Annex 1

Review of national educational activities after EURACT Council meeting in Kusadasi, 2001

EURACT Council meeting
April 4 – 7, 2001
Eger, Hungary

ALBANIA

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Rr. Durresit, P. 85, Sh. 7, N. 57
Tirana

The preliminary work for setting up the department of family medicine started in 1994. On January 1995 two of the lecturers were sent for training (3 months) in University of Utah, Salt Lake City, USA. On October 1995 with the support of PHARE Project, 3 lecturers were trained for 9 months in the Royal Free Hospital School of Medicine, University of London and one in Brussels, Belgium.
Actually the department of family medicine is one of the departments of Faculty of Medicine and provides postgraduate training in family medicine. There are four full-time lecturers and several part-time lecturers in this department.
The postgraduate training in family medicine in Albania started on January 1997 (duration two years). Until now 45 physicians have completed the training in family medicine. The department plans in the near future to increase the number of physicians participating the training and to extend the training in three years (one year will be spent completely in community under the tutorial of already trained physicians). The department will try also to introduce family medicine as an academic discipline in the curricula of medical students.
Short term training (3 months) for general physicians was supported by PHARE project and was carried out by 4 groups of doctors (4 doctors each) in Tirana, Shkodra, Korca and Vlora. The trainers were trained for 6 months in Glasgow, Scotland. Nearly one third of the physicians in primary care (more than 500) were trained through this programme.

AUSTRIA

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Pregraduate education

The new medical curriculum will start in autumn 2001. The preparations at all 3 universities (Vienna, Graz and Innsbruck) are still going on. The first year will be an entrance phase for the students with a summative examination at the end.
Family medicine / General Practice will be part of this orientation phase. The number of students who will start studying medicine in Vienna will be about 1400 (in Graz and Innsbruck about 500 students each university).
The examination at the end of the first year should cut down the students number to about 600 in Vienna and those students should have the chance to get a good medical education with a problem-oriented curriculum within a shorter study time compared to now.
From autumn 2001 all students have to pay 800 Euro per year for their studies.
Within the universities big changes are going on and big discussions are opened (shorter contracts for assistants and professors, more women for top posts, more money for research, better teaching for the students...etc.)

Postgraduate education

From January 2001 G.P. Training practices are financed for the trainees from the Ministry of Health at any time. So that trainees can come to the G.P. Training Practices right after graduation (while waiting for the Vocational training post in hospital).
There is still no payment for the trainer of the Training practice for teaching.
Training courses for trainees have started all over Austria.

The Austrian Society of General Practice (ÖGAM) and the Doctor's Chamber are offering and developing the final exams of the V.T.(written short answer questions) in a very good and well accepted way.
Within the Doctor's Chamber a discussion for better training in hospital for the G.P. trainees has started. The head of the departments want to know what the needs of hospital training are for the future G.P.s

CME

Quality circles are working and in development.
Besides the traditional form of all sorts of CME projects the so-called „bedside teaching" was a new success. It brings the G.P.s in better contact with specialists in hospital (CME in the ambulatory and bedside care of the hospitals).
Training courses for better communication with people from other countries are in development in Vienna.

Politics

The vote in the town of Vienna made the Social Democrats the leading party again.
The loss of the Freedom Party brings discussions on all levels.
Many changes have to be accepted everywhere and I think we get used to it.
The confusion with the payments for the patients when they need ambulatory care in hospital does not make medical treatment easier.

BELGIUM

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Basic Medical Education

The curriculum reform proceeds at all Flemish universities: blocks and lines means integration of related topics into blocks of a limited number of weeks, and lines all over the different years in a concept of growing experience. In our university, we are very much involved in the « person, community and environment » line. We organise the first patient and practice contact in the second year, community health care organisation in the third year, primary and secondary care cooperation in the 4th year and prevention and environment in the 5th year. Parallel with this, we are involved in the communication training over the same 4 years. It is very new and promising.

Our department is asked by the faculty to propose a network structure for a new style « epidemiology department » that relates as well to the community epidemiology, clinical epidemiology and biomedical statistics. A new challenge.

Postgraduate specialist training

New « primary health care network » training program : learn to see your practice not merely as an individual caregiving place, but as a part of the primary care level in the health care organisation. We spent a complete month of our 1st year training program on this. It was a success : students where enthusiast, our 15 academic teaching practices opened up their action fields, and the local networks showed the best of their cooperation. The minister herself came to the final congress day that ended the new training program.

In the Flemish interuniversity specialist training program, a new educational model is discussed: the selfdirected learning program, based on the « social constructivistic learning theory ». There is a lot of IT support related to this, with students dispersed all over the country in their teaching practices. Introduction of a rather fundamental change means a lot of discussion at all levels: human resources, individual expectations, finances and power balances.

CONTINUING MEDICAL EDUCATION
From CME to CPD: I introduced successfully the concepts of our EQUIP/EURACT preliminary document in an invitational conference by the « organisation of medical scientific societies ». There is a lot of enthusiasm for it. Next year a national open conference on this topic is envisaged.

In parallel the government proceeds (slowly) with a fundamental change in the re-accreditation procedures. The accreditation board will be placed under a national board for the quality promotion, bringing CME (and the credit system based on seminars and lectures) more close to quality improvement (by peer review, competence and performance review)

HEALTH CARE
The wealth of ministries for health at the different Belgian levels also has some advantages: they all ask universities to make decision preparing studies for them. Suddenly our department is asked to deliver conceptual plans on territoriality of care, integrated care management planning, health indicators in primary care, health status and care needs instruments etc. We became a very busy department.

BOSNIA & HERZEGOVINA

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Introduction
Since of the end of the war Bosnia and Herzegovina is engaged in process of health care system reform. This is based on the development of family medicine as a foundation of reformed primary care system. All process started with partnership with the Department of family medicine of Queen's University Canada. Project Queen's Family medicine development program in Bosnia Herzegovina (director prof. dr. J. Hodgetts) funded by SIDA, Canadian government and international community (Word Bank Basic Health Project).

Undergraduate Medical Education
The academic department of family medicine (DFM) established in four University centres in Bosnia Herzegovina (Sarajevo,Tuzla, Banja Luka, Mostar). Tuzla DFM got from the beginning full departmental status and responsibilities within the Faculty of Medicine what gradually happened and with the other centres. DFM introduces and develops special undergraduate program in Family medicine for medical students. This new curriculum and equipment in teaching centres (part of FMD) provides students: access to the most recent medical literature, an evidence–based medicine approach to problem solving and decision making, improving their clinical skills, communication skills, critical appraisal skills and motivation for independent learning. New methods of evaluation specially OSCE -(Objective, Structured Clinical Examination) and increased exposure to positive primary care experiences help to students to think about family medicine like first choice in their future careers.

Postgraduate specialist training

A specialisation programme in Family medicine started on Sept.1 199 under the leadership of the Queen's University Family medicine development program. A project funded by the Canadian government. Duration of specialisation lasts 2 or 3 years depending on past work experience specialty or re training qualifications and individual needs for education.

The plan and program was officially accepted and now it runs all over Bosnia and Herzegovina. Over 150 residents in Family medicine in 11 Family medicine Teaching Sites work under standardized didactic program which is oriented on getting clinical and problem management skills. Evaluation and certification board established from four University with international participation. New evaluation's methods measure not only knowledge, but appropriate communication skills, professional and ethical attitudes towards patients and other health care workers. FMD in four University now is preparing now examination methods which will consist of two parts: SAMEQs (short answer modified essay questions) and OSCE.

Postgraduate study in family medicine

The established working group is running for a new curriculum in postgraduate study in Family medicine that can be accepted by official organs of each faculty. This very important plan and other activities is going to start this academic year with intention that this activities and final certification in getting master's and PhD degree will be recognised beyond the borders of Bosnia Herzegovina. Project: Development of an International Family medicine Master of Science Programme by distance Learning interFaMM) would be very useful for the future of Family medicine in Bosnia Herzegovina. Family medicine doctors, participants in this study will be future leaders in education, practice and research so those activities present essential part of the overall reform process.

Continuing medical education:

Large numbers of physicians and other health professionals are participating in peer group and other community development activities aimed at improving the level of primary care. EU PHARE Program and MSF Family Medicine Training Program in Bosnia Herzegovina lasted until 200l .

CROATIA

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General Practice within Health Care System

Health Care in Croatia is undergoing transitional period. Healt Centres have been the only one organization for provision of Primary Health Care. General Practitioner have been the most responsible for PHC besides pediatritioners, school medicine specialist and gynecologists. Now, all of them are becoming to be independent contractor with Health Insurance, almost 80%, and responsible for provision of PHC for the patients on the doctor's lists. The big debate is going on concerning GP as the only one discipline in PHC. We will see the results of debate?

Undergraduate medical education

GP/Family Medicine subject is tought during basic medical education in Croatia. It is placed within the sixth year (XI semestar) and lasts 4 weeks. 30.3.2001 a meeting of representatives of departments of GP/FM from 4 Medical was held. A interdepartmental cooperation was the main objective of meeting. We decided that the main areas of cooperation well be: definition of core curriculum in GP, a selection and introduction of the most appropriate methods of curricula's evaluation and student's

assessment, teachers exange and futher proffesional development, writing a handbook and other teaching materials.

Postgraduate education (Vocational Training - specialization)
In Croatia VT started in 1961, but it was and still it is allowed that basicly educated doctor can work within GP. In some periods it has been about 60% of GPs vocational trained. During the last 10 years the situation has been dramatically changed. Vocational training has almost been stopped. The main reasons is lack of awarenes for public benefits of VT general practitioners, coming from new health politicians and organisers of health care. The second reason is lack of financial resources. It seems that situation will change in near future thanks to the political movement toward European integrations.

Continuing Medical Education (CME)
CME activities are expanding very fastly due to the GPs obligation for relicencing (collection of CME credit points during period of 6 years). During last year, over 600 GPs have participate in different CME courses organised by the Association of Teachers in GP. Here are the list of subjects: The new technologies in GP, Care of elderly people, Care of terminally ill and communication with such patients, Acute respiratory diseases and the use of antibiotics, Making a consensus (gidelines) in the care for hpertonics, diabetics, and COPD, A care of the family, The most frequent sexual problems in GP. Although the intention for active participation is present the majority of the courses are still lectures based.

CZECH REPUBLIC

No report received.

DENMARK

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Summary
BME to be shortened ½ year and in consequence a minor reduction of general practice BME.
PST is undergoing change, training time in general practice enhanced to at total of 1½ years (from 1 year) and maybe we will get a total training period of 6½ years with 3 years in general practice.
CME/CPD is popular. The pharmaceutical industry as sponsor of CME is cause of concern and debate.

Pregraduate education (BME)
At the three universities reduction of study time from 6½ to 6 years are in progress. General practice BME has been reduced with some 10% of the theoretical part, but exams uphold.

Postgraduate specific training (PST)
An overall revision of specialist training has resulted in a "revised training scheme for general practice" enhancing training time in the practices from 1 to a total of 1½ years. A realistic vision is that - what we call – an ideal training scheme of general practice (in Danish context) will be reality in 2-3 years, consisting of 1½ years of internship (½ year general practice) followed by a specific training period of 5 years (2½ years in general practice).
At the same time shortage of doctors in almost all specialities is apparent. General practice so far seems to obtain a sufficient number of applicants.

Continuous Medical Education (CME)
The pharmaceutical industry as sponsor of CME is cause of great concern and heated debate in many places. The independence of doctors of any speciality (as prescribers) is considered at risk/under threat and (more) strict rules of conduct for both doctors and industry are supposed to appear.
Still GP CME is a story of success. More than 90% of GPs utilise their money in the CME fund and 98% of all GPs are included in at least one (local) small group, defined by geography, interest, theme etc. The small groups are foci of change with facilitators (sponsored by the quality assurance fund) workshopping with the groups to implement guidelines etc.

ESTONIA

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Family doctors are nowadays widely accepted in the Estonian health care system- good news. On the other hand, more and more tasks without appropriate funding is tried to put into our contract- not so good news. After big changes in primary care in 1990s now government is planning a radical reform of specialist care diminishing number of hospital beds. It can be effective only with development of long-term care and social support but the latter part of the reform is not so well planned yet.

In coming three years our undergraduate teaching is going to change: one-year postgraduate internship will be changed into 6-month undergraduate internship. It means the model of medical education 6+1+residency (3-5 years) will change into 6+residency (3-5years). There are threats that general practical training before specialist training will be too short, therefore all programs for residencies will be reviewed in order to increase common trunk training at the beginning of residency.

Funding of residencies in family medicine seems quite favourable in coming years. The retraining programs for previous district doctors to become family doctors are coming closer to the end: in 2003 the last groups will finish and thereafter residency will be the only way to specialize in family medicine.

FINLAND

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Health Care
Finnish health care, which for years has been a model of good organisation is in trouble today. Many of our health authorities did not believe their eyes, when WHO reported last summer Finland to be in a quite low position compared to many other western countries. It was felt bitter, but is felt even bitterer today, when the physicians have started their strike actions. The Finnish Medical Association and the Commission for Local Authority Employers were unable to negotiate any agreement for the salaries of

the publicly paid doctors nor for the improvement of the working conditions and long working hours. The strike actions are taken stepwise within most specialties, e.g. during one week the anesthesiologists and during the next week the surgeons were on strike. Also public general practitioners in big cities are on strike for first two weeks, then get back to work for two weeks etc. The private sector is working all the time, and in addition, on the public sector the urgent cases are taken care of. What a mess! Many of the doctors report they are striking to get resources for the public health care, not only for their salary. It takes a long time to recover from this strike if it will last for months as has been suggested.

Basic medical education

There is a shortage of publicly paid doctors even if Finland has more doctors than ever before. The educational authorities are willing to try to solve the problem by increasing the annual student intake. Anyhow, our five faculties are not willing to accept the higher admission rate, because they are not getting any more resources. The debate will go on, but most experts believe we have 10 % more students next fall with a little bit better resources. The medical faculty of Turku is piloting a new system of student selection next June. Also the personal attributes of the students are assessed and they will have a minor influence on the selection. Otherwise, no big changes are going to happen. Tampere and Helsinki go on with their PBL-curricula, but Oulu, Kuopio and Turku are more traditional. Once again, the authorities are planning changes in the licensing system.

Specialist education

No big changes. The specialist training in general practice will take six years. The specialty training is very popular, including supervised service in general practice and in hospitals, theoretical courses, assessment, and a written, national final examination. According to the law, the trainees have to assess their edcuation and educational environment as well.

CME

Planning of the big WONCA conference is in good progress. We are expecting 1000 - 1500 participants, and most of them have already made their registrations. The amount of early bird rates was very high as well, so financing has meant quite a lot of work for the Host Organising Committee. There are going to be 15-18 parallel sessions all the time. And we have planned an inspiring social program! So, please, you are welcome to Tampere, Finland for WONCA Europe 2001!

FRANCE

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Basic Medical Education

Numerous clausus after the first year raises to 4100 students: it was necessary to compensate for the decreasing number of doctors. A new program will start in October for the 3 last years of BME (4°, 5° and 6°): it is a big change because the certificates of specialities will disappear. Transverse modules about physio-pathologic mechanisms, anatomic systems, public health problems, are proposed and GP teachers are involved in the teaching process. Practical training in general practice is also planned, but unfortunately, there is no money for it. After 6 years, the “Internat” examination will be open for general practice.

Specialist Training

The curriculum of specialised education in general practice (like for the others specialities) is planned for 2004 and the 3 years of specialist training in general practice will begin in November 2001. The discussions with ministries for health and for education are very hard to obtain twice 6 months in general practice. There is an agreement about a tutor who will follow the student during his entire

specialist training; a status of assistant during the last 6 months in general practice is proposed but not yet accepted.
Nevertheless, it's really a revolution: each student will have a specialist training and will become a specialist in his discipline, including general practice.
There are now 68 GPs associated teachers in the French Universities: 24 professors and 44 lecturers. All the universities have now one or two associated teachers but none of them a full teacher !

Continuing medical education :
The obligation is still not applied. A new way for CME starts now: Professional Education within the context of convention between National Insurance and Trade unions. But there is only a convention for GPs and only GPs can participate: they get financial compensation for each day of education. National Insurance gives money for the organisation and the compensation. The educational topics are definite by the convention.

Health Care System
The situation is the same: no change for the specific convention between GPs and National Health Insurance, but no convention with specialists.
There are some projects for a real change of the health care system and many contacts between medical and other trade unions, but, near the national election, it's not the good time to propose a reform !!!

French National College: CNGE
The CNGE school organises 10 sessions for 2001 for GP trainers and teachers. The annual workshop with EURACT is planned for November 10-11, about "How to teach research".
The College prepares its second National Congress, instead his annual meeting, in November 2001, in Rouen, about Quality in care, in connection with the regular EQUIP meeting.
The College started work on a big research project about chronic pain with 200 GPs.
The journal EXERCER has some difficulties with his sponsor and the future is not yet clear.

GREECE

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General
It seems that we are going to experience another reform of the health system. As it was reported in last council meeting the negotiations (government-health professionals-insurance companies) on the reform of the health system were to end in last November. In January, the first law was voted according to which the decentralisation of the health services of the Ministry was realised. There are now 17 regional-mini- Ministries. The rest part of the reform concerning the funding system and the Primary Health Care is still article of negotiations.

BME
As it was reported many times, no one of the 7 medical schools (except that one of Crete) have included in their programme any lesson, course or seminar in general practice. It is very important and worth mentioning the fact that a group of medical students of the University of Ioannina, sent a letter to ELEGEIA (Greek Association of GPs), requesting more information about our discipline; ELEGEIA responding to this demand is going to organise a series of meetings, round-table discussions to meet students' needs.
We hope that very soon every medical school will have a general practice department.

Specific training
No changes concerning the curriculum and the content of the specific training. The main problems are: a) the specific training is mostly hospital centred, b) the trainees are trained by specialists-with the exception of 10 months in Health Center-, c) the majority of tutors is specialists.

CME
Since CME is under the responsibility of ELEGEIA, things are much better than in BME and ST. So, concerning CME activities it would be interesting to be reported that the following activities have already been planned:

- Teaching the teachers course (30 hours); annual
- Management of hypertension in PHC; two series of 4 courses (6 hours), every three months.
- Management of hypelipidemia in PHC; two series of 4 courses (6 hours) every three months.
- Management of depression in PHC; a series of 10 courses (4 hours) all over Greece.
- Teaching management of health services (30 hours); annual (*planning*).
- Teaching assessment methods (30 hours); annual (*planning*).
- Establishment of credit system; unofficial initiative of ELEGEIA.

HUNGARY

No report received.

IRELAND

No report received.

ISRAEL

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In the past 6 months we have seen continued growth and development in family medicine in Israel. In Tel Aviv we are pleased to announce the promotion of Euract member Michael Weingarten to full professor. Eli Kitai is a new professor in family medicine heading the undergraduate department and Simon Zalewski is a new lecturer.

In BME Shmuel Reiss reports from Haifa on a new course for undergraduate students on the Holocaust and medicine. This is tied to a multi-national research grant together with schools in Germany and Austria. In Tel Aviv the integrated program of behavioral sciences in medicine continues to grow.

In vocational training, Haifa has completed curricular reform to make residency education more relevant to everyday general practice. The program is called “Connecting Wednesday (the day for day release courses) to Thursday (an ordinary workday)”.

A workshop was held in February to help set the national multiple choice exams for vocational training in family medicine. As I wrote in my column for the EJGP, 30 teachers were locked in a hotel for two days until they produced a 150-question exam.

We just completed a cycle of national oral examinations for family medicine specialization in March with 50 candidates sitting the exam. There was an 80% success rate at the exam centre in Tel Aviv.

In CME we have just completed a pilot project on distance learning. Over 50 gp's in 4 locations (Nazareth, Haifa, Ashkelon and Tel Aviv) participated in a workshop on the management of patients with heart failure. A lecture was broadcast from a television studio at the university to the remote sites via Internet allowing for interaction with the participants in real time. Initial feedback has been favorable and we plan to develop a full year course for distance learning.

Howard Tandeter of Beer Sheva has been busy preparing the national faculty development program in family medicine. We have a sponsor and hope to begin the program in the next academic year.

In Research news: Today in Tel Aviv we participated in the second annual research fair of the medical school with a record 23 posters from family medicine.

The national conference of the family medicine research network Rambam was held in Tel Aviv in March. Aya Biderman of Beer Sheva was elected chairperson. The scientific debate at the meeting focussed on the ability of gp's to do randomized controlled drug trials in practice.

Preparations are underway for the national family medicine research conference to be held in Jerusalem in May. Scientific presentations from 36 gp's have been accepted for presentation.

ITALY

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Basic Medical Education

No basic medical education is yet organised by law in Italy. Now, in 2001, we have some experimental courses taken in Udine, in Monza and in Modena, for students in their sixth year of curriculum. These courses are managed as local agreements between groups of doctors and local University. No payment is there. There are few seminars, and a tutor system. In Milan, I'm organising a tutor system with a University's Chair for students at their final certification level (sixth year end, before exams before thesis discussion).

Postgraduate specialist training

We have a postgraduate specialist training since 1994. This is a two year long training, managed in hospitals for one year, in district services for six months, in tutor GPs' practices for six months. Also, half of seminars are managed by GPs' teachers.
Now, we are preparing to change this training as a real specialist certificate, with a three year course, one year in the practices. Teachers are paid for seminars, tutors are paid monthly, coursists are paid at lowest level for hospital doctors, obliged to refuse by law every contemporary other work.

Continuing medical education

It was obligatory for National Contract with NHS, to take 32 hours of CME, (16 with Health Local Authorities, 16 with Scientific Societies or in other places of choice).

Now , we are managing to arrive to a national CME system , with an accreditation of events , by credits and points attributed to events.
There is a six month period of prove between January and June 2001. Meanwhile, we are studying how it's working to arrive at a system accrediting also curricula, active participation at congresses, and distance learning systems (more difficult to organise and value).
Also, there is a fighting about "who" has to accreditate "whom": Government, General Medical Council, Local Medical Councils, Scientific Societies, a National College or Academy, Trust Doctors' Organisations.

Health Care
New input in this field is coming from agreements between Local Health Authorities and GPs' organisations with health programmes finalised to objectives of result: breast cancer screening, smoking cessation campaign (we bring two work about this topic at WONCA Europe Congress in Tampere). Also, Scientific Societies of GPs realised a common political and scientific document stopping a specialist initiative about prostate screening, also managed taking out GPs.

LITHUANIA

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Development of Family Medicine in Lithuania is considered to be a stable process, even if it is going slower than expected. Private GPs are expanding their activities, but the time until now is too short to make any decisions about their success. Financial problems of government are also influencing in a negative way the status of health care system. At the same time due to problems in the health care organisation and patient dissatisfaction with delivery of health care services, the idea about privatisation of primary health care services seems reasonable. The main problem with the implementation of health care strategies is changing leaders of the MoH. We have had 4 Health Care Ministers during the previous 4 years.

Teaching of Family medicine is undergoing some changes too. The decision to introduce a Family medicine as a discipline as early as on the 3rd year of studies, is already made in Vilnius University. Also program of family medicine teaching is changing towards a patient-centred approach, including longer time for studies of psychology during he course.

Continuing Medical Education requires major organisational changes too. The future of the CME is under intensive discussions now- what organisations will be responsible for CME in Family Medicine, which ones will be allowed to organise the courses, can professional organisations of specialists organise the CME for family

NETHERLANDS

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Basic Medical Education
All 8 medical schools are reorganizing BME. Many elements of PBL are integrated in the new curricula. Other features are: early contacts with patients, growth of responsibility for the students, and growing involvement of primary care/general practice.

Postgraduate training
The GP-training is a national programme, but executed by the 8 departments of general practice. Each department has its own 'couleur locale'.
Also in this area a lot of innovation is planned and in preparation. New is the emphasis on learning the practice and a more individual (tailor made) curriculum for the trainees. For the assessment use will be made of a portfolio system. Another new element is 'differentiation' (sports medicine, ophthalmology, managenent, research, education etc.). In due course a connection with the Higher Professional Training programme will be established.
Many more GPs are needed than are in training. The interest in GP-training is not encouraging.

CME/HPT
A lot of debate about the involvement of pharmaceutical industries in
the CME-programmes ! Each GP has to show that he 'did'40 hrs of CME, for reimbursement.
The Higher Professional training Programme (HPT) gets gradually on a structural and national position. Recently a training programme in palliative care started with the participation of 50 GPs. Other programmes will follow soon.

Health care
The national association of GPs is organising another strike to put pressure on the minister, to provide more funds for practice management and to make the profession more attractive.
The establishement of regional GP-call centres, more or less related to hospitals, is in full swing. This movement is supported by the government and the health insurance companies. It is clear that the workload of being on call is reduced by these centres.

NORWAY

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Basic medical education:
- Last autumn at the University of Bergen, we started with voluntary discussion groups on “self development” and also “thematic self development” among the students. This is an offer to students two years before finishing their study. All groups are conducted either by psychiatrists or by a general practitioners (as myself). 1 ½ hour one time a week and 20 times during this year of studying.
- A major subject is also how to communicate with the patient. The model developed in Bergen, in contact with the Leuven University, is rather popular.

Postgraduate specialist training:
- The (postgraduate) specialist training is as before. A lot of younger colleagues are starting their training, and a lot of guided groups (as I am leading at the moment) are active all over the country.
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Continuing medical education:
- The Norwegian Medical Association and all local groups of this, are making and arranging a lot of courses all through the year.

Health care:

- Still the most important subject in Norway now a days, is the plans to work out the patient-list-system. It seems that all plans will be finished and the new system in our health care starts from the 1st of June this year. A lot of details has been discussed and from the GP's point of view, the new system seems to be rather good on a lot of main points.
- But the lack of GP/FP seems to be about 800, before this reform can be a good reality all over the country.
- This is a major problem that a lot of districts and health centres all over the country does not have enough GP's/FP's.
- The new reform will be named something as a "firm patient-doctor-reform", or a "firm doctor reform".

POLAND

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Undergraduate education:

Some progress in negotiations about the minimum for undergraduate teaching in family medicine. The Board of Higher Education – an independent body consisting of representatives of universities and attached to the Ministry of Education proposes now 50 hours. We are still fighting for 100 hours. Results however are uncertain at the moment.

Postgraduate education:

There is shortage of training places for family physicians. The Ministry of Health wants to stimulate vocational training in this discipline and allocate in it at least 1000 places a year. Incentives and possible solutions are sought. New law about medical profession is in parliament. Some articles (accreditation of the courses, clear rules for financing) can stimulate further development of the training. We have to wait.

Continuous Professional Development:

The School of Tutors started by the College of Family Physicians in Poland was big success. Graduates started their peer-review groups and some of them developed even quite good QA projects. New edition of the school is planed. The application for financing is submitted to the Ministry.

RUMANIA

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National items

Romania is experiencing the early stages of healthcare reform. The previous hospital oriented system is changing into a primary care focused one. Therefore the position and status of family doctor is

strengthening. Nowadays the family doctors fulfill the gate keeping function, have their own lists of patients, and are no more employed, being paid mainly by capitation. Furthermore the addressability to primary care significantly increased. As a result this specialty became interesting and the number of family doctors increased. Untrained doctors are still allowed to practice as family doctors.

Basic Medical Education

In the last years there were set up Departments of Family Medicine in the accredited Medical Universities. Some of them occurred by the transformation of formerly Ambulatory Care Departments (Internal Medicine) and their Heads are not family doctors, but newly employed staffs are. Unfortunately there are not too many changes in the educational curriculum, the main focus being also in internal medicine.

Postgraduate specialist training

The postgraduate training in Family Medicine was introduced in early 90s. The entrance into the Residentship Program is based on a national contest and the number of positions is regulated by the Government (approximately 500 per year). Unfortunately this is not mandatory for practicing Family Medicine. The Residentship Program last 3 years; 15 months is in primary care facilities, under the supervision of trainers in Family Medicine. In the last 10 years the educational curriculum was significantly improved accordingly with the primary care domain.

Continuing Medical Education

The CME became compulsory for all medical practitioners since 1999. There is also an accreditation system for CME events. The CME system is linked with the accreditation and revalidation of medical practitioners. This task is fulfilled by the Romanian College of Physicians. The accreditation of doctors is based on the accumulation of 200 credit points in 4 years. There is not qualitative assurance of CME events.

Until 1998, different Departments of the Medical Universities organized educational events for GPs. Since 1998 there were organized programs for training the trainers in Family Medicine, some of them in cooperation with external programs (Matra, Nicare) and The Ministry of Health established a new position in medical postgraduate training for Family doctors: the trainer in Family Medicine. Now the trainers in family medicine are involved in the CME events for family doctors.

Conclusions

- The Development of Family Medicine is already a reality but it seems to be a difficult process.
- The main issues in Family Doctors' education are domain orientation and quality assurance.

SLOVAKIA

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Undergraduate education

At two, out of four Medical schools in Slovakia, there are still no Departments of General practice and Family medicine, although teaching of General practice and Family medicine is a compulsory part of undergraduate educational at all Slovak Medical Schools. At those Medical schools, where none Department of GP/FM is established, teaching of GP is provided by the Internal medicine Departments. General practitioners are involved in the practical part of teaching - medical students are obliged to spend at least one week at an accredited primary care teaching practice.

New **Document on Medical Education** has been recently prepared by the Ministry of Health and submitted for ratification to the government, taking in considerataion the ***EU Directive 93/16 -*** *to*

facilitate the free movement of doctors. In accordance with the mentioned document all Slovak Medical schools will need to put more stress on GP/FM teaching.

Postgraduate education

The duration of the Vocational trainig for General Practice is 3 years. Future GP must spend two years on various hospital and polyclinic departments (1 year Internal medicine, 3-4 months Surgery and Traumatology, 1-2 months ENT, Emergency, Dermatology, Neurology, Urology, Psychiatry or Gynecology, etc.), and there is a request for spending 6 months in a Teaching practice. There is still lack of teaching practices, so the last mentioned condition is in many cases not fulfilled in practice. The process of accreditation of teching practices is in progress, so finaly also the stay in a teaching practice is more and more often becoming a reality.

Continuous Medical Education

Recent system of obligatory continuous medical education: *„CREDIT POINT SYSTEM CME IN GENERAL PRACTICE" was* introduced in January 1998 as an inniciative of Slovak Association of Private Physicians. Later on it was accepted and supported by the SPAM (Slovak Postgraduate Academy of Medicine), responsible for whole postgraduate medical education in Slovakia and by the MOH. This model of CME is now accepted with real respect.

The principle is that different courses and lectures, organised by Slovak Postgraduate Academy of Medicine in Bratislava, Regional medical educational bodies or Pharmaceutical companies are bonused with certain number of credit poits. GP´s are obliged to prove the attendance of educational activities by collecting certain number of credit points (200 points per year). The evaluation is in the competence of elected representatives of the Regional Medical Chamber and is provided every 5 years as **„recertification"**. Recertification is one of the conditions for renovation of GP´s contract with the Health insurance companies, every 5 years.

Courses organised for CME are mainly focused on 1/ Practice management, 2/ Health financing, 3/ Cost effective drug prescription, 4/ Primary care development, 5/ Introduction of new diagnostic and treatment guidelines and 6/ Clinical practice.

Health care

Total lack of money is the main and chronical problem of our health care. The explanation would need another separate sheet of paper.

SLOVENIA

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Undergraduate education

A new reform of undergraduate program is underway at the faculty. The changes are towards problem based learning. I was especially proud to be appointed as one of the people to prepare the changes in the programme. The department is slowly gaining recognition: after almost ten years without anyone defending a PhD on family medicine, we have got two new GPs with PhD since the last meeting.

Vocational training

There are big problems in negotiationg the vocational training programme with the medical chamber. They are clearly having problems with logistics, and some of the young GPs are still witing to enter the vocational training scheme. The arrangements for the tutors' payment are still unclear, and nobody

gets paid for the training at this point. We are still developing different modules for trainees who are already working in practice and it takes a lot of negotiations.

On the other hand, we have succcessfully started with the new end exams for the trainees. It is a general feeling that the exam is a very good one. There are still some problems in criteria for the MCQ and OSCE, but we are planning this year to be "an introductory year".

CME
We are busy planning this year's Bled which is going to be the 10th in a row. The theme has beed agreed to be "out of office medicine" and one of my tasks here is also to prepare the first draft of the final programme together with Yonah. The Bled course announcement is already on the web, linked to the EURACT website. There is quite a lot of interest in it and I hope we gat a good mix of participants.

OTHER
I have received a reply from the European Journal of General Practice that they are interested in publishing the paper on basic medical education in Europe which was prepared by the BME group. I only need to shorten it by 20-25%.

SPAIN

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Undergraduate Education
There are still no Departments of General Practice and Family Medicine at all our Medical Schools, but teaching of Family Medicine is increasing.
The situation in Spain nowadays is reflected in the figure.

Postgraduate Education
All over the country is a big discussion to work more for formative assessment that for summative assessment during the vocational training program. We are exploring different methods (self audit, feed back interviews, video recording,..) and we hope in a short time we can offer the Health ministry a good proposal that allow us to change the current evaluation system. Semfyc has started with a course for tutors, and in different regions teaching activities oriented to them are available.

Continuing medical Education
The introduction of clinical evidence based guidelines is the most important event of the last few months. The summer school of semfyc is a national event, also since two years an update meeting in primary care, based on workshops with a little number of participants has been very successful. The attendance to that kind of activities provides credit points, but we still don't know the utility of that credit point system.

Others
The workload of the GP's is very high. A campaign to increase the time to be expended in each visit is running all over the country: we claim on at least 10 minutes for each patient, actually the average time spent for each visit is only of 5 minutes.

University	Resources			Teaching activity		
Medical School	Health Centres	Assistant professors	Lecturers	In Heath Centres (practical)	Seminairs Workshops	Lectures
Alicante	10	2	1	Compulsory 6 th year: 1 month	yes	optional
Cadiz	4	15	-	Compulsory 6 th year: 32 hours	yes	no
Tenerife	3	3	1	Compulsory 6 th year: 32 hours	yes	no
Las Palmas	4	4	-	Compulsory 6 th year: 3 weeks	yes	no
Madrid (Autónoma)	15	23	1	Compulsory 6 th year: 1 month	yes	optional
Murcia	5	6	-	Optional 6 th year: 5 weeks	yes	no
Navarra	1	0	-	Compulsory 6 th year: 32 hours	yes	no
Oviedo	14	3	-	Compulsory 6 th year: 3 weeks	no	no
Salamanca	4	4	-	Compulsory 6 th year	no	no
Santiago	1	2	-	no	yes	no
Sevilla	15	15	-	Compulsory 6 th year: 1 month	yes	Compulsory 6 th year
Valencia	4	10	-	Compulsory 5 th year: 2 weeks	no	no
Valladolid	5	8	-	Compulsory 6 th year: 1 month	yes	optional
Zaragoza	10	10	-	Compulsory 6 th year	no	optional
Lleida	5	8	-	Compulsory 6 th year: 1 month	yes	no
Tarragona	7	7	-	Compulsory 6 th year: 1 month	no	no
Barcelona	25	19	-	Compulsory 5 th year: 1 month	no	Compulsory 6 th year

Source: Josep Mª Cots

SWEDEN

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Basic medical education

Sweden has 6 universities with medical faculties (from north to south: Umeå, Uppsala, Stockholm, Linköping, Göteborg, Lund/Malmö) and the undergraduate period is 5 ½ years (11 semesters).

The general practice part in BME differs between the universities, both in content and length. Linköping, the youngest university, has by far the most GP content, almost every semester the student pays a visit to a health centre.
In most universities the GP contribution is during three periods of the undergraduate years.

* during the first two years the students visit a health centre, accompanying GPs for a couple of days and also carrying through minor tasks (about 1 week every semester)

* during the transition period , in the third year, between the pre-clinical and clinical years the students are attached to a health centre for about two weeks. At that time the student is often trained by a GP in consultation techniques, physical examination and how to document.

* during the last year, at the end of the clinical period, the student usually is attached for two or three weeks at a health centre. The GP-teaching is ordinarily a part of a course in community medicine. Tutorial sessions, seminars, video recording, lecture often frame these GP-weeks. A verbal and written exam is often included.

On the whole the GP-part in the BME in the country is increasing but in the educational university bodies there are sometimes hard discussions on the relevance of GP as a teaching subject. The students are usually in strong favour of more GP attachment and the political winds are also blowing in accordance with these opinions.

Postgraduate education
After graduating at the university the doctor has to do 18 months of internship (6 months internal medicine, 6 months general practice, 3 months psychiatry and 3 months in a voluntary discipline) giving a registration/licensing.
The vocational training programme in Sweden is usually 5 years but it has no mandatory components, it has a goal-oriented approach. At the beginning of the vocational training period a written personal contract is established between the trainee and a personal trainer/supervisor. The recommendation is that the trainee spend most of the time at a health centre (about 3 years) while about 2 years are spent in hospital (internal medicine, surgical discipline, paediatrics, ENT for example). The choice of hospital speciality depends on the earlier training experiences and on the direction the trainer want to focus.
The approval of the vocational training is made jointly by the trainer and the director of the vocational training scheme.
A voluntary specialist exam is possible to accomplish. Once every year an exam is carried through (various parts: written, oral, a written presentation of a small piece of research, a visit to the trainees health centre including sit-ins, talking to staff, looking at records etc). About 15-20% of the trainees passes this voluntary exam.

Continuing medical education
Small CME groups (FQ-groups F=fortbildning Q=quality) have been widely put into practice in the last years. In 1998, there were approximately 230 small CME groups in Sweden, which means that nearly half of Swedish GPs participated in such activities. This type of group work enhance knowledge development, enable the assessment of individual learning needs and facilitate the adoption of national guidelines and agreements between primary and secondary care. A competent group leader is crucial.
CME groups are yet less practised than "traditional" CME activities, such as lectures and the teaching tradition within the well-developed organisation of the drug companies. These drug-related activities include symposia and meetings during a couple of days or just shorter evening gatherings.
There is no compulsory CME activity so far – it is up to the individual GP to take care of his/her own CME.

Health care

Sweden is a comparatively hospital-oriented country. About 15-20 % of the doctors is GPs and only about 12-15 % of the money for the health care system is given to primary care.
Over the last 20 years many governmental reforms have aimed at promoting primary care, but so far mainly lip service has been given to the reforms.
Last year the Minister of Health presented a plan that 9 billion SEK (about 60 million pounds) between 2001-2004 will be given to primary care, psychiatry and care for he elderly. (Nationella Handlingsplanen – The National Action Plan).
That is said to be an injection for primary health care and the number of GPs will hopefully increase with 220 every year and reach the goal of 1 GP in 1500 inhabitants in 2008.
Every County Council (there are 13 of them in Sweden) is responsible for how the money best will be spent and The National Board of Health is going to do yearly check-ups of all the Counties.
Within the National Handlingsplan a new, independent Institute of Family Medicine is suggested (a yearly budget of about 1 million pounds) and the Institute will support CME, the vocational training, research and developmental work within general practice/family medicine. The Minister of Health has appointed Göran Sjönell, former president of WONCA to be the administrator of the idea and the Institute will hopefully start in 2002.

SWITZERLAND

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Pregraduate education

At all levels new forms of curriculums are going to be established at all our five medical schools. Although everyone is convinced that GP's schould have more and more infuence on these curriculums usually the money is missing. So all the efforts of our collegues are not very succesfull , but we hold on. As the problems within all our medical schools are more or less the same the idea of reducing the number of schools from 5 to 3 has already shown up. After the next accrediation in 2003 or 4 we will see further on as the governement has threatend to spend less money if this accrediation would not be the way they want it. In regard to this situation a group of private hospitals is planning to open their own medical school. This would be the first private medical school in our country since a very long time.

Postgraduate education

We still have our 5-years VT mostly in hospital posts with a 6-months training as an assistant doctor in general practice. Unfortunately these 6 months are still voluntary, bu we offer a very good 1 to 1 (trainee-theacher) training-situation. This seems to be so attracive that a lot trainees take the opportunity, and we do not have enough training places.From this year on the final exam is obligatory to get the title of a ispecialist in general practice. Every year about 120 persons pass the exam so there will be no shortage of doctors in the next 5-10 years, but the amount of women is raising every year so that we think the situation could change within this time. Students numbers are constantly high.
By the end of this year ,as an innovation, every medical teaching institution, has to define their posts, goals, and other possibilities on medical education at all levels.Centralized this will be an information base for our doctors after medical school to plan their VT.

CME

We try to continue to raise the influence of GP's on all CME-activities, mostly based on local sections of the GP's association .That means , that for example local practitioners work together with the

regional hospital to organize workshops. When al the conditions ,the GP's association has established are fulfilled the workshop gets the label „recommended by the GP's association.

Politics

As economics in Switzerland are going better we hoped that political influence on the Health system might lower.But never the less a flood of new laws and a raising influence of insurance companies make GP's life more and more difficult.

TURKEY

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Basic Medical Education

The number of universities which have a family medicine department has been 27 (out of 39 medical faculties currently being studied medicine). Dokuz Eylül University in İzmir is one of the biggest universities of Turkey, and there were a strong resistance from public health academicians against establishment of Family Medicine Department. But a few months ago the department was established and our sixth associate professor (she is a EURACT member) has been appointing to the head of the department nowadays.

Although number of teaching hours differs significantly family medicine is taught at all medical schools having department of family medicine. The academic career of family medicine is gaining a lot of interest for family physicians. New positions are opened for family medicine in the universities. As was mentioned before (in my past reports) a doctor graduating medical school can start practising as a GP without specific training. So the ever increasing contribution of family medicine departments to the basic medical education is having much more importance.

The second medical education congress will be held at the end of this month in İzmir. That will be a broader forum during which all contemporary innovations in medical education including community based medicine and contribution of FM to BME will be discussed. As the departments of FM we will be there and will participate in discussions in small group studies and with poster presentations.

In spite of this good progress in BME there has been a paradoxical and unwanted development concerning academic promotion in FM. As I mentioned in my presentation at the joint session before the last council meeting in Kuşadası, the career tracks for becoming professor in FM are the same as in any other medical discipline. The most critical stage of this track is the Board exam for promotion to associate professor. But this year the Turkish Council of Higher Education has proposed new regulations of this exam. If these regulations are accepted there will be no exam of Board in the field of FM (The bizarre reason for this is that family medicine does not have sufficient professor for setting the Board) . It is difficult to predict what happens in that case. For about one month we have been trying to change this unexpected situation.

Postgraduate specific training

No changes concerning the curriculum and the content of the postgraduate specific training. It is still exclusively hospital-based (at least in the teaching hospitals of MoH). The draft law for regulation of specialisation in all disciplines including family medicine is still waiting for being enacted.

Continuing medical education

No progress concerning the re-training of the medical graduates practising in primary health care. The Turkish Association of Family Physicians are preparing a detailed program for proposing to the other institutions involved in the re-training process (medical schools, Ministry of Health, Turkish Medical Chamber and other GP organisations). The 5th National Congress of Family Medicine will be held in Adana at the end of this October. We hope we are able to present and discuss this program at the congress.

Health care

Nothing changed. Big confusion and uncertainty regarding what should be done. We have still been experiencing negotiations on the reform of the health system.

UNITED KINGDOM

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We seem beset by disasters at present. Since we last met in Kusadasi we have had a winter of heavy rainfall causing severe flooding in many parts of the country, another major rail accident (in which one of our members was seriously injured – fortunately now recovering), a stock market collapse (presumably also affecting most countries to a greater or lesser extent) and now the farming crisis caused by foot and mouth disease. This last problem has been exacerbated by the pan-European nature of modern farming, with stock moving large distances both within the UK and also to and from other countries. Family doctors in affected areas are having to deal with the many stress problems produced in their communities, which have been devastated by this problem.

In the midst of all these problems there continue to be major changes in the health care system as the government tries to remedy the deficiencies of years of underspending initiated by "efficiency savings" introduced by Mrs Thatcher. To be fair to the government there are now significant amounts of new investment being provided, but with the associated problem of yet more major reforms to the health delivery and education system. The lack of stability in the processes of health care delivery is now a major factor in the low morale that is endemic in all staff. We are truly reform weary!

Doctor shortage

It is now accepted that there has been a major underestimate of medical workforce requirements for the next few years – by the government's own calculations 10,000 more specialists, and a minimum of 2000 extra GPs. The figure for GPs is being disputed, and the government accepts that this is probably an underestimate. This is being addressed in the short term by attempting to reduce the numbers retiring by offering financial incentives to stay on for 5 years (referred to as "golden handcuffs"), offering money to new GPs in under-doctored areas and trying to recruit all categories of health care staff from overseas – both within and outside the EU. Negotiations are going in more than 20 countries to recruit trained doctors, nurses, and other therapists – you have been warned!

In the longer term medical school intake is being immediately increased – but this will obviously take time to have any impact. None of the measures so far taken has had any effect on the retention of staff within the NHS, with many leaving to take up other careers, or simply retiring early.

Basic medical education

Medical schools are being invited to substantially increase student numbers very rapidly. When this is combined with a major increase in primary care based education then the immediate problem is that general practice has become a victim of its own success, with great pressure on finding placements for medical students. Maintaining the quality of the placements is a major issue over the next few years of expansion.

Vocational training

The standard three year training programme is being stretched and changed with the new flexible funding arrangements. There is a strong move towards the development of teaching programmes based on personal learning plans, and there is a major review of the junior hospital doctor grade, the SHO, under way at present. All one can say with certainty is that a lot of changes are about to happen, but what the final pattern will be is still unclear.

CPD

There are strong moves towards multidisciplinary CPD being delivered at practice and primary care trust level (these are the new management organisations based round primary care responsible for all elements of primary care, and with increasing responsibilities in commissioning secondary care services). Personal and practice development plans are being used more and more as the basis for determining CPD activity.

Annual Appraisal

It has been decreed by the government that every doctor is to have an annual appraisal. There is no clear understanding of its purpose, its format, or who is to do it – and no evidence of its value in improving patient care. However that has never been an impediment to governments in the past!