Temadag 2025: Kloka kliniska val

&

Core values in general practice

- a royal road to sustainable health care

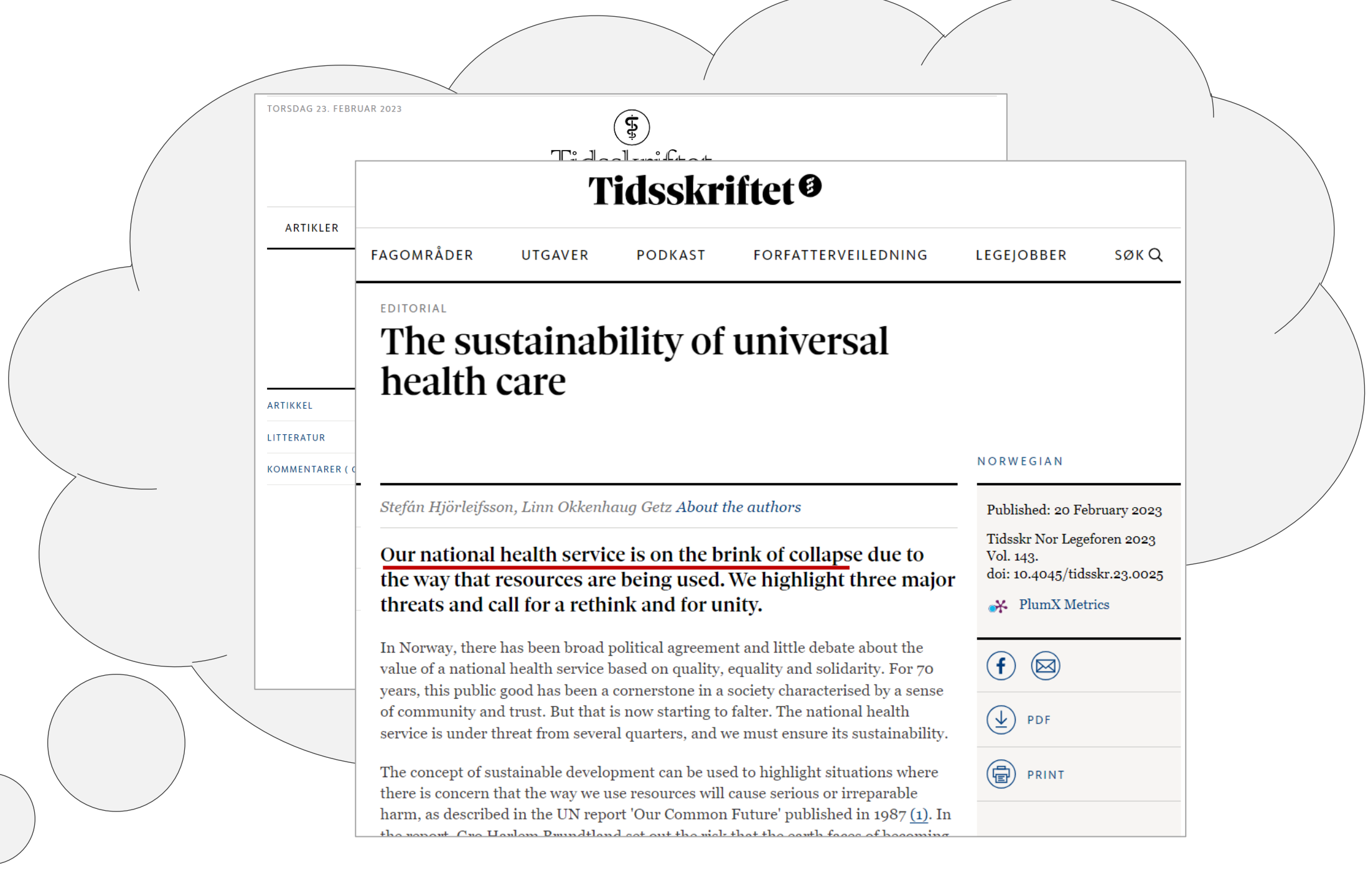
***Linn O. Getz**, MD, PhD, professor and*

leader, General Practice Research Unit, NTNU

NTNU
Norwegian University of Science and Technology

Competing interests: No financial

NTNU
Kunnskap for en bedre verden


TORSDAG 23. FEBRUAR 2023
ARTIKLER
ARTIKKEL
LITTERATUR
KOMMENTARER
Tidsskriftet
FAGOMRÅDER
UTGAVER
PODKAST
FORFATTERVEILEDNING
LEGEJOBBER
SØK
EDITORIAL
The sustainability of universal health care
NORWEGIAN
Stefán Hjörleifsson, Linn Okkenhaug Getz About the authors
Published: 20 February 2023
Tidsskr Nor Legeforen 2023
Vol. 143.
doi: 10.4045/tidsskr.23.0025
PlumX Metrics
Our national health service is on the brink of collapse due to the way that resources are being used. We highlight three major threats and call for a rethink and for unity.
In Norway, there has been broad political agreement and little debate about the value of a national health service based on quality, equality and solidarity. For 70 years, this public good has been a cornerstone in a society characterised by a sense of community and trust. But that is now starting to falter. The national health service is under threat from several quarters, and we must ensure its sustainability.
The concept of sustainable development can be used to highlight situations where there is concern that the way we use resources will cause serious or irreparable harm, as described in the UN report 'Our Common Future' published in 1987 (1). In
PDF
PRINT

Our most precious institution is at stake…

Nyheter for deg som jobber i helsesektoren. Annonser er kun beregnet for helsepersonell.

DAGENS Medisin

DM Debatt DM Arena Stilling ledig DM +

MINDRE: Etter iherdig jobbing gjennom mange år, har man lykkes med å snu folks syn på antibiotikabruk. – Vi prøver å formidle budskapet om at mindre kan være bedre, bare på et annet område enn antibiotikabruk, sier Stefán Hjörleifsson som er spesialist i allmennmedisin, fastlege og forsker ved UiB. Foto: Colourbox

– Den mest dyrebare institusjonen vi har bygget opp står på spill

Man må få bukt med unødvendig utredning og behandling – og det må skje fort – hvis man skal klare å bevare en sterk, offentlig helsetjeneste i Norge, mener initiativtakerne bak prosjektet Bærekraft på legekontoret.

Leni Aurora Brækhus
JOURNALIST

PUBLISERT Tirsdag 06. februar 2024 - 13:39 SIST OPPDATERT Tirsdag 06. februar 2024 - 13:44

«A threatened diamond»
Chat GPT4 /LOG 10.02.24

Aim of lecture

- Context and point of departure:
  -our common, equitable healthcare is at stake
  -strong primary care (including general practice based on continuity of care) is an ideal basis for effective healthcare

- How to advocate for «kloka val» and medical moderation in an era of uncritical medical expansion and fragmentation

- The official UN's SDG discourse aligns with the Core Values of General Practice; the combination is useful for GP advocacy

GENERAL PRACTICE

Born in Edinburgh, 1963

SCANDINAVIAN JOURNAL OF PRIMARY HEALTH CARE
https://doi.org/10.1080/02813432.2024.2335537

Taylor & Francis
Taylor & Francis Group

REVIEW ARTICLE

OPEN ACCESS

Check for updates

The transition of general practice into an academic discipline: tracing the origins through the first four professors in general practice/family medicine

Jørund Straand[a] and Niek de Wit[b]

[a]General Practice Research Unit (AFE), Department of General Practice/Family Medicine, University of Oslo, Oslo, Norway; [b]Department of General Practice, Julius Center of Health Sciences and Primary Care, University Medical Center (UMC) Utrecht, Utrecht, The Netherlands

ABSTRACT

Being the 'mother' of most clinical specialties, general practice is as old as medicine itself. However, as a recognized academic discipline within medical schools, general practice has a relatively short life span. A decisive step forward was taken in 1956 when the University of Edinburgh established its Department of General Practice, and appointed the world's inaugural professor in the field in 1963. During the 1960s, the pioneering move in Edinburgh was followed by universities in the Netherlands (University of Utrecht), Canada (Western University, Ontario), and Norway (University of Oslo), marking the beginning of global academic recognition for general practice/family medicine. Despite its critical role in healthcare, the academic evolution of general practice has been sparingly documented, with a notable absence of comprehensive accounts detailing its integration into medical schools as an independent discipline with university departments and academic professors. Last year (2023) marked the 60th anniversary of Dr. Richard Scott's historic appointment as the first professor of General Practice/Family Medicine. Through the lens of the first four professors appointed between 1963 and 1969, we explore the 'birth' of general practice to become an academic discipline. In most western countries of today, general practice has become a recognized medical discipline and an important part of the medical education. But many places, this development is lagging behind. The global shaping of general practice into an academic discipline is therefore definitively not completed.

ARTICLE HISTORY
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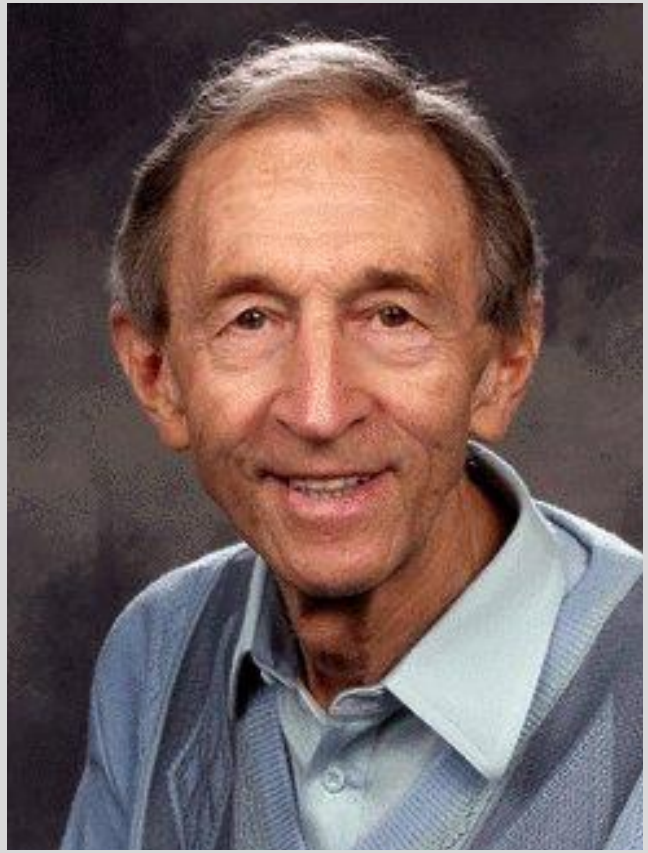
KEYWORDS
Family medicine/history; university departments/professors; Edinburgh; Utrecht; Western Ontario; Oslo



1981

Features

I. R. McWhinney

Teaching the Principles of Family Medicine

SUMMARY

Nine principles of family medicine can be described: an open-ended commitment to patients; an understanding of the context of illness; the use of all visits for preventive purposes; the view of the practice as a population at risk; the use of a community-wide network of supports; the sharing with patients of the same habitat; the care of patients in office, home and hospital; a recognition of the subjective aspects of medicine; and an awareness of the need to manage resources. (Can Fam Physician 1981; 27:801-804).

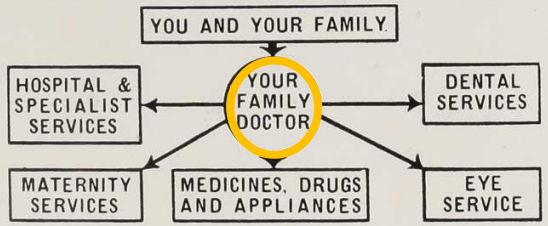
What then, are the principles of family medicine? I will describe nine. None are unique to family medicine; not all family physicians exemplify the whole nine; nevertheless, when taken together, they do represent a distinctive world view—a system of values and an approach to problems which is identifiably different from that of other disciplines.

1948

YOUR NEW NATIONAL HEALTH SERVICE

On 5th July the new National Health Service starts

Anyone can use it—men, women and children. There are no age limits, and no fees to pay. You can use any part of it, or all of it, as you wish. Your right to use the National Health Service does not depend upon any weekly payments (the National Insurance contributions are mainly for cash benefits such as pensions, unemployment and sick pay).



CHOOSE YOUR DOCTOR NOW

The first thing is to link up with a doctor. When you have done this, your doctor can put you in touch with all other parts of the Scheme as you need them. Your relations with him will be as now, *personal and confidential*. The big difference is that the doctor will not charge you fees. He will be paid, out of public funds to which all contribute as taxpayers.

So *choose your doctor now*. If one doctor cannot accept you, ask another, or ask to be put in touch with one by the new "Executive Council" which has been set up in your area (you can get its address from the Post Office).

If you are already on a doctor's list under the old National Health Insurance Scheme, and do not want to change your doctor, you need *do nothing*. Your name will stay on his list under the new Scheme.

But make arrangements for *your family* now. Get an application form E.C.1 for *each* member of the family either from the doctor you choose, or from any Post Office, Executive Council Office, or Public Library; complete them and give them to the doctor.

There is a lot of work still to be done to get the Service ready. If *you* make *your* arrangements in good time, you will be helping both yourself and your doctor.

A

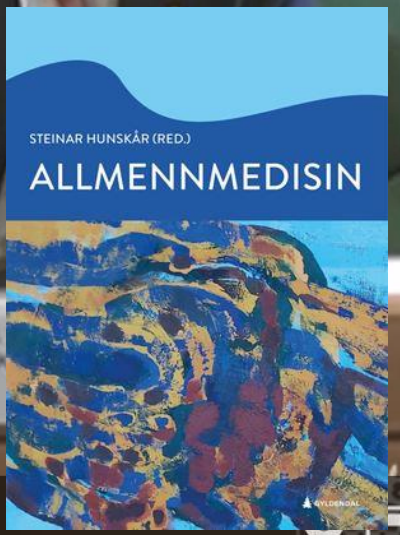
Issued by the Department of Health for Scotland

This advertisement appears in selected Sunday, Morning and Evening newspapers in Scotland.

UK Parliament

The future of general practice

*It is documented that strong primary care with general practice offering **open access** and **continuity of care** is effective – the question is simply how to do it even better*



DR KATE SIDAWAY-LEE

DR REBECCA ROSEN

PROFESSOR STEINAR HUNSKÅR

2022: Prof Steinar Hunskår, expert witness in The British Parliament

15:47:36

15:56:35

Distriktläkarföreningens och Svensk förening för allmänmedicins
Tänkargrupp för God och Nära vårds genomförande

Världens bästa PRIMÄRVÅRD

– en sjukvårdsreform

DLF:s och SFAM:s Tänkargrupp

En sjukvårdsreform

1 **År 2027 är alla innevånare i Sverige är listade på namngiven fast läkare.**

Detta är möjligt om rätt beslut fattas på nödvändiga nivåer. Det är rimligt att såväl grundutbildning som specialistutbildning styrs för att motsvara befolkningens behov av god primärvård, vilken alltid måste utgå från namngiven fast läkare.

Ledare

Retorikens konst inom allmänmedicinen

När jag läste vilket tema detta nummer har kom jag att tänka på allmänläkare och att skriva och associerade vidare till mitt eget skrivande och varför jag skriver och hur.

Vi är alla drillade i att skriva journal, vissa av oss dikterar och andra skriver. I skolan lär man sig att ju längre du skriver desto högre betyg får du, vilket jag alltid har hatat. Jag skrev alltid korta texter och fick visserligen bra betyg men ofta någon liten kommentar om att jag borde ha skrivit längre. Som vuxen får jag min revansch. Nu är det ingen som säger åt mig att skriva längre, bara kortare.

De värsta journalanteckningarna är de långa, utsmetade helt utan mål och mening där samma saker upprepas gång efter annan. De bästa är de som är korta, koncisa och har en tydlig bedömning och en plan. Det försöker jag förmedla till alla yngre kollegor jag handleder eller på annat sätt kommer i kontakt med. Jag gör den här bedömningen på grund av det här och det här och om det blir som na numera själva kan läsa sina journaler eftersom det har tvingat oss att använda ett enklare och tydligare språk med färre medicinska termer, förutom där det är nödvändigt av precisionsskäl. Enligt en bok jag läste i somras, ”Tänka snabbt och långsamt”, som för övrigt är en av de bästa böcker jag har läst, uppfattas man tydligen som smartare ju enklare man skriver. Yes, tänkte jag, accepterade genast detta påstående som bekräftade min egen tes, utan närmare granskning av fakta i ämnet.

Efter att ha läst en av mina många debattartiklar konstaterade min klart mer belästa och allmänbildade bror att ”Du har ju lagt upp det precis enligt konstens alla regler med ethos, logos, pathos…” Nöjd klappade jag mig själv på axeln och kände mig som en riktig Cicero. Kanske skrev jag så för att det är ett helt naturligt sätt att argumentera eller kanske har jag lärt mig detta tack vare allt journalskrivande. Förmodligen en kombination av bägge och annat.

gon annan också vill läsa. Såsom politiska partier borde vara. Man formulerar en politik så som man tycker att samhället borde fungera, och om du sedan vill rösta på den politiken så gör du det.

Varken skrivande eller politik får vara publikfrieri, inte helt i alla fall. Jag kan aldrig skriva en text utifrån vad jag tror att läsaren vill läsa, precis lika lite som jag bör formulera politik utifrån vad väljarna vill rösta på.

Oavsett vad väljarna vill ha kommer jag fortsätta tjata om att slutmålet med primärvårdsreformen måste vara att hela Sveriges befolkning ska vara listade på en specialist i allmänmedicin med en lista på max 1 000 till 1 500 individer. Det är det samhälle jag tror på.

PVreform.pdf (sfam.se)

HOW TO «DO IT EVEN BETTER»?
2 STRATEGIES FOR GP ADVOCACY

TERRIER BITES AND OWL VISIONS

Chat GPT 4/LG

TERRIER BITE METHOD

Critique tendencies in direction of “too much medicine”

2003

RISK EPIDEMIC

Education and debate

bmj.com

Is opportunistic disease prevention in the consultation ethically justifiable?

Linn Getz, Johann A Sigurdsson, Irene Hetlevik

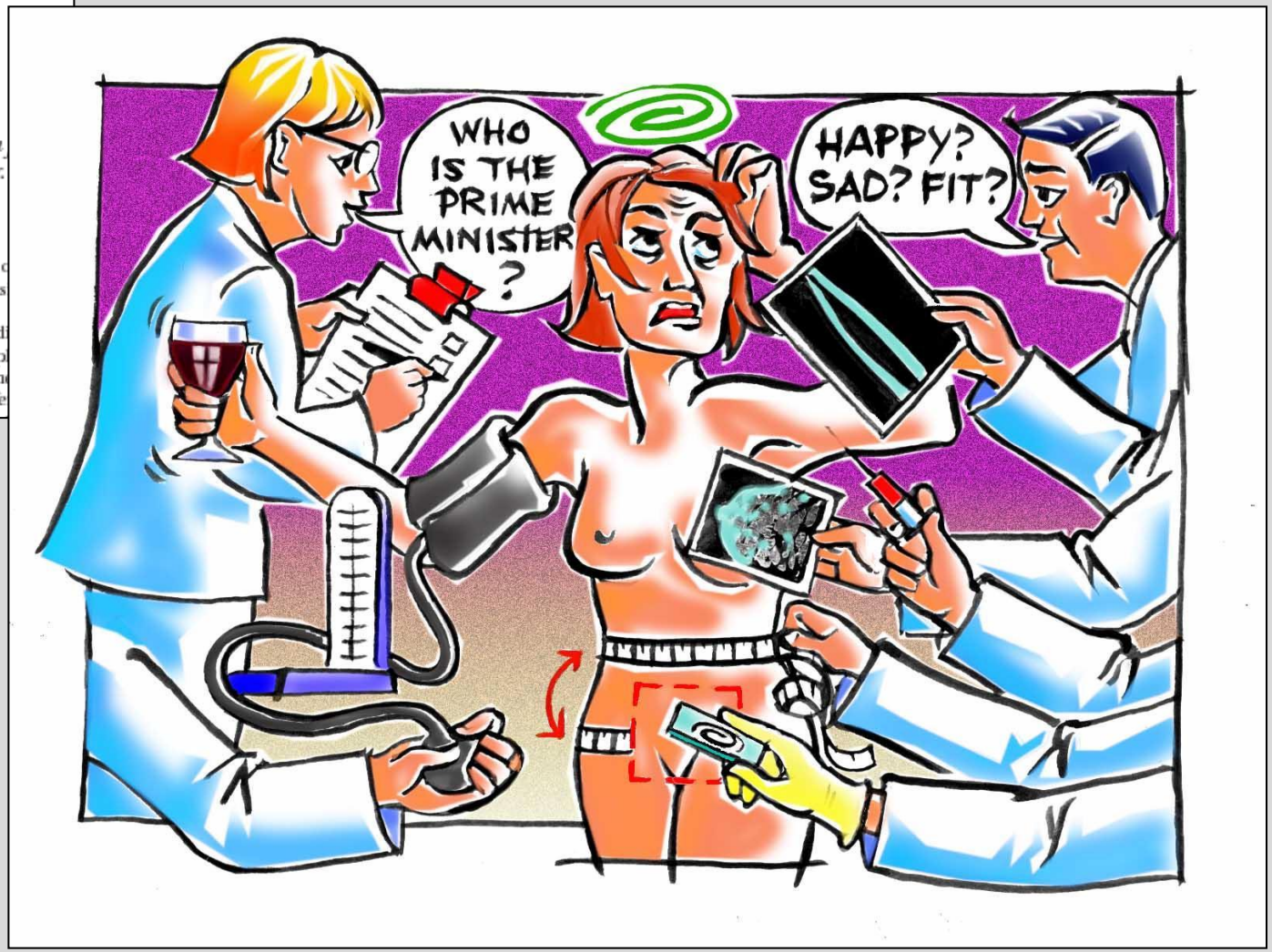
Medical resources are increasingly shifting from making patients better to preventing them becoming ill. Genetic testing is likely to extend the list of conditions that can be screened for. Is it time to stop and consider whom we screen and how we approach it?

Office of Human Resources, Landspitali University Hospital, IS-101 Reykjavik, Iceland
Linn Getz
occupational physician

Most medical experts and health authorities consider consultations in primary health care ideal for opportunistic health promotion and disease prevention. Doctors are thus expected to discuss preventive measures even when they are not among the reasons for contact. But are such opportunistic initiatives ethically justifiable in contemporary Western medi-

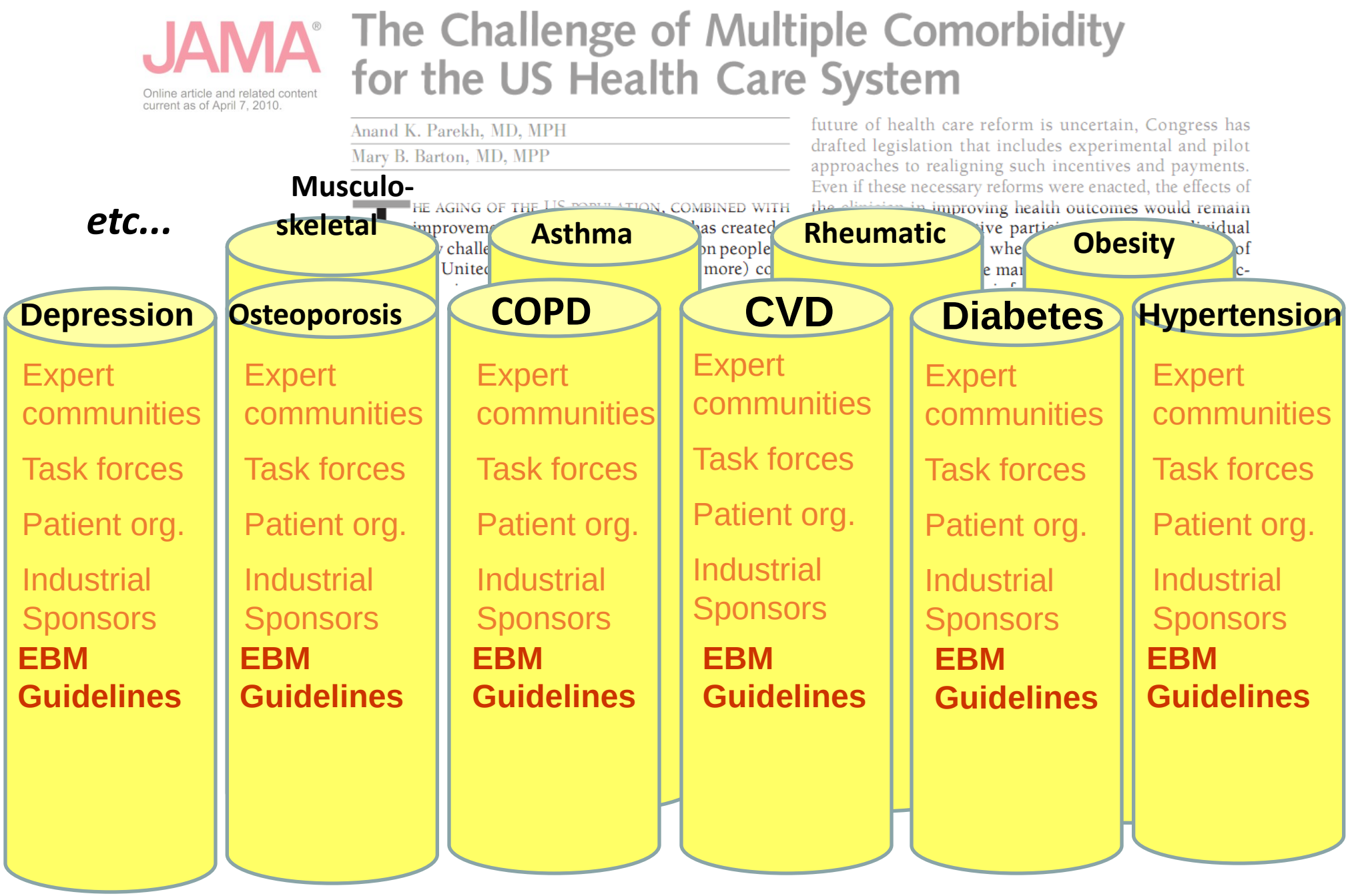
opportunistic health promotion.[2] Since then, o
tunistic preventive initiatives have become cons
to be part of good medical practice.

From a moral point of view, preventive medi
that is, initiatives to improve health among peop
are currently free of symptoms—is fundam
different from curative medicine, which is offe



FRAGMENTATION

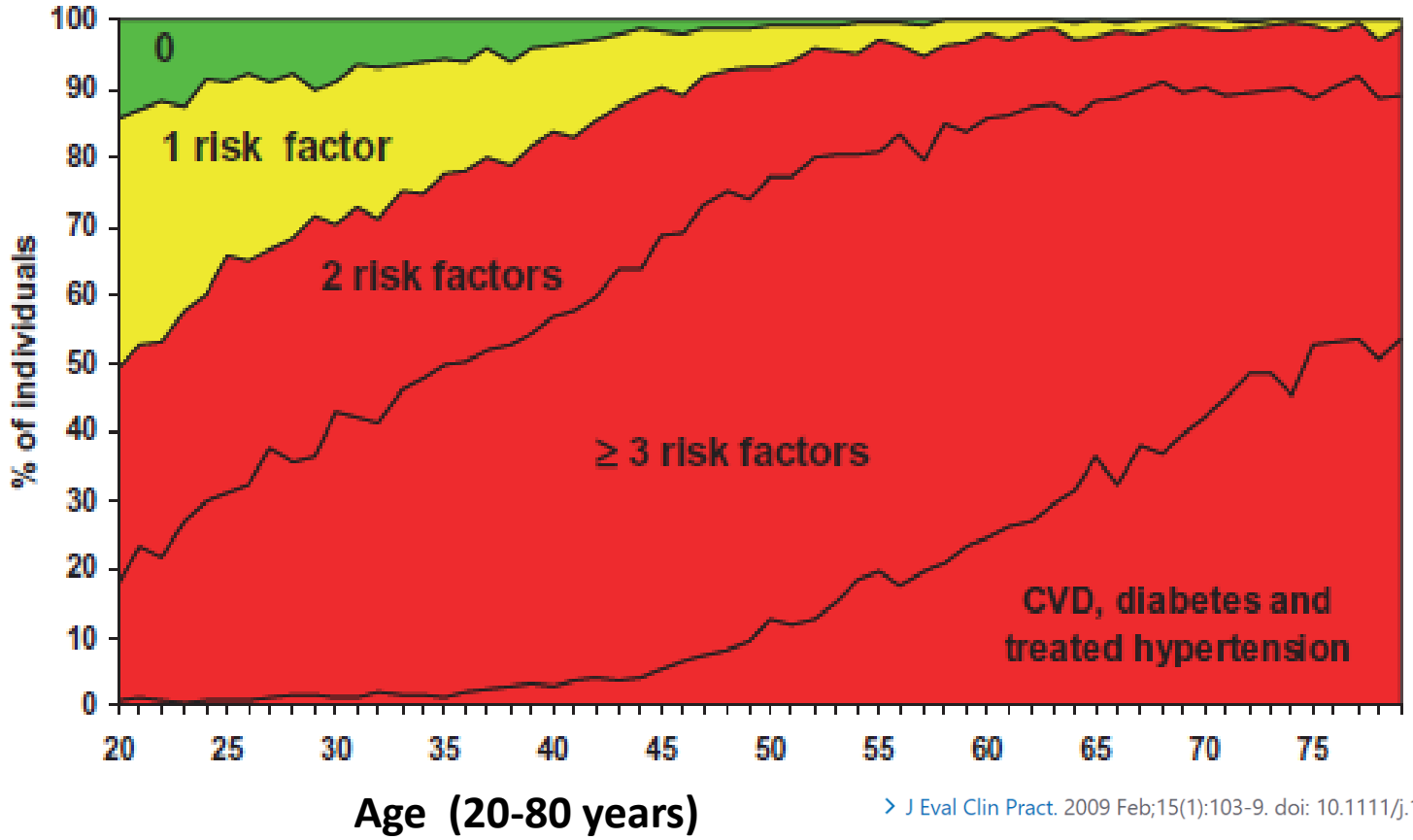
2010


JAMA
Online article and related content current as of April 7, 2010.
The Challenge of Multiple Comorbidity for the US Health Care System
Anand K. Parekh, MD, MPH
Mary B. Barton, MD, MPP
future of health care reform is uncertain, Congress has drafted legislation that includes experimental and pilot approaches to realigning such incentives and payments. Even if these necessary reforms were enacted, the effects of
etc...
Musculo-skeletal
Asthma
Rheumatic
Obesity
Depression
Osteoporosis
COPD
CVD
Diabetes
Hypertension
Expert communities
Task forces
Patient org.
Industrial Sponsors
EBM Guidelines

How many at risk? CVD & diabetes guidelines applied to the general, adult Norwegian population

2010

% of individuals with diagnosis or risk factor(s) according to EBM guidelines



> J Eval Clin Pract. 2009 Feb;15(1):103-9. doi: 10.1111/j.1365-2753.2008.00962.x.

Can individuals with a significant risk for cardiovascular disease be adequately identified by combination of several risk factors? Modelling study based on the Norwegian HUNT 2 population

Halfdan Petursson [1], Linn Getz, Johann A Sigurdsson, Irene Hetlevik

BMJ

BMJ 2014;348:g3725 doi: 10.1136/bmj.g3725 (Published 13 June 2014)

ANALYSIS

ESSAY

Evidence based medicine: a movement in crisis?

Trisha Greenhalgh and colleagues argue that, although evidence based medicine has had many benefits, it has also had some negative unintended consequences. They offer a preliminary agenda for the movement's renaissance, refocusing on providing useable evidence that can be combined with context and professional expertise so that individual patients get optimal treatment

Trisha Greenhalgh *dean for research impact*[1], Jeremy Howick *senior research fellow*[2], Neal Maskrey *professor of evidence informed decision making*[3], for the Evidence Based Medicine Renaissance Group

[1]Barts and the London School of Medicine and Dentistry, London E1 2AB, UK; [2]Centre for Evidence-Based Medicine, University of Oxford, Oxford OX2 6NW, UK; [3]Keele University, Staffs ST5 5BG, UK

thebmj covid-19 Research Education News & Views Campaig

Analysis

Guidelines should consider clinicians' time needed to treat

BMJ 2023 ; 380 doi: https://doi.org/10.1136/bmj-2022-072953 (Published 03 January 2023)
Cite this as: *BMJ* 2023;380:e072953

BMJ Evid Based Med 2023 Oct;28(5):354-355. doi: 10.1136/bmjebm-2022-112225.
Epub 2023 May 24.

Applying the time needed to treat to NICE guidelines on lifestyle interventions

Loai Albarqouni [1 2], Victor Montori [1 3], Karsten Juhl Jørgensen [1 4], Martin Ringsten [5 6], Helen Bulbeck [7], Minna Johansson [8 9]

TOO MUCH MEDICINE

Chat GPT 4/LG

An ongoing dispute….

ESC
European Society of Cardiology

The ESC | Congresses & Events | Journals | Guidelines | Education | Research

2024 ESC Guidelines for the management of elevated blood pressure and hypertension

30 Aug 2024

The current guidelines support healthcare professionals with the diagnosis and management of elevated blood pressure and hypertension. This 2024 guideline, developed by a multidisciplinary Task Force, updates the 2018 ESC/ESH guidelines on the management of arterial hypertension, using the most robust contemporary evidence. The new updated guideline provides a new simplified classification of blood pressure and outlines processes for the diagnosis, evaluation, and management of individuals with elevated blood pressure and hypertension.

1999

Avoiding the Unintended Consequences of Growth in Medical Care

How Might More Be Worse?

Elliott S. Fisher, MD, MPH
H. Gilbert Welch, MD, MPH

The United States has experienced dramatic growth in both the technical capabilities and share of resources devoted to medical care. While the benefits of more medical care are widely recognized, the possibility that harm may result from growth has received little attention. Because harm from more medical care is unexpected, findings of harm are discounted or ignored. We suggest that such findings may indicate a more general problem and deserve serious consideration. First, we delineate 2 levels of decision making where more medical care may be introduced: (1) decisions about whether or not to use a discrete diagnostic or therapeutic intervention and (2) deci-

GROWTH IS A MAJOR FEATURE OF American medicine. Over the course of this century, the proportion of the economy devoted to medical care has more than quadrupled. TABLE 1 details this growth over the past
spending on h
vices has dou
home health
than 10-fold
cians per capi
while the nu
doubled and t
has increased
similar magni
communities.
Although
benefits, man
cal care must l
well-being. T
sons, howev
tional growth

Increasing medical activity

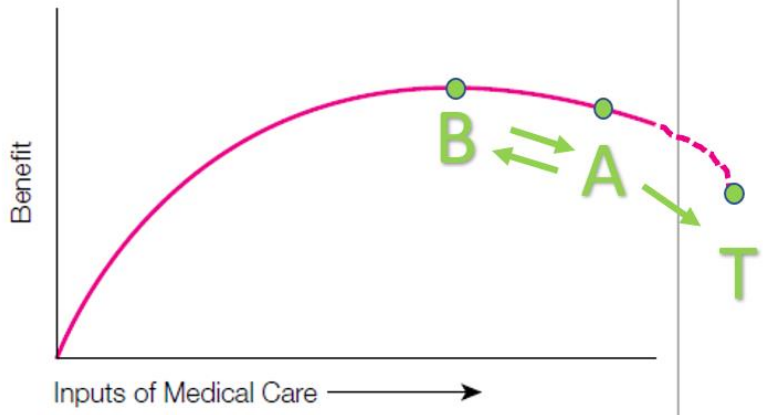
- Fragmented disciplines/specialities
- Technology trumps clinical wisdom
- «Be on the safe side» / defensive

Cultural backdrop in the Nordic countries

- accessible healthcare taken-for-granted
- «more is better»

Revidert 2022 SHj & LG

Figure The Law of Diminishing Returns



The first unit of input provides substantial benefits (imagine the first physician in a community), while additional units provide declining additional benefit (imagine the thousandth physician). Eventually, increasing inputs lead to no additional benefit (the "flat of the curve"). At some point, in theory, additional inputs lead to harm.

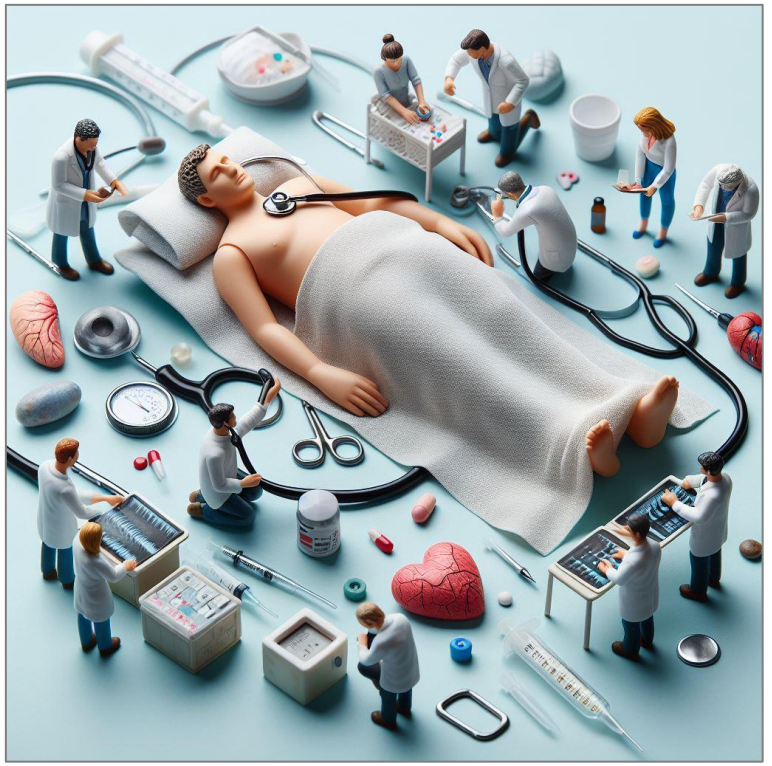
A resourceful, sustainable healthcare system should function at top benefit level (B) without overuse (A). Ultimately, overuse can lead to irreversible breakdown of healthcare services if allowed to increase beyond a hypthetical tipping-point (T). Green elements added to original figure by Getz & Hjörleifsson.

Low value care

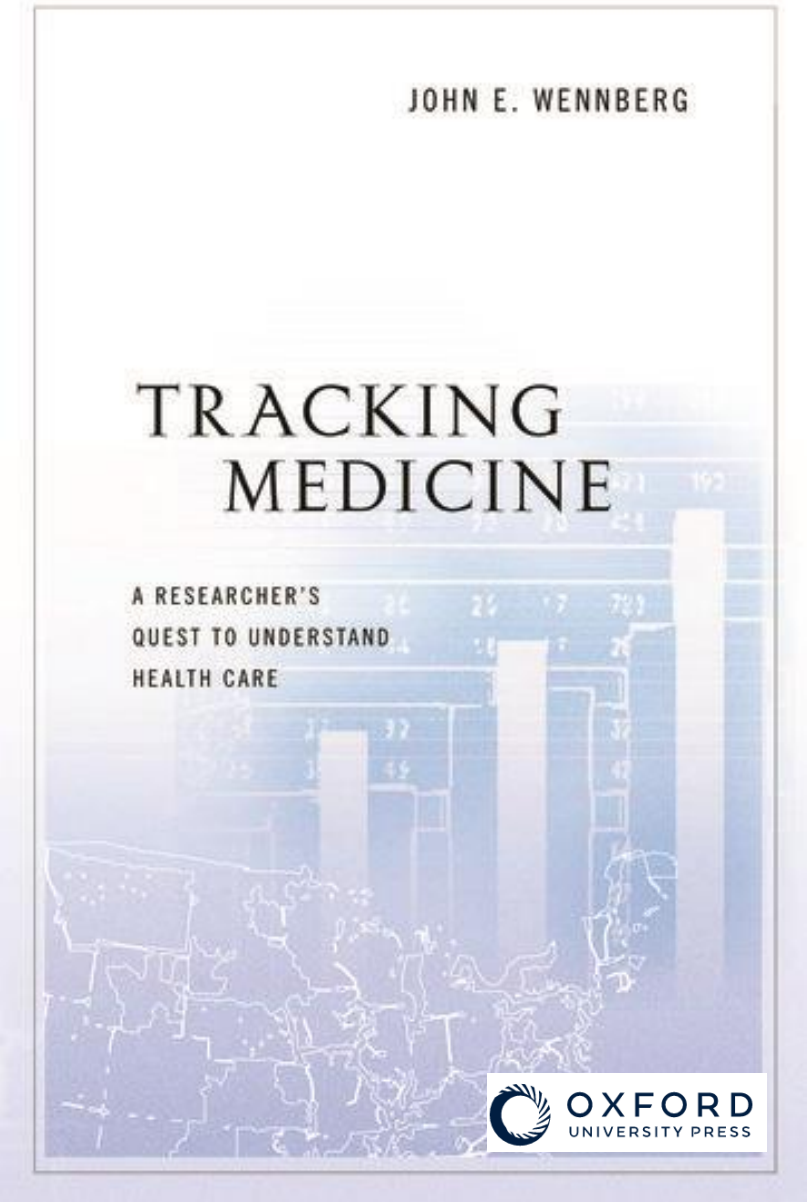
20%

One fifth of health expenditure makes no or minimal contribution to good health outcomes

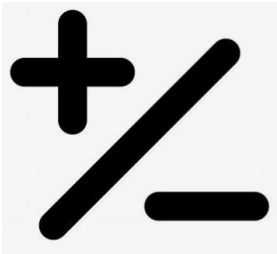
-and can even inflict harm



Tackling Wasteful Spending on Health | 2017



Effective care (60%?)



Preference-sensitive

Supply-sensitive (market sensitive)

International movements from around 2010…

2012

RIO+20
United Nations Conference on Sustainable Development

Editor's Choice

Less medicine is more

BMJ 2009 ; 338 doi: https://doi.org/10.1136/bmj.b2561 (Pub
Cite this as: *BMJ* 2009;338:b2561

Preventing overdiagnosis: how to stop harming the healthy

BMJ 2012 ; 344 doi: https://doi.org/10.1136/bmj.e3502 (Published 29 May 2012)
Cite this as: *BMJ* 2012;344:e3502

2012

Choosing Wisely

Our Mission | Clinician Lists | For Patients | Getting Started

Choosing Wisely

MER ER IKKE ALLTID BEDRE

En nasjonal kampanje mot overdiagnostikk og overbehandling

#mererikkealltidbedre www.klokevalg.org

PREVENTING OVERDIAGNOSIS

Winding back the harms of too much medicine

Home | About | Resources | Definition Reform | Associate Pa

PREVENTING OVERDIAGNOSIS

2023

PODC

The 2023 I
held at the
Call for Abs

GEN

JOHN E. WENNBERG

TRACKING MEDICINE

A RESEARCHER'S QUEST TO UNDERSTAND HEALTH CARE

Global Center for Sustainable Healthcare

Choosing Wisely i Sverige

Kloka Kliniska Val

För en förbättrad hälsa & sjukvård

OWL VISION STRATEGY

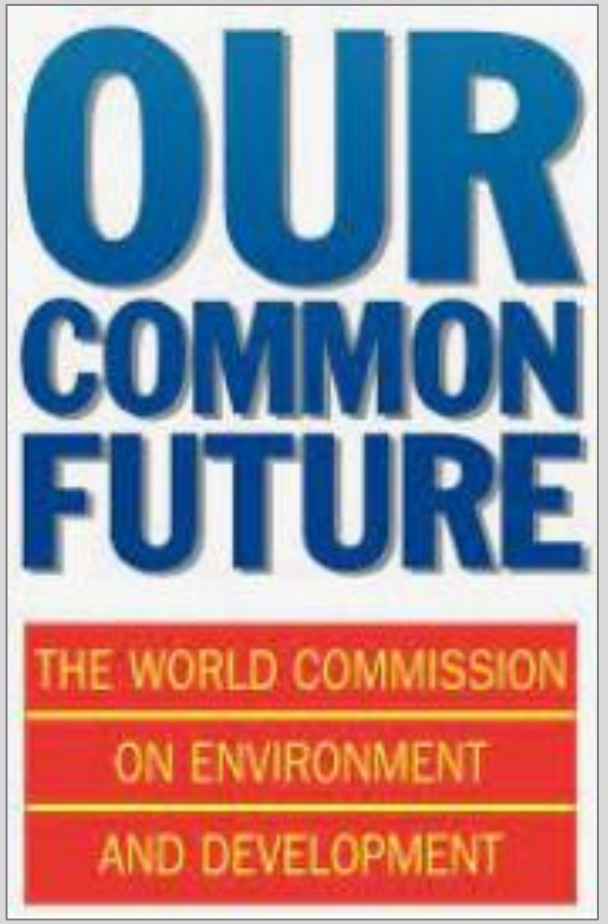
"See in the dark"

communicate a desired future for healthcare

- and the planet

1987

«The Brundtland report», United Nations / Oxford University Press 1987



The report defined **'sustainable development'** as

"***Development that meets the needs of the present without compromising the ability of future generations to meet their own needs"***

Both the Norwegian and Swedish governments are formally committed to the United Nations' Sustainable Development Goals (SDGs).

Sustainability - so what?

Chat GPT4/LOG 11.02.24

TIDSSKRIFT FOR DEN NORSKE LEGEFORENING TIRSDAG 23. JANUAR 2024

Tidsskriftet

KRONIKK

Kirurgisk engangsutstyr fra Pakistan – en kasuistikk om bærekraft

BÆREKRAFT

ARTIKKEL
LITTERATUR
KOMMENTARER (0)

Robert Pedersen, Knut Mork Skagen, Borgar Aamaas, Pia Uhre Trulsen
Om forfatterne

Publisert: 23. oktober 2023
Utgave 15, 24. oktober 2023

Tidsskr Nor Legeforen 2023
doi: 10.4045/tidsskr.23.0510

Mottatt 4.8.2023, første revisjon innsendt 30.8.2023, godkjent 4.9.2023.

Engangsutstyr er som regel et dårlig valg fra et miljø- og klimaperspektiv. Utstyret produseres også under helseskadelige forhold, i områder som blir hardt rammet av

Sykehusinnkjøp er først i verden med miljøkrav

Norske Sykehusinnkjøp har gjennomf
legemiddelanskaffelse med miljøkrav

PUBLISERT: 09.11.2020 · OPPDATERT: 09.11.2020

ÉN OPERASJON: Utstyret som vises på bildet, stammer fra én operasjon. Nå tas initiativ for mer bærekraftige medisinske produkter. Maria Koijck/Sykehusinnkjøp HF


SUSTAINABLE DEVELOPMENT GOALS
1 NO POVERTY
2 ZERO HUNGER
3 GOOD HEALTH AND WELL-BEING
5 GENDER EQUALITY
6 CLEAN WATER AND SANITATION
7 AFFORDABLE AND CLEAN ENERGY
8 DECENT WORK AND ECONOMIC GROWTH
11 SUSTAINABLE CITIES AND COMMUNITIES
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
13 CLIMATE ACTION
14 LIFE BELOW WATER
15 LIFE ON LAND
16 PEACE, JUSTICE AND STRONG INSTITUTIONS
17 PARTNERSHIPS FOR THE GOALS

3 Health: A global, low-income countries centred perspective…

Targets

3.1 reduce maternal mortality
3.2 reduce deaths of newborns and children
3.3 compat epidemics of AIDS, tuberculosis, malaria hepatitis, neglected tropical diseases, etc...
3.4 reduce premature mortality from non-communicable diseases
3.5 Strengthen **prevention/treatment of substance abuse.**
3.6 halve global deaths/injuries from **traffic accidents.**
3.7 universal access to **sexual and reproductive health-care services.**
3.8 Achieve universal health coverage access to quality essential health-care
3.9 reduce deaths / illnesses from **hazardous chemicals and air/ pollution**

3.A Tobacco Control in all countries

3.B Research and development of **vaccines and medicines** for the communicable and noncommunicable diseases that primarily affect developing countries

3.C Substantially **increase health financing and the recruitment,** development, training and retention of the health workforce

3.D Strengthen the **capacity for early warning**, risk reduction and management of national and global health risks.

Something is missing

Sustainable Development Goals (SDG 3) | United Nations Western Europe (unric.org)


SUSTAINABLE DEVELOPMENT GOALS
1 NO POVERTY
2 ZERO HUNGER
3 GOOD HEALTH AND WELL-BEING
4 QUALITY EDUCATION
5 GENDER EQUALITY
6 CLEAN WATER AND SANITATION
7 AFFORDABLE AND CLEAN ENERGY
8 DECENT WORK AND ECONOMIC GROWTH
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
10 REDUCED INEQUALITIES
11 SUSTAINABLE CITIES AND COMMUNITIES
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
13 CLIMATE ACTION
14 LIFE BELOW WATER
15 LIFE ON LAND
16 PEACE, JUSTICE AND STRONG INSTITUTIONS
17 PARTNERSHIPS FOR THE GOALS

United Nations Educational, Scientific and Cultural Organization

Sustainable Development Goals

Education for Sustainable Development Goals

Learning Objectives

Chat GPT 4/LG

Education 2030

Box 1.1. Key competencies for sustainability

Systems thinking competency: the abilities to recognize and understand relationships; to analyse complex systems; to think of how systems are embedded within different domains and different scales; and to deal with uncertainty.

Anticipatory competency: the abilities to understand and evaluate multiple futures – possible, probable and desirable; to create one's own visions for the future; to apply the precautionary principle; to assess the consequences of actions; and to deal with risks and changes.

Normative competency: the abilities to understand and reflect on the norms and values that underlie one's actions; and to negotiate sustainability values, principles, goals, and targets, in a context of conflicts of interests and trade-offs, uncertain knowledge and contradictions.

Education for Sustainable Development Goals: learning objectives; 2017 (unesco.de)

Enter values…

2019

https://www.cebm.ox.ac.uk/resources/reports/defining-value-based-healthcare-in-the-nhs

Value-based healthcare is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person

CEBM

UNIVERSITY OF OXFORD

Strong values

NTNU colleague
Prof of medical ethics
Berge Solberg

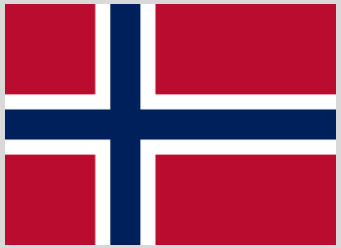
- Are supported by sound arguments and evidence

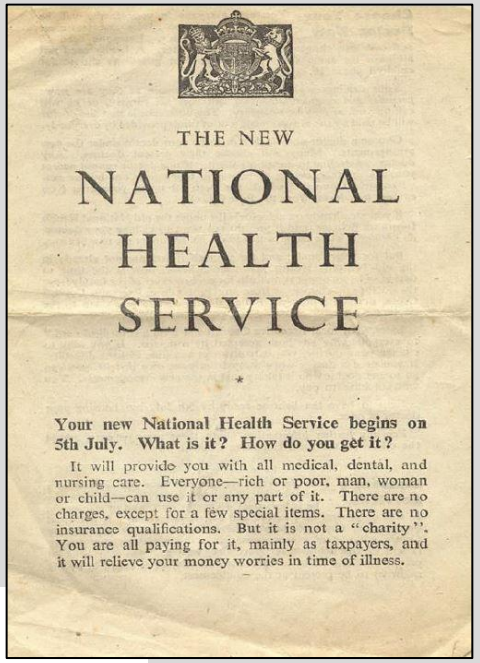
- Are not self-evident!

- Realistic legitimate alternatives must exist

→ **Represent something that is "at stake"**

«Quality»
«Respect»
«Professional»





THE NEW

NATIONAL HEALTH SERVICE

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

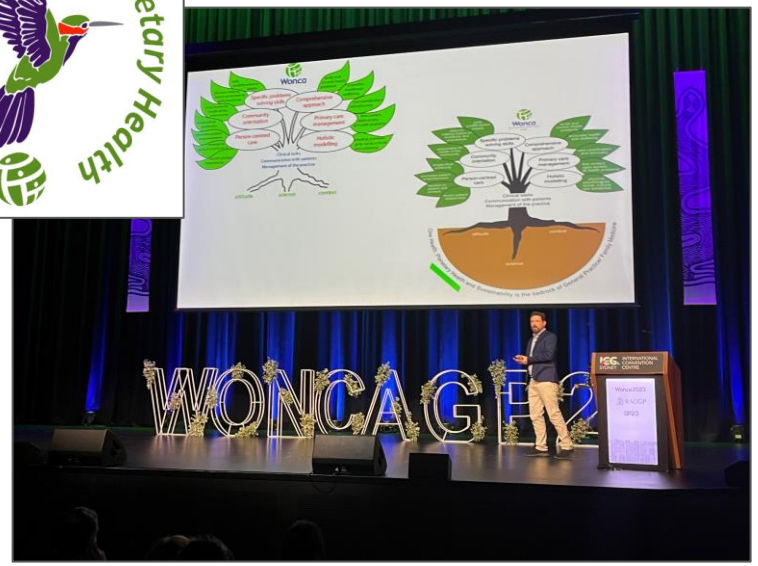
You

can you compare the normative value basis of the Swedish and Norwegian healthcare systems

ChatGPT

Both the Swedish and Norwegian healthcare systems are built upon the principles of universal access, equity, and solidarity, but they have nuanced differences in their normative value basis.

On the main stages of Wonca: **SDGs** and **Core Values**



Wonca Europe: Core GP Competencies (2023) are rooted in Planetary Health and Sustainability

Wonca president Anna Stavdal launches a global Wonca World Core Values Project 2023-2025

Wonca World in Sept 2025 will focus on Sustainability

NORDIC FEDERATION OF GENERAL PRACTICE APS
A FORUM FOR NORDIC GENERAL PRACTITIONERS

Scand J Prim Health Care. 2020 Dec;38(4):367-368. doi: 10.1080/02813432.2020.1842674. Epub 2020 Dec 7.

Core Values and Principles of Nordic General Practice/Family Medicine

Nordic Federation of General Practice (NFGP)

PMID: 33284030 PMCID: PMC7782180 DOI: 10.1080/02813432.2020.1842674
Free PMC article

CORE VALUES AND PRINCIPLES OF NORDIC GENERAL PRACTICE/FAMILY MEDICINE

1. **We promote continuity of doctor-patient relationships as a central organising principle.**

The doctor-patient relationship is based on personal involvement and confidentiality. Continuity of care helps build mutual trust and enable high-quality person-centred care.

2. **We provide timely diagnosis and avoid unnecessary tests and overtreatment. Disease prevention and health promotion are integrated into our daily activities.**

We care for our patients throughout their lives, tending to them through disease and suffering while encouraging progress toward health. We help patients understand their own health – to confront and manage their limitations, improve and maintain their well-being.

Overexamination, overdiagnosis, and overtreatment can harm patients, consume resources and indirectly lead to harmful underdiagnosis and undertreatment elsewhere. When equally effective interventions are available, we choose those that cost less.

3. **We prioritise those whose needs for healthcare are greatest.**

We aim to minimise inequalities in how health services are provided. We organise our practices to devote the most time and effort to those whose needs for treatment and support are greatest.

4. **We practice person-centred medicine, emphasising dialogue, context, and the best evidence available.**

We engage professionally with our patients' current life situations, biographical stories, beliefs, worries, and hopes. This helps us to recognise the links between social factors and sickness, and to deepen our understanding of how life and life events leave their imprint on the human body. We promote patients' capacity to make use of their individual and communal resources.

To safeguard our long-term resilience as caregivers, we attend to our own well-being.

5. **We remain committed to education, research, and quality development.**

We engage actively in the training of our future colleagues We implement and promote research that is suited to the knowledge needs of General Practice/ Family Medicine. We take a constructively critical view of new knowledge and approaches within our areas of specialisation.

6. **We recognise that social strain, deprivation, and traumatic experiences increase people's susceptibility to disease, and we speak out on relevant issues.**

Respect for human dignity is a prerequisite for healing and recovery.

We acknowledge that many circumstances contribute to health inequalities: childhood experiences, housing, education, social support, family income/ unemployment, community structures, access to health services, etc.

We recognise our duty to speak out publicly on specific factors that cause or worsen disease, increase inequality in health outcomes, or make resources less accessible to certain people.

7. **We collaborate across professions and disciplines while also taking care not to blur the lines of responsibility.**

We engage actively in developing and adapting effective ways to cooperate.

Read more about The Nordic Federation of General Practice on **www.nfgp.org**


NORDIC FEDERATION OF GENERAL PRACTICE


CORE VALUES AND PRINCIPLES OF
NORDIC GENERAL PRACTICE/FAMILY MEDICINE
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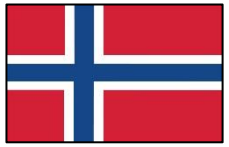
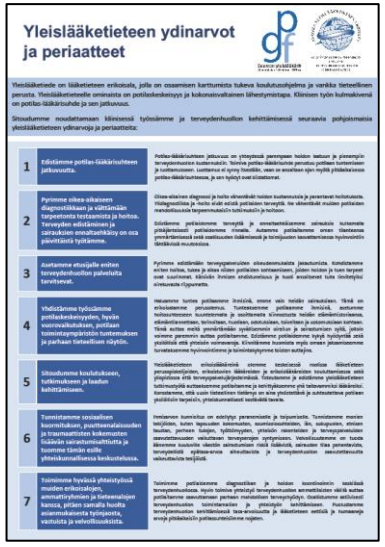
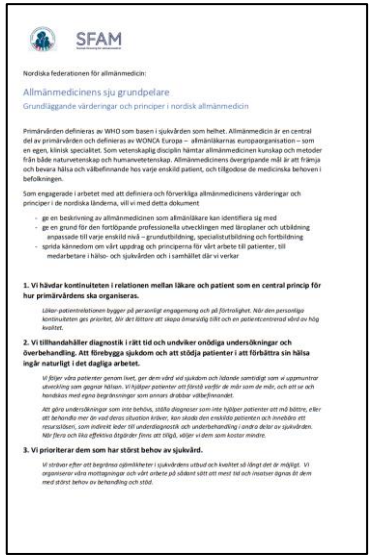
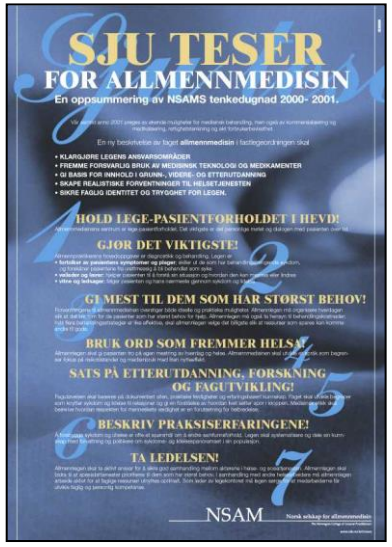
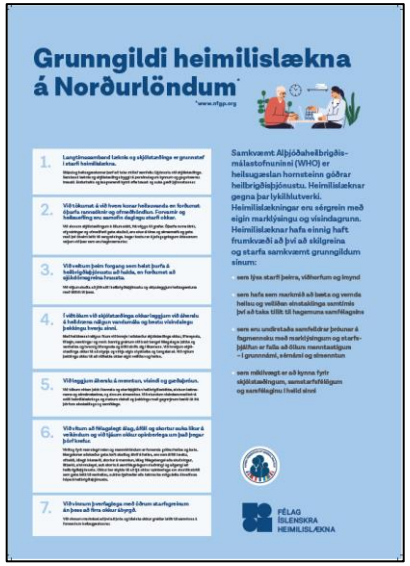


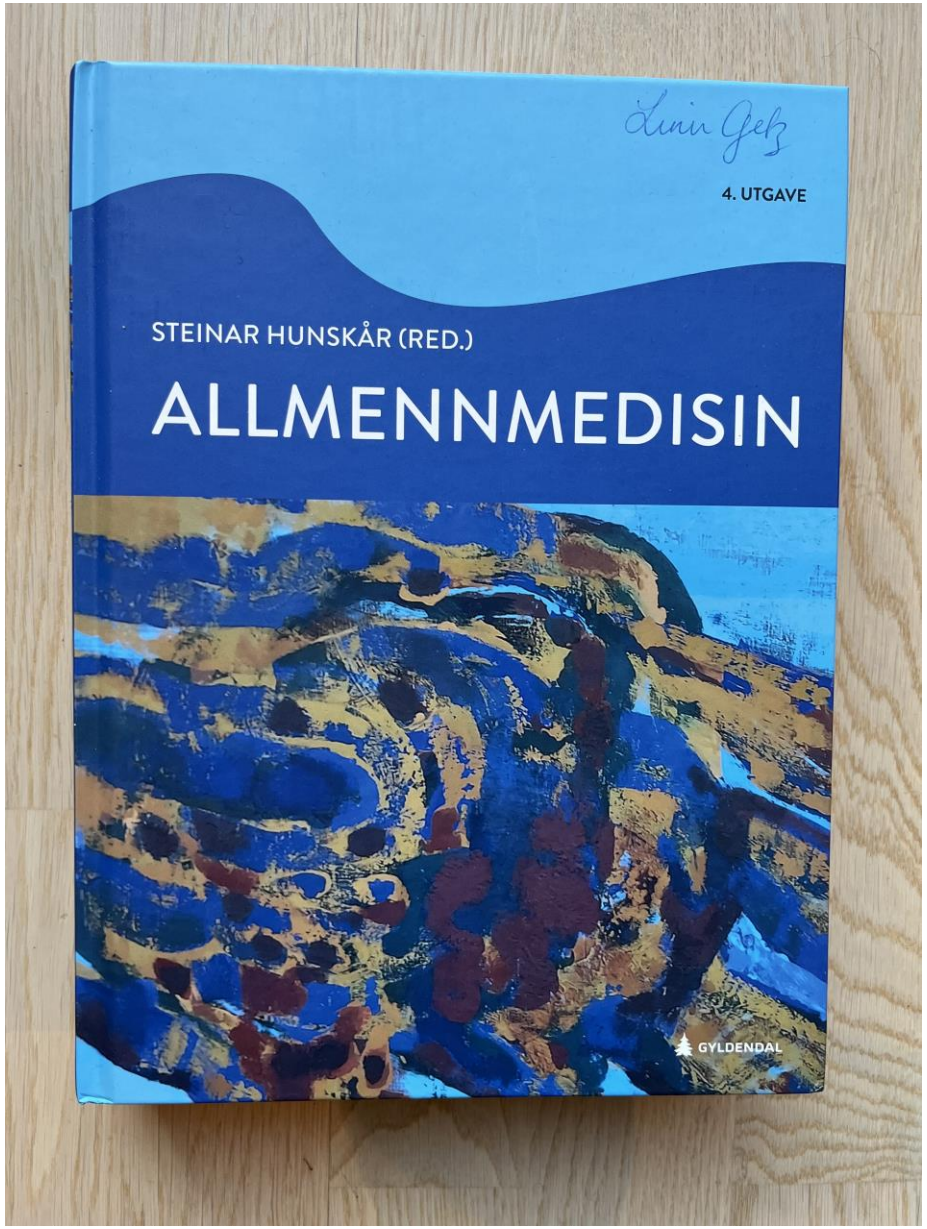

Yleislääketieteen ydinarvot ja periaatteet
1 Edistämme potilas-lääkärisuhteen jatkuvuutta.
2 Pyrimme oikea-aikaiseen diagnostiikkaan ja välttämään tarpeetonta testaamista ja hoitoa. Terveyden edistäminen ja sairauksien ennaltaehkäisy on osa päivittäistä työtämme.
3 Suotamme etusijalle eniten terveydenhuollon palveluita tarvitsevat.
4 Yhdistämme työssämme potilaskeskeisyyden, hyvän vuorovaikutuksen, potilaan toimintaympäristön tuntemuksen ja parhaan tieteellisen näytön.
5 Sitoudumme koulutukseen, tutkimukseen ja laadun kehittämiseen.
6 Tunnistamme sosiaalisen luonnollisuuden, psyykkenalaisuuden ja traumaattisten kokemusten lisäävän sairastumisalttiutta ja tuomme tämän esille yhteiskunnallisessa keskustelussa.
7 Toimimme hyvässä yhteistyössä muiden erikoisalojen, ammattiryhmien ja tieteenalojen kanssa, pitäen samalla huolta asiakasmukaisesta työnjaosta, vastuista ja velvollisuuksista.


SFAM
Nordiska federationen för allmänmedicin:
Allmänmedicinens sju grundpelare
Grundläggande värderingar och principer i nordisk allmänmedicin

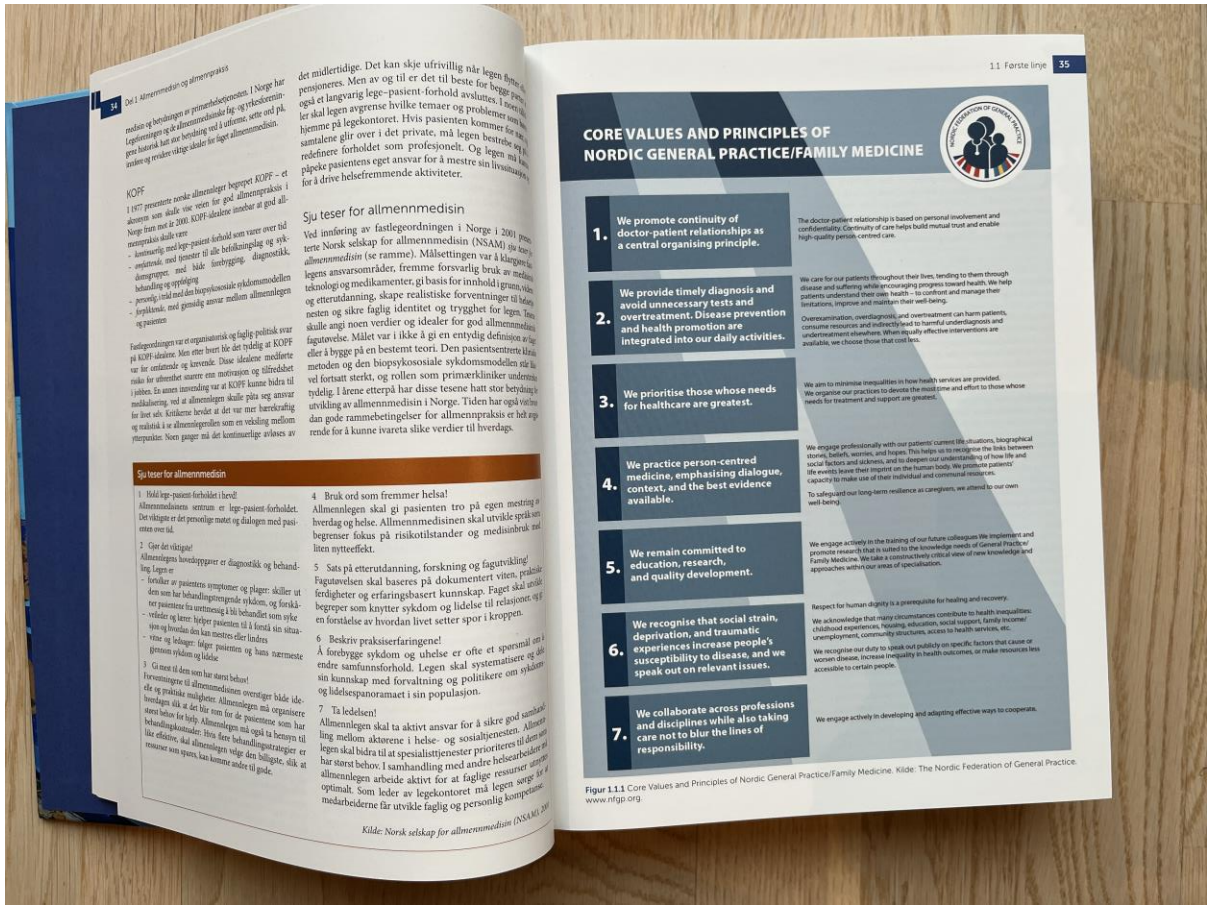

SJU TESER
FOR ALLMENNMEDISIN
En oppsummering av NSAMS tenkedugnad 2000- 2001.
HOLD LEGE-PASIENTFORHOLDET I HEVD!
GJØR DET VIKTIGSTE!
GI MEST TIL DEM SOM HAR STØRST BEHOV!
BRUK ORD SOM FREMMER HELSA!
SATS PÅ ETTERUTDANNING, FORSKNING OG FAGUTVIKLING!
BESKRIV PRAKSISREARINGENE!
TA LEDELSEN!
NSAM

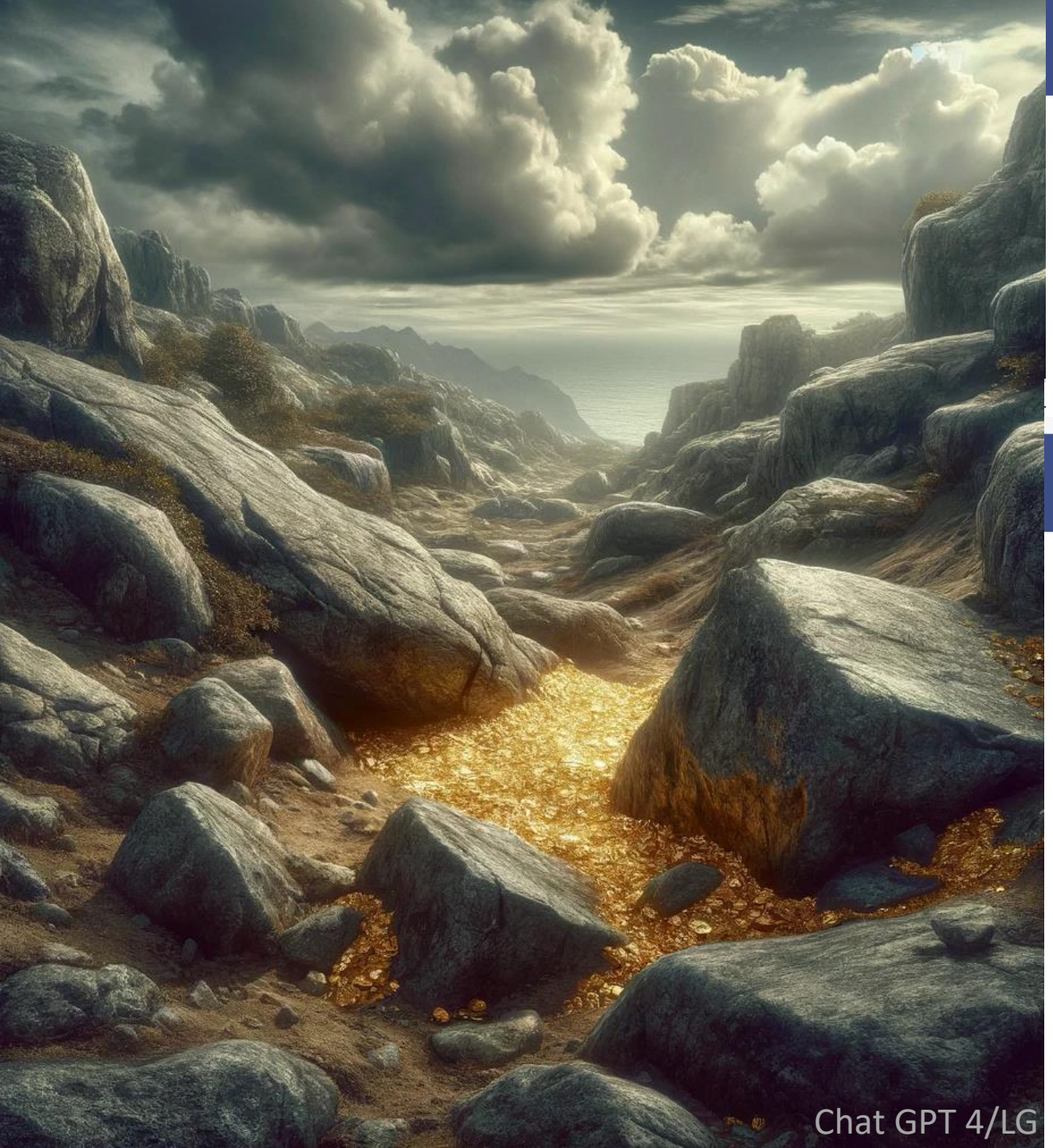

Pejlemærker for faget almen medicin
dsam
Vi holder læge-patient-relationen i hævd
Vi finder og behandler de syge og lader de raske være raske
Vi giver mest til dem, som har størst behov
Vi skaber en dialog, der fremmer sundhed hos den enkelte
Vi deltager i uddannelse, forskning og udvikling af kvalitet
Vi tager ansvar lokalt, tværfagligt og tværsektorielt
Vi beskriver og bruger erfaringerne fra praksis
Læs mere på dsam.dk/fs/pejlemaerker


Grunngildi heimilislækna á Norðurlöndum
www.nfgp.org
Samkvæmt Alþjóðaheilbrigðismálastofnunni (WHO) er heilsugæslan hornsteinn góðrar heilbrigðisþjónustu. Heimilislæknar gegna þar lykilhlutverki.
Heimilislækningar eru sérgrein með eigin markþýsingu og viisindagrunn.
Heimilislæknar hafa einnig haft frumkvæði að því að skilgreina og starfa samkvæmt grunngildum sínum:
FÉLAG ÍSLENSKRA HEIMILISLÆKNA



General Practice,
4th ed. 2023





SFAM

FÖRENINGEN LOKALFÖRENINGAR UTBILDNING

Allmänmedicinens sju grundpelare.

UNCATEGORIZED

De nordiska allmänläkarföreningarna i Nordic Federation of General Practice har i ett gemensamt uttalande formulerat **Allmänmedicinens sju grundpelare**. Läs dokumentet här.

JANUARI 29, 2021 / AV KARIN LINDHAGEN

SFAM

FÖRENINGEN LOKALFÖRENINGAR UTBILDNING

Policydokument

Policydokument: SFAMs rekommendationer för ST-läkare (2023)

Policydokument: Allmänläkares yrkeslånga lärande (2023)

Policydokument: Allmänmedicinens roll i förebyggande och hälsofrämjande arbete (2023)

Policydokument: Så kan vi erbjuda alla invånare i Sverige fast läkarkontakt i primärvården 2027. Från SFAM:s och DLF:s tän

Policydokument: Fast läkare i praktiken (SFAM & DLF 2022-03-14)

Policydokument:Allmänmedicinens sju grundpelare 201015 Nordic Federation of General Practice, uppdaterat 2021-03-16

Policydokument: Genomsnittligt allmänmedicinskt specialistarbete i Sverige (2020)

Policydokument: nfgp_2020_statement_specialist_training, uttalande av de nordiska allmänläkarföreningarna 2020-03-27)

Policydokument: Övergångslösningar till fullt utbyggd primärvård, SFAM & DLF (2022-12-02)

Policydokument: Utvidgad primärvård för sköra äldre (2019-12-17)

Powerpointpresentation: Vad är allmänmedicin (SFAM & DLF) 2019-11-xx)

OWL VISION: Combine SDGs & Core Values

Upholding a well-functioning regular GP scheme

1. **We promote continuity of doctor-patient relationships as a central organising principle.**

The doctor-patient relationship is based on personal involvement and confidentiality. Continuity of care helps build mutual trust and enable high-quality person-centred care.

Counteract «the inverse care law»

3. **We prioritise those whose needs for healthcare are greatest.**

We aim to minimise inequalities in how health services are provided.
We organise our practices to devote the most time and effort to those whose needs for treatment and support are greatest.

Wonca
World family doctors. Caring for people

VALUE-BASED HEALTHCARE

When people are cared for, and are enabled to care for each other, global stability increases.

16 PEACE, JUSTICE AND STRONG INSTITUTIONS

Slide borrowed from Anna Stavdal, Wonca president, 2023

THE LANCET

NB: Overuse and underuse go hand in hand

Addressing overuse and underuse around the world

The benefits of modern medical care have advanced the health of populations around the world, but with better health has come rising health-care spending. Not surprisingly, there is global interest in optimising the delivery of health services, exemplified by the universal health coverage (UHC) and waste in research campaigns.[1,2] Comparatively neglected is a central paradox that afflicts high-income countries (HICs) and low-income and middle-income countries (LMICs) alike: the failure to deliver needed services alongside the continuing delivery of unnecessary services. The *Lancet* Series on right care[3-6] aims to bring these two issues—by the continuing burden of poverty, malnutrition, and infectious disease, rapidly rising rates of chronic diseases,[13] and the adoption of expensive yet unproven medical technologies.

Defining the right care and understanding the forces that work against it constitute a crucial pathway to real affordability. Failing to do so will leave universal access to high-quality, cost-effective, and compassionate care an ever-receding mirage. The Right Care Series creates a framework for understanding overuse,[3] and underuse[4] around the world, the common drivers of poor care,[5] and the potentially scalable remedies to each.[6]

Published Online
January 8, 2017
http://dx.doi.org/10.1016/S0140-6736(16)32573-9

See Online/Series
http://dx.doi.org/10.1016/S0140-6736(16)32585-5,
http://dx.doi.org/10.1016/S0140-6736(16)30946-1,
http://dx.doi.org/10.1016/S0140-6736(16)30947-3, and
http://dx.doi.org/10.1016/S0140-6736(16)32586-7

Addressing overuse and underuse around the world - The Lancet

We speak out against injustice!

6. We recognise that social strain, deprivation, and traumatic experiences increase people's susceptibility to disease, and we speak out on relevant issues.

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To safeguard our long-term resilience as caregivers, we attend to our own well-being.

Chat GPT4/LG

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7. **We collaborate across professions and disciplines while also taking care not to blur the lines of responsibility.**

We engage actively in developing and adapting effective ways to cooperate.

Key topic: teamwork in general practice while maintaining continuity of care

STRONG PHC: INNOVATIVE FLEXIBILITY AND CRISIS RESPONSIVITY

Tsopra *et al. BMC Fam Pract* (2021) 22:96
https://doi.org/10.1186/s12875-021-01413-z

BMC Family Practice

RESEARCH ARTICLE Open Access

Reorganisation of GP surgeries during the COVID [illegible] of guidelines from

Rosy Tsopra[1,2*], Paul Frappe[3,4,5,6], Sven [illegible], Ana Belen Espinosa-Gonzalez[11], Berk Ger[illegible], Gabriella Pesolillo[18], Øyvind Stople Sivert[illegible], Shérazade Kinouani[24,25]

SCANDINAVIAN JOURNAL OF PRIMARY HEALTH CARE
2024, VOL. 42, NO. 2, 276–286
https://doi.org/10.1080/02813432.2024.2309633

Taylor & Francis
Taylor & Francis Group

RESEARCH ARTICLE

OPEN ACCESS Check for updates

How general practitioners used job crafting strategies during the COVID-19 pandemic in Sweden

Helena Månsson Sandberg[a,b], Åsa Tjulin[a], Emma Brulin[b] and Bodil J. Landstad[c,d]

[a]Department of Health Sciences, Mid Sweden University, Östersund, Sweden; [b]Unit of Occupational Medicine, Karolinska Institutet, Stockholm, Sweden; [c]Faculty of Human Sciences, Mid Sweden University, Östersund, Sweden; [d]Unit of Research, Education and Development, Östersund Hospital, Östersund, Sweden

Do the right things - «Less is more»

2. **We provide timely diagnosis and avoid unnecessary tests and overtreatment. Disease prevention and health promotion are integrated into our daily activities.**

We care for our patients throughout their lives, tending to them through disease and suffering while encouraging progress toward health. We help patients understand their own health – to confront and manage their limitations, improve and maintain their well-being.

Overexamination, overdiagnosis, and overtreatment can harm patients, consume resources and indirectly lead to harmful underdiagnosis and undertreatment elsewhere. When equally effective interventions are available, we choose those that cost less.

Kloka Kliniska Val

För en förbättrad hälsa & sjukvård


SUSTAINABLE DEVELOPMENT GOALS
1 NO POVERTY
2 ZERO HUNGER
3 GOOD HEALTH AND WELL-BEING
QUALITY EDUCATION
5 GENDER EQUALITY
6 CLEAN WATER AND SANITATION
7 AFFORDABLE AND CLEAN ENERGY
REDUCED INEQUALITIES
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Pharmaceutical and antimicrobial precautions and moderation

Is there a future for cultural moderation and «realistic medicine»?

«Sparrow argues with Eagle»
Chat GPT4/LOG 11.02.24

Society admires **the biomedical «eagle's» narrative, promising progress and new opportunities to take ultimate control:**

-Testing eliminates uncertainty

-The sooner and the more we test, the better outcome for you (and the nation)

-All ailments need a clear diagnosis

-Ageing is defeat, but it can be combatted by technological means

Helse- og omsorgsdepartementet

Strategi

Preservation of precious healthcare systems: a missing element of general health literacy?

Strategi for å øke helse-kompetansen i befolkningen

2019–2023

https://www.regjeringen.no/contentassets/97bb7d5c2dbf46be91c9df38a4c94183/strategi-helsekompetanse-uu.pdf

Oppsummert er helsekompetanse viktig fordi:

- Høy grad av helsekompetanse gir folk forutsetninger til å treffe sunne livsstils-valg.
- Helsekompetanse skaper forutsetninger for egenmestring og egenbehandling, både av forbigående ufarlige sykdommer og kroniske sykdommer.
- Helsekompetanse setter folk i stand til å navigere i og bruke helse- og omsorgs-tjenestene på en hensiktsmessig måte.
- Helsekompetanse kan bidra til mindre feilbruk av medikamenter, overdiagnos-tikk og overbehandling, og derigjennom også økt bærekraft.
- Helsekompetanse er viktig for folks evne til å finne og kritisk vurdere helseinfor-masjon fra ulike kilder, f.eks. internett eller sosiale medier.
- Helsekompetanse kan også bidra til å redusere sosial ulikhet i helse.

Innovation project (2023) hosted by the Norwegian College of General Practitioners

Norsk forening for allmennmedisin

Bærekraft på legekontoret

I samarbeid med allmennmedisinske forskere i Bergen og Trondheim har NFA startet prosjektet Bærekraft på legekontoret. Målet er å motvirke medisinsk overaktivitet og ikke-bærekraftig bruk av den felles, offentlige helsetjenesten i Norge.

30. mars 2023

Prosjektets mål

1. Styrke befolkningens helsekompetanse ved å informere om hvordan allmennleger arbeider, inkludert allmennlegenes ansvar for å koordinere bruken av spesialiserte undersøkelser og behandling (portvaktfunksjonen).
2. Informere om at overdiagnostikk og overbehandling er uheldig og potensielt skadelig for den enkelte pasient og truer bærekraften i det offentlige helsevesenet.

Per F, 1943-2017

The Lancet's cover, January 16th, 2016

Thank you

Linn.getz@ntnu.no

NTNU
Norwegian University of Science and Technology