A medical practice serves as a connecting point in a rural community, bringing together young and old, rich and poor. In rural communities, family doctors are important influence leaders and help to identify needs that may otherwise go unnoticed. By considering the whole person and by caring for the entire community, family doctors provide an important source of cohesion in rural communities.

The rural family doctor plays a vital role as community leader and confidant, and provides extraordinary service despite resources that are often inadequate. Through their personal relationships, community connections, and ecological perspectives, rural family doctors promote healthier and better communities. For those who question the relevance of rural practice styles in an urban setting, the behaviour of urban people demonstrates that large cities are mainly a collection of small villages and that the human need for whole person care and community cohesion appears universal. Rather than serving as a quaint anachronism, I believe that rural family doctors, as exemplars for continuity and comprehensiveness, point the way to better health and health care.

WONCA Europe, Warsaw 2011

The WONCA Europe Conference took place 8th – 11th September in Warsaw, Poland, with the theme: Family Medicine - Practice, Science and Art. The following is a report from John Wynn-Jones, President of EURIPA:

Some conferences are entirely academic/scientific events but others such as WONCA Europe provide an opportunity for like-minded individuals and groups to meet and network. In fact many of us are so busy that we can miss out on the wealth of scientific thinking and scholarship that goes on in the main sessions and workshops. I am still somewhat bemused by the logo of a GP on a pedestal. This is at odds with our philosophy of working closely with other professionals in teams.

I found the choice of keynotes interesting and thought provoking. One of the stars was the economist from the World Bank who implored us not to make the same mistakes with the design of health care that the economists had done with the world economy!

Among the high points was the work of Vasco de Gama which has changed WONCA Europe forever. It's even more exciting to see 3 VdG members representing their countries on the Council. It gives me confidence for the future! We are seeing more young doctors at our rural meetings. The first EURIPA workshop was shared with VdG and we had an excellent turnout. It's very encouraging to have Dutch GPs admitting that they have recruitment problems in their rural areas in the south and north of the country.

Networking between the networks and special interest groups continues to improve. We are working on an ongoing basis with VdG and EQUIP and hope to develop a relationship with EURACT after our 3rd Rural Health Forum meeting in Portugal next year. EGPRN have suggested that we hold a joint international meeting.

I have great admiration and gratitude for the help and support that we have had from the WONCA Europe Executive. Much of this is due to Tony Mathie who has supported us since his time as Hon Treasurer. I also note a change in the attitude of WONCA Europe to countries in trouble. Many of the countries of south east Europe are struggling to provide comprehensive care due to poor support and investment from their governments. WONCA Europe sees itself as support for these countries.

However I have an ongoing issue with these conferences. They are expensive and elitist. Most of the rural GPs that EURIPA represents would be unable to afford the high costs. In addition the social programme was far too expensive. We need to make WONCA Europe more affordable and approachable. The dilemma lies in the fact that WONCA Europe derives significant revenue from these conferences and it is not in its interest to change. EURIPA runs an annual European Rural Health Forum meeting. We keep the meetings small and keep the costs under €150. It can be done on a larger scale. Warsaw was a great city to hold a conference in however. In general, this was a well organised professional conference. Well done!

Suggestions for future Conferences

- WONCA Council meetings to last a day
- Incorporate a networking afternoon/day into the programme
- Give priority to workshops that encourage networking and crossing boundaries
- Keep costs down

During the conference EURIPA held its AGM and the following points are worth noting:

In Memoriam

The AGM stood for a minute's silence in memory of Claudio Carosino and conveyed their condolences to his family

Romania

The chair asked Dr Paul Serban to convey the gratitude of EURIPA to the Romanian Society and especially to Sandra Alexiu and Szusanah Farkas Pall for their special contribution towards the 2nd EURIPA Rural Health Forum in Romania.

At the conference there were preliminary discussions for an initiative on Patient Safety in Rural Practice, as a collaboration between EURIPA, Linneaus and EQUIP.

The EURIPA Constitution

The AGM agreed amendments to the Constitution for EURIPA. The full text is available on the website but it may be useful to note the significant changes:

- The role of Immediate Past President has been created.
- The election of vice president, vice president elect and president has been formalised.
- The Executive Committee is formally constituted to have 13 members, comprising representatives of the WONCA Europe networks, the Journal and 5 from the membership, as well as the President, Vice President and Immediate Past President.
- The AGM will take place at the most appropriate opportunity each year.
- Members will be elected to the Executive Committee each year. The term is 3 years.
- An international advisory group has been established. Each country in Europe is entitled to nominate an advisor.

Conference of the Hungarian Scientific Association of Rural Health (MFTT)

We have received a report from Dr Agnes Simek, President of MFTT, of the 20th September 2011 conference which had the theme of “**Ensuring equality of underprivileged populations in Public Health**”:

Dr. Attila Beneda, Head of the Health State Secretariat’s cabinet in the National Ministry of Human Resources and **Dr. Judit Paller**, Chief Medical Officer, emphasized in their addresses the important role in health promotion and prevention of the local Public Health authorities in the districts and the strong political decision to establish an independent scientific and methodological centre of Public Health.

The members of the society explained that the civil organisations' role is outstandingly important in patient information, in motivation, in mobilisation and in changing experiences. A civil organization can reach many people and areas, where the official organization moves with difficulty, achieves fewer results and works with less efficiency because of its more rigid system. One of the important objectives in a well organized public health system is to guarantee equal opportunities to underprivileged populations in screening and prevention, as part of the ongoing care of chronic non -communicable diseases.

Professor Károly Cseh, Head of the Public Health Department in Semmelweis University,

Budapest, talked about the importance of the scientific background of public health and about the public health system in Hungary.

Head of the Family Medicine Department of the Professional Chamber, **Professor Ferenc Hajnal** presented the role of family medicine in the public health system. He underlined that even the best national health plans cannot be delivered without the enthusiastic, active role of GPs. The connection between public health and health economy was discussed by **Professor Imre Boncz**, Head of the Health Management Department of Scientific University, Pécs. He raised an economic-ethical question - to make a decision on the utilization of a given sum: - should it be allocated to health prevention for 250 000 persons or to 33 bone-marrow transplants?

A very timely lecture given by **Dr. József Vitrai Ph.D.**, independent health care expert, highlighted the inequalities in medical care in Hungary and introduced and analysed their causes. The morning concluded with a comprehensive lecture on providing equity in different European public health systems by **Professor Éva Orosz**, Head of Health Policy and Health Economy Department in Eötvös Lóránd Scientific University, Budapest.

In the lunch break, in the general assembly, members of MFTT made decisions on the future of the Association. In addition to its

concern for the rural population, the Society will include in its activity the interest and care of all handicapped and underprivileged populations. MFTT is making further efforts to establish an independent institute of Rural and Remote Health in the medical universities besides its participation in CME. The Society continually strengthens its cooperation with NGOs, and promotes their initiatives. MFTT plans new studies and surveys in collaboration with Universities and National Institutes.

The afternoon sessions considered the good practice by which the objectives of the National Public Health Program can be realised. **Dr. Annamária Somhegyi PhD**, the Preventive Director of the National Spine Therapy Centre, spoke about children's healthy nutrition, effective motions and mental-hygiene in the schools, emphasizing the necessity of the support of governmental authorities and their cooperation in planning and decision-making. **Dr. Ágnes Simek PhD**, President of the Hungarian Scientific Association of Rural Health (MFTT) talked about the difficulties, and the range of tasks in care of the homeless and above all about the maintenance of human dignity of the homeless

people. She emphasized that the answer to the complex problems of the underprivileged people should to be managed by the support and collaboration of different bodies in society, with the cooperation of NGOs and governmental offices.

Dr. János Szabó, lecturer in the Family Medicine Department, Semmelweis University, Budapest showed in his presentation the customs and cultural characteristics of Gypsies and talked about the necessary knowledge of GPs on these topics. **Gabriella Varga**, facilitator of the Líceum Foundation spoke about the assertive support of aggressive young people, about their re-integration into society and the results of this work in the VIII. district (the poorest and most underprivileged) in Budapest. **Pregunné Puskás Gyöngyi**, psychologist of 'Don't hurt me world!' Foundation presented to the audience some good practices of interactive education with different age groups of children and young adolescents in the prevention of sexual abuses.

Contributions from members

Claudio Carosino – to honour his memory

We have received from Raquel Gómez Bravo the following tribute to Claudio Carosino and more on the special Hippokrates exchange programme that honours his memory :

The human doctor

It was just a year ago (though time goes faster than we can possibly imagine) that the rural health community was shocked by the news of the death of Dr Claudio Carosino during a home visit. The huge gap left by his absence is still tangible and his memory has become a legend. Claudio Carosino was a great and popular Rural General Practitioner in Bussetto (Parma, Italy) who upheld the principles of care for his patients, a critical enquiring intellect, a leader among his fellow colleagues and a loving family man.



Enthusiastic, dynamic, he was involved in promoting research in Rural Practice through his membership of the European General Practice Research Network (EGPRN) and also involved in the European Rural and Isolated Practitioners Association's (EURIPA) Research Group, and involved in

projects in the developing world. Everybody underlines his great qualities: his knowledge, his willingness, his competence, his involvement, his optimism, his goodness, his passion for our profession...but all the adjectives are not enough to describe him. John Wynn-Jones, current President of EURIPA, described him brilliantly as a natural ambassador and diplomat in the field of Rural Health Care.

“He was known as a remarkable and delightful man who oozed enthusiasm, and touched the working lives of many doctors across Europe and beyond”- wrote David Hogg in his blog ruralgp.com, where more than seventy people have left a tribute under “Claudio Carosino: remembered” to express their condolences to his family and friends.

The Vasco da Gama Movement had been working with him very closely, not only in the Research Group but also in the Beyond Europe Group, because of his continuous involvement with GP training and trainees. So we are especially concerned to pass on his way of teaching, of being, of working as the model of a rural GP, as an example of a great professional.

EURIPA, WONCA and VdGM would like to honour Claudio Carosino’s memory by offering a prize of 700€ to support a GP trainee, or GP within 5 years of qualification as a GP, who has taken part in a Hippokrates exchange to a rural GP practice (as defined by EURIPA) within the previous year, and has provided high quality learning outcomes and a final report with an impact on the field of rural general practice. Thanks to this initiative, VdGM and Euripa have recruited more than twenty rural European GP practices in order to participate in this special Hippokrates exchange programme, that enables GPs to exchange learning, and enjoy, understand and feel how wonderful and difficult is the life of a rural GP.

Hippokrates is an exchange programme of VdGM for medical doctors specialising in Family Medicine/General Practice and junior Family Doctors/General Practitioners (within 5 years of completing specialist training), who is supported by WONCA Europe and by the European Academy of Teachers in General Practice (EURACT). The aim of Hippokrates is to encourage exchange and mobility among young doctors in the course of their professional formation as General Practitioners; thus providing a broader perspective on the concepts of Family Medicine at both professional and personal levels.

Participants of the programme acquire an insight into the context of General Practice in the primary healthcare systems of other European countries, either by hosting an exchange participant or visiting a GP practice in a another country. Through this they gain knowledge that will inspire them to undertake an active part in the development of Family Medicine at all levels.

Furthermore the programme enhances collaboration among national colleges of Family Medicine and the recruitment of young professionals to these.

At the individual level the benefits are numerous – gaining international experience in a vocational setting, improving knowledge and skills, getting an inspirational introduction to methods of professional development for lifelong learning, improving language skills and creating new friendships. The duration of an Exchange is normally two weeks, though in some cases 1 week is acceptable, and during this time the visitor will obtain an introduction to the character and the role of Family Medicine in the that country by shadowing all the activities of the Host Practice.

The visitor should also meet, shadow and exchange views with local trainees specialising in Family Medicine and will be encouraged to gain insight into local resources and quality improvement activities as well as local healthcare structures.”¹ We want to thank all the rural doctors who have joined this initiative, giving GP trainees and Young GPs the extraordinary opportunity of spending two weeks in a rural practice and of observing their daily work. And we want to invite all those who might be interested in participating in this programme because we want to encourage rural rotations.

Medical education is based on an archaic and outdated structure, where knowledge is basically theoretical and is provided vertically. There is an obvious gap in training in primary care, which is fundamental, and needless to say, rural education is the great unknown. We propose that all health professionals should have a rural element to their education, not only to enable them to appreciate the work of rural doctors, but to encourage their own involvement and awareness in work in these areas. Creating and establishing an international program of rural assistance could be the key to reducing the shortage of health workers in remote and rural areas. It would be wonderful to improve this situation in memory of Claudio Carosino

¹ www.vdgm.eu/

Raquel Gómez Bravo, Charilaos Lygidakis, Sara Rigon, VdGM Beyond Europe Group.

Elisabeth Swensen is this year's Dandelion!

The article below is translated from the Journal of the Norwegian Medical Association (JNMA) published on 15th November²

During the Nidaros Congress in Norway in October this year, Elisabeth Swensen (b. 1951), Chief Medical Officer in Seljord Municipality, received the Dandelion Award for 2011. Swensen graduated from the Faculty of Medicine in Oslo in 1980 and was certified as a specialist in family medicine in 1994.

Each year during General Practice Week (PMU) or the Nidaros Congress, the Norwegian College of General Practice announces the winner of the Dandelion Award. The award consists of a lithography by Barbara Vogler and 20 000 Norwegian kroner. The award is given to a general practitioner who has made a special contribution to the field. This contribution may have been made at the central or at the local level, quietly or in the media, professionally or organisationally, practically or theoretically.

The nomination for this year's Dandelion Award states the following: "Her work as general practitioner and Chief Medical Officer in a small, rural community in Eastern Norway for more than thirty years has established the legitimacy of her numerous initiatives, contributions, ideas and provocations. She has taken the floor in many forums and has always defended her position well – be it as a board member of our professional

association, as editor of Utposten, as associated editor of the Journal of the Norwegian Medical Association, as a member of the Working Party of Rural Health of WONCA, as an organiser and lecturer, as a contributor to the news media and to EYR or as a supervisor for a great number of residents and candidates for specialisation in general practice.



She has achieved the unusual feat of remaining critical of established positions while constantly being brought forward as the NMA's representative in a variety of contexts, most recently in professional forums discussing how practices related to medical certification and emergency response are to be regulated. With a critical eye, she infused the thinking related to risk

in medicine with a new content in the early 1990s, and she was the first to challenge the revelation of truth when the EBM (Evidence-based-medicine) wave reached our shores just before the turn of the millennium.

Before rural medicine became a familiar concept in this country she saw the need for a debate on the health services in rural Norway and for a description of how the services provided to the public are linked to social development in general. She also pioneered the establishment of the Norwegian Centre for Rural Medicine at the University of Tromsø, where she currently participates as a regional coordinator and as a member of the steering group.

She is in favour of plans to downscale psychiatry, she is an uncompromising defender of a wide normal variation in the life of humans as biological and psychological beings, and she claims that the GP should act as a guarantor who protects all patients from being arbitrarily treated as ill. Anyone who has viewpoints regarding these issues will not deny that her arguments are well-founded and hard to refute.

Her ability to express herself cogently is enviable –and her clever turns of phrase can most often

be tolerated even by those who are the targets of her attacks when she is on warpath, which she occasionally is. Examples are easy to find; some of these include major issues concerning regular salaries for Norwegian GPs, the struggle against corruption and increasing commercialism in the health services, and the use of Nordic languages, if at all possible, when colleagues meet abroad. When asked to make an intellectual or creative contribution, she seldom declines – or perhaps she declines too seldom? But when she accepts, she is always up to standard, regardless of whether this involves spending hours at the steering wheel, sleeping short nights and mastering the logistical challenges involved in a life with four children, as well as heading the municipal health services and taking care of her own health as her primary areas of responsibility. The discourse on general practice would not have been what it is without her.

The Dandelion of the Year is Elisabeth Swensen!”

²Tidsskr Nor Legeforen nr.22.2011: 131

AIMCARE

David Hogg, a GP on the Isle of Arran, Scotland, has recently shared their experience in developing a model of integrated rural pre-hospital care. AIMCARE seeks to provide a useful model of rural emergency care to improve the availability of skilled casualty care at times of high or complex demand.

The AIM CARE project came about from a GP Rural Fellowship, one of several offered each year by NHS Education for Scotland. Aimed at newly-qualified GPs, or GPs wanting to switch into rural practice, these provide a year of work in a rural/remote area along with additional study leave and support to develop the enhanced skills required in rural practice. During their Fellowship year, Fellows are expected to complete a project on a particular aspect of rural health care.

For David Hogg, Rural Fellow for Arran 2010-2011, the year offered an opportunity to develop some ideas of how the emergency response of GPs could be better integrated into the systems of the Scottish Ambulance Service. However, the idea developed and more agencies became interested in contributing to this work.

We include a poster for the project:



What?

Arran Resilience offers a cost-neutral, easily implemented model of immediate care delivery in rural areas. It seeks to integrate the skillbase of emergency teams, and improve co-ordination of emergency responses at times of high demand or in the event of a major incident.

Why?

Arran is a busy island community, that sees its base population of 5,000 rise to 25,000 over the summer months. Home to many outdoor sports and visiting tourists, there is a constant need for good immediate medical care.

Poor weather (in both winter and summer) and service pressures can see the island cut off from ferry and helicopter transfer. Optimising locally available resources therefore makes sense.

Who?

Arran benefits from having an active and skilled range of more than 120 emergency service responders including: police, fire, ambulance and NHS, as well as coastguard, mountain rescue and RNLI lifeboat. Responders are well trained in casualty care and incident response. However there is an appetite to improve access to training, through simulation and table-top exercises.

The involvement of mainland organisations including the Emergency Medical Retrieval Service and Strathclyde Emergencies Co-ordinating Group has indicated that the Arran Resilience model of integration may offer useful ideas to other rural and remote communities in Scotland.

How?

Regular liaison meetings have resulted in quality dialogue and pragmatic solutions to incident response planning on Arran. In addition:

- All team leaders are now networked via an email Google Group
- More than 50 responders have attended eight workshops in CPR, triage and scene approach
- A week of NHS medical simulation training has been opened up to other agencies, as part of the AIM CARE project
- Information regarding team deployment, equipment and communication has now been collated
- Novel concepts are being implemented in the form of an integrated major incident plan and the use of rendez-vous points for effective command and control



Find out more from Dr David Hogg, GP info@aimcare.org.uk www.aimcare.org.uk

My Practice

Working with a view of the Castle

Our practice is located in a little, historic and very picturesque town of Nowy Wiśnicz, 45 kilometers east of Cracow. There are two smaller practices connected to our main practice in the villages of Muchówka and Królówka. The up-to-date patient list size for Nowy Wiśnicz- 8500, Królówka- 2500, Muchówka- 1000.



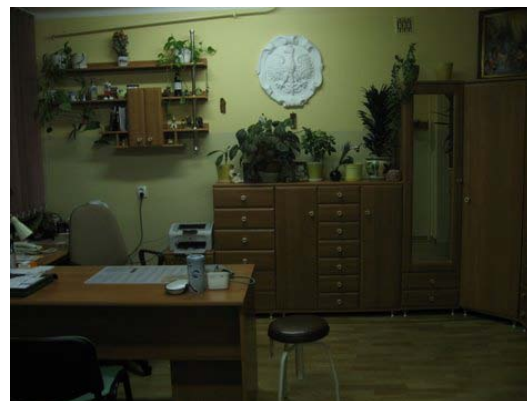
The practice with satellite filiae is owned by the local government (which is quite rare, most of the primary health care centers in Poland are in private hands). The services are paid by the National Health Fund and in case of primary health care the system is "per capita" (the amount of money received depends on patient list size).

In our practice we provide healthcare for all - children, adults and elderly. The out-of-hours and emergency services are located in the nearby hospital in the city of Bochnia (6 km from Nowy Wiśnicz). The office hours are 7 a.m. - 6 p.m. Monday through Friday (most surgeries in Poland work between 8 a.m.-6 p.m.). Our centre has extended hours which is more convenient for those who commute (many people travel to work or school to Bochnia or even to Cracow).

In our primary care practice in Nowy Wiśnicz we have three salaried GPs, two contract GPs (paid on an hourly basis) and two paediatricians. Additional staff include four nurses, midwife, two receptionists, a driver and administrative workers. There are four specialist practices within our health centre: rheumatology, Ob&Gyn, rehabilitation and

dental. Twice a week a psychologist comes who deals mainly with alcohol and drug-addicted patients. There is also a diagnostic center here. Blood and other samples are taken every day and most of the lab test results can be received on the same day they were ordered. X- rays, ultrasounds and colonoscopies are performed in the Bochnia hospital.

A patient needs to have an appointment to see a doctor unless there is an emergency or the doctor decides otherwise. Consultation time is normally 10 minutes. We also make home visits on a regular basis, especially for the elderly patients living in more rural places. The health centre is equipped with a four wheel drive vehicle (very useful especially in winter). The driver takes doctors on housecalls. He also drives the community nurse or midwife to the patient's house when necessary. The area where our patients live is very large, houses are sometimes hard to find and someone who knows the people and the neighborhood is a must. A skilled driver is more valued than even the most modern GPS.



Our practice now is undergoing major reorganization. The lab was translocated to a new building. There are rooms available for further development. An electronic system for medical documentation is being introduced (with quite a bit of resistance from older doctors used to paper forms). We are planning to apply for a licence to become a teaching practice for GP trainees and last but not least to be included in the near future as a centre for the Hippocrates Exchange Programme.

Anna Pawelec, MD

Recipes

A specially extended recipe selection this time since Christmas is coming . Firstly two from Zsuzsanna Farkas Pall in Romania:

Poppy-seed or Nut Roll

0.5 kg flour
200 g butter
2 eggs
1 spoon of sugar
20 gram yeast
0.1 litre of milk
salt



Soak the yeast in lukewarm milk, then add the flour, butter, sugar, a bit of salt, two egg yolks, and knead together. Allow it to rise, then divide it into four parts, and let it rest for half an hour. Stretch it as thin as you want (2-3 mm) into a rectangular shape, then spread the filling on it, then roll it up. Then spread egg yolk on it, and let it rise a little more, then put in a hot oven.

for the filling:

poppy seed roll - 500g ground poppy-seed, 500g sugar, 50ml of milk, vanilla, raisins.

nut roll – 400g ground nuts, 350g sugar, 50ml of milk, lemon peel, vanilla, raisins

Honey-cake

1 kg flour
0.3 kg granulated sugar
0.3 kg liquid, cold honey
0.2 kg melted butter
2 eggs
1 tablespoon of baking soda
cinnamon, clove, salt



Knead all the ingredients together, and let it rest for a couple of hours. Then stretch it out 3-5 mm thick, and using various types of cutters form shapes (heart, star, moon etc.). Put these shapes on a greased, floured baking tray, and put the tray into a hot oven, until the cakes are golden brown. Allow to cool. Then spread egg yolk on the little cakes and let it dry (this makes it shine). Beat up the white of an egg, then slowly add 150g of granulated sugar, until the mixture flows slowly from the egg-beater. Put it into an icing bag with a small opening and decorate the cakes. These little cakes can be strung on a thread and used for decoration.



Then one from Oleg Kravtchenko in Norway:

Lutefisk (or lyefish) is one of the most traditional Norwegian Christmas dishes. One of the legends on the invention of the dish is that once upon a time in Lofoten there was a fire in the stockfish warehouses just before Christmas. The fire was extinguished, but the stockfish (dried cod) was covered with ashes and then with water, leaving it uneatable. However because of Christmas Eve the owners of the warehouses were in a festive mood and kindly gave the spoiled fish to the poor people of Lofoten who cleaned the fish, rinsed it thoroughly in ice-water and then baked it using cooked potatoes, mashed cooked peas and some small fried bacon pieces as a side dish. The final result was so delicious that it gradually became one of the Christmas favourites first in Norway and then in the whole of Northern Europe.

250 to 500g lutefisk per person. Some recipes suggest soaking the fish in ice cold water overnight, or sprinkling the fish with salt and letting it stand for a few hours, both of which will result in a firmer flesh. (Since it will be difficult for many of us to get the genuine dried cod soaked in lye we suggest that you use any firm-fleshed white fish)

salt

about 150 g smoked bacon, thinly sliced

bacon drippings or melted butter

coarsely ground allspice

hot, freshly boiled potatoes

béchamel sauce

pureed green peas:



Cut larger pieces of lutefisk into several smaller pieces of equal size. Place the fish (skin-side down, if it has its skin attached) in a buttered oven dish (not aluminium)

Sprinkle or rub the fish with salt, using about ½ to 1 teaspoon of salt per 500 grams of fish. Cover the pan tightly with a lid or a piece of foil (not letting it touch the fish), so that the steam building inside will not escape. Bake the fish at 200 °C until the flesh is starting to turn white and flaky, (between 15 and 40 minutes)

While the fish is cooking, prepare the trimmings – boiled potatoes, thin strips of bacon fried till crisp, béchamel sauce (made with a coarse wheat flour, butter, and milk), and pureed green peas.

Assembling the dish:

Gently lift a piece of newly-cooked lutefisk and place it on a (preferably warmed) plate. Drizzle the fish partly with a bit of bacon drippings (or melted butter) and pour over some béchamel sauce. Grind allspice on top and sprinkle with bacon bits. Place potatoes and a dollop of pea puree beside the fish. Serve immediately.



Publications

Two working papers have been produced by the Rural Health Implementation Group in support of the Welsh Rural Health Plan:

Delivering Rural Health Care Services and **Rural Health Telemedicine**. These are available from the Welsh Government www.cymru.gov.uk

Christos Lionis has sent us details of 8 publications that were cited during the period 2009-2011, all of them relevant to rural health:

Tsiligianni IG, Delgatty C, Alegakis A, Lionis C. **A household survey on the extent of home medication storage. A cross-sectional study from rural Crete, Greece**. Eur J Gen Pract. 2011 Aug 31. [Epub ahead of print].

Oikonomidou E, Anastasiou F, Pilpilidis I, Kouroumalis E, Lionis C; Greek General Practice Dyspepsia Group. Collaborators: Glystra A, Dimopoulou S, Tsiligianni I. **Upper gastrointestinal endoscopy for dyspepsia: exploratory study of factors influencing patient compliance in Greece**. BMC Gastroenterol. 2011 Feb 14;11:11.

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Upcoming events

The 3rd EURIPA Rural Health Forum will take place in Oporto, **Portugal** 11th-13th May 2012

The 18th WONCA Europe Conference will be held in **Vienna, Austria** 4th -7th July 2012 with the theme of 'The Art & Science of General Practice' www.woncaeurope2012.org

South Europe Primary Care Forum/Conference It is proposed to hold this in Pag, **Croatia** in the autumn of 2012. The majority of countries within the old Yugoslavia and neighbouring post-Soviet countries are struggling to develop primary care as a speciality and as a service which will improve the health and wellbeing of their populations. Healthcare services, health planning and academic medicine

are dominated by the secondary sector. Primary care organisations report poor morale, poor investment and a lack of emphasis on community-based care throughout the region. There is a growing consensus that change must be multidimensional. Not only must governments understand the importance of investing in primary care but family physicians need to organise and empower themselves to affect change, improve services and strive for quality. Change is already happening but the progress is slow. There is an opportunity to bring physicians, planners, governments, academic bodies and NGOs together from across the region and further afield to share good practice, break down barriers and hostilities and improve services by learning from each other.

20th WONCA World Conference, Prague, Czech Republic 25th-29th June 2013 with the theme of 'Family Medicine – Care for generations' www.wonca2013.com

Innovation in Primary Care Seminar, Madrid, 22nd September, 2012: What role for primary care? Juan Gervas has sent us information about this seminar, which will try to answer questions raised in the papers below, (for example, about the role of nurses and the coordination of care of complex patients). Those who can only participate online are also welcome. 'Join us in understanding the services primary care should include and how to organize them.'

The core paper:

<http://www.equipoesca.org/organizacion-de-servicios/what-role-for-primary-health-care-in-modern-health-service-provision-seminar-of-innovation-in-primary-care-madrid-spain-22nd-september-2012/>

Subsidiary papers:

<http://www.equipoesca.org/organizacion-de-servicios/critical-steps-in-europe-to-set-up-phc-under-conditions-of-resource-constraint-the-case-fo-the-mediterranean-countries/>

<http://www.equipoesca.org/organizacion-de-servicios/phc-western-european-best-practices-of-institutional-responsibilities/>

<http://www.equipoesca.org/wp-content/uploads/2011/08/brasil-report-abstract-english-final-2011.pdf>

<http://www.equipoesca.org/organizacion-de-servicios/primary-care-financing-and-gatekeeping-in-western-europe/>

<http://www.equipoesca.org/uso-apropiado-de-recursos/family-medicine-should-encourage-its-clinicians-to-subspecialize-negative-position/>

<http://www.equipoesca.org/organizacion-de-servicios/western-european-best-practice-in-primary-healthcare/>

And finally some very early notice of the first **South American Wonca World Rural Health Conference** which will be held in **Brazil** in 2014. Dr Leonardo Vieira Targa is organising this event and the new website of the Brazilian Working Group on Rural Practice now has an English (and Spanish) version. Please see www.sbmfc.org.br/medicinarrural and click on the appropriate flag. You can contact Leonardo direct on targalv@gmail.com.

The next issue of the Grapevine will appear in April 2012 and contributions are welcome, by 15th March please, to helenp@irh.ac.uk

Happy Christmas!

