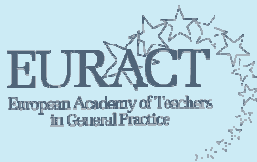




EURACT Newsletter



Updating formation agenda for evolving family doctors

**By Francesco Carelli
& Lucca Puccetti**

The family doctor (even agiographically) is well recognized as a person-committed doctor rather than a disease – oriented physician.

In the common sense this expression is taken as “a doctor who is attentive not only to technical aspects but also to human and social relationships”. So, family doctor is considered a physician who takes overall care of a sick person in his family and social environment, not only a technician who cures a disease. General practice, in different ways according to different countries, is strongly associated with indexes of better overall health and lower costs, however Primary Care is now on the verge of collapse due to a dysfunctional financing and delivery system. In US very few young physicians are going into primary care and those already in practice are under such stress that they are looking for an exit strategy. (1). Also general practice has a conflict: to do not enough, while specialist medicine tends to do too much. General practitioners do not let third parts earn, they, in fact, do not prescribe innovative, expensive drugs, neither adopt expensive medical devices for diagnostic or therapeutic purposes and therefore have few resources to develop and to promote themselves in the media and in decision makers, because they are not inte-

The family doctor is well recognized as a person-committed rather than a disease-oriented physician.

resting for the various decision makers.

To motivate Family doctors to get targets (that are almost always uncritically accepted from international guidelines proposed by other specialists, often full of conflict of interests by stakeholders) some models of proactive medicine have been proposed, with disease addressed consultation services, separated like in other specialties and paid for performances, with process or surrogate indicators and poor results in terms of serious endpoints, as reduction in mortality or hospitalization rates (2, 3). At the same time the needs of accountability generate increase of bureaucratic tasks and of costs, and further reduction of time devoted to patient care. So it will be necessary to provide standard care by lower grade health professionals. Furthermore, the idea that informatics and telematics can solve any problem is just a delusion. As it was shown by the University College of London independent review of Summary Care Record in UK (4), triumphal expectations and huge in-

vestments didn't produce the expected results, on the contrary there are serious risks for privacy. Evident examples of these risks are the fight for opting out from the Spine and the request by Police to gain access to citizens' health information, causing potential risks for the patients reluctant to share vital information with their doctor (5-9).

In recent years, stakeholders have invested huge sums to medicalize more and more human life. The same WHO definition of health (10) is misleading and dangerous to the sustainability of public health and universal access to health care and it has been used to expand the margins of medical intervention. The total control of the media by advertisers, the uncontrollable circulation of false or exaggerated health news via social networks, increase noise and generate unrealistic expectations in the population. This results in an increase in litigation for alleged medical malpractice that, in turn, results in an increase in costs for defensive medicine. Supporting individual specialist disciplines, both via medical specialists and patient organizations, stakeholders and their conscious or unconscious bearers lowered more and more the thresholds, raised the bar of therapeutic targets, expanded prevention relegating it to a to a mantra slogan, devoid of any beneficial effect on

Inside this issue:

<i>Editorial:</i>	1
<i>Country report: Family Medicine in Switzerland</i>	3
<i>Country report: Family Medicine in Albania: work in progress.</i>	5
<i>Main article: Researching the Learning and Teaching of communication skills</i>	8
<i>Thesis Reports</i>	11
<i>The 22nd Bled course</i>	13
<i>Literature Reviews</i>	14
<i>Eurogentest</i>	17
<i>Agenda</i>	18

health, but very useful for those who have to sell something to someone. The invention of new "diseases," the illusion of being able to always prevent the development of complications, has led States or Third Party Paying to try rationing care via a progressive increase in bureaucratic procedures and copayments, that take time away from care to patients. The result of this inflation of the tasks is the need to overcome the pattern of the individual physician, and move towards a model of territorial medicine socio-epidemiological-based in which many general practitioners, paediatricians, and sometimes also some other specialists, work all together to deliver standardized care, controlled by nurses on the basis of rigid protocols, focusing on models of specialized care of the individual diseases. The risk is to loose completely the deepest sense of the complexity and of the time-continuum dimension of the personal care. At the same time the hospital is becoming increasingly reserved for acute patients, discharging the burden of chronic care management (more and more increasing, because of aging population and the inability of medicine to heal) on family doctors and families, left without resources to deal with a real biblical plague.

The economic crisis plaguing many western countries makes unbearable the weight of this situation, especially in the absence of provisional funds to manage disability, and threatens to blow up the universal health care system (11-15). But in addition to these professional, economic and organizational aspects exists a problem of strategic perspective. The need to have evidence pushed towards a cure based on the reductionist method applying the theorem of Pareto that identifies the few factors that explain most of the variance in diagnosis and treatment of diseases. With such a model it is possible to cure 70-80 percent of the population, but the personalized care is another thing. There are clinical and biological factors (not just human or social) which are very important in a single person and unimportant in a population because they are rare. These factors are not assessable and correctable in complex multifactorial condition by the application

All of these requirements, to which the general practitioner is unable to resist because he does not possess economic resources, political influence, and visibility in the media, should be taken into account in the training of future family physicians.

of reductionist models, but through the application of the "System Medicine", an approach which borrows from molecular biology the ability to evaluate a large number of variables each of which has little weight, but which, taken together, makes the difference in individuals (16-18). This is even more true if one considers that the family medicine does not cure specific diseases, but persons with multiple problems connected to each other and modulated by the family and society environment.

All of these requirements, to which the general practitioner is unable to resist because he does not possess economic resources, political influence, and visibility in the media, should be taken into account in the training of future family physicians.

In the training process it should therefore be necessary to implement also theoretical and practical skills to conduct first level diagnostics in primary care facilities (ultrasound, doppler spirometry, for example) and to deal with the diagnostic anticipation expectation that comes, often wrongly misled by media, aimed to reduce patients hospitalization.

In addition, the need for complex territorial organizational models also makes it necessary to learn the rudiments of managerial and human resource management. Family and social disintegration, poverty back, loneliness of the elderly, blur the boundaries of social and health problems in a continuum that needs to be

dealt with knowledge of the tools of social security and the possibilities offered by telemedicine in its various forms: from remote monitoring to remote diagnostics i.e. Whole System Demonstrator preliminary results (19).

And finally there ought not be lacking the techniques that confer future family physicians the ability to communicate not only in doctor-patient relationship, but also with media, in order to get the attention needed to influence public opinion and beliefs of citizens towards health objectives really achievable and sustainable and to support models of medicine truly personalized.

Paraphrasing Edgar Morin (20), the agenda of the next training family doctors should be more geared to Pascal than to Descartes. The more general practice will be strong, not only from the point of view of the social perception of the value of individual physicians, but also of the awareness of identity, the more it will be able to develop its own paradigms and fight those the stakeholders are trying to implement.

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Country Report : Switzerland

By Bruce Brinkley

Well known as a small and wealthy country in the middle of Western Europe, a closer look to Switzerland shows an astonishing complexity and oddities.

Its official name is "Swiss Confederation", a build of 23 independent states (Cantons) of unequal importance.

Two thirds of its 8 Mio citizens speak local German dialects, a fifth speak French, a tenth Italian.

The language barrier is a major problem when these culturally distinct communities must work together...

Furthermore, health and education are not federal, but cantonal prerogatives, meaning 23 health and education systems.

Very few tasks in these areas are assumed at a national ("Federal") level, among which the health insurance law.

This is why such a considerable amount of energy and means is spent trying to coordinate the politics of little kingdoms fiercely jealous of their power.

Health system in short

Since 1996 all inhabitants must subscribe to a so called "basic" health insurance,

covering ambulatory and hospital costs, but not loss of income like in social security systems.

Insurance premiums are not proportional to income, but the same for all. Their actual levels (close to 300 € per month, with differences by Canton of course) are cause of inequities in access to care because of non-payment, requiring complex welfare interventions.

The health system offers top-quality care, with numerous world-class hospitals less than 100 km apart : every Canton able to pay for it wants to have the best and prestigious hospital, staffed with the many foreign nurses and doctors attracted by the high wages prevailing in the country and the value of the Swiss currency.

Like in all western countries, health-care personnel shortage is severe, but its consequences are, luckily for us, dampened by the "brain-drain"...

The public-sector (Cantonal) consists almost exclusively hospitals (teaching policlinics exist within the five University Hospitals), whereas the private sector dominates the ambulatory care, with self-employed doctors.

In short, one of the best and most costly systems in the world...

For more details, see the 2011 report by WHO and OECD on the Swiss health system.

Medical Studies

Switzerland harbours ten Cantonal Universities and two prestigious Federal Polytechnic Schools (EPFL and EPFZ).

Five universities have medical faculties, all now participating to the Bologna Process and offering Bachelor and Master degrees in Medicine.

Universities are Cantonal, therefore totally independent in their prerogatives, and teaching programs...

After a long gestation, a "Swiss Catalogue of Learning Objectives for Undergraduate Medical Training" was agreed on and published in 2008, revised in 2011 (see footnote).

Medical studies take six years to complete, one of the last years (5th or 6th) is devoted to loosely organized internship rotations.

Students completing their studies are awarded a Master Degree in Medicine of the University of (Canton).

At a national level, the Federal Office of Public Health organizes a Federal Licensing Exam giving the right to "practice under supervision", i.e. entering postgraduate training. It is also the key for international recognition of the Swiss medical diploma.

Postgraduate Training

The Federal government is responsible for postgraduate training, and has accredited the Swiss Medical Association to supervise the postgraduate education: training programs, learning objectives and evaluation for the 44 medical specialities.

Postgraduate training is a professional training, not an academic degree. Reality is of course a bit more complex, as hospital heads are often also University Professors. Postgraduate training is meant to be, generally, five years long (six for surgery).



But the time between the end of medical studies and obtaining the title of the specialist title is closer to eight years, due to many factors: the absence of organized curriculums, the practical advantages of being employed by a hospital, lack of medical workforce in the lower hierarchical positions.

This specificity is an important contribution to the quality of medical training, but also a heavy load for the Cantons carrying the costs of hospital postgraduate education. It may well change in the coming years. Another specificity is that postgraduate training is a public sector duty, and therefore almost exclusively hospital-based.

General Practice and Internal Medicine

The Swiss Society of Internal Medicine was founded in 1961, aiming to offer a higher training and medical education than the average GP would get, for hospitalists and internists in ambulatory sector. At this time Internal Medicine was regrouping general internal medicine and sub-specialties (cardiologists, gastroenterologists, etc). With the occurrence of a postgraduate program in General Practice and the later separation of the subspecialties from Internal Medicine, the distinction between General Internists working in the ambulatory sector and Family Physicians was more and more difficult to justify, and to understand by the patients.

Merging of the two societies and their training programs (effective in 2012) is now a very hot and busy topic in Switzerland, a real cultural shock for older doctors who were brought-up under the traditional animosity and mutual contempt between internists and GP's... This new, strong association is aiming to strengthen the key concept of Generalism, in hospitals as well as in ambulatory care.

General Practice/Family Medicine in Undergraduate Medical Education.

Academic General Practice/Family Medicine

As in many European countries, having General Practice/Family Medicine admitted as an academic discipline was a long



The Swiss GP/FM is a highly qualified practitioner, with five years of postgraduate training.

and difficult struggle for the last twenty years. Although the five Medical Faculties have now a Professor to champion our discipline at academic level, the structures lack staffing, funding and tenure tracks for tomorrow's FM academicians.

Reform of medical education with implementation of Problem Based Learning was a real opportunity that we seized enthusiastically.

Undergraduate teaching has been and is still a strength, thank to the many engaged and competent colleagues devoted to teaching and hosting generations of students in their daily practice.

Now, establishing a robust academic position is more depending on the development of a specific research of international quality level.

Family Medicine/General Practice in Postgraduate Medical Education

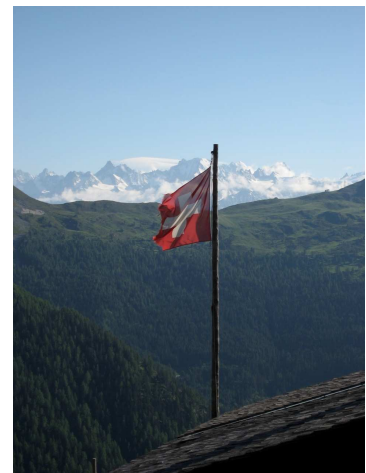
The Swiss GP/FM is a highly qualified practitioner, with five years of postgraduate training. But training in his specific setting, i.e. ambulatory practice, is still at a confidential level of development. The reason for this particularity is historical: until 2011, funding of postgraduate medical education was included in the funding of the hospitals. And the latter had no reason to forward part of these funds to ambulatory care, largely dominated by the private sector.

Setting up the idea that the postgraduate education of Family Physicians should be done in their future work setting, i.e. ambulatory care, was a major achievement of the Swiss General Practice Association after twenty years of hard work.

Since 2012, funding of the postgraduate education of physicians has been individualized and funding for training of young colleagues in our GP practices is now available, but as everywhere, changes take time...

And for the future

Working hard to improve the image of GP/FM among students and medical faculty academics (remember Kos 2005 and the Vasco de Gama outing: "Keep General Practice Sexy!"), setting up a network of training practices and their accreditation, bringing their teaching to a level of excellence, consolidating academic structures, initiating political pressure towards lowering income differences among specialities, are a few examples of the complex tasks the Swiss GP's organizations are now vigorously working on and coordinating, with a very strong popular support. Our patients are our best allies!



Additional readings and references

- See the [three excellent films by S. Gindrat](#) showing the daily work of happy Swiss GP's (<http://www.atthedoctorside.ch>)
- WHO and OECD report on the Swiss health system (<http://www.bag.admin.ch/themen/internationales/11287/12297/index.html?lang=en>)
- Swiss Catalogue of Learning Objectives for Undergraduate Medical Training (<http://scllo.smifk.ch>)

Country Report : Albania

Family Medicine in Albania 2014: work in progress

By Eralda Turkeshi

The aim of this report is to provide a snapshot of current developments and challenges of family medicine/general practice in Albania.

Since 2004, through its long term strategy for healthcare, the Ministry of Health in Albania has recognized that many of the current healthcare challenges in Albania would be best addressed by a primary care oriented healthcare system with qualified family physicians as the first line physicians in the community, so the development of a family medicine based primary care model has been the priority of the healthcare reforms in Albania in the past decade. The Reform in Primary Health Care that was launched in December 2006 aiming to improve performance and financing in primary care has been supported by several international funding agencies such as USAID, World Bank, etc. As a result of this joint efforts of the Albanian healthcare authorities and key international health and aid organizations, several achievements have been accomplished by the primary care reform in Albania especially in regard to its the financial and organizational aspects :

- Autonomous health centers have been established to contract with the Healthcare Insurance Institute (HII) for the provision of primary care services in their area.
- The package of basic primary care services has been developed and included in the contract of the health centers and primary care physicians with the HII. The package is a comprehensive

description of the scope of care that should be provided in primary care by general practitioners/family physicians (GP/FPs) and nurses including 7 core areas: emergency care, adult care, pediatric care, women and sexual health, care for the elderly , mental health and prevention & health education.

- Reinforcement of referral system to secondary care through the primary care has been given a lot of emphasis aiming to increase access to primary care services and regulating the overloaded referral system of the hospital specialists
- Recently quality indicators of the work of the primary care physicians have been defined and are being implemented esp. in regard of care for chronic diseases such as diabetes and hypertension as well as women and child health.

Beside the upgrade of organizational and financial aspects of the primary care, the international projects supporting primary care development in Albania in the past decade have also invested a lot in the re-training of the primary care workforce. The majority of physicians working in primary care are graduates of the medical school with no postgraduate training in family medicine or specialists in general internal medicine, pediatrics or gynecology. Through the support of the USAID project Pro-Health approximately 600 primary care physicians (almost 50% of the primary care physicians in Albania) have received a training package in key clinical topics of family medicine during 2005-2009 (6 out of 12 regions of the country were included in this peer-led training program). The training package with 48 teaching modules was developed by the staff of the department of family medicine of the Faculty of Medicine, University of Tirana with the support of experts of the American Academy of Family Physicians in USA. Through the support of the World Bank this training package as been run for 3 more regions in Albania during 2012.

Although there have been extensive efforts and funding involved in developing this training package in family medicine for the practicing primary care physicians and recommendations to use it as apart of a conversion/bridging package for the current primary care workforce, up to this date , there is still no official recognition of such a package. As recommended in the Framework for Family Medicine Development in Albania that was developed through the USAID funded primary care project and endorsed by the Ministry of Health in 2009, this bridging package to convert the current primary care workforce into GP/FPs and the decision to stop the further employment in primary care of non-specialized GP/FPs is a very important decision that has been on-hold for too long now in Albania and is a major hurdle for the further improvement of the quality of primary care services albeit all the organizational and financial improvements of the past decade.

No sustainable change in primary care and health care in Albania can take place without serious and continuous commitment to the medical education and formation of its workforce. System and organizational level changes need to go along with educational changes.



None can be successful without the other. So it is crucial for Albania and its ongoing primary healthcare reform to focus its attention to the education of its primary care physicians in all levels of medical education.

Postgraduate family medicine education

Family medicine was recognized as a medical specialty in Albania in 1996 when the department of family medicine was established at the Medical School, University of Tirana through the support of the European Union PHARE program, as part of the government's reform to develop quality primary care in Albania. Since then a two year postgraduate training program has been run by the department with approximately 150 graduated family medicine specialists so far. This is only 10% of the number of physicians currently working in primary care all over Albania.

Family medicine is usually one of the postgraduate training programs that has been assigned a high number of specialty training posts (10-12 posts previously and 24 posts since two years), but it ranks very low in preference. The graduates of the family medicine postgraduate specialty program end up either working in healthcare related governmental or non-governmental organizations with no opportunity for clinical practice or are practicing fragmented family medicine in the current public primary care clinics (working either as GPs for adults or GPs for children). This fragmentation of care is more evident in major urban areas. They are not distinguished from general physicians (graduates of medical school with no postgraduate training) in scope of practice, payment or professional recognition. Currently, there are no significant academic or financial incentives that would attract trainees to the family medicine postgraduate training program even though the posts assigned to this specialty training program have doubled.

Until this year the postgraduate specialty program in family medicine was 2 years

and consisted mainly on rotations of trainees in the clinical wards of the university hospital centre in Tirana with almost no direct responsibility of care for patients. Based on best international models and recommendations, a new 3 year curriculum was developed by the department using the EURACT educational agenda and the WONCA framework of 6 competencies of family physicians. The new program has been approved by the educational authorities and will be implemented with the new cohorts of trainees expected in the spring of 2014. Beside the introduction of a competency based model of curriculum development, the new program also provides the opportunity for trainees to spend a considerable time (44 weeks) in primary care health centers as part of the specialty training program. It is hoped that this new development will provide better training for the future family medicine specialists as well as an opportunity for the current family medicine specialists to get involved in teaching



the trainees in their health centers.

The challenge ahead for the postgraduate training program of family medicine is the translation into practice of its new 3 year curricula in order to provide quality training for the future FP/GPs. The new curricula requires selection and appointment of training health center as well as trainers that would be involved in teaching the trainees. The Ministry of Education and Science in Albania has recently published the criteria for accreditation of medical specialty training programs including criteria for teaching centers and trainers. The criteria for family medicine were prepared with the consultation of the department of family medicine adapting international models and EURACT recommendations. The challenge

will be the implementation of these criteria and especially the negotiation with both the local primary healthcare authorities and the medical school on the recruitment and status of the training centers and the FP/GP trainers as well as the training and support of these trainers.

Undergraduate medical education and family medicine

Although the department of family medicine has been part of the Faculty of Medicine, University of Tirana since 1996, up to this date there has been no opportunity for the department to contribute to the basic formation of the future physicians. The traditional discipline-based 6 year curriculum of the medical school in Tirana is overly specialized and totally hospital based leaving no room for exposure to primary care and the benefits of such exposure both for the formation of the students as well as for their future specialty selection.

In 2012, after the department developed and presented the request for the inclusion in the undergraduate curriculum of a family medicine clerkship and in light of the current efforts of the Faculty of Medicine in Tirana to transform its undergraduate curriculum to comply with international standards, a 3 weeks course in family medicine for 5th year students has been approved and expected to be implemented in the academic year 2015-2016. In the meantime further pursuits are being made to start introducing medical students with some of the core principles and approach of family medicine in the earlier years of the curriculum.

Creating space for family medicine in the currently overloaded undergraduate curriculum that is dominated by an overly specialized and hospital focused model of medicine remains a big challenge to overcome in the following few years, but promising changes in the undergraduate curriculum are underway that will hopefully make room for more primary care exposure in the undergraduate level.

Continuing Medical Education (CME) for GP/FPs in Albania

Since 2010, CME has become obligatory for relicensing of physicians in Albania. The first 5 years cycle will be over in 2015 and relicensing will require the acquisition until then of 150 CME credits (1 hour CME activity = 1 CME credit) to be followed afterwards by 250 credits/cycle. This development has been a major booster to the CME activities in Albania, but still GP/FPs (as the majority in numbers among physicians) remain in need of CME activities that will not only provide the necessary CME credits for them, but will also equip them with the necessary competencies to provide quality primary care services.

Since 2004, the department of family medicine together with an Albanian non-governmental organization and UK and USA based partners offers the annual two day training event for GP/FPs in Albania "Transformation". Due to the increase in demand and the desire to reach more GP/FPs in the north of the country, since 2010 this training runs twice a year (May in Tirana and October in Shkoder). Each year a specific topic is selected and a team of trainers from Albania, UK and USA offers a high standard educational experience for around 160-180 GP/FPs. In 2013, the topic of Transformation has been "Quality improvement in primary care" aiming to help the GP/FPs to look at their work with a critical eye, apply improvements in line with best available evidence and local needs, measure the impact of these improvements and share with their colleagues. Colleagues from Kosovo have recently joined some of the Transformation training weekends.

The challenge ahead for CME activities for family medicine is the development of programs that are based on the needs of GP/FPs, delivered by them or jointly with other specialists and introducing distance/online learning platforms to increase the access by the widely spread primary care workforce.

Family medicine professional association



While both the CME activities and the postgraduate training program in family have increased the capacity of GP/FPs to provide more comprehensive and evidence based primary care services, the primary care system is still quite rigid in providing room for the trained physicians to practice new competencies and enlarge their current limited scope of practice even though the officially endorsed basic package of primary care services is quite comprehensive in its scope. There is a need now for a strong advocacy by GP/FPs for system changes that allow them to practice the whole set of services described in the basic package of primary care as well as advocacy for strengthening the professional status of the GP/FPs as specialists in primary care.

Unfortunately, up to this date no family medicine association has been available to take on this task. The current association of general and family practitioners established in the late 90s has been 'inactive' in the active scene of primary care and family medicine developments described above and several attempts of its 'resuscitation' have failed raising the urgent need for the establishment of a new association of family medicine that will be the educational and professional home for GP/FPs in Albania.

This long awaited development requires a core group of committed GP/FPs ready to take over this task. It will be important and a challenge for the new association to keep



its focus in the professional development of family medicine and the strengthening of the status of GP/FPs in primary care and society rather than being just a union-like organization.

Research and family medicine

Research in primary care esp. in its clinical aspects is almost inexistent in Albania. The encouraging development in the past couple of years has been the start of doctorate program in family medicine at the Faculty of Medicine in Tirana in 2011 run under the umbrella of the public health doctorate program. It is hoped that this development will increase the research capacity in primary care.

In the meantime, CME events like the annual Transformation training as well as the postgraduate specialty training program will need to focus on developing basic research and quality improvement skills of practicing GP/FPs so that gradually the practice-based research in primary care will be developed. This will be important to further strengthen the status of family medicine in Albania.

It has been a long way for family medicine in Albanian since 1996 with the establishment of the department of family medicine. While major changes and improvements have taken place in primary care providing more opportunities for family medicine to develop as clinical and academic specialty, they have progressed very slowly and still many challenges lie ahead calling for clear vision, engagement, collaboration and perseverance as well as political will to achieve the aim of making family medicine the core of healthcare in Albania not just in paper, but also in practice as this is the only way to improve the healthcare system and the health of the whole population in Albania.

Main article

Researching the teaching and learning of communication skills in the vocational training of General Practitioners.

By **Marc Van Nuland**

Doctor-patient communication is at the heart of daily medical practice, especially in general practice. During consultations general practitioners (GPs) have to master four inextricably linked aspects of their work which together determine their overall clinical competence, namely knowledge, communication skills, problem solving and physical examination. This means that communication is not merely an optional extra, it's a core clinical skill. This has also been recognized in the EURACT educational agenda¹. Despite the recognized importance of mastering communication skills there seems to be a problem in the teaching and learning of these skills: on finishing vocational training young GPs perform below expected levels and older GPs with a lot of experience, but mostly without any prior communication training, aren't doing that much better. These considerations made me to start doing research related to the teaching and learning of GPs' communication skills and I specifically focused on the period of vocational training. There are good reasons to believe that this phase of learning is of paramount importance in the development of a personal consultation (and communication) style.

What do we learn from published trials?

To begin with it seemed interesting to evaluate the existing literature regarding controlled trials that aim to examine the outcomes of educational interventions aiming to improve communication skills of general practice vocational trainees. We therefore performed a systematic and thorough literature review in order to know 'what works' during vocational

training². Unfortunately, the number of studies fulfilling our strict inclusion criteria was rather small (only 6 studies met our criteria) and these studies showed substantial heterogeneity regarding the educational interventions used and the outcome measures used to evaluate the intervention effects, making meta-analysis problematic. So instead of being able to provide an overview of what works and what does not, our review rather revealed the many methodological problems associated with investigating educational interventions in the area of communication in general practice vocational training. As a first reflection I would like to call for a presentation of a clear theoretical framework linking the content and methodology of specific interventions to the tools used to assess the intervention effects in such educational trials, since such a framework is lacking. Such a framework should consider how interventions are expected to realize educational effects in the field of communication skills acquisition and which endpoints are really measuring the related intervention effects. With the exception of one of our included studies (Greco et al. 2001), all other studies poorly addressed this relationship or used discussable assessment procedures. A second reflection relates to the interpretation of the relevance of the obtained 'statistically' significant intervention effects. Are these observed differences between study and

control groups also 'clinically' (or 'educationally') relevant and this both in short and long term? This issue was also poorly addressed in most of the included studies. A third reflection regards the lack of a learner-centred approach in the training strategies that were evaluated in the studies included in our review. Interventions not suited to the learning needs and preferred learning methods of individual participating trainees may jeopardize the educational effect of a 'good' training course that has proven to be effective in other circumstances. Moreover, aspects such as diversity among trainees (in terms of needs and preferences) and training fatigue should also be considered.

This is suggesting that 'learner-centred' educational interventions are to be preferred to the more traditional preference for 'skills-centred' interventions. A final reflection relates to the hidden curriculum. This was not taken into consideration in most of the investigated studies, so that its subversive effect may be underestimated. If trainees are confronted in their daily practice with practice trainers (and other doctors) who conducts their consultations in ways that differ from what trainees are being taught through specific educational interventions, the educational effect of such



such interventions when measured by trainees' consultation behavior may be severely reduced.

What are the views and experiences of general practice trainees?

We examined the views and experiences of general practice vocational trainees in relation to their learning of communication skills by means of a qualitative focus group study³. The main findings of this study were that trainees value communication skills but that these are often not a priority within training practices, that many contextual factors need to be taken into account when considering to assess the communication skills acquaintance both when they are observed within daily practice and when they have a summative assessment in more standardized situations, like during OSCEs. Finally, our study showed that training would probably benefit from a learner-centred approach. Based on the qualitative analysis of the transcriptions of the focus group discussions we also constructed a framework that may be helpful to better understand the ways in which trainees learn and apply communication skills within their training practices. Especially worth mentioning is that trainees voiced important problems in relation to their training practices. It appeared that communication skills were scarcely addressed at all in those practices unless trainees mentioned them themselves. Further on it appeared that some practice trainers were not interested in paying attention to communication skills. This is in line with the observation of Ruiz Moral⁴ that trainees working in training practices where the trainer had received prior communication skills training appeared to have greater improvements in communication skills acquisition. These observations may explain part of the hidden curriculum effect and are strong arguments to focus interventions not only at the level of trainees but also at the level of the trainers. Another related reflection regards 'integrated skills learning'. The learning of consultation guidelines in the undergraduate period, like many other types of learning, is basically

The hidden curriculum was not taken into consideration in most of the investigated studies, so that its subversive effect may be underestimated.

presented separate from other learning activities. This means that the vocational training period in training practices is the period par excellence for trainees to integrate all the knowledge and (clinical) skills that they have learned. If, however, practice trainers are not interested in communication skills or if they are not convinced that they deserve substantial attention during the training period, there is a significant chance that the training will focus mostly on other priorities and this will then take place at the expense of addressing communication skills. Real integration of what has been learned previously would mean simultaneously integrating the case-specific medical knowledge, clinical reasoning, technical skills and more general communication skills all at once. This constitutes a real intellectual challenge for both trainees and trainers. This stage-specific challenge may also help to account for the seemingly weaker 'training effects' found among vocational trainees when compared to training effects found among undergraduate students or with qualified physicians.

What can be learned from the comparison of two communication assessment tools?

In search for an appropriate assessment instrument to evaluate the communication skills of our trainees we wondered to what extent two instruments that have been rated by experts in the field among the better communication skills assessment tools⁵ had convergent validity. Our comparison of communication assessment tools in a setting with simultaneous direct observation in an OSCE was a novelty in the medical education literature. We choose to compare the older Maas Global with the more re-

cently developed Common Ground instrument and found that they are comparable in terms of identifying weak trainees and they showed similar case-specificity⁶. By contrast, the tools proved to be different in terms of item content, internal consistency, variance of scores within trainees, variance between trainees and inter-rater reliability. Multi-level analysis showed a significant item-rater interaction effect for both tools, shedding new light on the complexity of inter-rater agreement in communication assessment. Our results helped in choosing between the two tools for use in our communication skills curriculum development including the design of a new communication skills OSCE (see below). We finally chose the Common Ground because of the smaller number of items to be rated, the item content which was closely related to the essential communication tasks in clinical communication⁷ and the communication model (Het Leuven Consultatiemodel⁸) that has been instructed during vocational training. Apart from using the instrument in our OSCE, we also advocated its use during communication skills training, and during undergraduate clerkships in general practice.

Choosing the same tool at different instances offers the advantage that the same typical words, concepts and expressions characteristic to the tool will be used by all those involved in training: students, communication trainers, practice trainers and finally raters in the communication OSCE (see below). Using the same tool at different points and over a longer period of time will result in constant progress in its implementation and allow the tool to be transmitted to others by those who have acquired experience in using it.

How to improve the utility of a newly developed ten-station communication OSCE intended for summative assessment of vocational trainees?

The utility concept of assessment procedures has been introduced in medical education literature by van der Vleuten^{9,10}

and emphasizes that not merely reliability and validity issues should be addressed, but that acceptability, feasibility, costs and educational impact should also be considered.

So we investigated all these utility components in a newly designed ten station communication skills OSCE¹¹. Based on the results of our focus group research we also provided the trainees with feedback from both standardized patients and faculty members who were approached to rate the trainees. Supplementary we compared the use of a generic assessment instrument (Common Ground) with the use of station-specific checklists. Using the Common Ground in all stations proved more reliable than using the station-specific checklists or both. Furthermore costs would be 6,5% lower when station-specific checklists were not used. Provision of narrative feedback seemed to enhance the educational impact but it also increased the costs with 5%. Since 2008 our communication skills OSCE has been implemented in the general practice vocational training program at the KULeuven. It takes place near the end of the first year of the three years of vocational training and since 2011 passing this exam has been a requirement for continuation of general practice vocational training. Evaluating communication skills in the first year of vocational training rather than close to the end of training increases the likelihood that the assessment will have a formative effect because trainees still have to work and learn in training practices for the following two years. Assessments at this point may help trainees to identify their learning needs and make them more intensely aware of communication skills during subsequent training. This is closely related to the perspective that 'assessment drives learning'. The questions of whether the implementation of the communication OSCE has meant that trainees focus more on communication skills and whether trainees' learning practices in subsequent years were really altered by their communication OSCE results, however, remain unanswered because we didn't have the opportunity to investigate these effects in our research project.

Communication skills are a core clinical skill and they deserve special attention during general practice vocational training. Interventions aiming to improve trainees' skills should rely on a theoretical model linking how and what is learned to relevant outcome measures.

But we did investigate one specific way of improving the educational effect of the communication OSCE. We used the results of the OSCE to find those trainees who are most in need of additional training in terms of their communication skills. In a pilot project conducted in the second year of training those trainees with low scores on the OSCE were invited to participate in remedial teaching. The main objective of this pilot project was to explore the feasibility of an individually tailored coaching program and to disclose weaknesses that should be taken into account if such 'remedial teaching' were to be implemented in future training. It appeared that the participant drop-out rate was substantial (only 10 of the 17 trainees approached actually participated). For those who participated in the evaluation of this pilot project, the learner-centred approach was much appreciated and it transpired that trainees were all using different learning methods, which suggests that the learner-centred approach was useful. Furthermore trainees expressed the view that, thanks to the project, communication skills were once again on their agenda and they valued the provision of a comprehensive toolbox of learning strategies. It became clear from evaluation of the pilot project that further improvements would be expected if the project had been introduced more clearly at the outset, if greater attention were paid to optimizing the trainee-supervisor relationship and if practice trainers were more involved in contributing to the project, although some

of the practice trainers appeared to show little interest.

Implications for educational practice

Communication skills are a core clinical skill and they deserve special attention during general practice vocational training. Interventions aiming to improve trainees' skills should rely on a theoretical model linking how and what is learned to relevant outcome measures. Furthermore these interventions will surely benefit from a learner-centred approach and from taking the hidden curriculum in account (e.g. by involving the practice trainers). Good assessment procedures will put the trainees' learning of the skills on their agenda. Assessments in earlier stages of training permit trainees to detect their learning needs at a moment where they still have the time and possibilities to bridge the gaps in their communication competence.

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Good assessment procedures will put the trainees' learning of the skills on their agenda.

Thesis Report

Training in genetics for primary care health care workers.

**Thesis by EJF Houwink
VU Amsterdam**

Reviewer Jan Degryse

“Medical professionals in primary care are increasingly expected to deliver genetic services in daily patient care and need to be prepared for patients asking for information and advice on genetics. This requires appropriate skills and knowledge of genetics needed for daily practice. However, postgraduate (physician training) and master (midwifery training) programmes in primary care and public health are currently failing to meet these perceived educational needs. Improvements in genetics education for primary care providers are thus needed to keep up with the rapid developments in genetics/genomics.

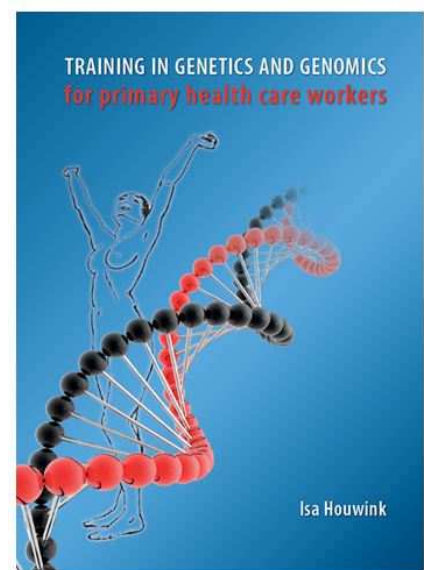
The main objectives of this study project were to reflect on current genetics/genomics developments with primary care workers, to help them identify their learning priorities and to evaluate

three CPD modules in oncogenetics developed in collaboration with multidisciplinary team of general practitioners (GPs), educationalists and clinical geneticists familiar with genetics in primary care. Key factors for successful future training were identified and could make integrating genetics step by step in daily genetic primary care possible.

The results of the studies presented in this thesis have provided better insight into how non-genetic specialists (e.g. GPs and midwives) perceive the increased role for genetics in primary care and consequently recognized the importance of genetics education. The responsibilities of primary care providers with regard to genetics require further study. The GP-specific oncogenetic CPD modules supported by the Dutch genetics website huisartsengenetica.nl, suggest to be a feasible, satisfactory and clinically applicable method to improve oncogenetics

competences in daily practice and suggests to be an adaptable and effective educational framework to inform future training activities with the ultimate aim of improving genetic medical care.”

To download the thesis, click <http://hdl.handle.net/1871/49347>



Thesis Report

'Training Challenging the unlimited exposure. The patient mix of GP trainees and their trainers: gaps, disparities and active steering'

**Thesis by Jip de Jong,
University Amsterdam (AMC-UvA),**

Reviewer Guy Gielis

Jip de Jong wrote an intriguing dissertation about the influence of patient mix on learning processes and learning outcome. He did this in a scientific way and with the eye of a pragmatic learning process coach.

Via a systematic review he concludes that there's a positive relationship between patient mix and positive self-assessment (self-confidence, learning outcomes, efficacy and instructive quality) but that there's no approved relationship between patient mix and formal assessment. More experience doesn't lead automatically to more competences.

He analyzed the patient mix of 73 GP trainees (first and third year) and of 114 GP trainers during two periods of three months. The results:

The number of patient contacts was not significantly different between the first- and the third year trainees. Third-year trainees had a patient mix that was more comparable with the mix of their trainers: more diseases of the blood and blood-forming organs, psychiatric diseases, metabolic diseases and chronic diseases. Differences in patient mix seem at least partly related to year-specific learning objectives.

GP trainers realized three times more tele-consultations and two times more consults and visits than their GP trainees. The patients of the GP trainees presented more symptoms relating to eyes, ears, skin, respiration and minor illnesses. Female trainers and trainees encountered almost twice as many female conditions compared to their male peers. Male conditions were seen more often systematically by male doctors.

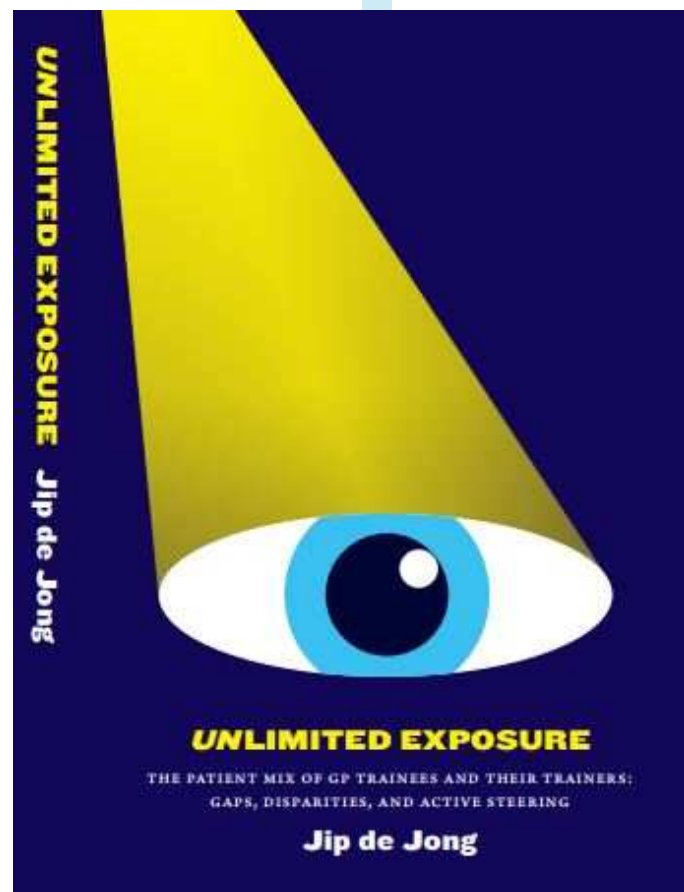
326 training practices returned their answers to a questionnaire about the assigning behaviour of the medical receptionist. Most receptionists considered the patient mix of trainees and trainers to be similar. However, the receptionists reported that they assigned complex and new patients to the trainers more often than to the trainees. A logical choice in accordance with the competences of doctors and the importance of a first contact.

Furthermore Jip investigated whether patient mix can be steered. He set up an interventional study: patients with skin conditions and psychosocial conditions were actively assigned to trainees in the intervention group (n=37). There was no difference in patient volume and patient diversity between the

intervention group and the control group. Only the psychosocial self-efficacy was increased in the intervention group.

Advices for the learning process: Trainers, coordinators and trainees must be aware of areas of low exposure and trainers should ensure trainees handle more chronic, complex, psychosocial and circulatory conditions. Feedback about patient mix in combination with feedback on formal tests seems to stimulate active learning and steered training. In any way reflecting about one's patient mix is advantageous.

To download the thesis, click <http://dare.uva.nl/en/record/429576>



22nd INTERNATIONAL EURACT BLED COURSE

BLED, SLOVENIA 24. 28. September 2013

By Jo Buchanan

This was my third trip to EURACT's course for established educators on Lake Bled, Slovenia and each year I wonder how it will be. Five days is a long time to spend on a course and it is important that participants feel their time has been well spent.

This year's topic, 'Teaching and Learning about Doctors' Wellbeing' was one that attracted more participants than previous courses and the 60 plus participants came from 15 different countries.

The format of starting the day with a plenary session on one aspect of the topic and then spending the rest of the day in small groups worked particularly well this year. The morning lecture sets the scene for the day's work and offers some reflections from the literature. The groups then are offered tasks to help them cover the subject in greater depth.

Jaime Correia de Sousa started the week off with an overview of the work that has been done over the last few years to increase our understanding of the problems with doctors' well being and what suggestions have been made for prevention and management. Jaime commended 'The Canadian Medical Association Guide to Physician Health and Wellbeing' as an excellent resource.

I provided a review of the different strategies that can be used when consulting with doctors as patients and explored our responsibilities when we as doctors present as patients.

Yonah Yaphe's session on the the mental health of doctors and understanding burnout enabled us to explore the causation signs and symptoms of this

important condition. He concluded with some wise words on preventing and treating burnout.

Henri Finnegan ended the taught days in style with a presentation of how we can use the arts and humanities to monitor and support our wellbeing. The work he offered the groups for that day involved reviewing two works of art in depth and each group member sharing with the group a hobby, work of art or poem that sustained and nurtured them.

The groups quickly gelled and we were soon discussing the issues that we have with colleagues who appear to be unwell and developing strategies to help participants manage these difficult situations. As the week progressed we started to explore our own issues with burnout and how we have managed this.

As always a highlight of the week was the visit arranged by Bled Health Centre to doctors who are patients there.

It was instructive and inspiring to hear how retired doctors who had worked hard for so many years had managed to deal with the inevitable problems of professional life.

The Bled course has an active social programme which is relaxing and refreshing – particularly relevant this year given our topic.

By the end of the week each group had developed a teaching module to take back to their own country and we concluded on Saturday morning with presentations about these modules and finally feedback from the participants. It was clear that this had been a very useful course which gave many participants new tools to use in their teaching and in their professional life.

Date for your diary: 23rd International Bled Course: Teaching and Learning about the Scope and Limits of General Practice' Bled, Slovenia September 23-27 2014



Literature Reviews



Writing an article about feedback. What is important to know about it?

Reviewer Natalia Zarbailov

Veloski J, Boeks JR, Grasberger MJ D, Evans A & Wolfson D. Systematic review of the literature on assessment, feedback and physicians' clinical performance?: BEME Guide No. 7. Medical Teacher, Vol. 28, No. 2, 2006, pp. 117-128

Summary

The use of feedback to enhance physicians' clinical performance has been debated in the literature for over 30 years. The authors located 3702 articles by searching 11 electronic databases, by performing Internet searches and by checking the reference lists of published articles. Screening and initial attempts to review eliminated over 80% of these articles, which were either non-empirical, involved non-physicians or used the term feedback to refer to other types of interventions such as prospective reminder systems.

Of 220 remaining empirical studies on feedback, nearly two-thirds were set aside because they involved a combination of feedback and other interventions. Examples of the other interventions included educational programs, workshops, guidelines, academic outreach visits, reminders, patient education and the use of local opinion leaders. The designs of these studies and the reports of results made it impossible to isolate the effect of feedback from the other interventions. However, about three-quarters reported positive effects for feedback in

combination with the other intervention. Another group of studies set aside involved resident physicians in training. The training level of the residents was not usually specified, and it was impossible to gauge the extent to which the residents' performance was influenced by other residents and fellows at higher levels of training and by attending physicians. Finally, the authors set aside another small set of studies that involved studies of hospitals or group practices in which the unit of analysis was not physicians and the outcome variable could be affected by a number of different factors in the environment in addition to physician performance.

Eventually 41 studies were selected and systematically analyzed these involved baseline measurement of physicians' clinical performance, feedback and follow-up assessment. The physicians' performance was usually measured by reviewing medical charts or billing records and was frequently related to clinical processes or test ordering. It was found that feedback provided by administrative units or professional groups was more effective than feedback provided by research teams. Furthermore, it was noted that the studies lasting two years or more were more likely to have a positive effect. The results of this review of published studies indicate that feedback does have a positive effect on physicians' clinical performance. The most effective feedback is provided by a

credible, authoritative source over a number of years.

Comments

I found this article a good example of the methodology required for a systematic literature review.

The *purpose* of the article was to summarize evidence related to the impact of assessment and feedback on physicians' clinical performance. This study deals with four issues: the definition of feedback and assessment; a description of the methodology of a systematic literature review; how feedback affects physicians' clinical performance and the variables that influence this; recommendations for the designers of future theoretical as well as practical studies of feedback.

The study began in the Jefferson's Center for Research in Medical Education and Health Care and this probably assured the correct *methodology*. While working on the search for articles related to the question, "what is the impact of assessment and feedback on physician performance?" the authors found that this process of testing the coding form and associated procedures strengthened their understanding of the operational definitions of assessment, performance and feedback. They were also able to identify a set of moderating variables, or conditions, that affect the relationship between feedback and physicians' performance were made public, and whether the feedback was

Literature Reviews

written or verbal. Studies of feedback with other interventions were also mentioned.

What do the findings mean? The findings of this study support the use of feedback to influence the clinical performance of physicians. The results indicate that large, systematic efforts at feedback supported by an authoritative source and sustained over time have a greater chance of success than short-term interventions introduced as research studies.

The process of developing and implementing the protocol for the review and related findings has implications for readers of future studies of the impact of feedback on physician performance. When reading the literature, readers must ask the following four questions: How was physician performance measured? What was the source of the feedback and did the physicians view it as important? How long did the feedback continue? Did the study isolate the effects of feedback from the effects of other, concurrent interventions?

Finally, these results have implications for the designers of future theoretical as well as practical studies of feedback alone. More carefully controlled studies that separate the effects of feedback from other concurrent interventions will better inform policy-makers and the profession about the moderating effects of some important characteristics of feedback.

Well-designed studies are needed to examine the effects of characteristics of feedback and the process of communication with physicians. Relevant characteristics include the

length, format and content of feedback reports.

Related characteristics include the level of physicians' involvement in the design of the feedback system, the nature of standards used to judge performance, and the mode of communicating the feedback to the physicians.

This review of over three decades of literature has *several limitations*. The first is related to the lack of a standardized nomenclature to describe the two basic constructs of feedback and physicians' clinical performance. The second limitation is related to the articles themselves. In general, the uneven quality of technical writing presented barriers when individual articles were reviewed. The lack of standardized nomenclature made it difficult to compare studies, and impossible to compare effects quantitatively across studies. The uneven level of detail in reporting methods and results interfered with the process of data extraction. Finally, the wide array of outcomes measures made it impossible to compare effect sizes across studies.

This review has the potential to *guide future investigators* as they design studies related to feedback and physician performance and to evaluate future research. One important finding of this study is that feedback can have a greater impact when it is provided over a period of several years. Therefore, the most effective new studies of feedback will involve

interventions over an extended period of time.

The most effective studies will involve experienced, licensed physicians who have completed their medical education.

Conclusions of the article are very clearly formulated and precisely focused on the future use of feedback for physicians' clinical performance improvement.

Implications for training

The systematic review of the literature is time a consuming process but you can analyse the whole picture in time. If you are interested to learn how to organize the process correctly, if you want to know more about giving and receiving feedback, if you plan to study the effects of feedback, if you wish to identify the best design for your study go and read this article.



Literature Reviews



Receiving and using feedback—is something missed in between ?

Reviewer Natalia Zarbailov

Sargeant J, Mann V, Van der Vleuten C, Mestsemakers J. Reflection: a link between receiving and using assessment feedback. Adv in Health Sci Educ (2009) 14:399–410 DOI 10.1007/s10459-008-9124-4

Summary

This article focuses on the study of the reflection that occurs when physicians receive multi-source feedback and the effectiveness of that reflection in contributing to the acceptance and use of the feedback. The study was carried out by applying semi-structured interviews using open-ended questions to explore how physician's reacted to Multi-Source Feedback [MSF]. The results of the study emphasize the importance of understanding how the reflective process can be enhanced, both for professionals in practice and learners in formal programs. The authors also suggest that for feedback to improve practice, the facilitation of reflection may be of equal importance to the provision of effective feedback. The "Reflection and decision making" step is introduced into the formative assessment model.

Comments

I found this article easy to read and useful for people who give or receive feedback. When we give feedback, we expect the person who receives it to change. However, it is not always accepted and can lead to an opposite effect, where the person rejects any idea of

changing his or her own performance. So, feedback could have a positive or negative effect. In the article you can find an answer to the question "what influences our reaction to feedback and how we use it?"

Authors based their study on an existing model of formative assessment. According to this, there are three processes or steps, commonly understood to be involved in a link between receiving and using assessment feedback: assessing the performance, providing assessment feedback, and using the feedback for learning and change. The authors conducted a qualitative study based upon the principles of grounded theory. To better understand the connections between being assessed, receiving assessment feedback and using that feedback from the recipients' perspectives, authors conducted studies of 144 family physicians in one type of formative assessment program who had received multi-source feedback. From the pilot study 20 physicians were randomly selected, by confidential code, from each of 3 groups—those receiving the highest, mid-point and lowest scores in standardized MSF program. Authors received positive responses from 28 physicians: 12 in the highest-scoring group, 10 in the mid-point group and 6 in the lowest-scoring group.

In the results section the authors present the content analysis of the semi-structured interviews with participants. The participants described a series of stages or phases in response

to their feedback and evoked extended reflective responses at each stage. Notably, each phase appeared to stimulate reflection. Many participants described the importance of facilitation in enabling assimilation, acceptance and use of the feedback.

The discussion relates these findings to other studies to develop our understanding of how to ensure physicians are able to use MSF findings. The facilitation of reflection upon feedback is strongly suggested as a positive influence for assimilation and acceptance. I think that the main success of this article is its "theoretical-practical" outcome. Drawing from their own findings and the literature, the authors propose adding a fourth step to the three-step model proposed in the introduction to this paper to aid understanding of the related phases of performance assessment, provision of feedback and use of feedback for improvement.

This is "Reflection and decision-making" and occurs, as seen from these results, upon receiving feedback and before the final step of acceptance and use. This step appears instrumental to the integration of external feedback with self-perceptions and feedback acceptance and use and was proposed by authors for the first time. This is an original article which shows that by performing an analysis of a phenomenon in depth in order to understand things better, it is possible to find links in the logic chain that have been missed.



EuroGentest is a project funded by the European Commission to harmonize the process of genetic testing, from sampling to counseling, across Europe. The ultimate goal is to ensure that all aspects of genetic testing are of high quality thereby providing accurate and reliable results for the benefit of the patients.

As patients' understanding of the results and consequences of a genetic test is an integral part of the testing process, EuroGentest aims at improving the quality of counselling and health services in genetic testing across Europe. The information in this section of the website is to help professionals in the field of genetic testing to provide these services to their patients.

EuroGentest is a project funded by the European Commission to harmonize the process of genetic testing, from sampling to counseling, across Europe. The ultimate goal is to ensure that all aspects of genetic testing are of high quality thereby providing accurate and reliable results for the benefit of the patients.

Website: www.eurgentest.org.

The clinical utility Gene Cards as well as the patient leaflets are valuable resources for every clinician. Of particular interest for EURACT members is a document called: [Suggested core competences for health professionals who are generalists or specialising in a field other than genetics](#)

Two nice publications on this topic :

Houwink EJ, van Luijk SJ, Henneman L, van der Vleuten C, Jan Dinant G, Cornel M. Genetic educational needs and the role of genetics in primary care: a focus group study with multiple perspectives. *BMC Fam Pract.* 2011 Feb 17;12:5. doi: 10.1186/1471-2296-12-5.

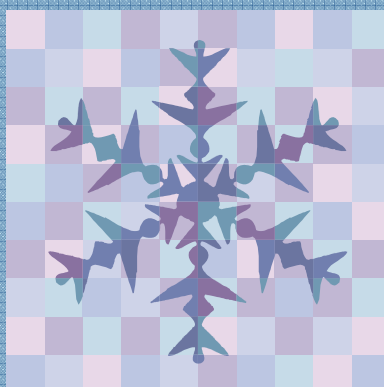
<http://www.biomedcentral.com/1471-2296/12/5>

Houwink EJ, Sollie AW, Numans ME, Cornel MC. Proposed roadmap to stepwise integration of genetics in family medicine and clinical research. *Clin Transl Med.* 2013 Feb 16;2(1):5. doi: 10.1186/2001-1326-2-5.

<http://www.clintransmed.com/content/2/1/5>

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CONFERENCE IN LISBON

2-5 July 2014



Agenda

EURACT

24-26 april 2014

Euract Council Meeting
Skopje, Macedonia

November 2014

Euract Council Meeting
Porto Lisbon

WONCA – Europe

2-5 July, 2014

Lisbon, Portugal
Theme: “New routes General Practice and Family Medicine”
www.woncaeurope2014.org

EGPRN

6-11 May 2014

Barcelona, Spain
« *Preventive Activities in Primary Care; an approach from clinical and health services research.* »

25-26 October 2014

Heraklion, Greece
The theme for this meeting is:
“*Economic crisis and research in General Practice*”.

OTTAWA CONFERENCE

25-29 April 2014

Ottawa, Canada
« *Transforming Healthcare through Excellence in Assessment and Evaluation* »

AMEE

30 August -3 September 2014

Milan, Italy
The theme for this meeting is
« *Excellence in Education* »



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Responsible editor:

Prof. dr. Jan Degryse—K.U.Leuven/UC Louvain

Phone: +32 16 33 75 37

Fax: +32 16 33 74 80

E-mail: jan.degryse@med.kuleuven.be

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- Jan Degryse, Professor of Primary Health Care and Clinical Epidemiology KUL/UCL Belgium.

<http://www.euract.eu/>