

UEMO WORKING GROUP

SHARED CARE

The Group considered a proposal of the Danish Delegation as an alternative to the UEMO's statement and the Group welcomed the statement and suggested corrections on the questions of resources and the need for condition specific shared care agreements and a number of alterations that were made to the American phrasiology.

The draft report is presented to the Plenum.

UEMO WORKING GROUP – SHARED CARE

List of participants

Chairman – Dr. Ole Swendsen (Denmark)

Rapporteur – Dr. José Luís Gomes (Portugal)

Dr. Roger Chapman (United Kingdom)

Dr. Christina Fabian (Sweden)

Dr. Steinunn Jonsdottir (Iceland)

Dr. Anthony Hynes (Ireland)

Dr. Jerónimo Foez-Torrente (Spain)

Dr. Willy Andre (Belgium)

Dr. Volker Van der Damerau (Germany)

Dr. Robert Festersen (Germany)

Dr. Martin Junker (Germany)

Dr. Romain Stein (Luxembourg)

Dr. Ute H. Leutloff-Simons (Germany)

Dr. Reto Laetsch (Switzerland)

Dr. Oseph Pace (Malta)

Dr. José Luís Gomes (Portugal)

Draft Alternative UEMO Statement on Shared Care
submitted by the Danish Delegation

The health care systems of Europe are faced with the following future situation:

- a) A demographic development by which an increasing proportion of the population will be elderly, a large proportion of them being healthy and in need of efficient treatment when they become ill. In combination with this will be an increasing number of elderly people with chronic diseases who must be treated to alleviate their symptoms.
- b) Information technology will create a conscious and informed consumer which can also be foreseen in an increasing number of EU projects. The conscious consumer is more and more informed via the influence of the media affecting their awareness about the demands and expectations in relation to the health care system.
- c) Diagnostic possibilities will be developed quickly with gene-technology which is an example of the fact that early diagnosis and the proof of possible illness genes will require more information from the doctor to the citizen. The information must be ethically justifiable and create a sense of security rather than fear.
- d) An increasing individualization is taking place with the individual being brought into focus, and the demands upon and respect for the individual is increasing.

For the Health care sector, this means a need to share responsibility for treatment, i.e. shared care with a focus on the individual patient's course of treatment.

We will all become consultants and advisors for our patients. The question is how this can best be done in a manner fulfilling the following requirements:

- with a high level of professionalism,
- in relation to all illness of the patient,
- in relation to the individual's family, work and social life, and

- as easily and simply as possible so that the everyday life continues without repeated interruption.

A fulfilment of the above four requirements demands:

- A doctor who knows the patient well and continuously over a long period of time and who has the ability to collect the information needed for a general over view.
- Access to a person with the highest professional expertise.

For the health care system this means that both a family doctor who in most European countries is a specialist in general medicine and other specialist colleagues inside and outside the hospital sector are necessary, and it is these persons who must co-operate concerning the treatment of the patient.

The practical accomplishment of the co-operation on shared care demands the following:

1. The will to co-operate and the provision of adequate resources.
2. A common attitude on treatment with clear agreement as to the division of responsibility.
3. Such agreements will be condition specific and will depend at least in part on the experience, training and interest of both GP and specialists.
4. Clinical guidelines co-operatively developed and adjusted to local circumstances.
5. Quality assurance of the patient's experience with the establishment of goals, evaluation, correction, measurement, etc. in a progressing quality spiral
6. Named hospital doctors as point of reference both in hours and out of hours.
7. Portable patient records – perhaps electronic – carried by the patient.
8. Extended Information Technology between the primary and secondary sector.

The success of this co-operation for the optimal benefit of the patient will require a spirit of mutual professional respect as well as respect for the patient's autonomy.