# Newsletter

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## Table of Contents

# Country Case Report: Turkey

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The WHO has hesitated to make the pandemic declaration and said, "Pandemic is not a word to use lightly or carelessly. It is a word that, if misused, can cause unreasonable fear, or unjustified acceptance that the fight is over, leading to unnecessary suffering and death".

However, on March 11, 2020, WHO announced COVID-19 could be described as a pandemic. Moreover, as time passes, we have realized that it is a real pandemic. On March 6, as the first appearance of the first COVID-19 case in Turkey, various precautions have been taken to combat the pandemic in our country. In Turkey, combating disease outbreaks was conducted by the Ministry of Health.

For Turkey, the COVID-19 guide, regularly updated according to the developments, was created by Ministry of Health Coronavirus Scientific Committee. Hospitals and Family Health Care Centers were rapidly organized in line with the outbreak. Elective examinations, procedures, and operations were postponed.

It was suggested that non-emergency patients should receive service from their family physicians. Educational Family Healthcare Centers (E-FHC), which are affiliated with universities, are training environments for under- and post-graduate medical education and family medicine vocational trainees as well as providing health services to the patients in Turkey.

We have four Educational Family Healthcare Centers in our university. Our vocational trainees, general practice specialist, and faculty members work in these E-FHCs. In EFHCs organized essential arrangements done urgently with the disease seen in Turkey. We have taken protection and control measures to prevent the spread of the disease from health facilities. We quickly completed the training on COVID-19 of our team.

The team started to use personal protective equipment. Many patients applied to E-FHC at the same time to receive services on different topics. In the pandemic process, triage was applied in E-FHC to prevent the coexistence of healthy individuals and possible COVID-19 cases and contamination. Patients with possible COVID-19 diagnosis were referred to the hospital.

Patients with COVID-19 diagnosis who had no indication for hospitalization and COVID-19 contact were taken into home isolation and were called and followed up daily.

Apart from this group of patients, registered patients over the age of 65 who are under lockdown were also called by phone every week to evaluate their health status.

The areas where possible COVID-19 patients will receive care are separated from the care areas of other patients. In addition to fighting against infection, follow-up and immunization services for babies, children and pregnant continued.

During this period, our patients often called us for all health problems or information over the phone. We tried to solve the health problems of the patients without coming to the family healthcare center, so we tried to minimize the contamination.

In the first weeks following the detection of the first case, a large number of patients with suspicion of COVID- 19 applied to our EFHCs with the symptoms of infection. Now, this number is decreasing.

In Turkey, the infection has begun to bring under control. In the COVID-19 pandemic, we have struggled with the disease at the forefront.

As Family Healthcare Centers, we have an important function in gatekeeping and clinical responses. Identifying and managing possible cases as quickly as possible, reducing the risk of infection contact to patients and healthcare workers, helping vulnerable people to cope with their concerns about the virus, and reducing demand for hospital services, maintaining family healthcare service delivery.

We continue our functions to increase existing surveillance, such as acute respiratory infection, and to strengthen risk communication and community participation.

With the awareness of the importance of primary care in outbreaks, we continue to fight with COVID-19.



# Core Values and Principles of Nordic General Practice/Family Medicine

By Nordic Federation of General Practice

*Accepted June 8th, 2020.*

General Practice/Family Medicine is a fundamental element of primary care, defined by WONCA Europe as an established clinical discipline and by the WHO as the basis of all healthcare.

As an academic discipline, General Practice/Family Medicine is based on knowledge and methodology drawn from the Natural Sciences as well as the Humanities.

As committed leaders in the ongoing process of defining and implementing core values and principles, General Practitioners aim to:

- Promote and protect the health and well-being of each individual patient while keeping in mind the needs of the general population
- Provide a frame of reference for our professional identity
- Provide a basis for continuing professional development, with curricula and training adapted to every educational level – undergraduate, post-graduate, and beyond
- Communicate our mandate and the principles of our work to patients, fellow healthcare workers, and the communities we serve.

**1. We promote continuity of doctor- patient relationships as a central organising principle.**

*The doctor-patient relationship is based on personal involvement and confidentiality. Continuity of care helps build mutual trust and enable high-quality person-centred care.*

**2. We provide timely diagnosis and avoid unnecessary tests and overtreatment.**

*Disease prevention and health promotion are integrated into our daily activities. We care for our patients throughout their lives, tending to them through disease and suffering while encouraging progress toward health. We help patients understand their own health to confront and manage their limitations, improve and maintain their well-being. Overexamination, overdiagnosis, and overtreatment can harm patients, consume resources and indirectly lead to harmful underdiagnosis and undertreatment elsewhere. When equally effective interventions are available, we choose those that cost less.*

**3. We prioritise those whose needs for healthcare are greatest.**

*We aim to minimise inequalities in how health services are provided. We organise our practices to devote the most time and effort to those whose needs for treatment and support are greatest.*

**4. We practice person-centred medicine, emphasising dialogue, context, and the best evidence available.**

*We engage professionally with our patients' current life situations, biographical stories, beliefs, worries, and hopes. This helps us to recognise the links between social factors and sickness, and to deepen our understanding of how life and life events leave their imprint on the human body. We promote patients' capacity to make use of their individual and communal resources. To safeguard our long-term resilience as caregivers, we attend to our own well-being.*

**5. We remain committed to education, research, and quality development.**

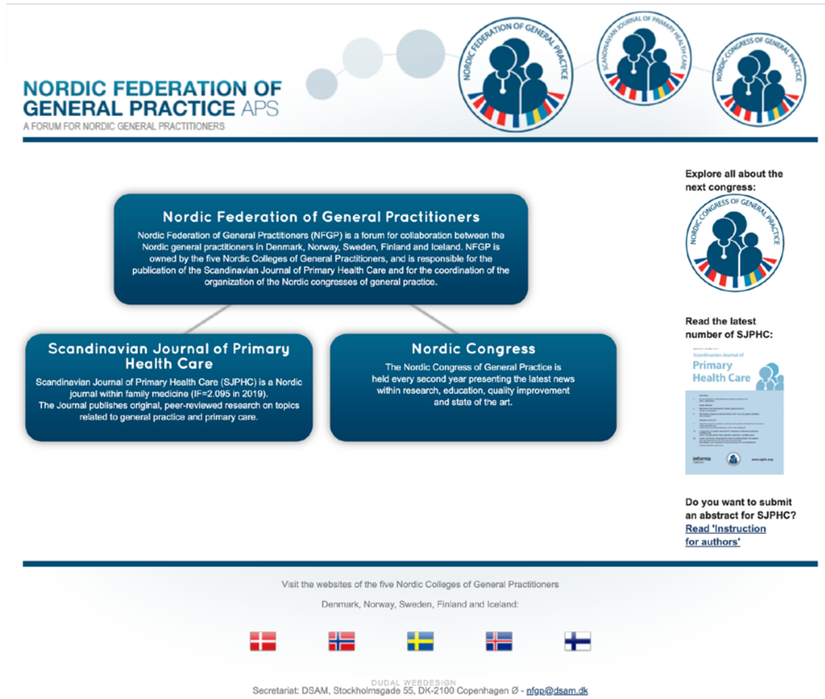
*We engage actively in the training of our future colleagues We implement and promote research that is suited to the knowledge needs of General Practice/Family Medicine. We take a constructively critical view of new knowledge and approaches within our areas of specialisation.*

**6. We recognise that social strain, deprivation, and traumatic experiences increase people's susceptibility to disease, and we speak out on relevant issues.**

*Respect for human dignity is a prerequisite for healing and recovery. We acknowledge that many circumstances contribute to health inequalities: childhood experiences, housing, education, social support, family income/ unemployment, community structures, access to health services, etc. We recognise our duty to speak out publicly on specific factors that cause or worsen disease, increase inequality in health outcomes, or make resources less accessible to certain people.*

**7. We collaborate across professions and disciplines while also taking care not to blur the lines of responsibility.**

*We engage actively in developing and adapting effective ways to cooperate.*



# An International PHC and COVID-19 Study (WONCA)

By Prof Felicity Goodyear-Smith, Karen Kinder, Robert Phillips, Andrew Bazemore, Cristina Mannie, and Stefan Strydom.

**Aim**
This multinational survey aimed to understand characteristics and strategies employed by different countries to deal with COVID-19 from a PHC perspective to determine:

- Factors most associated with national mortality rates during the pandemic period to date
- Lessons to better address both current and future pandemics

**Preliminary Results (1035 responses, 111 nations):**
***What factors correlated most with lower death rates?***

***Testing***: *Lower death rates were observed in countries where participants indicated that the following testing practices were employed:*

- Having readily available testing at the time of first COVID death
- Testing all incoming travelers
- Testing symptomatic persons
- Testing those exposed to COVID positive individuals

***Movement Restrictions:*** *Lower death rates were observed in where participants indicated that the following testing practices were employed:*

- Physical distancing o Event closures
- Closure of all but essential services o Isolation based on contact tracing
- Self-Isolation in households
- Quarantine for suspected cases

***Strong PHC System and Death Rates:*** *Existing strong PHC systems were not correlated with death rates. This may be attributed to:*

- Uncoordinated responses between public health and PC personnel
- Lack of PPE and testing for community-based workers
- Irrelevance of PHC if potential carriers were stopped at the border (most relevant to small island nations)
- PC not being engaged

**Methods**
1131 surveys were collected from PHC clinicians (73.0%), researchers (16.9%), and policymakers (10.0%) across the world. The survey was distributed in both English and Spanish via PHC networks and snowballing.

Participants were asked a series of questions that addressed the nature of their PHC system, how it responded to the pandemic, the use of health information technology in their country, if their country had a pandemic plan, and various strategies utilized to respond to the virus. Countries that had 10 or more surveys are referred to as the 'top 21 countries'.

**Data for Each Country:**
For each country, the maximum death rate on a 7-day moving average served as the response variable in the survey.

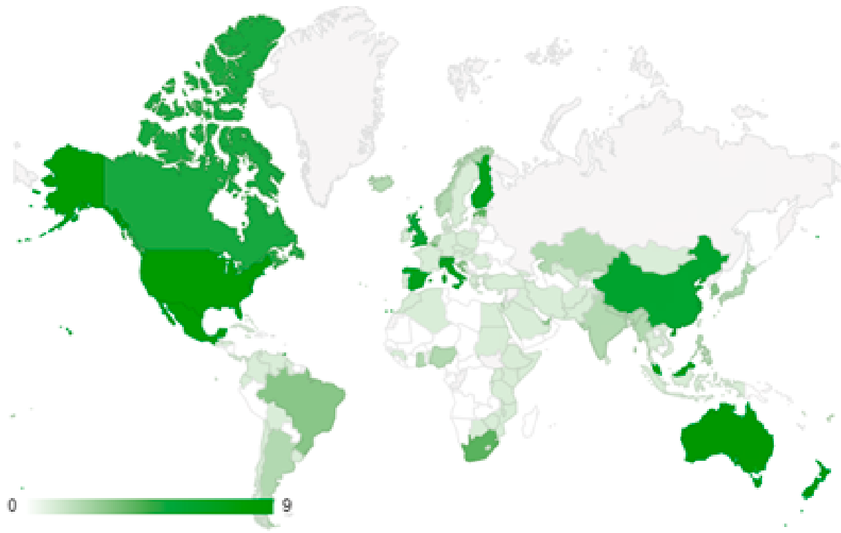
**Analyses:**
Univariate, bivariate, regression model analyses, and thematic analysis were employed to arrive at the preliminary results.

**Current Public Health and Primary Care Responses:**

- Hygiene Measures: hand washing and wearing PPE
- Limit person-to-person contact: physical distancing, ban mass gatherings, primary care provided remotely, self-isolation, and shutdown
- Identify Cases: testing, contact tracing, and surveillance

**Current Approaches to Address the Pandemic:**
Most countries utilized a combination of the following strategies:

- Blocking entry to country: border control, testing and or quarantining new arrivals
- Reducing the spread within the country: employing a variety of public health and primary care measures
- Managing severe cases to reduce deaths: hospitalization, oxygenation, ventilation, and intensive care




*'Primary health care perceptions of COVID-19 responses on rate of death: an international study', Felicity Goodyear-Smith, Karen Kinder, Andrew Bazemore Robert Phillips, Stefan Strydom, Cristina Mannie, under consideration for publication, 2020. For further information, please contact Andrew Bazemore: abazemore@theabfm.org.*

# Dr Austin O'Carroll - WONCA Europe 5 Star Doctor 2020

By WONCA Europe

WONCA Europe is proud to announce the winner of the WONCA Europe Award of Excellence in Health Care: ***The 5-Star Doctor 2020:*** **Austin O'Carroll** from Dublin, Ireland  Dr O'Carroll will be one of the European candidates for the WONCA World 5-Star Doctor Award of 2020 in Abu Dhabi in November. The WONCA Europe 5 Star Doctor Award 2020 will be presented at the European Conference of Family Doctors in Berlin, December 17 - 19, 2020.

About Dr Austin O'Carroll - a short extract from the winner's application:

- Dr Austin O' Carroll is a **GP in inner city Dublin**. He has a profound interest in health inequalities, and started eight specialised primary care services for homeless people. He raised funding for and established a mobile outreach clinic for rough sleepers. He was a founding member of the out of hours services D-Doc for the Dublin area.
- He founded **Safetynet**, the umbrella organisation for primary care services providing health care to homeless people which is delivered in 18 hostels and food halls/drops in the centres of Dublin, Limerick and Cork. Safetynet also provides services to the Roma community; methadone services to homeless people; and services to migrants. He co-founded GMQ GP services for homeless people. He co-founded Curam, a new social enterprise that is setting up New GP practices in areas of deprivation.
- Dr. Austin O'Carroll is also the founder of the **North Dublin City GP Training programme** (NDCGP). In Ireland as well as internationally, NDCGP is the first GP training programme which specifically trains GPs to work in areas of deprivation and with marginalised groups. As part of their fourth year all NDCGP trainees work one day a week in homeless/prison/migrant/or drug addiction health services.
- Dr. Austin O'Carroll is a member of the steering group of the **Partnership for Health Equity of the National Health Service Office of Social Inclusion**, NDCGP, the Irish College of GP and the University of Limerick.
- He holds a PhD in **ethnographic research into homelessness**.
- Dr. Austin O'Carroll sails on the **Irish Paralympics Sailing Team**.

# General Practice after COVID-19

By Dr. Thomas Micklewright

The reality of working at a General Practice COVID hot hub only sunk in when I entered my consulting room for the first time. For GPs, this is usually a time of giddy excitement. Your room, with its desk, leaflet stands, equipment cupboards and examination couch, becomes a steadfast partner throughout your career. Not in the hub. A smell of disinfectant, a box of PPE and a large TV with a webcam had replaced the usual, friendlier amenities. This was General Practice at war.

The hot hubs across the country epitomise the rapid change occurring in general practice. Patient empowerment, self-monitoring, remote consultation and hub-based working are not new ideas. However, the speed of their adoption in recent months has been unprecedented. Now as lockdown begins to ease, 3 questions about these changes have become pressing: which of these will stay? Which will go? And which will continue to evolve? Welcome to General Practice post-COVID-19.

**Remote consultations post-COVID**

Since the COVID-19 outbreak, the number of face-to-face General Practice consultations has plummeted from 80.8% to just 7-8%. Almost all of these are now triaged beforehand. Online consultations are now available in all GP surgeries in England and GPs are having to reconsider the role of clinical examination. Which bits are needed? What can the patient do (I've previously covered this in a video)? And how do I manage the unknown?

As GPs warm to this new digital paradigm, they will manage more patients by video, email and signposting to other services. NHS England still advise "you don't need a video consultation if a phone call will do". Many still hold this attitude. But the huge time and cost saving to running an entire GP appointment list by video, rather than individual appointments, has yet to be realised. With time though, online consultations will only become more embedded in practice.

*Source: https://tommicklewright.com/general-practice-after-covid-19/amp/*

**Remote consultations: beyond GPs**

I believe that allied health professionals will soon go digital as well. Once the limitations of telephone appointments becomes apparent, we will see mental health therapists, specialist nurses, dieticians, physiotherapists and health coaches start to adopt these technologies too. Patients will also become more heavily involved in their care (more on this below). The increased uptake of health apps strongly supports this. ORCHA, the Organisation for the Review of Care and Health Apps, has reported a 6500% increase in health app recommendations from health and care professionals.

The next radical leap though, will be devices that enable remote measurements to be taken. "If only he could measure his own oxygen levels", I've heard many a colleague vent. "Then I wouldn't need to see him at all". In fact, we built General Practice COVID hot hubs because of this particular thorn. There is an enormous demand for mobile technology that can record blood pressure, 02 saturation, heart sounds, respiratory rate, ECG and more, especially during COVID-19. This is fertile ground for innovation. With companies like Fitbit exploring 02 monitoring in their devices and Public Health Wales recently announced an online home STI testing service, I expect much more to enter this space soon.

**Patient Empowerment post-COVID**

After remote consulting, the second biggest change will be in the relationship between patients and healthcare. Within days of the announcement that fever and a new cough were indicative of COVID-19, thermometers disappeared off the shelves. Once asthmatics were marked as 'high risk', inhalers and peak flow monitors began to disappear too. Many patients I now consult with have already measured their pulse, temperature and blood pressure on their home devices.

I believe this represents a paradigm-shift. The public are taking back responsibility for their health. Of course, they've had little choice. Government guidance has put the onus on patients themselves to recognise symptoms, identify risk factors and self-isolate appropriately. I believe this will lead to an increase in the use of home devices, wearables and health apps that patients use.

The pressure to take more responsibility has been even greater when we consider the utilisation of digital first services. The pandemic has birthed online isolation notes, 111 online, online COVID test requests, the NHS Contact Tracing app and a plethora of new online consultation providers. The message appears to be: if you want healthcare, get online. We must also determine the impact of this on equality of access in the coming months.

**Conclusion: General Practice after COVID-19**

Let's return to our 3 questions: which changes will stay? Which will go? And which will continue to evolve? Remote consulting is certainly here to stay and will continue to evolve. Opportunities for remote examination and patient health apps will only grow exponentially. Whether the public will retain their sense of agency and responsibility for their health remains to be seen. The response of General Practice to COVID-19 has also given us a teaser of the future of PCNs; a hub-and-spokes model that can integrate the care sector and sustain professional clinical communities, whether online or face to face.

We *must* remember though, that this has come at a terrible cost. The loss of thousands of lives and livelihoods, across the country. For the sake of our patients, we have a responsibility to rise from this with a renewed vision for General Practice. Let's build a system that is stronger and more resilient than ever before.