**Report of the COGITA group meeting on 21st of May, 2016**

**Participants**: Marie Barais, Laurence Baumann-Coblentz, Bernadino Fanlo, Johannes Hauswaldt, Erik Stolper, Paul van Royen. Later joined: Ronen Bareket (Israel)

**Opening** of the meeting by PvR offering an agenda for today’s meeting. A round of short self-presentation is run.

**Outlines of the history of COGITA**:

ES presents a version of his invited presentation to EGPRN, on coming Monday, on history of the COGITA group and its results. He starts with the expression ‘niet pluis’ which is unique in the Netherlands and Flanders, and the first research question “Do you have the same gut feeling in your country?”, and extends on the consecutive steps and results of the gut feeling research agenda as it has been done, also refers to the website [www.gutfeelings.eu](http://www.gutfeelings.eu) . There is an offer from the Clinical Decision Making group to take part in their meeting in Bergen, Norway, 22nd to 24th of March, 2017. ES suggests as a next step in research to find what comes out in our practices using the Gut Feeling Questionnaire (GFQ).

Additionally, JH gave a short overview of the linguistic validation procedure of the GFQ, translating the questionnaire into French, German and Polish. MB presented some findings from her research on suspecting pulmonary embolism. BF introduces the Spanish word for gut feelings which is “corazonada” which may be translated as a feeling from the heart.

**Discussion**

PvR: GFQ is constructed in a scientific surrounding but how it may be used in every-day practice remains doubtful. Does it work when implemented into real life?

RB enjoys the difference if following your personal gut feeling in contrast to following guide lines. PvR using GF is not a contradiction to GL, but a genuine part of evidence based medicine and evidence based practice *(JH: see also the “Father of EbM” Sackett DL et al. Evidence based medicine: What it is and what it isn’t. BMJ 1996;312:71–2)*

**Collaborative Feasibility study**

MB then presents preliminary results from a feasibility study concerning the GFQ which had been performed on GPs in Brittany, France, and the Netherlands, with ES.

It has quantitative and qualitative results.

**Discussion**

The problem of recall bias is raised. PvR states that personal interviews with as little time delay as possible are preferable to telephone or E-Mail follow-up. MB suggests an addition to the 6th item of the GFQ at 3rd position, to advice the patient to come back if the problem persists. JH questions this procedure - the patient to decide when to show up again - and prefers the physician to fix the date of next encounter. LBC stresses the influence of different surroundings, here that in France patient has to pay for every visit. PvR gives suggestions on new wording also for 7th position, to start treatment, will invite the patient if the problem persists for a follow-up appointment. MB suggests changes to item 8 and item 9.

PvR suggests to allow for the practitioner to make a list of 1 up to 3 probable diagnoses. Discriminate two levels (a) important diagnoses, (b) diagnoses connected with gut feelings. Do we really need a list of dx? What for?

The percentages asked for in item 9, could it be that they are “pseudo-quantitative”?

MB also suggests to have item 10 to be moved to the top as new item 1. We decided to postpone this discussion to the afternoon; meanwhile Marie will formulate some proposals.

11:45

**Additional participants**: Slawomir Czachowski, Helga Dascal-Weichhendler, Agnieszka Sowinska.

BF presents on **Gut feelings in the diagnostic process of Spanish GPs**. From focus group interviews the Spanish equivalent for gut feeling was “corazonada” meaning a feeling from the heart, but also association with “a guiding / leading light” or with “guardian angel” had been made. BF stresses that the General practice way of work is different from the way of work at hospital.

**Discussion**

The question if it is okay for the Spanish GFQ developers to bypass the focus group and the Delphi procedure step and to directly have the GFQ translated into Spanish according to the procedure which has been previously followed, is answered positively. PvR points at cultural differences in handling GF, therefore a meta-ethnografic study may be of interest, and maybe also a linguistic study. LBC wonders if we should imagine GFs inside or outside the GP. For this, PvR recalls that we had a similar discussion some years ago (at Basel) and reflects on mirror neurons being involved

LBC presents on **the trans-disciplinarity of gut feelings in pediatric infectious disease**, which has been done and finished actually by Thomas Pernin, and reports on some major problems they run into concerning trans-disciplinary communication and mutual respect.

**Discussion**

PvR states that we have to realize that as before, there is a neglect of GF in primary care. Nowadays, you have to have it on the record; one way of not writing it in a referral letter directly could be to report the GP’s gut feeling to the mother of the child; there is a time issue reaching the specialist by phone. Anyway, there may be problems of hierarchy in focus groups of GPs; also male vs. female, which would ask for separate focus groups. MB points at nurse triage and their GFs along, also realizing the GFs of parents. Participants discuss missing trust between GPs and pediatricians. HDW warns that anticipatory ideas and concepts could bias the focus group’s performance and outcome. She stresses that you should not ignore your GF. PvR says that in a referral letter, wording must be done very carefully.

PVR presents –also on behalf of Nydia van den Brink, Birgit Holbrechts and ES- the results of **the Hospital specialist gut feelings study done in the Netherlands and in Belgium**. After a short recap of the literature review about the topic – non-analytic diagnostic reasoning is not inferior to other kinds of reasoning including EBM but complementary- he explained the research questions and the methods. Every participant recognized intuitive knowledge but the terminology denoting that knowledge was vague and differing. Experience was the main determinant. Other determining factors were ‘the clinical eye’, history taking, contextual knowledge, the role of recognizing the pattern and empathy. There were a lot of interfering factors. The researchers found differences and similarities between specialties, depending to the urgency of the medical problem. They did not find differences between the participants in the Netherlands and in Flanders. We **discuss** the conclusions and noted the differences in attitude between the participants in this study and in the one of Thomas Pernin and Laurence Baumann in France (see above).

ES presents –also on behalf of PVR- the **Gut feelings patients study in the Netherlands and Flanders**: preliminary results. The GF concept of the Dutch GPs, the Flemish GPs and the Dutch practice-nurses are similar. Dutch patients have a lot of wordings or phrases to express their uneasy feelings about their state of health apart from non-verbal signals, and a few wordings or phrases to express their sense of reassurance. They never use the expression ‘het is niet-pluis’ or ‘my intuition tells me’. The researchers found some indications that a patient’s GF influences a GP’s decision-making process. Dutch and Flemish GPs and Dutch practice-nurses take patients’ GF serious, particularly expressed by a parent or care provider about their child.` Sometimes they encourage patients to communicate their GF. The GF concept of Dutch and Flemish GPs (and practice nurses) compared to the patients’ concept seems to be more rich because of their knowledge and experience but appears not to fundamentally differ. We then discuss the next steps in this new research line.

The last session is focused on

**Future of COGITA:**

PvR explains that we have to consider financial means of the group as the financial support by EGPRN HQ has been finished, and have to think about ways how to meet expenses for future COGITA meetings.

JH suggests aiming at co-ordinated feasibility studies of the GFQ, in several countries in a parallel procedure.

HDW asks for over-lapping with other groups with similar or neighbouring interests.

PvR verbalizes the need to open/broaden gut-feeling research to primary care, even to medical care in general. Also to consider relevance of GF research for teaching; for research into medical errors; for inter-professional collaboration.

HDW asks for extension into other continents. Participants raise the issue that for this it is difficult to get the people together, and COGITA does not offer more than a loose infra-structure.

MB points at her observation that the topic of GF in medicine is touching the people. But we have to be aware of the gap between research and physicians’ work in real life and therefore to be strategic.

PvR we should find connection to secondary care / specialist care because of increasing number of chronic patients and multi-morbid patients.

Participants agree to focus on realizing feasibility studies of the GFQ in the different countries, in a collaborative way, using the COGITA group as a platform for communication and exchange.

**The day after:**

PVR, MB and ES make **a proposal based on the Feasibility study to adjust the GFQ**. They will ask the other users of the questionnaire for comments.

* In line with the COGITA meeting in Marburg (where the results of the thinking aloud study were presented), item 10 moves to the top of the list and will be repeated at the end.
* Item 6: some more possibilities will be added
* Item 8a will be changed into: which diagnosis/es are you thinking about? (3 at most).
* Item 8b: which diagnosis has determined your course of action?
* Item 9 is removed.
* We change the order of the items following the stream of diagnostic reasoning of GPs.
* We propose to repeat the Feasibility Study in France, Belgium, Germany and the Netherlands, with 10 participants in each country.
* We propose to repeat the linguistic validation procedure as to the changed items: 8, 9 and 10 in the new version (see attachment). A cultural check is not necessary.

**Two days later:**

On the EGPRN-conference, ES, JH, MB and FB give together an oral presentation with an overview of the history of the COGITA network group. MB presents her poster about the linguistic validation procedure in French, German and Polish, and BF presents his poster about the Spanish GPs’ gut feelings. All presentations receive good critics

**New members of the COGITA group:**

* Bareket Roonen (Israel): ronenba@gmail.com
* Pavlo Kolesnyk (Ukraine): dr.kolesnyk@gmail.com

**Appendix**

The latest version of the Gut Feeling Questionnaire before the second step of the feasibility study in France, Germany, Belgium, Netherlands.

|  |  |
| --- | --- |
| Gut Feelings Questionnaire | **Completely disagree****Disagree****Neutral****Agree****Completely agree** |
|  **1 2 3 4 5** |
| 1. Please indicate what kind of gut feeling you have at the end of the consultation. If you can’t answer this question now, go further to the next 9 items and give your answer afterwards.

Ο Something is wrong with this picture.Ο Everything fits. Ο Impossible to say, or not applicable. |
| 1. It all adds up. I feel confident about my management plan and/or about the outcome.
 |  Ο Ο Ο Ο Ο |
| 1. Something does not add up here. I am concerned about this patient’s state of health
 |  Ο Ο Ο Ο Ο |
| 1. In this particular case, I will formulate provisional hypotheses with potentially serious outcomes and weigh them against each other
 |  Ο Ο Ο Ο Ο |
| 1. I have an uneasy feeling because I am worried about potentially unfavourable outcome
 |  Ο Ο Ο Ο Ο |
| 1. To prevent any further serious health problems this case requires specific management
 |  Ο Ο Ο Ο Ο |
| 1. This patient’s situation gives me reason to arrange a follow-up visit sooner than usual or to refer him or her more quickly than usual to a specialist.
 |  Ο Ο Ο Ο Ο |
| 1. Which diagnosis/es are you thinking about?

………………………………………………………………..………………………………………………………………..……………………………………………………………….. |
| 1. What course of action have you chosen?  (Please tick one answer.) I will:

Ο Not yet take action; wait and see.Ο Not yet take action, but advice the patient to come back if the problem persists. Ο Not yet take action, but invite the patient for a follow‐up appointment  either face‐to‐face or by phone.       Ο Order further testing (laboratory tests, X‐rays, etc.). Ο Order further testing, and in the meantime, I will start treatment (medicinal or other). Ο Start treatment, but will not arrange a follow‐up. Ο Start treatment and give the advice to the patient to come back if the problem persists.Ο Start treatment and invite the patient for a follow‐up appointment  either face‐to‐face or by phone.Ο Refer the patient. |
| 1. Which diagnosis has determined your course of action?

 ………………………………………………………………. |
| 1. This question is the same as the first item. If you already gave a response, you have not to answer this one. Please indicate what kind of gut feeling you have at the end of the consultation.

Ο Something is wrong with this picture.Ο Everything fits. Ο Impossible to say, or not applicable. |