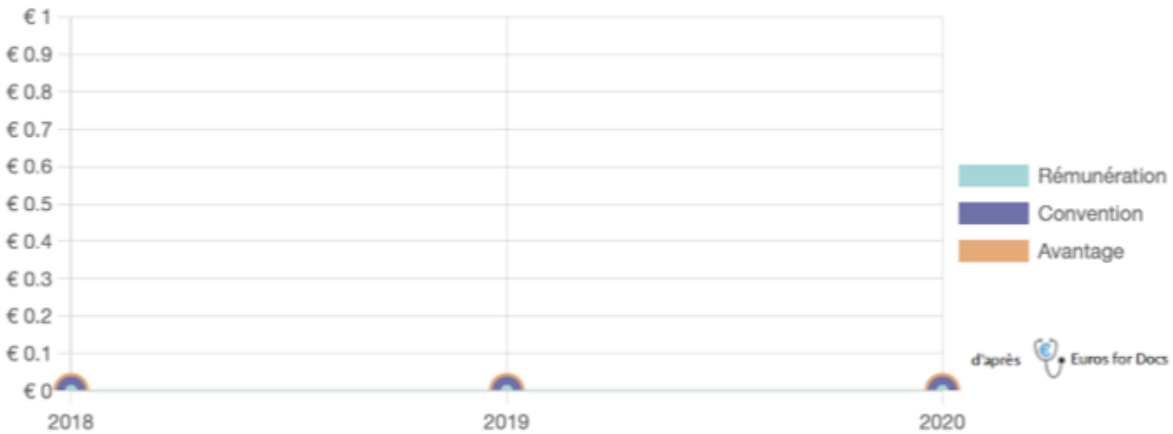
Ouverture du 16ème CMGF

Cyril Bègue
Président du comité scientifique

Déclaration publique d'intérêts de Bègue Cyril

02/03/2023

Financements reçus de l'industrie



Liens spécifiques à l'intervention

« Ouverture CMGF 2023 »

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Autres liens d'intérêts

Activité professionnelle

- Médecin généraliste (2014-en cours)
- Maître de Conférences des Universités (2020-en cours)
- Président du comité scientifique du Congrès Médecine Générale France (Depuis 2023)
- Secrétaire Général Adjoint du Collège de la Médecine Générale (Depuis 2023)
- Président du comité scientifique du Congrès Médecine Générale France (Depuis 2018)
- Participation à des groupes de travail avec la CNAM ()

Engagements

- Collège National Généralistes Enseignants (2014-en cours)

Principaux financeurs

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Déclaration complète

- disponible sur Archimede.fr

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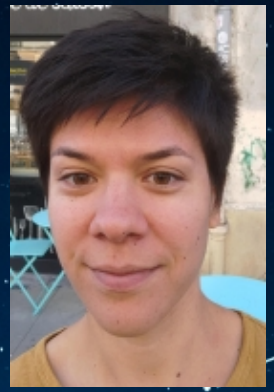



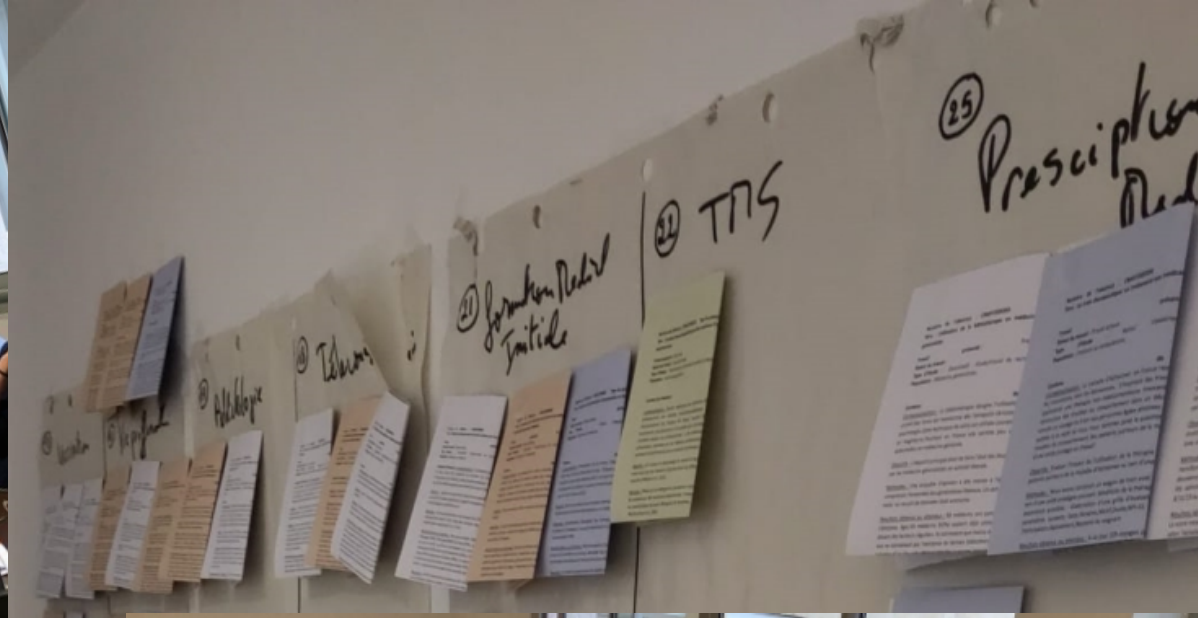


Evian

Hogne Sandvik, Øystein Hetlevik, Jesper Blinkenberg and Steinar Hunskaar

Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care:

a registry-based observational study in Norway

Abstract

Background
Continuity, usually considered a quality aspect of primary care, is under pressure in Norway, and elsewhere.

Aim
To analyse the association between longitudinal continuity with a named regular general practitioner (RGP) and use of out-of-hours (OOH) services, acute hospital admission, and mortality.

Design and setting
Registry-based observational study in Norway covering 4 552 978 Norwegians listed with their RGPs.

Method
Duration of RGP–patient relationship was used as explanatory variable for the use of OOH services, acute hospital admission, and mortality in 2018. Several patient-related and RGP-related covariates were included in the analyses by individual linking to high-quality national registries. Duration of RGP–patient relationship was categorised as 1, 2–3, 4–5, 6–10, 11–15, or >15 years. Results are given as adjusted odds ratio (OR) with 95% confidence intervals (CI) resulting from multilevel logistic regression analyses.

Results
Compared with a 1-year RGP–patient relationship, the OR for use of OOH services decreased gradually from 0.87 (95% CI = 0.86 to 0.88) after 2–3 years' duration to 0.70 (95% CI = 0.69 to 0.71) after >15 years. OR for acute hospital admission decreased gradually from 0.88 (95% CI = 0.86 to 0.90) after 2–3 years' duration to 0.72 (95% CI = 0.70 to 0.73) after >15 years. OR for dying decreased gradually from 0.92 (95% CI = 0.86 to 0.98) after 2–3 years' duration, to 0.75 (95% CI = 0.70 to 0.80) after an RGP–patient relationship of >15 years.

Conclusion
Length of RGP–patient relationship is significantly associated with lower use of OOH services, fewer acute hospital admissions, and lower mortality. The presence of a dose–response relationship between continuity and these outcomes indicates that the associations are causal.

Keywords
continuity of patient care; emergency medical services; family practice; general practice; hospitalisation; mortality; Norway.

INTRODUCTION

Continuity is a core value of primary care. McWhinney described continuity as an implicit contract between a patient and a GP, who then takes personal responsibility for the patient's medical needs.[1,2] Continuity is not limited by the type of disease and bridges episodes of various illnesses. Greater continuity with a primary care physician has been shown to be associated with lower mortality rates,[3] fewer hospital admissions,[4,5] less use of emergency departments,[6] and fewer referrals for specialist health care.[7,8] Nevertheless, continuity has been declining in recent years.[9]

There is no uniform agreement about how continuity should be defined, but three aspects are usually described: informational, longitudinal, and interpersonal.[10] Informational continuity means that the doctor has adequate access to all relevant information about the patient. Longitudinal continuity means that it transcends multiple episodes of illness, and interpersonal refers to a trustful relationship between patient and physician. Various methods have been used for measuring continuity. Most of them are based on visit patterns with different providers over time.[10,11] An example is the Usual Provider of Care (UPC) index, which calculates the percentage of all contacts that is with the most frequent provider.[12] Most of these studies have been conducted with limited patient samples and rather short observation periods. There is scarce literature on studies with large- or full-scale populations, long follow-up, and hard endpoints.

In a limited number of countries, such as the UK, the Netherlands, Denmark, or Norway, most inhabitants are listed with a general practice or a named regular general practitioner (RGP) who is responsible for taking care of their medical needs. Such RGP schemes are usually established not only to increase continuity of care as an assumed aspect of quality, but also to prevent unnecessary spending by introducing the RGP as a *gatekeeper*. It should be noted, however, that patients also value such personal relationships with their RGP.[13]

The aim of the present study, based on Norwegian registry data, was to analyse, on a national level, the effects of longitudinal RGP continuity associated with use of out-of-hours (OOH) services, acute hospital admissions, and mortality.

METHOD

The Norwegian RGP Scheme

In Norway, the state is responsible for hospitals, while the primary healthcare system is the responsibility of the

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Avril

Société américaine de cardiologie

Juin

Annals of Internal Medicine

Août

Société française d'allergologie

Décembre

SPILF

Janvier

BMJ

Février

BMJ

Expérimentation du Temps Partagé Solidaire pour contribuer à l'accès aux soins primaires dans les zones sous-denses.

Contextualisation : Avec 17% d'illectronisme dans la population, la santé numérique n'est pas une solution dans la crise de l'accès aux soins. Cette impasse nous oblige à repenser notre organisation, pour y trouver une réponse humaniste et de proximité. Puisqu'on ne peut pas demander beaucoup de contraintes à peu de médecins, pourquoi ne pas demander peu de contraintes, mais à beaucoup de médecins ? La solidarité des médecins généralistes vis à vis de cette population précarisée est un levier essentiel à mobiliser.

Objectifs : Immédiat : expérimenter le temps partagé solidaire. A moyen terme : créer un réseau de 150 centres médicaux animés par un collectif national de médecins généralistes solidaires, qui consacrent une semaine de leur agenda médical à cette activité, en marge

Méthodes : Nous avons créé un centre de santé dans un village rural qui n'avait plus de médecin depuis deux ans. Nous avons embauché une coordinatrice, née dans le village, qui est en charge de la gestion du centre et du planning, ainsi que de l'accueil des médecins. Ces derniers sont logés dans un gite, un véhicule leur est mis à disposition, et le centre est totalement équipé. Les médecins sont recrutés par différents canaux, avec la solidarité comme levier principal d'adhésion.

Résultats obtenus ou attendus : Le planning des médecins est complet Le centre médical permet chaque semaine à 125 patients de retrouver un accès aux soins proche de chez eux. 52 médecins généralistes vont se relayer pendant toute l'année, afin de garantir une permanence des soins.

Discussion : L'enjeu est de garantir aux patients une continuité de soins malgré la prise en charge pluri-médicale. Le développement d'outils numériques, le rôle de la coordinatrice, la sensibilisation des praticiens, la traçabilité et la transmission des dossiers en sont les axes principaux. Cette inovation permet de créer un nouveau flux médical dans un village. Cela permet à de jeunes médecins de faire l'expérience de l'exercice dans ce territoire, et de s'y projetter éventuellement, favorisant ainsi la possibilité d'une installation.

Conclusion et perspectives : Le projet est viable. Il ne reste qu'à le déployer. Si 10% des médecins participent, nous pouvons ouvrir 150 centres.

⇨ **Samedi à 10h45, Salle 242B, Martial JARDEL**

VIOLENCES SEXUELLES AU COURS DE LA VIE CHEZ LES RÉFUGIÉ·E·S & DEMANDEUR·EUSE·S D'ASILE VIVANT DANS LES PAYS OCCIDENTAUX

REVUE DE LA LITTÉRATURE & MÉTA-ANALYSE

Dr L.CAYREYRE, Dr J.KHOUANI, Dr D.THERY, Pr G.GENTILE

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ÉTAT DES LIEUX

2021

- **89,3 MILLIONS DE PERSONNES DÉRACINÉES** par la guerre, les violences et les persécutions.

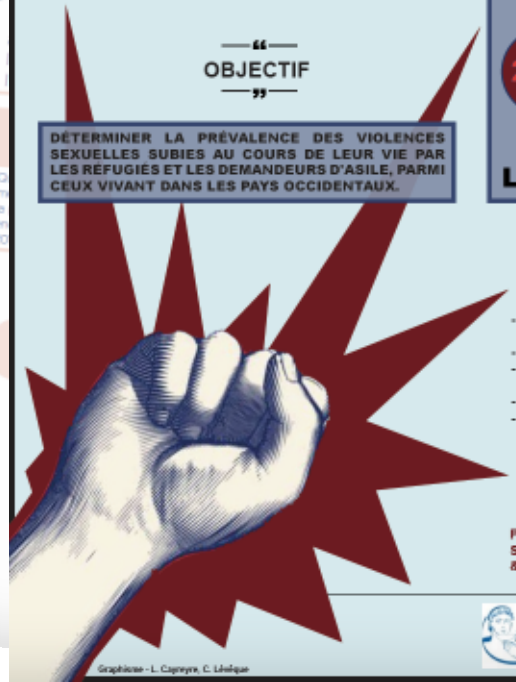
Parmi elles :
- **27,1 MILLIONS DE RÉFUGIÉS**
- **4,6 MILLIONS DE DEMANDEURS D'ASILE**

Les réfugiés et demandeurs d'asile sont considérés comme étant à haut risque de **VICTIMISATION SEXUELLE**, engendrant des conséquences à la fois psychologiques, physiques et sociales.

Alors que **17 % DE CES PERSONNES EXILÉES** sont accueillies dans un pays occidental, les réponses des politiques de santé des pays hôtes sont entravées par l'absence de données de prévalence précises des violences sexuelles subies par ces populations.

OBJECTIF

DÉTERMINER LA PRÉVALENCE DES VIOLENCES SEXUELLES SUBIES AU COURS DE LEUR VIE PAR LES REFUGIÉS ET LES DEMANDEURS D'ASILE, PARMI CEUX VIVANT DANS LES PAYS OCCIDENTAUX.



Graphisme - L. Cayreyre, C. Lévêque

MÉTHODE

Une méta-analyse à été réalisée consécutivement à une revue systématique de la littérature. Critères d'inclusion :
- Échantillon composé exclusivement de demandeurs d'asile ou de réfugiés > 16 ans
- Résidant dans un pays occidental
- Étude rapportant une prévalence de la violence sexuelle subie au cours de leur vie.

1059 articles enregistrés, 11 répondant aux critères d'inclusion, avec recrutement de 941 femmes, 1665 hommes et 61 personnes de la communauté LGBT.

CHIFFRES-CLÉS

44 % C'EST LE POURCENTAGE DE VIOLENCES SEXUELLES SUBIES PAR LES FEMMES RÉFUGIÉES OU DEMANDEUSES D'ASILE AU COURS DE LEUR VIE, SOIT :

PRÈS D'1 FEMME / 2

IC 95%, 0,24-0,67

27 % C'EST LE POURCENTAGE DE VIOLENCES SEXUELLES SUBIES SANS DISTINCTION DE GENRE, SOIT :

> 1 RÉFUGIÉ OU DEMANDEUR D'ASILE / 4

IC 95%, 0,18-0,38

LE VIOL EST LA VIOLENCE SEXUELLE LA PLUS MENTIONNÉE

AUTRES CONSTATS

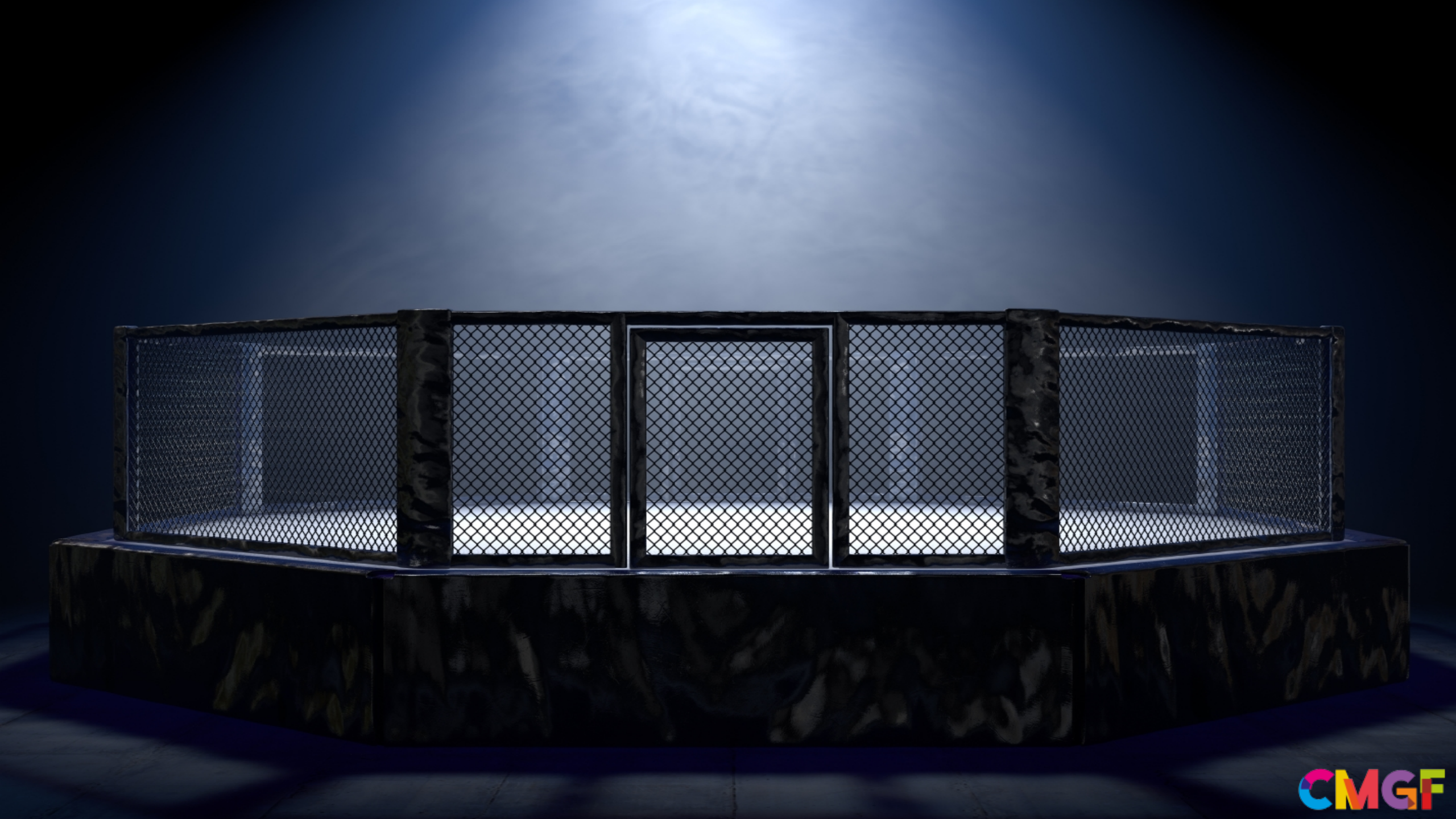
- Prévalence > de Syndrome de Stress Post-Traumatique par rapport aux victimes d'autres formes de violences
- Prévalence accrue de syndrome dépressif
- Association significative entre agressions sexuelles et douleurs abdominales & génitales
- Surexposition des femmes par rapport aux hommes
- Surexposition des demandeuses d'asiles par rapport aux réfugiées

PERSPECTIVES

PROGRAMMES DE DÉPISTAGE SYSTÉMATIQUES DES VIOLENCES SEXUELLES CHEZ LES RÉFUGIÉS ET LES DEMANDEURS D'ASILE & PARCOURS DE PRISE EN CHARGE SPÉCIFIQUE EN SOINS PREMIERS

Faculté des sciences médicales et paramédicales
Aix-Marseille Université

CMGF 2023 23 - 25 MARS PARIS


CMGF

Predictors of Canadian Physicians' Prevention Counseling Practices

Erica Frank, MD, MPH,[1,2] Carolina Segura, MD,[1] Hui Shen, PhD,[1] Erica Oberg, ND, MPH[3]

ABSTRACT

Objective: To understand predictors of Canadian physicians' prevention counseling practices.

Methods: A national mailed survey of a random sample of Canadian physicians conducted November 2007-May 2008.

Results: Primary care physicians (n=3,213) responded to the survey (41% response rate); those with better personal health habits, female physicians, and physicians aged 45-64 years old were more likely to report "usually/always" counseling patients than did others, but there were no significant differences by province, origin of one's MD degree, or practice location. There was a clear and consistent relationship between personal and clinical prevention practices: non-smokers were significantly more likely to report counseling patients on smoking cessation; those who drank alcohol less frequently, drank lower quantities or binged less often were more likely to counsel on alcohol; those exercising more to counsel patients more about exercise; those eating more fruits and vegetables to counsel patients more often about nutrition; and those with lower weight were more likely to counsel about nutrition, weight or exercise. Physicians who strongly agreed or agreed that "they will perform better counseling if they have healthy habits" averaged higher rates of counseling ($p<0.001$).

Conclusions: Personal characteristics of Canadian physicians help predict prevention counseling. These data suggest that by encouraging physicians to be healthy, we can improve healthy habits among their patients – an innovative, beneficent, evidence-based approach to encouraging physicians to counsel patients about prevention.

Key words: Physician; health; health education; counseling; patient counseling; Canada; prevention

La traduction du résumé se trouve à la fin de l'article.

Can J Public Health 2010;101(5):390-95.

It is a health policy goal across North America to increase the proportion of persons appropriately counseled about health behaviours.[1-6] Some literature from outside Canada has suggested that one way to promote counseling may be to encourage physicians to have healthier personal practices, as doctors may "preach what we practice".[7] However, this personal–clinical relationship has only been reasonably well established in the United States,[7-9] a country that is socio-culturally similar to Canada but with a very different health system. We therefore had two questions to investigate: 1) whether this personal–clinical relationship held in a second country (or whether there were unusual factors in the US that created this relationship), and 2) specifically whether the personal–clinical relationship was a function of the peculiarities of the US system or could be found in a system with universal access. We investigated these questions with a large survey of Canadian physicians.

METHODS

Our survey was developed in collaboration with the Canadian Medical Association (CMA), with input from the Association of Faculties of Medicine of Canada, Physician Health Program of British Columbia, Canadian Association of Interns and Residents, Canadian Physician Health Network, the College of Family Physicians of Canada, and the Royal College of Physicians and Surgeons of Canada. Ethical approval was obtained from the University of British Columbia.

Prior to distribution, the survey was promoted in several CMA-related venues, and the protocol was piloted and University of British Columbia Institutional Review Board-approved. We sent the questionnaires and cover letters to 8,100 randomly selected physicians, excluding residents and retired physicians. From the original mailing list, 166 physicians had no known mailing address, or were retired, residents, or working abroad; eliminating these cases reduced the original study population to 7,934.

All materials were available in English and French. The initial survey mailing (late November 2007) and first follow-up mailing (mid-December 2007) were sent to the entire sample of 7,934 physicians. A reminder e-mail was sent (where e-mail addresses were available) in January 2008, followed by a third survey mailing to all non-responders, and a fourth follow-up to British Columbia physicians in March 2008. Survey responses were accepted until May 2008. To ensure anonymity, an external third party created a blinded system. As an incentive, all sampled physicians could participate in a draw for two $1,000 prizes.

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Conflict of Interest: None to declare.


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Bon congrès !