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TRIP REPORT NO. UKR-41

STRENGTHENING CLINICAL AND EDUCATIONAL ASPECTS OF FAMILY MEDICINE

LVIV OBLAST, UKRAINE

Trip Report
September 12 - October 3, 1996 (Dr. Reeves)
September 17 - September 28, 1996 (Dr. Grover)

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1. SUMMARY

Progress made in the September trip for the strengthening of family medicine in the L'viv Oblast includes, but is not limited to:

- Drs. Fred and Theresa Grover did side-by-side teaching at 3 family medicine ambulatories in L'viv and one each in the Zhovka and Yavoriv Rayons.
- Trial introduction of ophthalmoscopes and otoscopes (6) was accomplished to determine how well they would be received. Reception was enthusiastic, and their use was demonstrated by the Drs. Grover.
- Medicines (retail value about $15,000 US) were delivered to the ambulatoriesof Hospital #1 and the advantages and disadvantages of the particular medications was discussed.
- Examples of patient education materials were delivered in translation to the ambulatories and were well received. These will be reviewed by the counterparts for reproduction and distribution in the ambulatory waiting rooms.
- Psychological - social - emotional assessment was carried out by survey (NADIYA members Carol Reeves, Licensed Professional Counselor, and Marta Arnold, Medical Social Worker) in more than 100 family medical patients waiting to see the physician. The results showed eager patient receptivity for medical information/education and substantial emotional need.
- Review of the completed Patient Satisfaction Survey showed the value of the Pol'ova Ambulatory (Hospital #1), compared to internal medicine and pediatric specialists functioning in Polyclinic #2 and Hospital #1.
- Approval was obtained from the ambulatories for the introduction of family planning into the family medical ambulatories, where an important aspect would be the use of Depo-Provera for the protection of unwanted pregnancies.
- Dr. Theresa Grover introduced patient record documents including pediatric growth and development charts to the counterparts in an effort to improve record keeping. These were well received.
- Plans were made for the introduction of professional doctor's bags to be carried by the family physicians.
- Physician's skills survey was initiated to provide a guide to the teaching curriculum.
- The journal "Practical Medicine" was received from Dr. Zaremba, Editor-in-Chief, and her article on family medicine in the L'viv Oblast was abstracted. Plans were made to utilize this journal to strengthen family medicine by having Colorado family medical doctors contribute to the journal.
- Video taping was done and arrangements were made to obtain a clip from Colorado for possible inclusion.
- Report on 'The Future of Primary Care' published in 1996 after two years of study by a 'blue ribbon' panel (including Dr. Larry Green of Colorado) was summarized by Drs. Reeves and Fred Grover and translated for delivery to the counterparts.
- Delivered from the Colorado Department of Family Medicine were reports from Colorado and elsewhere in the USA on the cost effectiveness of family medicine compared to specialist care.

The above activities were perceived to strengthen family medicine in the L'viv Oblast. Further, foundations were laid for substantially more progress in 1997. An extensive list of recommendations is presented in section 6. These rest firmly on continued collaboration between Zdrav-Reform and the University of Colorado/NADIYA. The collaboration uses the strengths of each to allow the total result to be more than the sum of the parts. Working together the goal can be reached of a healthier, happier, more prosperous Ukraine.

2. BACKGROUND

In the August 1996 visit, Dr. Reeves evaluated clinical practices in the L'viv Oblast, but there was little opportunity for side-by-side patient examination with the Ukrainian counterparts. Side-by-side examination by a fully trained family physician was needed to give a more complete evaluation of family medicine in the L'viv Oblast. Dr. Frederick Grover, Jr. MD is a fully trained family medicine physician, and he was the Colorado Physician of the Year for 1995 - 1996. Further he was the preceptor for Dr. Yuri Chaika, a Ukrainian national who had two months training in family medicine in Colorado in 1996. In addition, the plan was to bring with Dr. Grover, his wife, Dr. Theresa Grover, a pediatrician skilled in growth and development and the acute care of ill children. A part of the NADIYA strategy to strengthen family medicine in Ukraine was to deliver to the counterparts an experimental supply of instruments including otoscopes and ophthalmoscopes, as well as medicines. It would be the responsibility of the Drs. Grover to observe and instruct the counterparts in the use of these items. They would also address whether or not the items were appropriate or whether other items would be more useful. Also, Dr. Theresa Grover would be responsible for discussing with the counterparts the clinical records and the possible introduction of growth and development charts. The overall result of their presence would be to develop expert recommendations to supplement and/or alter those of Dr. Reeves's August visit.

Dr. Reeves August visit indicated the impersonal nature of Ukrainian medical practice which to some extent included family medicine. The evidence included emphasis on physical illness in clinical training with not sufficient consideration of the whole patient or patient dignity, the impersonal management of patient visits, and the near total absence of personal counseling and medical social work in an environment of severe economic depression. These observations were important as emotional depression usually has a profound effect on health, and vice-versa, ill health profoundly affects emotional well being. Further, there is a great need for healthier life styles in Ukraine including less smoking, less alcohol abuse, less fat in the diet, and more exercise. Public education is required, but persons with emotional illness, hopelessness or depression will not be capable of assuming more responsibility for their own health. Given these consideration, the Department of Family Medicine and the NADIYA group felt it was important to assess the mood of the Ukrainian patient with regard to their knowledge of healthy life styles, their receptivity to health education, the severity of emotional stress in the population, the need for trained persons to deal with life problems, and the receptivity of

the population to counseling and instruction on mental health. The Strategy was to develop an instrument to investigate these issues and to field a team of experts to administer the survey.

3. Objectives

A. To complete the collection of data for products II G (strengthening family medicine) and III H (recommendations for strengthening family medical education)

B. Complete input into the video

C. Interpret survey results

Close technical report

E. First draft of II G and III H.

F. Make recommendations for rural rayon family medicine delivery system.

4. Activities Narrative.

Report By Dr. Fred Grover

LVIV MEDICAL REPORT FOR SEPTEMBER 18TH, 1996

WARSHAVA AMBULATORY

● Observations

The consultant team spent the morning with Helena, head staff family physician observing her interaction with patients, and medical care. Observed were five patient visits, four adults, one child. The patients were interviewed by Helena as well as by the consultants with the help of an interpreter.
Complaints/Diagnoses of patients included:
1. Abdominal pain in Type II diabetes mellitus patient, diagnosis (dx):. constipation, with probable gastroparesis.
2. A fainting episode in elderly patient with sinus tachycardia by EKG,
3. An adult with polyuria, polydypsia, and weight loss, probable diabetes.
4. A 9 month old male with colic type symptoms, dx: viral upper respiratory infection

5. An elderly diabetic patient with LLQ pain. dx: probable diverticulitis, constipation.

In general the level of care, given their resources was adequate, however there are a few recommendations as follows:

It would be nice if the doctor could see patients in a separate exam room, away from office. This would allow the patient an opportunity to have more privacy and confidentiality. Telephone calls, interruptions by additional patients in doctors office and staff were frequent. Gowns would be a nice addition for the doctor and patient. It would allow the patients more modesty, and would improve the thoroughness of the exam. Breast exams would be easier to perform, and more likely to be routinely done. This may be difficult due to time constraints, and cold room temperature, but would be in the patients best interest. Blankets in room could alleviate the cold factor.
Realizing that it is difficult to get patients into the office for immunizations, each child should have routine exams and anticipatory teaching done at these visits. Specifically, teach about feeding, developmental issues, safety, etc. This is assuming that the children don't already have routine well child checkups. Combining routine visits for teaching with immunization administration would be optimal. For example, the child with the upper respiratory infection today had received her DPT (diphtheria-pertussus-tetanus) shot yesterday, and could have been examined them, thereby avoiding one visit today.
Medical records could use improvements in organization and content. Recommended was the addition of growth charts and developmental charts to every pediatric medical record. Also, for all charts, a set of permanent forms including the patient's medical history, chronic and acute problem list, and a medication list. These would be easy to implement in the charts and would quickly familiarize the physician with the patient's history on each visit, which would improve patient care. Additionally, it was noticed that the patients take the chart home with them, which does help with continuity with other specialty clinics, since charts could get lost in the system otherwise. However, should the patient become ill in another city and not have the chart with them, lose the chart, or forget to bring it to the visit, the physician is completely at loss for information about the patient's history. At a bare minimum, the office should keep a record of the patient's history, problem list with diagnoses , and medications.
In order to operate more efficiently, the office could greatly benefit from urine dipsticks, and a glucometer. For example, today the patient with suspected diabetes needed a referral to an endocrinologist for his work-up rather than two simple tests which could have given a diagnosis in five minutes in the office. Additionally, the patient with tachycardia and fainting episode was unable to have a thyroid screen (TSH) which could be drawn in the office and sent to a laboratory.

POL'OVA AMBULATORY

Observations

Observations of patients with Slava , a family physician, along with the help of an interpreter. Nine patients were observed , including seven adults and two children. Diagnosis and complaints included:

1. Fatigue, fever in adult. dx: influenza and new hypertension
2. Anxiety and hypertension
3. A 10 yr. old with upper respiratory infection, fever, and nausea. dx: influenza
4. Chronic low back pain, dx: osteochondritis
5. Schizophrenia and hypertension
6. Need for copy of vaccination compliance before specialist visit
7. Abdominal pain. Ultrasound report reviewed, nondiagnostic.
8. A 5 month old former premature in for weight check and immunizations
9. Chest pain with slightly abnormal EKG. dx: possible angina

Recommendations:

Again, a separate room for exams would be preferable to reduce the number of interruptions by staff, phones, and other patients.

This particular physician was very good at explaining treatment plans and helping to ensure medications were available at the pharmacy. It was felt that the patients would also benefit if more emphasis were placed on teaching them about their particular conditions and diagnoses as well.

The medical records in this clinic had problem lists with diagnoses, but lacked medication lists, growth charts, and developmental charts. The physician was shown how to use growth charts, and he seemed enthusiastic about using these. He was given copies of the Colorado forms for each of these. In this clinic, the pediatric charts were kept at the clinic, but the adult patients kept theirs at home. Again, the clinic should keep a record of the patient's diagnosis, medications, and history in case of emergency.

Discussed was the medical applications of the computer, such as record keeping and using the internet to obtain medical information.

SEPTEMBER 19, 1996

OBSERVATIONS

Today was spent visiting and examining patients at the Family Medicine Department of Polyclinic #2, with Dr. Sudova, Dr. Lessum, and another doctor. All were trained as Family Physicians, and apparently, each follows approximately 300-400 families of patients. The patients that were seen today included a variety of diagnoses, including acute bronchitis, pharyngitis, follow-up on cough after treatment, scabies, and a visit for immunizations. One of the most notable aspects of the visit to the clinic today was the amount of paperwork that the physicians were required to do. This obviously was impacting on the time available for the treatment of patients. Physicians routinely are given lists of military recruits, people needing TB tests, etc. and then are required to research those charts for information. Also, the physicians are responsible for ensuring that patients are immunized, and are fined if their patients are not in compliance. This often requires several home visits per patient to perform the immunization.

RECOMMENDATIONS:

At the Polyclinic the doctors were vigilant about washing their hands between patients. This should be stressed at the other clinics as well. This will reduce the spread of disease and also will be a good example to show patients. If water is not available during all times, an alcohol based solution could be used to kill pathogens. When looking at patients' throats, no light source is available besides sunlight. This will be improved when otoscopes are available, but if they are not available, at least a penlight or small flashlight would be very useful for the doctors. Maglite makes a compact flashlight which would serve this purpose well.

The Polyclinic, doctors are not able to send vaginal cultures such as chlamydia because their lab is not able to run these tests. Instead, the patients are referred to a specialist at the hospital to obtain the cultures. These cultures are relatively easy to obtain, and should be able to be performed by family physicians. It would be preferable for the family physicians to obtain the cultures and have a courier periodically bring the samples to the hospital lab for analysis. Chlamydia samples can sit around for awhile. Gonococcal cultures must be plated and stored in an anaerobic container. A jar with a candle that can burn out once it is sealed works well.

As stated above, the physicians waste a huge amount of time doing paperwork , which seriously cuts productivity. Ideally, each physician should have some ancillary help with this, even if it is only a trained clerk who can pull charts and search them for information such as compliance with TB tests. The nursing staff could help by filling out forms for sick leave, excuse from physical education class at school, immunization compliance forms, etc., then just have the physician sign the form. If the physicians could reduce their paperwork by even fifty percent, they could use their time much more efficiently for such purposes at health maintenance , preventative counseling and teaching, and for seeing ill patients. Specifically, infants should have regular visits during the first year of life at the

time of their visits for immunizations. Children receive such visits only at the two year visit.
Teaching women about birth control, and how to do self-breast exams, could also be done. These are only a few of many ways that preventative medicine teaching could be improved.

SEPTEMBER 20, 1996

OBSERVATIONS

Today was spent visiting the rural clinic in Zibolka, seeing patients and speaking with Slava. We accompanied him on a home visit to see a patient with a gastrointestinal bleed, and her grandson had a upper respiratory infection and cough. Only one other patient was examined, a child with an earache - this gave Slava an opportunity to use his new otoscope. His schedule was very impressive as he stated that he does 5-7 home visits per day in addition to seeing patients in the office. He often works 20 hours a day and is required to see patients at their homes each night. The feldcher in his community can assist with a small number of his patients, but no feldcher is available in 6 or the 7 areas where he is responsible. Apparently feldcers take care of pap smears, pre obstetrics /gynecology care in the villages. Slava's office is poorly equipped. Bathroom facilities consist of a run-down outhouse behind the clinic. There is no sink in the exam/office room. Lighting is poor, and heating was nonexistent here, as it has been in all the clinics.

RECOMMENDATIONS:

The workload for the rural doctors seems tremendous, and it would be best for both the patient and physician if this could be alleviated at all. A few ideas that could help with this. The feldcher's role could possibly be expanded to at least give coverage of home visits one night per week. This would give the physician one night free of seeing patients. It would be advantageous for patients and physicians if rayon medical directors could find additional staff to help family physicians with home visits and immunizations. This would free up more time for them to educate their patients and perform additional procedures that are usually referred out.
On a more fundamental level, educating patients about their diseases and conditions will benefit them in several ways. First, it will teach the patients that they do have some control and can influence their health. Second, patients will eventually be able to judge the seriousness of their illnesses to a certain degree, and will recognize whether or not they need to be seen at home instead of the clinic, and whether or not the visit can wait until the next morning. Patients and their families can be educated to call the physician to discuss the illness that they feel needs a home visit that night. If the physician feels the visit can wait until the morning, they should be asked to use this option. Although this is not the way practice is handled now, and the physician is expected to go when asked, but with education, the patients should appreciate that he is potentially working 24 hours every day.

A portable glucometer for rapid blood glucose measurements would be a useful tool for the clinics. It would be very valuable for monitoring diabetic patients, and is relatively inexpensive. The main drawback is the potential problem of keeping an adequate supply of the paper test strips available, as they do expire with time and may be difficult to obtain here. Informational handouts either given to patients to bring home or available in the office to read while waiting are a valuable tool for educating patients about common conditions. Colorado could make these available to the doctors to give to their patients. Nadiya has 80 topics available which will be translated. Also, Colorado could obtain a copy of Dr. Bart Schmidt's (Univ. Colorado) book of pediatric patient education handouts which include a section that instructs patients when to call their doctor (for certain symptoms) and when they should seek medical care. The handouts for more common conditions could then be translated into Ukrainian as well.
Obtaining reliable birth control appears to a major problem here. The Health ministry should give family physicians free or reduced price birth control (OCP's, condoms, intrauterine devices, depo-provera, and norplant.) for patients. Depo-provera, our recommendation, is relatively cheap, and can be injected by a nurse or physician in the clinic once every three months.
As mentioned above , more effort should be placed on teaching preventative medicine. Efforts should specifically address teaching breast self exam, dangers of smoking, healthy eating habits, and contraception. Apparently there are health classes in the schools, though it is not clear how much knowledge is gained through these. Morbidity and mortality statistics suggest that preventative medicine is desperately needed here.

SEPTEMBER 23, 1996
Went to the Lubine clinic in Yavoriv, to see patients with Elena. This was another small rural clinic with minimal equipment no heating, and an outhouse. She currently serves a population of about 5000 patients, and does five to seven home visits per day.
We saw only one patient with her, on a home visit. The patient had had a hypertensive episode with headache, epistaxis, visual changes, and weakness two days ago. She had been treated with antihypertensive medications and was much improved. Elena was impressive with the amount of teaching and educating that she performed with her patient. She appears to be stretched thin with the amount of time, equipment and staff to serve her population.

We also spoke with Oksana, one of the coordinators for outpatient clinics. We asked her about the availability of birth control for the rural population. According to her, the availability of contraceptives is very limited. Patients have to go to the larger cities to receive birth control pills which are often too expensive. She feels that birth control for rural populations could be significantly improved with greater access to birth control pills in rural clinics. She was also open to the idea of depo-provera injectable contraceptives, which could be used if adequate training of family physicians is performed.
Recommendations

Clinic needs similar equipment as described in previous recommendations for other clinics. Improved allocation of time would allow Elena to give more preventative teaching as well. Her clinic would be ideal for a rural Depo Provera pilot demonstration. Availability of depo or oral contraceptives at an affordable price for the patient would be advantageous for the prevention of unwanted pregnancies. This would save money for the overall system by decreasing the number of abortions needed . It would also allow physicians to assume a more active role in family planning and sexual counseling. Oksana and other physicians are concerned that hormonal contraceptives may increase the risk of cancer in Chernobyl victims. However, this is very unlikely, and there is no additional increased risk of cancer from radiation exposed patients taking OCP's or depo- provera. We will however look for any reports on this subject. The estrogen found in OCP's has been noted in some studies to slightly increase the risk of breast cancer, but decreases the risk of ovarian and endometrial cancer. Depo Provera contains only progesterone, and therefore should not increase the risk of breast cancer.

SEPTEMBER 24TH, 1996

MORNING DISCUSSION

The morning was in describing the role of family medicine in Ukrainian health care in front of the video camera. Drs. Reeves and Grover also described the role that Nadiya plays in strengthening family medicine here. Instruments and medications were given to Slava (Pol'ova Ambulatory) and Dr. Zaremba. Drs. Theresa and Fred Grover instructed them on the use of the instruments. Extra bulbs should be obtained for the otoscopes and opthalmoscopes. The list of the drugs in the box of medicines was reviewed, as were dosages and indications for some of the medications they will be using. They plan to fill out a chart listing the medication used, diagnosis and treatment. This will give a rough idea of their utility in the clinic.

Discussed later in the day was the family medicine curriculum in Lviv as directed by Dr. Zaremba. The overall curriculum and her ability to include important clinical information in such a short period of time was impressive. Wherever possible she should try to add more clinical 'hands on' experience. The Drs. Grover suggested that more time spent in the emergency room performing procedures may be helpful to the family medicine trainees. Additionally time spent in ambulatory ob/gyn clinics could be beneficial. Time and money is the issue as usual, and the curriculum should therefore be adjusted to best meet the clinical skills needed given these constraints. Should a family physician feel that they are not competent in a particular skill, they should be given the opportunity to preceptorship with a specialist or trained family physician to learn this skill. Some skills will be more important in rural vs urban clinics. Being able to perform more ob/gyn and minor surgery skills is more important in rural areas, since specialists will not be around to assist when needed.

FAMILY PHYSICIANS AND RURAL EMERGENCIES
Stabilization of critically ill patients for transfer to the hospitals should also be emphasized. Clinics should be better equipped to deal with rural emergencies. Basic things such as IV fluids, oxygen would be helpful. Without these, rural inhabitants suffering from blood loss secondary to farming injuries, postpartum hemorrhage, or cardiogenic shock secondary to a myocardial infarction would have a tough time making it to the emergency room in a salvageable state. The roads are in poor shape here, and ambulance transport appears to be limited.

SEPTEMBER 26, 1996

The morning at Emergency Hospital with Dr. Zaremba. Short lectures were given to a large group of family physicians and internists. Fred Grover spoke about prevention of heart disease, Theresa Grover on current management of otitis media, Carol Reeves on the results of her psychological survey, and Jack Reeves on the role of physicians in effecting governmental change. Dr. Zaremba also spoke to the group for quite a while (Jack has the information translated from that speech). Each of the lectures were well-received by the audience, and they appeared grateful for new knowledge.
After the lectures the group met with Dr. Zaremba in her office. Discussed was the family medicine training curriculum again, specifically our concerns that clinical training time was being cut due to budget constraints. Reemphasized was the importance of maintaining maximal clinical exposure for the residents. A good clinical preceptor was defined. Most importantly the preceptor should allow the resident to perform the exam, and procedures as independently as possible, followed by discussion of the disease with the preceptor. Dr. Zaremba is doing her best to ensure the best training possible for the residents.

Later in the day the group returned to the Warsawska clinic. The Drs. Grover instructed the physicians on the proper use of the otoscopes and ophthalmoscopes. In addition the depo-provera demonstration was discussed with the physicians. They seemed very receptive, but wanted more information regarding this form of injectable contraceptive. They will be provided with informative articles and pamphlets in the near future. The Warschava ambulatory may be the best site for the study, given the interest, patient population, attached gynecologist, and independent nature of the facility.

Dr. Reeves discussed the use of the donated medications with the physicians. Concern has been raised by the physicians that the medications given to patients may be sold on the streets. They felt that injectable antibiotics would be better to donate, since the patient wouldn't be able to extract and sell the medication from his hip. For this reason Depo-Provera will be better than dispensing oral contraceptives as well.

SEPTEMBER 27TH, 1996

The group met with the head of the Lviv City Health Administrator, Dr. Huzar. Reviewed were the observations made by the group, including the survey performed. Stressed was the importance of family medicine clinics functioning better in independent environments, as compared to the multi-specialty environment. Recommended was the establishment of clinics in the new housing developments throughout town. Housing for family physicians should be provided within the complex as well. Emphasized was the importance of giving family physicians more time to see patients, by decreasing the paper work and delegating nurses and other personnel to help with these tasks.
The group spent the rest of the afternoon speaking with Dr. Pavlovsky, the Rector of the University. The talk was productive about the role of family medicine in the Ukraine, and goals of NADIYA and the Abt partnership reemphasized. He agreed to continue to support our efforts to insure the strengthening of family medicine. Following this meeting there was a meeting with Nadiya Melnick MD. Once again the group spoke of improving the role for family physicians, by supplying more diagnostic equipment, medicine, and teaching.

Drs. Fred and Theresa Grover left L'viv September 28, 1996, following a debriefing breakfast with Mr. John Stevens and Dr. Reeves.

4B. ADDITIONAL ACTIVITIES

Instruments.

An otoscope, opthalmoscope, stethoscope, blood pressure cuff were delivered to the Zhovka Rayon for use in Zhibodka, to Dr. Sudova for Family medicine at Polyclinic #2, to the head physicians at both ambulatories of Hospital #1, and to Dr. Zaremba for instruction at the L'viv Medical university. These were the vanguard of basic instruments to be supplied to family physicians for their personal, professional use. The result was that the physicians were grateful, they felt the instruments were appropriately useful to expand their practice, and the replacement of batteries would not be burdensome. They were

immediately comfortable with the otoscope. Being far more convenient and diagnostic than the head mirror, it should expand the recognition of otitis media, one of the most common illnesses of children. The team emphasized that the ear drum should be examined in each child, particularly if there were respiratory tract infection.

The opthalmoscope is not as familiar to them. The team demonstrated its use, but experience is required to interpret the fundoscopic examination. The physicians indicated they would enlist the help of the ophthalmologists in the use of this instrument, and Dr. Zaremba will incorporate fundoscopic examination in her training courses.

Pharmaceuticals

Two boxes of pharmaceuticals, mostly antibiotics, non steriodal anti-inflammatory drugs, and vitamins of retail value of about $15,000 US were delivered to Dr. Jemma Jafarova of Hospital #1 for delivery to the two ambulatories. Dosage and use were explained to the counterparts. The contents of the boxes were reviewed with Dr. Jafarova to learn which medicines were most useful so that more effective help can be delivered in the future.

Patient information sheets.

Delivered to the Abt office was a computer disk containing 80 different one page patient information sheets. Each sheet contains information on a condition such as hypertension or depression, or on health issues such as smoking, breast examination, infantile colic, etc. Translation of examples were shown the counterparts, and they were enthusiastic about this printed material. The strategy is to have these translated, printed, and distributed to family medicine clinics for patient use.

Practical Medicine.

The Ukrainian medical journal is edited by Dr. Zaremba and is sponsored by the L'viv Medical University. Volume #1, issue #2 has just appeared, and it contains an article on the origins of family medicine in Ukraine. The journal is scheduled four times/year. Plans are for contributions by the University of Colorado faculty.

Patient Satisfaction Survey.

This survey by the Ukrainian Marketing group has interrogated more than 1200 patients after seeing the physician at either the Polyclinic #2 or the ambulatory at Pol'ova. Compared were internists, pediatricians and family medicine at Polyclinic #2, and the family physicians at the ambulatory. The graphs from the survey are included as an annex and the results discussed under findings.

Psychological and Social Assessment.

A patient survey was prepared by expert members of the NADIYA group in conjunction with the research group at the University of Colorado Family Medicine Department. The survey was for family medicine patients waiting to see the physician. It was intended to indicate how receptive the patients were to health education, to examine the extent of their knowledge was on health matters, and the need for psycho/social counseling. The analyses of more than 100 surveys is being compiled. A preliminary analysis of 53 of the surveys is presented in the results section.

Physician skills assessment survey.

The family medicine 4 month course has been in effect for several years. At issue was whether the training was preparing graduates for the tasks they would face. A list of target skills was prepared by Dr. Zaremba and this list was distributed to 10 graduates to indicate which skills they used frequently and which they used rarely or not at all. The analysis is presented in the results section.

Summary on the Future of Primary Care in the USA

Depo-Provera for birth control. Abortion with all its complications, suffering, and costs is the primary form of birth control in Ukraine. The number of abortions exceed the number of live births by about 50%. The University of Colorado Department of Family Medicine has a large experience with Depo-Provera in preventing unwanted pregnancies. The medication is the method of choice as it is 99% effective, is relatively inexpensive, one intramuscular injection gives protection for 3 months, and the side effects are few and tolerable. Dr. Jack Westfall, of the Colorado faculty has made contact with the Upjohn Company to consider using the drug in L'viv. The Ukrainian counterparts are enthusiastic about the prospect.

Patient Records.

The patient records used in Colorado were demonstrated in the L'viv ambulatories by Dr. Theresa Grover. These included the growth charts for boys and girls and the psychomotor charts. They were well received and will be translated for distribution.

5. FINDINGS

A. Instruments.

The advantages of the hand held otoscopes over the traditional mirror are that the ear drum can actually be visualized with the former but in the usual absence of an external light source, not with the latter. The evidence that the counterparts had little prior

experience with examination of the ear drum, was that they needed to be taught to retract the pinna upward and posteriorly to see the drum. Further magnification provided by the hand held instrument and not available with the mirror, showed them details which they had not seen. The implications are that they have not previously distinguished between minor degrees of fluid in the middle ear which require no antibiotics and more serious effusions which need antibiotic treatment. A preliminary check with two of the ambulatories revealed that these instruments were in daily use, and the major problem was that the entire ambulatory had to share only one instrument. The physicians were instructed that these instruments with their inherent light source are ideal for the examination of the nose, the turbinates, the throat and with a laryngeal mirror, the vocal cords. Plans were made to obtain an instrument for each physician.

OPHTHALMOSCOPES.

Nearly all of the family physicians presented with the ophthalmoscopes had never seen the fundus of the eye or had only seen it demonstrated only once in their teaching course. Thus to be able to look at the lens, the cilliary body, the aqueous and the vitreous humors, and the retina was a new and remarkable experience for them. A preliminary check indicated that they are using this instrument on each patient seen in order to learn the normal appearance of the internal structures of the eye, and to educate themselves on the presence of pathology when it should present itself. The implications are substantial not only for diseases such as hypertension and diabetes where the retinal changes are of great importance, but more subtly, it means that the in the use of these two instruments, physician must touch the patient, which is the essence of the physical examination.

B. Laboratory Examinations.

The ambulatories visited had little basic equipment - usually stethoscope, blood pressure cuff, eye chart (sometimes), weighing scales (sometimes), pelvic examining table, primitive monocular microscope, centrifuge (often hand operated), Ambu bag for artificial respiration (rare), instrument sterilization by alcohol (usual) or boiling water (unusual), refrigerator, an electric room heater (rare), some injectable medicines or immunization vaccines, clear intravenous fluids, simple bandages, and stains for blood smears. “Pap” smears could be obtained in the ambulatories and even feldcher stations, for review in hospitals. Tubes for culture were rarely seen and some of them were not sterile. Tubes for chemistries were not seen.

Dr. Fred Grover recommended that efforts be made to upgrade the laboratory diagnostic capacity. Battery powered glucosometers are now available and are not expensive. They give a reasonable estimate of blood glucose from a paper strip and a blood drop from a finger stick. Further, the instrument could be taken on a home visit if needed. The usefulness will be to assess diabetes control. It is now clear that the complications from diabetes (renal failure, blindness, peripheral vascular disease, and neurological damage) can be greatly postponed by careful control of blood sugar. Reported by the leading diabetologist in Kiev (Dr.Boris Mankovsky) indicated complications of diabetes are seen

after about 7 years in Ukraine as opposed to more than two decades in the USA. Further, the evaluation of diabetes, and the need for referral can be determined by such an instrument.
This examination of blood can be nicely complemented by urine strips which indicate urine sugar, acetone, protein, infection, bilirubin, pH, and specific gravity. The advantage of such strips is that they will enhance the practice in the clinics and also can be carried by physicians on home visits.

Other tests which will enhance the function of the ambulatories are hematest kits for occult blood in stool for the early detection of colon cancer. Strategies need to be developed for the culture of organisms responsible for the common sexually transmitted diseases, like chlamydia and gonococcus. Sample tubes for serum or plasma which after being separated from blood can be frozen and transported to central laboratories for analysis should be considered. A simple turbine for measurement of peak air flow will be of great help for the management of asthma, and for the diagnosis of early emphysema or bronchitis. These are among the most common of respiratory diseases, and fall within the scope of the family physician. These tools are being considered for introduction into the ambulatories by the Colorado group to strengthen family medicine, consistent with the goals of Zdrav Reform.

C. Patient education (See activities of 20 September).

Patient education will encourage patients to take more control over their own health, and will considerably relieve the burden on the physicians and the clinics. The educational - psychological - social assessment done by NADIYA personnel (see section D below) indicated that patients were receptive about more information about their illnesses and how to stay healthy. With this information, the technical consultants Drs. Grover and Reeves introduced from Colorado some 80 patient information forms. In Colorado these are available as one page information sheets in the clinics which the patients are welcome to read and to take home with them. A sample sheet on hypertension was distributed to the counterparts who agreed that such sheets were a good idea and would strengthen the health education function of the ambulatories. Strategies are being developed to have these translated, tried in the clinics, and if successful, printed in substantial numbers for distribution.

D. Educational - psychological - social assessment.

NADIYA members, Carol Reeves, MA, LPC and Marta Arnold, medical social worker (an American and a native Ukrainian speaker) conducted the survey of patients in the family medical ambulatories while they were waiting to see the physician. The instrument was developed by them in conjunction with the Research Group of The Colorado Department of Family Medicine. The first paragraph of the survey indicated that the patient was under no obligation to take the survey, and that it was completely confidential. The survey was read and approved by the head physician of each ambulatory. More than

one hundred patients were interviewed, and an initial, preliminary analysis of 53 of these is reported below.

DEMOGRAPHICS.
The analysis was of 17 males and 36 females, of age range 12 to 72 years, with the bulk of the patients being in the decade 20 to 30 years. Represented were households containing 200 persons (139 adults 18 or over and 61 children.) Of the households, 30% contained grandparents, 68% of households were in apartment buildings, and 53% were one or two rooms, not counting the kitchen. 56% of the households had combined incomes of 80 Hr or less.
The visit. The leading reasons for the visits were, respiratory illness (20%), routine examination (14%), dental problems (12%), gastrointestinal problems (12%), and children's health (6%). The question was asked what the patient expected from the visit, and the patient was to check all of the choices that applied. Of the responses, 55% were for information and/or education from the doctor or ambulatory and 45% were for diagnosis and treatment. 58% of the respondents said that they always saw the same doctor and only 2% said they never saw the same doctor. 96% said that the doctor gave them the opportunity to ask questions. In a very high percentage the patients said the doctor understood the questions and gave understandable answers. The surprising finding from the analysis so far is that there was so much interest by the patients in educational information from the physicians. Furthermore, the ambulatories are sensitive to the patient requests for information about their illnesses.

GENERAL HEALTH.
90% of the respondents indicated some degree of concern about their health and 62% considered their health poor or only fair. When asked who they talked to about their health concerns, 55% said they talked to family members and 34% indicated the doctor. In order, to help them with their health concerns, 79% of respondents said they needed consultation, education, and advice. This part of the survey reinforced that the family medicine patients wanted health education, and that the education should include the family members, as it is the family where most health discussions take place.

DIET.
91% of all respondents indicated that diet was very important to health, and 59% were concerned that their own diet was not healthy. 33% of the total sample were concerned that their diet was not well balanced, and 39% were concerned about the high fat content in what they ate. Most (71%) would like education about nutrition and health.

SMOKING AND ALCOHOL
Nearly everyone (98%) indicated that smoking was harmful and most (58%) were concerned that smoking was harming the health of someone in their family. 73% wanted education on the relation of smoking to health. About 1/3 of persons felt they should

reduce alcohol intake and an equal number wanted more information on alcohol and health.

BIRTH CONTROL AND SEXUALLY TRANSMITTED DISEASE.
The majority of persons in their reproductive years wanted information on birth control and sexually transmitted diseases.

EMOTION AND COUNSELING
Of the respondents, only 19% indicated they were satisfied with their lives, the others being either dissatisfied or not sure. When troubled by life issues persons turned to family members or friends (64%) and less often to doctors (10%) or priests (10%). Most (60%) would like group discussions on health practices and mental health, and 55% wanted individual counseling on marriage and family relations.

DEPRESSION.
Nearly 40% of persons indicated definite or possible discouragement severe enough to make them "wonder if it all was worth while". Emotional problems severe enough in the last month to interfere with day-to-day activities were reported by 70% of respondents. Regarding suicide, 11% have considered it and 4% actually attempted it.

GENERAL PRELIMINARY CONCLUSIONS.
The family medicine patients want and appreciate health information from their physician. Patients are generally aware about life style issues which affect health (diet, smoking, alcohol, exercise) but they want more information. There is considerable general discouragement and depression in the population, and many commented on their economic situation. Personal counseling for groups and individuals appears to be both needed and desired. The patients were open minded about health issues and are receptive to health education.

E. Patient Satisfaction Survey

Hospital #1.

The survey compared responses of patients after they had seen the doctor at the Pol'ova Ambulatory with those following visits to pediatricians and internists at

Polyclinic #2.

The important results are shown in the following table.

Interview Question	Indicated Response	Family Medicine Ambulatory	Internist	Pediatrician
What was facility hygienic condition?	good	65%	56%	58%
Would you return to this facility?	Yes	82%	77%	68%
Would you recommend this facility?	Yes	80%	47%	38%
What is physician professional level?	High	79%	58%	53%
Was the physician friendly?	Yes	84%	69%	69%
Was the physician kind?	Yes	62%	49%	40%
Were you educated about your condition?	Yes	84%	67%	67%
Are you willing to change doctors?	No	86%	76%	69%
How many visits to reach a diagnosis?	One	85%	62%	60%
Should the facility be open 24 hr./day?	Yes	40%	62%	77%
Were you hospitalized in the last year?	Yes	9%	19%	5%
Were you referred to another specialist?	Yes	16%	41%	37%

The results showed more favorable responses for family physicians at the ambulatories than for internists and pediatricians at the polyclinic, even though the specialists chosen for

comparison were those most likely to provide primary care. The favorable responses included the facility, the friendliness and competence of the physician, and less hospitalization and referral. In addition the number of ambulance calls from the district ambulatory decreased by 60% after the ambulatory began operation. The results comparing the ambulatory with the Family Medicine Department located within the polyclinic are in the annex, and not presented here in detail. However, in general those results were not different from the results of the internists and pediatricians in the polyclinic.

The Family Medicine Department at Polyclinic #2 was compared to the Hospital #1 Family Medicine Ambulatory at Pol'ova.

Interview Question	Indicated Response	Department	Ambulatory
What was the facility hygienic condition	Good	53%	68%
Would you return to this facility?	Yes	68%	82%
Would you recommend this facility?	Yes	49%	80%
What is professional level of physicians	High	53%	79%
Was the physician friendly?	Yes	72%	84%
Was the physician kind?	Yes	58%	62%
Were you educated about your condition?	Yes	72%	84%
Are you willing to change doctors?	No	79%	86%
How many visits to reach a diagnosis?	One	57%	85%
Should the facility be open 24 hours/day?	Yes	59%	40%

The results show a more favorable response for the ambulatory than for the Polyclinic Department. The question is why the ambulatory at Hospital #1 was more successful than other primary care specialties and more successful than the family medicine Department at Polyclinic #2. Those who conducted the interview identified likely reasons. The

ambulatory is a free standing unit. Administrative autonomy may be greater when the unit is detached from the parent and some distance from it. There is more control over the environment, including the space utilized in the ambulatory than in the polyclinic. The patients can more easily identify and relate to the smaller unit. The patients identified a friendlier atmosphere at the ambulatory, which could relate to its smaller size and the fact that physicians and nurse can be more easily seen as they go about their work.
The ambulatory is close to the population being served. The ambulatory serves 10,000 people while the Polyclinic serves more than 10 times this number. The ambulatory is therefore much more of a neighborhood facility which is often accessible by foot. There was more budgetary control in the ambulatory than in the Department at the polyclinic. The ambulatory also had physician incentive payment which the Polyclinic did not have.

F. Medical journal exchange. Dr. Zaremba will receive the American publication, Journal of Family Practice which will give her information about family medicine and allow her to summarize certain articles for her own readers of "Practical Medicine" of which she is Editor-in-Chief. In addition, American authors may contribute articles of interest to the journal of which she is editor.

G. American Institute of Medicine report on "The Future of Primary Care". This summary of the two year report was important for the counterparts because it gave the definition of primary care, its value, the nature and delivery of primary care, the workforce involved, the training and education of that workforce, research and evaluation, and methods for implementation. The original document was shortened and altered slightly by Drs. Reeves and Grover to make it more readable and applicable for Ukrainian readers. Its translation into Ukrainian and duplication made it appropriate as a handout to the counterparts at all levels of administration.

H. Evaluation of the 'skills list' developed by Dr. Zaremba as a target for her graduates. Ninety practical skills were identified. Ten program graduates were surveyed to determine whether the skills taught were actually being used. The survey indicated that 70% of the skills listed were frequently used y the graduates practicing in an urban ambulatory. One reason for infrequent use of skills was clearly the lack of an opportunity to use them. For example, understanding exercise testing, the meaning of the arterial blood gases, the use of cardiac defibrillation, and ventilatory resuscitation are examples of activities for which the family physician has no equipment. Other skills that are infrequently used, but for which there is considerable need are methods for identifying the gonococcus, culturing throat discharge, pregnancy diagnosis, the use of local anesthesia. In these instances, the limitations in facilities are limiting the scope of work for the physicians and probably adversely impacting health of the population.

I. DENTISTRY.

Dental services are available in many of the family medicine ambulatories, and account for a large number (10-15%) of the visits to the ambulatories. The equipment is old and the drills are slow. This plus the frequent absence of novocaine for local anesthesia, means

that dental filings and extractions are very painful. Dental floss is practically unknown by the population, so that prophylaxis is poor. There is not the concept that gingivitis is the frequent cause of loss of teeth. An upgrading of dental services is important. This is a project that NADIYA will consider for the ambulatories of Hospital #1.

6. RECOMMENDATIONS

A. Instruments.

Increase the number otoscopes and ophthalmoscopes made available to family physicians. The goal is to see that each practicing family physician has such a kit. A Physician evaluation should be done to see how effective the introduction of these instruments has been. Dotor's bags. In addition to the above, provide family physicians with a bag containing the basic instruments and tools that are needed for his/her practice. A potential list of contents for the bag has been provided by Dr. Zaremba and will be reviewed by the University of Colorado and the NADIYA Group.

B. Laboratory diagnosis

. Provide the ambulatories with the diagnostic tools mentioned, glucosometers, urine analysis strips, hematest kits, peak flow meters, and evaluate the extent to which these improve clinical practice. The provision of these items will be from the NADIYA Group.

C. Patient education materials.

The patient information materials from Colorado are to be translated by Zdrav Reform. They are to be reviewed by the counterparts, and after approval will be duplicated. Duplication will be arranged by Zdrav Reform and duplication costs borne by NADIYA.

D. Medications.

A list of the most useful pharmaceuticals is being prepared by the counterparts so that these can be supplied.

E. Medical Records.

Medical records as supplied from Colorado to the L'viv family medical ambulatories should be reviewed and approved by the counterparts. Strategies should then be developed for reproduction and introduction of these.

F. Psychological/social/ educational assessment.

The data analysis will be done at the University of Colorado Family Medicine Department. These results should then be summarized and circulated to the counterparts, and to interested parties in health administration. Publication could be in the journal "Practical Medicine". Strategies need to be developed in Ukraine for the development of psychological
support services.

G. Patient satisfaction survey.

This instrument should be considered one of the foundation studies for the development of future family medicine urban sites, as it points to certain characteristics of a successful model. It also provides a god example of how an experimental model should be evaluated.

H. The journal

"Practical Medicine" should be used to its utmost potential to promote family medicine.

I. Family planning

including the use of Depo-Provera should be encouraged as a legitimate family medicine activity.

J. The survey of family medicine

graduates relative to the practical skills list should be analyzed and the results forwarded to Dr. Zaremba for consideration of alteration of the training course.

K. Use of information's systems.

The computers to be provided by Zdrav Reform should be used for educational purposes. E-mail contacts should be established for consultation purposes inside and outside Ukraine. Compact disks from Scientific American Medicine should be introduced to selected computer terminals.

L. Dental services

should be upgraded. Recommended is recruitment of a dentist for side-by-side teaching in Ukraine and to advise for how the dentistry can be
strengthened. NADIYA will attempt to accomplish this goal.

M. Communication for rural ambulatories

should be improved, possibly through better patient education, upgrading of nurses and feldshers to use them more efficiently, better transport, more communication to and from referring physicians, more effective use of telephones, upgrading the diagnostic and treatment capacity of the ambulatories.

7. PERSONS CONTACTED

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