



Editorial: National undergraduate curricula for primary care



by **Francesco Carelli**

Andrew Blythe and Julian Hancock write the attraction – and the challenge – of a career in general practice and family medicine is its diversity (1). I'd underline its specificity. Core competences for a GP are not ill defined, as expressed by John Wayne "a GP's got to do what a GP's got to do". Since 2002, we have the European Definition of General Practice / Family Medicine by WONCA/EURACT, with eleven fields of specific action, and six core competencies (primary care management, specific problem solving skills, person centered approach, comprehensive approach, community orientation, holistic approach), that define the role of Family Medicine and family doctor in the Society.

Of course, GP trainers need clear objectives to ensure they deliver high quality education and specialty trainees require clarity about what they should learn. But here we have since 2005 the EURACT Educational Agenda, defining in deep what to teach and how, what to learn and how, exactly according to the eleven fields and the six core competences as defined in the European Definition.

Every country should build on the success of its postgraduate curriculum by creating a na-

tional undergraduate curriculum for primary care. Many GP trainees have spent no time in primary care since they were at medical school and, anyway, all future doctors will be in contact in some way with primary care and must study a core part during their undergraduate curriculum.

There are significant differences across the European Union in GP training and in family medicine (FM) teaching. GP training and the choice of general practice as a profession depend, to a large extent, on the level of FM teaching at the undergraduate level. Only if we introduce students for a short clerkship

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in the practices, will we get new doctors really willing to train as a GP. Also, all doctors, whatever their final speciality, will understand the place of FM in the healthcare system.

As the EURACT Basic Medical Education Committee, we produced and presented research (2, 3) on FM under-

graduate teaching in Europe, using a Delphi study to determine a minimal curriculum.

The length of the FM/GP clerkships/undergraduate programs ranges from one to 12 weeks in different countries, and among different universities in a single country. Inter-country and intra-country variations are seen not only in the length of the program but also in its content. Since, in fact, there is no uniform curriculum for FM/GP across Europe (and also nationally), the aim of this study was to create/suggest one.

The Delphi method was used among the National Representatives ($n = 40$) and the final third round closed the final 15-item list.

This document could be used in the future for the development of a uniform undergraduate curriculum for FM/GP across Europe to promote its development in Countries at a lower academic level in FM and to achieve the reputed uniformity required for high levels of teaching and better free movement of future doctors in the labour market internationally (4).

Also, a nationally agreed curriculum will facilitate the exchange of good practice between schools sharing teaching resources and examination questions and would strengthen the core

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curriculum itself and get medical students more prepared.

According to David Bird (5), the Foundation Programme is an excellent setting for improving communication skills within the doctor – patient consultation. Many patients choose to see a trainee rather than the regular GP, because trainees can spend more time on each consultation and thus feel that their concerns can be expressed and addressed more thoroughly. A Foundation Programme so increasing patient satisfaction and also maintaining safe patient care should be possibly developed in many European Countries.

Reference and reading list

1. Blythe A., Hancock J., *Time for a national undergraduate curriculum for primary care.* Br.J.Gen.Pract. 2011, Oct. 61 (591): 628
2. EURACT BME Committee. *Family medicine/general practice undergraduate teaching in Europe: a Delphi study to determine a minimal curriculum.* Oral presentation 499. WONCA Europe Conference in Malaga. October 2010.
3. Tandeter H., Carelli F., Brekke M. et al. *A 'minimal core curriculum' for undergraduate Family Medicine in Europe, in undergraduate medical - The European Journal of General Practitioners*, 2011, (1):1-4.
4. Carelli F. *Minimal Undergraduate Teaching Curriculum in Europe.* Br.J.Gen.Pract. 2011 Jul. 61 (588):440.
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Country Report

Family Medicine in Macedonia.

By Katarina Stavric

The Former Yugoslav Republic of Macedonia is a small country with population of 2 055 004 on an area of 25 713 km². It is located in the middle of the Balkan Peninsula in south-eastern Europe. Out of 5541 medical doctors, 1490 are working in primary health care (1 physician /1379 population). Originating from the previous societal organization, where the primary health system was based on Polyclinics in primary care, there are 5 different types' physicians who provide primary healthcare: general doctors (small number of them are specialists of general practice), paediatricians, specialists of school medicine, occupational medicine specialists and gynaecologists. Besides the chosen general doctor, women had to select also a gynecologist.

From January 1, 2007, GPs have become private contractors and are paid on a capitated basis by contracts with the Health Insurance Fund (HIF). About 97% of the population has medical insurance covered by the HIF.

There are three medical faculties in the country, the oldest one in Skopje (established in 1947) and two relatively newly established faculties (5 years old) in Tetovo and Stip. The Department for Family Medicine was established in 2012 at the Medical Faculty, University Ss Cyril and Methodius Skopje.

Since independence, The former Yugoslav Republic of Macedonia has embarked on a number of reform initiatives in the field of health care. All reform initiatives are undertaken with the aim of sustaining access for the whole population to a comprehensive health system, as well as improving the quality of health services and enhancing financial sustainability. According to the Health Strategy 2020, developed by the Macedonian Government in 2007,



the accent was put on introduction of specialized family physicians as the main team leaders providing health care at primary health care (PHC) level till the year 2020.

The decision of the government to introduce high quality trained specialists of family medicine in PHC is in line with the overall government policy of achieving quality standards that would offer good, equal and quality health care to the population as a whole, and as such enable the country to join the European Union. According to these standards, all doctors in medicine should have adequate postgraduate specialist training before working independently in practice.

The first residency programme

The first residency program starts in 1972 as general medicine but the training was not obligatory. In 2000, as a part of the World Bank project, starts the process of developing family medicine. Continual Medical Education for general doctors was developed and the curriculum for FM was prepared. But the real development happened in year 2009, again through the World Bank project working under the consultancy of the Department of Family Medicine Ljubljana Slovenia, when the Center for Family Medicine at the Medical Faculty, University Ss Cyril and Methodius Skopje was established and family medicine was recognized as a specialization. A lot of preparatory work was done at the Medical Faculty to develop environment to introduce modern postgraduate training of family medicine. The system of educators, mentors, modern teaching and assessment methods were introduced at the Medical Faculty. Also a special program was developed for retraining of existing general doctors, pediatricians and specialist in occupational medicine and school medicine.

The postgraduate training program includes three year residency while the retraining program depends on the professional background and working experience from and lasts 3-12 months. The training process includes 3 months of teaching in Center for family medicine, half in approved teaching practices under

the supervision of educator, and the other half of the training is in hospital departments. In addition, residents participate in a weekly course during the hospital posts. The retraining program includes training in hospital posts, pediatric and gynecologic practices and teaching modules in training centers. The practical training aim is to refresh the clinical skills. The modules are organized during weekends and cover topics specific for family medicine. The doctors who are attending the retraining program pass the same final exam as the trainees who run regular postgraduate training, so mainly they obtain knowledge and skills by individual learning and work with their mentors.

The final exam consists of three parts: trainee's report about his practice and work; the second part is the visit to the trainee's practice by one of the mentors who assesses the trainee's working conditions and his performance; and finally, the third part is the final exam consisting of MCQ test with 120 questions, modified essay question (one case), 12 OSCE stations and oral exam. At the oral exam the trainee presents 5 cases out of which 2 are selected and discussed. After that, each of the commission asks 1-2 questions on any topic in family medicine. Thanks to the collaboration with the Department for Family Medicine in Ljubljana we continuously have their representative as an external examiner at each final exam.

In 2010, the specialization in FM started, and the retraining program for general doctors began in 2011. Since today we have 17 doctors enrolled in specialization and 132 doctors have finished the retraining program. Out of those, 85 doctors have already become specialists in family medicine, most of them by finishing the retraining program.

We are working on the professional development of our educators and mentors. Each year they attend international courses as well as national courses for improvement of their teaching and mentoring skills. Due to our international activity in international Networks we develop active communications especially with our neighborhood countries.

Since school year 2012/2013 we organize also undergraduate program at the Medical Faculty. It is a small step forward, but with the enthusiasm of the teachers and educators we are trying to animate the students to become interested in family medicine.

Challenges

- In the moment the training is not obligatory so most of the doctors are not interested to start the vocational program. The specialization is private so the doctors need to pay by themselves. We have to work with the Ministry of health to introduce family medicine as an obligatory specialization. The problem is that the average age of the existing doctors working in primary care is over 55, and very soon we will have deficit of doctors in primary care. Also a lot of young doctors are living Macedonia. Therefore, we need to work on affirmation of family medicine at the Medical Faculty and keep young doctors in the country.
- Desired collaboration with the Ministry of Health and Health Insurance Fund to recognize the specialist of family medicine would increase the competences of the family medicine specialists and transform them in real gate keepers. In general, it will improve the position of the family medicine specialist and will attract the interest of the young doctors.
- Work on introducing of indicators for better care of patients.
- Develop research in primary care and develop academic staff.

Family medicine is developing rapidly the last 3 years in Macedonia, and it has made a great impact in the changing the attitude of the doctors to deliver comprehensive and continuing care. In this process, the Center for Family Medicine plays an important part.



*Do you want to share an experience with other teachers in family medicine in Europe ?
Send us an article !*

Vunicred: Dutch trainers visit Romania.

By Karin Verschoor

Introduction

More or less by chance some teachers of the Vrije Universiteit (VU) Amsterdam came in contact with some general practitioners in Romania. Notwithstanding the fact that in both countries the education to become a general practitioner takes 3 years it points out that there are big differences. In the Netherlands the residents (general practitioners to be) are working autonomous in their own consultancy, daily they discuss with their trainer the things they did during office hours, and they also address other relevant subjects. In Romania they principally observe their trainers and work very little on their own. During office hours they discuss subjects, but a structural learning conversation about the topics relevant for a general practitioner they don't have.

Because in Romania they felt a need to shape the general practitioner education in a different way Vunicred took shape, a cooperation project between the University of Craiova and the VU of Amsterdam.

Content of the project.

In the education of a general practitioner the residents learn most by working on their own during office hours. In addition there is education at the university, in the Netherlands 1 day a week, so called return days. Here a general practitioner and a psychologist together give education and coaching (medical, communication and personal) to a group of an average of 12 residents. The first step was to organize in Craiova similar return days. A number of trainers and teachers from Craiova came to visit the VU. They attended return days and visited Dutch practices. And they discussed a lot about education and the organization of it. Some Dutch teachers went to visit Craiova and did the same over there. This led to a weekly return day where the residents exchange their experiences.



And they also teach each other, supported by their teachers. They observe one another during office hours and give feedback on what they see. The residents are very much satisfied about the new way of education and they do rather well with the theoretical exams.

After the change in the return day we also wanted to change the education given by the trainers in the practice. A group of experienced trainers together with two teachers of the university were asked to find a way to do this and to affect this in practice.

Accomplishment of the project.

They chose a form in which first training during the weekend was planned. This was done in the form of work shops. The trainers and teachers from Craiova didn't mind to work during their free weekend. The subjects were tuned in advance as much as possible by email. Subjects addressed were giving and receiving feedback, observing the physical examination and having a teaching conversation (among others). After that two days of visiting the practices followed. During this visits a teaching conversation between resident and trainer was observed and giving feedback on. Before the visit they discussed with the trainer the topics to be specially observed by the visiting Dutch

There was a lot of attention for doing office hours by the residents by their selves. They

practiced with observing a consultation by the resident and with discussing about it. Also having a teaching conversation was sometimes practiced.

Evaluation.

Looking back we can establish that the residents are doing office hours on their own rather often, sometimes in a room that was not used before or in the office of the trainer, who can use the time left over by not working in the practice to work on their administrative duties, they have a lot of those tasks in Romania. The trainers have learned to give positive feedback and the residents appreciate this very much.

In the 5th year of visiting the University of Craiova organized a symposium for all other universities of the country. They gave (sometimes together with the Dutch) with much enthusiasm workshops about the didactic skills they learned and practiced for the last years.

We ourselves look back with satisfaction on the last 5 years. We became sort of friends with the trainers and teachers from Craiova and each year we were curious about the progress we hope they have made

For us each year it was a challenge to tune up to what *they* wanted to learn and what *they* required at that specific moment.

Sometimes it was hard to not go to fast. And sometimes it was difficult to keep fixed on educating the trainers' didactic skills instead of medical subjects.

How to go on?

Both the trainers and teachers from Craiova and we have the idea we are 'finished' over there. Some other universities showed interest during the symposium to hear and learn more about our way of teaching. They asked about the possibility for a course on their own university. We think teachers and trainers from Craiova

are capable to teach their colleagues what they learned from us. In the beginning we could support them while doing this.

Maybe also in other universities people are interested in this way of teaching and learning.



A Dutch –Danisch exchange in Aarhus Denmark

This was really valuable !

By Yvonne van Leeuwen

It was a longer voyage than expected but after 10 hours we arrived in Aarhus! The 10 hours were of much use to us, being 'on the move' with colleagues who were, for a moment, not in a hurry! The most creative ideas popped up in the buses and airplanes about a variety of aspects of GP-education. The following day we were very warmly received by Roar Maagaard, GP, regional GP-training organizer, and secretary of EURACT and his delegation. Even a professor in Medical Education was present. From 9 am till 15.30 pm there were short presentations alternating between the Netherlands and Denmark. The subjects were not random. Both parties had sent their preferences on beforehand: what they wanted to know and discuss. There was much time for discussion about: the duration of the GP-training (see chart), the aims of the hospital post. The GP-internship for nearly all doctors in Denmark, assessment, portfolio, the train the trainers program. After 15.30 pm we were invited to visit Roar's GP-practice, which is very sophisticated (with



even wifi in the waiting room for patients!) and we have discussed the Hippocrates exchange program for trainees. At several

"The Danish delegation was impressed by the extensive day release course scheme for trainees (about 40 days/year) and especially for trainers (9 days a year)."

points we saw opportunities for international research, e.g. the outcome related to the duration of training, the validity of the methods for recruitment etc.

Denmarks selling points from the Dutch point of view are: the 6 month GP-

internship for nearly all doctors, the role of the GP-trainer in the assessment of the trainee (including direct observation of skills), the e-portfolio.

The Danish delegation was impressed by the extensive day release course scheme for trainees (about 40 days/year) and especially for trainers (9 days a year). There will surely be a return visit. The Danish delegation will then of course check, they said(!), "whether this extensive train the trainers program really exists!"

For the trainees it was an eye-opener to look 'backstage' and to see how much effort is put in their education! We all agreed these exchange visits are very inspiring!



Quaternary prevention: an explicit task of the family physician.

Interview conducted by Julien Nève with Marc Jamoulle

Abstract

In health care, it is generally believed that prevention defines itself according to a chronological model from primary, to secondary and tertiary prevention. With his extensive experience in the field of family practice, Marc Jamoulle questions this model but also expands it with a relational dimension. By questioning his family physician status, he is defining what could be termed quaternary prevention: the prevention of non-required medicine, or the prevention of overmedicalization

I know you have questioned your role as a family physician. What does this role mean to you?

The central issue is about my relationship with the patient. This particular meeting is between two human beings, each filled with different knowledge; one demanding care and the other offering it. I am willing to understand what makes people come to me, to choose me as a discussion partner to talk about what can sometimes be extremely personal subjects. What is the legitimacy of this label of a physician who, under the pretext of my body of knowl-

edge, gives me the right to intrude into someone's private life? It's surprising to see that fields like mental health or sexuality have been entirely absorbed by medicine. Many family physicians have become psychotherapists without thinking or questioning it. They have granted themselves the right of inspection into people's lives without having an ethical reference guide. Now, nothing escapes medicine; from birth to death you can no longer exist without a doctor. This medical priority in the name of health is astonishing from a sociological point of view, or even an anthropological one. What can be stranger than being in consultation with someone, in front of me, who considers it a legitimate situation that I hold the power of telling or defining normality?

It's on the basis of this thought that you've built your relational model of prevention?

A long time ago during a public health lecture, I amused myself by using the "chi-square" tool and, putting the patient into abscissa and the doctor in ordinate. Doing so, I realized we could build a typology of relations that bind patient and doctor.

If we draw a cross in the middle of the square, we obtain four different situations in the relationship between patient-doctor.

The definitions of the first three situations already exist. You just have to think about the chronological model of prevention: primary, secondary and tertiary. The first situation corresponds to what is meant by primary prevention: the illness is absent, and seeing that the illness can't be found by the doctor, he tells the patient about potential problems or some other nonsense about what should be done or not, and what is dangerous or not. The whole education to health can be found in that box, as well as immunizations. In the second box, doctors are looking for an illness that the patient doesn't have. For example, you come to me and I announce to you that I want to perform a rectal examination because I am looking for a cancer and I was trained to do that. That's the exact definition of screening. The doctor "bets" on the illness being there. The third box corresponds to the situation where people are actually sick. The doctor knows it and so we try to avoid complications. That's the tertiary prevention.

What is the situation regarding the fourth box?

The fourth box needs to be defined as patients or future dependents of medicine who are coming to consult the doctor.

It's the box of imaginary illness as described by Molière, the box of somatic symptoms and of the Medically Unexplained Symptoms (MUS). Doctors tend to create those kinds of persons, being encouraged in this by the model of capitalistic production dominating our health system. It's no mystery that those who produce medications or scanners aren't doing it for the great good of the people but to make profits. As a result, we create inflation, a constant overproduction in order to fill in the fourth box. By making the choice to prescribe a scanner for every headache or illness, we've come to over determining the anxiety expressed by the patient who is facing death. And by investing this symbolic but specific function to human beings, we make a

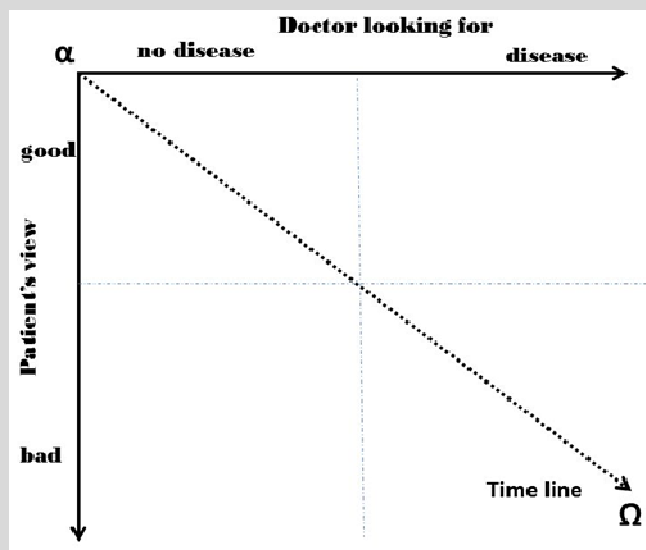


Figure 1 : on the nature of P 4 (Courtesy Marc Jamoulle 1986)

huge amount of profits but we also see the spending for health care explode in all countries without anyone who can control them. Interestingly, according to the timeline of the relational world, doctors and patients meet at the end point (Ω) that faces both illness and death.

In specific terms, what do you recommend?

First, sit and think about it because those questions can't be solved by books or in conferences but, rather, by day-to-day, one-on-one consultations, one after another.

When a patient tells me they'd like to have a scan, am I going to take the time to explore their hidden anxiety? Or am I going to get rid of them by signing a paper without caring about the financial cost, the radiation risks, or knowing if it gets them further into undue medicalization?

There is no recipe. It's a question of attitude and we need to be pragmatic in every single consultation. For example, it is estimated that in a local hospital a million consultations are made per year. That's a million occasions to question the right that medicine has to investigate all the fields that exist. But considering the actors involved, are they trained enough to think through this kind of question?

You advocate for the doctors to be more trained. What should they be trained to do? Can you give me an example?

Future doctors are being trained as medical experts, not as listeners. Let us take the case of a Moroccan mother who was expatriated in Belgium for being married to a cousin who was born in Belgium. She gave birth to her first baby but, seeing that it is impossible for her to go back to Morocco in order to be with her family, and above all her mother, she can't stop crying. A typical doctor would tell her that it's the consequence of her baby blues. But most of them don't know that, in the culture the north-African countries, the relationship between a daughter and her mother during the experience of childbirth is crucial. Instead of prescribing an antide-

pressant for her to feel better, it would be sufficient to give her the option to take a plane ticket to visit her mother for 40 days. At present, we diagnose a depression or postpartum without really questioning the reason for this depression. We make the decision to choose the medicalization instead of choosing the development of an approach based on the link between the young mother's distress and the cultural extraction from which she suffered.

Is this still about avoiding medicalization?

Not necessarily. In the case of a patient who is affected by a multi-disease with severe immunological problems, my role has been to help them get a clear understanding from the specialized doctors.

The aim of our program is to build, in the long run, an online library for the GP trainers that can be used individually but also during joint training sessions to respond to the bottom-up needs of the GP trainers.

For example, I had to control and manage the information so I didn't do too much and miss problems in order to determine that her epileptic seizure was caused by a new medicine. Here, my role consists of telling her that she is indeed sick and that she had nothing to do in the Box 4 of imaginary illness, but she had to join the Box 3 where people are really ill. In the end, and against the advice of officials of Social Welfare who had denied her illness and had refused her a pension supplement, I helped her recognize her rights.

To you, is it that state of mind which seems to be lacking among doctors?

Medicine is focused on the doctor and not the patient. The motive which made the patient get in touch with the healthcare system is not really of interest to them. What really matters is the results their healthcare produces. The position of the doctor is vertical and dominant. He is not in a horizontal relationship with the patient. The patient's underlying need in itself is not considered. Naturally, that's not the case with every doctor. Nobody wants to make bad medical

Patient's feeling	Doctor's knowledge Disease natural evolution	
	Absent —————> Present	
Well being feeling	I Primary prevention Action taken to avoid or remove the cause of a health problem in an individual or a population before it arises. Includes health promotion and specific protection (e.g. immunization)	II Secondary prevention Action taken to detect a health problem at an early stage in an individual or a population, thereby facilitating cure, or reducing or preventing it spreading or its long-term effects (e.g. methods, screening, case finding and early diagnosis)
	IV Quaternary Prevention Action taken to identify patient at risk of overmedicalization, to protect him from new medical invasion, and to suggest to him interventions, which are ethically acceptable.	III Tertiary prevention Action taken to reduce the chronic effects of a health problem in an individual or a population by minimizing the functional impairment consequent to the acute or chronic health problem (e.g. prevent complications of diabetes). Includes rehabilitation.

Figure 2: Definitions according to WICC/ WONCA

decisions but there are few who think about the medicine they practice.

If I understand you right, quaternary prevention is a form of resistance in relation to a position of overmedicalization?

In some ways, yes. However, there are as many risks rushing someone into Box 4 through overmedicalization by making them believe they are sick, when they actually are not, than by filling this box with people who don't believe they should be in it because they are actually sick. I also think about this patient because of a blunder by the radiologist who missed the diagnosis of a multiple sclerosis condition that was rather evident. The patient was told that the loss of the use of her arm was due to a psychological problem. Believing that she had made her illness up, she thought she belonged in Box 4 and she imagined that she needed a psychotherapist.

That kind of bad medicalization could be avoided by the construction of a transmission device for quality control which medicine doesn't presently have in Belgium. Of course, the very expensive campaign that is aimed to encourage doctors to prescribe fewer antibiotics has very well worked. After 2 years, however, bad habits have taken over again. Why? Because, this campaign ignores the influences that pharmaceutical companies have relating to the doctors, and this is precisely the essential point. If we would dare to denounce that practice of medical representation, we would seriously disrupt the provision of prescriptions being put forward as useless, dangerous and inadequate products, but we'd be killed by the pharmaceutical industry for saying that

Your relational approach of prevention is, in a way, a transposition of your practice?

I think the relational prevention model could replace, with great use, the chronological model where prevention boils down to the view of the doctor about a

task to be done before the events occur. In this chronological vision, quaternary prevention corresponds to the palliative care. The originality of the model that I suggest is not about having this new definition of quaternary prevention, but about developing a relational vision of prevention, more qualitative and also more individual. I am obviously interested in public health care but I am first of all a clinician of individual patients and a family physician. "What should I do, doctor?" That is the question that attracts me in the first place. And it's up to me to help the patient find what to do for him to survive. Because in the end, the central question that remains is still the same. How to survive socially, politically, economically and mentally?

Further readings

1. Kueblein T, Sghedoni D, Visentin G, Gervas J, Jamoulle M., 'Quaternary Prevention: a Task of the General Practitioner.', *Primary Care*, 2010 http://www.primary-care.ch/pdf/f/2010/2010-18/2010-18-368_ELPS_engl.pdf
2. Marc Jamoulle's web page on Quaternary Prevention http://docpatient.net/mj/P4_citations.htm

Literature review

Self-efficacy revisited

Reviewer: Jan Degryse

Artino AR (2012) Academic self-efficacy: from educational theory to instructional practice. Perspect Med Educ 1:76-82

The Dutch society for Medical Education has been editing for many years its own journal in Dutch, but has decided recently to move further and to enter on the international scene with a new Journal: *Perspectives in Medical Education*. In the first issue of this journal a interesting review on "academic self-efficacy" caught our attention.

Self-efficacy is a personal belief in one's capability to organize and execute courses of action required to attain designated types of performances. Often described as task-specific self-confidence, self-efficacy has been a key component in theories of motivation and learning in varied contexts. The purpose of this article is to describe the nature and structure of self-efficacy, a key component of social-cognitive theory, and to provide a brief overview of several potential instructional implications for medical education.

Bandura defined self-efficacy as: 'People's judgments of their capabilities to organize and execute courses of action required to

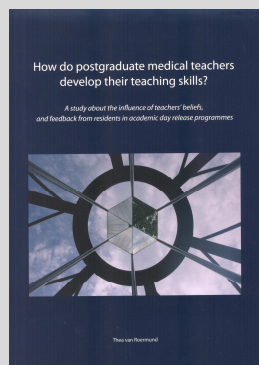
attain designated types of performances.' Two important aspects of this definition warrant further explanation. First, self-efficacy is a *belief* about one's capability, and as such, does not necessarily match one's actual capability in a specific domain. A second aspect of Bandura's definition of self-efficacy is the idea that individuals make use of their efficacy judgments in reference to some *goal* ('attain designated types of performances'), which reflects both the task- and situation-specific nature of efficacy beliefs.

Results from a meta-analysis of more than 100 empirical studies conducted over the last 20 years found that of nine commonly researched psychosocial constructs, academic self-efficacy was the strongest single predictor of college students' academic achievement and performance. It seems, then, that cultivating students' academic self-efficacy is a worthwhile goal for any educator.

Ultimately, by explicating Bandura's theory of self-efficacy, this article encourages medical educators to consider and explicitly address their students' academic self-efficacy beliefs in an effort to provide more engaging and effective instruction.

I must admit that this paper induced a "aha-erlebnis". However more research

Thesis report



How do postgraduate medical teachers develop their teaching skills?

A study about the influence of teacher's beliefs, and feedback from residents in academic day release programmes.

Thea van Roermund,

Reviewer Paul Ram

For all medical teachers (faculty), especially for the members of EURACT, this thesis on faculty development is a “must”.

In the Netherlands trainees work and learn three to four days a week in general practice under supervision of an experienced doctor and attend one day a week a ‘academic’ day release course in a group of about 12 peers. Important elements of the academic programme are reflection on practical experiences and training a variety of competencies within the CanMeds framework.

This thesis focuses on the academic teachers, experienced general practitioners and behavioral scientists who combine part time teaching with their work in practice.

Firstly, the author outlines a short history of the day release courses of GP-trainees, proposing an educational model that discerns learning and teaching in practice from the ‘school’, the academic environment. Learning in practice is learning by doing, under time pressure, in a role with high responsibility, supervised by a GP-trainer who slowly ‘fades away’. Academic teaching implies view-

ing experiences in a broader perspective, and relate them e.g. to medical guidelines or societal values.

The author selects relevant competencies for academic teachers from the literature, based on the model described above, such as facilitating small group learning, and skills in EBM, educational, teaching and assessment skills.

The authors explore the ideas of teachers about the “good teacher”. Surprisingly, their beliefs differ from the experts’ description in the competency profile of the academic teacher. The beliefs of teachers and residents about the good teacher are explored, analyzed and compared. In order to make education effective, it is important that there is a certain level of agreement between their mutual expectations. This however, is only partly the case. They seem to agree on the importance of the teacher as a role model but disagree on its implications for teaching. Residents appreciate the confidential relationship, introduced by teachers feeling responsible for the well being of the residents, but they prefer a professional relationship. These differences appear to be difficult to discuss!

Further study indicates that the appreciation of the trainees for their teachers is generalizable for different educational settings (reflection, medical & psychosocial content) but not for sessions with the focus on individual progress. Finally, the results of the feedback with the evaluation

instrument have been discussed with the teachers, comparing their individual result with the averages of their peers.

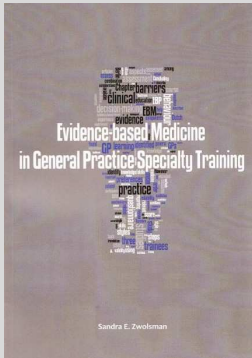
Teachers stated that they would take the evaluations from “good residents” more seriously than the evaluation from residents qualified by the teachers as “not doing their best”. Moreover, the main finding was that neither the reports nor the discussion related to the outcomes, challenges the teachers to make concrete plans for change or improvement of their performance, even after identifying areas in need of attention. So, personal beliefs of the teachers are stronger than external standards and feedback by residents.

To my opinion, the authors are too friendly in their recommendations towards the teachers. The competency profile should be much more leading in the compulsory training and assessment (by residents and peers!) of academic teachers in order to enhance their teaching competencies to a level higher than beliefs.

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Thesis report.



Evidence-based medicine in general practice speciality training.

*Sandra E. Zwolsman.
University of Amsterdam.*

Reviewer Valérie Dory

This thesis takes a very comprehensive approach to the study of evidence-based medicine in general practice. Its six studies, using diverse methods, seek to gain a better understanding of the barriers to evidence-based general practice and of the influence of postgraduate training. Its conceptual framework defines evidence-based practice as a decision-making process which integrates evidence with physicians' expertise and preferences and with patient preferences.

In her systematic review, Dr Zwolsman found evidence of barriers to evidence-based general practice stemming from each of these three components as well as obstacles linked to the practice setting such as a lack of time and incentives. She surveyed general practice trainees for their perception of some of these barriers and found that participants stated time as the main barrier to evidence-based practice. Interestingly, participants also stated lack of knowledge or experience with acquiring and appraising evidence despite performing reasonably well on an objective test of EBM skills (the Dutch version of the Berlin questionnaire which was developed and tested as part of the thesis). It appears that GP trainees may have low self-efficacy in acquiring and appraising evidence.

Because assessment drives learning, the author turned her attention to potential instruments to measure evidence-based practice during general practice training. Consistent with her broad conception of evidence-based practice, the author sought tools that go beyond assessing knowledge to evaluating actual competence in integrating evidence, expertise and patient preferences in decision-making. In another systematic review she found several instruments with evidence pertaining to their validity and reliability. However only one addressed all the steps of evidence-based medicine and did so using self-reports.

She then went on to observe how GP trainees and trainers integrate evidence, expertise and patient preferences in actual clinical decisions. Because evidence-based practice is first and foremost a cognitive, decision-making, process, it does not lend itself well to observation. Follow-up interviews however provided some insights including the fact that doctors do not always integrate all three components in their decision-making. Doctors did take patient preferences into account although more often than not, based on their own knowledge and perceptions of patient preferences rather than on systematic enquiry into these. Interviews also revealed that doctors cannot always determine the exact source of their knowledge. Evidence from the literature may indeed become so integrated with their formal and experiential knowledge that it becomes tacit. Together with findings that trainees believe that

they often use intuition in decision-making, this points to the difficulties inherent in studying evidence-based practice as a decision-making process. The author suggests that encouraging reflective practice during postgraduate training may be an important way to foster more evidence-based practice. This thesis certainly paves the way for further research in this area.

Finally, the thesis includes the Sicily statement on the classification and development of evidence-based practice learning assessment tools as an addendum. The statement provides a useful framework for teachers selecting existing assessment tools and for researchers seeking to develop new tools or improve on existing ones.

This thesis will be of interest to those involved in teaching and assessing evidence-based practice as well as those interested in the clinical reasoning and decision-making processes of general practitioners and general practice trainees. Its comprehensive framework situates evidence-based practice as integrative reasoning. Implicitly it points to the importance of having sophisticated epistemological beliefs (beliefs about knowledge and knowing) to appraise diverse types of knowledge and integrate them in the care of individual patients. Evidence-based practice is clearly not just about applying algorithms from guidelines.

[Discover this work here.](http://dare.uva.nl/record/433900)

<http://dare.uva.nl/record/433900>

Agenda

EURACT

4-7 April 2013

Euract council meeting
Graz (Austria)

3-6 October 2013

Euract council meeting
Tirana (Albania)

WONCA – Europe

2-5 July 2014

Lisbon, Portugal
“New Routes for General Practice
and Family Medicine”

WONCA – World

25-29 June 2013

“Care for generations”
Prague Czech Republic

EGPRN

16-19 May 2013

Kusadasi – Turkey
The theme for this meeting is:
“Risky Behaviours and
Healthy Outcomes in Primary
Health Care”.

17-20 October 2013

Attard, Malta
Theme: “Joint EGPRN-
EURIPA meeting”

AMEE

24-28 August 2013

AMEE 2013,
Prague, CZECH REPUBLIC

6-10 September 2014

AMEE 2014
Milan, ITALY

25-29 April 2014

OTTAWA conference on
assessment of medical
competence
Ottawa, CANADA



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