The Grapevine

2018-19

A quick look in the rear-view mirror, what happened in EURIPA in 2018 ?

A new membership scheme adopted, wide attendance and participation in WONCA Europe Krakow 2018, success for our 8th forum in Israel, thanks to the support and hospitality of the Israeli society of general medicine.

We strengthened links with other networks of WONCA Europe and with WONCA Europe itself and our involvement with WONCA World and the WWPRP has grown.

What are our wishes for 2019?

A great success for the 9th forum in the Azores in collaboration with APMGF (see page 9), good participation at WONCA Europe in Bratislava, involvement in new projects and completion of our existing research projects, publications, an increase in the number of individual and institutional members.

Further development of the IAB to involve more countries in EURIPA and to develop our profile in individual countries by possibly regional or national rural networks.

All this is so that the voice of EURIPA is heard and influential in supporting rural practitioners and the well-being of rural populations.

Jean Pierre Jacquet
President EURIPA

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Maale Hachamisha, Israel; November 14th – 16th 2018

This edition of the Grapevine is the first since our meeting in Israel, which already seems a long time ago and we report back to you as we begin planning for the 9th EURIPA Rural Health Forum .

Hello and best wishes to all EURIPA members and colleagues. Through the Grapevine, please allow me to take this opportunity to declare how much of a privilege it has been to host the 8th Forum on behalf of the EURIPA network of rural doctors.

Firstly, I feel compelled to mention how fortunate it must be for all those European rural inhabitants to have you as their doctors. If the colleagues who came together for this meeting (about 70 of you) reflect a cross- section of the current primary caregivers in your respective countries, it must be said that such attentive and motivated professionals must definitely deliver the most optimal care possible.

At the outset of the meeting in the opening session, I mentioned that sometimes we become so preoccupied with disparities, insufficiencies and gaps between needs and supply that we forget how privileged we really are. This was shown clearly by a physician named Nikola Lilic from New Zealand who, after returning from a mission in sub-Saharan Africa, recently published in the New England Journal her experience[1]:

> "…Then he comes in: a 12-year old waiting all day, they sit down smiling. “Muli bwanji,” the father says.“Muli bwanji.” I curve my lips around the foreign words, semi skilled in forming them at last.The interpreter does the rest forme. “Where have you come from? ”They name a place, but I don’t recognize it. “How far away is that?” “Four-hour walk.” “Oh. How did you get here?” The boy looks at his father, then at me. “We walked.”
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> I swallow. Hard. I force a smile, and my cheeks burn at the thought of leaving the clinic for a drink. “What’s been the matter?” “I get breathless when I play soccer,” the boy says, still smiling. The walk that morning hadn’t been too bad in terms of breathing, he tells me, but when he exerts himself, breathing becomes very difficult. It has been coming on for a couple of years and worsening over time. Easy, I think: it’s got to be asthma. I’ll get them inhalers, and they’ll be on their way. I ask the boy to hop up on the examination table, and I pretend we have privacy by pulling makeshift curtains around him. I get my stethoscope out, tap it, and then pop it onto his chest. Clear breath sounds. No hint of wheeze.
>
> I place it on his left parasternum, and the culprit blasts out of the med-school textbooks, through the bell and earpieces, into my ears. A diastolic murmur with a soft presystolic accentuation. Mitral stenosis. Rheumatic heart disease, no doubt. For a second, I smile, proud that I recognized the diagnosis, and I even call the other whitecoats to come have a listen — none of us have heard a mitral stenosis murmur before. Then, as the sun sets outside the window, the thought dawns on me: This kid is doomed. Advanced rheumatic heart disease in sub-Saharan Africa. Translated into normal English, that means “no hope.” The drum in my chest thumps, and I manage to mutter that the boy can go take a seat next to his dad. He jumps up, smiles, and runs back to safety. I stand behind the curtain, in pretend-privacy, and attempt to settle the sympathetic overdrive coursing through me. The sole attending physician in the hospital, serving 2 million people, comes along and

> congratulates me on identifying the diagnosis. She offers advice that will not change the prognosis and then leaves to deal with a ward bursting with sick children…"

She concludes after citing many of the petty matters we are overwhelmed with in westernised medical practice in politics, economics and priorities to state:

> "It would also go a long way toward explaining why a 12-yearold boy has to walk 4 hours to hear that nothing can be done for his preventable and treatable disease."

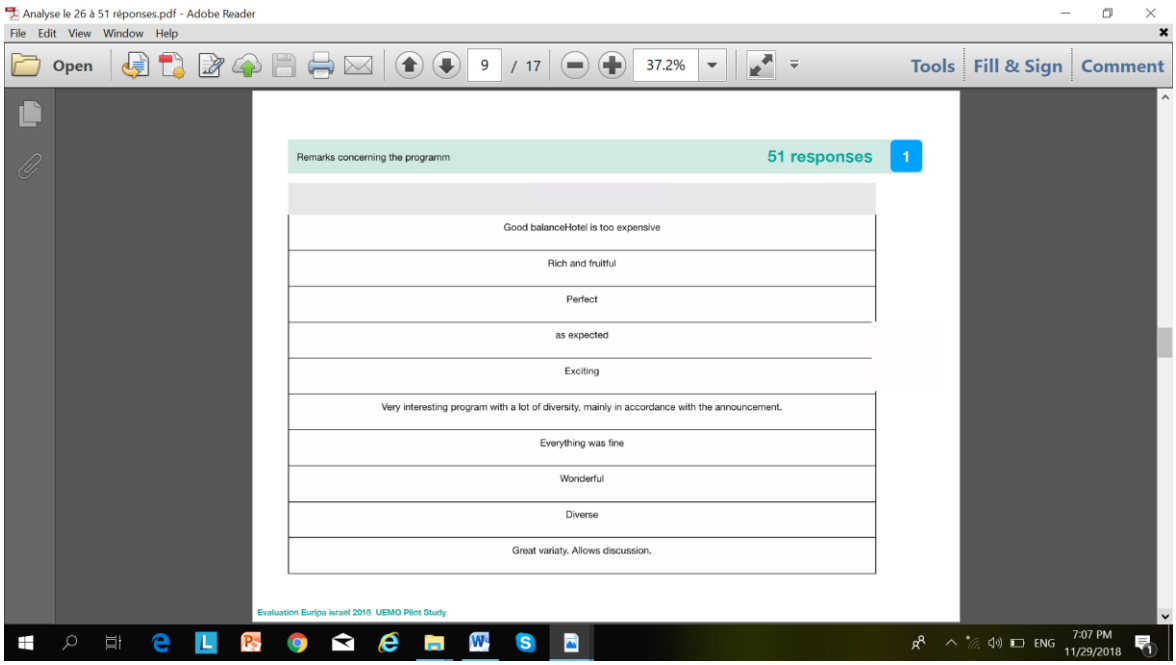
We must never forget that basically, each and every one of us are lucky enough to practice in far more advantageous conditions and yet, we are still a minority of the population of this earth.

I extend my thanks to all those that really did put in the hard work and deserve credit for their perseverance in achieving a successful conference. As the contributors were many, I will ask forgiveness for not thanking you all personally, including both the scientific and organizing committees. Nevertheless the brunt of the burden fell on the shoulders of Jane Randall –Smith, Burak Usgurlu, Dr. Ferdinando Petrazzuoli and, above all, Prof. Sholomo Vinker who never refused at any point to undertake any task necessary. Our President Prof. Jean- Pierre Jacquet, also undertook all the required activities with no less dedication. In fact, he addressed all the participants of the Israeli Annual Meeting of Rural and Frontier Practitioners (that took place on Wednesday morning prior to the conference) sharing his reflections on inequalities in rural health care. Last but not least, we owe a tremendous thanks to Dr. Michal Shani the president of the Israel Society of Family Physicians and the Society itself for covering all the necessary expenses and whose sponsorship allowed the Forum to proceed smoothly. The support was most appreciated.

We were all honoured by the presence of the President of WONCA Europe and new 'president elect' of World WONCA: Dr. Anna Stavdal, who spoke at the opening session and at the closing sessions. In the interim she found time to engage with us all and actively participated in the Forum. Anna also gave an address at the end of the EURIPA Annual Meeting which followed the closing ceremony of the Forum.

From left to right : Michal Shani - president of Israel Association of Family Physicians; Anna Stavdal – President of WONCA Europe; Sody Naimer- chairman of 8th Rural Health Forum of EURIPA and Shlomo Vinker- chairman of Scientific Committee of 8th Rural Health Forum of EURIPA

Delegates at the Forum were requested to provide formal feedback to test out the accreditation system being developed by UEMO for scientific conferences. President Jean- Pierre Jacquet has been involved in the development of this approach. Responses received show that of 51 attendees, 97% rated the organisation 4.5 on a 1-5 scale. The vast majority reported that the programme was as expected, the conflicts of interest were declared and satisfaction overall was high. Here are the first 2 pages of the remarks received:



Please be assured that the anonymous responses received were completely free of any coercion or peer pressure.

Despite the difficult logistics of the hands-on workshops with top quality ultrasound machines, we were inspired by the teaching sessions lead by Drs. Mihai Iacob, Alina Popescu from Romania. The invitation to visit primary care clinics in the area was well received. The visits, which included a detailed "tour" of our electronic medical records system seemed, at least for the group I escorted, almost not long enough (despite almost 2 hours long). The questions we were posed were very focused and stimulating.

The rich programme fulfilled our expectations. As usual the mutual nurturing of ideas, interaction and sharing of experiences through discussion of all topics served to whet our appetites for future meetings again.

Hoping to meet everyone again with an even larger and more diverse group of doctors at the next meeting in Portugal. Have a wonderful healthy and safe winter.

Sody Naimer
Chairman of 8th Rural Health Forum of EURIPA

[1] *Lilic N. Murmurs of Politics and Economics. N Engl J Med 2018:379;2012-3.*

Maale Hachamisha, Israel; November 14th – 16th 2018

Report on the poster sessions

As in previous years EURIPA ran poster sessions during the Forum. Ferdinando Petrazzuoli, Co-Chair of the Scientific Committee sent this report:

The poster presentation were split into two parallel sessions. Overall 8 posters were presented, 5 in session 1 and three in session 2. The chairs poster Session 1 were Donata KURPAS and Ferdinando Petrazzuoli. The title of the first poster was *Acute Reasons: The Chronic Issue of a Rural Health Unit - Research Study* and was presented by Tiago Sanches, Vanda Godinho, Helena Sousa and Ines Madanelo. It was an observational, retrospective study aimed at exploring the reasons for encounter in Portuguese primary care. The second poster was *Dosage adequacy of new oral anticoagulants in atrial fibrillation: continuous quality improvement"* by Ines Madanelo, Tiago Sanches, Lígia Martins, Helena Sousa. It was aimed at improving the dosage suitability of the new oral anticoagulants in the atrial fibrillation. The third poster *Leg ulcers - a problem in a rural ageing community* by Ines Madanelo, Tiago Sanches, Raquel Pereira, Bruno Barbosa, Rita Loureiro, André Tojal illustrated how telemedicine is a way of interaction between levels of health care with proven efficiency. The fourth poster *Multimorbidity, Polypharmacy, adherence and medical empathy* by Ines Madanelo, Marisa Marques, Luiz Santiago explored the level of adherence of the elderly, affected by multimorbidity and on polytherapy. The fifth poster *When the problem jumps to the sight* was a case report by Vanda Godinho, Ines Madanelo, Filipa Vicente, Tiago Sanches, Helena Sousa. It was a sad story which showed that even in current days breast cancer could be detected very late at an advanced stage, in patients living in poor conditions in a remote and rural areas.

The chairs of poster session 2 we Berit Hansen, and Oleg Kravtchenko. The first poster of this session *A positive FOB test. And what is next?* by Beata Blahova, Katarina Dostalova, Jana Bendova and Michaela Machacova showed that although the fecal occult blood test screening is nowadays quite a popular test and for sure a big step forwards in colorectal cancer screening, we still need to better clarify to the patients its real meaning and what are the next steps. The second poster *An analysis of correlation between economic, and psychosocial factors as well as factors contributing to health in the adult population residing in the post PGR (State Agricultural Farm) areas* by Bożena Mroczek, Anna Grzywacz, Joanna Chmielowiec, Krzysztof Chmielowiec, Aleksandra Suchanecka, Grzegorz Trybek and Iwona Małecka was aimed at assessing the quality of life of the inhabitants of a rural Polish area after retirement, taking into account their economic situation and health. The last poster in Session 2 was *Quality Gap at rural polyclinics based on patient experience assessment* by Maciej Prusaczyk, Artur Prusaczyk, Paweł Żuk, Sylwia Szafraniec-Burylo and Grzegorz Bukato was aimed at checking, if healthcare providers tend to meet patients' expectations, if they are not motivated by any financial incentives. A comparison between integrated care organisation, such as Medical Diagnostic Centre, versus an old-fashioned one form the patient perspective was also presented.

Both the poster sessions were interesting and highly interactive with plenty of questions to the poster presenters.

Watch out for the call for abstracts for the next EURIPA Forum (see page 9)

Maale Hachamisha, Israel; November 14th – 16th 2018

Each year at the WONCA Europe conference EURIPA holds a lottery to offer one free registration at the Rural Health Forum that will take place later that year. The winner of the free place at the Forum in Israel, from WONCA Europe conference in Krakow was Ines Madanelo from Portugal and she has written of her impressions of attending the Forum.

Israel, the birth of my faith in Rural Health improvement

Choosing to do residence in a rural context reveals clinical puzzles of difficult resolution.
In the rural context, the family doctor and his team are often the only accessible health resource, leading to the centralization of care.

Vouzela (Portugal) - the village where my health care centre is

Everything matters and the holistic approach of the patient and his problems is much more meticulous, necessary and frequent.
Thus, the autonomy in the medical exercise and the comprehensiveness of knowledge and competences is naturally required. We can call rural doctor as MacGuyver.

Nevertheless, this professional profile needs learning and training.
With this purpose, I decided to go to my first Rural Health Forum, promoted by EURIPA.
It took place in Israel at Maale Hachamisha, near Jerusalem.
The programme featured many workshops, from ultrasound technique to domestic violence.

It also has an amazing guided trip to a kibutz village, where we visited the health care center, and understood how the health care system work in Israel and how clinical data is managed.

Children's corner in the Kibbutz Health care

We also got to know the experience of people that work in remote and isolated areas.

As a young rural doctor, my favourite accomplishment was the symbiosis between different doctors from different places, going through similar problems. We discussed many global issues, learning from some local strategies, p.e. prescription and house calls.

Scientific work presentation

I was surprised but also sad since we, young rural doctors, were almost absent.
Are we ignorant of our own ignorance? Or do we ignore these formative events?

As Dr. Anna Stavdal said there, “advocacy” should be everywhere, in almost every task that belongs to our agenda. Having that in mind, let’s start from our inner side: ourselves as doctors. Let´s spread the message. Let’s improve our knowledge and skills. Let’s increase our bonds in health care, getting Family Medicine (and Rural Pratice) stronger and united. That’s the only way to recognise rural heath needs and demands, and for once meet the equity population needs. This is why I appeal on behalf of our patients to improve health care: come to EURIPA meetings, join EURIPA’s forum, join EURIPA as a member and more important than everything: GO RURAL!

We also had a number of new attendees in Israel. Kerstin Gardner from Denmark (but originally came from Sweden in 1983) came with a colleague. Kerstin had some important feedback for EURIPA that we will need to address:

I have been working here in Nysted for 13 years and have had different colleagues. About 1,5 year ago Christina Svanholm became my new partner and that has been very, very good. In September- I think it was - she wrote an sms and asked, if I wanted to go with her to Jerusalem, where she should hold a speech at a conference - and of course I said yes! On our way to Jerusalem she told me, that she was very fond of EURIPA and told me a little about it.

During all these years in Denmark I have had the medical weekly paper from both Denmark and Sweden and I have never, ever heard about EURIPA. And that was what I said that day where we were together and everybody should say something. There are about 8 million people in Sweden and there was only one at the EURIPA conference in Israel. The Italian member said something the same but he said: we are 16 million in Italy and I am the only one here!!! It was so thrilling to be in Israel that I couldn’t join the conference all the time - I just had to go and see as much as possible - but when I did, I noticed that the style was very informal and that it was easy to be a member of the Forum - there were not those high horses that looked down at you. It was friendly and you felt welcome.

Another first time attendee, Alain Geller from France, told us:

I registered at the 8th EURIPA 2018 forum in Israel without « a priori ». From the first oral presentations, I was particularly interested in the fruitful exchanges between speakers and participants.

At most congresses privileged research studies are presented at the expense of presentations regarding medical care.

The doctor "medicus" is the one who cares; themes and workshops where perfectly suitable to this medicine that "cares", and for us as the primary care actors.

I really enjoyed this Forum where we had scientific knowledge, sharing of experiences, and in a friendly atmosphere with excellent organisation.

During the Forum the EURIPA International Advisory Board ran a workshop:

Vulnerable populations – how they are addressed in rural medicine

Short presentations were given on the current situation in Poland, Romania, Israel, Italy Germany, UK, Czech Republic, Slovakia, and France. The IAB representatives identified their vulnerable populations, the current challenges, the urgent issues and examples of good practice.

Each country has its own health system and its own specific challenges but in terms of the challenges facing our vulnerable populations there was a coherence to the issues that need to be addressed.

Over all there was remarkable consensus as to who are the vulnerable populations (frail elderly, isolated and poorly educated young people for example) but different countries had their own particular vulnerable populations for example the Roma in Romania, migrants in Germany. Border populations are often marginalised.

Lack of manpower, access to specialist services including cancer services and mental health services, continuity of care and carer, barriers to prescribing.

The exodus of young people to find work in more urban settings and the impact on their rural communities was a common theme.

A priorities clearly identified were the need to prevent hospitalisation and the resulting institutionalisation of the elderly; increased activity by social services, multi-professional care teams, mobile services, telemedicine. Political will to address these rural challenges will be essential.

You can find the presentations on the EURIPA web site at:

http://euripa.woncaeurope.org/sites/euripa/files/documents/EURIPA%20IAB%20workshop%202018%20Israel%20%20Final%20.pdf

There will be the opportunity to consider these issues further and the potential solutions in the next Forum - see page 9

And, we are now looking forward to the 9th EURIPA Rural Health Forum

Whilst we were in Israel the next EURIPA Rural Health Forum was announced. From 6th to 9th November 2019, the Azores (São Miguel) will host the IX EURIPA Rural Health Forum, promoted by EURIPA and the Portuguese National Family Medicine Organization - APMGF.

The theme will be:

Isolation and Rural Medicine: Innovation solutions for developing local health services

This scientific initiative aims to develop rural primary health care.

IX EURIPA Rural Health Forum promoting photo (taken in Israel)

Why should I join IX EURIPA Rural Health Forum, in Azores?

The scientific programme is being built to meet clinical and scientific frailties and needs of rural health professionals.

Due to the global burden of ageing, particularly felt in rural areas thanks to migration of the youth to big cities, we need to improve our knowledge and skills in polypharmacy and multimorbidity. Physician house calls (organization and tasks) will also be approached, as an important tool to address the previous mentioned issues.

Deprescribing, as the medical challenge of the new century, is another focus of concern.
We will offer national and international keynote speakers.

We will have workshops on leg ulcers, psychiatric, respiratory and gynaecological issues, through interactive methodologies (developing and improving medical skills).

It's important to note that this scientific event is not only for rural practitioners. It's for every family doctor that has been, is or (maybe) will be working in the context!

Why should I visit Azores?

In the middle of the Atlantic, the Azores islands are made of isolated places caught between different shade of green hills, meadows and lush vegetation. The craters from several volcanos are now occupied by blue lagoons. Thanks to the heat from the volcanos, cooking is done underground. Azores is made of eye-catching contrasts.

You will see how family doctors work there, with a well prepared visit to the local clinics.

My Practice

In this edition of the Grapevine we focus on a rural practice in northern Norway, from our IAB member Marit Karlsen:

My point of view is that from Kautokeino, Norway's largest municipality in area, 10,000 square kilometers, but only 3,000 inhabitants. It is in the north, and east, part of Norway - close to both Finnish and Swedish borders.

Kautokeino center with the church (photo Pål Norvoll)

We have a stable, dry, inland climate - and very cold winters with temperatures down to - 45 Celcius.

Around minus 35 Celsius

The population of 3,000 people, where the vast majority, about 90%, are Sami - an indigenous Finno-Ugric population who are a minority in Norway. The total Sami population is about 70.000 people throughout Norway, Sweden, Finland and Russia. In Kautokeino, about 90% of the population speak the Sami language as their first language - a language in the Finnish-Ugric group, which is totally different from the Norwegian language, but recognized as one out of two official languages in Norway.

The main way of living in Kautokeino is nomadic reindeer husbandry. Kautokeino is also recognised as the «cultural capital» for the northern Sami area and the Sami college, the national Sami theatre, parts of the Sami parliament (education and language) are also sited here.

It is part of Norway's recent history - the assimilation of the Sami population where both language, culture and identity were strangled. These processes have caused deep collective wounds - and have had strong influences on the Sami society. The knowledge of this past in Norwegian Sami history is «a must know» for being a cultural competent doctor in a Sami population area.

Part of my family - traditional sami clothing

Compared to other municipalities of about the same population, Kautokeino has a quite favorable demography with relatively high birth-rates and on average a younger population.

So - how come that I was so lucky, or purposeful, to get here?

When we speak about good strategies for recruiting doctors - one strategy is that we say «catch them young» - and that was exactly what they did. I got my first job after an internship, in Kautokeino. It was actually a quite special way of recruiting as the chief medical officer of the county sent a letter to all interns in the whole county in the autumn of 2006: she asked if any of us would consider applying for a family doctor position in Kautokeino as the municipality was struggling in their recruitment work. She wrote – 'to consider it for half a year or for a year……' and so I did. I put my plans on hold to go back to Oslo, the capital, where I had planned on going for a hospital specialisation.

Now, still in Kautokeino - I stuck to my first «real job» and got my specialisation in family medicine four years ago. I got married to a Sami man and we now have 4 children who are bi-lingual, but Sami tends to be their preferred spoken language. Life doesn`t always turn out as planned - it sometimes turns out even better!

I work on my own list of patients, counting 750; in our office we have four such lists - and we are 5 doctors. Overbooked with doctors? No, not at all. This is a retain-strategy as we have a young average age, are having families and also, as part of the mandatory specialisation programme, we have to work in a hospital for one year, have to attend both mandatory, and choosable courses.

The doctors' office under the rainbow!
And left, overview of part of Kautokeino

So, instead of having random, short time substitute-doctors, we fill in the gaps ourselves. As it is too great a distance to the next municipality, we serve full after-hours service 24-7-365, and to have a «liveable» work/life balance we must be able to share this between at least 4. This is a privilege, the flexibility, and I think it must be because we (as doctors all over the world) tend to work for many and late hours. Different flexibility, easy organisation and good opportunity for doing the specialisation programme are all parts of the retain-work in our municipality - under the heading «treat them nice»

I cannot talk about working rural as a doctor without talking about the teams we work together in, with other healthcare professionals. In the daytime office we have a bioengineer working in the lab, taking blood samples, doing the in-house lab etc. We have 1,5 nurse positions and we have two secretaries.

After hours we have a nurse on demand, that is he/she works in the nursing home that is placed in the same building. We also have 3 beds for more advanced medical observations, iv-treatment and so on. These are the alternative to a hospital admittance - the hospital is 270 km away. The nearest airport 135 km away, and possibilities of getting helicopter-assistance within 45 minutes are dependent on good weather conditions.

Dressed for out of hours, possibly at -35 Celsius!

Working so far away from the hospital means that nothing bypasses you for rather a direct hospital-admittance. Starting treatment and stabilising patients, those critically ill and unstable - we prefer to have in our «acute-room» as it is much better working there while we are waiting for the helicopter - often, not so much due to bad weather - but more icing-problems of the rotors as they can not fly in to Kautokeino. We then have to work in the ambulance while going to Alta, where the we have an airport.

We cooperate very well with the doctors at the hospitals - both our local hospital, Hammerfest (270 km) and our University hospital, Tromsø (400 km)- and with AMK the emergency prehospital administration that administer and prioritises the resources un terms of planes, helicopters and ambulance-cars - we do teamwork in the range from selecting where the patient should be sent, and get advice according to treatment and procedures.

Very happy team after a (not planned) home delivery of a healthy boy.

Little patient and our nurse (with permission)

Telemedicine - do we use that? Not so much, and never in acute situations, is my experience. Pictures, of injuries, eyes (as the eye-specialists are based in Tromsø 400 km away after hours), sometimes skin rashes are what I and my colleagues mostly tend to send over for second opinions. Otherwise, the phone still is our favourite - and easy - also in 2018.

We do our best to spare patients from going unnecessarily to the hospital as it is a long journey - and then of course, we have to increase our range as doctors and in terms of lab, medical equipment and medications that we have in our office.

Of great importance is also identifying those who need a more advanced level - and to admit these.

As I said, training is crucial and every morning - we start the day with a big cup of coffee at 8 am and for a report of the last 24 hours by the doctor that has been on call. This is for learning and for information for follow-up by the other doctors.

We also work a lot with the paramedics in the ambulances - we have two ambulances based in Kautokeino. As I said, we are teams. Teams practice! We do our acute-learning practice once a month - doctors, nurses working as part of the after-hours team and the paramedic train together on different set-up scenarios. This training make us confident - in ourselves and as a co-ordinated group - and it is one of the most valuable things we do according to quality and communication skills especially in time-critical situations.

Getting "a hand" from the helicopter with anaesthesiologist in more time-critical situations.(photo Pål Norvoll)

From our monthly team-practice: demonstrating our new heart start and monitor system with doctors and paramedics

News from EURIPA

Executive Committee

At the EURIPA Annual General Meeting that took place in Israel at the end of the Rural Health Forum two new members of the Executive Committee were elected. Jean-Pierre Jacquet remains as President and the new committee is:

Jean-Pierre Jacquet,	President
Oleg Kravtchenko	Vice President
Josep Vidal Alaball	Treasurer
Sofia Ahman	Sweden
David Halata	Czech Republic
Berit Hansen	Denmark and VdGM Liaison Officer
Donata Kurpas	Poland, Chair EURIPA International Advisory Board
Enda Murphy	Ireland, link with EURACT
Ferdinando Petrazzuoli	Italy, link with EGPRN, chair of EURIPA Scientific Board
Jose Simoes	Portugal, host of IX Rural Health Forum
John Wynn-Jones	UK and World Working Party on Rural Practice

This left two vacancies and as it is possible to co-opt new members to the Executive Committee during the year a call was launched in December inviting nominations. The new co-opted members will be announced early in 2019.

EURIPA International Advisory Board

Donata Kurpas continues as the chair of the IAB. New members have also joined the International Advisory Board. The current list is on the web site:

http://euripa.woncaeurope.org/content/international-advisory-board

If your country doesn't have a representative, please get in touch. We are keen to have comprehensive representation from across Europe.

Scientific Board

Ferdinando Petrazzuoli is the chair of the Scientific Board and its members are:

Joyce Kenkre	Wales, UK
Jean-Baptiste Kern	France
Jose Simoes	Portugal

The scientific board advises EURIPA on scientific aspects of projects – research and educational.

Evaluating the impact of asynchronous telemedicine in the Catalan central Region

I have completed my PhD evaluating the impact of an asynchronous telemedicine in the Catalan central Region, a service that has been implemented in the professional´s daily clinical work since 2012

A teledermatology pilot scheme was first conducted in the city of Manresa (north of Barcelona) in the summer of 2010. The clinical success of the scheme prompted its expansion to the whole county of Bages in 2011 and to the adjacent county of Berguedà in 2012. In the teledermatology service, primary care physicians take a photograph of the lesion and attach it to the electronic medical records of the patient together with a brief clinical account. In the referral hospital, the consultant dermatologists access the electronic medical records, review the images and suggest a treatment or action plan. Next, the primary care physicians review these recommendations and call the patient to explain the results. This whole process is usually completed in less than 5 working days.

We have looked at the quantitative impact of the teledermatology service through an economic analysis comparing the teledermatology service with a conventional dermatology service. We have estimated cost savings per patient visited in the teledermatology service. To study the pattern of referrals from primary care to the teledermatology service, we have analysed the number of referrals to the conventional dermatology service after an initial referral to teledermatology and the number of visits saved. We have measured the degree of satisfaction of health professionals with the telemedicine services through a validated questionnaire.

The estimated added costs of the teledermatology service during 2016 amounted to 61,870 €. For the same period, the estimated costs of traditional outpatient dermatology services were of 113,034 €. This represents savings of 51,164 € per year. This is equivalent to a saving of 11,4€ per patient attended. Most of the savings come from a society point of view.

Although in 2016 there were more teledermatology visits than in 2015 (5.71% increase), this did not correlate with an increase in the conventional dermatology referrals, as at the contrary, they decreased 8.9%. Referrals to conventional dermatology after an initial teledermatology consultation also decreased 19.71% in 2016 compared to 2015. This effect was more pronounced in rural than in urban areas.

The validated questionnaire we distributed amongst primary care professionals showed that 2/3 of respondents rated the overall quality and the technical quality of the telemedicine consultations as good. More than 2/3 of respondents considered that telemedicine services could improve the health status of patients and wanted to keep using the services in the same way as they were using it. Nursing staff rated the overall quality of care delivered by the telemedicine services statistically significantly better that medical staff. Compared with nurses, physicians stated having more difficulties that could have affected the quality of care.

We finally concluded that the asynchronous telemedicine services in the Catalan central region are efficient as can save economic resources and enjoy a good acceptance among health professionals.

Dr Josep Vidal-Alaball

If you would like more information there are some articles from the thesis:

- Rural-urban differences in the pattern of referrals to an asynchronous teledermatology service
http://imedicalsociety.org/ojs/index.php/iam/article/view/2811

- A cost savings analysis of asynchronous teledermatology compared to face-to-face dermatology in Catalonia.
https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3464-4

As a follow up to reading this paper, Josep was asked about patient experiences of using telemedicine services. Patients seem to be very pleased and the next stage of the study will be to understand more fully the patient experience.

And from Raquel Gomez Bravo in Luxembourg:

It is my great pleasure to share with you two of the official videos of the TEDxUniversityOfLuxembourg that we have organised in the University last 26th of October 2018. We had the honoured to have among the speakers, Prof. Richard Roberts and our very active Sara Rigon (MSF).

Prof Roberts is well known around the world, he is the past president of WONCA World as you know and the and American Academy of Family Physicians (AAFP)? His talk is about "Healing by numbers: Strategies used in manufacturing are now being applied to healthcare: assembly line production, protocol-driven care, big data. These strategies promise improved population health at lower cost. Yet, linear production models can do great harm in healthcare. This is especially true in primary care where most care is obtained and where custom solutions must be developed for each patient." Here is the link:

https://www.youtube.com/watch?v=tr2sAvKl_qk&fbclid=IwAR34At5xh_kKL4GdtyQNlq2MOX08-8JU5zveZ2wz7BUIMYBC9zuURiAP6FQ

Sara Rigon is a very enthusiastic and committed colleague, who is a very active member of our Family Violence group and the Equally Different Group of VdGM . She is speaking about Virginity testing and her experience working with MSF in different parts of the world (Haiti, Irak, Bangladesh...). Here is the link:

https://m.youtube.com/watch?v=7P5p7hGB-Wc&fbclid=IwAR25sD4nw0ajiWnRhn1fKb5pOtFSmGw9_Vc-n1FYuQJ83PJ5u945qJHrqxE

I hope you enjoyed the talks as much as we did and help us to share it with those who might be interested and with our Primary Care community, as there is no so many talks of Family Doctors (if there is any at all before them!) and they are just amazing!!

UK Parliamentary Inquiry

The APPG (All Party Parliamentary Group) for Rural Health and Care has set up an Inquiry to look at the key issues facing the country in terms of providing good quality and effective health and social care in rural settings.

The first session was held in autumn 2018 and Rob Lambourne, Chair of the Royal College of GPs Rural Forum and the IAB UK member, gave evidence. A short report is available at https://www.ncrhc.org/assets/downloads/Parliamentary_inquiry_session_1.pdf

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.**

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

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

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.editorialsystem.com/family/journal/about/

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
Below are some recent publications that may be of interest to EURIPA members.

In Rural and Remote Health:

Developing the health visitor concept of family resilience in Wales using Group Concept Mapping
Authors: Carolyn Wallace et al
https://www.rrh.org.au/journal/article/4604

The prevalence of diabetes mellitus among Sami and non-Sami inhabitants of Northern Norway – the SAMINOR 1 Survey (2003–2004) and the SAMINOR 2 Clinical Survey (2012–2014)
Authors: Ali Naseribafrouei, Bent-Martin Eliassen, Marita Melhus, Johan Svartberg, Ann Ragnhild Broderstad
https://www.rrh.org.au/journal/article/4623

Social Networking App Use Among Primary Health Care Professionals: Web-Based Cross-Sectional Survey
The original paper was published in JMIR mHealth and uHealth in December 2018 Vol 6 No 12
You can find it here: https://mhealth.jmir.org/2018/12/e11147/

Calendar for the elderly
This calendar has been produced by Dr Pratyush Kumar
in India. Its really impressive and definitely worth taking a look:

https://drive.google.com/file/d/1rOzKyDa-3Z25m-bAsU_0sX4o3C6zN-YF/view?usp=sharing

In England the new **National Centre for Rural Health and Care** (https://www.ncrhc.org) has just published its first report. You can find the report on **Rural Workforce Issues in Health and Care** at https://www.ncrhc.org/news/rural-workforce-issues-in-health-and-care

This article does not feature specifically on rural but **International approaches to rural generalist medicine: a scoping review** has been published in Human Resources for Health. You can find the paper at:
https://human-resources-health.biomedcentral.com/track/pdf/10.1186/s12960-018-0332-6

Forthcoming Events

Below is a selection of events for 2019 that may be of interest to EURIPA members. Please send in your events for future editions of Grapevine so that we can make this section more comprehensive. Please send to the editor at jane@montgomery-powys.co.uk

Coming up in 2019:

EFPC Webinar PRIMORE Project – PRImary care Multi-prOfessional REsearcher network
15 January, 2019 @ 12.30 p.m. NL time
Free registration at info@europrimarycare.org

RCGP Rural Forum conference - Keeping Rural Practice Relevant
26th January 2019, Shrewsbury, Shropshire, England
More information https://rcgpportal.force.com/s/lt-event?site=a0d0Y00000AeOP6QAN&id=a1U1n00000G7XBjEAN

55th EQuiP Assembly: Healthy Practices, Healthy Professionals, Healthier Patients
29th – 30th March 2019 in Thessaloniki, Greece
More information is at: https://www.equip2019.eu
And, Facebook Page: https://www.facebook.com/equip2019eu

13th Congres Medecine Generale France conference, including sessions in English
4th – 6th April 2019 Paris, France
More information: https://www.congresmg.fr/en/programme-detaille/

And more ……..

88th EGPRN meeting "Research on Multimorbidity in Primary Care"
9th – 12th May, Tampere, Finland
More information is at: https://meeting.egprn.org/ Deadline for abstract submission is 15th January 2019

21st Nordic Congress for General Practice 2019
'Promoting General Practice Perspectives'
17-20 June 2019, Aalborg, Denmark
More information is available at: http://www.nordicgp2019.dk/

WONCA Europe Conference 2019
The Human Side of Medicine
26th – 29th June 2019, Bratislava, Slovak Republic
On-line abstract submission is now open. Extended deadline for submission is January 31st 2019
More information: www.woncaeurope2019.org

EFPC 2019 Nanterre Conference
29th September – 1st October
More information at www.europrimarycare.org

16th World Rural Health Conference
12 – 15th October 2019, Albuquerque, New Mexico, USA
More information is at: https://www.ruralhealthweb.org/wrhc Abstract submission is open to 29th March.

IX EURIPA Rural Health Forum
Isolation and Rural Medicine: Innovation solutions for developing local health services
7th – 9th November 2019, Azores
The web site is being developed and more information will be available shortly

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 Spring 2019; contributions are welcome by mid March 2019 for an April publication. 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 what you do in your practice and if you would like to contribute to the clinical case section, or send us a piece about your practice, tell us about research you are doing or have published, an event that is being held in your country ..... please do get in touch.

Disclaimer: The views contained in the featured papers above are those of the authors and not those of EURIPA.