

Minutes for Nordic Leader Seminar, 23-25 August 2018



Wednesday 22 August 2018 – Saturday 25 August 2018 at Hotel Marienlyst, Elsinore

Sweden, SFAM: Hanna Åsberg, Ulrika Elmroth & Gösta Eliasson
Sweden, DLF: Marina Tuutma & Ulrika Taléus

Finland, SYLY: Seija Eskelinen & Merja Laine
Finland, GPR ry: Jaana Puhakka & Arto Virtanen

Denmark, DSAM: Anders Beich, Roar Maagaard, Jette Kolding Kristensen & Bolette Friderichsen
Denmark, PLO: Christian Freitag, Niels Ulrich Holm & Jette Stagsted Galatius

Norway, NFA: Petter Brelin (absent), Ståle Sagabråten, Tor Carlsen, Nina Wiggen & Andreas Pahle (Henrik Vogt with presentation)
Norway, AF: Torgeir Hoff Skavøy & Christina Fredheim
Norway, WONCA Europe: Anna Stavdal

Island, FIH: Salóme Ásta Arnardóttir, Steinar Björnsson, Jón Torfi Halldórsson, Thordis Anna Oddsdóttir & Oddur Steinarsson

NFGP: Niels Saxtrup, Johann Sigurdsson & Sanne Bernard (secretary)

NYGP: Christina Svanholm & Gudrun Sigurdardóttir

Thursday 23 August 2018

Welcome by Anders Beich and Christian Freitag to our Nordic Leader Seminar, where all Nordic unions and colleges and now also NYGP (Nordic Young General Practitioners) are represented. A short presentation round took place, and our Nordic Leader Seminar with the purpose of networking, exchanging ideas and challenges and finding common solutions was to begin.

Presentation of WONCA by Anna Stavdal (president of WONCA Europe) and Roar Maagaard (member of the WONCA Europe executive board)

Anna Stavdal presented the organization, ideas, aims, challenges and work of WONCA Europe;

WONCA is a worldwide organization of family doctors, a global network with 7 regions (defined by WHO), Europe is the largest region with 47 member countries, 120,000 family doctors, and 12 networks and SIGs.

WONCA Europe is dealing with a variety of tasks and challenges that concern all of us. All five Nordic colleges are represented in WONCA Europe, and the idea is to support and learn from each other, and to create positive synergy.

The main goals are to achieve universal coverage through family medicine in all of Europe. Advocate integrated care to be implemented horizontally in primary care and vertically between levels of healthcare, support specialty training, strengthen research and quality work, and attracting new and future family doctors.

WONCA Europe has 6 main networks, and the aim is to join forces within the academic and professional field in the European countries.

WONCA Europe is among other tasks organizing annual conferences, runs the European journal, and is focusing on building on the future (young doctors, scholarships and exchange program).

Advocacy of WONCA Europe includes statements, declarations, collaboration with WHO/Europe and partnerships, also collaboration with other organizations as EFPC (European Forum for Primary Care), UEMO (European Union of General Practitioners), EMA (European Medicines Agency) and ECCO (European Crohn's and Colitis Organisation).

The vision and mission of WONCA Europe as well as their future plan in motion for 2016-2019 can be seen at [Anna's presentation slides here](#)

E.g. the NFGP position paper on overdiagnosis led to establishing of a WE working group, and the position paper was adopted by the WE council in Krakow in 2018.

WONCA Europe provides the possibility to support the less fortunate countries (e.g. to strengthen the education of family doctors), which will be for the benefit of all European countries. Furthermore, WONCA Europe works as a platform with the possibility to collaborate with countries who are interested in making changes.

Roar Maagaard, who is involved in specialist training and continued professional development in both Denmark and Europe, presented the WONCA Europe Networks and SIGs (Special Interest Groups).

The WONCA conferences are an important part of the networks, as they work as a "GP showplace" and national marketing of GP/FM for the hosting country. Every year between 2,000-5,000 participants from Europe and abroad attend the WONCA Europe conferences.

- EQUIP: Quality and safety of care of patients
- EGPRN: Research in primary care, coordinate multinational studies
- EURACT: Learning and teaching, support for trainer and trainees (both student training, specialist training and continued education). How can we train GPs in the best way to make excellent GPs in all European countries?
- Vasco da Gama Movement: For young doctors, a network for new and future general practitioners. Christina Svanholm added that NYGP is inspired by VdGM and aims to collaborate with VdGM.
- EUROPREV: To promote evidence-based prevention in general practice.
- Euripa: European association for rural and isolated practitioners.

SIG's – Special Interest Groups – deal with special topics in primary care, e.g. adjustment of guidelines into a general practice framework.

[Roar's presentation slides can be seen here](#)

Do the Nordic unions and NFGP wish development and influence outside the Nordic Countries, and if so - how?

Group work (collaboration of the two axes – unions and organizations), - what can we achieve together with collaboration, both within the Nordic countries and within Europe;

- E.g. support countries where education is less strong
- Meet and exchange Nordic experiences, and point out a person from the board who can be liaison officer with national organizations (WONCA Europe networks and SIGs) and providing economical support. Appoint liaison persons who will be able to speak up and are having a clear message to deliver, to disseminate matters into international importance.
- Barriers due to differences – can those be reduced by e.g. social media/chat discussions, funding of participation at conferences, creating new ways of attending & sharing?
- How can we contribute; yes to act as role models (important to be humble towards the social and cultural differences, context sensitivity) – no: difficult to member in another organization.
- What are included in General Practice, - a clear and common content/definition is necessary to discuss the need of education.
- Values as solidarity are challenged, - do we have an obligation to stand up for those solutions and civil rights.
- Should we aim at getting a representative in each network as well as in the executive board of WONCA Europe?
- How can we establish a systematic communication system in the Nordic community – to ensure information, ideas and core values are shared with our members?
- #nordicGP – do tweet 😊

Presentation by Norway: Will we with gathering of more data be able to make personalized medicine? (N) Henrik Vogt and Andreas Pahle:

Norway made their presentation upon personalized medicine, curative or preventing medicine, screening detection of early stages of diseases, what about overdiagnosis and big data, what is abnormal and dangerous – how do we define this.

[Norway's presentation slides can be seen here](#)

Group work:

What could be the benefit for general practice?

- One more tool to give us better judgement, but education is needed.
- If used on a focused basis we can get more focus on risk population – only screening of high risks groups.
- Decision support for subscription of the correct medicine for our patients.
- Can support us, but we should not forget our core ideas in order to remain holists.
- (Everyone defined as a patient, which means more patients to the doctors and more money).

What could be the challenges for general practice?

- Focus can be changed, - less focus on (distraction) healthy lifestyle.
- Difficult to guide the patients, when we cannot interpret the findings.
- How the politicians get away with talking about healthcare making fluffy visions. We need real healthcare based on being there for our patients and discuss lifestyle.
- Screening / DNA might deny you an insurance. Employers might demand those kinds of tests before hiring staff.
- How to explain patients about the results of their tests – time which could be used in better way.
- Higher educated people will take these tests and using more of our time and with a very little (or no) gain.
- Suggestion about doing studies about the economical (negative) results.
- Different rhetoric in order to get influence, - colleges and unions in debate with politicians and patient organizations.

Presentation by Finland: What is a diagnosis – is it crystal clear with an obligate treatment that can be measured and benchmarked? How do we prevent over diagnosis and –treatment? (SF)

First – what is diagnosis and then what is over-diagnosis? What is a diagnosis – is it crystal clear? We know the answer to this. Same diagnosis can have a very different impact depending upon the circumstances. Diagnosis can lead to relief for the patients; easier access to help etc. – but a diagnosis can create many problems as well. Is not a matter of too much medicine, but it is a matter of too much power.

[Finland's presentation slides can be seen here](#)

Group work on over diagnosis and –treatment:

What has already been done, how do we move on from here, how do we make the policy paper live?

- Do national guidelines exist, and if they exist, -how do we ensure that GPs get involved in this work?
- Lay people and patient organization should be involved too.
- Courses in how we use lab testing.
- Slogan/ticket which is understood by the lay people.
- Do incentives lead to overdiagnosis?
- Important to involve young doctors (VdGM and NYGP) – teaching about overdiagnosis, - also GPs and students.
- How to communicate, where and to whom?
- Visit and learn from the Scottish healthcare system (Gregor Smith, advisor director), keep focus on choosing wisely, avoid harm, new system to be implemented with no longer payment for performance but a quality driven system.
- Getting involved in political planning/decisions earlier (now energy is used to avoid accidents from happening instead of forming good solutions together).
- National Board of Health – try to get influence (it is an economic issue in some countries, as the authorities refuse to pay compensation for loss of salary. Earlier, it has been a struggle in Denmark too, but they have now accepted to pay for the GP's specialist advise.

- How do GPs get impact on population and politicians? How do we create efficient communication? We must be clear in our communication (it is a complicated subject), we should share our experiences, do we need communication people to advise us? How do we achieve a voice in newspapers, social media etc.?
- We should acknowledge the power of our patients and make campaigns targeted towards our patients.
- New guidelines, - it has to be transparent whom the authors are, and what their conflicts of interest are, if any.
- Concept/words – what would work in our countries (Norway uses “choosing wisely”, Ireland uses “realistic medicine”)?
- Reach social media, create something absurd, maybe using actors in a movie / video.
- Campaign in Norway regarding antibiotics has worked.
- Sweden has established a committee on sustainable diagnosis and treatment.

Discussion in plenary room – what to bring further for common Nordic union/NFGP policies/recommendations

- Establishment of a small group to gather ideas in terms of how to get impact in the discussion to avoid overdiagnosis and -treatment. Andreas Pahle, Anders Beich will take the lead.
- Suggestion about creating an umbrella organization/network group of the Nordic unions, - to be decided and carried out by the unions. Maybe starting in a small scale, - the first task could be to participate active in planning of the Leader seminar. [See slide from Johann here](#)

Friday 24 August 2018

Presentation by Sweden: What is good quality – can it always be measured? (S)

Sweden gave a presentation of the Swedish quality system, which is a national system for quality improvement in primary care. To secure the dataflow, outside health center only aggregated data is available. Aggregated data is available for all health centers to be used for benchmarking.

Education in the beginning is essential to ensure that the outcome of using indicators is correct. The aim is to identify patients who are in need, to lead to dialog and teaching. [Sweden’s presentation can be seen here](#)

[Here you can see a short film about the Swedish Primary Care Quality system](#)

Discussion on quality indicators and GP core values:

- In Sweden they have created indicators on the national goals.
- Maybe too many indicators in the Swedish system, - but there are only a few indicators per area.
- The collected data show large differences on the result of indicators – how can this be used?
- How to measure the “soft values” which are core values of general practice?
- Job satisfaction among GPs can be measured.
- No way of measuring all aspects of quality.
- Quality happens when we look at the data and discuss with the patients.
- When working on measuring team continuity, will it mainly be important when dealing with chronically ill or fragile patients?
- How are the results used in Sweden: on website GPs can find tools for improvement work, FQ groups in Sweden are working with these results (www.genombrott.nu).
- Hard end points – can this be followed – what is the outcome of using the system?
- How can prevention be measured? How do we keep the healthy people out of the health system?

Gösta presented the statements of family medicine and the Norwegian 7 theses. Quality of soft aspects – can it be measured? [See presentation from Gösta here](#)

In Denmark an important part of the new agreement (negotiated in 2018 between the union and regions) is about creation of mandatory clusters, consisting of 25 – 30 doctors in the same area. The aim to improve quality – not by controlling – but by taking part in a continued discussion with a group of colleagues. Part of the work will be data driven.

Presentation by Denmark: Who owns information/data about the patient (the state, the patient, the GP)? – What happens when we ruin the patient confidentiality? (DK)

These days we experience a confusion about data and knowledge. The doctor-patient relationship is based on trust, relation and confidence. Data is needed for quality improvement, sharing data with hospitals and nurses is logical, as well as using

data for GP research, but data goes out to RKKP (Regionale Kliniske Kvalitets Program), SDST (Sundhedsdatastyrelsen) and LSR (Lægemiddelstatistikregister)/LAR (lægemiddelanvendelsesregister), where persons can be identified by their cpr-number (a unique civil registration number). Our concern is that it is clear to no one for which purpose this information can/will be used over time.

Patients often share personal matters with their family doctor, and a part of them never “enters” the healthcare system, which can cause problems workwise.

[See presentation from Denmark here](#)

Discussion in groups:

How can we preserve some confidentiality in the relationship?

What do we do to ensure that the patient has an idea of what is going on?

- It is a very important questions for all Nordic countries, as all persons have a part of themselves they wish to keep private. If everything should be put into files we may lose confidentiality. Should this be a common working project for the Nordic countries? Finding good examples.
- Can we spread the message in the media, - that GPs feel they are having challenges keeping the trust/confidentiality?
- Raise the questions with civil rights organizations, and other who have interest in confidentiality as well.
- System level and society level, and on the other hand the consultation scene. Consultation process – discussion about what diagnosis to report (if any)
- Patient organizations are interested in large member numbers, - how do we get to the patients?
- Keep/higher the awareness of these matters to the patients/population, - go public.
- Involve patients in what is “private information” – what do we wish to keep private, and what is OK to share?
- We want to share information, but it should be the patients’ decision if they want to share it and with whom (98% patients wish to participate in research).
- Would the patients opt out treatment / risk health, because they do not wish to be registered?
- Should the GPs raise a general concern? All Nordic countries can get into the same situation as in Denmark.
- ICPC – expanding the social diagnosis field of ICPC – the social register in the medical journal.

A case in Denmark lately: A limited number of HPV vaccines were offered to young boys for free, for those who thought they had an interest in the same sex. A special form was to be filled in on the same day of the vaccine in order to get reimbursement. The GPs refused this, no politicians understood why – and they claimed that GPs did not want to help.

Presentation by Iceland: How much can we work, if we keep on using ourselves as a tool? Will we accept to be reduced to technicians instead of professionals? (IS)

Shortage of GPs in Reykjavik. Is there a golden number of panel size (is it 1,500?), this number has been used for 30-40 years, but much have changed since then. Number of patients per GP is increasing, both in the Nordic countries, but also in the rest of Europe.

- Patient type, age, disease burden, initiatives from hospitals, rising public expectations
- Office, working alone, in a team, full or part time
- GPs – how do we wish to live – only working, or also time for family, hobbies etc.

Panel size and quality. [See presentation from Iceland here](#)

[Link to films about overdiagnosis here](#) and another [here](#)

Group work - How we see our future, and how we think it should look like?

Group 1:

- What becomes the role of a GP in his community, considering a panel size of 1,500 patients? Difficult to say, as practices are so different from country to country, - tool to improve quality of care, extra staff to support us so GPs can do GP tasks only.
- How does lowering this number make a difference for the service? Yes of course, also a difference for the doctor. To prevent burnout (in Norway approx. 56 work hours per week).

- Gender perspective? Some tendency that female GPs is having more social problems, and it can really become too much.

Group 2:

- How do we see the need for a confidential conversation with a reasonable GP in a modern society of social media and open communications?
- Job satisfaction?
- What can we take out of our tasks? Forms, which are not medical, can they be filled in by someone else? At Øland in Sweden the leading GP succeeded to get a limit of 1,000 patients per GP, - and now this rural area has become very attractive for GPs as working place.

Group 3:

- Is continuity of care helpful in modern society? Yes
- If yes, to what cost – to us and the community? Save lives, keep patients out of hospital, no extra costs for the community, by shifting to another area maybe possibility to reduce work load (fewer conversations with patients).
- Need of a mindset challenge – give away tasks to other staff at the clinic (e.g. nurses), resistance from other GPs – afraid that others will take over their work. Changing the way of working and thinking takes a lot of energy. Gender perspective? Yes

Group 4:

- How would we like our practice to be? What happens if it becomes like that? (panel size, patients per day, content and context?) possibility to work privately or for salary, - it is a very subjective measure.
- Who rules our practice?

Other:

Roar thanks for the opportunity of presenting the thoughts and aims for WONCA Europe at our seminar, and suggests that at WONCA Seoul, the Nordic countries should support Anna Stavdal for the position as president for WONCA World.

What could be useful to bring further together;

- **Strengthening the Nordic network in a more formal way within the union field**, - mail each other when milestones come up between meetings and to gather at meetings and congresses. Establish a way to communicate in a structured way, seeking advices from each other, participate in planning of the Nordic seminars, meet up with each other on occasions as Nordic Congresses, pre-meetings etc. First step is to point out a responsible contact person in each country and to make a mailing list.
- **Overdiagnosis – realistic medicine**: Actions to be taken, what is the next step?
- **Try to unite upon core values** (build on 7 theses and 7 pejlemærker) – making an official statement and bring it further. Existing documents are now getting translated, and Sweden, Finland and Iceland should work with them as well. Johann will take lead, - aim is to strengthen our common values. A Nordic paper on core values could inspire WONCA Europe, and maybe give us influence. First step is taken by NFGP, and afterwards the unions will be involved.
- **Importance of confidentiality in our consultation room** – can we make a common Nordic statement, and afterwards maybe an article for the newspapers/public – get to the medias. We care about this and it is very important to us.
- **GP's autonomy** - all colleges and unions should work on their autonomy, - a subject for further discussions in the future.
- **The issue regarding BIG data to be brought further to NFGP** – Anders and Andreas will take the lead.
- **Politicians, authorities and medias – how do we get impact**, when we are having important messages to share/deliver?

Saturday 25 August 2018

Position Statement on General Practice

from “the Nordic Leader Seminar of General Practice” in August 2018

General practice and its current position was recently discussed at a meeting when the chairs and directors of the general practice associations and organisations in the Nordic countries met on 23-25 August 2018 in Helsingor in Denmark. A key issue was how to keep improving our professional competence in light of the emerging challenges in primary healthcare.

The main topics of concern were: How do we prevent overdiagnosis and overtreatment? How can we deal with the increasing workload combined with the shortage of general practitioners (GPs)? How do we handle big data driven by new technology in the meeting with the patient? And how can we improve the quality of data for use in primary care?

A steadily increasing amount of data is being collected in our healthcare systems from patient records, test results and other critical data. This information is of valuable use in research and for quality assessment purposes aiming to improve healthcare quality and patient safety. The efforts of the welfare state to continuously enhance the services, especially the planning and monitoring of healthcare, are acknowledged. The citizens in the Nordic countries are known for their great confidence in the state, and citizens and GPs have a common interest in sharing information.

We can all agree that it is important to improve healthcare. We all support this. However, it should always come secondary to safeguarding the confidentiality between doctor and patient. The doctor-patient relationship is built on trust, and confidentiality is a crucial cornerstone. In the light of the fast development in the collection of electronic data from encounters between GPs and their patients, we would like to stress the importance of preserving our professional confidentiality in the consultation room.

It is important that the consultation room remains a place of trust for the patient; a place where concerns, anxieties and sensitive emotional, psychological or physical information about the health can be shared without concern that this could be transmitted outside the room. We consider it a democratic and human right that the citizen can consult his or her GP in private matters while knowing for sure that the confidentiality is respected.

This implies that - if information or electronic data are made accessible outside the consultation room - the system must be transparent. It must be obvious which kinds of personal information are transferred to central data storage at other institutions or administrative units within the healthcare system and for which purposes. The patient or citizen should be fully informed by the responsible authorities about such transfer, and the patient or citizen should give some form of consent. Likewise, the patient or citizen should have a secured right to the information and should consent to new ways of using the information in databases in the future. The General Data Protection Regulation of the EU introduces “the right to be forgotten”, which safeguards the individual’s right to have personal data erased.

The patient record is primarily a working tool for GPs, and the files may contain confidential personal information about the patient that he or she does not want to have copied into registers. Therefore, we must be able to exercise some level of discretion towards the patient who comes to see us.

If confidentiality is breached, this could potentially harm the individual. It would also risk damaging patient trust and thus posing a severe threat to the patient-physician relationship upon which our work as GPs depends.

[The signed final statement can be seen here](#)

Next time Norway will host the leader seminar, which will take place in 2020.

Norway will therefore host the next pre-meeting/lunch in Aalborg in 2019 (practicalities to be arranged together with the Host Organizing Committee for the congress in Aalborg, Denmark).

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