

FALL 2007

***Invitation to family physicians to participate in a research project:
How do physicians learn and change their practice?***

FMPE is undertaking a two-year research project to gain a better understanding of how family physicians learn and change their practices. This research project was developed under the leadership of Dr. Heather Armson and has received funding from the Society for Academic Continuing Medical Education (SACME) and ethics approval from the University of Calgary. The project will explore the differences in the nature and diversity of commitment-to-change statements made by family physicians on a newly developed practice reflection tool. All family physicians participating in small group learning sessions (PBSG groups and AdHoc workshops) and those who learn on their own (PBIL) are invited to participate in this research project. Family physicians agreeing to participate would be asked to complete a one-page questionnaire evaluating their learning session, and a two part practice reflection/commitment-to-change tool right after their learning session with a three-month follow-up on any of their commitment-to-change statements. Some participants may also be asked to take part in an individual telephone interview to further explore what factors during their learning session may have influenced them to make certain commitment-to-change statements. For further information and to sign up for the research study, please contact our FMPE research coordinator, Stefanie Roder at 905-525-9140 ext. 22223 or roders@mcmaster.ca.

Editors' Corner — Have Your Say

Here are some questions and comments about recent modules. Editors' Corner is a forum that not only gives voice to your views and questions, but also provides our best response to them.

Urinary Incontinence (February 2007)

Q: *When providing instructions for Pelvic Muscle Exercises, many authors/organizations suggest "try to hold the pelvic muscle squeeze for 10 seconds" (or while counting to 10). Why recommend "hold and count slowly... 1-and-2-and-3-and"? Does it matter?*

A: The key issue with Pelvic Muscle (Kegel) Exercises is the consistency and rhythm of doing the exercise. There needs to be equal contraction and relaxation of the muscle to tone it. The next contraction should not be started until the muscle has been fully relaxed. The problem with "holding for 10" is that most patients are not really sustaining the contraction that long. Then, when they do the relaxation for 10, they actually are developing an irregular pattern.

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Clinical experience has shown that most patients cannot hold for more than a slow count to 3 when they start. The other issue is that when patients are trying to hold for 10, they are usually holding their breath and tightening other surrounding muscles in order to hold on for the count of 10. Focusing on the rhythm of “Squeeze: 1-and-2-and-3-and...Relax: 1-and-2-and-3-and” is much easier *and* they are more likely to continue with this process. When taught the counting method of “1-and-2-and-3-and”, patients who have tried doing PME by holding for 10 are surprised that they now are successful.—JS/JGW

Q: *When trying to improve bladder control, why is it now advised **not** to try to stop the stream while voiding? Is it harmful?*

A: “Stopping and starting” actually can lead to incomplete emptying of the bladder, as many patients have difficulty restarting their stream. This is not too surprising, as it is the signal from the brain that controls the external sphincter contraction and relaxation. So, using the pelvic muscle to stop the stream is like overriding the brain’s signal. In addition, it is not a valid test of pelvic muscle strength. Therefore, stopping is *not* recommended.—JS/JGW

Heart Murmurs (May 2007)

One of our reviewers alerted us to the fact that the guidelines for antibiotic prophylaxis were recently changed...making Appendix 3 in that module out-of-date. A new version is included in this mailout, and there are significant changes!

As it could be quite helpful to understand why the changes were made, and thus to explain it to our patients, we are summarizing the primary reasons given for revision of the guidelines:

1. The basis for past recommendations for antibiotic prophylaxis to prevent infective endocarditis was not well established and the quality of evidence was limited. Indeed, it appears that infective endocarditis is much more likely to result from frequent exposures to random bacteremias associated with daily activities (e.g., brushing and flossing, use of wooden toothpicks, etc.), than from bacteremia caused by a dental, GI tract, or GU tract procedure.
2. No published data demonstrate convincingly that the administration of prophylactic antibiotics prevents infective endocarditis associated with an invasive procedure. Prophylaxis may prevent an exceedingly small number of cases of, if any, in individuals who undergo a dental, GI tract, or GU tract procedure.
3. At this time, the risk of antibiotic-associated adverse events exceeds the benefit, if any, from prophylactic antibiotic therapy.
4. Maintenance of optimal oral health and hygiene may reduce the incidence of bacteremia from daily activities and is more important than prophylactic antibiotics for a dental procedure to reduce the risk of IE.

As a result, antibiotic prophylaxis is now recommended only for those cardiac conditions associated with the highest risk of adverse outcome from endocarditis: prosthetic cardiac valve, previous infective endocarditis, specific forms of congenital heart disease (see revised appendix), and cardiac transplantation recipients who develop cardiac valvulopathy.

Bottom Line:

- Many fewer patients will now be candidates to receive prophylaxis (many forms of congenital heart defects no longer require prophylaxis). We need to be aware of the reasons for this and help educate patients.
- We should take an active role in encouraging good oral hygiene, as this may be more effective in reducing the incidence of IE than prophylactic antibiotics.

—CK/DJR/JGW (with GB and DH on revised appendix)

Errata

Newborn Screening (May 2007)

The acknowledgements for the module on *Newborn Screening* should have included the following:

Authors: **June C. Carroll, MD, CCFP, FCFP**
Sydney G. Frankfort Chair in Family Medicine
Mount Sinai Hospital
Principal Investigator, The Genetics Education Project
Toronto, Ontario
Andrea L. Rideout, MS, CCGC, CGC
Genetic Counsellor/Project Manager,
The Genetics Education Project
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The Genetics Education Project is an initiative fully funded by the Ontario Women’s Health Council whose goal is to promote and facilitate genetics education in primary care.

Premenstrual Syndrome (November 2006)

In the *Premenstrual Syndrome* module, Info point 38 contains a typo in the dosing information. The first sentence should read: “Spironolactone (50-200 mg/day during the luteal phase)...”

Did you know?

It takes about 7 to 9 months to produce a module, from conception to publication.

A module begins with the **identification of a topic**, which is done by regular review of participant requests, important new tests or treatments, and/or suggestions from consultants or professional organizations (most often a combination).

To get the module started, a **“needs assessment” summary** is done by a researcher/literature searcher. This includes a “gap analysis” (gap between best practice and current practice) and a summary of factors/barriers that likely impede a move to better practice.

Patient cases are selected by the family physician author(s). These become the foundation for stimulus cases in the final module.

Next, a **roundtable discussion** is held to briefly review, and validate or revise, the “needs assessment” summary that has been forwarded to all participants prior to the meeting. Most of the participants are active in the PBSG Learning Program, as this is the primary target audience, and at least one will have been author to another module.

Based on discussion at the roundtable, the medical writer prepares a **first draft** of the module for the family doctor author(s) to review. The authors make suggestions or corrections.

The writer then prepares a **second draft**, which also is reviewed by the authors and editor for additional suggestions and changes. A “trial run” by a volunteer **“pilot test group”** PBSG is done. This group provides feedback which is carefully considered, and appropriate changes are made in the module.

Without knowledge of the authors’ names, two physicians who have expertise in the module topic **review** the next draft of the module—primarily to ensure accuracy of the information and to identify any significant omissions. These reviewers may make specific suggestions for module revisions.

Final corrections are made. This **final draft** of the module is checked over and formatted for printing.

New Board Member

Representing Alberta/British Columbia and the Yukon

At the June 23, 2007 Annual FMPE Board of Directors’ Meeting, Dr. Sarah Cairncross was appointed to the Board of Directors as Representative for the Region of Alberta, British Columbia, and the Yukon. Dr. Cairncross replaces Dr. Adrian Gretton who has stepped down after 6 years on the Board.

For a current list of Board members, please refer to our website at <http://www.fmpe.org/en/contact/board.html>

Fall 2007	Spring 2008
Facilitator Training Workshops	Facilitator Training Workshops
Hamilton, ON October 13, 2007	Hamilton, ON April 5, 2008
Calgary, AB October 20, 2007	Vancouver, BC April 19, 2008
Montreal, QC October 20, 2007	Montreal, QC April 19, 2008
Contact Heather Haywood , Member Services and Facilitator Training 905-525-9140 x 22750 or 1-800-661-3249, option 1 or e-mail haywood@mcmaster.ca	

Administrative Matters

Attention, PBSG members! Watch the mail for PBSG invoices. Beginning in August 2007, in response to requests from facilitators and members, we will be sending invoices directly to members, rather than sending to facilitators for distribution.

If your mailing address has recently changed, we ask that you contact us as soon as possible so that we can update our member database.

Attention, PBIL members! By the end of 2008, a common renewal date for all PBIL memberships will be established. Details will be sent to you as they become available later this year.

Would your group like to pilot test an upcoming module?

Into the process of module development, we incorporate a phase of pilot testing of a draft of each module. A PBSG peer group is asked to do a "dry run" of the module during one of its regular meetings, as though it were a completed module and as though the group were discussing it during the normal course of meeting. This group then provides important feedback, which enables us to make improvements to the content and format of the module. The pilot test group does an invaluable service to our module production team and to fellow PBLP members who will be using the module. We have received very positive feedback from groups who have taken part in this phase of the development of a module.

For more information on pilot testing, please contact Nancy McInnes at mcinn@mcmaster.ca or complete the form below and fax back to us.

Name(s): _____
Preferred method of contact: _____
Preferred module topic/subject area: _____

Visit our booth
at the
2007 Family Medicine Forum
to take place in Winnipeg from October 11th to 13th

Upcoming Modules

Learning Problems in Children
Peripheral Neuropathy
Acute Coronary Syndrome
Dementia
Enuresis
Insomnia