



Education and Culture DG

Lifelong Learning Programme

Leonardo da Vinci

**Bridging the gap of general practitioners' competence on  
European Market**

***Project n° 2008-1-PL1-LEO05-02080***

**GAP Project**

**Work Package 4**

**Defining the deficit competencies of general  
practitioners in the field of disease prevention  
and health promotion**

**2010**

**Content:**

<b>I. Introduction</b> .....	3
<b>II. Methods and work packages</b> .....	4
<b>III. Results</b> .....	8
<b>IV. Summary</b> .....	13
1. Summary in Greek.....	15
2. Summary in Lithuanian .....	17
3. Summary in Polish.....	19
<b>V. Attachment</b> .....	21

## **I. Introduction**

The key role of general practitioners in the area of disease preventive and health promotion is recognised by experts, patients and can not be disputed. At the same time the content of disease prevention and health promotion, which should be a part of their everyday activities still is not agreed. Until the recent days we do not have consensus on the framework and list of areas, sub-areas, which should be covered by GPs in their work in the context of disease prevention and health promotion. Also collaboration of GPs with the other specialists of primary, secondary health care (obstetricians, psychiatrists, paediatricians etc.) in the area of prevention is under discussion.

The main goal of the GAP project was to define what are in practice the competencies of GPs in the area of health promotion and disease prevention and subsequently to develop the training program and guidelines for family medicine teachers aimed at filling the gap between expected and existing competencies in the mentioned area.

## **II. Methods and work packages**

All GAP project activities were scheduled to carry out in five Working Packages. Working Packages 1-4 were developed mainly for the purpose of analysis and synthesis of data on the real situation and practices of training, provision of services in the area of disease prevention and health promotion. This is why this report for WP 4 covers also some components of packages mentioned below:

- WP 1. Analysis of the training programmes and description of GP's role in health promotion and disease prevention;
- WP 2. Analysis of GP's competencies which should be achieved during the specialisation
- WP 3. Development of the tool for measuring the level of GP's professional competencies (Note! This was more technical than analytical working package)

### **Methods in WP1:**

WP1 main objective was to produce the detailed mapping of current training programs of GPs in the area of health promotion and disease prevention. Another aim was to analyze and describe the role of GPs by existing legislation of their functions competencies in the countries. The project team members in each of 4 participating countries have collected the information on the existing legislation and teaching curriculum in this area and have conducted the analysis, presented conclusion and recommendations.

### **Methods in WP2:**

WP2 was aimed at gathering information on family physicians competences in the field of health promotion and disease prevention. The specific objective was to identify the GP's competences which are needed in their daily practice (from GP's perspective) and should be achieved after the specialization (from the Family Medicine experts point of view). In order to standardize the research procedures, the health promotion and disease

prevention framework was established and used. The framework divided all GPs' competences into three main areas:

- educational competences (Health Promotion area)
- clinical competences (Disease Prevention area)
- organizational competences (Service Prevention area)

Two research methods were used:

- Focus groups research with GPs
- Depth interviews with the experts of Family Medicine

The questions addressed to the FM experts as well as to the focus groups research participants were chosen according to the common scenario, however slightly variations by country were permitted. Such variations allowed analysis of the country specific areas and was decided as common in that kind, mainly qualitative method of surveys.

Data concerning competences of general practitioners were obtained as a result of focus group interviews conducted among general practitioners in Lithuania and Poland and individual structured interviews with experts in the field of family medicine in Great Britain and Greece. All surveys were carried out in June and July 2009.

Because of the qualitative nature of data, it is possible to relate results to one another and create a final synthesis in spite of the use of different research tools.

Different types of respondents (doctors and experts) can also be regarded as a chance for the final result in the light of results obtained from both groups.

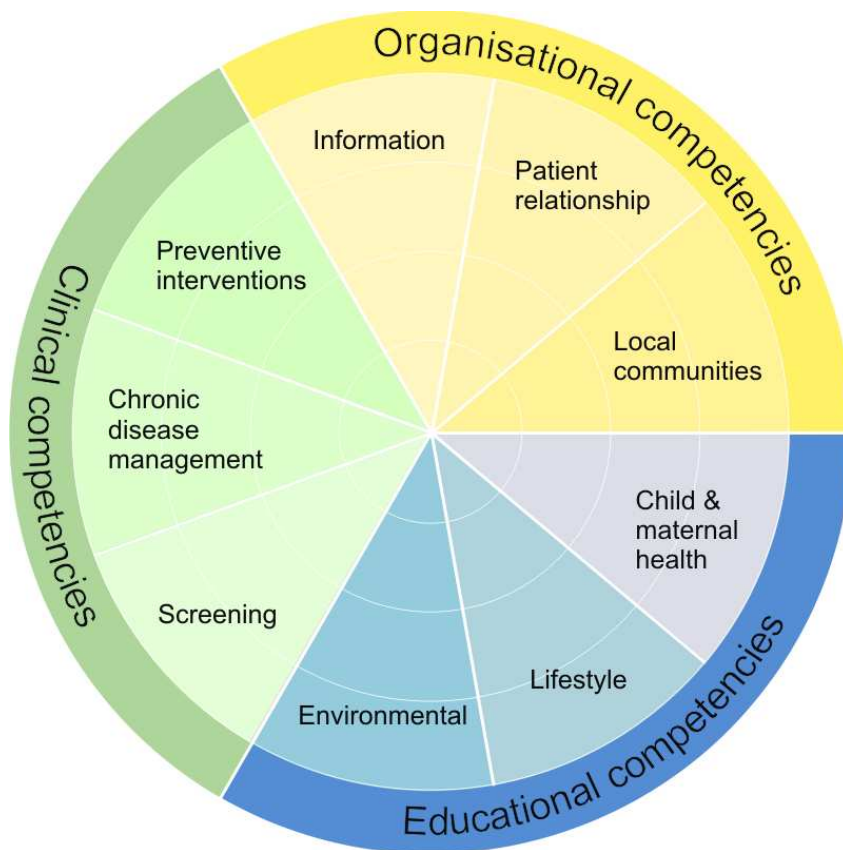
General practitioners spoke of the current situation and shortcomings in everyday work of GPs, whereas experts, when speaking of the same aspects of functioning of GPs, focused on the "duty" part and determination of directions of development. Therefore, collected data make it possible to describe the current situation and to indicate on the gaps in the preventive services, competencies of GPs and to define the ways of filling the gaps.

## Methods in WP4:

**Internet based tool** for measuring general practitioners competencies in the field of health promotion and disease prevention was developed (WP3) and subsequently applied to the group of about 160 respondents.

The construction of the tool is based on the health promotion and disease prevention framework which divides the whole field into three areas, with three subareas each, as shown on the graph:

Graph 1. Health Promotion and Disease Prevention Framework



The tool consists of two parts – the first one allows subjective assessment, whilst the second one is an evidence based objective measurement with relevant references for correct answers. Questions in both parts are assigned to each of nine subareas.

Respondent could choose the full or short version of the questionnaire – the first one consist of 117 questions (27 in Part I, and 90 in Part II) whilst the short one has 36 questions (9 in Part I and 27 in Part II).

The scores show the gap between respondent subjective and objective assessment (whether he/she underestimate competences, overestimate them or is perfectly aware of his/her 'health promotion and disease prevention' competences level).

**Selection of respondents:** It was planned to invite 20-30 GPs as the respondents, who are testing/piloting the TOOL in each of 4 countries. In result 154 GPs responded have filled in the questionnaire in 4 countries. The answers of 134 respondents (only fully completed questionnaires) we included into the final analysis (Lithuania- 22; Poland -68; Greece – 12; UK -33)

Table 1. Distribution of the respondents by country

<b>Country</b>	<b>LT</b>	22	16.4 %
	<b>PL</b>	67	50.0 %
	<b>UK</b>	33	24.6 %
	<b>GR</b>	12	9.0 %
<b>Total:</b>		134	100.0

**Statistical analysis.** SPSS 13.0 statistical package was used to analyze the data. Data tables and figure were developed for further analysis of data and making conclusions.

### **III. Results**

**WP1 Results** - gaps and deficits of the training programmes for GP's in the area of health promotion and disease prevention

The main conclusions which describe the gaps in teaching curricula, in legal documentation on competencies, functions according the analysis results made in 4 countries are as following:

- The analysis of legislation on the functions and competencies of family doctors in the area of health promotion and disease prevention showed that these functions and competencies are described not sufficiently, without details and relevant context.
- In general teaching curriculum of undergraduate, postgraduate and continuing education of medical doctors covers the major areas of clinical, educational and organizational competencies, which are necessary to have in the field.
- Methods of training applied are more theory and knowledge oriented rather than skills and practical implementation aimed.
- The legal documents of health care services in many cases do not promote the implementation the skills which were acquired during the medical studies into the practice at the level of GPs working place.

**WP1 recommendations** on legal documentation and teaching curricula made by project team from 4 countries are as following:

- designing training programs related to family medicine/general practice, and focusing on health promotion and disease prevention represent a priority;
- in addition, it is important to take into account the continuity of instruction throughout the undergraduate and postgraduate training, in combination with the contents of other specialty courses (e.g.: in cardiology, oncology, or endocrinology),
- it is recommended to share knowledge and experience between the medical centres, in which preventive care is being provided, including academic as well as other training facilities for family doctors, in both the EU and non-EU countries,



- Learning of the practical preventive skills and "vigilant" attitudes, necessary for safe and efficient primary preventive health care delivery, should be focused on early diagnosis and effective screening procedures.
- Medical professionalism in the field of health promotion and disease prevention should be taught by "learning from a master", or in small groups, using modern methods, and providing feedback and evaluation of students' and residents' progress,
- It is essential to promote the role of family physician as a "gate-keeper", who coordinates and assures continuity of patient care, and focuses on health promotion and disease prevention in an economical way, at a level of the health care system,
- Planning of the health promotion and disease prevention programs should be preceded by evaluation of the family physician's time availability, interests, technical capabilities, and motivation; family physicians should be financially compensated for this part of their medical practice.

**WP2 Results** - gaps and deficits of competencies: data from interview surveys and focus group discussions.

The research was conducted in all Partners countries: Greece, Lithuania, Poland and United Kingdom in the period from March to July 2009.

According to GPs participating in the focus groups research Service Provision (organizational competences) is the area of largest competence gaps. The second important area with regard to the elimination of GP's competence gaps is Health Promotion (Educational competences). However, GPs combine the areas of Health Promotion and Disease Prevention as interactive and suggest the education combining those two areas. Respondents evaluate positively the scope of education with regard to diagnosis and disease management. Development areas concern rather communication skills: doctor – patient relationship, impact on the change of patients' attitudes, as well as improvement of GP's skills related to management of the practice.

The area experts emphasized that the most important GP's competences, which should be achieved after the specialization are related to:

- acquiring clinical/prevention skills, necessary for safe and efficient preventive practice, focused on appropriate screening tests, vaccinations, early diagnosis and treatment of diseases
- initiating, coordinating and maintaining continuity of the patient care, in collaboration with professional team members and community resources,

- designing and implementing the HP & DP actions in the local community,
- conducting research projects, based on the principles of clinical epidemiology,
- communicating efficiently with patients, their families, other professionals and community members to achieve and maintain the highest quality of patient care.

In general, the GP experts have agreed upon the fact that in order to improve their competences in the field of HP & DP, the GPs should have an opportunity to participate in relevant educational and training courses, and should be financially reimburse for this type of professional activity.

In generally, both GPs and area experts emphasized the need of developing organizational competences as well as those related to effective communication with patient and others health care professionals.

### **WP2 Conclusions:**

- Prevention of chronic diseases and the FP/GPs' clinical competences are considered to be the most important function of primary care physicians. Preventive programs have been successfully implemented in the area of CVD, cervical, breast and prostate cancer, dental health, and diabetes. In contrast, preventive screening (with no additional financing) has not been successful.
- Educational and organizational competences are the two weakest areas in HP & DP, and therefore, the need of their development should be emphasized. The GPs should participate in health-promoting actions in their communities.
- There is a gap between relatively good training programs in the HP & DP and the practical implementation of prevention.
- Obstacles to providing more extensive HP & DP by the GPs include lack of financial promotion, work overload, and loss of patients' follow-up.

### **WP2 recommendations:**

- Opportunities for evidence based, community oriented training, focused on educational, clinical and organizational skills should be offered during undergraduate, postgraduate and specialty training courses for the FP/GPs.

- Team work approach should be expanded at the Primary Health Care centers. Nurses, psychologists and social workers should be involved in HP & DP educational activities together with the FP/GPs.
- Models of quality evaluation of work of family physicians should include components and indicators on efficiency in disease prevention and health promotion.
- Strategy of financial motivation for the FP/GPs, who provide both preventive and educational work, should be developed.

**WP3 Results** - development of the Internet based tool for measuring general practitioners competencies in the field of health promotion and disease prevention (see at: [www.gaproject.klrwp.pl](http://www.gaproject.klrwp.pl))

#### **WP4 Results**

WP 4 was aiming to define the deficit competences on the basis of comparison between actual and needed competences in the field of disease prevention and health promotion. Development of the special website tool for measuring the gaps in GPs professional competences was only one methods of defining the deficit of competencies in the whole GAP project. As was told before WP 1-2 also were aiming for mapping of the deficits in GPs competences. It means that only combining the results of all analytical work (WP 1-2 and WP 4) could provide conclusive implications on the existing deficits in competencies.

**WP4 Conclusions** – analysis of the database of the Internet based tool for measuring GP's competencies in the field of health promotion and disease prevention

- GPs were self-rating their disease prevention and health promotion competencies sparsely, with caution (score mean 3.34) in comparison with the objective rating (mean score 3.77,  $p < 0.05$ ) of their competences based on the knowledge/competence tests.
- Mean scores for subjective competencies were ranging in narrow range (3.14 to 3.54), while mean score of objective competences – in wider range (3.26-4.36).
- No statistical difference was observed between subjectively evaluated competencies in 3 areas (educational, clinical. Educational), however some more pronounced difference was observed in objective competencies.
- GPs from UK provided higher self-ratings of their competences. Therefore, objective rating also demonstrated statistically higher objectively rated competences of GPs in

comparison with Greek, Lithuanian or Polish respondents. Objective competencies were rated higher for PL doctors in comparison to LT; No statistical difference was established between objective rating of GPs of LT and GR. Only clinical competences were rated higher for PL in comparison to GR respondents.

- Only minor and statistically non significant difference was established both for subjective and objective competences of urban and rural GPs.
- The largest gaps were established in 2 sub-areas of organizational competencies (Information and Local communities) and 1 sub-area of clinical competencies – (chronic disease management).

## IV. Summary

The GAP tool provides the possibility for identifying and analysing gaps at the individual level as well as in the groups of GPs. The pilot survey we have conducted provides possibility for further development of the tool and is a good background for implementing the larger scale questionnaire survey on competencies of GPs in partner countries.

Some statistical differences established between the competencies of GPs in 4 countries does not imply the generalization that such differences exists in GPs competencies on the country level, because our respondents for pilot groups studies were not randomly selected but were taken as the "convenient samples" (first or second year residency doctors were dominating in some country groups).

The pilot questionnaire survey on evaluation of gaps in GPs competencies does not provide a sufficient evidence on the deficit of competencies. This is why only analytical comparison of data from WP1, WP2 and WP4 allows making the conclusive generalizations. These more generalized conclusions are as follows:

- The largest gaps were established in the areas of educational and organizational competencies (see results of WP1 and WP2)
- Despite clinical competencies were considered as more developed competence area the results of objective evaluation showed the significant gap in sub-area of **chronic disease management**. Despite this sub-area of preventive intervention were quite well represented in the rating of competencies (see results of WP4)
- Another two deficit sub-areas were established in the organizational field – competencies on **local communities** and competencies on **information** were at the quite low level both by objective and subjective evaluation. On another hand, in organizational area one sub-area – patient relationship - has demonstrated rather high rating in competencies (see results of WP4)
- Significant gap was established between relatively good training curricula/programs and **practical implementation** of health promotion and disease prevention activities at the GPs office (see results of WP 1-2)
- Significant gaps exist in **national legislations** (on functions, competencies, services, reimbursement for GPs for preventive activities). This also does not permit the implementing of health promotion and disease prevention in population on the larger scale.

Table 2. Areas with examples of diagnosed deficit competencies

Area	Subarea	Examples of diagnosed deficits
<b>I. Educational competencies</b>	1. Child & maternal health	-
	2. Lifestyle	<i>impact on the change of patients' attitudes, influence on the families – knowledge on the most effective methods of the healthy lifestyle promotion</i>
	3. Environmental	-
<b>II. Clinical competencies</b>	1. Screening	-
	2. Chronic disease management	<i>practical implementation of the health promotion and disease prevention knowledge in the area of chronic disease management</i>
	3. Preventive interventions	-
<b>III. Organisational competencies</b>	1. Information	<i>communication with the practice personnel and other health care professionals, preparation of health promotion and disease prevention informational materials</i>
	2. Patient relationship	<i>effective communication with the patient, impact on the patient's attitude</i>
	3. Local communities	<i>cooperation with the local communities representatives, construction of the effective health promotion and disease prevention programmes</i>

## 1. Summary in Greek

Το εργαλείο που αναπτύχθηκε από το GAP παρέχει τη δυνατότητα της αναγνώρισης και ανάλυσης των ελλειμμάτων γνώσης τόσο σε ατομικό επίπεδο όσο και σε ομάδες ΓΙ. Η πιλοτική μελέτη που διενεργήσαμε παρέχει τη δυνατότητα περαιτέρω ανάπτυξης και εξέλιξης του εργαλείου και αποτελεί ένα εξαιρετικό υπόβαθρο για την εφαρμογή μιας έρευνας σε ευρύτερη κλίμακα μέσω διανομής ερωτηματολογίων, αναφορικά με την επάρκεια των ΓΙ σε κάποιες δεξιότητες στις χώρες που συμμετέχουν στη μελέτη.

Κάποιες στατιστικά σημαντικές διαφορές που διαπιστώθηκαν μεταξύ της επάρκειας των ΓΙ σε ορισμένες δεξιότητες στις 4 χώρες που συμμετείχαν, δεν είναι σωστό να γενικευθούν ως διαφορές μεταξύ των ΓΙ σε επίπεδο χωρών, καθώς τα άτομα που συμμετείχαν στην παρούσα πιλοτική μελέτη δεν αποτελούν τυχαίο δείγμα αλλά ένα «βολικό δείγμα» (σε κάποιες χώρες οι ειδικευόμενοι ΓΙ στο πρώτο και δεύτερο έτος της ειδικότητας αποτελούσαν τον κύριο όγκο του δείγματος).

Η πιλοτική μελέτη μέσω διανομής ερωτηματολογίου για την αξιολόγηση των ελλειμμάτων στις δεξιότητες των ΓΙ δεν παρέχει επαρκή στοιχεία για την πιστοποίηση της ύπαρξης ελλείμματος στις αντίστοιχες περιοχές. Αυτός είναι και ο λόγος για τον οποίο μόνο η αναλυτική σύγκριση των δεδομένων από τα πεδία WP1, WP2 και WP4 επιτρέπει την εξαγωγή των γενικευμένων συμπερασμάτων. Αυτές οι πιο γενικευμένες διαπιστώσεις που έγιναν έχουν ως εξής:

- Τα μεγαλύτερα ελλείμματα διαπιστώθηκαν στις περιοχές των εκπαιδευτικών και οργανωτικών δεξιοτήτων (βλ. αποτελέσματα των πεδίων WP1 και WP2)
- Παρά το γεγονός ότι οι κλινικές δεξιότητες θεωρήθηκαν ως η πιο ανεπτυγμένη περιοχή δεξιοτήτων τα αποτελέσματα της αντικειμενικής αξιολόγησης ανέδειξαν ένα σημαντικό έλλειμμα στην υπο-περιοχή της **διαχείρισης χρόνιων νοσημάτων**. Παρά το γεγονός αυτό, η υπο-περιοχή της προληπτικής παρέμβασης παρουσιάστηκε αρκετά αντιπροσωπευτικά στην βαθμολόγηση των δεξιοτήτων (βλ. αποτελέσματα της περιοχής WP4)
- Δυο ακόμα ελλειμματικές υπο-περιοχές αναγνωρίστηκαν στο οργανωτικό πεδίο-οι δεξιότητες αναφορικά με τις **τοπικές κοινωνίες** και την **πληροφορία** ήταν σε αρκετά χαμηλό επίπεδο, τόσο από την υποκειμενική αξιολόγηση των ιατρών όσο και από την αντικειμενική εκτίμηση. Από την άλλη, μια υπο-περιοχή στο οργανωτικό πεδίο-η σχέση με τους ασθενείς-ανέδειξε μάλλον υψηλή βαθμολογία στις δεξιότητες (βλ. αποτελέσματα του πεδίου WP4)

- Ένα ακόμα σημαντικό χάσμα αναδείχθηκε ανάμεσα στα σχετικά ικανοποιητικά προγράμματα σπουδών και την **πρακτική εφαρμογή** των παρεμβάσεων πρόληψης και προαγωγής υγείας στα ιατρεία των ΓΙ (Βλ. αποτελέσματα στα πεδία WP 1-2)
- Σημαντικό χάσμα, τέλος, παρατηρήθηκε και στην **κρατική νομοθεσία** ανάμεσα στις χώρες που συμμετείχαν (αναφορικά με τη λειτουργία, δεξιότητες, παροχή υπηρεσιών, αμοιβή των ΓΙ για τη διεξαγωγή προληπτικών παρεμβάσεων). Αυτός είναι ένας ακόμα παράγοντας που δεν επιτρέπει την εφαρμογή παρεμβάσεων πρόληψης και προαγωγής υγείας σε ευρύτερη πληθυσμιακή κλίμακα.

**Πίνακας 2. Περιοχές με παραδείγματα διαγνωσμένου ελλείμματος δεξιοτήτων**

Area	Subarea	Examples of diagnosed deficits
<b>I. Εκπαιδευτικές δεξιότητες</b>	1. Υγεία μητέρας και παιδιού	-
	2. Τρόπος ζωής	<i>Αποτέλεσμα στην αλλαγή της συμπεριφοράς των ασθενών, επίδραση στις οικογένειες- γνώση των πιο αποτελεσματικών μεθόδων της προαγωγής του υγιούς τρόπου ζωής</i>
	3. Περιβάλλον	-
<b>II. Κλινικές δεξιότητες</b>	1. Προσυμπτωματικός έλεγχος	-
	2. Διαχείριση Χρόνιας Νόσου	<i>Πρακτική εφαρμογή των γνώσεων σχετικά με την πρόληψη και την προαγωγή υγείας στην περιοχή της διαχείρισης χρόνιων νοσημάτων</i>
	3. Προληπτικές παρεμβάσεις	-
<b>III. Οργανωτικές δεξιότητες</b>	1. Πληροφορία	<i>Επικοινωνία με το προσωπικό και τους άλλους επαγγελματίες υγείας, προετοιμασία πληροφοριακού υλικού αναφορικά με την πρόληψη και προαγωγή υγείας</i>
	2. Σχέση με τον ασθενή	<i>Αποτελεσματική επικοινωνία με τους ασθενείς, αποτέλεσμα στη συμπεριφορά του ασθενή</i>
	3. Τοπικές κοινωνίες	<i>Συνεργασία με τους αντιπροσώπους των τοπικών κοινωνιών, διαμόρφωση αποτελεσματικών προγραμμάτων πρόληψης και προαγωγής υγείας.</i>



## 2. Summary in Lithuanian

GAP projektas sudarė galimybę nustatyti ir analizuoti individualaus ir grupių lygmens BP gydytojų kompetencijų spragas. Pilotražinis tyrimas, kurį mes atlikome leidžia toliau tobulinti sukurta kompetencijų vertinimo instrumentą ir yra pagrindas leisiantis vykdyti platesnės apimties anketines apklausas šalyse projekto partnerėse.

Keturiose projekto šalyse rasti kai kurie šeimos gydytojų kompetencijų skirtumai neleidžia šių rezultatų apibendrinti ir generalizuoti išvadų, kad egzistuoja patikimi kompetencijų skirtumai tarp šių šalių gydytojų. Tai yra todėl, kad bandomajame tyrime respondentų grupės sudarytos patogiųjų imčių principu, o ne atsitiktinės atrankos būdu (pvz., kai kurių šalių respondentų daugumą sudarė jauni gydytojai rezidentai).

Be to, remiantis vien tik pilotražiniu tyrimu negalima susidaryti pilno vaizdo apie kompetencijų trūkumų struktūrą. Tik kartu apibendrinami darbo temų WP1, WP2 ir WP4 analizės duomenis galime plačiau apibendrinti BP gydytojų kompetencijas sveikatos stiprinimo ir ligų profilaktikos srityse. Šios platesnės apibendrinimų išvados yra tokios:

- Didžiausios kompetencijų spragos nustatytos sveikatos mokymo ir organizacinėje srityse (žr. WP1 ir WP2 rezultatus)
- Nors BP gydytoju klinikinės kompetencijos buvo geresnės, tačiau lėtinių ligų prevencijos posirtyje objektyvus vertinimas parodė dideles spragas. Tai šiek tiek prieštarauja WP4 rezultatams, kur lėtinių ligų prevencija buvo laikoma viena iš sėkmingiau vykdomų veiklų.
- Darbas su vietinėmis bendruomenėmis ir informacinė veikla – tai kiti du spragų posričiai nustatyti pilotražiniame tyrime (tiek objektyviai, tiek subjektyviai). Tuo pačiu, organizacinėje srityje nustatyti ir aukštos kompetencijos posričiai (pvz., bendravimo su pacientu posirtyje (žr WP4 rezultatus)
- Žymi spraga buvo rasta tarp pakankamai gerų BP gydytojų profrsinio rengimo programų ir praktinio ligų prevencijos, sveikatos stiprinimo darbo įgyvendinimo (žr. WP 1-2 rezultatus).
- Šalių sveikatos sistemos įstatymuose, dokumentuose, aktuose skirtuose BP gydytojų ligų profilaktikos, sveikatos stiprinimo funkcijoms, kompetencijoms, darbo apmokėjimui ir kitiems dalykams aprašyti yra nemažai spragų. Tai stabdo platesnį sveikatinimo programų įgyvendinimą.

Lentelė 2. Veiklos sritys bei nustatytų kompetencijų spragų pavyzdžiai

Sritis	Posritis	Nustatytos kompetencijų spragos
<b>I. Sveikatos mokymo kompetencijos</b>	1. Vaiko ir motinos sveikata	-
	2. Gyvensena	<i>pacientų požiūrio keitimas, poveikis šeimoms – efektyviausių gyvensenos keitimo metodikų žinojimas</i>
	3. Aplinka	-
<b>II. Klinikinės kompetencijos</b>	1. Profilaktinės patikros	-
	2. Lėtinių ligų kontrolė	<i>praktinis ligų prevencijos ir sveikatos stiprinimo veiklos įdiegimas kontroliuojant lėtines ligas</i>
	3. Profilaktinės intervencijos	-
<b>III. Organizacinės kompetencijos</b>	1. Informacija	<i>bendravimas su sveikatos sistemos personalu ir kitais gydytojais, ligų prevencijos bei sveikatos stiprinimo literatūros rengimas</i>
	2. Bendravimas su pacientu	<i>efektyvus bendravimas su pacientu, paciento požiūrių į sveikatą įtakojimas</i>
	3. Vietinė bendruomenė	<i>bendradarbiavimas su vietine bendruomene. efektyvių ligų prevencijos ir sveikatos stiprinimo programų kūrimas</i>

### 3. Summary in Polish

Narzędzie GAP daje możliwość identyfikacji i analizy luk kompetencyjnych lekarzy rodzinnych na poziomie indywidualnym, jak również grupowym. Przeprowadzone badanie pilotażowe stwarza podstawy do dalszego rozwoju narzędzia i realizacji na większą skalę badań ankietowych dotyczących kompetencji lekarzy rodzinnych w krajach partnerskich.

Stwierdzone w toku analiz różnice statystyczne zaistniałe pomiędzy poziomem kompetencji lekarzy rodzinnych w 4 krajach, nie oznaczają, iż można wnioskować o występowaniu takich różnic na poziomie krajowym. Należy bowiem zaznaczyć, iż respondenci w badaniu pilotażowym nie byli dobierani losowo, lecz w drodze celowej selekcji (w niektórych grupach dominowali lekarze na pierwszym lub drugim roku rezydentury).

Ankietowe badanie pilotażowe dotyczące oceny luk w kompetencjach lekarzy rodzinnych nie daje wystarczających dowodów na deficyt umiejętności. Dlatego, wyłącznie porównanie danych analitycznych z WP1, WP2 i WP4 pozwala na podjęcie ostatecznych wniosków. Te uogólnione wnioski są następujące:

- Największe luki zostały zdiagnozowane w obszarze kompetencji edukacyjnych oraz organizacyjnych (zobacz wyniki WP1 i WP2)
- Pomimo uznania umiejętności klinicznych za obszar stosunkowo dobrze rozwinięty, wyniki obiektywnej oceny wykazały istotną lukę w podobszarze chorób przewlekłych. Z kolei podobszar badań przesiewowych był dość dobrze reprezentowany w rankingu umiejętności (patrz wyniki WP4)
- Kolejne dwa deficytowe podobszary zostały zdiagnozowane na polu organizacyjnym – umiejętności dotyczące komunikacji z lokalną społecznością oraz umiejętności informacyjne, których poziom okazał się dość niski zarówno w ocenie obiektywnej jak i subiektywnej. Podobszar relacji z pacjentem – wykazał relatywnie dobry poziom kompetencji (patrz wyniki WP4)
- Istotne różnice wykazano pomiędzy stosunkowo dobrym zakresem procesu edukacji lekarzy rodzinnych a praktyczną implementacją działań z zakresu promocji zdrowia i prewencji chorób (patrz wyniki WP 1-2)
- Znaczne luki istnieją w ustawodawstwie krajowym (dotyczące funkcji, kompetencji, usług, zwrotu kosztów lekarzom rodzinnym za działalność prewencyjną). To również nie pozwala na wdrażanie promocji zdrowia i profilaktyki chorób w populacji na większą skalę (patrz wyniki WP2)

Tabela 2. Obszary z przykładami rozpoznanego deficytu umiejętności

Obszar	Podobszar	Przykład rozpoznanego deficytu
<b>I. Umiejętności edukacyjne</b>	1. Zdrowie matki i dziecka	-
	2. Tryb życia	<i>wpływ na zmianę postaw pacjentów, wpływ na rodziny - wiedza na temat najbardziej efektywnych metod promocji zdrowego stylu życia</i>
	3. Środowisko	-
<b>II. Umiejętności kliniczne</b>	1. Działania prewencyjne	-
	2. Leczenie chorób przewlekłych	<i>praktyczna implementacja wiedzy na temat promocji zdrowia i zapobiegania chorobom w zakresie chorób przewlekłych</i>
	3. Badania przesiewowe	-
<b>III. Umiejętności organizacyjne</b>	1. Informacja medyczna	<i>komunikacja z personelem praktyki i innymi pracownikami ochrony zdrowia, przygotowanie materiałów informacyjnych w zakresie promocji zdrowia i zapobiegania chorobom</i>
	2. Relacja z pacjentem	<i>efektywna komunikacja z pacjentem, wpływ na postawę pacjenta</i>
	3. Społeczność lokalna	<i>współpraca z przedstawicielami społeczności lokalnych, budowa skutecznych programów promocji zdrowia i zapobiegania chorobom</i>

**V. Attachment – statistical analysis of the Internet based tool for measuring general practitioners competencies in the field of health promotion and disease prevention database.**



**EVALUATION OF DEFICIT  
COMPETENCES OF FAMILY  
PHYSICIANS IN FOUR COUNTRIES**

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**Kaunas, 2010**

## **Work Package 4. Defining the gaps in competences of GPs in the field of disease prevention and health promotion**

**Aim:** To define the deficit competences on the basis of comparison between actual and needed competences in the field of disease prevention and health promotion

### **METHODS**

<b>Type of study:</b> questionnaire survey (piloting stage)
<b>Number of respondents:</b> at least 20 respondents from 4 countries
<b>Target group of respondents:</b> general practitioners (family doctors)
<b>Type of questionnaire:</b> self completed web on-line form
<b>Number of questions:</b>
Part 1: 27 questions
Part 2: 90 questions
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Total: 117 questions

### **METHODS**

<b>Completing the questionnaire:</b>
<b>Part 1. Evaluation of the competences by self-rating</b>
Options for answers:
1 - Not competent
2 - partially competent
3 - Competent
4 - Highly competent
5 - Expert
<b>Part 2. Evaluation of competencies by answering knowledge competence test questions</b>
Options for answers:
1 - Yes
2 - No
3 - I don't know

**RESULTS**

Filled in questionnaires - 154:

12 – short forms

8 – not complete forms

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134 –questionnaires - selected for analysis

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**Distribution of the respondents by country**

<b>Country</b>	<b>LT</b>	22	16.4 %
	<b>PL</b>	67	50.0 %
	<b>UK</b>	33	24.6 %
	<b>GR</b>	12	9.0 %
<b>Total:</b>		134	100.0

**Distribution of the respondents by gender**

<b>Gender</b>	<b>Male</b>	47	35.1 %
	<b>Female</b>	87	64.9 %
<b>Total:</b>		134	100.0

### **Distribution of the respondents by urban/rural GPs service location**

<b>GP service location</b>	<b>Urban</b>	111	82.8 %
	<b>Rural</b>	23	17.2 %
<b>Total:</b>		134	100.0

### **GAP classification of competences**

#### I. Educational competences:

- Educational 1 - Child & maternal health
- Educational 2 - Lifestyle
- Educational 2 – Environment

#### II. Clinical competences:

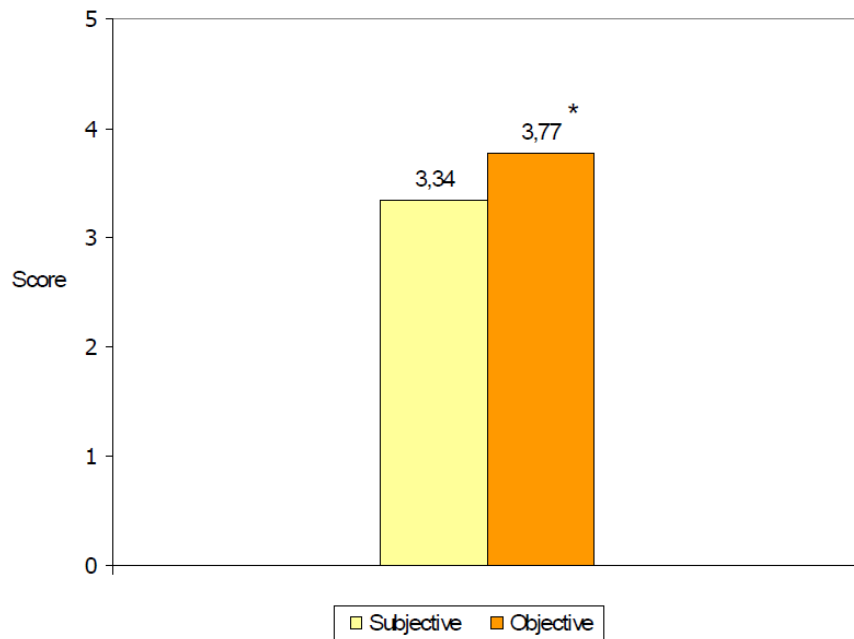
- Clinical 1 - Screenings
- Clinical 2 - Chronic disease management
- Clinical 3 - Preventive interventions

#### III. Organizational competences:

- Organizational 1 - Information
- Organizational 2 - Patient relationship
- Organizational 3 - Local communities

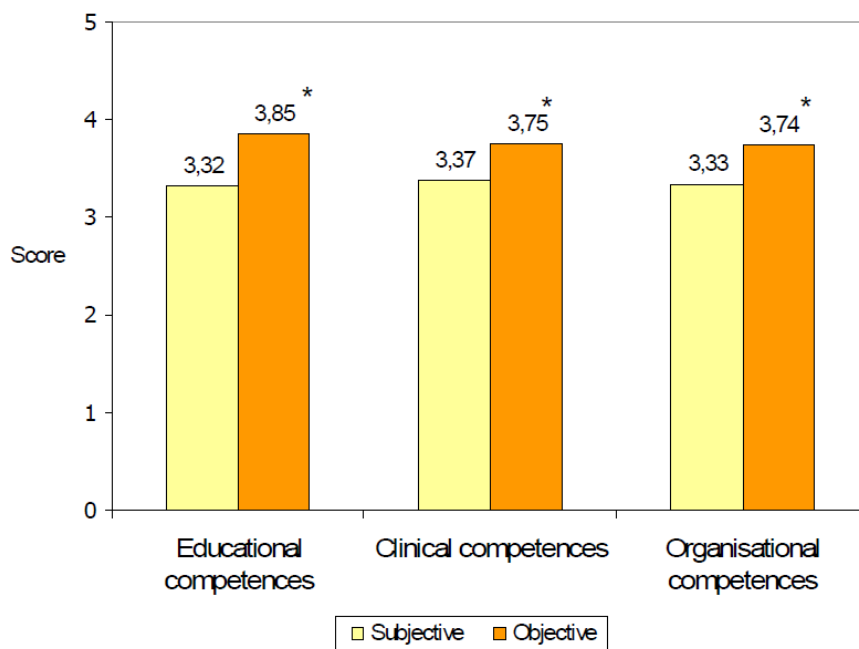


**Comparison of subjective and objective competences of GPs of 4 countries  
(n=134)**



\*p<0.05

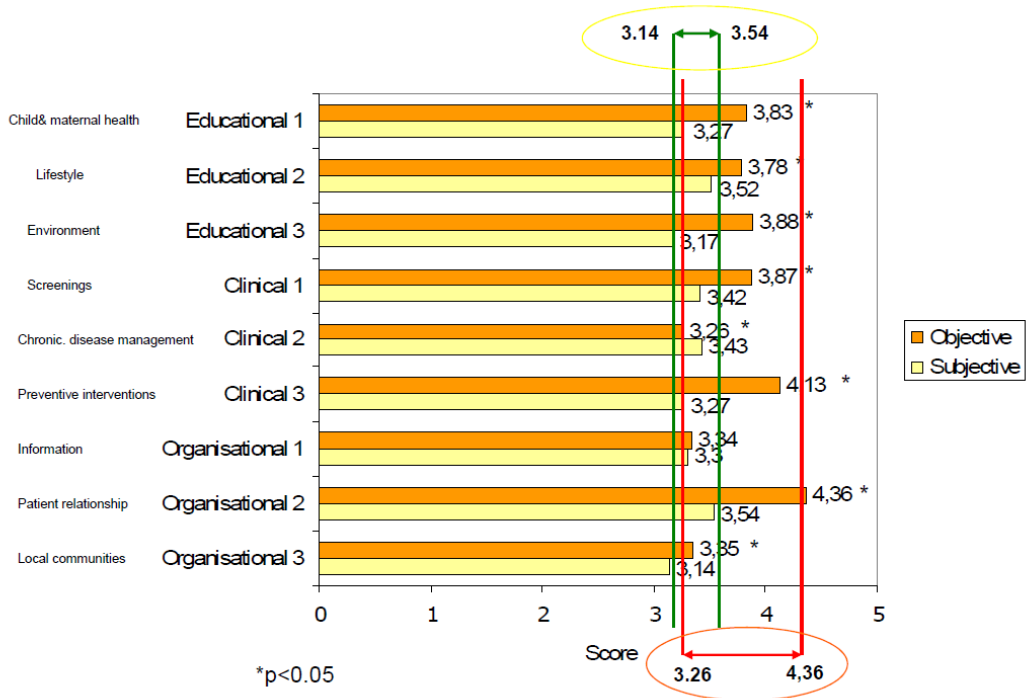
**Comparison of GPs subjective and objective competences: educational, clinical and organizational**



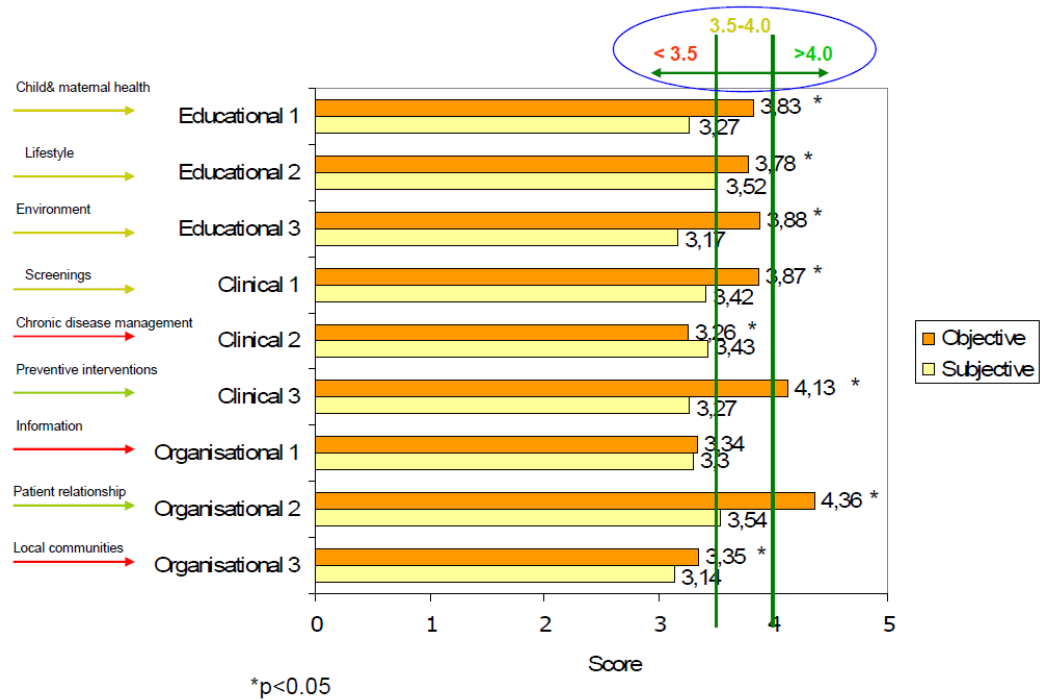
\*p<0.05 between subjective vs objective

p>0.05 between areas

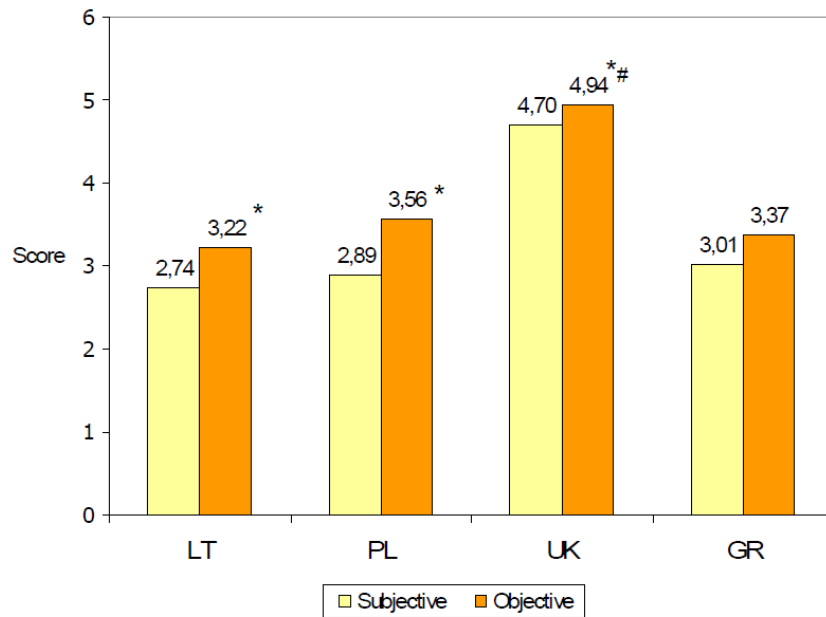
**Comparison of 9 areas of GPs subjective and objective competences**



**Evaluation of gaps in GPs subjective and objective competences by relative-normative score mean intervals**

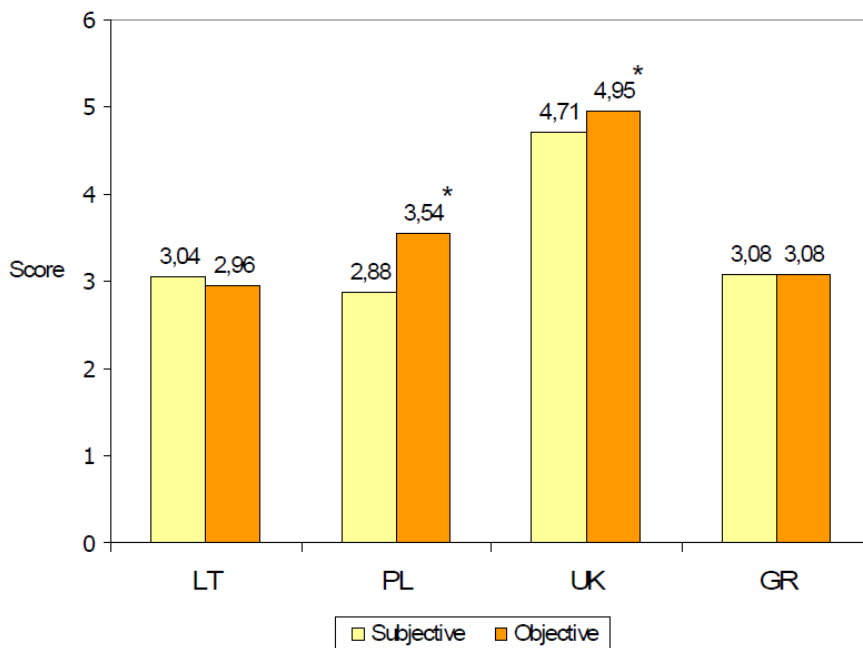


### Comparison of GPs subjective and objective educational competences between 4 countries



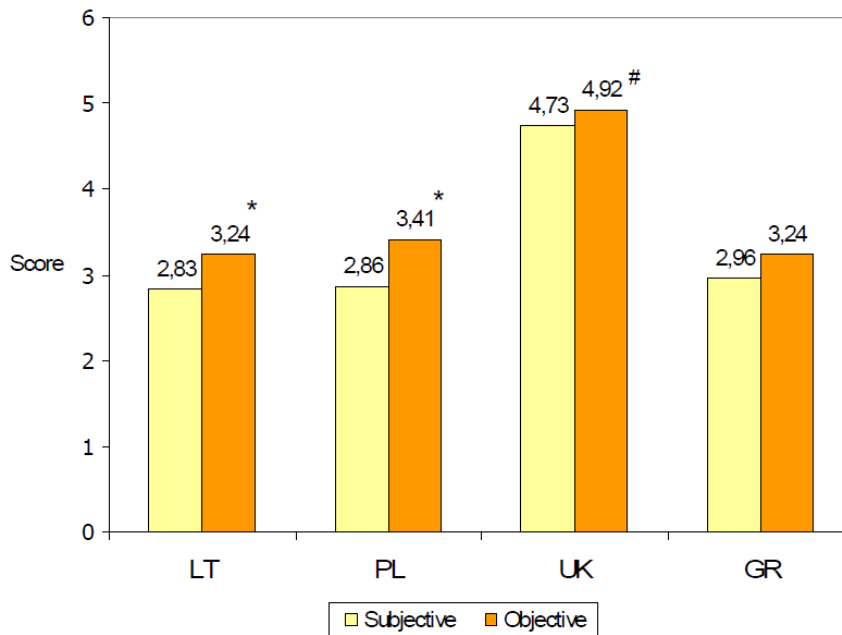
\*p<0.05 between subjective and objective #p<0.05 between UK and other countries

### Comparison of GPs subjective and objective clinical competences between 4 countries



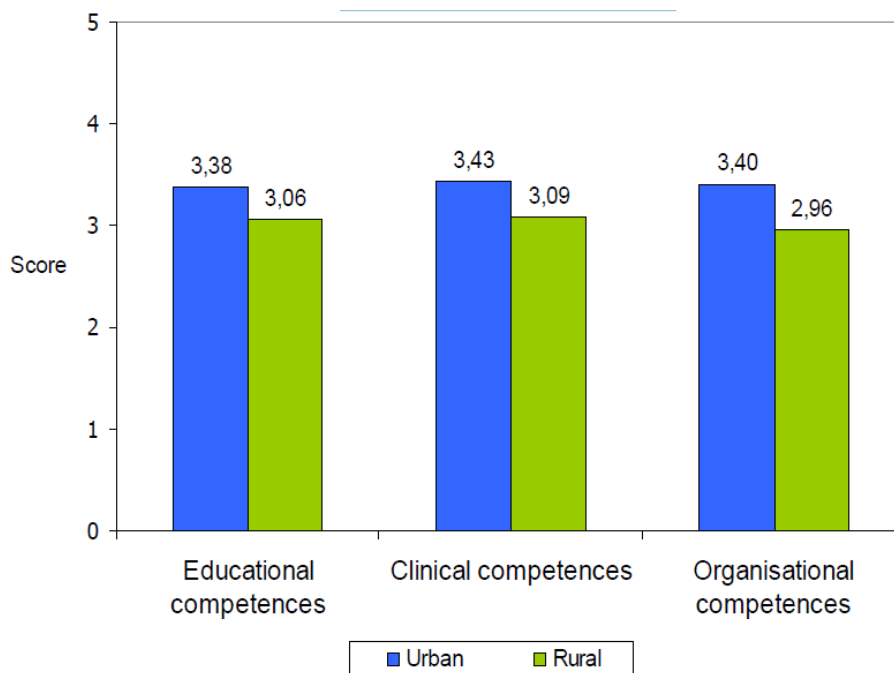
\*p<0.05 between subjective and objective #p<0.05 between UK and other countries

**Comparison of subjective and objective organizational competences  
between 4 countries**

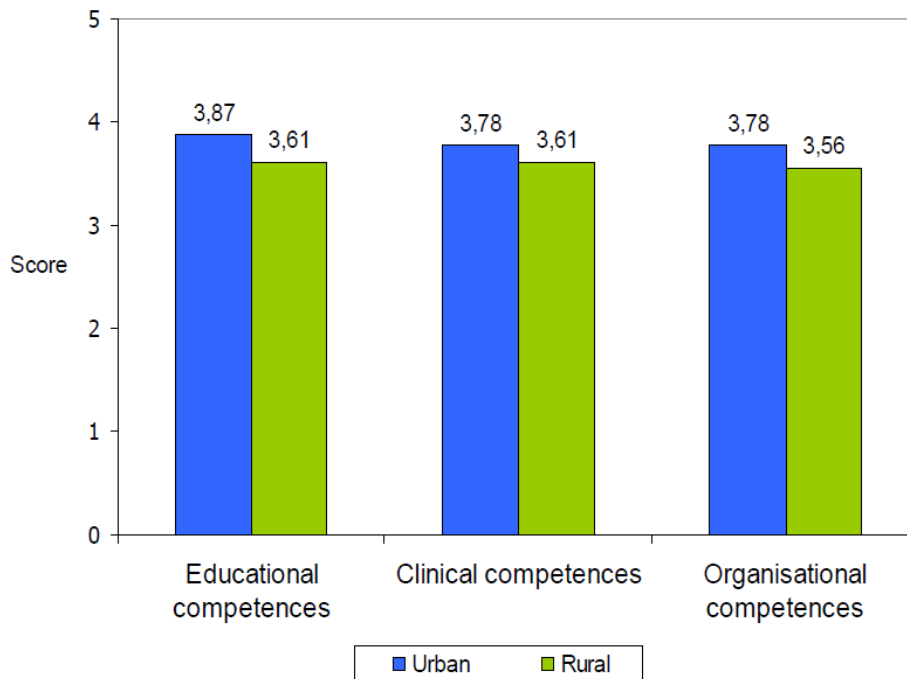


\*p<0.05 between subjective and objective #p<0.05 between UK and other countries

**Comparison of subjective competences (educational, clinical and organizational)  
between urban and rural respondents**



**Comparison of objective competences (educational, clinical and organizational)  
between urban and rural respondents**



**CONCLUSIONS**

1. General practitioners were self-rating their disease prevention and health promotion competencies sparsely (score mean 3.34) in comparison with the objective rating (mean score 3.77,  $p < 0.05$ ) of their competences based on the knowledge/competence tests.
2. Mean scores for subjective competencies were ranging in narrow range (3.14 to 3.54), while mean score of objective competences – in wider range (3.26-4.36).
3. No statistical difference was observed between subjectively evaluated competencies in 3 areas (educational, clinical. Educational), however some more pronounced difference was observed in objective competences.

4. GPs from UK provided higher self-ratings of their competences. Therefore, objective rating also demonstrated statistically higher objectively rated competences of GPs in comparison with Greek, Lithuanian or Polish respondents. Objective competencies were rated higher for PL doctors in comparison to LT; No statistical difference was established between objective rating of GPs of LT and GR. Only clinical competences were rated higher for PL in comparison to GR respondents.

5. Only minor and statistically non-significant difference was established both for subjective and objective competences of urban and rural GPs.

6. The largest gaps were established in 2 sub-areas of organizational competencies (Information and Local communities) and 1 sub-area of Clinical competencies – (Chronic disease management).

## **SUMMARY**

The GAP tool provides the possibility for identifying and analyzing gaps in individual level and in the groups of GPs. This small pilot survey provides possibility for further development of the tool and is a good background for conducting the larger scale questionnaire survey on competencies of GPs in our countries. Some statistical differences established between the competencies of GPs in 4 countries does not imply the generalization that such differences exists in GPs competencies on the country level, because our respondents for pilot groups studied were not randomly selected but were taken as the "convenient samples" (first or second year residency doctors were dominating in some country groups).