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EDITORIAL

"Caring for people where they are": Addressing the double challenge of general practice at the 17th Nordic Congress of General Practice in Tromsø 2011

At the first Nordic Congress of General Practice in Copenhagen in 1979 Christian Borchgrevink, the first professor of general practice in Norway, stated in his key note lecture:

> Research is important for recruitment and status of our specialist discipline. Through research we raise our critical sense. I believe that general practitioners who organise their curiosity through little or more research will be better doctors in many respects.

We think the subsequent 15 congresses, arranged in the five Nordic countries and again in Copenhagen in 2009 [1], have been a manifestation of Borchgrevink's words. When we issue invitations to the 17th Nordic congress in Tromsø in June 2011 – for the first time north of the Arctic Circle – we feel proud to belong to this tradition and to be responsible for bringing it a further step towards the future. Our vision for the congress, c*aring for people where they are*, is inspired by life and nature in the northern and rural areas. It refers to the double challenge for all doctors in general practice: to care for people both where they are living, and where they are in their lives.

Biography, biology, and health

In 1977–1978, Anders Forsdahl, the first professor of general practice in Tromsø and in Northern Norway, published groundbreaking epidemiological findings suggesting an association between having suffered years of deprivation and poverty in childhood and ill health and early death in adult life [2,3]. Forsdahl's original suggestion, further expanded by studies of Barker and recognized as the *Forsdahl-Barker hypothesis* [4], in many respects corresponds with the concept *allostatic load* proposed by Bruce McEwen [5]. Allostatic load implies a compound reaction to distress engaging neurological, endocrine, immunologic, and mental systems in a united way. Interdisciplinary research related to this concept has led to novel perceptions concerning how past and present life experiences influence future health, through an interdependent effect on mind and body as a unity, and not as two separate worlds [6]. This insight may be especially relevant for a more appropriate approach to patients with complex diseases, such as cardiovascular disease, anxiety, depression, and chronic pain and fatigue syndromes. These patients, for whom customary medical care often turns out to be unhelpful, represent a difficult challenge in everyday general practice. The interest of Nordic general practitioners in this was conveyed by Linn Getz in her keynote lecture in Copenhagen 2009, where she used information from an e-mail communication with Bruce McEwen as an intriguing element of her presentation. In Tromsø 2011, Bruce McEwen has been invited in person to present recent scientific evidence on this matter as a keynote speaker.

Context and care

In a rural context, as in Northern Norway and many similar regions in the Nordic countries, *caring for people where they are* has an obvious geographical dimension. The traditional commitment of GPs to provide personal care close to their patients, if wanted and appropriate in their homes, is under increasing pressure. Predominant scientific, technological, and bureaucratic interests tend to impose more distant and specialist-oriented care, based on ideas that this is generally of higher quality and that it will save time and costs. We believe that this may often be incorrect, at least from many patients' perspective and from a rural point of view. To travel long distances and to be away from home and work will always imply use of additional time and expenses. In addition, specialist care, which is mainly obliged to search for biological explanations, will tend to overlook stressful contextual and biographic facts of fundamental importance to understand and help the individual patient [7,8]. Failing to spot such facts may easily be counterproductive and lead to recurrent appointments and inadequate care. The future hope for

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chronically suffering individuals, who are today deficiently helped, relies on the competence of wise general practitioners with awareness of the importance of context and biography for appropriate understanding and care. We ourselves believe in the necessity of medical research to focus on context and subjective experiences in order to better understand complex diseases. We also want to believe that participation in the congress in Tromsø will add positively to wisdom and patient care among our Nordic colleagues.

Community-based medical education

Traditionally and still most commonly, medical education takes place in university hospitals in large cities. In such contexts, dominated by specialist-oriented scientific perspectives, it is natural to put more emphasis on diseases appropriate for advanced hospital treatment and less on the low-technological person-oriented medical challenges of primary care. Since 1970, when general practice has gradually been acknowledged as a special and major medical teaching discipline, there has been a movement away from considering large hospitals as an exclusive and optimal setting for learning medicine. When the medical school in Tromsø was launched in 1973, it represented an early experience of including general practice as a relevant arena for training [9,10]. Since then, a growing trend worldwide has been to base more education in community settings, and this has contributed to promoting recruitment to and retention of doctors in general practice and under-served rural populations [11–13]. In Tromsø 2011, we will address issues related to education and professional development including primary care as a context for preparing future generations of physicians [14]. The discussions will be based on updated international experiences and documentation in the field. In 2008 and 2009, David Price, chair of the Department of Family Medicine at McMaster University, visited Norway with stimulating presentations on Canadian innovations and experiences with primary care-oriented medical education. We have the pleasure to announce that David Price has again accepted to visit us as keynote speaker at the congress in 2011.

Palliative care in the community

To include patients' contexts and life experiences is also important for palliative care, another core topic in Tromsø 2011. To meet death without a surfeit of pain and discomfort is a fundamental right. According to a report from the Economist Intelligence Unit this right is denied to all but 8% of patients who need terminal palliative care worldwide every year [15,16]. Denmark was 22nd among 40 countries assessed, and this may indicate low priorities and important challenges in this field in our Nordic countries. In Copenhagen 2009, however, several initiatives to improve the situation were presented. Figures from Finnmark, the most arctic and remote Nordic region, indicate that well-organized primary care, including small-bedded units run by GPs (community hospitals), contributes to more terminal care in and close to the patients' homes than elsewhere in the country [17]. Among critical questions in support of an integrative approach to education and palliative care in the community are: (1) To what extent are home visits included in general practice and in medical curriculums today? (2) How can GPs and allied health professionals provide care so that incurably diseased and dying patients can stay at home or at least in their communities to the extent they and their families desire? (3) How can GPs be involved to avoid naturally dying patients being adversely assessed as emergency cases, and transferred to technologically advanced hospital wards to end their lives? These and similar issues related to palliative care will be addressed in further depth in Tromsø 2011.

Conclusions

- Central aims embedded in our vision are: (1) to draw a line from pathogenetic to salutogenetic perspectives of illness and health, and (2) to show how this may be helpful to fulfil the double challenge of general practice, *to care for people where they are living, and where are in their lives.*
- We wish all Nordic GPs a hearty welcome to the congress in Tromsø 2011, either with presentations of their own projects, or by being involved as listening and learning participants. We want to include contributions related both to the core topics described above, and to any other topic relevant for general practice. For more detailed information we refer to our home page: http://www.gp2011tos.com.

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References

[1] Reventlow S, Sångren H, Brodersen J, Christensen B, Grauengaard A, Jarbøl D, Rosendal M, Søndergaard J. Addressing the future role of general practice at the 16th Nordic Congress in Copenhagen 2009: How can we ensure sustainable care in a complex world of evidence, context, organization, and personal care? Scand J Prim Health Care 2008;26:193–5.

[2] Forsdahl A. Are poor living conditions in childhood and adolescence an important risk factor for arteriosclerotic heart disease? Br J Prev Soc Med 1977;31:91–5.

[3] Forsdahl A. Living conditions in childhood and subsequent development of risk factors for arteriosclerotic heart disease. J Epidemiol Community Health 1978;32:34–7.

[4] Vangen S, Nordhagen R, Kveim Lie K. [Revisiting the Forsdahl-Barker hypothesis]. Tidsskr Nor Legeforen 2005;125:451–3.

[5] McEwen BS. Protective and damaging effects of stress mediators. N Engl J Med 1998;338:171–9.

[6] Kirkengen AL, Ulvestad E. [Heavy burdens and complex disease – an integrated perspective]. Tidsskr Nor Legeforen 2007;127:3228–31.

[7] Kirkengen AL. Inscriptions of violence: Societal and medical neglect of child abuse – impact on life and health. Med Health Care and Philos 2008;11:99–110.

[8] Wyller VB, Eriksen HR, Malterud K. Can sustained arousal explain the chronic fatigue syndrome? Behavioral and Brain Functions 2009;5:10. (doi:10.1186/1744-9081-5-10).

[9] Nordøy A. Tromsø: Lessons from a new curriculum. Lancet 1985;2:485–7.

[10] Knutsen SF, Johnsen R, Forsdahl A. Practical training of medical students in community medicine: Eight years of experience from the University of Tromsø. Scand J Prim Health Care 1986;4:109–14.

[11] Magnus JH, Tollan A. Rural doctor recruitment: Does medical education in rural districts recruit doctors to rural areas? Med Educ 1993;27:250–3.

[12] Hays R. Establishing successful distributed clinical teaching. Aust J Rural Health 2005:366–7.

[13] Tesson G, Hudson G, Strasser R, Hunt D, editors. The making of the Northern Ontario School of Medicine: A case study in the history of medical education. Montreal: McGills-Queen's University Press; 2009 (ISBN 978-0-7735-3649-4).

[14] Clavet D, Walsh AE. Helping to prepare future physicians. Every family physician's responsibility? Can Fam Physician 2009;55:862–3.

[15] Painfully slow progress on palliative care (Editorial). Lancet 2010;376:206.

[16] http://www.eui.com/sponsor/lienfoundation/qualityofdeath

[17] Aaraas I, Langfeldt E, Ersdal G, Haga D. [The cottage hospital model – a key to better cooperation in health care]. Tidsskr Nor Legeforen 2000; 20:702–5.