



Yonder: a diverse selection of primary care relevant research stories from beyond the mainstream biomedical literature

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Frailty, gestational diabetes, shared cancer care, and Positive Health

Frailty. Given that it's known to be associated with a range of adverse health outcomes, it is unsurprising that frailty has been a major buzzword in healthcare circles in the last decade. Although a wide range of interventions have been developed to prevent or delay frailty, they have mostly been delivered by geriatrics services, which don't exist in many parts of the world.

A research team from one such country, Greece, therefore sought to explore the possibility of developing a primary care frailty service.¹ They found that primary care clinicians considered the main barriers for the identification and management of frailty to be associated with the structure of the healthcare system, including duration of appointments, a focus on prescribing, a lack of allied health professionals, and a lack of training opportunities. The authors offer various solutions as to how primary care clinicians can be trained to improve frailty care but notably, do not include the apparently more obvious solution of developing geriatric medicine as a dedicated specialty training pathway.

Gestational diabetes. In addition to increasing the risks of pregnancy complications for mother and baby, gestational diabetes mellitus (GDM) is also associated with a significantly higher lifetime risk of type 2 diabetes after pregnancy. Despite guidelines recommending that women who have been affected by GDM should be screened for glucose abnormalities during the postpartum period and beyond, uptake is typically low and a research team from Cambridge sought to explore the views of women with GDM about why.²

They found that the current system is not easily compatible with family life, and suggest that greater flexibility in appointment location and times, including 'baby friendly' clinics, would be beneficial. Interestingly, the nature of the test itself was not found to be a barrier to attendance.

Shared cancer care. Advances in cancer diagnosis and treatment have led to an epidemiological shift, with a growing population of people living with and beyond a

cancer diagnosis. Policymakers are therefore considering various new care models for patients with cancer. One such model is 'shared care', defined as cancer care that is shared between specialist and primary care services.

A recent Australian systematic review synthesised the evidence about implementation of this model, finding that there was a need for more clearly defined roles for each healthcare provider, rapid sharing of diagnostic and treatment summaries with GPs, better use of electronic medical records, and improved survivorship care plans to be used as communication tools.³ Among their many recommendations, those categorised under the 'policy' domain, including resource distribution, seem to be the most pertinent.

Positive Health. Although many of us are (rightly) cynical about talk of 'wellbeing', there can be no doubt that clinician burnout and mental health are major issues of our time. Positive Health (PH) is an upcoming, comprehensive health concept from the Netherlands that claims to promote primary care physicians' job satisfaction.

A recent ethnographic case study focused on a Dutch general practice that is currently implementing PH.⁴ It showed that PH supported doctors to express, legitimise, and promote their distinctive approach to care work and its value, stimulating autonomy in their practice. PH also enabled doctors to change their financial and organisational structures, notably freeing up time to spend on patients and their own wellbeing. The authors recognise that PH is not a magic bullet, but do present a compelling case to suggest that it can function as an adaptable framework to improve the job satisfaction of GPs.

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