Advances in Clinical and Experimental Medicine

MONTHLY ISSN 1899-5276 (PRINT) ISSN 2451-2680 (ONLINE) advances.umw.edu.pl

2024, Vol. 33, Special Issue 1

13th The European Rural and Isolated Practitioners Association (EURIPA) Rural Health Forum

University of Lincoln, UK
June 20–22, 2024

ABSTRACT BOOK

doi:10.17219/acem/2024euripa-abstractbook

Impact Factor (IF) – 2.1
Ministry of Science and Higher Education – 70 pts
Index Copernicus (ICV) – 161.11 pts

Wroclaw Medical University

Advances
in Clinical and Experimental Medicine

ISSN 1899-5276 (PRINT) ISSN 2451-2680 (ONLINE) advances.umw.edu.pl

MONTHLY 2024
Vol. 33, Special Issue 1

Advances in Clinical and Experimental Medicine (*Adv Clin Exp Med*) publishes high-quality original articles, research-in-progress, research letters and systematic reviews and meta-analyses of recognized scientists that deal with all clinical and experimental medicine.

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Publisher
Wroclaw Medical University
Wybrzeże L. Pasteura 1
50-367 Wrocław, Poland

Online edition is the original version of the journal

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Pursuant to the ordinance of the Rector of Wroclaw Medical University No. 37/XVI R/2024, from March 1, 2024, authors are required to pay a fee for each manuscript accepted for publication in the journal Advances in Clinical and Experimental Medicine. The fee amounts to 1600 EUR for all types of papers.

Advances in Clinical and Experimental Medicine has received financial support from the resources of Ministry of Science and Higher Education within the "Social Responsibility of Science – Support for Academic Publishing" project based on agreement No. RCN/SP/0584/2021.

Ministry of Education and Science
Republic of Poland

Czasopismo Advances in Clinical and Experimental Medicine korzysta ze wsparcia finansowego ze środków Ministerstwa Edukacji i Nauki w ramach programu „Społeczna Odpowiedzialność Nauki – Rozwój Czasopism Naukowych" na podstawie umowy nr RCN/SP/0584/2021.

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Edukacji i Nauki

Indexed in: MEDLINE, Science Citation Index Expanded, Journal Citation Reports/Science Edition, Scopus, EMBASE/Excerpta Medica, Ulrich's™ International Periodicals Directory, Index Copernicus

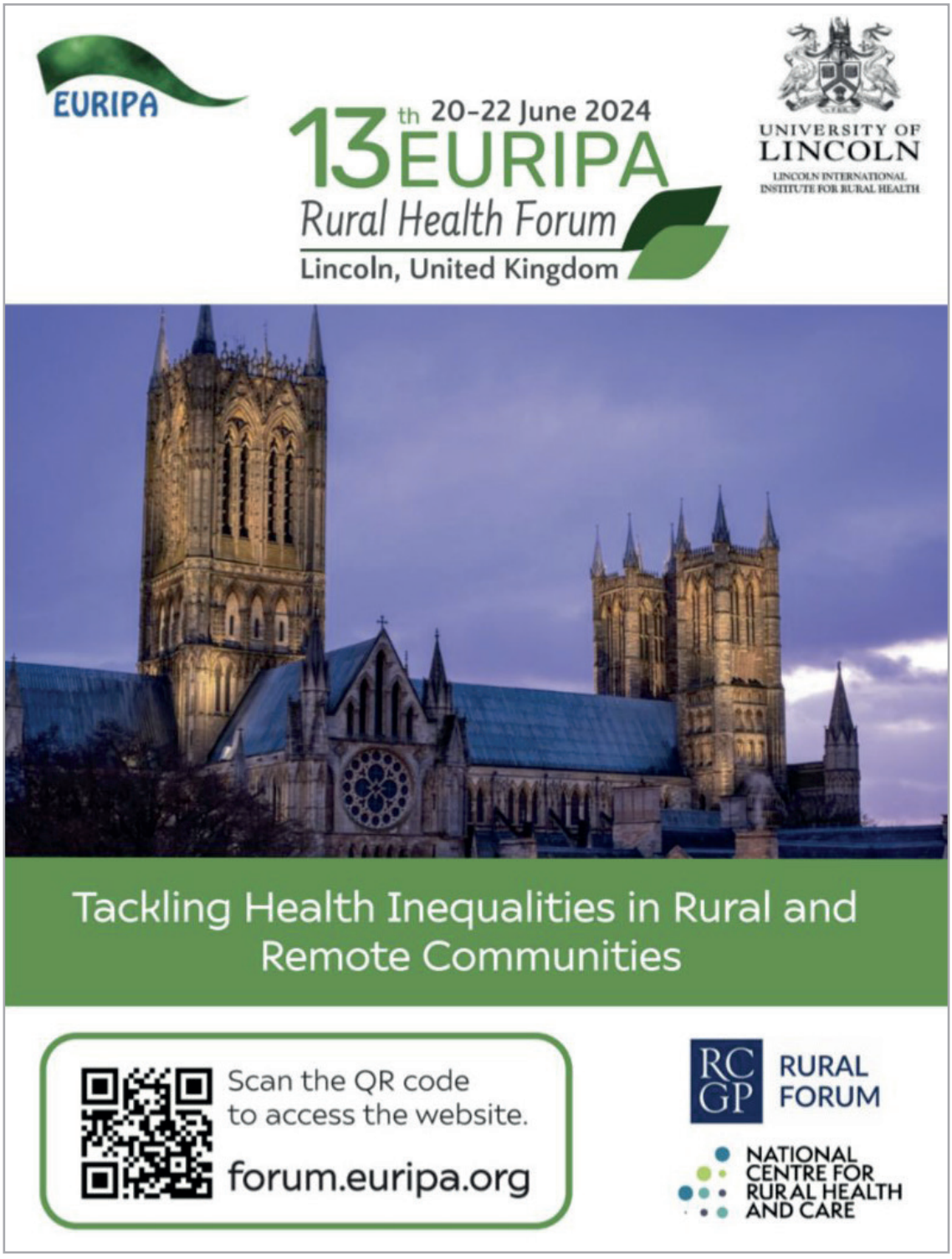
Typographic design: Piotr Gil, Monika Kolęda
DTP: Wydawnictwo UMW
Cover: Monika Kolęda
Printing and binding: PRINT PROFIT Sp. z o.o., Koźmin 27, 59-900 Zgorzelec

The European Rural and Isolated Practitioners Association

13th EURIPA Rural Health Forum

University of Lincoln, UK
June 20–22, 2024

ABSTRACT BOOK



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Tackling Health Inequalities in Rural and Remote Communities

As we approach the end of the first quarter of the 21st century globally populations are experiencing urgent place-based inequalities. Responding to these growing population health and wellbeing challenges are strategic and urgent priorities for healthcare professionals and organizations around the world. Rural, remote and coastal communities are disproportionately challenged by complex factors exposing their indigenous and migrant populations to higher levels of deprivation, economic shock and weather-related disasters and climate change impacts. Residents in isolated, rural or peripheral communities experience significant levels of deprivation with poorer health outcomes, culminating in higher rates of preventable conditions, increased incidences of emergency presentations and shorter life expectancies, in some cases up to a decade shorter than national averages.

The reality of isolated or rural living is that communities experience significant challenges in accessing major services and infrastructures due to failing or inadequate road networks, poor digital coverage, and the withdrawal of business and public enterprises on economic grounds. For coastal, estuary and island communities there are additional impacts of flooding and physical geographic hazards because of rising sea levels and climate change. These multi-factorial challenges are creating a "perfect storm" in public health, which is challenging the capacity and capability of primary, secondary and tertiary healthcare systems to provide effective responses. In the United Kingdom, 85% of the landmass is rural and home to 10 million people, with around 17% of the population living as coastal residents. With more than 50 miles (80 km) of coastline and wetlands, Lincolnshire is one of the largest counties in England facing both environmental and social challenges relating to geographical place of residence - these challenges will produce huge strain on all levels of society and human services and our responses will have long-lasting impacts.

Tackling health inequalities in rural and remote communities is an imperative need that requires collaborative, co-produced and inclusive responses across governments, academia and communities to develop effective and sustainable solutions. Engaging with communities to understand what the problems are and working to find simple solutions that are context-appropriate can be extremely empowering for people and bring solutions that are more sustainable. Developing, co-designing and connecting research agendas and healthcare delivery solutions regionally, nationally and internationally through the EURIPA forum will enhance our understanding of urgent place-based inequalities. Through a shared vision on rural health promotion and inclusive health provision this year's delegates at the Forum in Lincoln contribute to the step-change required to weather the coming storms.

Professor Mark Gussy
Director Lincoln Institute for Rural and Coastal Health (LIRCH)
Global Professor of Rural Health and Social Care
13th EURIPA Rural Health Forum Co-chair

13th EURIPA Rural Health Forum – outline program

Rural Healthcare: Tackling Health Inequalities in Rural and Remote Communities

THURSDAY 20/06/2024

Hours	Room 1 (TBC)	Room 2 (TBC)
	Posters will be displayed throughout the Forum in the Seminar Room	
09:30–12:00	EURIPA Executive Committee and International Advisory Board Joint Meeting (with coffee)	
12:00–14:00	Registration	
14:00–14:45	**Official Opening Ceremony** 1. Dr Sunil Hindocha, Medical Director, Lincolnshire Integrated Care Board & Chair of the Clinical and Care Directorate, Lincolnshire 2. John Wynn-Jones, EURIPA and Visiting Professor in Rural Health of the College of Social Science, University of Lincoln 3. Dr. Oleg Kravchenko, EURIPA president 4. Dr. Ferdinando Petrazzuoli, 13th EURIPA Forum Scientific Committee Co-Chair 5. Professor Neal Juster, Vice Chancellor of the University of Lincoln 6. Inaugural Address Prof. Sir Jonathon Van-Tam, Senior Strategy Advisor in Medicine, University of Nottingham	
14:45–16:15	**Workshop 1** **#17 Team working in rural Primary Care** Rosario Falanga, Anna Falk, Mateja Kokalj Kokot, Anette Fosse, Markus Hermann, Katerina Javorska, Pawel Zuk, Beata Blahova, Gindrovel Dumitra, Joyce Kenkre	**Panel discussion on developing a Forum Statement** *Session Title: E.G. Exploring the Long Tail of Health Inequalities in Rural and Remote Communities*
16:15–16:45	Coffee break	
16:45–17:45	**Oral Presentation 1** Outreach/Community **Moderators:** David O'Brien, Anna Falk **#4 Integrated home care in Primary Care: An observational study in a rural area** Rosario Falanga, Silvia Bond, Amanda Joan Keefe, Gessica Sacchet, Nicol Teston, Elizabeth Katherine Gura, Elena Monte, Olga Mistruzzi, Irene Filippin **#12 The home palliative care net in the Frignano: A virtuous example in rural medicine** Balbarini Andrea, Martucci Gianfranco, Vacondio Paolo **#29 Identifying and examining the effectiveness of interventions to support carers of people with cancer in rural settings** Saimah Uddin, Isabel Jeffrey, Samuel Cooke, David Nelson **#27 Evaluating drone-based medication delivery in Ukraine: Enhancing access and adherence in the framework of the Affordable Medicines** Inna Maslenchuk, Pedro Kremer, Maria Jose Ospina Fadul	**Oral Presentation 2** Miscellaneous **Moderators:** Samuel Cooke, Veronica Rasic **#18 Applying a toolkit for increasing the participation of rural and coastal communities in health and social care research** Hayden Bird, Ava Harding-Bell, Mark Gussy, David Nelson **#7 Utilising COM-B to identify what factors influence health behaviours amongst farmers at risk of cardiometabolic disease** Rebecca Orr, Helen Reid, Mark Tully, Nigel Hart **#2 Rural hospitals and substance use: A 10 year retrospective analysis of three rural hospitals' inpatient data on substance use in Ireland** Sadie Lavelle Cafferkey, Fintan Sheerin, Catherine Comiskey **#39 Community Intervention Project: Enhancing colorectal cancer screening among the communityy** José Pedro Machado, Daniela Oliveira, Ines Rebelo, Marlene Ferreira, Margarida Mano, Helena Duarte, Ana Manuela Rocha, Carolina Vaz Calado

THURSDAY 20/06/2024

Hours	Room 1 (TBC)	Room 2 (TBC)
17:45–18:45	**Oral Presentation 3** Workforce **Moderators:** Helene Markham-Jones, Oleg Kravtchenko **#113 E-Learning for rural and coastal primary healthcare professionals in Europe** Miriam Dolan, Tamara Hynkova, Mary Roberston, Rebecca Orr, Iva Petricusic, Dirk Pilat, Veronika Rasic **#37 Strategies for recruiting and retaining medical staff across the European continent: A systematic review** Momina Iqbal, Lewis Kenney, Maxime Inghels, David Nelson **#38 How to improve the availability of primary health care in rural regions of Latvia?** Liga Kozlovska, Gunta Ticmane, Ainis Dzalbs, Maija Kozlovska **#15 The use of remote healthcare to address health disparities and achieve best practice in rural Lincolnshire** Danielle Reesby, Carl Deaney, Meredith Donaldson, Agne Meskauskiene, Victoria Scott, Natalie Daly, Lisa Haith	**Workshop 2** **#5 Rural Stars Project: Developing a practical guide for rural health promotion and advocacy** Veronika Rasic, Amber Wheatley, Angelus Cyrus, Osama Anita Michael, Nabilah Ali, Mared Thomas, Momina Iqbal
19:00–22:00	**Welcome reception** Welcome from Mayor of Lincoln (819th Mayor of Lincoln)	

FRIDAY 21/06/2024

Hours	Room 1 (TBC)	Room 2 (TBC)
	Posters will be displayed throughout the Forum in the Seminar Room	
08:00–12:00	Morning: Trip to Mablethorpe: Rural, coastal GP practice visit & Tour of Campus for Future Living	
12:00–13:00	Return to Lincoln	
13:00–14:00	Lunch time – packed lunch provided Planting of an EURIPA Tree	
14:00–15:15	**Moderator:** Veronika Rasic **Opening addresses** Dean of the Medical School Professor Thomas Frese, President-elect WONCA Europe **Keynote addresses** 1. Key Note 1 – Dr. Pauline Wilson, Consultant Physician/Associate Medical Director, NHS Shetland 2. Key Note 2 – Dr. Toni Dedeu, Senior Advisor on Integrated Primary Health Care, WHO European Centre for Primary Health Care	

FRIDAY 21/06/2024

Hours	Room 1 (TBC)	Room 2 (TBC)
15:15–16:15	**Oral Presentation 4** Enhancing Primary Care **Moderators:** Farhana Haque, Gindrovel Dumitra **#11 Evaluation of the care gaps and inequalities that arise in Continuing Healthcare (CHC) delivery in a rural setting** Carl Deaney, Victoria Scott, Elizabeth Hemingway **#19 An experience from GP with special Interest Clinics (Gynaecology) in Rural Lincolnshire** Rama Mark **#21 Impact of family health unit location on contraceptive method choice: An observational study in urban area vs rural area** Daniela Oliveira, Diana Correia, João Dionísio, Inês Rebelo, José Machado, Rita Nércio, Fábio Nunes, Silvia Gomes, Gonçalo Magalhães, Helena Duarte **#32 Addressing health inequalities through colorectal screening: Insights from rural Romania** Roxana Surugiu, Loredana Maria Nicolae, Adriana Besteliu, Diana Dumitra, Alexandra Dumitra, Gindrovel Dumitra	**Oral Presentation 5** Clinical **Moderators:** Michael Toze, Andrea Balbarini **#28 Effects of vitamin D status on health status in patients with chronic obstructive pulmonary disease (COPD) living in rural areas** Izolde Bouloukaki, Antonios Christodoulakis, Ioanna Tsiligianni **#45 Diabetic hand syndrome: Prevalence and clinical diagnosis in primary care** Carolina Calado, Diogo Lobo, Raquel Araújo, José Pedro Machado, José Néri, Ana Cristina Oliveira, Manuela Pereira **#48 Access to sexual and reproductive health services by adolescents living in rural or coastal areas: A rapid review of the global literature** Tia Saggiorato*, Tharunya Sivarupan*, Agnes Nanyonjo, Helene Markham-Jones, Marishona Ortega, Ros Kane (*) these authors ontributed equally to this work **#26 Do practice staff perceptions of rurality influence care? Lessons from a national survey of postural hypotension measurement and management** Christopher Clark, Sinead Mcdonagh, Rosina Cross, Jane Masoli, Judit Konya, Gary Abel, James Sheppard, Beth Jakubowski, Cini Bhanu, Jayne Fordham, Katrina Turner, Sallie Lamb, Rupert Payne, Richard Mcmanus, John Campbell
16:15–16:45	Coffee break	
16:45–18:15	**Workshop 3** **#8 Healthcare in rural agricultural areas: Exploring experiences of caring for farming patients across Europe** Rebecca Orr, Miriam Dolan, Helen Reid, Mark Tully, Nigel Hart	**Workshop 4** **#25 Creating a European dialogue with academics (Research and Education) across Europe with the aim of developing a working network to meet the needs of rural, coastal and remote communities across Europe** John Wynn-Jones, Rosario Falanga et al.
18:15–19:15	**Poster presentations (the 5 posters with the highest scores)**	
20:00–22:00	Rural Dinner – Lincoln Cathedral Chapter House (booking required)	

SATURDAY 22/06/2024

Hours	Room 1 (TBC)	Room 2 (TBC)
	Posters will be displayed throughout the Forum in the Seminar Room	
9:30–11:00	**Workshop 5** **#14 Helping healthcare students and trainees engage with their patients and their communities to understand the concept and benefits of community orientation** Miriam Dolan, Joyce Kenkre, Ferdinando Petrazzuoli, Juan Barranco, Miguel Casali, Jane Randall-Smith	**Workshop 6** **#36 Meeting the health needs of rural coastal and island communities: Overcoming the barriers** Brian Norton, Ferdinando Petrazzuoli, Juan Barranco, Joyce Kenkre, Maria Antonopoulou, Sarah-Ann Munoz, Anette Fosse
11:00–11:30	Coffee break	
11:30–12:30	Plenary session – discussion panel, chaired by the Lincoln Institute for Rural and Coastal Health	
12:30–13:00	**Closing Ceremony** Award presentations Presentation of the Forum Statement for adoption Presentation of the 14th EURIPA Rural Health Forum Thomas Frese, Halle University, Germany	
13:00–14:00	Planetary Health Lunch – provided	
14:00	Tourist Excursion Lincolnshire (booking required)	

Advances
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MONTHLY 2024, Vol. 33, Special Issue 1

ISSN 1899-5276 (PRINT)
ISSN 2451-2680 (ONLINE)
advances.umw.edu.pl

Contents

Keynote lecture

15 Pauline Wilson
**Credential in rural and remote health: Unscheduled and urgent care.
Quality-assured learning: Equipping doctors, assuring employers and benefitting rural communities**

17 Toni Dedeu
Addressing rural health inequities: Strategies and policy implications

Oral presentation

18 Saimah Uddin, Isabel Jeffrey, Samuel Cooke, David Nelson
#29 Identifying and examining the effectiveness of interventions to support carers of people with cancer in rural settings

19 Rosario Falanga, Silvia Bond, Amanda Joan Keefe, Gessica Sacchet, Nicol Teston, Elizabeth Katherine Gura, Elena Monte, Olga Mistruzzi, Irene Filippin
#4 Integrated home care in primary care: An observational study in a rural area

20 Inna Maslenchuk, Pedro Kremer, Maria Jose Ospina Fadul
#27 Evaluating drone-based medication delivery in Ukraine: Enhancing access and adherence in the framework of the Affordable Medicines

21 Andrea Balbarini, Gianfranco Martucci, Paolo Vacondio
#12 The home palliative care net in Frignano: A virtuous example in rural medicine

22 José Pedro Machado, Daniela Oliveira, Ines Rebelo, Marlene Ferreira, Margarida Mano, Helena Duarte, Ana Manuela Rocha, Carolina Vaz Calado
#39 Community Intervention Project: Enhancing colorectal cancer screening among the community

23 Sadie Lavelle Cafferkey, Fintan Sheerin, Catherine Comiskey
#2 Rural hospitals and substance use: A 10 year retrospective analysis of three rural hospitals' inpatient data on substance use in Ireland

24 Rebecca Orr, Helen Reid, Mark Tully, Nigel Hart
#7 Utilizing COM-B to identify what factors influence health behaviours amongst farmers at risk of cardiometabolic disease

25 Hayden Bird, Mark Gussy, David Nelson, Ava Harding-Bell, Ashhad Farooqui, Ffion Curtis
#18 Toolkit for enhancing the participation of rural and coastal communities in health and social care research

27 Danielle Reesby, Carl Deaney, Meredith Donaldson, Agne Meskauskiene, Victoria Scott, Natalie Daly, Lisa Haith
#15 The use of remote healthcare to address health disparities and achieve best practice in rural Lincolnshire

28 Momina Iqbal, Lewis Kenney, Maxime Inghels, David Nelson
#37 Strategies for recruiting and retaining medical staff across the European continent: A systematic review

29 Liga Kozlovska, Gunta Ticmane, Ainis Dzalbs, Maija Kozlovska
#38 How to improve the availability of primary health care in rural regions of Latvia?

30 Miriam Dolan, Tamara Hynkova, Rebecca Orr, Iva Petricusic, Dirk Pilat, Veronika Rasic, Mary Robertson
#13 E-learning for rural and coastal primary healthcare professionals in Europe

31 Roxana Surugiu, Loredana Maria Nicolae, Adriana Besteliu, Diana Dumitra, Alexandra Dumitra, Gindrovel Dumitra
#32 Addressing health inequalities through colorectal screening: Insights from rural Romania

32 Rama Mark
#19 An experience from GP with special interest clinics (gynecology) in rural Lincolnshire

33 Daniela Oliveira, Diana Correia, João Dionísio, Inês Rebelo, José Machado, Rita Nércio, Fábio Nunes, Silvia Gomes, Gonçalo Magalhães, Helena Duarte
#21 Impact of family health unit location on contraceptive method choice: An observational study in urban area vs rural area

34 Carl Deaney, Victoria Scott, Elizabeth Hemingway
#11 Evaluation of the care gaps and inequalities that arise in Continuing Healthcare (CHC) delivery in a rural setting

35 Izolde Bouloukaki, Antonios Christodoulakis, Ioanna Tsiligianni
#28 Effects of vitamin D status on health status in patients with chronic obstructive pulmonary disease (COPD) living in rural areas

36 Christopher Clark, Sinead Mcdonagh, Rosina Cross, Jane Masoli, Judit Konya, Gary Abel, James Sheppard, Beth Jakubowski, Cini Bhanu, Jayne Fordham, Katrina Turner, Sallie Lamb, Rupert Payne, Richard Mcmanus, John Campbell
#26 Do practice staff perceptions of rurality influence care? Lessons from a national survey of postural hypotension measurement and management

37 Carolina Calado, Diogo Lobo, Raquel Araújo, José Pedro Machado, José Néri, Ana Cristina Oliveira, Manuela Pereira
#45 Diabetic hand syndrome: Prevalence and clinical diagnosis in primary care

38 Tia Saggiorato, Tharunya Sivarupan, Agnes Nanyonjo, Helene Markham-Jones, Marishona Ortega, Ros Kane
#24 Access to sexual and reproductive health services by adolescents living in rural or coastal areas: A rapid review of the global literature

Poster

39 Veronika Rasic
#3 Exploring the experience of patients in rural and coastal communities in the United Kingdom

40 Elizabeth Katherine Gura
#6 Experimental GP clinical in rural environment

41 Meredith Donaldson
#10 Using technology to reduce health inequality while managing asthma and COPD in a rural practice

42 Danielle Reesby, Carl Deaney, Adam Marshall
#16 The use of remote clinical testing to improve early detection of chronic kidney disease (CKD) in rural populations: A retrospective review

43 Andrea Fuleova
#20 Hepatitis A: What they didn't teach me about it at school

44 Anna Owczarczyk, Magdalena Bogdan, Paweł Zuk, Maciej Karaszewski
#22 Implementation of coordinated care in PHC in Poland: Preliminary results

45 Anna Owczarczyk, Magdalena Bogdan, Paweł Żuk
#23 "Scirocco" tool usage: Medical and Diagnostic Centre case-study

46 Sabina Karczmarz, Paweł Żuk, Marika Guzek, Marta Miros, Joanna Oberska
#30 The attitudes of patients, under coordination in primary care, in rural areas on vaccinations against COVID-19: Research results and further recommendations

47 Joanna Oberska, Joanna Siennicka, Jolanta Pańkowska, Błażej Jurewicz, Damian Chaciak
#31 Pharmaceutical care introduced in coordination with PHC in Poland: Perspectives of physicians, pharmacists and patients

48 Mared Thomas
#33 Exploring the motivations for, and the experiences of GPs working in rural West Wales: A qualitative study

49 Jose Daniel Cara Martin, Irma Vílchez García, Antonio Ramírez Fernández, Zahira Galindo Salmeron, Irene Mayol Comas
#35 Starting a Young Doctors' Community Medicine Work Group in a rural area

50 Liga Kozlovska, Matiss Kore, Gunta Ticmane, Ainis Dzalbs, Maija Kozlovska
#40 Diversity of manipulations and differences in primary care practices in cities and rural regions in Latvia

51 Maija Kozlovska, Liga Kozlovska, Gunta Ticmane, Ruta Vintere
#41 Per aspera ad astra: Smoking cessation in Latvia and the footprints being left behind

52 Carl Deaney, Meredith Donaldson, Agne Meskauskiene, Danielle Reesby, Victoria Scott, Natalie Daly
#42 Key considerations to addressing the challenges of secondary prevention cardiovascular risk reduction in rural communities

53 Magdalena Bogdan, Artur Prusaczyk, Paweł Żuk, Łukasz Śmiejkowski, Anna Świrska, Kamil Cołoś
#43 Attitudes of future physicians in the context of searching methods for reducing medical deserts

54 Magdalena Bogdan, Małgorzata Kalisz, Mariusz Zamyłko, Anna Kordowska, Anna Krawczyk
#44 Future of Polish primary care: Projection of demand and number of family doctors till 2045

55 Oleg Kravtchenko
#46 EC and OOH in rural European locations: Ongoing project

56 Oleg Kravtchenko, Alexandra Stanescu
#47 Virtual Exchange in Europe: Pilot proposal

Workshop

57 Rosario Falanga, Anna Falk, Mateja Kokalj Kokot, Anette Fosse, Markus Hermann, Katerina Javorska, Paweł Żuk, Beata Blahova, Gindrovel Dumitra, Joyce Kenkre
#17 Team working in rural primary care

58 Veronika Rasic, Amber Wheatley, Angelus Cyrus, Osama Anita Michael, Nabilah Ali, Mared Thomas, Momina Iqbal
#5 Rural Stars Project: Developing a practical guide for rural health promotion and advocacy

59 Rebecca Orr, Miriam Dolan, Helen Reid, Mark Tully, Nigel Hart
#8 Healthcare in rural agricultural areas: Exploring experiences of caring for farming patients across Europe

60 John Wynn-Jones, Rosario Falanga
#25 Creating a European dialogue with academics (research and education) across Europe with the aim of developing a working network to meet the needs of rural, coastal and remote communities across Europe

61 Miriam Dolan, Joyce Kenkre, Ferdinando Petrazzuoli, Juan Barranco, Miguel Casali, Jane Randall-Smith
#14 Helping healthcare students and trainees engage with their patients and their communities to understand the concept and benefits of community orientation

62 Brian Norton, Ferdinando Petrazzuoli, Juan Barranco, Joyce Kenkre, Maria Antonopoulou, Sarah-Ann Munoz, Anette Fosse
#36 Meeting the health needs of rural coastal and island communities: Overcoming the barriers

Credential in rural and remote health: Unscheduled and urgent care

Quality-assured learning: Equipping doctors, assuring employers and benefitting rural communities

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

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Abstract

In June 2019, the General Medical Council (GMC) agreed a process for the 5 early adopters for GMC credentials. Rural and Remote Health was chosen as an area for credential development.

In September 2020, work began on the development of a Credential in Rural and Remote Health focusing on unscheduled and urgent care.

In December 2021, the Rural and Remote Credential curriculum was endorsed by the GMC. Since then, the credential team has worked to move the credential from design to delivery, this has included the design of an e-portfolio and quality assurance framework.

Practising medicine in rural, remote and Island settings areas is challenging. Compared to their urban counterparts, doctors practising in these locations may be described as "extended generalists". They provide a wider range of clinical service, sustain a heavy workload, and carry a high level of clinical responsibility, all in relative professional isolation.

Although bespoke posts have emerged as a pragmatic response to service need, in the UK there was no shared underpinning competency framework and the background, clinical training and skill levels of doctors practicing in rural general hospitals vary significantly.

The credential aims to provide a consistent approach to the training of the "extended generalist" required to provide unscheduled and urgent care in rural and remote hospitals and at the interface with the community. The Credential in Rural and Remote Health (Unscheduled and Urgent Care) aligns with the key principles of the UK Shape of Training Review.

The credential in Rural and Remote Health will help to address the service and patient safety need for doctors working in remote, rural and Island settings to extend and enhance the skills not covered in speciality training. In doing so the credential will:

- Provide a supportive training framework
- Enhance skills and expertise in the provision of unscheduled and urgent care
- Create a flexible training culture for doctors in rural and remote areas
- Support flexible career development and facilitate credential holders to change career direction.

Holders of the credential in Rural and Remote Health will not have the scope of practice equivalent to doctors on the specialist register for other GMC-approved curricula. It is a generalist credential of core emergency skills capable of being delivered in a non-specialist environment.

Aligned with "Excellence by Design", the Rural and Remote Health credential curriculum is outcomes-based. The credential is made up of 3 generic capabilities in practice, 9 clinical capabilities in practice, as well as a range of procedural skills. The credential is underpinned by an assessment and governance framework. There is a toolbox of learning that has been developed that will sit alongside the curriculum.

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Credential in rural and remote health: Unscheduled and urgent care

Quality-assured learning: Equipping doctors, assuring employers and benefitting rural communities

There are 2 routes for credential awards:

1. The Recognition Route – for those who already meet credential requirements.
2. The Learner Route – Progression will depend on capability rather than time. Attainment of the competencies may accordingly be achieved at different times depending on clinical placements as well as pre-credential experience and training.

The credential will provide a consistent approach to the training of the "extended generalist", who is often required to provide unscheduled and urgent care, both in rural and remote hospitals and directly with patients in their community. The credential launches for the Recognition Route in June 2024 and Learner Route in September 2024.

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Addressing rural health inequities: Strategies and policy implications

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Rural populations face significant health, social, and economic inequities. They tend to be poorer, have worse health outcomes, and experience higher rates of unemployment and informal employment. Approximately 51–67% of rural populations lack adequate access to essential health services, leaving about 2 billion people underserved. In some regions, the number of health workers in rural areas is 10 times fewer than in urban areas.

In the EU, rural areas cover over 80% of the territory and are home to 30% of the population, a trend even more pronounced across the WHO European region. Despite potential health benefits, many rural areas face challenges such as demographic decline, low income, poor access to services, and low employment rates, particularly among women. The risk of poverty and social exclusion is higher in rural areas, with average distances to essential services being much longer than in urban settings.

Demographic issues, such as out-migration and ageing populations, exacerbate these challenges, leading to higher poverty rates. Furthermore, the rural dimension is often overlooked in health status and system performance analyses, resulting in limited data and policy focus on rural health needs. Clear inequities exist between rural and urban health systems across the WHO European region. Rural areas generally have fewer qualified healthcare workers, greater distances to major hospitals, less access to specialised services and pharmacies, and higher financial barriers due to lower incomes and additional costs like travel and lodging. Emergency care services in rural areas are often less effective, and infrastructure quality is typically lower.

To address healthcare challenges in rural, isolated, remote, and dispersed population areas, key strategies include integrating rural primary health care (PHC) within the broader PHC framework, coordinating efforts for maximum impact, and involving local stakeholders and communities to ensure success with tailored approaches.

We have identified good practices worth sharing, and the challenge lies in better documenting the health outcomes and impacts of these practices. Expanding primary care services, establishing multidisciplinary teams for integrated care, and developing mobile services to bring care closer to communities are essential. Additionally, deploying digital health solutions, implementing comprehensive health workforce strategies, investing in infrastructure, aligning health financing, and fostering intersectoral collaboration with local partners is crucial for creating vibrant local economies and improving health outcomes.

Policy decisions often target urban populations, potentially adversely affecting rural communities. To address this, the WHO advocates for policy development to incorporate a rural perspective. The WHO adopts the concept of "rural proofing" to create health impact assessments for policy interventions to ensure rural needs are considered. Integrating rural proofing into the policy process is essential for equitable outcomes. Generating evidence and fostering collaboration are crucial to achieving this goal.

Key words: health inequities, rural health, policy implications

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#29 Identifying and examining the effectiveness of interventions to support carers of people with cancer in rural settings

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Supporting the health and wellbeing of those caring for someone with cancer is a priority particularly in resource limited rural areas where there is a lack of support for both the patient and the carer. Informal caregivers (close family and friends) can also have their own psychosocial needs that often go unmet. To date, there have been no systematic reviews that have examined the solely rural evidence in this area, so it is crucial to explore the effectiveness of interventions designed to support informal caregivers of people with cancer in rural settings. Objectives. To identify and examine the effectiveness of interventions that are delivered to support informal caregivers of people with cancer in rural and remote settings.

Methodology. The protocol was registered on PROSPERO (CRD42023468015). MEDLINE, CINAHL, PsycINFO, and Scopus, were searched using both subject headings and keywords for articles published between 2013–2023. The review was conducted in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. The included studies were critically appraised using the Mixed Methods Appraisal Tool (MMAT). To visualize the risk-of-bias assessment, the Risk of Bias Visualization (ROBVIS) web-based tool was employed. Data extraction was performed using a predetermined template in Microsoft Excel.

Results. Overall, 8,314 articles were screened against the eligibility criteria. A total of 23 articles were included in the review. Interventions that actively involve caregivers in their development and implementation tend to be more successful, leveraging their expertise and ensuring relevance, while interventions solely reliant on digital or telehealth solutions may face challenges in rural areas due to limited infrastructure and digital literacy.

Conclusions. The synthesis of these studies underscores the variation of interventions currently available for rural caregivers and the effectiveness of the interventions. The studies offers crucial insights into the complexities and challenges faced by this specific group of caregivers.

Key words: rural health, cancer, informal caregivers, carers, intervention

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#4 Integrated home care in primary care: An observational study in a rural area

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. As the elderly population grows, healthcare has moved from hospitals directly to people's homes, where multiple healthcare providers facilitate care. Strong and integrated primary care and home care are fundamental components of an effective management of chronic and degenerative diseases in rural areas and allow for reduced emergency room visits and hospital admissions.

Objectives. How is integrated home care (IHC) provided to the elderly and patients with special needs in our rural areas?

Methodology. Retrospective observational cohort study, which investigated a population sample in a rural area of the province of Pordenone, in Northeast Italy. The data relating to the quantity and type of IHC services provided (from January 1st to December 31st, 2023) were extracted from the Local Health Authority database.

Results. The total population in the area (200 km^2), is 14,554 (3,868 over 65, 27%). General Practitioners (7), family nurses (5), patients treated at home: 402 (27.7 × 1000 inhabitants, 90% >65), female 251 (63%), male 151 (37%). General practitioner's home visits are around 1500 (based on 2018 data), nurses home visits (7,333), for a total of 20,223 services. Many patients are affected by heart failure (17.3%) and malignant tumors (9.4%). Type of services provided: wound dressing (vascular/pressure/diabetic ulcers): 6135; therapeutic education (patient/caregiver): 1970; blood withdrawal: 1047; nasogastric tube/PEG management: 503; parenteral nutrition management: 388; bladder catheterization management: 351; IV therapy: 340.

Conclusions. The IHC in this rural area involved GPs, nurses, physical therapists, social workers, palliative care doctors, dieticians, and psychiatrists. Such a comprehensive primary health care system showed itself to be a positive reality for person-centered care. Further studies would be useful to evaluate the level of satisfaction of patients and their caregivers.

Key words: primary care, home health care, integrated care, and person-centered care

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#27 Evaluating drone-based medication delivery in Ukraine: Enhancing access and adherence in the framework of the Affordable Medicines

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Since its inception in 2017 by the Ministry of Health, Ukraine's Affordable Medicines Program (AMP) has significantly enhanced the provision of essential medications for chronic conditions amidst demographic challenges and a high disease burden, particularly in conflict-affected and remote areas. However, rural regions, including the Bucha community in the region (which was liberated after the Russian occupation in 2022) continue to face access barriers, as evidenced by low prescription fulfillment rates and limited pharmacy participation in the AMP.

Objectives. This study aims to assess Zipline's impact on improving medication access and adherence for patients with chronic diseases within the AMP by facilitating direct deliveries to healthcare facilities near patient residences, potentially diminishing travel requirements and associated costs.

Methodology. Adopting a mixed-methods design, this research will compare prescription fulfillment rates and patient adherence between communities served by Zipline and those without this service. The study will focus on the Bucha community, encompassing 7 villages and 7 PHC providers, serving over 13,000 residents, from May 2024 to July 2024. Data collection will involve surveys administered to chronically ill patients during GP visits and follow-up home visits, focusing on adherence, travel distances, and out-of-pocket expenses for prescribed medicines.

Results. The research is aiming to be provided in the mid of May 2024. Affordability and lack of access to pharmacies in the rural areas result in a very low rate of prescriptions fulfillment. In 2023, only 16.37% of the nation's e-prescriptions were for rural residents, and only 60% of the pharmacies in villages participated in the program.

Conclusions. This investigation aims to clarify the relationship between patient adherence and healthcare facility proximity while exploring the impact of drone deliveries in enhancing health outcomes by reducing geographic barriers. By addressing the accessibility gap, the study intends to highlight the transformative potential of aerial logistics in healthcare delivery, particularly in areas with logistical and pharmaceutical constraints.

Key words: drone-delivery, prescribed medicines, remote communities, Ukraine, Affordable Medicines Government Program

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#12 The home palliative care net in Frignano: A virtuous example in rural medicine

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. The palliative care net in Italy was established in 2010. The province of Modena, Emilia Romagna region is divided into 9 districts. The district of Pavullo nel Frignano extends for 689,53 km^2 and has a population of 41,925 people, with a population density of 60 people per km^2. Moreover, local altitude varies from 400 m to 1500 m. The old age index is 1.9.

Objectives. This study aims to describe the organization of the home palliative care net in the area of Frignano.

Methodology. The home palliative care net in Frignano is made up of 22 local GPs, 4 nurses, a specialist doctor in palliative care, and a psychologist. The net is activated following a specific request by the hospital or the local GPs. During the 1st encounter, the patient's GP and the net's nurse meet the patient to discuss care objectives, the patient's requests and beliefs, the presence or absence of disabling symptoms, and the settings of a specific therapy. The subsequent follow-up is then organized and when the patient's condition gets worse, it is possible to organize the end-of-life phase at home.

Results. Data were collected focusing on the population of people over 65 who had been taken care of by the home palliative care net in 2023. Overall, 1,344 people were enrolled by the net, with a prevalence of 12.7%. In comparison with data from 2022, there was a prevalent increase of 1.3%. The total amount of home visits in 2023 was 2,813.

Conclusions. The palliative care net in Frignano represents an essential tool of Primary Care improving the quality of life of patients and their families. This is achieved through prevention and relief of suffering via early identification, assessment and treatment of pain and other physical, psychosocial, ethical, and spiritual problems.

Key words: palliative care, rural medicine, home care

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#39 Community Intervention Project: Enhancing colorectal cancer screening among the community

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Colorectal cancer (CRC) is the 2nd most prevalent and fatal cancer worldwide. In Portugal, there is a national screening campaign for CRC (CRCS), based on a fecal immunochemical test (FIT) in the asymptomatic population between 50–74 years old without risk factors. In January 2023, our Primary Care Centre (PCC) screening coverage was below national average. This PCC is located in a rural environment, whose population has a low level of awareness for the importance of CRCS and low capability of correct sample collecting, with a high FIT rejection. A need for measurements to enhance CRCS proved to be an urgent priority.

Objectives. To increase the CRCS coverage of the PCC, and to educate the population regarding CRCS's relevance.

Case report

Methodology. Between May and June 2023, information concerning CRCS was displayed in the PCC's waiting room, local newspapers, local radio and social media. A partnership with the local county council was established, where doctors visited multiple small villages of the county to give educational sessions. "Screening afternoons" were organized between June and December 2023. In each session, 120 patients were summoned to hear an explanation on the correct sample collecting process and to receive a FIT.

Results. After 6 months, there was an 85% increase in the total number of FIT delivered (944) and a 28% reduction in rejected FIT. The positivity rate was 2.97%. By December 2023, the CRCS coverage (measured by a specific performance indicator) increased 6.16 percentual points compared to December 2022.

Conclusions. This project had a major impact, markedly improving the number of patients screened for CRC and raising awareness among the community regarding the importance of screening. Though a discernible improvement in CRCS coverage was achieved, there is still room for improvement in order to achieve the ideal coverage of 100%.

Key words: colorectal cancer, screening, Community Intervention Project

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#2 Rural hospitals and substance use: A 10 year retrospective analysis of three rural hospitals' inpatient data on substance use in Ireland

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. The United Nations 2017 policy on "The Prevention of Drug use and Treatment of Drug Use in Rural Settings", reported that while substance use and its associated problems is on the rise in rural areas, comprehensive rural data are not widely available. The scale of substance use has not yet previously been examined from a solely rural inpatient perspective in Ireland.

Objectives. This research is forming part of a PhD for the development of a nurse-led addiction model of care for resource poor and rural settings. The purpose of this secondary data analysis was to determine burden within a community by providing estimating prevalence and local needs within a defined rural region, based on inpatient hospital data records from 2010–2021.

Methodology. Anonymized secondary data from 3 rural general hospital HiPE datasets were analyzed using descriptive statistics. This analysis is part of an explanatory mixed methods study, where the quantitative aspect will analyze secondary data from three separate databases.

Results. The main substance that inpatients presented with was alcohol. The number of men presenting was greater than that of women. Individuals may not access their closest healthcare provider. Majority of people are discharged home or self-discharge. Treatment is not widely provided across all 3 hospitals.

Conclusions. While people may not be presenting primarily for substance use, there is a need for alcohol and drug use to be considered within in-patient treatment and discharge plans. Accounting for the scale of mortality and morbidity related to substance use globally, and national policies on "making every contact count", there is a need for promoting these topics within in-patient setting. This research will give insight and perspective to the direction of care in relation to substance use in rural areas.

Key words: substance use, rural hospitals, inpatients

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#7 Utilizing COM-B to identify what factors influence health behaviours amongst farmers at risk of cardiometabolic disease

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Agriculture is rapidly changing and so too is the lifestyle that farm families live. Limitations within rural wellbeing statistics may also subsume pockets of deprivation within sparsely populated agricultural areas. Farmers appear to carry a higher proportion of cardiometabolic disease (CMD) risk compared to other rural occupational groups.

Objectives. 1. To identify what capabilities, opportunities and motivations (COM) influence farmers' current behavior to seek or not seek healthcare once prompted to do so. 2. To determine farmers current perception of their knowledge of CMD risk and whether or not knowledge about CMD correlates with responsible health behaviors. 3. To analyze the data produced using the COM-B model to inform future healthcare behavioral change interventions (BCI).

Methodology. This mixed-methods rural proofed study was co-designed from inception with farmers through patient and public (PPI) contribution. Using the COM-B framework, designed by Michie et al., we designed a questionnaire. Eligibility criteria included active farmers aged 24–85 years of age with 1 or more risk factor for cardiometabolic disease. Multivariate descriptive statistics were used to analyze the questionnaire data. Questionnaire participants were invited for a face-to-face interview. Participants were purposively sampled for maximum variation and geographical spread. Interview data were organized using NVivo software and deductively analyzed using thematic analysis.

Results. This study remains ongoing however it provides an example of community-based research designed with a "hard to reach" patient group. Data analysis is ongoing and early results will be shared at time of presenting. Participants (n = 226) in the questionnaire have commented it was a useful tool to reflect on their health behaviors. It also yielded successfully a sample (n = 138) for interview.

Conclusions. This community-based study is an example of a mixed method design which has successfully engaged an under researched patient group with early involvement of PPI contributors.

Key words: farmer health, occupational health, cardiovascular, cardiometabolic, health behaviors, behavioral change

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#18 Toolkit for enhancing the participation of rural and coastal communities in health and social care research

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Rural and coastal communities are underrepresented in health and social care research. This can impact the quality of the research by reducing the generalizability of findings and/or by limiting the "strength" of the research methods being used by researchers. The result of this is twofold. Firstly, there is limited understanding of health and social care as it operates in rural settings and, secondly, research conclusions give an incomplete picture of the entire population. It is also unfair, from an equity perspective, that groups traditionally underserved by research continue to be excluded from studies because of where they live. A Toolkit for Increasing the Participation of Rural and Coastal Communities in Health and Social Care Research has recently been developed under the leadership and collaboration of a multidisciplinary group of researchers, stakeholders, and residents from a variety of backgrounds. It includes those who live, work, volunteer and undertake health and care research with rural and coastal communities.

Objectives. The presentation introduces the Toolkit, funded by the National Institute for Health and Social Care Research (UK, East Midlands Clinical Research Network). If focuses on the rationale for the toolkit, the 7 guidelines developed and its real-world applications. The guidance is intended for use at different stages of research and evaluation, including: Before and during public/stakeholder engagement; informing collaborative research design; and shaping studies formatively as they develop in real time. Finally, they provide a summative tool to reflect on completed studies, to promote learning that can be applied to future engagement, funding bids, Continuing Professional Development, and inform future studies.

Methodology. Hayden Bird, the co-facilitator and one of the authors of the Toolkit for Increasing the Participation of Rural and Coastal Communities in Health and Social Care Research will seek to reflect on engagement and collaboration with diverse stakeholders and communities. This project involved a rapid evidence review, conducting focus groups and interviews, developing case study vignettes and a workshop to refine and develop guidance content. Hayden is currently a Post-Doctoral Research Associate at the Lincoln Institute for Rural and Coastal Research, a team of researchers dedicated to bringing together rural and coastal health and wellbeing research to help understand and tackle the place-based inequalities experienced in these communities.

Results. The reasons for the ongoing exclusion of rural and coastal communities are multifaceted. The literature tells us it is likely due to difficulties with travel time and/or communication technology, comparatively higher costs of involving rural and distanced residents, cultural aversions, and values and concerns about privacy in small communities. This toolkit shows that there are other more nuanced barriers, but also potentially more effective ways of including residents of isolated communities that can only be known by engaging directly with them. In this respect, inequities experienced in accessing services are somewhat mirrored in the challenges of engaging these communities in research. There are practical and emotional implications for both those undertaking research and those who are included as participants.

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#18 Toolkit for enhancing the participation of rural and coastal communities in health and social care research

Conclusions. Despite being home to significant national assets including health-supporting blue and green spaces rural and coastal communities are disproportionately vulnerable to deprivation, economic shock, climate change, higher disease burdens, and inequalities in health and wellbeing outcomes. Rural populations, small seaside towns, and sparse settings are generally less ethnically diverse and have higher proportions of older people. Access to health services and hospitals is more challenging in rural areas with reduced services, poor transport infrastructure, and consequently greater cost incurred by residents. Although the COVID-19 pandemic reaffirmed the importance of access to timely health, care, and wellbeing services, the impact on access to services and wider social determinants of poorer health remains omnipresent. The Toolkit highlights a more lateral and inclusive approach to appreciating Equalities, Diversities and Inclusion in developing both approaches to research and service delivery. One that explores diversities of experience that are shaped by place-based characteristics and often complex interactions.

Key words: rural and coastal, health, community engagement, social participation, research and evaluation design, NIHR, diversities, underserved populationsAbstract

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#15 The use of remote healthcare to address health disparities and achieve best practice in rural Lincolnshire

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. In rural and remote communities, access to healthcare services is often limited, leading to significant health disparities that ultimately affect best practice delivery. Our practice sits in East Lindsey, which is ranked as the 30th most deprived area in England, with 34% of people living in deprivation. Despite this, advancements in remote healthcare technologies offer a promising solution to bridge this gap and are particularly useful in serving remote communities where access is limited.

Objectives. We aim to highlight the vast opportunity to reach more patients by utilizing remote ways of working, from diagnostics to monitoring, provision of management plans, and even improving the uptake of vital screening programmes. The central question we aim to address is: How can remote healthcare technologies be utilized most effectively to improve access to quality healthcare and reduce health inequalities in rural and remote areas?

Methodology. Our methodology is grounded in a retrospective case-study approach, drawing on the successes, challenges, and experiences of a rural Lincolnshire practice. This practice has been at the forefront of employing remote ways of working in a wide variety of disease areas, from respiratory to chronic kidney disease. By sharing these real-world examples, we aim to demonstrate the effectiveness and feasibility of remote diagnostics, long-term condition management, and patient monitoring, enhancing the credibility and reliability of our research.

Results. Through case studies, we can vividly illustrate the transformative power of remote healthcare solutions. These include significant improvements in CKD diagnosis, uptake of cervical cancer smears, and bowel cancer screening, aligning with national targets. We also demonstrate how remote working can enhance patient adherence to medications and foster a deeper understanding of their long-term conditions. These outcomes underscore the potential of remote working to significantly improve health outcomes, even in rural and deprived communities, instilling a sense of hope and optimism.

Conclusions. Using standard IT systems, our rural East Lincolnshire practice has demonstrated the importance of incorporating remote working methods with best practices to address health inequalities in rural and remote communities.

Key words: primary care, remote healthcare, health disparities, rural practice

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#37 Strategies for recruiting and retaining medical staff across the European continent: A systematic review

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. The global shortage of healthcare professionals in rural areas is a growing issue, resulting in poor health outcomes for rural communities and increased workload for healthcare staff. Despite extensive research on strategies for recruiting and retaining medical staff in rural areas of N. America and Australia; Europe remains underexplored, with no systematic reviews synthesizing European strategies.

Objectives. To identify and explore the effectiveness of interventions to recruit and retain medical healthcare staff in rural and remote settings across the European continent.

Methodology. We conducted a systematic review by searching the following databases: PubMed, CINAHL, Web of Science, and Cochrane. Peer-reviewed studies reporting quantitative and/or qualitative data on medical healthcare staff recruitment and retention interventions in rural and/or remote European settings were included. We followed PRISMA guidelines, tabulated an overview of the interventions, used MMAT for quality assessment, and performed a thematic synthesis.

Results. Overall, 3,389 articles were screened; 15 met the eligibility criteria and were included in the results. Five themes were identified through analysis: 1. Educational and Professional Development (e.g., establishment of medical schools and postgraduate training/education opportunities in rural regions). 2. Personal factors (e.g., mentorship/supervision, career aspirations opportunities, proximity with family). 3. Financial factors (e.g., salaries, financial schemes, funding packages). 4. Working environment (e.g., supporting workload, working hours and conditions). 5. Rural exposure (e.g., rural origin/background and exposure to rural settings. While financial factors can improve initial recruitment, they are insufficient for long-term retention. Interventions related to education/professional development and rural exposure were more likely to lead to higher recruitment and retention.

Conclusions. Interventions that improve education and training opportunities, enhance the work environment, and enable rural exposure (e.g., rural placements) during training are to be prioritized to facilitate short and longer-term medical staff recruitment and retention in rural and remote settings.

Key words: medical staff, healthcare professionals, doctors, GPs, students, rural, remote, recruitment, retention, intervention, strategies, incentives

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#38 How to improve the availability of primary health care in rural regions of Latvia?

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. In Latvia, the problems of primary health care (PHC) availability are increasing every year, especially in rural regions. The main reasons include 1) 1) the aging of the general practitioner workforce, with 30.2% of general practitioners reaching retirement age, and as high as 40% in rural areas; 2) low local government support; 3) ineffective cooperation with secondary care specialists; 4) slow digitization process. The consequence of this is that family doctors and team members alike are experiencing excessive workloads and burnout. Furthermore, the younger generation of doctors is reluctant to work in this environment.

Objectives. The aim was to study and analyze the problems of PHC availability in rural regions. Our research question was: "Can constructive cooperation between organizations of family doctors, the Ministry of Health, the government, parliament, universities, and municipalities significantly improve access to PHC in rural regions?"

Case report

Subjects and methods. This year, after analyzing the work of the PHC in Latvia, a 3-year development plan was developed, which includes certain goals and tasks to improve the work of family doctors with additional funding from the state budget, hoping for development in rural regions.

Results. The plan covers expansion of the PHC team with another state-paid employee and the implementation of a rural support factor in wages, which is related to the distance from the capital and the population density of the territory. It includes review and expansion of the manipulations (or activities) performed by the family doctor; implementation of performance indicators; introduction of vaccination coverage payment; multi-professional PHC development; facilitated implementation of the joint practice model, and development of digitization.

Conclusions. As a result of the implemented measures, the patient will be provided with better access to PHC services, especially in rural regions, and the workload of secondary health care specialists and hospitals will be reduced.

Key words: PHC, family doctor

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#13 E-learning for rural and coastal primary healthcare professionals in Europe

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Primary healthcare professionals in rural and/or coastal areas require diverse and unique skills, knowledge and attitudes to ensure safe, effective and sustainable primary healthcare delivery. This can involve providing rural-specific health and urgent care, working in a resource-poor healthcare environment, or dealing with an increasingly rurality located ageing population with multi-morbidity. EURIPA is a representative network organization addressing the health and well-being needs of rural, remote and coastal communities, as well as the professional needs of those serving them across Europe. The oral presentation will see a "coming together" of rural and coastal primary healthcare professionals and academics across Europe during the EURIPA conference to brainstorm and connect on how the continuous professional development needs of rural practitioners could be better addressed through evidence-based, rurally focused, accessible computer-assisted learning.

Objectives. The presentation aims to harness collective expertise and creativity to generate ideas for e-learning initiatives tailored to the unique needs of rural and coastal primary healthcare professionals.

Methodology. The authors from various parts in Europa with a special interest in e-learning will share their experiences to stimulate others to share their ideas online for e-learning initiatives tailored to the unique needs of rural and coastal primary healthcare professionals.

Results. The presenters will explore topics and methodology for e-learning particular to rural primary care which are currently not covered by mainstream CPD providers. Aspects like content, accessibility, technology and platforms, and accreditation related to e-learning targeted at the specific needs and realities of rural and coastal primary care settings will be presented and shard among the attendees.

Conclusions. Rural and coastal family doctors have specific learning needs to enable their continuous professional development which partially can be addressed using e-learning. Shared experiences and insights will form the basis of further collaboration and development of e-learning for rural and coastal primary healthcare professionals. Consensus themes will be sough and recommended to the relevant committees of the RCGP and EURIPA.

Key words: e-learning, rural healthcare, primary healthcare, remote and distance education, computer aided education

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#32 Addressing health inequalities through colorectal screening: Insights from rural Romania

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Colorectal cancer (CRC) is a significant global health burden, ranked as the third most common cancer worldwide and the fourth leading cause of cancer-related deaths. Despite advances in screening and treatment, CRC incidence and mortality rates remain disproportionately high in rural and remote areas compared to urban regions.

Objectives. The aim of this retrospective study was to assess the effectiveness of CRC screening in a rural setting, specifically focusing on identifying disparities between patients who declined colonoscopy after a positive fecal immunochemical test (FIT).

Methodology. This retrospective study analyzed data from enrolled cases for CRC screening conducted in Sadova, focusing on the disparities between patients who refused colonoscopy after a FIT and those diagnosed with CRC. The study utilized existing records from the CRC screening program in Sadova, including patient demographics, FIT results, colonoscopy referral, diagnostic outcomes, and follow-up information. Data were collected from medical records, screening registries, and administrative databases.

Results. Out of the total 4,920 patients registered in the Family Medicine Practice in Sadova (Romania), 25.39% met the inclusion criteria for colorectal cancer screening. Among these eligible patients, 51.28% were women and 48.72% were men. Of the eligible patients, 18.78% enrolled in the screening program and progressed through various stages of the screening process. Out of enrolled patients that underwent a biopsy and received histopathological results, 5.88% were diagnosed with CRC. Among patients who declined to proceed with colonoscopy, common reasons of refusal included fear, low perceived risk, embarrassment, and a lack of prioritization of their health.

Conclusions. Despite efforts to increase participation, a significant proportion of eligible patients did not enroll or complete the screening process. By understanding and addressing these factors, healthcare providers and policymakers can enhance the effectiveness and reach of CRC screening programs, ultimately reducing the burden of CRC in rural communities.

Key words: rural medicine, screening, colorectal cancer

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#19 An experience from GP with special interest clinics (gynecology) in rural Lincolnshire

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Accessing expert care for common gynecological conditions is a challenge for women in rural Lincolnshire due to a lack of dedicated funding for specialist primary care-based clinics. Patients and their GPs rely on secondary care to provide this expertise which is not ideal given the poor transportation networks in Lincolnshire and long waiting times in secondary care. In 2023, the UK Women's Health Strategy has identified the establishment of Women's Health Hubs (WHH) as a priority in order to address the current deficit in the provision of easily accessible, coordinated services for women's health problems.

Objectives. The aim of this study was to look at the value of providing a local gynecology service for women in a rural Primary Care Network (PCN) of practices in Lincolnshire.

Methodology. Between February and March 2022, a total of 6 clinics were held in 2 GP surgeries within a PCN by a GP with special interest (GPSI) in gynecology supported by a nurse from the GP surgery. Patients were booked by their GPs into these clinics within agreed inclusion and exclusion criteria. The GPSI had extensive gynecology experience as also close links with specialists in secondary care with whom management guidelines had been previously drawn up for common gynecological conditions.

Results. A total of 52 patients were seen of whom 92% had their care completed at their first clinic appointment and only 8% required referral to secondary care for further input.

Conclusions. An expert first contact gynecology specialist service based within a primary care setting can benefit women from prompt solutions to their gynecology problems and the healthcare system from reducing unnecessary expensive referrals into secondary care and is in keeping with the objectives of the UK Women's Health Strategy 2023 and its recommendation for setting up women's health hubs. The experience gained from this work can inform setting-up of such hubs in rural Lincolnshire.

Key words: women's health, GP with special interest, gynecology

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#21 Impact of family health unit location on contraceptive method choice: An observational study in urban area vs rural area

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. According to the literature, cultural and sociodemographic characteristics influence knowledge, attitudes, and beliefs while choosing contraceptive methods. The choice of method should be free, individual, and informed. The family doctor, as the proximity doctor, can support decisions through informed dialogue considering individual circumstances.

Objectives. Characterize contraceptive knowledge and preferences among childbearing-age women in an urban and a rural Family Health Unit (FHU) and understand whether unit location can be a factor in the use of long-term methods.

Methodology. Retrospective, observational, and descriptive study in two FHU (rural "R" and urban "U") focused on women between 18 and 50 years old using a contraceptive method. A questionnaire was applied to collect sociodemographic information, use of contraception and factors influencing it. Microsoft Excel® and R were used for descriptive and exploratory statistical analysis.

Results. The final sample consisted of 211 women, 91% of which sexually active. Regarding sociodemographic data, there were only significant differences between the FHU in education ($p < 0.001$). Regarding the use of contraception, the majority used short-term methods, with non-significant differences between urban (69%) and rural areas (79%). Significant differences were observed between the FHU ($p < 0.005$) in the number of known contraceptive methods (U – 7.7; R – 6.1). There was a significant reduction of 60% in the use of long-term methods in the rural FHU when compared to the urban one, even when adjusted for age group and education. Older women and women with lower education are more likely to use long-acting contraception.

Conclusions. This study demonstrated the impact of FHU location on the knowledge and choice of contraceptive methods. Data showed that women in urban areas are more likely to use long-term methods. These results reinforce the importance of adoption of guidelines to mitigate differences between professionals and to promote information for equitable decision-making.

Key words: contraception, urban health, rural health, family planning

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#11 Evaluation of the care gaps and inequalities that arise in Continuing Healthcare (CHC) delivery in a rural setting

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Continuing healthcare funding is provided to eligible patients who have qualifying health and/or mental health issues arising from complex health needs. Individuals must be assessed as having a primary need for health care using a nationally approved toolkit which is delivered via locally commissioned services.

Objectives. The aim is to analyze the provision of CHC. NHS England (NHSE) is responsible for planning, procuring services, and managing CHC demand. There appears to be a mismatch between requirement and delivery. This is a retrospective review of NHSE-published data and local experience that evaluates the situation of awarding and delivering CHC in a rural area in the east midlands of England.

Case report. The published data only captures patients who have been assessed as eligible for funding. It excludes cases under dispute and does not provide information on those not receiving care. Local evidence suggests that even when CHC is awarded care is not always provided. This impacts primary care services which ends up providing non-commissioned services to fill the care gap. It is recognized that care may be delayed for a variety of reasons including patients waiting for care even when a personalized health budget has been awarded. Other issues can include geography and inefficient care delivery which may be driven by staff shortages.

Conclusions. Patients and their carers may find that even if CHC has been agreed upon, care cannot be delivered. This can be driven by the higher costs and scarcity of care providers in rural areas. This can cause unnecessary suffering and financial harm driving health care inequalities with unfunded primary care services plugging the care gaps. Factors such as age may exacerbate the situation whilst families may be left without care support having further socio-economic/health impact. The overall system is complex and requires simplification to make it sustainable in an ageing population.

Key words: healthcare inequalities, care gap, continuing healthcare (CHC)

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#28 Effects of vitamin D status on health status in patients with chronic obstructive pulmonary disease (COPD) living in rural areas

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Vitamin D deficiency can lead to rapid deterioration in lung function and elevated risk of worse health status in patients with chronic obstructive pulmonary disease (COPD).

Objectives. To assess the prevalence of vitamin D deficiency among patients with COPD living in rural areas and explore its impact on disease severity and overall health status.

Methodology. This cross-sectional study included 138 participants >40 years from the prospective COCARE COPD study. Sociodemographic characteristics, medical history, disease-specific quality of life, the COPD Assessment Test (CAT), fatigue, the Fatigue Severity Scale (FSS), phycological parameters, Patient Health Questionnaire-9 (PHQ-9), and General Anxiety Disorder-7 (GAD-7), sleep complaints, the COPD and Asthma Sleep Impact Scale (CASIS), Athens Insomnia Scale (AIS) and the Epworth Sleepiness Scale (ESS) were collected. Vitamin D deficiency was defined as levels of 25-hydroxy (OH)-vitamin D below 20 ng/mL. Multiple logistic regression analysis was conducted to test for associations of vitamin D deficiency with COPD and overall health status, adjusting for age, gender, smoking status, comorbidities, and seasonality.

Results. Most of the participants were men (70%) with a mean age of 68 ±9 years and a mean BMI of 30 ±6 kg/m2. Moreover, 33% of the participants had vitamin D deficiency. Vitamin D deficiency increased the risk for worse COPD health status (CAT ≥10 OR: 2.713, 95% CI: 1.068–6.896, p = 0.036), excessive daytime sleepiness (ESS, OR: 1.067, 95% CI: 0.990–1.151, p = 0.04), depressive symptoms (PHQ-9 ≥5, OR: 2.762, 95% CI: 1.236–6.170, p = 0.013), insomnia symptoms (AIS score OR: 1.169, 25%CI 1.058:1.292, p = 0.002), and sleep impairment (CASIS OR: 1.046, 95%CI: 1.015–1.078, p = 0.004).

Conclusions. Our findings indicate that a significant number of patients with COPD in this rural population, who have been consistently exposed to sunlight and predominantly engaged in agricultural activities, exhibit vitamin D deficiency. However, further research is needed to determine the role of vitamin D in the health status of these patients.

Key words: vitamin D, health status, COPD, rural areas

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#26 Do practice staff perceptions of rurality influence care? Lessons from a national survey of postural hypotension measurement and management

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Staff perceptions of rurality may affect the care they deliver, e.g., through assumptions about feasibility of investigations in their setting.

Objectives. 1. Explore consistency of judgements regarding practice setting where multiple survey responses were received from practices. 2. Establish impact of inconsistency on observed associations with postural hypotension (PH) outcomes, as an example.

Methodology. We surveyed primary care clinicians regarding their management of PH between August and December 2022. We used setting definitions of urban (secondary care in same town), semi-rural (secondary care in another town; public transport available), or rural/remote (secondary care involves substantial journey; public transport difficult). Standard deviations (SDs) of numerically encoded setting responses within practices were inspected to assess inconsistency. Responses were compared to Office for National Statistics (ONS) Rural-Urban Classifications using $\chi 2$ tests. Associations of the 2 setting classifications with survey outcomes for PH were compared.

Results. Responses were received from 703 participants in 242 individual practices; median (range) 1 (1 to 18) participant per practice). Office for National Statistics data were matched for 595 responses. Observed SDs for individual practices settings confirmed inconsistency. All survey rural/remote responses and 1.5% of urban responses mapped to the ONS rural category; survey semi-rural responses mapped 77.5% to urban, 22.5% to rural ONS categories ($p < 0.001$). Lower measurement rates for PH were reported for survey rural/remote settings than for other settings ($p = 0.022$), whereas ONS settings did not differ ($p = 0.379$). Survey rural/remote settings were associated with fewer repetitions of PH measurements than other settings but ONS settings did not differ ($p = 0.047$ vs 0.926).

Conclusions. Clinicians are inconsistent in judging practice setting. Perceived rurality may affect services offered to patients, perhaps due to considerations of practicality, as exemplified here with measurement of PH. Defining rurality is complex; validated definitions are required to improve generalizability of findings and to avoid erroneous associations between practice setting and service outcomes.

Key words: postural hypotension, blood pressure measurement, rural practice, primary care

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#45 Diabetic hand syndrome: Prevalence and clinical diagnosis in primary care

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Diabetic hand syndrome (DHS) is characterized by limitation of finger movement and sensation. The estimated prevalence is 8–50% in type 1 diabetes mellitus (DM) and 20% in type 2 DM. Its prevalence in the Portuguese diabetic population is unknown. It is believed that it increases with disease duration and the co-existence of diabetic neuropathy. It is theorized that its presence might predict other complications, so it might help identify patients who require closer follow-up. Optimized treatment could delay its development. You can assess the presence of DHS by testing with the "prayer sign" and "table top sign".

Objectives. The primary aim is estimating the prevalence of DHS in the Portuguese diabetic population. The secondary aim is describing the population with DHS and correlating its presence with HbA1c levels.

Methodology. Observational, transversal, descriptive study of a convenience sample, gathered from 2 patient lists in 1 primary care center, observed in DM follow-up. The patients were given and signed a consent form to collect data related to gender, age, presence of "prayer sign" or "table top" sign, HbA1c level, year of DM diagnosis, presence of retinopathy, nephropathy, neuropathy or diabetic foot, risk of developing diabetic foot and presence of other diagnosis that might cause changes in hands.

Results. We gathered a total of 141 valid forms, representing 45% of the studied population (314). There was a prevalence of 37.6% of positive table top sign and 57.2% of positive prayer sign. There was no correlation between the positivity of the clinical signs and the remaining data collected.

Conclusions. Even though there was a high prevalence of positive clinical signs suggesting DHS, it was not possible to find a correlation with the remaining data. The assessment of DHS could help with early detection of patients with a higher risk of microvascular complications, but we need more data to confirm this.

Key words: diabetic hand

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#24 Access to sexual and reproductive health services by adolescents living in rural or coastal areas: A rapid review of the global literature

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

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Abstract

Background. Adolescence is a precarious period, sometimes characterized by sexual exploration and those in rural/coastal environments face disproportionate challenges to maintaining good sexual and reproductive health (SRH). Geography and high levels of deprivation create barriers to accessing appropriate services which, in turn, puts adolescents at increased risk of adverse health outcomes, compared with their urban counterparts. This study provides a global overview of the factors that place rural/coastal adolescents at increased risk of poor SRH.

Objectives. To understand the factors that place adolescents in rural/coastal environments at increased risk of poor SRH.

Methodology. A rapid literature review on adolescent SRH in rural/coastal environments published in English (2013–2023), in Medline and CINAHL. The quality of studies was assessed using the Mixed Methods Appraisal Tool (MMAT) and extracted data were analyzed thematically.

Results. Overall, 106 articles met the inclusion criteria. The main thematic areas in access to SRH services were physical geography and socio-cultural barriers. Specifically, barriers to the use of contraception included lack of access, religious and community beliefs, and lack of accurate knowledge. Residing in rural or coastal environments was associated with adolescent sexual risk-taking behaviors in all but two studies. Key factors influencing sexual initiation and high-risk behavior included being married young, being in love, and coercion. High rates of pregnancy in adolescence in rural environments were associated with poor use of contraceptives and sex with multiple partners, alcohol and other substance use, sexual coercion, having older parents, engaging in transactional sex.

Conclusions. Lack of access to SRH services among adolescents in rural/coastal settings remains a salient issue. There is a need to further understand the nuances of how different access barriers place adolescents at risk of poor SRH in order to co-create innovative effective, tailored intervention, and strategies for equitable access to appropriate services for this population.

Key words: sexuality, adolescent, adolescence, sexual health, reproductive health, risk factors, rural, coastal

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#3 Exploring the experience of patients in rural and coastal communities in the United Kingdom

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. People living in rural and coastal communities in the United Kingdom have reported inequalities in access to healthcare and other vital services which can have an impact on their health and wellbeing. About 16% of the population or about 1 in 6 people in the United Kingdom live in rural areas (World Bank, 2021). There are a number of challenges facing rural communities such as an aging population, larger distances to services and poor connectivity, both in regards to transport and telecommunications. To start to address inequalities it is important to have a good understanding of current rural and coastal contexts as well as the needs of the local populations in regard to their health and wellbeing taking into account the wider social determinants of health.

Objectives. The aim of this exploratory study is to gather the experiences of rural and coastal patients to develop a better understanding of their needs and the barriers they face in regard to improving their health and wellbeing.

Methodology. The study was conducted via an online questionnaire which was shared with members of the UK Patients Association. The questionnaire was comprised of 15 questions. The questions gathered basic demographic data such as age, gender and geographic locations, and participants were asked to grade the access to services on a 5-point Likert scale. The last 4 questions allowed the participants to describe their experience in accessing healthcare and services important for their wellbeing.

Results. This will be a presentation of the initial results of the patient experience survey gathered between March 2024 and May 2024.

Conclusions. This study supports the inclusion of patient voices into the work on reducing rural and coastal inequalities in health and wellbeing. The outcomes will be used to plan further research with rural patients and rural communities as partners.

Key words: rural health, healthcare access, patient experience, health equity, social determinants of health

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#6 Experimental GP clinical in rural environment

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. The development of the advanced solutions for primary care shortages (ASAP) program stems from a serious shortage of primary care physicians in the Friuli Venezia Giulia region of Northern Italy.

Objectives. This project report describes the ASAP program aimed at addressing primary care workforce shortages and ensuring the provision of health services and continuity of care in rural areas.

Case report. The ASAP project provides the involvement of 3 young doctors, with approx. 1500 patients assigned to each of them. These patients are those who no longer have a traditional GP. The clinic is organized in 6-h shifts, further subdivided into 3 h of clinical activity such as medical visits, and 3 h dedicated to back-office activities or home visits. The Local Health Authority provides the premises, secretarial staff, and IT support. Payment is made on an hourly basis. I have been working in one of these ASAPs since October 2023, along with 2 colleagues, responsible for 1350 patients, for 18 h per week. This experience highlighted several strengths: direct experience in the field for young doctors training as family doctors; and work experience in a pre-existing district facility with nursing support and financial benefits. Some of the weaknesses are: inadequate computerized medical record system not even used by regular GPs; difficulty working in a team environment (i.e., not everyone logs visits consistently); high workload because the patient's medical history is not available to the team; lack of time needed to build a relationship with patients; assigned support staff not versed in new system; no technical support in case of need or doubt.

Conclusions. The ASAP strategy has shown several strengths but also weaknesses. A possible solution to address these weaknesses could be to pair a young doctor with a senior GP who is near retirement to ensure continuity of care during the transition.

Key words: primary care, rural areas, shortage of physicians

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#10 Using technology to reduce health inequality while managing asthma and COPD in a rural practice

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Chronic obstructive pulmonary disease (COPD) and asthma are highly prevalent chronic respiratory conditions. One of the largest barriers to managing these chronic conditions is health inequality. Health inequality is a world-wide problem that leads to negative patient outcomes as it increases a patient's morbidity and mortality, while decreasing quality of life. During COVID-19, more practices became involved in remote consultations and tools which helped expand access to healthcare. With remote IT tools and consultations, patients in rural areas no longer had to worry about the logistics of getting to a primary care practice which mitigated transportation issues, transportations costs, and concerns about limited mobility. In our practice, we have also seen improved management of chronic conditions, as various factors such as the number of in-office visits have increased dramatically with this expanded access to healthcare.

Objectives. IT tools embedded into our e-healthcare system allow us to engage patients previously lost to follow-up due to difficulty making it into the practice. Our practice uses validated assessment tools to enhance our chronic respiratory condition management.

Case report. 1. Search for patients overdue a respiratory review. 2. Patients sent validated e-questionnaires via accurx 3. Triage of responses with non-responders being contacted directly by phone. 4. Timely telemedicine reviews enabling best practice management. 5. Follow-up as required.

Conclusions. In-date reviews of over 90% for both asthma/COPD. Zero asthma patients with >6 SABA issues in the last 6 months need review. Majority of 6–19-year-old patients responding to the online questionnaires. Addressed frequent exacerbations and established on appropriate preventors. Education to support self-management including addressing inhaler technique and care plans Our process suggests that remote tools can improve respiratory management in vulnerable groups to help reduce health inequality. Expanding access to these vulnerable populations may lead to a reduction in exacerbations, complications, and hospital admissions.

Key words: asthma, COPD, rural practice

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#16 The use of remote clinical testing to improve early detection of chronic kidney disease (CKD) in rural populations: A retrospective review

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Approximately 7.2 m people, more than 10% of the UK population, suffer with chronic kidney disease (CKD) yet around a million people remain undiagnosed. Early diagnosis of CKD relies on compliance to routine screening of serum estimated glomerular filtration rate (eGFR) and urinary albumin : creatinine ratio (ACR) in those patients with risk factors such as diabetes and hypertension however uptake to annual urine testing is largely poor

Objectives. This is a retrospective review of home ACR testing which aims to highlight the important place of remote clinical testing in the early detection of CKD. At home ACR testing kits were utilized to reach at risk patients from their homes. Kits were sent out to at risk patients enabling these patients to obtain immediate results via their smartphone. These results were also transmitted to patients' clinical records for analysis by our clinical team

Case report. 108 patients were reached by the at home ACR testing kits, 69% performed the test, 73% of tests returned were normal and 17 patients had abnormal urinary ACR. All patients surveyed said the test was "very easy", and all said they would prefer at-home testing in the future.

Conclusions. Chronic kidney disease is a leading cause of years of life lost therefore appropriate screening, diagnosis and management by primary care clinicians is essential to prevent adverse CKD-associated outcomes, including cardiovascular disease, end-stage kidney disease and, ultimately, premature death. Remote clinical testing has an important role in the early detection of CKD in primary care. It was well received by patients, improved CKD detection, and promoted adherence to future urinary testing, an essential component of CKD screening.

Key words: chronic kidney disease, remote testing, glomerular filtration rate

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#20 Hepatitis A: What they didn't teach me about it at school

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Hepatitis A is a highly contagious, short-term liver infection caused by the hepatitis A virus. In rare cases, hepatitis A can cause liver failure and even death; this is more common in older people and in people with other serious health issues, such as chronic liver disease. Hepatitis A can be spread from close, personal contact with an infected person, such as through certain types of sexual contact (like oral-anal sex), caring for someone who is ill, or using drugs with others. Hepatitis A is very contagious, and people can even spread the virus before they feel sick. Residents living in slums are a vulnerable group. There are many Roma slums in the east of Slovakia, where hepatitis epidemics have already been recorded in the past.

Objectives. The aim of the poster is to show how the habits of local Roma residents contribute to the transmission of Hepatitis A and look for preventive measures.

Case report. A big family is one of the core aspects of Romani life. So, funerals and wedding will be attended by many relatives. Before funerals friends and loved ones stay with the dying person, day and night. Family members do not bathe, comb, eat, or shave during mourning. These habits can significantly contribute to the spread of infectious diseases.

Conclusions. Knowledge of the residents' lives can contribute to quick diagnosis and effective prevention. The best way to prevent hepatitis A is through vaccination with the hepatitis A vaccine. Practicing good hand hygiene — including thoroughly washing hands after using the bathroom, changing diapers, and before preparing or eating food — plays an important role in preventing the spread of hepatitis A.

Key words: hepatitis A, traditions and customs of local residents – influence on disease transmission

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#22 Implementation of coordinated care in PHC in Poland: Preliminary results

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Coordinated healthcare is a concept that aims to improve the quality of healthcare delivery and the efficiency of resource use in healthcare. The Polish legislator has defined it as an integrated system of providing health care services, covering all stages and elements of the process of their implementation, with the use of ICT systems, electronic communication tools or available public telecommunications services. Coordinated care services address the diagnosis and treatment of selected chronic diseases, such as hypertension, heart failure, diabetes, bronchial asthma and chronic obstructive pulmonary disease, hypothyroidism and chronic kidney disease and can be carried out in PHC entities.

Objectives. The aim is to present the process of implementation of coordinated care in Polish healthcare system as well as the preliminary results of its implementation.

Case report. Coordinated care (CC) was introduced with the PHC+ pilot program in 2017, with the pilot covering more than 350,000 patients. The idea of coordinated care worked well, and in 2022 financial support from the National Health Fund and legislation were introduced to formally anchor coordinated care services in clinics. The proposed changes within CC, according to the Health Ministry, are aimed at increasing the availability of services at the PHC level to expand initial diagnosis at this stage. This will speed up the determination and implementation of appropriate therapy. In addition, the changes are expected to have the effect of relieving the burden on hospital emergency departments.

Conclusions. The number of providers providing coordinated care in 2023 were 418. This represents 23% of total providers in Poland. The largest number of contracts for the provision of services, financed under coordinated care budget were 957, assigned to clinics with up to 5,000 patients. In 2024, the number of CC services amounted to 2,168,361, with a value of more than PLN 220 million ($547).

Key words: coordinated healthcare, primary care, quality

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#23 "Scirocco" tool usage: Medical and Diagnostic Centre case-study

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. The Scirocco tool was developed by the B3 Action Group on Integrated Care of the European Partnership for Innovation, Active and Healthy Ageing to determine the level of readiness for integrated care based on the concept of regionalization of PHC. Scirocco allows all health care entities, including PHC, to give a holistic view of their own activities, showing the strengths and weaknesses in the regional context for integrated care, and allows for the exchange of experiences and good practices between institutions. It is available in an on-line questionnaire format for all interested stakeholders. An analysis of the areas included in the Scirocco model allows for the conclusion that they are so universal that it is possible to use this questionnaire not only to assess readiness for the implementation of integrated care, but also coordinated healthcare.

Objectives. Presentation of the maturity model for the implementation of integrated care "Scirocco" and an attempt to evaluate its application in the Medical and Diagnostic Center in Siedlce area for coordinated care.

Case report. The study at the Siedlce Medical and Diagnostic Center was carried out in 2017, at the time when the pilot national coordinated care program "POZ+" was implemented. In 2017 an initial assessment of maturity of the CMD and the Polish healthcare system for the coordinated care was made. In 2024 – re-examination the maturity of CMD. The Authors examined the degree of changes that have taken place in healthcare both in CMD as in the Polish healthcare system.

Conclusions. A comparative analysis of the CMD's responses allows us to conclude that there has been a significant change in the assessment of areas that determine readiness for coordinated care. It was possible mostly due to regulations that have been introduced in Polish legal system, changes in the funding system, and the development of digitization.

Key words: primary health care, coordinated care, maturity

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#30 The attitudes of patients, under coordination in primary care, in rural areas on vaccinations against COVID-19: Research results and further recommendations

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med.* 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Vaccinations are recognized in the history of medicine as the most effective method of prevention in combating infectious diseases. They allow for the control of the course and extent of these diseases, and also significantly contribute to the complete elimination of these diseases. However, the implementation of a global vaccination program requires a high level of social approval, and thus factors that influence patients' attitudes toward vaccinations.

Objectives. The main aim of the study was to determine the factors determining the willingness or refusal to be vaccinated against COVID-19.

Methodology. The test was performed using the CAPI technique at the Medical and Diagnostic Center in Siedlce. Interviews using the LSQ-Cavendish diagnostic questionnaire were conducted among healthy and chronically ill patients. The study took into account the influence of socio-demographic characteristics and lifestyles of patients coordinated in primary care in rural areas and small towns. Categories of vaccinated and unvaccinated subjects were compared using chi-square and Mann–Whitney U tests.

Results. The results show that there are significant differences between vaccinated and unvaccinated groups in terms of gender, age, and professional status. Women, people aged 65 and older, actively working and working physically were more often vaccinated against COVID-19. There was no significant impact of place of residence, education, relationship status, and household size on patients' attitudes. The study showed that the categories of vaccinated and unvaccinated patients differ in their health lifestyles. Interestingly, unvaccinated people had a higher rate of healthy lifestyle, while vaccinated people were more likely to follow an unhealthy lifestyle.

Conclusions. The conclusions of the study indicate the need for further research on the effectiveness of information campaigns and flexible communication strategies that take into account social diversity and patient concerns. These actions can help increase public acceptance of vaccination programs and ensure public health protection.

Key words: COVID-19, vaccines, primary healthcare, patient attitudes, coordinated care

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#31 Pharmaceutical care introduced in coordination with PHC in Poland: Perspectives of physicians, pharmacists and patients

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Care coordination improves health care outcomes and facilitates the utilization of efficient, safe, and high-quality services while maximizing the accessibility of services offered to patients. In collaboration with other healthcare professionals, pharmacists can ensure that patients receive the most effective and safe treatment possible. In many countries such as the United States, the Netherlands, and United Kingdom, pharmacists are actively involved in providing care in primary care and ensuring continuity of care for patients. Coordinated PHC care in Poland has been introduced to include GPs, specialists, nurses, and dietitians, but without the involvement of pharmacists. Pharmacists in Poland have received rights to provide additional services to patients already in 2021, but new services have not yet been implemented.

Objectives. The study aims to explore the perspectives of physicians, pharmacists, and patients on pharmaceutical care, physician-pharmacist collaboration, and advanced pharmacy services that could be introduced in coordination with PHC in Poland.

Methodology. A method used in the project will be an online survey (CAWI) which will be distributed by e-mail to all invited to the survey. Three separate questionnaires will be developed for physicians, pharmacists, and patients. The survey will consist mainly of closed questions. Survey items will be adjusted to each group, but they will cover the same themes: current approach to pharmacotherapy management, collaboration between physician and pharmacist, and need for additional services delivered by pharmacists. A random sample of 1000 respondents will be selected from each group in order to ensure a measurement error of 5%.

Results. Statistical analysis will be performed on the obtained results. Comparative analysis will be used to compare results between groups.

Conclusions. The obtained results may provide perspectives of different groups on pharmacists' role in pharmacotherapy management and what additional tasks they can take on. Conclusions from the study can be used in designing policies including pharmacists in coordinated care in Poland.

Key words: pharmaceutical care, pharmacists, patients, coordinated care, advanced pharmacy services

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#33 Exploring the motivations for, and the experiences of GPs working in rural West Wales: A qualitative study

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Whilst the whole of the UK faces GP recruitment challenges, rural areas bear the brunt of this challenge, facing particular difficulties in maintaining a sufficient GP workforce supply. West Wales, a predominantly rural area of the country, exemplifies this problem due to its rural geography and competition from nearby urban areas. To encourage and secure future GP supply to rural West Wales it is essential to know why current working GPs choose to work and stay in this region.

Objectives. This research aims to explore why GPs have chosen to work and stay in rural West Wales and learn about their personal experiences of rural work and life. An important consideration within this area is its significant Welsh-speaking population. Consequently, the secondary aim of this study is to further explore how the Welsh language affects rural GPs' work and their professional relationships.

Methodology. 18 semi-structured 1:1 interviews were conducted with GPs currently based in rural West Wales. Participants were recruited through collaboration with local organizations and social media advertisement. The data will be analyzed via thematic analysis and the study will be completed in May 2024.

Conclusions. Insights and findings from this research could contribute to targeted recruitment and retention schemes within West Wales and provide beneficial lessons for rural regions facing similar challenges. Further understanding of issues facing GPs within rural areas can ultimately lead to improved healthcare provision within West Wales and similar communities.

Key words: rural, rural health, rural GP, Wales, West Wales, GP, Welsh language, retention, recruitment

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#35 Starting a Young Doctors' Community Medicine Work Group in a rural area

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. The workgroup emerged from a recurring need for resident doctors in our area to acquire skills in community research and intervention, addressing a fundamental gap in basic training. Our group recognizes the necessity for Primary Care to be responsive to the community's needs.

Objectives. The main objective of the Community Medicine work force was to train Family Medicine residents in intervention and research in community medicine in rural areas, valuing the particularities of these contexts, with a focus on health inequities. We intended to create a network of professionals in the area to share and coordinate community actions.

Case report. Based on the training programs of our medical specialty in Spain, we developed a specific training in community medicine that was lacking in our area. The group consisted of resident doctors at various levels of training and a mentor. The team met every two weeks to engage in self-directed learning, research and intervention to develop projects in rural areas.

Conclusions. The working group offers a platform for exchanging issues, experiences, and training, while also establishing an interprofessional network. The rural setting provides easy access to the community and allows more time to dedicate to community medicine. Rural settings offer opportunities to develop longitudinal relationships with patients that foster valuable doctor-patient connections. The rural context may be ideal for focusing on population health, prioritising the interests of the community itself. By enabling the population to be active participants in their own health-disease processes, it strengthens health promotion efforts. This work group becomes a flexible, adaptable and resilient pathway that adjusts to our training needs connected to providing holistic medicinal care based on principles of population healthcare. This initiative could be replicated in other health areas. It enables broad actions to be taken with a direct impact on health from a social, gender, demographic, ethnic and migratory perspective.

Key words: community medicine, rural medicine, self-training

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#40 Diversity of manipulations and differences in primary care practices in cities and rural regions in Latvia

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. In order to accurately understand and consider the differences between the range of manipulations provided by urban and rural practices and the factors that influence them, an analysis must be done looking at it from different angles.

Objectives. The study was conducted with the aim of comparing the differences in the range of manipulations performed by PHC practice in 2023 between cities and rural regions.

Methodology. Methods. The division into cities and regions was based on the classification used by the National Health Service (NHS). Data from the Latvian open data portal and NHS open access data were used as primary data sources.

Results. Results. Mainly in the regions, more extensive manipulations are often carried out, which in cities would normally be carried out by laboratories or secondary care facilities

Conclusions. 1. There are significant differences in the work of GAP and the number of proposed manipulations between cities and regions. 2. The number of visits in Latvia, both in cities and regions, is higher than in the literature with data from other countries, and it is higher in regions than in cities. 3. The most frequent episodes with a statistically significant difference, with a tendency to be more in the region, are episodes with a preventive purpose, episodes related to chronic patient care and dynamic observation, as well as home episodes. 4. Differences between cities and regions are most noticeable in the variety of manipulations.

Key words: PHC, family doctors

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#41 Per aspera ad astra: Smoking cessation in Latvia and the footprints being left behind

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Smoking cessation is not easy for heavy smokers. Children are a specific vulnerable group of smokers. From the 1st of January 2025 Latvian legislation will prohibit selling oral tobacco and e-cigarettes with aromatization to minors.

Objectives. To evaluate the drawbacks of implementing legislation in Latvia on tobacco use by minors.

Case report

Case 1. The patient presented to the GP office complaining of sweating, dyspepsia, dizziness and feeling very sick after smoking a lot of e-cigarettes. The patient was 12 years old. The patient was hospitalized after referral to the emergency department with an overdose of e- cigarettes, which is called SALT. The 12-year-old patient received IV fluids in the hospital and was recommended not to smoke anymore. After being discharged, the patient felt happy and proud of the event, and confessed that once he would feel better, he would start using oral tobacco (put tobacco between his lip and gums), which induced severe dizziness, palpitations, sweating, and severe dyspepsia. Since the boy's birth, the patient's mother has been smoking cigarettes regularly at home – in the room. The boy's younger brother, 9 years old, also smokes e-cigarettes. The boys used to fight over stolen e-cigarettes. The parents were aware that e-cigarettes were often disappearing at home, especially the ones with a nice odor. The family was referred to social services.

Case 2. A 13-year-old patient presented to the doctor with symptoms of severe nicotine dependency using e-cigarettes. The boy told the doctor how he and his classmates regularly search through trash cans for used e-cigarettes and then reuse them.

Conclusions. Families in Latvia need health education regarding tobacco usage/dependency syndrome in children.

Key words: quit smoking, general practice, family doctor

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#42 Key considerations to addressing the challenges of secondary prevention cardiovascular risk reduction in rural communities

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. The rise in premature cardiovascular disease (CVD) death rate, associated with deprivation, is a concerning trend. However, the NHS England Long-Term Plan offers hope. It presents a proactive population health management approach to keep people healthy and prevent illness. This includes the early detection and treatment of high-risk conditions, such as raised cholesterol. The plan's focus on population health is a strategy to improve health while reducing health inequalities. This is particularly crucial in rural areas where access to secondary care may be limited. A recent European study revealed that only 33% of patients managed to reach LDL-C goals with lipid-lowering therapy, and a staggering 80% of very high-risk patients were unable to achieve the goals of statins alone. In England, data indicate that approx. ¾ of patients with cardiovascular disease have LDL-C levels above 1.8 mmol/L. Here, we review our approach to CVD risk reduction using medications available in primary care.

Objectives. We describe the implementation of CVD risk reduction with medications in our rural population. This is achieved through the following steps: Education and empowerment of the primary care, the use of automated searches, addressing other CV risks and providing optimal management, communication with and education of patients.

Case report. Using a retrospective case series analysis, we present the results of deploying lipid-lowering therapies to optimally reduce LDL-C levels to meet targets while addressing residual risk factors identified via raised triglyceride levels. We review the utility of inclisiran, bempedoic acid, and icosapent ethyl.

Conclusions. A proactive approach using guidance improves patients' lipid management. Automated searches enable rapid identification of patients and using existing IT systems reduces work burden. Using all team members allows rapid assessment and optimization of care.

Key words: LDL-C, triglycerides, siRNA, icosapent ethyl, bempedoic acid, statins, ezetimibe, inclisiran

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#43 Attitudes of future physicians in the context of searching methods for reducing medical deserts

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Shortages of primary care, specialized, and emergency care contribute to the emergence of medical deserts, which are regions where the population lacks sufficient access to healthcare. Access to high-quality care, essential medicines and assistive technologies should be available to all patients, regardless of where they live.

Objectives. The main aim of the study is to identify factors influencing the career decisions of medical students. These factors have a significant impact on the subsequent allocation of the medical workforce in Poland.

Methodology. For the purposes of the study, a conceptual research model was followed, which included analysis and inference procedures. The model consists of 5 sections grouped into 3 research stages: Preparation, diagnosis and verification. The study included 1st, 3rd and 6th year medical students at the Medical University of Warsaw. The preparation stage comprised the analysis of professional literature and existing data. The diagnosis stage consisted of carrying out planned quantitative and qualitative research. During the verification stage, the results obtained from the quantitative and qualitative research will be evaluated by a group of experts.

Results. The study classifies factors influencing career choice among medical students and the factors influencing this choice. The various factors identified by the students of specified years will be sorted and analyzed. This will provide information on the problems of the medical deserts in Poland.

Conclusions. It is assumed that the research findings will assist in optimizing the medical education system as well as managing human resources more effectively in the health care sector. The research results should thereby improve the quality and availability of health care in Poland, including reducing medical deserts.

Key words: medical deserts, medical students, medical staff, healthcare organization

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#44 Future of Polish primary care: Projection of demand and number of family doctors till 2045

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Family doctors are a key link in the healthcare system, especially in primary care. In 2020, the number of family doctors in Poland only reached 64.4% of the required number needed as defined by the National Consultant for Family Medicine. The average age of family doctors is 55.23 years, while for all physicians (excluding physicians with no specialization) the average age is 54.97 years. People of retirement age (65+) accounted for 19.82% of all professionally active family doctors.

Objectives. The aim of the study was to project the demand and the number of family doctors in Poland until 2045. This study can be used as an assessment of current staffing strategy in primary care.

Methodology. The analysis was based on the data from the Database of Systemic and Implementation Analyses of the Polish Ministry of Health. The projection model was developed using Microsoft Excel, including specially prepared life tables as the basis of the model. The following groups of supply factors were taken into account: age structure, inflow of family doctors to the labor market, outflow of family doctors from the profession, and as a demand factor – the demand for family doctors.

Results. Values projected with the model demonstrate a persistent future shortage of family medicine specialists in Poland. In 2020 there was a shortage of 6,029 family doctors, which resulted in only 64.40% of needs being met. Over the next 25 years, this percentage will increase to 78.25%, lacking 3,352 specialists.

Conclusions. The results of the study show that the current strategy for improving the health care system in the case of primary care and family medicine is not effective in the long term. Worrisome prediction yields call for an alternative systemic approach; one targeted more towards primary care physicians and implementation of telemedicine and new technologies.

Key words: primary care, family doctors, project of demand

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#46 EC and OOH in rural European locations: Ongoing project

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Emergency care and out-of-hours are perhaps the most challenging parts of primary health-care, especially in rural locations.

Objectives. This is a continuation of the pilot study, conducted about 1 year ago in 10 European countries. The statistical significance of the results was not achieved due to the relatively low level of participation. Therefore, we have started a re-launch of the project on a different level and with a slightly adjusted design.

Methodology. The study is based on the questionnaire developed by the author with some support and additional ideas from colleagues on a national and international level.

Results. According to the preliminary results of this study and the results of the previous pilot study, there are certain common features in every European country.

Conclusions. The final conclusion is yet to be formulated. However, there are some rather promising results (although not uniform).

Key words: emergency, out-of-hours, rural, project

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#47 Virtual Exchange in Europe: Pilot proposal

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med.* 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Background. Virtual Exchange is becoming more recognized now, in part due to the recent COVID-19 pandemic and travel restrictions, and in part to reduce costs and CO_2 emissions.

Objectives. To find out if Virtual Exchange could add value to traditional exchange programs for young doctors and students.

Methodology. It was suggested that the pilot study by EYMDF and EURIPA should be continued with virtual exchanges in other rural locations in Europe and perhaps overseas.

Results. This is a project proposal only and the pilot study has not been finalized as yet.

Conclusions. To be published after the continuation of the project is finalized.

Key words: virtual exchange, COVID-19

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#17 Team working in rural primary care

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Justification. In Europe, there are shortages of primary care physicians and an increased demand for services in a multimorbid, aging population. This has provided the impetus for the implementation of team-based primary care. Accordingly, the EURIPA Blueprint for Rural Practice in Europe states that "quality, patient-centered rural health care should be delivered by teams of health professionals." Interdisciplinary teamwork is important in primary care, especially in rural areas, to provide cost-effective and comprehensive care. International research shows that this is not routine practice in many health systems, so it is important to understand the levers and barriers to implementation.

Objectives. 1. Learn about teams working in rural primary care across Europe. 2. Looking at the push factors or the barriers and chances. 3. Actions needed to improve the situation. 4. Develop a registry of good practices.

Organization. Brief presentations by the workshop leaders will highlight the current situation of teamwork in rural primary care across Europe. Then, the audience will be divided in small groups, each of them led by a moderator. At the end, the outcomes will be summarized in a plenary session.

Participation. Interactive participation of healthcare practitioners in practice (GPs, nurses, social workers, etc.). Estimated number of participants: max. 40.

Expected outcomes. This workshop will help us identify valid teamwork models in rural primary care, for a "person-centered care" approach, from a "comprehensive primary healthcare" perspective.

Key words: primary healthcare, rural general practice, organizational models, team work

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#5 Rural Stars Project: Developing a practical guide for rural health promotion and advocacy

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Justification. The Rural Stars Project was launched by Rural Seeds in 2024 to support rural healthcare workers in advocating for rural healthcare in their communities and improving the longevity of the rural workforce. The rural healthcare workforce has historically struggled with recruitment and retention of healthcare workers. There is significant evidence that empowering young people in rural communities to pursue healthcare careers leads to greater recruitment and retention. As many countries lack dedicated training pathways for rural health careers, we are exploring what practical measures could be used at the local level in different contexts to promote rural health and rural health careers. The guidebook will be a freely accessible tool that can be used by students and early career clinicians. It will provide practical examples and links to useful information that can be adapted to their local context.

Objectives. Utilize the shared experience and knowledge of rural healthcare workers to develop strategies that are a viable guide for rural healthcare workers working alone or early in their careers.

Organization. 1. Explain objectives of the guide (10 min) 2. Gather what information participants would like to know about rural health promotion and advocacy (20 min) 3. Discuss what strategies have been put in place in different parts of the world and their practicality (20 min) 4. Summary of the group discussion (10 min). This will be a hybrid session with a small group discussion in person and an online discussion via Zoom.

Participation. Target audience: rural healthcare students and professionals, community leaders in rural areas, community members in rural areas.

Expected outcomes. The workshop outcomes will contribute to the development of the guidebook. Rural healthcare professionals play an important role in the promotion and development of rural health in their communities. By developing this practical guide, we aim to support them in this role, empowering them and their rural communities.

Key words: rural health, advocacy, health promotion, rural healthcare workforce, retention. rural health careers, career development

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#8 Healthcare in rural agricultural areas: Exploring experiences of caring for farming patients across Europe

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Justification. Agriculture employs 1 in 4 people globally. It is changing rapidly and so are the lifestyles of farming families. Mechanization means farmers move less, and chronic stress and mental illness are on the rise due to financial pressures. Recent statistics suggest farmers are not benefiting from improvements in mortality when compared with the general public. As is the case with all rural residents, this patient population is affected by the well-documented health inequalities that are characteristic of rural areas. Despite these considerations, farmers may delay seeking healthcare advice for many reasons. Clinicians acknowledge that they may present with advanced disease. The environmental context of their livelihoods can also present complexities in creating acceptable shared management plans. This workshop will allow primary care professionals to share their experiences in serving agricultural communities.

Objectives. To explore the experiences of clinicians who have served farmers, with a focus on identify the barriers/facilitators guided by health behavior theory and sharing best practices.

Organization. The workshop will be a focus group with an observer taking notes and recording with appropriate consent and explanation. Workshop facilitators will guide the group in comparing and contrasting the barriers and facilitators identified by participants across the diverse landscapes of Europe.

Participation. Participants will be grouped to achieve the best experience mix and geographical spread. There will be an icebreaker question followed by a 12-min discussion using the 1-2-4-ALL method. A ranking method will then be used to put ideas in order of priority.

Expected outcomes. Participants will learn from each other to improve their understanding and skills in communicating with patients who are farmers. Together, participants will also identify the factors that they believe influence the health behaviors of patients in agriculture. The workshop will enable wider dissemination of examples of innovative local community practice-based initiatives, which will support the development of future collaborative research among rural primary health care professionals in Europe.

Key words: farmer health, occupational health, health behaviors, consultation skills, rural health inequalities

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#25 Creating a European dialogue with academics (research and education) across Europe with the aim of developing a working network to meet the needs of rural, coastal and remote communities across Europe

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Justification. Rural health is now moving up the political and academic agenda in Europe, but the infrastructure to support both rural health research and rural education initiatives is significantly limited at both national and regional levels. Most of the studies cited are from other regions of the world with different health services, geography and demographics. It is time that we in Europe build a meaningful academic response by connecting academics working across Europe through a research and educational network with the aim of meeting the needs of our rural communities

Objectives. We aim to bring together academics who are working in isolation to develop a European perspective through a network of individuals, institutions and professional bodies within EURIPA. Our aim is to promote the sharing of ideas and the development of partnerships through collaboration.

Organization. EURIPA is the natural body with which to take this initiative forward. EURIPA has become a successful, vibrant and respected network of rural family doctors across Europe with a growing track record in research. We aim to engage with the academic sector to meet the distinct inequalities that exist in rural Europe.

Participation. The session will be open to all delegates. The academics present will give short presentations outlining their work, their interests and their aspirations for the future. They will identify what they could do in collaboration across Europe. This will be followed by small group work to determine how they can work together and identify research and educational priorities for the future. We hope to end with a plan to go forward.

Expected outcomes. Getting to know each other. Identify special interests, past and present research and educational initiatives: What a network/collaboration could look like. The priorities for the future: Investigate possible funding streams. Work with family doctors, with NGOs and political, professional and statutory bodies.

Key words: research, education, network, collaboration, European region, rural inequalities

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#14 Helping healthcare students and trainees engage with their patients and their communities to understand the concept and benefits of community orientation

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Justification. The World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Historically, healthcare education has focused on the diagnosis and treatment of disease. The WONCA Europe Special Interest Group on Social Prescribing and Community Orientation (SPCO) is concerned with how connecting people to non-clinical initiatives in the community can improve health and well-being. This is especially important within rural primary care due to the higher prevalence of social isolation and loneliness. The SPCO SIG is reviewing and promoting integration of community orientation into healthcare education. The goal is to create an understanding around the needs and assets within communities for future healthcare professionals.

Objectives. Explore how undergraduate students and postgraduate trainees in rural medical school and training programs are engaged with the concept of community orientation in various European contexts. Find inspiration to explore how social prescribing and community orientation can be incorporated into curricula and rural primary care placements within your own context.

Organization. After a short introduction, the participants will explore in small break-out groups how undergraduate students and postgraduate trainees in rural medical schools and training programs can be or are engaged with the concept of community orientation. The findings of the smaller groups will be shared in a plenary.

Participation. This workshop is for rural healthcare practitioners, students, trainees and academics. Active participation is encouraged.

Expected outcomes. Participants will develop an understanding of social prescribing and community orientation. Shared experiences on how community orientation can be or is integrated into healthcare education will inspire participants to further develop and incorporate it within their own context. The findings of the workshop will help to develop a toolkit to promote integration of Social Prescribing and Community Orientation within European healthcare education.

Key words: medical education, social prescribing; community referral, rural healthcare, general practice, community orientation

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#36 Meeting the health needs of rural coastal and island communities: Overcoming the barriers

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Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2024;33(Special Issue 1)

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Funding sources
None declared

Conflict of interest
None declared

Abstract

Justification. Theme: Providing quality health care to those on the periphery of care in rural coastal and island communities. There is an essential need to address the healthcare provision in coastal and island communities and access to primary and secondary care for acute and chronic conditions. These communities have particular health needs due to their combination of particular physical, social, cultural and economic geographies. Long and arduous transportation, weather challenges, recruitment and retention of health workers are some examples of issues in these geographic areas. In addition, the effects of climate change on weather patterns, rising sea levels and coastal erosion, which may lead to desertification and abandonment of some islands, poverty and social deprivation, will adversely affect key health determinants and health care delivery.

Objectives. To identify the issues that are currently being faced by coastal and island communities. To gain knowledge of how the wide range of issues in different geographical contexts and how social, cultural, linguistic and other barriers are successfully addressed or not. To explore how community awareness and active engagement in their perceived health improves self-care, social support, and collaboration.

Organization. Brief presentations will be made to present the diverse issues such as lack of facilities, staff, drinking water, drugs, equipment, transportation and resources. The audience will be divided into small groups, each of them led by a moderator. At the end, the outcomes will be summarized in a plenary session.

Participation. Interactive participation of healthcare practitioners in practice especially those working in remote, coastal, and island communities (GPs, nurses, social workers, policymakers). Estimated number of participants: max. 40.

Expected outcomes. Knowledge of barriers, innovative solutions, and community-based responses that must be addressed to achieve equity in health care in coastal and island communities. Establishment of needs, resources and policy issues required to make changes happen.

Key words: coastal, remote, island communities, equality, healthcare

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