Volume 1, Number 2

INTERNATIONAL FEDERATION OF PRIMARY CARE RESEARCH NETWORKS
UNDER THE TASK FORCE ON RESEACH OF WONCA

NEWSLETTER

IFPCRN

Wonca

An international forum for Primary Care Investigators

CONTENTS

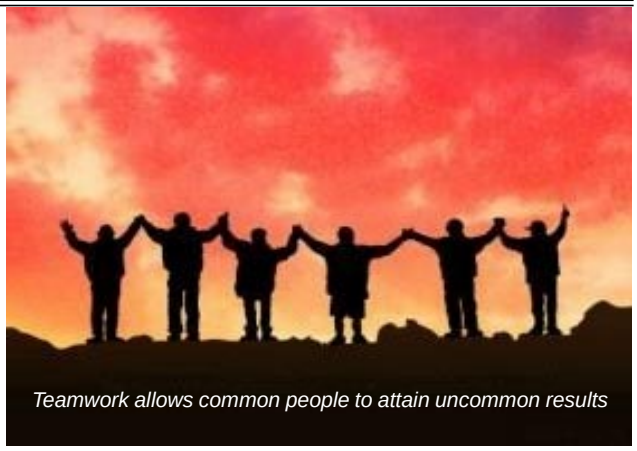
From the IFPCRN Chair

IFPCRN: First Steps and Horizons

The IFPCRN is part of a growing movement to develop international programs in primary care research. There are a number of reasons that these programs, including the IFPCRN, are needed.

They include:

- The intellectual stimulation that different national perspectives provide for our research agenda is a source of energy and ideas.
- Increasing the availability of resources, especially those needed for training and mentoring of researchers, across national lines is a high priority issue, especially for those countries with less support for primary care. One example is the Brisbane Initiative which will promote the development of multi-national training resources
- Multi-national research studies in primary care will increase the validity and generalization of some study results. Elsewhere in this newsletter, you will read of the Linnaeus group studying medical errors in several countries. There is the possibility of an international study of medical ethics as perceived by family doctors and their patients in many different countries, which I would find personally an exciting topic.
- International primary care research will help to develop support for primary care research within each of our countries by highlighting both the need and potential for our work.
- For all of us involved, it adds richness and interest to our own professional and personal lives. I greatly value the friendships and collegial relationships that have enriched my own life over the past several years.



Teamwork allows common people to attain uncommon results

The IFPCRN will continue to bring us together to communicate, collaborate and be colleagues in an exciting endeavor. There is much work ahead for all of us, especially as we proceed to develop multi-national studies. Funding always remains a critical issue. I believe it's the Chinese who said "the journey of a thousand kilometers starts with a single footstep". We have taken the first several steps and will continue, I hope at an even more rapid pace, to make progress.

Finally, my sincere thanks, on behalf of us all, to Francisco Gomez-Clavelina for taking the initiative in pulling together this newsletter. It has been a lot of work on his part and we are all indebted to him. Thank you, Francisco!

John W. Beasley

From the PCRNs

The Mexican Academy of Family Medicine Professors. Origins and Challenges

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The Mexican Academy of Family Medicine Professors (AMPMF) started its activities on 1999 to join Mexican Family Medicine Professors and to foster their research activities. After six months, several meetings and legal council, the steering committee published the AMPMF bylaws and internal regulations. Twenty-three family medicine professors founded the AMPMF. To achieve its aims, the president of this unique organization in Mexico and Latin America, organized some strategies to identify the knowledge of the 23 AMPMF members. The panorama was very heterogeneous; there were family doctors specialists, some with master degree and a few with philosophy degree. The postgraduate members' expertise was not on Primary Care or Family Medicine but on Public Health, Sociology and Epidemiology. The family medicine specialists had a big experience on family practice and of course, on teaching. There were also psychologists, social workers, and one anthropologist. It was an urgent need to design the prototype of The Family Medicine Professor-Researcher.

With this aim, on February 2000 was organized the First Colloquy of Family Medicine Preofessors-Investigators. The prototype and its characteristics were identified as well as the challenges of family medicine practice in Mexico with three approaches: teaching, investigation and clinical practice. AMPMF steering committee organized the National Award for Family Medicine Investigation which purpose is to incentive family practitioners to investigate. This award is annual and the judge members rigorously enforce its regulations and methodological requirements. As consequence of this award, the steering committee has the option to publish the results of the winner paper on the AMPMF website. There have been three awards with the participation of 35 papers and an average of three authors of each document.

The AMPMF has members from The National Autonomous University of Mexico (UNAM), Mexican Institute of Social Security, Ministry of Health, Institute of Social Security for Governmental Workers, National Institute of Public Health, National School of Social Workers, Autonomous University of Nuevo Leon, Monterrey University and Ipas Mexico (an international non governmental organization for women's health). The organization of AMPMF as a Primary Health Care Network (PCRN) is on its beginnings. This PCRN do not have funding finance from other organizations, so this issue is one of its more important priorities. However, the investigators are doing efforts to optimize their own resources, and to do as much as they can from their institutions to coordinate the strategies to share their experiences on AMPMF.

AMPMF steering committee has executive relationships with the Family Medicine Department of UNAM, the Mexican College of Family Doctors and The National Board of Family Medicine. The AMPMF and UNAM are working together on two projects:

1. **The Systematic Model of Family Practice, which objective is to improve family practice quality by following operative strategies:**
   - **Identification of the most important health problems, both in the doctor's office as community**
   - **Identification of training needs of health professionals**
   - **Evaluation of user's satisfaction**
   - **Implementation of a program for health professionals with emphasis on risk approach**
   - **Creation and reinforcement of social networks for health**
   - **Design of low-costs projects oriented to solve the health problems detected**
   - **Evaluation program for each one of the strategies**
2. **The training of family medicine professors-investigators, with the implementation of the following strategies:**
   - **Training course of research with emphasis on:**
     a) **Tutorial activities with family medicine residents with focus on research**
     b) **Quantitative and qualitative research designs**
     c) **Statistic methods**

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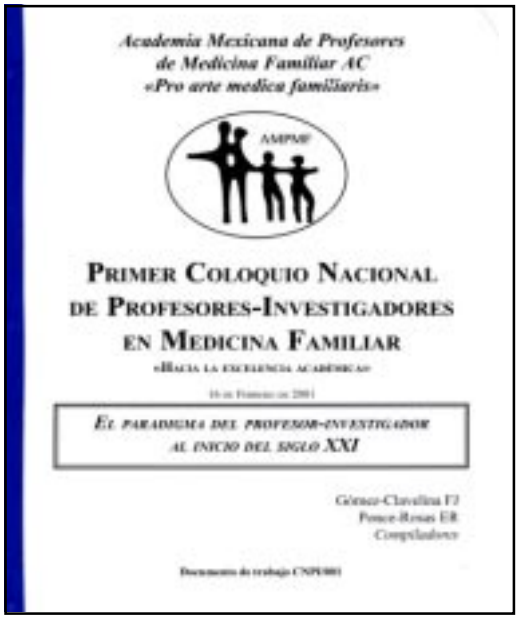
IFPCRN Newsletter: design, graphics, text, typography and edition by Francisco J. Gómez-Clavelina. Editorial assistance and review by John W. Beasley.

AMPMF members. Second National Colloquy of Professors-Investigators on Family Medicine. Mexico City, February-2002.

At the same time the AMPMF has been working on the design of family medicine textbooks that will be the final result of monthly academic meetings.

The AMPMF members are sure that there is so much to do. AMPMF has an annual Colloquy, a forum to analyze its achievements, to share experiences of its members and to plan the future activities to improve its operation strategies. The challenge is the family medicine practice, teaching and investigation of high efficiency with optimal use of existing resources.

We think that this panorama of AMPMF work can be helpful for many other family doctors /general practitioners of other countries, perhaps to start, perhaps to improve.



Frontpage of The Official Document . First National Colloquy of Family Medicine of Professors-Investigators on Family Medicine. Mexico City, February-2001.

Meetings and Projects

THE LINNAEUS COLLABORATION

An International Network for research on primary care quality

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In early 2001, primary care researchers from Australia, Canada, England, the Netherlands, New Zealand, and the United States (U.S.) formed a research collaboration to investigate threats to patient safety observed by family physicians. In 2002, Germany was added. The group adopted the name "The LINNAEUS Collaboration" and established that its purpose would be to improve the quality of primary care in participating countries through a research program focused on aspects of primary care that protect or threaten patient safety. The group's name has significance on two levels. As well as providing a suitable acronym to describe the purpose of the LINNAEUS Collaboration (**L**earning in an **I**nter**N**ational **N**etwork **A**bout **E**rrors and **U**nderstanding **S**afety), the name is also that of the "Father of Taxonomy", eighteenth century Swedish doctor Carl Linnaeus.[1]

How did it start?

The Linnaeus Collaboration grew from a specific need. During 2000, our small team of researchers in the Robert Graham Center of the American Academy of Family Physicians investigated medical errors in primary care in the United States.[2] While conducting this study we became aware of primary care system infrastructures that seemed to be specific to the U.S. and also seemed to dispose towards certain types of errors. We wondered if we could find out whether our hunches were right, and if it might be possible to find out exactly which parts of a primary care delivery system were the problem parts – were they the same across countries? Did we all have the same agenda to follow? If we did, couldn't we increase the power of our research by working together, rather than pursuing the same agenda in parallel? And if they were different, if some errors occurred in some countries but not others, maybe then

Carl Von Linnaeus. (1707-1778)

we could all learn about the specific things that different countries did best. We could investigate how "good" processes might be able to replace "harmful" ones, so that patients could be protected from harm. As well, characteristics of a country's primary health care system that protect patients from certain kinds of harm may be unknown (and therefore under-valued) until they can be identified through their absence in other countries. We constructed statements of the Linnaeus Collaboration's Vision and Mission (see boxes).

Why these countries?

Countries participating in the LINNAEUS Collaboration were chosen for two reasons. First, they share a common understanding of the primary care function[3] so differences between countries in the types of errors reported in primary care are more likely to be due to the way the primary care function is executed than to different interpretations of this function.[4] Shared use of the English language is another characteristic of most countries represented in the Collaboration although the Netherlands, a non-English speaking country, was originally included because we expected that data collection in English would be possible from Dutch family medicine, without the need for translation of the study methodology and tools. In Germany, doctors contributed study data in German and the translation to English was made before the data were aggregated with data from other countries.

Personal relationships have been a key ingredient in the success of the Linnaeus Collaboration. The Collaboration started with a group of "mates" – people who knew each other from past encounters – but has grown to include a group of new friends as well as old, and young general practice researchers as well as experienced ones. We have made strenuous efforts to have regular face-to-face meetings and have managed three so far – in February 2001 in Washington DC, USA, in October 2001 in Halifax, Canada, and in June 2002 in London, UK. Two of our meetings have been attached to major international general practice conferences (the North American Primary Care Research Group conference in Halifax and the WONCA conference in London). The search for funding to help with meeting costs has led to the extension of the original group. The US Agency for Healthcare Research and Quality provided a grant to help with the Halifax meeting on condition we invited people from more countries. As a direct result of this requirement, we now have Germany as an active member of the Collaboration and more countries are likely to follow suit. This has been enriching for the Collaboration.

Products of the Linnaeus Collaboration

Since establishing the LINNAEUS Collaboration in 2001, we have been successful in attracting two grants in support of our meetings and we have so far produced:

1. An established international research collaboration.
2. A taxonomy of medical errors in family medicine.
3. Endorsement of the research agenda by the World Organization of National Colleges, Academies and Academic Associations of General Practice/ Family Physicians (WONCA).
4. A paper reporting the final results in review at Health Affairs.
5. A paper reporting researchers' experiences of gaining ethics committee approval in six countries, in review at *J Med Ethics*.
6. A paper reporting the Australian experience in PCISME is due for publication in the Medical Journal of Australia on July 15.
7. At least five other papers are being developed to report major findings and implications for the countries represented in PCISME.
8. Two posters were presented at the annual research meeting of the Academy for Health Services Research and Health Policy in Washington DC in June 2002.

9. Germany has joined the LINNAEUS Collaboration and repeated the PCISME protocol in that country, adding further data for analysis.
10. Other countries have expressed firm interest in joining the Collaboration.

What's next for the Linnaeus Collaboration?

The Collaboration's goal for 2002 is to devise a programme of research to fulfill its vision and mission by building on the first collaborative project – PCISME. We also aim to further evolve and use the taxonomy of medical errors in primary care that was created from this study. A key aspect of future research will be to secure adequate funding in advance. Our early successes were achieved quickly, with little or no financial support. This had advantages in that it meant we could rapidly establish our credibility and complete the necessary foundational work. The strategy we intend to adopt in the future is (1) we share protocol development tasks but one researcher leads this process, (2) we independently submit the protocol for funding in our separate countries, (3) we try to attract additional funding for the "international-izing" part of the study, (4) we collect the data within each country and then pool centrally for the international analysis, (5) we publish both in our own countries independently and together internationally. We decided that it was essential for us not to expect that any single country would fund any project in all participating countries as this smacks of colonialism and presents real threats to the sovereignty of individual participants – hence the term "Collaboration" in our name.

Finally, we intend not to be a one-study-wonder international network. Keep on the lookout for us! We're in this for the long haul and plan to make real contributions to the development of new knowledge about general practice and family medicine locally and internationally.

Vision Statement

The quality of primary health care will be improved in all countries through international collaborative research to better understand aspects of primary care delivery systems that protect and threaten patient safety.

Mission Statement

The purposes of the LINNEAUS-PC collaboration are:

1. **To conduct research in patient safety that is strengthened by international collaboration.**
2. **To share information to improve patient safety across countries.**
3. **To advocate for improvement in patient safety in family practice, general practice and primary care settings.**

Participants in the Linnaeus Collaboration, July 2002

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Dr. Meredith Makeham, University of Sydney

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England
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Dr. Susan Dovey, Chair of the Linnaeus Collaboration
Professor Larry Green, Director of the Robert Graham Center
Dr. Robert Phillips, Assistant Director of the Robert Graham Center

Endnote References

1. E. Pennisi. "Taxonomy. Linnaeus's Last stand?" *Science*, 291 (2001): 2304-7.

2 . S. Dovey *et al.* "A taxonomy of Medical Errors in Family Practice" *British Medical Journal (Submitted)* 2001.

3. All countries represented in the LINNAEUS Collaboration support a primary health care system that has accessibility, comprehensiveness, coordination, continuity, and accountability as its key attributes. Primary care medicine is practiced by family physicians (U.S. and Canada) and general practitioners (Australia, England, the Netherlands, and New Zealand) whose role in their health system is to provide integrated, accessible health care services, to be accountable for addressing a large majority of patients' personal health care needs, to develop a sustained partnership with patients, and to practice in the context of family and the community.

4. C. Van Weel. "Primary care: political favourite or scientific discipline?" *Lancet* 348 (1996): 1431-2.

Bioethics Project

Francisco J. Gómez Clavelina
Editor

Bio-ethics is a part of applied ethics, which uses ethical principles and decision making to solve actual or anticipated dilemmas in medicine and biology. There is evidence that suggests differences in the way the principles of biomedical ethics are applied across different societies and cultures.

Dr. Waris Qidwai, Assistant Professor of The Aga Khan University, Karachi, Pakistan has been working on this subject. ***Perceptions on Bio-ethics Among General Practitioners in Karachi, Pakistan*** is the name of an interesting document that Dr. Qidwai sent on May 2002 to Dr. Beasley, interim Chair of IFPCRN. Only the summary of this document is included here. Dr. Beasley and the editor of this Newsletter have the intention to promote the publication of the results of investigations of IFPCRN members and to give opportunities to share experiences with other investigators.

Abstract

Qidwai W, Qureshi H, Syed IA, Ali SS, Ayub S. Perceptions on Bio-ethics Among General Practitioners in Karachi, Pakistan *Pak J Med Sci* 2002; 18(3);221-226.

Objective: To study the Perceptions on Bio-Medical Ethics among patients presenting to Family Physicians at a teaching hospital in Karachi, Pakistan.

Settings: The study was carried out at the Community Health Center (Family Practice Center), of The Aga Khan University, Karachi, from December 1999 to May 2000.

Methods: A questionnaire and a form on the demographic parameters was developed and administered to 420 adult patients. The participating respondent signed consent form, after confidentiality was assured.

Results: Majority of the respondents were married men, with mean age of 33.7 years (SD=11.98). Around 248 (59%) of them were educated beyond grade 12 (high school level). Most of them were in private service, government service, self-employed or were students. Time management, keeping up to-date, truthfulness, honesty and lack of greed were reported to be the top five moral duties of a physician. In reaction to the death of a close relative due to a physician's negligence, 190 (45.2%) said that they would forgive the doctor, 77 (18.3%) said that they would warn him/her, while 76 (18.1%) said that they would report to authorities. 258 (61.4%) of the respondents agreed that a "doctor is next to god" while 153 (36.4%) didn't. 236 (56.2%) of the respondents stated were in favor of discontinuing life support to a patient with no chances of survival, in order to save another life, in contrast to 166 (39.5%) who were against it. Other issues studied include giving of gifts by pharmaceutical companies to doctors, sickness certification, organ donation, human cloning, disclosure of information to cancer patient and patient confidentiality.

Conclusion: We have found interesting patient's perceptions on Bio-Medical Ethics with important implications for clinical practice.

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The editor will be pleased to receive the scientific contributions of every IFPCRN and WONCA members, as well as comments, letters, PCRNs' reports and official announcements of scientific meetings.

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10	Dahlman	Bruce	U.K.	
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_____( ) Personal ( ) Network

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