Annex 1

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

EURACT Council meeting
October 10–12, 2001
Barcelona, Spain

ALBANIA

Dr. Llukan Rrumbullaku
Rr. Durresit, P. 85, Sh. 7, N. 57
Tirana

Basic Medical Education (BME)
Until the late 80s BME in Albania was 5 years and overloaded with political subjects, military training and "productive work" that displaced the medical part of the education. Since that time it is 6 years. The curriculum has been restructured in the recent years through two European Union TEMPUS projects in collaboration with the Medical School of the University of Padova in Italy and the Faculty of Medicine of the University of Paris in France and other fruitful exchange with different universities around the world. The BME is mostly hospital-oriented and PHC elements are only now being systematically included.

Postgraduate Training (PT)
Postgraduate training in Albania varies in length from 2 to 4 years according to speciality. PT in Family Practice started for the first time on January 1997. The Department of Family Medicine is one of the independent departments of the Faculty of Medicine and is in charge of this training. There are four full-time lecturers and several part-time lecturers in the department. With the support of the European Union PHARE Project the members of the department were academically trained for 9 months abroad, three of them in London and one in Brussels. Two were further trained for 3 months in Salt Lake City, USA.
The duration of the PT in Albania is 2 years. Until now 48 doctors have completed the training. A textbook is in process at the Department of Family Medicine to be published later this year. A CD on primary care and public health issues is under completion in collaboration with the Medical School of the University of Ioannina in Greece through the European Union INTERREG 2 Program.

Continuous Medical Education (CME)
CME is not yet fully established in Albania. With the support of the PHARE program a short-term (6 months) instructor course was given to 4 groups of general physicians (4 doctors each) in Glasgow, Scotland. 540 physicians in primary care have then in turn been trained by these instructors through the same program for three months in Tirana, Shkodra, Korca and Vlora. A CME curriculum has been developed for this year in collaboration with the Universities of Crete and Ioannina, Greece, and Linkoping, Sweden for the 48 doctors that have completed the postgraduate training.

AUSTRIA

Dr. Gertraud Rothe
Sternwartestr. 6/23
A-1180 Wien

Pregraduate education

The official start for the new medical curriculum will be October 2002. This year the new curriculum will be implemented for 150 students in Vienna (and a similar number at the other universities) on a voluntary basis. The students will also come for one week to a G.P. Teaching Practice and they will get some basic information about general practice and family medicine in lectures and seminars. There is an official election process going on for a

Professor of General Practice at the Department of Pre-and Postgraduate education at the University of Vienna. We are having a lot of changes at University level now. And one of the problems is the lack of money, but G.P. does definitely get more importance. Also teaching methods are more discussed and there will be a big conference about the "Quality of Teaching" at the beginning of November in Vienna.

Postgraduate education

The Austrian Society of G.P. is discussing in a working group the structure of a 5 year period of Vocational Training for the specialization of G.P. The exam at the end of the V.T. makes the trainees more interested in G.P. and raises the question of the quality of hospital training for future G.Ps.

CME

The doctors Chamber is looking for a good working classification system for G.Ps and so the newly translated ICPC-2 was tried out in 10 practices compared to the ICD classification system. Quality circles are established all over Austria and the Austrian Society of G.P. is offering many training courses for circle-trainers. Also specialists are starting quality circles now. From the 19 – 26 of January 2002 the Austrian Society of G.P. (ÖGAM) is organizing the first Winter Conference of General Practice in Lech am Arlberg. In summer the law permitting the Group Practices in Austria has passed Parliament. So from now on there can be a lot of changes going on also in this area.

BELGIUM

Prof. Jan Heyrman
Catholic University Leuven
Kapucijnenvoer 33/Blok J
B-3000 Leuven

Basic Medical Education

Step by step, which means year by year, the curriculum reform proceeds at all universities. Our department brought in the 3 year a format of "community health care organisation", and a second level "communication training". Things are going well.

Postgraduate specialist training

Our new educational model came in action. It is based on self-directed learning with the support of small « learning groups » and intensively web based. The learning philosophy is now « social constructivism ». Lectures and seminars gradually are replaced by learning trajects, electronic discussion groups, interim tasks and tests. In new important element of the final proof is the « digital portfolio » judged by the « electronic tutor ».

In the interuniversity 2nd and 3rd year program also more web based learning modules are introduced. The Flemish government granted us for developing this system.

Continuing Medical Education

The government has set a new step from CME tot CPD, including QI. Legally a new « National board for the quality promotion » is installed, bringing CME (and the credit system based on seminars and lectures) more close to quality improvement (by peer review, competence and performance review). A challenging concept, but the medical field is very slow in changing.

Health Care
Last July, 8 ministers involved in health care organization (for Belgium, Flanders, Walloon and Brussels!) officially presented together their political options about primary care. They are going to build a legal multidisciplinary structure around the General Practitioner, on territorial bases. Primary Care regions will be installed, and supported for management and data handling. Local representative GP boards will be recognized Home nurse organizations, which have already a representative organization will be paid separately for the care and for the structure. This is a new trend in a basically fee for service based health care. And GP's will have a new payment for « multidisciplinary contacts ». All these evolutions are crucial: until now we have only one legal structure in health care, the hospital network. The ministers deliberately aimed to put in place a second structure to find a new balance between primary and secondary care. Hopefully the balance is will not be too skewed.

BOSNIA & HERZEGOVINA

Prof. Muharem Zildzic
Dept of Family Medicine
University of Tuzla
Univerzitska Broj 1
75000 Tuzla

Undergraduate medical education
During the academic half year four Department of family medicine continue to work in cooperation with the Department of family medicine Queen's University Canada. All members of academic departments have tried to improve new teaching methods for students in 6 year. In every segment of effective clinical education (structural clinical experiences, appropriate role models, planned teaching curriculum and supportive learning environment.) Three members of Academic departments spent 3 wows in Canada to learn about teaching methods which are in use in Queen's University in Canada. By the end of this academic year students demonstrated through new methods of evaluation and assessment: Effective communication skills; Competency in clinical skills and minor procedures; Ability in problem formulation and problem solving; Ability to develop management plans for common problems. Department of family medicine in Tuzla University developed advanced level of OSCE examination introducing new own stations for common problems related to local context. Written examination was the same in all departments of family medicine in Bosnia Herzegovina. Medical students' evaluation for validity of the education in the department of family medicine showed that 85% of students approve new approach (because they think it develops skills for future practice and skills for lifelong learning)

Specialization in family medicine
The most important event for full implementation of family medicine and the reform of the Health care system in Bosnia Herzegovina have happened by the end of this academic year. In September of this year was held final examination for 56 residents in family medicine. By the end of specialization program 56 candidates had satisfactory completion of all components of the plan including and resident's project. 56 candidates came to exam in the same place - Sarajevo from different parts of Bosnia Herzegovina (it was success before final result). An Evaluation and Certification Board was established with members from four Academic departments of family medicine in Bosnia &Herzegovina and international experts. Passing rate was 90%. The main examination task was written component: SAMPS and Short answer/modified essay questions to assess knowledge and problem solving skills

across the spectrum of family medicine.
Next step for this very important group of specialists will be crucial moment for the future of family medicine in Bosnia Herzegovina: to practice family medicine throughout of country.

Postgraduate study
Four members of Academic departments finished official general postgraduate study and they are now preparing final version of project for getting master's degree certification. It is necessary according to University's law to become academic teacher. Unfortunately specific postgraduate study in family medicine for all University still is not running. After finishing first examination for residents priority within all educational activities will be implementation the curriculum in postgraduate study in Family medicine which is accepted by all medical faculties.

CME
Teaching center in every department of Family medicine have now responsibility for annual activities in CME. Several courses related to common problems in post-war period (PTSD, palliative care, Evidence based management of common chronic diseases) are running now. National association of family medicine/ general practice introduced working group for planning, accreditation and quality in this educational activities.
Association of family medicine - Bosnian College of Family medicine
First step in research process was done. Third conference focused on residents' project and presentations of research studies on primary care themes was held in Jun with participants from all Universities in Bosnia & Herzegovina.

CROATIA

Dr. Mladenka Vrcic-Keglevic
School of Public Health "A. Stampar"
University of Zagreb
Rockefeller 4
10000 Zagreb

Health Care System
There will be some reforms, and General Practice/Family Medicine will be the only one discipline working in Primary Health Care. A Pilot Project is going on in one county.

Undergraduate education
A revision of undergraduate curriculum is in discussion, as well as introduction of new curriculum in English.

Postgraduate education and VT
As I have mentioned in previous reports VT in GP had been almost stoped, becouse of financial reasons and a lack of notions of its necesity from the side of decision makers. Only 4 new trainees started VT this year.

CME
Many CME activities are going on, and the main reason is the obligation for relicencing by collecting CME credit points.

CZECH REPUBLIC

Dr. Ivana Bogrova
Stankova 12
602 00 Brno
Czech Republic

Primary Care and its Teaching in Czech Republic

Primary care is still divided into five parts in Czech Republic and it is provided by these kinds of physicians:

- General Practitioner for Adults
- General Practitioner for Children
- Gynaecologist of the first contact
- Stomatologist of the first contact
- Physician of Emergency /Urgent/ care

Most of these physicians /except emergency doctors/ work in their private practices and have contract with one or several insurance companies in our country.

Every medical doctor must become a member of the Czech Medical Chamber after graduation.

It does not exist the system of 24 hours care of GPs in our country. All GPs have their working hours during a day but in the nights, since 7 p m. to 7 a m, only some GPs /always one for adults and one for children in a town or villages/ are on duty for the acute patients in a special Medical Centers and alternate each other.

Emergency Doctors figure out all life threatening cases with Ambulance all day.

Some of the recent serious problems in Primary Care:

- the lack of money in the whole health care system
- General Practice /GP/ is not an academic discipline in our country
- the possible straight access of the patient to the specialist of secondary care without a referral from GP /expensive care/
- the level of communication and the quality of relation between patient and doctor must be improved
- communication between GPs and secondary care specialists must be improved
- increasing of the interest in General Practice among a young physicians
- improvement of GP teaching on all the levels

This system of divided Primary Care is working quite well and it is so functional that there is a major tendency to save it.

Primary Care Teaching

1/ Undergraduate education

There are 7 faculties of medicine in our country but only at 3 of them the Departments of General Practice exist. The teaching of GP is compulsory at all of the faculties of medicine. At those faculties where are not established the department of GP the teaching of GP is provided by the Department of Internal or Social Medicine. .

The way of GP teaching and the numbers of hours are different at each of these faculties.

The GP teaching is mainly focused on the essential competencies of GP, on the different ways of work of GP, on the good communication skills and on the special content of GPs work.

The GP is usually taught in the fifth school year. At some faculties our students meet GP also in the earlier school years /communication skills training in seminars, home visits of chronic

patients/.
At some faculties the GP is taught also in the last sixth school year /several weeks stay in a cooperating teaching practices/.

2/ Postgraduate /advanced/ studies

Medical students are not specialized during their basic six years University studies /except stomatologists/. After graduation young physicians interested in GP are admitted to the "Institute of further medical education". He or she has to go through 3 years cycle consisting of following stages:

- 12 months - internal medicine
- 18 months - surgery, neurology, gynaecology, dermatology, ophthalmology and so on
- 6 months - GP

After passing the GP examination the physicians obtain the professional licence and can start to work in his/her practice.

3/ Continuous Medical Education

The system of CME is compulsory for every medical doctor in Czech Republic. New system is valid since January 2001. It is based on collecting certificates and credits during the period of five years and obtaining of CME Diploma. Certifications and credits are assigned for participating in conferences, seminars, lectures, workshops, clinical days and for publications according the rules released by the Czech Medical Chamber.
These educational activities are mostly on the high level and GPs are interested in attending them very much.

PRIMARY CARE in CZECH REPUBLIC

- divided into five parts
- provided by these physicians : General Practitioner for Adults
- General Practitioner for Children /0 – 19/
- Gynaecologist of the first contact
- Stomatologist of the first contact
- Physicians of Emergency /Urgent/ care
- functional system
- working quite well
- tendency to save it

THE MAIN FEATURES

GPs: mostly work in private practices
contract with one or several insurance companies
membership in the Czech Medical Chamber is compulsory
capitation system of payment for care
system of 24 hours GPs care does not exist

SUCCESSES since 1989

- possibility of the free choice of GP
- arising of private practices
- improvement of quality of GPs care
- increasing of reputation of GPs among patients and specialists
- improvement of relation and communication between patient and doctor
- better technical equipment of practices
- functional system of CME and interest of GPs in it
- teaching of primary care /including communication skills/ at all the medical faculties

- at some of them The Departments of General Practice established

PROBLEMS IN PRIMARY CARE
- the lack of money in the whole care system
- General Practice is still not an academic discipline /no possibility to obtain an academic degree such a PhD and so on/
- the possible straight access of patients to secondary care specialists
- further improvement of communication between patient and doctor
- further improvement of communication between GP and specialists
- low interest in General Practice among a young physicians
- further improvement of GP teaching especially on the undergraduate level
- extending of activities in research

EDUCATION IN GENERAL PRACTICE
Undergraduate level
- 7 faculties of medicine
- in 3 of them The Department of General Practice established
- compulsory GP teaching
- different teaching methods and numbers of hours
- focusing on - a special way of GPs work
- - a essential competencies
  - communication skills training
  - practical skills

Postgraduate studies
- after graduation – admission to the "Institute of further medical education"
- 3 years cycle of following stages - 12 months – internal medicine
  - 18 months – surgery, neurology, dermatology, ophthalmology and so on
- 6 months in General Practice
- GP examination
- obtaining of professional license

Continuous Medical Education
- present system valid since January 2001
- compulsory for every medical Doctor
- system of collecting certificates and credits in the period of five years
- participating in conferences, seminars, lectures, clinical days, publications
- the rules of this system was released by the Czech Medical Chamber
- continue high level of educational activities

interest of GPs in CME

DENMARK

Dr Ivar Østergaard
Søndergade 18
DK-8464 Galten

Summary:
In BME reform of curriculum causes a minor reduction of general practice BME.
General Practice PST located in general practice is enhanced by longer stays and return-days in general practice.
CME/CPD has active participation of 95% of GPs, voluntary registration is popular.

Pregraduate education (BME)
At the three universities a reform of curriculum is an ongoing process in consequence of reduction of study time from 6½ to 6 years; preclinical (basic sciences) elements being reduced and most clinical elements maintained. General practice BME has been reduced with some 10% of the theoretical part, but exams are uphold.
Intake to medical schools has been doubled to ca. 900 per year, causing capacity challenges to the postgraduate educational system.

Postgraduate specific training (PST)
A revised training scheme for general practice enhancing training time in the practices from 1 to a total of 1½ year, combined with 1/1 return-days to the practice every month during hospital training, in total 24-28 days of general practice attachment during the period. 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).
Shortage of doctors in all specialities is apparent. So far general practice training obtains a sufficient number of applicants.

Continuous Medical Education (CME)
GP CME is a story of success. More than 95% of GPs utilise their money (ca. USD 1500/year) from the CME fund and 75% spend more on CME. 98% of all GPs are included in at least one (local) small group, defined by geography, interest, theme etc. Voluntary registration of CME is now established AND used! Pedagogical development & quality assurance and accreditation of CME providers are working initiatives together with more strict evaluation of CME and developing a manual of personal learning plans guiding individual GPs.

ESTONIA

Dr. Margus Lember
Dept. of Family Medicine
University of Tartu
Puusepa 1A
EE-2400 Tartu

In undergraduate medical education a new curriculum is implemented, for general practice this means more time at the 6th year. The introductory course for the 2nd year students is unchanged.

The residency program is well established, it takes 3 years to specialize in family medicine. The retraining program for experienced primary care doctors is planned to run for 3 more years, thereafter all postgraduate training will be in residency. The whole medical curriculum will change in 2003: instead of 6 yr undergraduate + 1 yr internship + 3..5 yr residency will

change into 6 yr undergraduate + 3.5 year residency.

In May 2001 the Estonian parliament approved a new health care organization act. For the first time family medicine is acknowledged in the law, all basic principles of family medicine are there: primary care provided by family doctors who have had specific postgraduate training, the principle of independent contracting in the public system, patient lists and capitation payments etc. It took 10 years to reach this law.

At the department of family medicine at the university of Tartu a doctoral thesis was defended on quality issues in family medicine, this was the first doctoral thesis in family medicine at the university of Tartu.

Estonian Society of Family Doctors celebrated its 10th anniversary. I finished my job as a chairman of the society having been at the post for 5 years (two periods).

In spring and summer I have been as a consultant to family medicine development projects in Uzbekistan and Russia.

FINLAND

Prof. Paula Vainiomäki
Dept. of General Practice
University of Turku
Lemminkäisenkatu 1
FIN-20520 Turku

Health care

The strike of public physicians lasted for months: March-August 2001. The strike was functioning in an alternating way between different groups of doctors and locations. Urgent cases were treated everywhere, but in many places no elective measurements were done. Private sector was working all the time. There were a lot of discussions in media, if this kind civilized model of a strike broke the old traditional labour way of striking. It was also discussed, if the strike should be closed down by using force, e. q. passing a law, which would stop doctors' right to be on strike. Anyhow, the public opinion seemed to be mostly on doctors' side. Finally, the negotiations succeeded, and doctors got 10 % more earnings emphasising the younger generation (doctors' request was 20 %, average in the public sector was 3,5 %). Anyhow, the strike made a lot of harm to the public health care sector in Finland. There is a shortage of doctors in primary health care, and also in the hospitals nearly everywhere in the country. Long waiting times and queues are everyday phenomena. Competition about doctors has started inside the public sector; salaries are sometimes bigger than defined in the contract. Some doctors have moved to private sector because the earnings are huge better there. The politicians are looking forward trying to help the situation with different committees and working groups. No one seems to know which direction we should choose. This is a critical point for the former model country.

Basic medical education

Of course, politicians were willing to help the situation by increasing medical student intake. The student intake of 420 moved to 550 without adequate improvements of teaching resources. This helping method may make the situation even worse in the years to come. No small groups any more, no relevant possibilities to practise clinical skills. Anyhow, we are quite happy, when having still a lot of good applicants willing to study medicine. We in

Turku piloted a new selection method, a minor part of the applicants were interviewed. Just on the day of interviewing, the government made the decision to increase the student intake, and all the applicants we interviewed got in. We liked the pilot, and maybe are going on next year. Actually there are no big changes in the basic medical education, but a shortage of resources, which is harmful to all**.**

Specialist education in general practice
The discipline is still today popular among young doctors, and the trainees got quite a high improvement in their salaries in the new contract, so we are waiting enthusiastically good times to come for general practice. But there is a bad shortage of doctors and trainers in general practice.

Continuing medical education
We are now recovering from the burden of WONCA last summer. It was really a great success, and we got a lot of positive thanks after the conference. It was a demanding task at the same time. Good luck to London! Let us hope, the world will not change too much to have a good conference next summer. In general, the topic of CME has been lively discussed, also in the negotiations for the new contract. All the concerned seem to have understood that the well being of the personnel and opportunities to continuing professional development are key points in the functioning health care. But how to solve the problem of resources?

FRANCE

No report received.

GREECE

Dr. Athanasios Simeonidis
37, Kerasountos
55131 Thessaloniki

Pregraduate education
The need of establishing chairs of general practice in some of the 7 medical faculties has turned to a must, to a demand of the GPs. There is no exposure of the medical students to general practice, except in the University of Crete. The Deans and the Executive board of some Universities started thinking of establishing department of general practice.

Postgraduate education
There are a lot of negotiations, actions and plans running this period:

- Negotiations with the ministry for increasing the number of post for VT from 534 to 1500
- Changes of the content of the curriculum: the 48 months to be separated into 3 parts – internal medicine, surgery and PHC- each of which will be separated into special parts according to trainee's needs (tailor made)
- Training of tutors and trainers
- Log book
- Harmonization of the 3 existing committees for summative assessment.

CME
The Educational Committee of the Greek Association of General Practitioners has been preparing a comprehensive program of CME trying to cover all the country. A new effort has been taken over to implement a credit system for CME activities.

General
The reform of the National Health System is running progressively mainly in the administrative field.

HUNGARY

No report received.

IRELAND

Dr. Fergus D. O'Kelly
478 St. Circular Road
Rialto
Dublin 8

Basic Medical Education
There are four University medical schools and one independent school; all have undergraduate departments of General Practice. There are about 660 graduates per year about 330 of them are foreign graduates (mainly non-EU graduates).

Postgraduate specialist training
There are ten independent GP training programmes with a total intake of 63 trainees.
It is intended to expand the intake to 100 over the next couple of years, with the addition of one or two new schemes. For the last ten years places on the training schemes are highly prized and training schemes have attracted the highest calibre of graduate. A national conference is planned to discuss the expansion of numbers in training and also the length of training. The Irish College of General Practitioners (ICGP) policy is to extend training to five years; that is two years rotating through hospital specialist training posts and then three years in supervised training in General Practice.

Continuing Medical Education
There is an active network of local ICGP faculties each with one or more CME groups, which are supported by CME tutors. These CME tutors are remunerated by the ICGP for their work in supporting these groups.

Health Care
There is a mixed public health and private care system, which was grossly under-funded throughout the 1980's during a period of financial hardship. We now enjoy a much-improved financial situation, however the medical infrastructure is badly in need of a great deal of investment to increase the numbers of acute hospital beds and general facilities. General Practice is still the poor relation in the medical family and does not receive proper funding.

ISRAEL

Dr. Yonah Yaphe
Kibbutz Harel
Israel 99740

Basic Medical Education
In Jerusalem, Arthur Furst reports that the medical school has asked the department to double its teaching time in the final-year medical student clerkship in family medicine from 2 to 4 weeks. It remains to be seen if the university will provide the resources necessary to accomplish the increased workload. The Jerusalem department will be celebrating its 25th anniversary this year. In Tel Aviv, the department has introduced a new logbook for medical students to record activities during the clerkship, to demonstrate the wide range of activities in general practice and to promote reflective learning.

Vocational training
The national examination committee for vocational training, under the direction of Chava Tabenkin from Afula, has been busy revising the format of the summative examination for specialization in family medicine in Israel. At the upcoming exams in November, the clinical section will include a new map of domains to be tested and new standardized questions and the practice organization section will be changed to reflect changes in practice in the country. A national workshop for examiners was held in June. It included video exercises of simulated oral examinations and showed the difficulties in standardizing oral exams.

Continuing Medical Education
The national family medicine conference was held in May in Jerusalem and was opened by our new Minister of Health. A large number of original research presentations by family doctors made for a successful conference. In Tel Aviv a poster fair for young specialists in family medicine will be held October 17. This fair will highlight teaching research and administrative projects done by Tel Aviv graduates in the past year. A teacher-training program for young teachers began in September, led by Howard Tandeter from Be'er Sheva. The program will run over 6 weekends during the year and will provide hands on experience with learning theory, teaching methods, writing and computer skills, and use of video. A program of CME by distance learning via Internet is still in the planning stages after a successful pilot lecture.

ITALY

Dr. Francesco Carelli
Via Ariberto 15
20123 Milan

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 (fourth year in Modena). 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 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 were studying how it's working to arrive to a system accrediting also curricula, active participation at congresses, and distance learning systems (more difficult to organise and value).
But, 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.
Since Council in Hungary, there was a change in Minister and a change in the Government, after political elections. Now nothing is clear: Scientific Societies are taken away from real discussion, CME by Internet accreditation is not working and points are attributed automatically not seriously, not getting real control on providers, the period as prove will be surely delayed for other six months or more. Confusion is general. Debate is degenerating with fighting between all, and not good figures appearing in the scenario using the situation for commercial purposes.

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 brought two works 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 of not proven efficacy about prostate screening, also managed taking out GPs. …But nothing in common was done after, debate on CME is teaching, and General Practice is now in strong danger on a political change toward an " American " way of primary care.
Regional devolution is going on profile, and GPs' role also as gatekeepers and mainly as specific professional (still lacking in Italy) is in danger. From looking to University, we are in danger to have to look for surviving in a new economic system managed by private insurance.

LITHUANIA

Prof. Egle Žebiene
Staneviciaus 33-6
2029 Vilnius

General situation in health care system has not changed much during the previous year. Widely declared of priority of Primary care level has remained mostly theoretical declaration.

The overall economical situation has been informed to stabilize (GDP increase during the last half a year was 5,1%), so it would be reasonably to expect stabilization of situation in health care system. Unfortunately, it became a tradition to reduce funding for Health care for 0,1% every year. Law of Health care defined 5% of GDP level for health care financing, but it has not been reached until now (this year it was 4,3% of GDP).
So, no wonder, that health care reform is slowing down, only cosmetic changes being made. Limits on financing of health care institutions (quotation of health care services) are considered as not popular but necessary measures of balancing limited resources. Revision of list of essential medications is another unpopular measure causing a lot of dissatisfaction both for physicians and population.

The good news is that politicians start to understand that only strong primary health care based on general practitioners can affect the situation in a positive way. The question is how to implement priority of PHC, as resistance from the side of narrow specialists is becoming more and more aggressive proportionally to the worsening of current situation in Health care.

Teaching of General Practice is undergoing some positive changes too. Not only undergraduate and postgraduate training of GP is provided more and more by general practitioners. We are trying to start at Vilnius University courses on CME organised by GPs, which were run until now only by specialists of different specialties. Most of GPs agree that specific requirements of primary health care as well as GP teaching can be met best GPs organizing the courses.

NETHERLANDS

Prof. Harry Crebolder
Maastricht University
Dept. of General Practice
P.O. Box 616
6200 MD Maastricht

Basic Medical Education
The construction and introduction of a new curriculum in Maastricht and other medical schools as well is in full swing.
At the national level can be mentioned that the book "The medical process" is very well received and sold. A second book containing "Problems" related to the first book is in statu nascendi. These books are written by a "consortium" of GPs, representing all medical schools.
The Blueprint 1994 "Training of doctors in the Netherlands" is revised and will be published soon. There are no major changes. This blueprint is the official cornerstone and gold standard for all medical schools.
Europe is entering the medical training via the Bologna declaration. The Bachelor Master (BAMA) structure has in one or another way to be introduced in the basic medical training.

Postgraduate training
A new programme is conceived and worked out. It is gradually introduced.
A major point of concern is the lagging interest in GP-training. A point of vigilance remains the integration of the postgraduate training in the academic department.

CME/HPT
No news on the CME front, apart from a change in the accreditation financing.

The HPT programme is gradually getting shape and will be presented to you next year in April.

Health care
A national debate on the position and function of the GP is going on. Representatives of the Dutch College and the National Association of GPs are together touring the country to investigate and collect the feelings, opinions and ideas about the future of the GPs and the trainees. There is an overwhelming sense of being overburdened and underpaid. The question is whether working in the call and emergency centres, put up in all the regions, are still being regarded as a primary task of the GP. This might have major (negative) consequences for the future position of the GP in the health care system.

THE NETWORK OF TEACHING CANCER CARE IN GENERAL PRACTICE. HIGHER PROFESSIONAL EDUCATION IN THE NETHERLANDS.

Report of Bernardina Wanrooij

The Network of Teaching Cancer Care General Practice.
At this moment the Network of Teaching Cancer Care in General Practice is looking for a way to stay alive. The second project year has ended officially in December 2000. Till that date the Network had financial support from the Europe Against Cancer programme to run the national programmes and the Network itself. Application for a third phase has not been accepted. In this third phase we aimed at organising a structure in which we wanted to combine courses in teaching cancer care in General Practice and Network meetings. The members of the Network were supposed to teach in the courses.
In order to keep the Network running we now consider organising our Network meetings during international conferences like WONCA. A clear structure has not been developed at this moment.
The outcome of the two-year's project can be seen on national levels and on a smaller scale internationally. In most countries the programmes have had a much wider impact than only the benefit of one teaching programme for the participants. The experience acquired in the projects has been used to set up similar programmes in other places. Participants and teachers of the projects are involved in national developments because of their expertise gained in the Network.

I will now describe the development of Higher Professional Education programmes in the Netherlands in some more detail because of my involvement in this field.

Higher Professional Education
Since 1996 the Dutch College of General Practitioners, together with the Dutch Organisation of General Practice, is developing Higher Professional Education Programmes. By following such a programme a general practitioner has the opportunity (at this moment) to become more skilled in one of the following fields in general practice: cardio-vascular diseases, diabetes II, Astma/COPD, psychiatric diseases, Gastro-enterology, Uro-gynaecology and Palliatieve care.
This development wants to meet the needs deriving from developments in health care and demographic changes. It also wants to meet the needs of GPs to develop their career in the field of management, policymaking, consultation and teaching of other general practitioners. The first programme, palliative care, has started in January 2001. The second programme will start in April 2002.
CME in the Netherlands is organised on a regional level. One of the options for GPs with a diploma in one of the above-mentioned fields is that, after finishing the course, they will work at this level in order to make use of an already existing system for CME. GPs who

follow the course in palliative care are trained for consultation and educational tasks. When working at a regional level, they can make them selves known to their colleagues. This is an important condition for giving consultation to others.

The palliative care programme
The palliative care programme started in January 2001. The duration of the programme is 1 ½ years. The main issues in the programme are content, consultation skills and teaching skills. In other programmes the focus may change, according to the goals set in the programme.
In the palliative care programme we have chosen for three steps in the learning process: reading of literature preceding a course day, application of the subject on the course day and home work to stimulate reflection and implementation of changes in the daily practice. For the provision of literature we co-operate with the distant learning course in palliative care in Cardiff. The participants work with a portfolio, they have to fulfil a quality improvement task and do a hospice apprenticeship. The participants have to bring the above-mentioned tasks to a good end, and to pass a post course extended match questionnaire in order to fulfil the diploma requirements.

Organising a Higher Professional Education for the first time has not been an easy task. It is important to take sufficient time to prepare a course like this. The outlines of the programme have to be clear, together with the diploma requirements and the methods used in the programme. The secretarial support is of great importance
Lessons learned from this project are being used in the organisation of the second programme. This is due to start in April 2002.

NORWAY

Dr Anders Baerheim
Division for General Practice
Ulrkisdal 8C
N-55009 Bergen

THE SITUATION IN NORWEGIAN GENERAL PRACTICE 2001
Norwegian general practice has experienced two innovations last year.

1. The list system
The first of June the former free for service system of Norwegian general practice was changed to a list system. All Norwegians were asked by the health administration to choose their GP by listing three choices. Were no choice given, they would be placed at the list of a nearby GP. 20% of the population were expected to make an active choice, 80% did.
GPs were free to discuss the length of the list between 500 and 2500 inhabitants, with a norm 300 for each working day. There was a lot uncertainty in the preparation of the list system, but we also experiences that most GP who then worked private outside the health system, went for the list system, turning their private shops into general practices within the system. Now, four months after, some patients, mostly living in Oslo West end, are dissatisfied with the increased necessity for a referral to go to a second-line specialist. In many rural or semi-rural districts however, the waiting lists in the GP surgeries are shortened, and people's utilisation of the on-call system evening and night has diminished drastically.
More than 100.000 Euro has been granted by the Norwegian medical association for small-scale evaluation of the system, and the health authorities plan some bigger evaluation

projects.

2. A new deal for general practice

The Norwegian Society for General Practice (NSAM) sees the need for redefining core concepts of general practice, and has adopted the following working strategy over the last two years. This working strategy encompasses the following steps.

- Biannual meetings among interested members of the NSAM, exploring different aspects of the work in general practice. An anthropologist was also present.
- Concepts were elaborated between meetings by the NSAM board, and sent members for feedback.
- Results from each meeting were used in the planning of the next.
- Speeches from the biannual meetings were printed in Utposten, the Norwegian journal for general practice
- A stage-by-stage writing dialogue in Utposten, in co-operation with the editorial board and the readers.
- Presentation of and feedback on the working process wherever GPs met.

The present working document "Seven postulates" (see below) has recently been put together by the NSAM board in co-operation with a selected group of experienced Norwegian GPs.
The process is not finished. The "seven postulates" is printed in a form suitable for putting on the wall of GP surgeries all over the country. This may be regarded as an fermentation process preparing the next step of our working strategy. Let us see what then happens.

SEVEN POSTULATES FOR GENERAL PRACTICE - a working paper from the think tank of the Norwegian society for General Practice.

Anno 2001 there are increased possibilities for medical treatment, but also for commercialisation, medicalisation and consumerism.

A new description of **general practice** in the new list system shall

- Clarify the responsibilities of the GP
- enforce properly use of medical technology and medicaments
- provide a base for the content of the CME
- create realistic expectations to the health system
- strengthen the doctor's professional identity and security

1. Maintain the doctor-patient relationship!

The doctor-patient relationship forms the centre in general practice. The most important is the personal meeting and the dialogue with the patient over time.

2. Do what is most important!

The main task of the GP is diagnostics and treatment. The doctor is:
An interpreter of the patient's symptoms and complains: identifying those who need treatment, and sparing the healthy patient from unjustified being treated as ill.
Tutor and teacher: Helps the patient to understand his situation and how it may be mastered or relieved.
Witness and companion: follows the patient and his family through illness and suffering.

3. Give most to those having the greatest needs!

Expectations to general practice surpass both ideal and practical possibilities. The GP must

organise his working day-to-day strategy to give room for the patients with the greatest needs for help. He should also consider treatment costs; if several treatment options are equally effective, the low cost option should be chosen in order to let the resources be of benefit also to others.

4. Use words that promote health!
The GP shall promote the patient's faith in own coping of his health and everyday living. The GP shall develop a language that limits the diagnosing of risk conditions and prevent prophylactic treatment with meagre outcome.

5. Promote CME, research and professional development!
Practice shall be founded on best documentation, practical skills and experience-based knowledge. We shall develop concepts that combine description of illness and suffering with human relations, and give an understanding of embodied life. Medical ethics shall describe the respect for human dignity as a necessity for health and cure.

6. Describe your experiences from your practice!
The prevention of illness and non-health is often a question of changing social conditions. The doctor shall systemise his experience and share his knowledge of illnesses and non-health in the population with governments and politicians.

7. Take the leadership!
The GP shall take active responsibility to ensure good co-operation between health- and social workers in the community. The GP shall contribute to prioritising second line health services for those with the greatest needs. In co-work with other health workers, he must promote an optimal use of medical resources. As an leader of his surgery he must facilitate professional and personal development of his co-workers.

Very unofficially translated for the EURACT meeting in Barcelona 2001 only, by Anders Baerheim.

POLAND

Dr Adam Windak
Department of Family Medicine
Collegium Medicum of the Jagiellonian University
Bochenska 4
31-061 Kraków

Undergraduate education
Number of teaching hours at BME for family medicine is still unclear. There is a progress on talks with the Board for Higher Education which agreed for 80 hours, however due to budgetary problems of the State we cannot expect any decision increasing expenses. So, we are still waiting for future development, while in the meantime big variation between the universities still exists (from 20 to 260 hour for a curriculum).

Postgraduate education
The law about vocational training of physicians is consistently changing. We manage to delete all the discriminating paragraphs, however new changes are expected even this week. We hope to strengthen the position of family medicine and of the College.
Continuous Professional Development

A little progress in this field. Although pharmaceutical companies still dominate on the educational market for CME, certain efforts have been undertaken to make an order. Firstly the bid of the College was accepted by the World Bank and we have received quite large grant for second edition of the school of tutors, who will be leaders of peer-review groups. So, in near future we can expect some influence on the contents and methods of CPD. Secondly, educational journal of the College is launching the educational company, which is going to organize courses for family physicians.

Other issues
On October 18, 2001 we start our III National Conference of the College with the participation over 500 physicians. There are over 80 presentations, workshops and seminars accepted. In the same time we host meeting of EGPRW, which visit Poland for the first time as a second European group after EURACT. You can imagine how I am busy with all the arrangements.

RUMANIA

Dr Iuliana Popa
Str. Soficu 22
6600 Iasi

Undergraduate education
Number of teaching hours at BME for family medicine is still unclear. There is a progress on talks with the Board for Higher Education which agreed for 80 hours, however due to budgetary problems of the State we can not expect any decision increasing expenses. So, we are still waiting for future development, while in the meantime big variation between the universities still exists (from 20 to 260 hour for a curriculum).

Postgraduate education
The law about vocational training of physicians is consistently changing. We manage to delete all the discriminating paragraphs, however new changes are expected even this week. We hope to strengthen the position of family medicine and of the College.

Continuous Professional Development
A little progress in this field. Although pharmaceutical companies still dominate on the educational market for CME, certain efforts have been undertaken to make an order. Firstly the bid of the College was accepted by the World Bank and we have received quite large grant for second edition of the school of tutors, who will be leaders of peer-review groups. So, in near future we can expect some influence on the contents and methods of CPD. Secondly, educational journal of the College is launching the educational company, which is going to organize courses for family physicians.

Other issues
On October 18, 2001 we start our III National Conference of the College with the participation over 500 physicians. There are over 80 presentations, workshops and seminars accepted. In the same time we host meeting of EGPRW, which visit Poland for the first time as a second European group after EURACT. You can imagine how I am busy with all the arrangements.

SLOVAKIA

Dr Eva Jurgova
Stefanikova 111
92101 Piestany

The recent main problem in Slovak health care is the total lack of money in the health sector. The health care transposition process, started in 1990, is recently in its deepest crisis.
It is clear that without radical changes, including reduction of health care services provided free of charge (as an inheritance of the previous, communist health care system), there is no chance to get the health care out of its huge debts. Of course this kind of changes are very unpopular. Patients, asked to pay more and more not only for medicines, but also for medical services, criticise the government and the government now, 8 months before the new election, is afraid from loosing popularity, so trying to postpone any radical changes for later. This is leading to a real problems and chaos in health care, both in hospital and in ambulatory care, caused by lack of ability to cover financially the appropriate health services, and in the end there are unsatisfied patients (very often reasonably unsatisfied).
Some health care experts are talking about the threat of health care collapse, but I do not see the situation that black, especially because most doctors - mainly in primary care - are willing to continue in providing health care, despite their low financial evaluation, with all their effort and devotion.
It is clear that in this situation not too much attention is paid to the medical education.

Undergraduate education
In accordance with the ***EU Directive 93/16*** all Slovak Medical schools started to put more stress on GP/FM teaching. There are four Medical schools in Slovakia, and at two of them there are still no Departments of General practice and Family medicine, although teaching of General practice and Family medicine became a compulsory part of undergraduate educational at all of them. At those Medical schools, where none Department of GP/FM is established, teaching of GP is provided by the Internal medicine or Social medicine Departments. Some 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.

Postgraduate education
Vocational training for General Practice is 3 years. Future GP must spend two and half years on various hospital and polyclinic departments and there is a request for spending 6 months in „teaching practice". Lack of teaching practices is the reason that the last mentioned condition is in many cases not fulfilled in reality. The process of accreditation of teaching practices is still in progress.

Continuous Medical Education
Recent system of obligatory continuous medical education: *„CREDIT POINT SYSTEM CME IN GENERAL PRACTICE"* is now accepted with real respect. 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.

SLOVENIA

Prof. Igor Švab
Institute of Public Health
Trubarjeva 2
61000 Ljubljana

Undergraduate education
The usual work is going on at the undergraduate level. We have introduced only a few minor changes in the curriculum. There have been some moderate changes towards problem based teaching at the medical faculty, but no major changes have happened. I have been asked by the dean to be one of the members of the group, but no major changes are expected. There is no real support.

On the other hand, I am no longer the only university teacher of family medicine at the Ljubljana medical faculty, since one of my co-workers has also obtained a title of a lecturer. This is a great relief: I do not have to do all by myself anymore.

Vocational training
We are still struggling with the vocational training. Although the changes in the vocational training scheme have been formally accepted according to the EU regulations and the new vocational training lasts for four years, two of them in general practice, the implementation of that is a big problem. The medical chamber which is the responsible body for the vocational training, refuses to acknowledge the work of the department and the society. The chamber wishes to do all the work by itself, which is a major problem, since we have no influence there and since it is heavily dominated by the specialists. The still want to sit in the final exams of the trainees which is not justified, since we have more than enough experts who can do that.

CME
The Bled course was a success. The theme was "learning and teaching about out of office medicine in general practice". It was the 10th anniversary of the course. We have had 47 participants from 13 European countries, East and West. I was especially pleased by the EURACT sponsored participants who have been all very interested and hard working. The work done by course directors, especially Yonah Yaphe, was excellent. We are planning to introduce some changes in the course next year, mainly to adapt to the growing number of participants and to accommodate participants with varying level of expertise in general practice. The theme next year will be "Medical errors in general practice".

SPAIN

Dr. Dolores Forés
Avda Bartomeu 37
Bellaterra
08193 Cerdanyola (Barcelona)

Undergraduate Education
In Spain we have 27 Faculties of Medicine and still there are no departments of Family and Community Medicine in Spain, but in 85% of the Medical Schools there are academic activities related with Primary Care, in 81% stages in primary health centres, in 22% optional subject and in 11% mandatory subjects.
Actually we have 143 associated professors and 4 nominated professors.
Prof. Martín Zurro is the first full professor of Primary Care *("catedrático")* in the Autonomous University of Barcelona. He is encharged to organise research and continuos medical education in Primary Care / Family Medicine and also to promote thesis and formal Academic work in that area.

Postgraduate Education
Courses for clinical tutors are widespread all around the country. Our tutors in short time will be not only good doctors; they will also become good teachers (trainee centred approach, problem based learning,) with widespread use of video recording for teaching.
Next year to become trainee all the candidates (newly licensed doctors) must pass the same unique exam for all specialities, no one exam for Family and Community Medicine and another exam for the other specialities like it has been in the last years. That is very important for family doctors because we want to stay at the same level as the other specialists.
The claims for a specific training of four years duration are each time bigger.
As each year our big annual meeting (November 2001 in San Sebastian) will be preceded by the teachers meeting, with different topics (analysis of the actual situation of the postgraduate teaching in a family and community medicine and also motivation in teaching).

Continuing medical education
Still working on clinical evidence based guidelines with a good acceptance by the colleagues. A very high number of activities are organised by our national society (semfyc) and also the local autonomous societies. Each times more and more the quality and the acceptance of that kind of activities are increasing, the accreditation of those activities still depends on the Ministry of Health.

Others
We export doctors and nurses to other European countries. Some of you will have an opinion of the professional quality of those brave friends. I can tell you, that in some countries the salary of those young professionals is more that two times higher as the salary of our more experienced doctors.

SWEDEN

Prof. Bengt Mattsson
Dept of Primary Health Care
Vasa Hospital

SE-411 33 Göteborg

Health Care
The implementation of the "Nationella handlingsplanen" (*The National Action Plan*) is in focus in Sweden these days. The Swedish government has given 9 billion SEK (Swedish crown, equal to about 60 million pounds) from the year 2002 to 2004 to the primary health care. The 13 County Councils of the country will in a couple of months' time present the strategy for how the money will be spent. We hope for a focus on the increase of the number of GP posts, that is the main obstacle for a more efficient primary health care in Sweden. During one week in early October the Swedish Association of General Practitioners launched a campaign in the country to focus on the need for more GPs. The campaign was also intended to be a reminder for the County councils to use the money in the way they were aimed at. In television, radio and some major daily papers the message has been renewed in various ways.

Another important issue is the start of an *Institute of Family Medicine*, probably from year 2002. The aim of the Institute is to stimulate and encourage CME among GPs (and to a certain extent also other primary health care personal like district nurses, physiotherapists, midwifes) and also to inspire research/developmental work and vocational training. We hope that the Institute will be a strong and autonomous body that hopefully in a couple years has tasks and functions as the British Royal College.
One question under debate in the planning of the Institute is a proposal of a new official name of our profession - a change from the most used term "allmänläkare" (General Practitioner) to "familjeläkare" (Family Practitioner). It is motivated by the need of more of family orientation in the daily work but the suggestion has not received acceptance among all colleagues.

Basic medical education
Primary care has in all universities been accepted as a necessary part of the undergraduate curriculum. Almost all schools are now engaged in a change, always including more involvement of GPs as teachers. In Göteborg for example, this autumn a new course (Early Professional Contact - EPC) has started. It encompasses one week every semester in two years and the students will be presented and introduced by a GP in the first clinical contact.

Vocational training
There is still a great need of more trainee posts in general practice. According to the calculation by the Swedish Association of General Practice every second of all new trainee posts during the coming four years need to be established within general practice if the goal of 1 GP per 1.500 inhabitants will be reached.
The goal-oriented approach of the vocational training seems to work out quite well. More and more of the GP spend less time in hospitals and longer period in general practice during the suggested 5 years.

SWITZERLAND

Dr. Andreas Rothenbühler
Fabrikstr. 4
CH-3250 Lyss

Undergraduate education
Also in this year the number of students wanting to start at our medical schools is higher than the places available. But only in one of our five schools exists a „numerus clausus".(Although we evaluate the process of students-selection we are not sure we take the ones that later become good doctors, but they seem quite good to pass the exams.) So there will probably be no shortage of doctors for the next time.
At all our schools the reform of the curriculum are continuing and will probably be finished within the next 3-4 years. At the university of Bern we start with the reformed 3.year this autumn, that means the first clinical year.
At the moment we are fighting for money to introduce a 4-weeks block in general practice in a one-to-one teaching situation in the 4.or 5.year of BME. At the same time we try to establish a network of around 150 teaching practices and how to select, assess and train them.
What stimulates us very much is that in students-evaluations we see that more and more GP-activities are demanded within all sorts of lectures, workshops and so one, often together with the specialists. But as the GP usually is not paid for such activities we have a shortage there.

Postgraduate education
No important changes have taken place since my last report, except that the obligation of a thesis to get the title of a specialist in GP has been cancelled. Within the departments of GP at the universities we are unhappy with this as we try to stimulate research in GP as much as possible.
The problem of financing the 6- months training in GP is still not solved so that a lot of trainees cannot take that opportunity and we cannot declare it as compulsory.

CME
Slowly the influence of GP's on CME-activities even those led by hospitals or drug-companies is increasing so that the outcome is more and more valuable. We have trained regional CME-responsibles (GP's) to work together with local organizers since 2 years, to control that the criterions the GP's association has established are checked.
The system that every GP has to fulfil 80 hours of CME per year has found wide acceptance.

Health System
Following the changes within society, the motivation of the young doctors to become a GP in the traditional way is lowering, namely in remote areas. A lot of them are looking for sub-specialisation (e.g. acupuncture) and then working mostly in this field. Together with a rapidly increasing amount of women we fear a substantial shortage of GP's within the next 5-10 years.
The other problem we face at the moment is that we loose our right for the obligatory contract with the insurance companies having received our title as GP. So the companies become a lot more power, trying to select cheaper GP's. Without such a contract it is impossible to work as a GP in our system.

TURKEY

Dr. Okay Basak
Adnan Menderes Univ. School of Medicine
Dept. of Family Practice
09200 Aydin

The developments of family medicine teaching

The role of family medicine in undergraduate medical education is being discussed within the academic settings. The training of medical students in general practice is now in the agenda of medical schools in Turkey. This requires preparing the primary care settings for teaching and training the teachers in general practice.

As Turkish EURACT members we have been holding 'teaching courses' for training the interested family physicians and general practitioners in primary care. As you all know the first course was held just before the EURACT council meeting in Kuşadası in October 2000 (29 participants). The second was in the end of June 2001 in İzmir (32 participants). Again, thanks to Mladenka for her contributions to the course as a course leader. We have just carried out the third course in Aydın last week (18 participants). These courses were on the national level and under patronage of the EURACT. We intend new courses before the end of this year and thereafter.

The activities for training the teachers in general practice have resulted in an opportunity of co-operation between family physicians and GPs for joint efforts towards developing the discipline. The second and third EURACT courses were carried out by participation of both family physicians and general practitioners. The next courses will be held with the participation of both as well. Now re-training of the GPs in general practice is in the first rank of the agenda of the joint action of the GPs and family physicians.

In my last report I mentioned that we were in trouble concerning the academic development of the family medicine. There was a proposal of new regulations on academic career track from Turkish Council of Higher Education. The most critical stage of this track is the Board exam for promotion to associate professor. Fortunately this proposal was not accepted and the Board exam in the field of FM will go on to be done.

UNITED KINGDOM

Dr. Justin Allen
Countesthorpe Health Centre
Central Street
Countesthorpe
Leicester LE8 5QJ

You will remember that in my last report I described the large amount of change that the National Health Service is undergoing and commented that we are all reform weary. Things have got worse! A whole series of management re-organisations is currently being undertaken, many of these with little in the way of preparation or even thinking. Some examples of these follow.

Funding medical education

The funding for undergraduate and postgraduate medical education is being merged with funding streams for nurses, midwives, and other care professionals. New bodies called Workforce Development Confederations have been set up but are not yet working fully, even though the funds have already been merged. In my own region I am unable to appoint new staff, as the employing authority will cease in this function from 1 April, but the new employing authority still doesn't exist. To add to the confusion it was decided that from 1 April next year I would be responsible for all postgraduate medical training in the county of Northamptonshire. It has now been decided that I am no longer going to be responsible for postgraduate medical education in the county of Lincolnshire. I am supposed to produce an investment plan for general practice training in the area for which I am responsible but as this area varies from week to week this is rather difficult.

General practice developments
There have been some welcome developments, and major cash injections. However the lack of forward planning means that these will be difficult to achieve. It was announced that funds would be made available to develop general practice premises in order to increase teaching capacity, but details, and amounts, are still awaited. There has also been announced funding to support an education programme for those entering general practice for the first time. This will provide them with 20 days of protected learning time during their first year in practice in order to consolidate their learning from general practice training. Sufficient funds have been provided some of these doctors can be released from their practices, but very little for the provision of the education that they will require.

Doctor shortage
As I reported to you six months ago this is still a major issue and the overseas recruitment drive continues apace. Advertisements have been placed in many national journals, and it is reported that for general practice these have appeared in Holland, Germany, and Sweden. An agreement has been negotiated in Spain to recruit doctors and nurses. However the New Zealand government has taken exception to this approach and has refused to allow advertisements to be placed there. There is also a major drive to trained more at home, hence the support for increasing a general practice training capacity. However although we have produced more training places there has only been a marginal increase in the numbers taking them up.

Annual Appraisal
Plans for annual appraisals have developed in so far as funding has been earmarked for the appointment of appraisers. It is not clear who is to train them or how they are to be trained. A large amount of time and effort is being expended in the identification of under performing doctors. Very little time and effort is being expended in developing a structured educational programme for those that are so identified. There has been a government statement suggesting that the culture of blame should change within the National Health Service. Unfortunately they do not appear to practise what they preach - "doctor bashing" is alive and kicking.