The Grapevine

Summer 2021

Hello EURIPA!

Its high summer and unbelievably we are more than halfway through 2021. July saw EURIPA lead two special interest session at the 26th WONCA Europe conference and we are currently planning for our next EURIPA Rural Health Forum. Although WONCA Europe was a virtual conference we are still hoping that some of us may be able to travel to Poland for our Forum but planning continues for a hybrid Forum. Virtual attendees will be able to join us at a reduced registration fee. And, of course, members of EURIPA receive a discount on their registration fee, for both the face-to-face and virtual conferences.

September in eastern Poland could be very pleasant! We hope to see you there!

Jane Randall-Smith
Executive Secretary EURIPA

Contents

10th EURIPA Rural Health Forum

Three months after our last Grapevine there is still uncertainty about international travel and we continue to plan for the Forum as a hybrid event: with a face to face event in Siedlce but also with the facility to join virtually:

10th EURIPA Rural Health Forum
"Understanding our patients – working closely together"
23rd – 25th September 2021 at **Siedlce, Poland**.

Click on **www.euripaforum2021.eu** for more information.

The **Call for Abstracts** is open and the deadline for submission has been extended to
10th August 2021.

We would welcome submissions for posters, oral communications and workshops. If you would like any help or support in writing your abstract please get in touch. As Ferdinando (co-chair of the Scientific Committee says:

> "Don't be shy, even if you are not a skilled researcher or educationalist, as a rural family doctor you can still contribute to the scientific programme and also enrich the cultural content of the Forum with your ideas too. You will make this event an important opportunity to contribute to the EURIPA vision for Rural Practice."

Please follow the instructions on how to submit an abstract on the Forum website at https://euripaforum2021.eu/call-for-abstracts/euripa-forum-presentation-guidelines/ .

When you are ready please submit your abstract at https://euripaforum2021.eu/call-for-abstracts/call-for-abstracts/

Pawel Zuk, Chair of the Organising Committee says

> ”We are preparing a safe and cosy place to re-establish our meetings in hospitable Siedlce, a town of interesting history and citizens. It will be a great honour to welcome all of you as our guests”.

We understand that Poland is a very quiet and secure country at the moment, with respect to the pandemic COVID19; Sieldce is a gentle place with a rural university which has kindly agreed to host us; and there is a high probability of travelling around Europe for fully vaccinated European GPs with their "green pass".

You can find out more about Siedlce at: https://siedlce.pl/en

You may be practising in a rural area for just a short period of time or if you have taken this as a life-long commitment, do consider contributing to the scientific content of our Forum. Even if you are a full-time practising physician and not familiar with the methodology of research, your contribution is highly welcome.

We are waiting to see you and exchange ideas with you. **Early bird registration** is open until **16th August.** EURIPA members receive a discount to register for the Forum and registration for the virtual Forum is a lower fee than for the face-to-face event. If you register for the face-to-face event but find you can’t travel you will be refunded the difference and your registration will be automatically transferred to the virtual Forum.

We are hoping that we will have the opportunity to meet face-to-face. See you soon!

EURIPA is working in collaboration with the Small Islands Special Interst Group of the International Foundation for Integrated Care, as there are areas of mutual interest:

IFIC – International Foundation for Integrated Care

Special Interest Group

Integrated Care in Small Island Systems

Small Islands…..Big Ambitions

Small island systems experience specific challenges, yet their size makes them an ideal platform for innovation and transformation. They share many common issues with rural and remote communities: outward migration combined with an ageing population and high levels of chronic disease; a limited workforce skills base within a small population; difficulties with recruitment and retention of specific specialist staff; and lack of economies of scale resulting in high costs for energy, infrastructure, transportation, communication and services; and a reliance on public sector. These issues are driving innovation and testing of new ways of working at a faster pace than in many urban and mainland systems.

The International Centre for Integrated Care (IFIC) established a Special Interest Group (SIG) on people centred integrated care in small island systems. This community of practice enables practitioners and managers from small island systems to learn from each other, share examples of innovation and understand how to build resilience, accelerate transformational change and strengthen health systems together and with their island communities.
The SIG currently has 141 members from 27 islands and 17 countries across the globe.

The SIG welcomes practitioners, managers, researchers, students, educational providers, regulators, policy makers and professional leaders. The SIG is free to join and resources are free to browse.

If you work in or with Small Island Systems please contact **Marie Curran,** SIG facilitator, with your name; organisation; email contact; and role at:
IFICscotland@integratedcarefoundation.org

Read on for a snapshot of the SIG collaborative activities:

- Exchange of good practice case studies and practical resources on integrated care
- Networking sessions at IFIC Conference workshops
- Informal, self organised study visits and twinning activities
- Series of webinars and virtual learning events
- Small Islands Learning Exchange

Small Islands Special Interest Group Forum, February 2020

This virtual islands forum brought together 63 people from 13 countries. Presenters and participants from Arran, Western Isles, Shetland, Orkney, Isle of Man, Guernsey and Malta shared insights followed by a reflection on Principles and Possibilities of rural Social Work in Scotland.
The Forum recording can be found at

https://vimeo.com/392687795

Special Interest Group eForum January 2021

This e forum welcomed 34 SIG members representing 10 Island regions and strategic partners from Scottish Rural Health Partnership, University of the Highlands and Islands, Rural Wisdom Project, IFIC and the Scholl Academic Centre.

The webinar recording is **here**, and presentation **slides here.**

Special Interest Group eForum September 2021

The next SIG eForum will take place on 22nd **September, 2 – 4 pm** (BST)

You can register to join for free here: https://form.jotform.com/211933794770363

Small Islands Learning Exchange (SmILE) – September 2019

Our first face to face learning exchange was hosted by SIG leads from the Isle of Man. The broad themes of the three day learning exchange were: Integrated Pathways; Older and Better Island Communities; and Community Wellbeing and Resilience. SIG members from Malta, Seychelles, Guernsey, Isle of Man and Scotland shared examples of innovation and considered how integrated approaches can build resilience, strengthen health systems and support islands to make progress on transformational change. Read the full report for more information at https://integratedcarefoundation.org/wp-content/uploads/2019/11/SmILE1-Report-v3.docx.pdf

My Practice

Veronika Vezjak is currently EURIPA's Liaison Officer for the Vasco da Gama Movement. Here she writes about her practice in rural Slovenia.

As a young doctor I worked in small town with a population of about 800 people. I was substituting a doctor on maternity leave. The team consisted of nurse Klavdija and me. This was an outreach office of a bigger nearby community health centre located in Vrhnika, Slovenia. My office was above the dialysis centre and a small pharmacy was in the same building. My working days were Monday, Wednesday and Friday. At that time I had around 400 patients, mostly locals and elderly. I had an ECG, a rapid CRP test and some essential medications. Laboratory testing etc was done at community health centre in Vrhnika.

I remember my first day in the office, the day ended with a patient with a pulmonary embolism, which was not an easy start. The following days were a little less stressful, but nevertheless interesting and every now and then very different from I was used to - working in a community health centre. For the patients who were unable to come to the office, we provided home visits.

Working as a family medicine specialist in Slovenia

After graduating from one of two Medical Faculties in Slovenia, we have 6-12 months of internship and then 4 years of training in Family medicine. Currently there are approx. 1100 family doctors in Slovenia, for a population of 2, 000 000. We have two Family Medicine departments, one in the Medical Faculty of Ljubljana and one in the Medical Faculty of Maribor. Currently family medicine in Slovenia is facing challenges with a shortage of family medicine specialist and trainees, especially in rural areas. The COVID-19 pandemic faced our healthcare system with unprecedented challenges and put a strain on our everyday practice. The lack of support in national policy makers makes the above even more difficult.

Personal View

Greetings to all readers.

This text is an article of opinion on some of the changes that the SARS-CoV 2 pandemic caused in my life, both personally and professionally.

My name is Filipe Mateus and I am in the third year of General and Family Medicine (GFM) residency, in a Family Health Unit (FHU), in the district of Setúbal, Portugal. My first year of residency was made up of huge changes in several aspects, as I came across a totally new work environment, with new colleagues and it was the beginning of what will be the specialty that I embraced and that I was fortunate to be able to choose.

In my opinion, GFM is the most beautiful and most complete medical specialty in the world: it allows us to work in different environments, to treat patients of all ages, from newborns to the elderly, pregnant women, chronically ill and even healthy patients. We can treat certain diseases, delay the evolution, sometimes inevitable, of others and still act to prevent the appearance of numerous situations. We act as doctors, but not exclusively: we are also confidants and some patients turn to us, in order to vent about the most varied subjects of their life, ask us for opinion and help regarding personal, family, work problems, among many others. We do preventive, curative and palliative medicine and much more than that. We put into practice, not only the scientific knowledge that we acquired in college, but we still have to use our skills of relationship with others; show our most human side; put ourselves in the place of the person that we have before us, who comes to us for a variety of reasons. The best way to truly understand him/her and to be able to do our best to help him/her is, precisely, to try to imagine what we would like do if we were on the opposite side of the desk. We feel extremely useful when we are able to solve a problem, help a patient, meet the expectations of those who come to us. On the other hand, we also feel frustrated when we have doubts, either diagnostic or therapeutic, difficult to solve; when we feel unable to answer questions and problems posed by patients; when we see people suffering, with serious pathologies, sometimes irreversible, in which we can do little more than comfort them, even though we know that the prognosis will not be the best. It was for these reasons and versatility that I chose GFM for my life.

I recognize that my experience is still sparse, but, in such a short time of expertise, I have already experienced countless episodes that I will remember and that marked me, for different reasons.

However, with the beginning of the second year of residency, the pandemic that currently plagues the world has also arrived: SARS-CoV 2. We were suddenly faced with an invisible enemy, like so many others that we have fought before. Nobody knew that it would spread across the planet. Nobody thought that it could affect our country in the way that it did and still does. Nobody thought that so many lives would change so dramatically in such a short time. And yet, it did; so it has been; so it will continue to be.

Until the beginning of February 2020, we heard the news of a virus that probably came from China, but nobody was sure; the symptoms were said to be mostly coughing, dyspnoea and fever, but no one was sure; it was said that it could kill, but that it would be more serious in the elderly, but no one was sure either; it first appeared in Asia and, as days went by, cases were being reported in different countries, but nobody was sure that it would spread in such a short period of time. However, it did.

How does this change the life of an GFM resident?

Let's start from the beginning: the unknown.

I think that all animal species are afraid of the unknown. Human beings are not an exception. The unknown is associated with insecurity, uncertainty, fear of possible consequences or complications that may arise. SARS-CoV 2 represents all of this: the symptoms it caused were first unknown, as well as some of the possible complications that it could cause. And there is still much to discover today. One of the aspects that I most feared was the fact that there could be infected people who were totally asymptomatic, but who could be carriers of the virus: a completely invisible enemy.

Personally, I recognize that at the beginning I felt some insecurity, as I was at the frontline of the battle against Covid-19, in a country where the lack of protective material in Primary Health Care was an issue. The news was showing, each day, that the numbers of people infected and killed by SARS-CoV 2 were progressively increasing. However, I quickly realized that the greatest danger would not probably be for me, for I am young and healthy, but for the people I dealt with on a daily basis: patients, wife, other family and friends.

The plan of action was different from Health Centre to Health Centre and from hospital to hospital. At the FHU where I work, I can say that the change was sudden and occurred on the third weekend in March 2020 (March 14th and 15th, 2020). Until then, we were making appointments at a normal pace: General Practice, Acute Illness, Pregnancy Surveillance, Family Planning, Diabetics and Child Health Surveillance; the professionals at my FHU got along relatively well, had lunch together. At home, I had the routine of washing my hands on arrival and nothing else. That weekend, everything changed...

In the following week, the number of infected and deaths caused by this new Coronavirus increased exponentially, insecurity among professionals grew and the fear was enormous among many patients. The first major change was the cancelling of appointments: we only kept appointments of Acute Illness, Pregnancy Surveillance and some Child Health Surveillance (at the ages of vaccination). The secretaries were busier than before and many doctors, myself included, chose to be the ones to call the patients to cancel the appointments. We took the opportunity to talk a little with people, ask if they needed prescriptions and gave isolation recommendations for everyone. We did not do teleconsultations yet. As for the few face-to-face appointments kept, mentioned above, many people would skip them and a large part of those who attended, were afraid and some did not even want to sit down. The fear was real. Of course, there were also those who didn't care and who kept their daily lives practically unchanged. This group was mainly constituted by some elderly people.

Another change was the lack of material: we had surgical masks, but very few FFP-2. I have always been of the opinion that it is not up to me to buy any type of protective material, in addition to the white coat, which, more than personal protective material, I consider as a work uniform. So I used the available masks. However, there were many professionals who bought FFP-2 masks with their own money. There were also those who bought themselves acrylic barriers for their offices and also for the FHU secretariat. Regarding disposable gowns, it was decided that they should only be used for Acute Illness or Child Health Surveillance, due to their scarcity.

Almost simultaneously, we reduced working hours to 30 hours a week, instead of 40 hours and started working in shifts, from 8 am to 2 pm and from 2 pm to 8 pm, with "mirror teams", between doctors, nurses and secretaries, with two goals: to have telephones available for all doctors, since only three offices have telephones that make calls to the outside and, mainly, to avoid contacting with the other team, so that, in case of infection of a person, only half of the professionals would be exposed. Moreover, there were elements that started to have lunch at home and a maximum of three elements were imposed simultaneously in the cafeteria. Gradually, teleconsultations also started to increase and replaced most face-to-face appointments, sometimes with some obvious limitations. This way, we tried to attend to the other problems and pathologies of our patients, besides the pandemic.

In terms of congresses, courses, lectures, workshops and other similar events, most were cancelled. The residents need these meetings to acquire better training and knowledge and, of course, to build our own curriculum. With almost everything cancelled, it will clearly impact our training, to a certain extent.

In addition, as of mid-March, all speciality internships at the Garcia de Orta Hospital, in Almada, were cancelled (the hospital for the residents of the Almada-Seixal Group of Health Centres). Therefore, me and many colleagues, will have to do some of these internships in 2021.

Almost daily, there were new guidelines and protocols. There were more questions than answers and they seemed to increase each day. All of this created great uncertainty in the professionals' day-to-day lives.

We also started prescribing Covid tests for suspected patients. In this region of Portugal, there were few laboratories that performed the tests and there was a long waiting time, up to more than 20 days in some cases, namely during the month of April (if a suspected person was, indeed, infected, he/she would risk being already cured when he/she was tested). After a few weeks, some more laboratories started to develop in Almada and in Seixal, which helped to reduce the waiting time.

Then, the Trace COVID® platform was created: in my opinion, an excellent idea, which was improved, as time passed. In the beginning, each doctor should call, every day, all infected or suspected patients from his/her patient list and update the information on the platform: assess symptomatic evolution; alert for signs that should motivate calling for emergency; provide laboratories' phone numbers, which the patient should call to schedule the test; provide the contact of the call centre, for the patient to call in case of any disease-related doubts; do the appropriate follow-up, taking into account the number of days with symptoms and order the test of cure. Initially, each patient needed to have two consecutive tests with negative results, but, at a later stage, only one started being required. As the platform evolved, changes emerged and we stopped calling all patients daily, because it did not make sense, on the one hand, since there were stable people and others who were asymptomatic and, on the other hand, because the number of suspects and/or infected began to increase in such a way that it was becoming unaffordable to do such work. From then on, each doctor stipulated the frequency of calls for each patient, adapting to each one's needs.

There was also a task to be performed, which represented one of the biggest changes due to the pandemic: screening of patients at the entrance of the FHU. In other regions of Portugal, this screening was done by security guards, secretaries, nurses and doctors. In our case, it was, from the beginning, provided exclusively by doctors, despite the initial indications that it could be done by doctors or nurses. The goal was to control the number of patients within the FHU, particularly in the waiting room, which, due to its small size, required the maximum number of patients to be six. In addition, the doctor at the door made a short medical history summary concerning the situation of each person who went to the FHU to an appointment of Acute Illness, to assess whether they really needed to be seen by a doctor, or whether the problem could be solved by teleconsultation; in this way, many face-to-face appointments were avoided, with identical therapeutic success. If, at the beginning, screening was a smooth job, due to the little scheduling of patients, as soon as some patients started to be less afraid of the pandemic, the affluence gradually increased and soon became an extremely tiring job, almost purely administrative, in which some of the questions most frequently asked by us were: “What doctor do you have an appointment with? You may come in"; “Do you want to order prescriptions? Please fill in this paper”; “Do you want to ask doctor X for an appointment? Yes, sir, it is noted”. Big gatherings started occurring outside; the needless reasons for appointments returned by some patients and the “heroes” of the beginning of the pandemic, as health professionals were nicknamed, quickly stopped being called like that and soon began some verbal threats from some patients, including insults to doctors, unjustified complaints, among many other things, that discourage professionals. The lack of recognition of the extra work provided, both by the patients and by the Government, increased the climate of dissatisfaction and rapid wear and tear of the professionals. The lack of compensation of any kind and the rude and unreasonable comments of various elements of the Government regarding the actions of doctors and other health professionals, increased this fatigue and weakened the mental health of professionals, some of whom are striding towards burnout.

Gradually, we restarted Child Health Surveillance for all ages; then we reintroduced appointments with diabetic patients. Only at a later stage, already in July 2020, did we start to assist patients with all other pathologies.

In these months, many people with chronic or even acute pathologies did not go to Primary Health Care, which contributed to the worsening of numerous situations. In addition, we found that many people decompensated their chronic pathologies, especially diabetes, high blood pressure, dyslipidaemia, heart failure, increased number and severity of anxiety and depression. This was due to the fact that many people are more confined to their home, with reduced physical activity, worse eating habits, social isolation and, in some cases, lack of chronic medication, for fear of going to get it at the pharmacy.

I can say that I held appointments with people who came only to talk about situations of their life and how they were afraid, for them and their families; I saw people with dependents, who had become unemployed; I saw people whose companies went into a lay-off regime, for which they received only 2/3 of their salary, and who claimed that it was not enough; I saw people in lay-off, but whose employers forced them to work, because they allegedly were not able to pay the 1/3 of the salary that was due to them (illegal situation); I saw people asking us to get the support of a social worker, due to the impossibility of doing their jobs: from marketers, taxi drivers, Uber drivers,

shopkeepers, cafe owners, supposedly on the verge of bankruptcy, among many other cases. I also saw people who were desperately waiting for a surgery, which would now be postponed for an uncertain time; I saw cancer patients stop having some treatments, which would be extremely urgent; I saw relatives of critically ill patients, cancer patients and others, who were no longer able to be with them on a daily basis and give them support and comfort, due to social isolation measures; I saw people complaining that they had family members who had died without Covid, but because of Covid, especially people who had a father or mother, who lived alone, but who went to visit practically every day and with whom they talked and spent time together, but, due to social isolation, they had stopped doing that, which may have contributed to the sudden deterioration of the physical and psychological state of that person; I saw desperate parents, when the Government ordered the people to return to work, but the kindergartens remained closed. To sum up, I saw a lot of very complicated situations, I realized that this virus completely ruined the lives of several people and that support and interpersonal relationships will take a long time to get back to what they were.

In fact, no health system in the any country was prepared for such a situation.

From a personal point of view, a lot has also changed: I started wearing surgical uniforms, instead of a white coat at work. I established, with my wife, that, being at the front of the battle, making appointments on a daily basis to people who may be asymptomatic carriers, as soon as I got home, I would leave my shoes at the door, leave my clothes at the entrance until the next day and immediately go to the shower without touching anything.

Another situation that suddenly changed was the vacation issue. In 2020, my wife and I had chosen to take 3 weeks of vacation in April and had already booked everything. Needless to say, it did not happen.

In addition, relations with other family members and friends also changed: I spent several months without seeing my parents, in-laws, grandparents, brother, brother-in-law, uncles, cousins and friends, except through social networks, which helped to appease the homesickness. When I finally came back to be with these people, I always did it in small groups at a time, without close greetings and keeping a distance. We lost those gestures of close contact that is so characteristic of the people of Southern Europe and we do not know when we will be able to be completely at ease again.

A lot of things have changed with the pandemic, mostly for the worse. So, I finish as I started, saying that I chose GFM, because it is the most beautiful medical specialty; but this is not the GFM I chose. Right now, we have all the work we had before, plus teleconsultations and Covid-related work; e-mails from directorates and patients have never been as numerous as now and the disinvestment in the National Health System continues, leaving us, health professionals, almost powerless, watching its degradation, which will culminate, almost inevitably, with its unfortunate fall, unless drastic measures are taken, for the benefit of all professionals and patients.

We hope to see the end of the pandemic soon and that new winds of change come with it…..

News from EURIPA

Annual General Meeting

This year's Annual General Meeting will take place during the 10th EURIPA Rural Health Forum. We are hoping that we will be in Siedlce but, if not, it will have to be virtual. All EURIPA Members are welcome to join us.

It will be an important meeting as Jean Pierre Jacquet will step down as President. Jean Pierre has been President since 2016 but will continue as Immediate Past president for a further year. As this is the last Grapevine before the Annual General Meeting I would like to take this opportunity on behalf of all our EURIPA colleagues to thank Jean Pierre for his huge contribution to EURIPA. EURIPA had a few turbulent years and Jean Pierre has brought stability and new ideas to EURIPA. Thank you Jean Pierre.

Paperwork for the Annual General Meeting will be circulated to Members in early September – which isn't far away!!

Charter for Rural Practice

The original Charter was published in 1997 in the very early days of EURIPA and is now undergoing a review. The purpose of the review is to update the Charter, to respond to the challenges that rural practice has faced and also to include newer evidence and new concepts that have been introduced such as Rural Proofing and Social Prescribing.

We'll update you on progress in the next Grapevine.

WONCA Europe

The 26th WONCA Europe conference took place virtually in early July. EURIPA hosted two live Special Interest Sessions:

Rural Practice in a Post-Covid World

Developing the Rural Workforce

If you were registered for the conference you can still access the content of the conference. And even if you missed the conference, you can still register and have access to great content about COVID-19, cardiovascular risk management, respiratory diseases, cancer and elderly care and many other topics.

You can check it out at your own convenience and earn up to 20 CME credits! It is open until October 10th 2021!

The web site is www.woncaeurope2021.org

Publications

Our Journal
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.** 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!

The Journal of Rural and Remote Health has also made a statement about Researching 'others':

> "The medical literature is replete with examples of studies about groups in which researchers from the 'outside' present and discuss their findings without any reflection of the views of those who have been researched. RRH has taken the decision that an article about people in any country or region without authors from that country or region will not be published and a recent RRH article provides an excellent example of how communities can be meaningfully engaged in research. This Editorial is a call to the international health science community to develop and adopt research and publication policies so that there is "nothing about us without us".

As well as the **International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy** (http://www.rrh.org.au/euro/defaultnew.aspof) you can also keep up to date with:

Family Medicine and Primary Care Review
https://www.termedia.pl/Journal/Family_Medicine_amp_Primary_Care_Review-95

The European Journal of General Practice: http://www.tandfonline.com/toc/igen20/current

The #EURIPA Rural Health Journal, published twice a week:
http://paper.li/EURIPA_EURIPA/1445814103#/

And, WONCA **e-news** at http://www.globalfamilydoctor.com/News.aspx

Recent publications
Journal of Rural and Remote Health
Clinical case report
The use of telemedicine to assess a paediatric patient with arrhythmia presenting to a remote community coronavirus assessment centre
A 5-year-old girl presented to the coronavirus assessment centre on a remote Scottish island with symptoms consistent with COVID-19, including an irregular pulse. To minimise potential spread of coronavirus in the healthcare setting, a portable ECG device was immediately delivered to the patient with the ECG tracing being sent electronically to the cardiologist, who was then able to communicate a diagnosis to the parents within 2 hours of the initial contact.
Shepherd N, Wilson P.
https://www.rrh.org.au/journal/article/6166

Short communication

Waterborne outbreak in a rural area in Greece during the COVID-19 pandemic: contribution of community pharmacies

This Short Communication reports on the first investigation of a waterborne outbreak of Escherichia coli in Greece performed with the collaboration of a local pharmacy. The COVID-19 pandemic favoured the use of alternative resources and channels of communication with the local population that can also be used in the future, especially in remote areas of the country.

Mellou K, Sideroglou T, Kefaloudi C, Tryfinopoulou K, Chrysostomou A, Mandilara G, Pavlaki M, Maltezou HC.

https://www.rrh.org.au/journal/article/6630

Personal views

A year as a prehospital physician in the Outer Hebrides, Scotland

Responding in the Scottish Outer Hebrides presents a number of challenges above and beyond standard prehospital work owing to its remoteness and the limited resources available on the island. As a prehospital physician, it is important to have an excellent working relationship with all local emergency services and with the wider community. One's emotional resilience will be tested when responding and living in a rural setting, when you are far less removed from the tragedies you encounter.

Mallinson T.

https://www.rrh.org.au/journal/article/6115

Erasmus medical students' experience and primary care on Crete island, Greece: narrative views and reflections

International electives and exchange programs for medical students have sometimes been criticized as providing little benefit for host institutions. This personal view is offered as an example of how international electives may contribute a helpful comparative perspective on a local healthcare systems, in this case, primary care.

Wieneke A, Iselvmo E, Kortsidakis E, Anastasiou F, Vasilopoulos T, Lionis CD, Symvoulakis E.

https://www.rrh.org.au/journal/article/6277

Project report

Analysis of the use of a mobile simulation unit using the principles of a managed educational network

Delivering safe, reliable quality health care involves ensuring the workforce has access to the right training at the right time wherever healthcare workers are practising, a particular challenge for rural and remote health practitioners. This paper shares the development of a national Managed Educational Network for clinical skills and how its principles were used to analyse the performance of a mobile simulation delivery unit.

Baker A, Hardie L, Somerville S, Ker J.

https://www.rrh.org.au/journal/article/5670

Social Innovations Journal
To a Blueprint for Rural Health
Chater, A. B. (2021).. Social Innovations Journal, 8. Retrieved from
https://socialinnovationsjournal.com/index.php/sij/article/view/1098

Family Medicine and Primary care Review
Prevalence of chronic obstructive pulmonary disease in general practice patients in the Central Region of Portugal
Jéssica Andreia Ricardo, José Augusto Simões, Luiz Miguel Santiago
https://www.termedia.pl/Prevalence-of-chronic-obstructive-pulmonary-disease-in-general-practice-patients-in-the-Central-Region-of-Portugal,95,44012,0,1.html

EJGP
Future-proofing the primary care workforce: A qualitative study of home visits by emergency care practitioners in the UK
Robert Oliver Barker, Rachel Stocker, Siân Russell & Barbara Hanratty
https://www.tandfonline.com/doi/full/10.1080/13814788.2021.1909565

Underdiagnosis, false diagnosis and treatment of COPD in a selected population in Northern Greece
Dionisios Spyratos, Diamantis Chloros, Dionisia Michalopoulou, Ioanna Tsiouprou, Konstantinos Christoglou & Lazaros Sichletidis
https://www.tandfonline.com/toc/igen20/current

Forthcoming Events

18th WONCA World Rural Health Conference
Again Rural WONCA is partnering with WHO to deliver a webinar series on Rural Health Equity. Two webinars have taken place following the conference virtual opening ceremony on 9th July:
Lesson in rural proofing of health policies, strategies , plans and programmes
Indigenous Rural Health in Africa
The next webinar will take place on October 8th 2021 on **African Women in Rural Health**
The links to the webinars can be found at:
https://ruralwonca.org/18th-wonca-world-rural-health-conference/

EFPC 2021 Conference Bergen Primary and long-term care in the age of changing boundaries: Policy, practice and imagination.
5th – 7th September 2021, Bergen – now **virtual**
More information at: http://euprimarycare.org/efpc-2021-bergen-conference-5-7-september-2021/

10th EURIPA Rural Health Forum: Understanding our patients – working closely together
23rd – 25th September 2021, Siedlce Poland and virtual as a hybrid conference
Call for abstracts closes on **10th August**
Click on www.euripaforum2021.eu for more information

Forthcoming Events cont'd

3rd EURACT Educational Conference - postponed to autumn 2022

EURACT Autumn symposium - online
13th October 2021, 17:00 CEST
More details to follow

93rd EGPRN meeting: Fostering clinical research in general practice and family medicine
14th – 17th October, Halle, Germany
More information at: https://meeting.egprn.org

WONCA World Conference 2020, now WONCA World Conference 2021 – Together, we own the Future
25th to 28th November 2021, Abu Dhabi, UAE – now **virtual**
More information at: http://wonca2021.com

And, in 2022

The WONCA World Rural Health conference "Improving Health, Empowering Communities"
17th – 20th June 2022, University of Limerick, Ireland
More information at: www.woncarhc2022.com

27th WONCA Europe conference: Innovating family medicine together for a sustainable future
28th June – 1st July 2022, London
More information to follow at: http://woncaeurope2022.org

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

Future Contributions to Grapevine

The next issue of the Grapevine will be Autumn 2021; contributions are welcome by the end of September for publication in October. Reminders for contributions will be circulated on the mailing list and announced at the web site.

If you are interested in contributing to the next edition of Grapevine please get in touch with the Executive Secretary, Jane Randall-Smith at Jane@montgomery-powys.co.uk . Please think about 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 new contributors are always welcome.

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