



## WORLD ORGANIZATION OF NATIONAL COLLEGES, ACADEMIES AND ACADEMIC ASSOCIATIONS OF GENERAL PRACTITIONERS/FAMILY PHYSICIANS

### Around the World

#### *Latin America*

Family medicine has been a relatively recent development in Mexico, Central America, and South America, beginning with programs through the Mexican Social Security System in the early 1970s. Traditionally, much of Latin America has followed the North American model of specialty and subspecialty training. Many teachers in Latin American medical schools have had part, or all, of their training in the United States and Canada. Most major cities in Latin America boast of facilities and specialists that are equal in quality, if not quantity, as those in many cities in the United States. However well cities may be supplied with physician manpower, rural areas, which still comprise the majority of the population in Latin America, have not had health care of sufficiently high quality to improve the overall quality of life for many citizens. Most strides in health have been taken through community education programs in sanitation and agriculture, while the delivery of primary care has been left to indigenous health workers, working in many cases with little or no backup. Many counties have instituted mandatory service for graduates of medical schools, which has resulted in the staffing of rural clinics and clinics in "marginal" areas with short-term, undertrained, and often unenthusiastic physicians who go back into specialty training as soon as the opportunity arises.

Most health planners have recognized the need

for the establishment of organized systems of primary health care and have begun to direct the resources of their government toward alleviating inequities in the current system. Many countries have well-outlined systems of care which begin at the local level with small dispensaries staffed by trained indigenous health workers doing first aid and immunizations. A group of dispensaries relates to the next level of care, which is a rural clinic staffed by a single physician and nurse and, in turn, a number of rural clinics relate to a larger health center containing diagnostic facilities, specialty consultants, and a larger number of general physicians. This pattern of health care organization clearly requires a well-trained generalist who will coordinate and carry out the system of health care delivery at levels below the district and regional hospitals. The traditional specialist dominated training system has been inadequate for the training of generalists.

The social security system in Mexico, a worker-, employer-, and government-supported organization of health care on a prepaid basis, recognized the need for generalists to staff the primary care aspect of that system. The first residency training programs in family medicine were begun in the social security hospitals, and after seven years the Autonomous University of Mexico in Mexico City began the first academic Department of Family Medicine (apart from Puerto Rico) in Latin America. The success of the Mexican educational system in family medicine inspired other educators and other governments to likewise look to develop training programs for family physicians. At meetings dating back to the 1960s, the need for generalist training in the Andean countries was discussed, but governmental changes and changing priorities delayed

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From the WONCA Standing Committee on Research; Research Newsletter edited by Dr. Peter Curtis, MECP, MRCGP, DObst, Department of Family Medicine, UNC School of Medicine, Trailer 15, 269H, Chapel Hill, NC 27514.

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the implementation of actual training programs. In the past two years, the governments of Venezuela and Panama have formally gone on record as supporting the development of training programs in family medicine in their countries.

The magnitude of the problem is matched only by the enthusiasm of educators who have decided to pursue family medicine in Latin America. The problems of facilities, faculty, residents, and overall national recognition of family medicine as a full-status discipline must be addressed if the movement is to succeed. Without a strong tradition of well-organized practitioners of general or family medicine in most countries, program designers have had to search long for educators with sufficient general background and interest and adequate educational credentials to begin programs. While many Western countries have been able to draw upon community practitioners, most of Latin America lacks sufficiently high quality practitioners to follow that tradition. Thus, a first priority for countries just beginning family medicine programs is to train faculty.

With this in mind, the Pan-American Federation of Medical Schools (PAFAMS) instituted a program to introduce educators and high-level governmental health officials to the concepts of family medicine. Dr. Julio Ceitlin, Director of Programming for PAFAMS, organized traveling seminars with the help of the American Academy of Family Physicians, the Society of Teachers of Family Medicine, and the Canadian College of Family Physicians, which took groups of educators from Latin America to visit programs in Mexico, the United States, and Canada. This tour culminated in the first Fellows spending six months in programs at the University of Western Ontario, the University of Iowa, and the University of North Carolina during 1981. There are also plans to have short-term workshops in university settings in those three countries as well as others. The Society of Teachers of Family Medicine has recently initiated a working group to explore educational relationships with the emerging family medicine movement in Latin America. The need for closer relationships between the United States, Canada, and the countries of Latin America arises from the necessary and beneficial economic and cultural ties that have increased in the past 25 years. While the United States and Canada have more experience in the education of primary physicians and

family physicians, most Latin American countries have spent a good deal of time and thought developing rational, multilevel, integrated systems of health care delivery which will get care to all citizens. The collaborative educational and research efforts of the countries of North and South America will have the potential for enriching all those involved.

Once training programs have begun, the long struggle for status within the medical establishment and for academic viability and acceptance will follow. It appears that, from interest shown by countries which do not currently have plans for training family physicians, the changes brought about by family medicine in Latin American medical education and patient care will be far reaching and permanent.

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### WONCA Research Committee

At the Ninth WONCA World Conference held in New Orleans in October 1980, the Research Committee was constituted for the following three years:

Chairman—Dr. Neville Anderson

Members—Dr. Yair Yodfat, Israel

Dr. F. Zacarias, Mexico

Dr. Chris van Weel, The Netherlands

Dr. Fredrick St. George,

New Zealand

Dr. Fernando, Sri Lanka

Dr. Karlearn, Sweden

Dr. Clifford Kay, United Kingdom

Dr. Peter Curtis, United States

Dr. M. Wood, Honorary Secretary,  
United States

Dr. Mike Hoyos, Barbados

Dr. Demanuel, Canada

Dr. Luterio, Phillipines

The responsibilities of committee members were:

1. To answer correspondence
2. To provide regular reports to the Chairman and Newsletter Editor



3. To organize the copying and distribution of the Newsletter to colleagues within his jurisdiction

4. To act as initiator and communicator of ideas and issues to the membership of the Research Committee of WONCA

5. To attend all research standing committee meetings, or to recommend an alternative representative in his place

6. To search for and identify funding sources for individual or collaborative research studies within their jurisdictions

### ***Reason for Contact Classification***

This classification system has been developed by a working party of the World Health Organization. The WONCA Committees on Classification and Research strongly support the pilot testing of this classification system.

### ***A Statement by the Joint Meeting of the Research and Classification Committees of WONCA***

The Joint Committee supports the principle of the need for a classification of reasons for contact with primary care services.

They acknowledge the work that has already been done, congratulate the working group, encourage them to continue development and research, including field testing, under the aegis of the joint committee. They designate the members as follows: Henk Lamberts, Classification Committee of WONCA; Maurice Wood, Research Committee of WONCA; Sue Meads, Senior Advisor to the North American Office for the Classification of Diseases; Martin Osnes, NOMESCO.

The Reason for Contact Classification, which incorporates medical, psychological, and social categories, is about to be tested in a pilot phase at 12 practice sites in Europe and South America. The ICD unit of the World Health Organization has committed support for this project over the next two years.

### **WONCA Secretariat**

The new WONCA Secretariat is now located at 70 Jolimont Street, Jolimont, Victoria, 3002, Australia, Telephone (03) 654-3000 (61-3-654-3000, International). The newly appointed Honorary Secretary is Dr. Wesley Fabb.

### ***New Members of WONCA***

The Icelandic College of Family Physicians  
Domus Medica  
101 Reykjavic  
Egilsgata 3  
Iceland

The Association of  
General Medicine Practitioners  
of Nigeria  
9 Sam Shonibare Street  
Surulere, Lagos  
Nigeria

The South African Academy of Family Practice/Primary Care-Suid-Afrikaanse Akademie Van Huisartspraktyk/Primeresong  
Rooms 24/25  
Medical House  
Central Square  
Pinelands 7430  
Republic of South Africa

### **Primary Care Classification**

#### ***1. A Process Code for Primary Care (NAPCRG-1) International Field Trial Version***

This coding system was developed by the Ad Hoc Committee for Process Coding of the North American Primary Care Research Group. This coding system is a natural sequel and accompaniment to the ICHPPC-2 diagnostic code and deals specifically with procedures in primary care. A hierarchical code usable at 2-, 3-, or 4-digit levels is used. The code is constructed in the following way.

Section 1: Disposition

Section 2: Preventive and Supportive Services

Section 3: Procedures

Section 4-5: Drugs and Pharmaceuticals

Section 6: Other Diagnostic Procedures

Section 7: X-ray and Ultrasound

Section 8: Clinical Laboratory

Section 9: Site and Duration of Service

A description of the code was published in the *Journal of Family Practice* February 1981.

The committee hopes to stimulate interest in



this pilot coding system and welcomes feedback in order to develop a validated international instrument complementing ICHPPC-2. Copies of the booklet are available at \$4 plus postage from:

*Dr. Herbert L. Tindall*  
*Lancaster General Hospital*  
*PO Box 3555*  
*Lancaster, Pennsylvania 17603*  
*USA*

## **2. Mental Health Classification**

Within the Mental Health Division of WHO, two separate enterprises involving primary care classification are currently underway. First, as part of a detailed review of the whole of classification methods in psychiatry undertaken by eight expert panels, the need for a specific classification of psychiatric problems in primary care was identified. A report was developed at a meeting at Zagreb, Yugoslavia, in December 1980.

Second, the Rockefeller Foundation is supporting a primary care classification system of psychological and social problems. The group is intending to develop a glossary of terms and definitions as well as a series of case vignettes for testing the classification and training of nonmedical providers who use it. A pilot and field test program will be undertaken over the next two years in six countries.

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## **International Invitational Conference on Academic Family Medicine, Florida 1980—Report**

This conference was sponsored by the Department of Family Medicine, University of Miami, School of Medicine, Miami, Florida, USA. The papers presented are published as a proceedings by the department and include several of research interest:

Priorities in Primary Health Care Research in the 1980s

Bent G. Bentsen—Norway  
Institutions—The Care of the Aged  
Zlato Dembic—Yugoslavia

New Yardsticks for Research into General Practice

Hans Dijkuis—The Netherlands  
Education and Socialization in Family Practice  
Brian Hennen—Canada

Some Aspects of the British Vocational Training Scheme and the Use of Project Work as a Learning Stratagem in the Field of Population Medicine

Philip Nolan and Brian Beaumont—England  
The Panamanian Experience in Family Practice  
Thomas P. Owen—Panama

A Short Review of the Development of General Medicine in Yugoslavia

Mijo Simunic—Yugoslavia  
Future Research Trends in Family Medicine  
Yair Yodfat—Israel

The proceedings are available from:

*Joan Carmichael, PhD*  
*Department of Family Medicine*  
*University of Miami*  
*School of Medicine*  
*PO Box 016700*  
*Miami, Florida 33101*  
*USA*

## **North American Primary Care Research Group**

The Ninth Annual Conference of the North American Primary Care Research Group was held at Lake Tahoe, Nevada, in March 1981. Again it was highly successful, with over 100 papers presented.

The liaison among the pediatric, internal medicine, and family practice ambulatory care groups was intensified. Three planning committees were developed: (1) a liaison planning group, (2) a research group, and (3) a joint proceedings publication group. It was agreed to exchange newsletters, resource documents, and conference abstracts.

### ***Task Force on Sentinel Practices***

This group has produced a position paper, and a collaborative study on headache is being planned.

### ***Clinical Decision Making***

A list of interested people has been developed as well as a compilation of relevant literature on decision making in clinical medicine. This will be distributed to NAPCRG members.



The next NAPCRG meeting will be held in Columbus, Ohio, May 19-22, 1982.

### European General Practice Workshop (EGPRW)

Since EGPRW began in 1974, the workshop has succeeded in finding a common goal: how to develop a way of doing research which is typical of general practice and therefore is easily recognized across the national boundaries as a sound basis for our work. This does take a lot of time, but then that is a little like the maturing of a good wine. . . .

How can the activities of the Workshop be classified?

1. Mutual information about the organization of research and its achievements in the several European countries
2. Support of international exchange of information and contacts about research
3. Organization of special courses of interest
4. Undertaking binational and multinational research projects
5. Future activities may include the organization of meetings for general practitioners involved in projects

### Annual Report 1980

Two meetings were held, in Antwerp (April 19-20) and in London (November 28-30), with attendances of approximately 27 participants. The next meetings will occur November 27-29 in Göttingen, Germany, and possibly in Bellagio, Italy, in 1982.

### *Selected Reports of EGPRW Projects*

#### *Research in the RCGP*

Dr. Clifford Kay, Chairman of the Research Division of the Royal College of General Practitioners, reported that in order to talk about the research undertaken by the College, it was necessary to demonstrate the way in which research was organized within the College. Such organization was embraced within the term "Research Division," which included the work of the six Research Units but also included the work of the Regional Faculties. The faculties are nearly all related to a university department of general practice, and it was hoped that the Research Division would be able to influence those departments; the

teachers of general practice had a representative on the Research Division.

There have always been trials of drugs in general practice. In the past year the College has drawn up guidelines for the conduct of clinical trials of drugs, from both the scientific point of view and the ethical standards required. These guidelines have been discussed with other bodies representing the pharmaceutical industry and the British Medical Association, and agreement has been reached.

The main effort of the Research Division has been in two fields. One was to try to encourage research throughout the country, starting with the faculties. About two years ago the executive of the division suggested that the faculty research committees have a symposium day in which they would invite people from their own areas to present papers on research. The aim was for each faculty to select from that presentation two or three papers to send to the College from which to construct a program at the time of the Royal College of General Practitioners Annual General Meeting. This was done, and the papers were presented recently to an audience of about 250; it proved a stimulating and exciting day.

The other concern was to try to provide some sort of training for research for general practitioners. It was believed that this training should take place at all levels but the most important was during the traineeship for general practice. The Research Division was encouraging simple projects for trainees (a trainee being the young physician in a three-year rotation system training for general practice).

There was an award each year from the Astra Pharmaceutical Company for just such projects. There was also a research bursary to enable an established practitioner to take three months off to study research methods in appropriate settings.

In addition, faculties were being encouraged to collaborate with their local university departments of general practice to set up courses for training in research. (Twenty-five medical schools now have such departments of general practice.)

A new venture was to provide much longer training periods of at least a year within the College's research units. These research fellowships were aimed at the physicians who had just completed their general practice training.

The opportunity for this had arisen because half



of the money raised by the College by its public appeal for academic funding would be allocated to maintain the organization without which the research projects could not be supported—the research infrastructure.

Dr. Kay went on to describe the work of the six units and the coordinating influence exerted by the Research Division, including the work undertaken by three of these units to study whooping cough, its natural history, the protection given by immunization, and the effects of prophylactic erythromycin.

The division had also been looking at computers, and a report, "Computers in Primary Care" had been published. A joint working group with the General Medical Services Committee had now been formed to speak for the whole profession and was shortly to meet to discuss policy.

Another major activity concerning the College had arisen partly because of the work of the Manchester Research Unit and the Oral Contraceptive Study, which was observing the effects of a drug after it had become available to the public. The College is to set up a regular scheme for the postmarketing surveillance of drugs in order to try to detect any serious adverse effects and was joining with a commercial group which would act as the contact with the pharmaceutical industry, the joint venture being known as the Medicines Surveillance Centre.

### *Summary from Belgium*

Dr. Theirs began by telling the group that he was at present working at the Institute for Hygiene and Epidemiology of the Belgium Ministry of Public Health; the Institute gives advice to the Minister for most health problems. There were three large departments: microbiology, environmental health, and pharmacology and toxicology. Dr. Theirs had been charged with the creation of a new department for epidemiology.

A project on sentinel practices had been started for a test period from March to September 1978 in the Flemish part of Belgium, and, after publication of an evaluation, had been extended to Brussels and the Walloon area from the beginning of 1979. About 150 general practitioners were taking part, using a very simple weekly return system, and they in turn received quarterly feedback. There was space on each return form for the physician to write his comments, and sometimes these were

extremely interesting. It was assumed that 2 percent of the physicians reporting presented 2 percent of the population as denominator.

Dr. Theirs pointed out that for example this was the first time there had been morbidity figures for measles, and the figures might be used as an argument for measles vaccination.

The most important decision from Dr. Theirs' point of view was a decision to use computers, which had been arranged with another department. The projects suffered from delays, and Dr. Theirs had been trying to obtain a minicomputer. This had led him to suspend all recording since the beginning of October, to restart when it was possible to handle the returns with the aid of a computer.

### *Draft Proposals for a Multicenter Trial of Prevention of Thromboembolic Stroke by Reduction of Blood Viscosity*

Dr. Julian Tudor-Hart spoke in reference to his paper, in which there was material about the classification of a stroke and the risk factors of stroke, the central feature of which, however, was a proposal for a trial to see if intervention was possible to reduce one of the major risks, atherothrombotic strokes. It was not suggested that high blood viscosity was a more important factor than hypertension, but it was an important one and probably reversible. Studies on a small number of cases had shown that brain blood flow rates were universally related to packed cell volume; it seemed that sufficient work had been done and that someone should set up a controlled trial. Dr. Tudor-Hart thought that a pilot study in three or four practices should be initiated.

Discussion ensued about the numbers to be involved in the trial, which was defined as complicated and sophisticated, and a follow-up. Screening might be difficult in different countries where different health care systems operated. Dr. Krogh-Jensen said that he felt the project would be an unacceptable one because of a large group of British physicians participating, which would thus make the results unrepresentative for Europe. Dr. Tudor-Hart acknowledged this, pointing out that practices which participated in research were not representative of other practices, although Dr. Krogh-Jensen thought that representivity of practices was not the point, but the representativity of



the population was—if there were no systematic differences, it would be seen that there was a biological and not a social difference. It was agreed that Dr. Tudor-Hart should be encouraged to develop a pilot study for the United Kingdom and report back to the workshop.

## Research Resources

*Primary Care Research in 1980: The Collected Abstracts of Four Societies.* Edited by Mack Lipkin, Jr., and Kerr L. White, 1981. Rockefeller Foundation, New York. This is a review of 295 abstracts from meetings held by several research groups in the United States: the Ambulatory Pediatrics Association, the North American Primary Care Research Group, the Society for Research and Education in Primary Care Internal Medicine, and WONCA.

*Primary Health Care in Europe—1979.* Leo A. Kaprio. Regional Office for Europe, World Health Organization, Copenhagen. 5 Fr (Swiss). This small text contains a review of the development of health care systems in Europe, particularly as it applies to the relationship between primary and hospital based care. A number of strategies are proposed for basing multidisciplinary services on the general practitioner.

*Health Education: Smoking, Alcoholism, Drugs. Review of selected programmes for schoolchildren and parents: EURO Reports and Studies 10.* K. Vuylsteck, 1979. (ISBN-92-9020-149-5) WHO Regional Office for Europe, Copenhagen.

*The Nation's Families: 1960-1990.* George Maswick, Mary Jo Bane, Neal Baer, John Pitkin, Lee Rainwater, Barbara Wiget, 1980. Joint Center for Urban Studies of MIT and Harvard, 53 Church Street, Cambridge, Mass. 02138, USA. \$10 paperback.

*Manual of Basic Techniques for a Health Laboratory 1980.* 1,300 illustrations. (ISBN-92-4-154145-8) WHO, Geneva.

*Health Handbook—An International Reference on Care and Cure.* Edited by G.K. Chacko, 1979. Amsterdam, New York, Holland Publishing Company, \$146.25. This book of over 1,100 pages is in five volumes, dealing with national organization of health services, health services management, computer assisted health operations, educational innovation, and health utilization.

*Survey Methods in Community Medicine.* J.H.

Abramson, 1979. Churchill Livingstone, London. £ 5.00. This is a clear and simple guide to the development and implementation of investigations. It is especially useful and readable for the clinician and family practice researcher.

*Information Systems for Health Services. Public Health in Europe, No. 13.* Edited by G. McLachlan, 1980. 132 pages (ISBN-92-9020-1320). WHO Regional Office for Europe, Copenhagen.

*Periodic Health Examination Monograph: Report of a Task Force to the Conference of Deputy Ministers of Health.* The Canadian Government Publishing Centre, 1980, Hull, Quebec. \$22.20 outside Canada. Orders payable in advance to the Receiver General of Canada.

*The Measurement of the Quality of General Practitioners Care, Occasional Paper 15.* Royal College of General Practitioners, 14 Princes Gate, London, SW7 1PU, England. £ 3.00. A review of the literature on the measurement of quality in General Practice.

*Health Care of the Aging.* American Academy of Family Physicians, 1746 West 92nd Street, Kansas City, Missouri, 64114, USA. This is a review and resource document on aging and reflects the Academy's opposition to the development of a new specialty or subspecialty in geriatrics.

*Family Practice Research: A Current Canadian Index.* Daniel Brachstone. College of Family Physicians of Canada, 4000 Leslie Street, Willowdale, Ontario, M2K 2R9, Canada.

*Uniform Ambulatory Medical Care—Minimum Data Set.* Report of the National Committee on Vital and Health Statistics. US Department of Health and Human Services, Office of Health Research, Statistics and Technology, National Center for Health Statistics, Hyattsville, Maryland 20782, USA.

*Scientific Research Within the Netherlands Institute of General Practitioners.* Postbox 2570, Mariahoek 4, 3500 GN, Utrecht, Netherlands. This is a small booklet describing the research activities funded by the institute.

*General Practice Research—Britain.* A summary of projects undertaken by the various research units operating under the auspices of the Royal College of General Practitioners, it is contained in the 28th *Annual Report* (1980) of the College. Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London, SW7 1PU, England.