Status report, March 2020

NFGP working group on

"Core Values and Principles of General Practice"

> *"Values act as guiding principles. When they are declared and followed, they are the basis of trust. When they are stated, and not followed, trust is broken. Values state what is important; standards state what is good or acceptable. Values tend to stay, standards may vary"*
>
> Pendleton and King, BMJ 2002

Summary of our suggestions.

Summary of our suggestions will be distributed in a separate file. This report is about the process and actions taken.

Background

In 2001, after some years of discussions and meetings within the Norwegian College of General Practice (NSAM, later NFA), a brief statement was distributed in which the college listed its core values and principles for General Practice in the form of seven theses – "Sju teser". At that time, Anna Stavdal was the leader of NSAM. These "Sju teser" were then formatted and published as an eye-catching poster. (Fig.1.) As we had hoped, they proved useful for our colleagues, patients, in pre- and post-graduate medical education, in policy dialogues with politicians, policy makers, and other healthcare stakeholders. They also inspired our Danish colleagues. Under the leadership of Anders Beich, the College of General Practice (DSAM) started their own large-scale "vision process" involving hundreds of GPs. This resulted in, "Pejlemærker for faget almenmedicin", published in 2016. (Fig.1.)

Fig.1. “Sju teser” from 2001, and “Pejlemærker” from 2016.

In Copenhagen, at NFGP’s 2017 annual meeting, the idea was launched to translate these theses into English and then agree upon a Nordic statement of our core values and principles.

Ideally, a Nordic paper could then serve as a template for more detailed elaborations of the discipline´s contextual, scientific and ethical foundations, inspiring courageous leadership at every level.

The task was handed over to the incoming Chair of the NFGP. It soon became apparent that it would not be easy to translate these documents directly, and that it was unclear whether this project was within the framework of the objectives and bylaws of NFGP at that time. Consequently, the first task for NFGP became to draft a new version of its vision and mission. This draft was circulated and later agreed to by the NFGP Executive Board at the annual NFGP meeting in Copenhagen 2018, which affirmed that formulating a description of Nordic General Practice was indeed part of their mandate. A working group focusing on core values and principles was established, with a representative from each of the five colleges. The Chair of NFGP was appointed as leader of this group. During the time it took to establish the working group, some enthusiastic and linguistically clever colleagues gathered at Bygdøy/Oslo, and later in Gothenburg, in the fall of 2018. This group included Jóhann Sigurdsson, Linn Getz, Anna Luise Kirkengen, Lotte Hvas, Stefán Hjörleifsson, and native English-speaking Iona Health. They went through the content of the Norwegian “Sju

teser" and the Danish "Pejlemærker" and came up with the first English draft of a new statement of core values and principles.

NFGP working group on Core Values and Principles of General Practice

The formal NFGP working group established at the end of 2018 included:

Anders Beich, DSAM, Denmark
Aleksi Varinen, SYLY, Finland
Carl Edvard Rudebeck, SFAM, Sweden
Margret Olafia Tomasdottir, FIH, Iceland
Petter Brelin, NFA, Norway*
Johann Ag. Sigurdsson, NFGP, group leader
Anna Stavdal, WE/WW, has also worked closely with the group from the beginning.

*Marta Kvittum Tangen, NFA took over as leader in 2019

According to the task letter, dated November 2018, the group was challenged to:

- make a draft of our view of the main Nordic Core Values and Principles of General Practice, based on the earlier work of our Norwegian and Danish colleges;
- stimulate a process of awareness and discussion among our colleagues within the colleges and countries about our core values and principles;
- develop and propose a workshop on this theme at the upcoming 21st Nordic Congress of General Practice in Aalborg, 17.-20. June 2019;
- engage actively in future meetings and workshops on this theme.

Why re-examine our core values and principles?

During the last 2-3 years, increasing interest in our core values and principles has been noted among General Practice leaders. Changes within society and culture in general and the healthcare systems in particular during the last decades create the need for the foundations of General Practice to be re-envisioned and updated.

We are observing new technologies and medical overactivity in many fields, and, in addition, increasing commercialisation, an increasing social gradient, and the emergence of

opportunistic “screen doctoring” companies. Digitalisation is on the rise in all aspects of healthcare, and we see an increasing interest among health authorities, investors and researchers to monitor and analyse “Big Data”. As patients and professionals become more mobile, fewer communities remain stable. Increasing numbers of people are not registered with any GP while the public expects ever faster and more accessible service. All these changes challenge such core values of General Practice as continuity of care and person-centred care. In addition, the problem of “Too Much Medicine” threatens our fundamental core value, “Do No Harm”, decreasing the quality of care while also wasting funds. This in turn contributes to an increase in the inequality of care.

Steps taken

During the last year, the working group delegates have engaged broadly in this core value process, as individuals, as professionals at our national colleges, as members of the Board of the Nordic Federation and as active members of the WONCA family. As mentioned above, we had Anders Beich, one of the authors of the Danish theses, as part of our working group and were also fortunate to collaborate closely with Anna Stavdal. Anna was 2001 Chair of NSAM, one of the architects of the “Sju teser”, President of WONCA Europe and, later, President-Elect of WONCA World. She served as a bridge to bring these unions together and as an important catalyst, energising their processes.

Below is a short summary of our contribution:

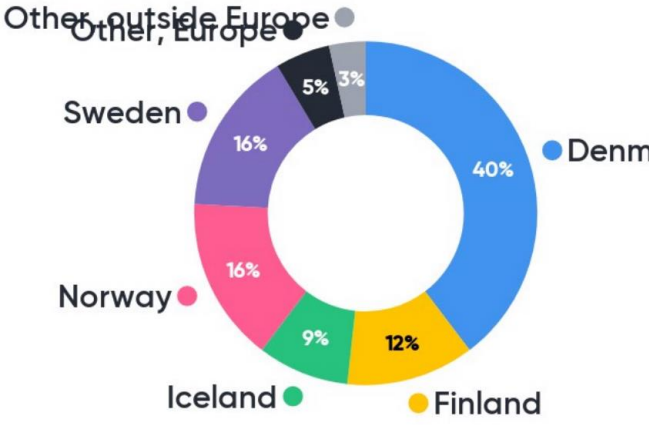
- The Icelandic College agreed to the Danish version (“Pejlemærkerne”), which was translated into Icelandic and presented as a poster in 2018.
- In Reykjavik, Iceland, at the 2019 General Assembly of the Icelandic College (involving around 50% of all the GPs in Iceland), the core values were tested against case histories and actual medical practice organisation, with the help of an interactive data program.
- Anna Stavdal held a plenary lecture on the core values at the 21st Nordic Congress of General Practice, Aalborg, Denmark, 17.-19. June 2019.
- The NFGP working group held a workshop on the core values at that same 2019 conference where our English version was introduced and discussed.
- With our colleagues from the Dutch College of General Practice, we organised a workshop on the core values at the 24th WONCA Europe Conference in Bratislava, 26.-29. June 2019.

- Carl Edvard Rudebeck published a paper about the concept in *Scand J Prim Health Care*, entitled "Relationship based care". https://www.tandfonline.com/doi/full/10.1080/02813432.2019.1639909
- We have submitted an abstract for a workshop to focus on our core values at the upcoming 25th WONCA Europe Congress in Berlin, 24.-26. June 2020.
- We have submitted an abstract for a similar workshop to be held at the upcoming WONCA World Congress in Abu Dhabi, 2020.
- Our prepared contribution includes a written historical overview of our core value concept, as embedded in the WONCA Europe definition of General Practice, and of the core competence of GPs. We aim to complete this report before the NFGP annual meeting in 2021.
- Our Nordic NFGP core values project was introduced at the WONCA Europe Council meeting in Bratislava, 26. June 2019. It was endorsed, and the WE Council decided to establish a core values work group within our European region. The Chair of NFGP was appointed as a member of this group, which will be led by Anna Stavdal.
- DSAM held a one-day conference on Realistic Medicine in Copenhagen, 28. January 2020.

Some of the opinions and messages from our workshops and meetings

We used "Mentimeter", an interactive software program, in some of our workshops (see figures below). The program allows organisers to raise questions for participants to discuss, responding either with free text to open questions, or yes/no answers which could be graded along visual scales.

Fig.2. Workshop in Aalborg



Where are you from? (N = 58)

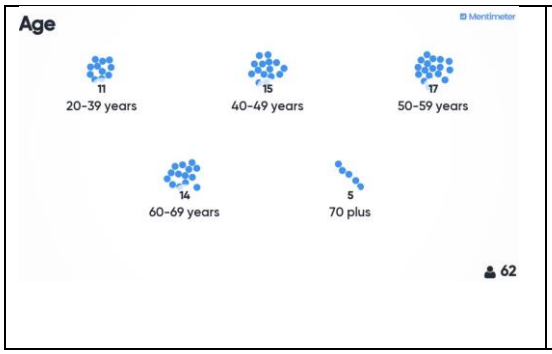


Fig.3. Age distribution of participants

Your opinion on continuity of care. (N = 62)

"Continuity of care" is a broad concept that has been defined in many ways. One of these, the hierarchical definition, may be sketched briefly as:

1. The informative level. This is a longitudinal collection of medical and social information about the patient (e.g. the medical journal), allowing some or all of those involved (including patients) to communicate about this information.

2. The longitudinal level. In addition to the informative level, each patient has a "medical home", which may be one specific GP, the GP's practice, a healthcare centre or any organised team of providers. The medical home might even be the patient´s own "home", including a private residence or nursing home.

3. The interpersonal level. In addition to 1. and 2., continuity of care consists of longitudinal personal relationships, defined traditionally as being between the patient and his/her own physician. In Primary Care, this is usually the GP**.**

According to McWhinney, Family Medicine is the only discipline to define itself in terms of relationships, the patient-doctor relationship in particular. Ideally, this longitudinal relationship evolves to forge a strong bond between patient and physician, one that is characterised by trust, loyalty, and a sense of responsibility. This underpins our prioritising of continuity of care in our suggested list of Core Values and Principles (see above).

In our workshops, we have discussed these elements in terms of the current state of General Practice. The opinions of our participants in Aalborg are illustrated in Figs.4. and 5.

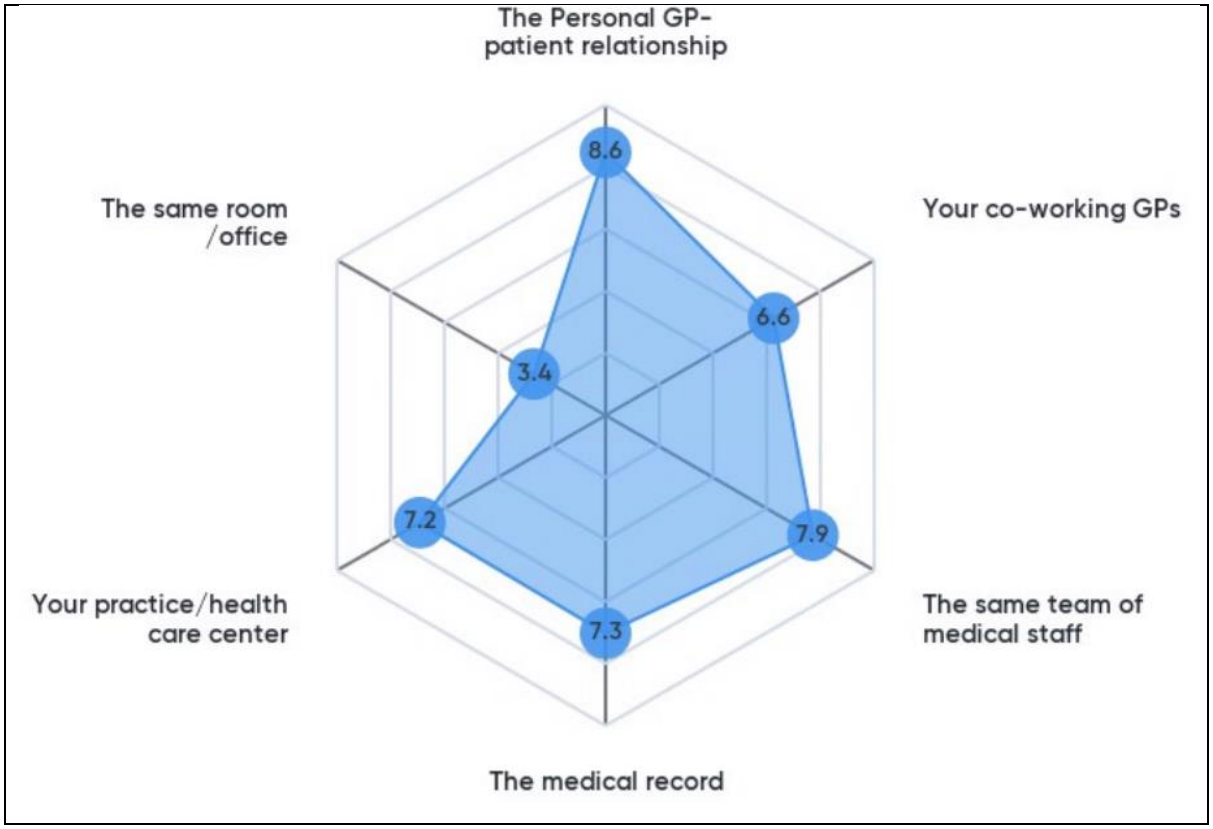


Fig. 4. Important elements regarding continuity of care (N= 60).

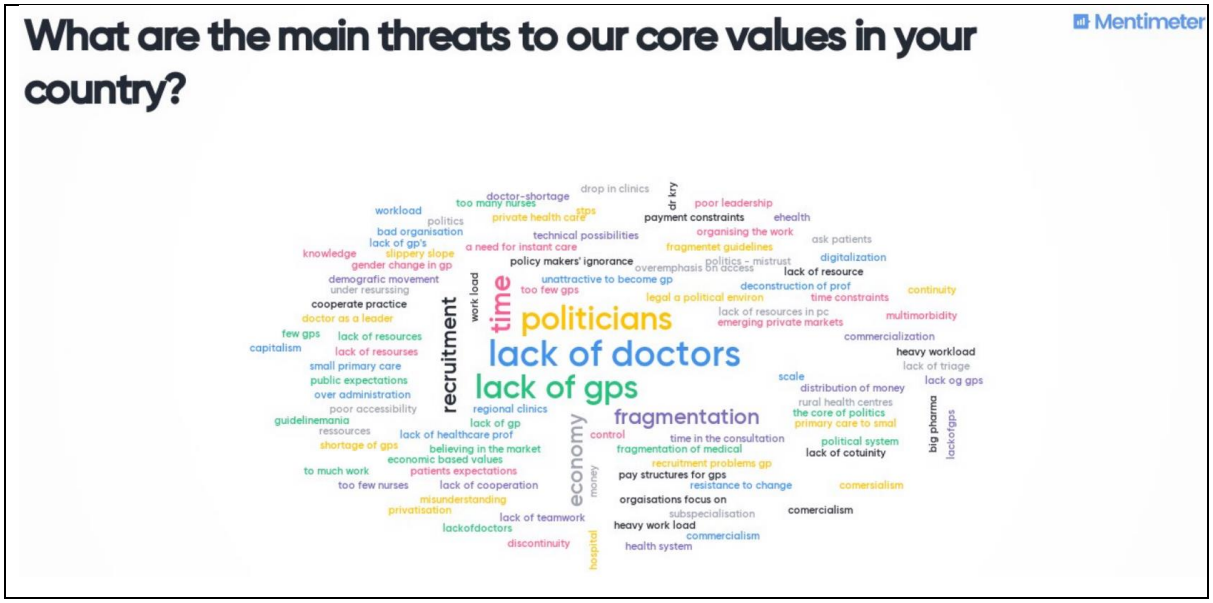


Fig. 5. Results regarding threats and opportunities.

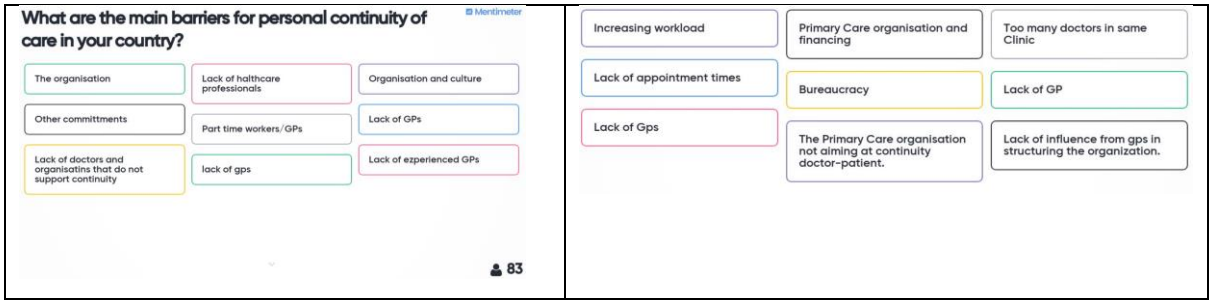


Fig. 6. Individual comments on the main barriers to continuity of care.

Using open discussion questions, we elicited opinions on possible barriers to continuity of care. Fig.6. illustrates the analysis of these results based on individual answers. The 86 comments may be condensed as follows:

- **organisational/political/financial;**
- **lack of GPs and increased workload/lack of time;**
- commercialism/culture;
- lack of ideology within our profession;
- in larger practices, shifting of GPs, and part-time GPs;
- task shift/teamwork;
- patients with complex complaints and diseases.

Of these comments, the organisational issues and the lack of GPs were the most frequently mentioned barriers to continuity of care. The results of the discussion of the utilisation of the core values are seen in Fig.7.

Fig. 7. How can you personally make use of "The Core Values and Principles Statements"?

Summary and conclusions

Values stay - but minor changes ahead

Our Nordic Core Values and Principles Statement is of great importance.
Values tend to stay, but standards (such as organisational structures, clinical guidelines, etc.) may vary, as mentioned at the start of this report. The results from our discussions, workshops and meetings, the opinions we have gathered from our Nordic colleagues as well as colleagues outside our Nordic region, all seem to confirm that our main values tend to stay. Within our Nordic region, they have remained almost the same for the last three decades. However, a new trend can be seen, expressed most clearly by our Dutch colleagues: Nowadays, there is greater focus put on the team of healthcare providers that is focusing on the person/patient than on the interpersonal relationship between the individual patient and his/her General Practitioner. In recent years, The Dutch College of General Practice (NHG) and the Dutch Association of GPs have been working on a project, involving thousands of GPs, focused on envisioning the future of General Practice in the Netherlands. They agreed upon 4 core values, shown in Fig.8, presented by Professor Henriette van der Horst at our 2019 WONCA Europe Conference in Bratislava. Our Nordic group, however, considers 'collaboration' to be a principle rather than a value, and that is the sense in which we have incorporated it into our suggested list (see above).

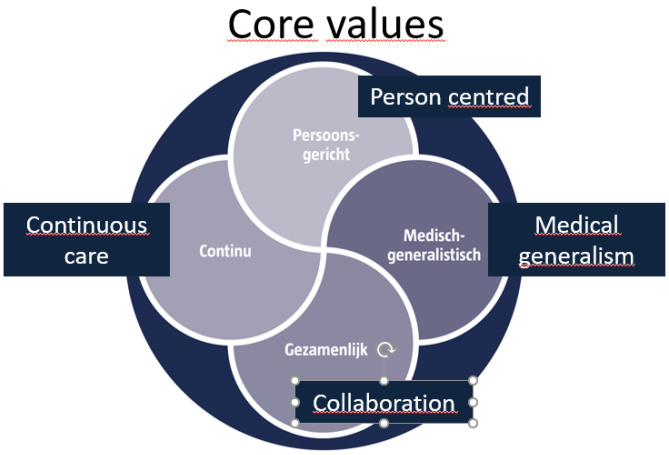


Fig. 8. The main core values agreed upon by NHG, Netherland, 2019.

Standards and organisational structures are changing rapidly

Cultural, societal and political changes threaten the personal primary healthcare concept, especially regarding continuity of care. Therefore, we need to attract the attention of policy makers and authorities within primary healthcare in order to inform them of the importance of this topic.

Usefulness

Revising and increasing awareness of the core values and principles of General Practice is a continual work-in-progress. Implementation of these values and principles is something to fight for. We need to express them in a catchy way. We recommend that our Nordic colleges translate our core values and principles into their native languages. Although our English version seeks to express our Nordic views, there will always be nuances of meaning and associations that come through best in one's own language.

As mentioned earlier, we recommend that these statements be introduced and applied among our colleagues, taught at our universities and at post-graduate levels, and be introduced and explained to all healthcare stakeholders, including politicians.

Reykjavik, 24. February 2020

On behalf of the NFGP working group

Johann Agust Sigurdsson, NFGP Chair

Appendix 1.

The Norwegian teses 2001

De sju teser for allmennmedisin

En oppsummering av NSAMs tenkedugnad 2000- 2001.

Vår samtid anno 2001 preges av økende muligheter for medisinsk behandling, men også av kommersialisering og medikalisering, rettighetstenkning og økt forbrukerbevissthet.

En ny beskrivelse av faget allmennmedisin i fastlegeordningen skal

- klargjøre legens ansvarsområder
- fremme forsvarlig bruk av medisinsk teknologi og medikamenter
- gi basis for innhold i grunn-, videre- og etterutdanning
- skape realistiske forventninger til helsetjenesten
- sikre faglig identitet og trygghet for legen.

1. Hold lege-pasientforholdet i hevd!

Allmennmedisinens sentrum er lege-pasientforholdet. Det viktigste er det personlige møtet og dialogen med pasienten over tid.

2. Gjør det viktigste!

Allmennpraktikerens hovedoppgaver er diagnostikk og behandling. Legen er

fortolker av pasientens symptomer og plager; skiller ut de som har behandlingstrengende sykdom, og forskåner pasientene fra urettmessig å bli behandlet som syke

veileder og lærer; hjelper pasienten til å forstå sin situasjon og hvordan den kan mestres eller lindres

vitne og ledsager; følger pasienten og hans nærmeste gjennom sykdom og lidelse.

3. Gi mest til dem som har størst behov!

Forventningene til allmennmedisinen overstiger både ideelle og praktiske muligheter. Allmennlegen må organisere hverdagen slik at det blir rom for de pasienter som har størst behov for hjelp. Allmennlegen må også ta hensyn til behandlingskostnader; hvis flere behandlingsstrategier er like effektive, skal allmennlegen velge det billigste slik at ressurser som spares kan komme andre til gode.

4. Bruk ord som fremmer helsa!

Allmennlegen skal gi pasienten tro på egen mestring av hverdag og helse. Allmennmedisinen skal utvikle et språk som begrenser fokus på risikotilstander og medisinbruk med liten nytteeffekt.

5. Sats på etterutdanning, forskning og fagutvikling!

Fagutøvelsen skal baseres på dokumentert viten, praktiske ferdigheter og erfaringsbasert kunnskap. Faget skal utvikle begreper som knytter sykdom og lidelse til relasjoner og gi en forståelse av hvordan livet setter spor i kroppen. Medisinsk etikk skal beskrive hvordan respekten for menneskets verdighet er en forutsetning for helbredelse.

6. Beskriv praksiserfaringene!

Å forebygge sykdom og uhelse er ofte et spørsmål om å endre samfunnsforhold. Legen skal systematisere og dele sin kunnskap med forvaltning og politikere om sykdoms- og lidelsespanoramaet i sin populasjon.

7. Ta ledelsen!

Allmennlegen skal ta aktivt ansvar for å sikre god samhandling mellom aktørene i helse- og sosialtjenesten. Allmennlegen skal bidra til at spesialisttjenester prioriteres til dem som har størst behov. I samhandling med andre helsearbeidere må allmennlegen arbeide aktivt for at faglige ressurser utnyttes optimalt. Som leder av legekontoret må legen sørge for at medarbeiderne får utvikle faglig og personlig kompetanse.

Appendix 2

The Danish teses 2016

http://www.dsam.dk/flx/pejlemaerker/

Pejlemærker for faget almen medicin

Almen medicin er et videnskabeligt funderet lægespeciale baseret på metoder og viden fra de tre klassiske videnskabsområder natur, samfund og kultur. Pejlemærkerne skal bidrage til, at vi som udøvende almenmedicinske speciallæger:

- skaber mest mulig sundhed og velbefindende for den enkelte patient
- har en indramning af vores fælles faglige identitet og vores faglige diskussioner
- har fælles referencer i forhold til grund-, videre- og efteruddannelse
- har et ensartet filter for samfundets forventninger til os.

1. Vi holder læge-patient-relationen i hævd

- Læge-patient-relationen er en grundsten i fagets fundament.
- Læge-patient-relationen opbygges på nærvær, fortrolighed, gensidig tillid og kontinuitet.

2. Vi finder og behandler de syge og lader de raske være raske

- Vi følger patient og pårørende gennem livsforløb, lidelse og sygdom og er primærbehandlere for udvalgte lidelser.
- Vi har fokus på den enkelte patients fysiske og mentale sundhed og forebyggelse af funktionstab.
- Vi arbejder bevidst på rettidig diagnostik og på at undgå overdiagnostik.

3. Vi giver mest til dem, som har størst behov

- Vi tilrettelægger arbejdet på en måde, så vi tilstræber at mindske ulighed i sundhedsvæsenet.
- Vi skaber tid og rum til dem, der har størst behov for støtte, hjælp og behandling.

4. Vi skaber en dialog, der fremmer sundhed hos den enkelte

- Vi kommunikerer på en måde, der giver syge og raske øget forventning og evne til at kunne mestre egen sundhed.
- Vi inddrager patientens tanker, bekymringer og ønsker og behandler derved hver enkelt patient forskelligt.
- Vi medtager patientens ressourcer, særligt familie og netværk, i en løsning tilpasset den enkelte.

5. Vi deltager i uddannelse, forskning og udvikling af kvalitet

- Vi tager ansvar for, at vores evidens- og færdigheds-baserede faglighed løbende vedligeholdes og udvikles.
- Vi forholder os konstruktivt og kritisk til ny viden og forslag til nye løsninger for faget.
- Vi deltager i uddannelsen af kommende kolleger.

6. Vi tager ansvar lokalt, tværfagligt og tværsektorielt

- Vi tager ansvar for at fremme samarbejdet med og mellem relevante sundhedsaktører.
- Vi vurderer, hvordan nye opgaver og løsninger bedst tilpasses klinikkens aktuelle patientsammensætning.

7. Vi beskriver og bruger erfaringerne fra praksis

- Vi samarbejder med fagets institutioner indenfor forskning og kvalitetsudvikling, som genererer specifik almenmedicinsk viden og stiller den til rådighed for fagets udøvere.
- Vi er opmærksomme på vores ytringspligt ift. særlige forhold, der fremkalder sygdom, øger ulighed i sundhed eller medfører uhensigtsmæssig ressourceudnyttelse.