Annex 1

Review of national educational activities after EURACT Council meeting in Vilnius, 2003

EURACT Council meeting
September 10–13, 2003
Leicester, United Kingdom

COMPILATION REVIEW OF ACTIVITIES
LEICESTER MEETING, September 10-14, 2003

ALBANIA
Basic Medical Education
The Basic Medical Education remains mostly hospital-oriented and Primary Health Care elements are only now being included, but very slowly. For many reasons we were not able to introduce Family Medicine in the curricula of the medical students for this academic year.

Postgraduate Training
The duration of Postgraduate Training in Family Medicine in Albania is still two years. We are negotiating to extend the programme to three years and to reorganize the curriculum, but due to economic constraints and many other reasons this can not be guaranteed for this year. Half of the training period is expected to be spent in primary health care settings under the supervision of qualified family doctors.

Continuous Medical Education
Using all the resources available and the international help, we have managed to develop a CME Curriculum for the doctors who have completed the Postgraduate Training.

AUSTRIA
Pregraduate education
The evaluation of the GP-lecturers by the students of the University in Vienna was very good. For the coming year there will be again a lot of students and a lot of GPs are involved in teaching at the university now. The summative examination was not passed by many students, but they will have a second chance and more detailed information about this situation should be known by the next meeting.

Postgraduate education
There is still no money for the teaching practices. Some new ideas are discussed, like while still being a member of the hospital staff and work for night duties, the trainee should be during day time in a teaching practice of a GP.

The taking over of a new GP-practice gets new regulations (EU laws make it necessary). It will be more difficult to find the proper follower, as there is a list of waiting GPs, set up by the Doctor` Chamber, that has to be followed. The list also includes a point system for the waiting GP.

CME
There will be another Winter-Conference on the Arlberg in January 2004 organised by the Austrian Society of GP (OEGAM).

Political situation
The insurance companies lack money, the politicians are discussing changes, but the situation for the GPs is still the same. After election in the Doctors Chamber a GP became the president of the Austrian Doctors Chamber again. The insurance companies are making a survey how easy it is to reach the GP-office for handicapped people and put much pressure to prescribe cheaper medications (generic products).

BELGIUM
Basic Medical Education

All of the medical faculties are preparing for the external visitation January 2005. It always is the moment for changes. It traditionally starts with the self-reflection document, and that means discussion and evaluation on the options and effect of the implemented innovations.

Vocational Training
The new introduction of limited placed in clinical specialty training, which is operational now, causes the expected problems of GP recruitment: for the 100 GP training places, we for our department have at the

beginning of the "flexible selection year" only 45 starting candidates. The expectation is that others will change during this year to general practice as a second choice.
After getting his doctoral degree, Jan Degryse is nominated as co-responsible for the GP specialty training program. Yesterday also Sandrina Scholl defended her doctoral thesis on the educational quality of our training posts. Basically the educational quality level is rather low, according to the OSTE- test battery she developed. Being a good GP does not automatically means being a good teacher. Learning plans and portfolio will be used to start a process of involvement and quality of teaching assurance.
With the interuniversity program group, we had in august a mission project to South Africa. The SA government decided to make GP a compulsory 4 years training program from 2009 on. There is a need to create some 2000 teaching places for that time. Our Flemish government created a support project for the 8 university departments joint program. We visited their district hospitals, primary care facilities and rural clinics. There is a huge teaching capacity. But the pressure of the clinical work is so big, that it will not be easy to but not enough time and focus for teaching.

Continuing Medical Education: no news, only impasse.

Health Care
A new government and a new minister again will give a lot of uncertainty as to the future government policy. The new minister is a Walloon socialist with no experience at all to the medical field. In good socialist tradition he will first organize "health hearings" where everyone involved in the field can say his things, and then nobody takes care of it.
The started change to regional primary care groups continues to develop. Last Saturday the Flemish support program started with the installment of the provincial facilitators that have to steer the process.
Within the different GP organisations, an important process is started to merge to one professional organisation structure. It is called the "domus medica" move.

What did I do as a EURACT council member

The Belgian Core Content Group, a strategic forum with the seven university departments and the two scientific societies, will meet next week to finish a policy document for the new minister. The new definition document in its practical implications, that is what will be in it.

BOSNIA AND HERZEGOVINA

Introduction
At the end of this academic year Family medicine in Bosnia Herzegovina have a lot of new specialists who start to work in different part of Bosnia and Herzegovina. In the same time many doctors have finished final exam after retraining program, therefore in this year family medicine has been implemented widely in practice. Health insurance, financing and payment system still do not follows development of family medicine in practice and education. There is still strong resist to accept family medicine as distinct and independence clinical discipline.

Undergraduate education
New curriculum in Medical faculties in four University centres in Bosnia Herzegovina (Sarajevo, Tuzla, Banja Luka, Mostar) has been accepted. Family medicine becomes the main clinical independence discipline for students in 6th.year. Additionally EURACT members accomplished to introduce family medicine as elective subject in early stage of study. Still there is continuing trend to increase number of students in all faculties, therefore we need many teachers in family medicine. University's payment system does not support this trend.

Postgraduate specialist training
A specialisation program in family medicine is going on successfully in all universities. This month new generation (52 residents) start to learn family medicine according to the accepted plan and program of specialisation. New teaching sites (satellite teaching centres) have been open. FMDs in all university are trying to keep international collaboration in all educational activities.

Postgraduate study in family medicine
There is not any change since last report.

Continuing medical education:
There is not any change since last report.

What I have done in my country as EURACT member

During last year my activity as a representative of Bosnia Herzegovina was:
To spread translated booklet WONCA "The European definition of GP/FM" to all doctors in FM practice and to Departments of Family medicine in Bosnia Herzegovina.
To introduce national network for research.
To support and to lead the group of family medicine doctors as participants for introduce Bosnia and Herzegovina in WONCA conference in Ljubljana.
To establish undergraduate curriculum for familymedicine.

CROATIA

News from Health Insurance

Besides obligatory, an additional, volontary, health insurance was introduced. In previous times, different types of participations (drugs, some diagnostic's tests, specialistic's consulatation, hospitals) were paid directly by the patients. Now, they are covered by additional insurance. Certain groups of populations (about 40%) do not need to have additional insurance: children, school children and students, and people under a certain amount of income (poore people).

News from GP Assotiation

Annual Conference was held in April in Zagreb. And the topis were "Acute respiratory diseases" and Respiratory alergics". About 800 GPs participated, almost 1/3 of all Croatian GPs, 120 scientific's papers were presented (different quality). Annual Symposium, more related to organisational issues, will be held 5-7 October.

Undergraduate education

Is continuing on regular basis, GP/FM subject is at 6th year, last 4 weeks, a Hanbook for Teachers and Student - **A Study Guide**, was finished. It contains: a description of subject, general objectives, organization and timetable, methods of evaluations and assessments, and description of each learning unit, including specific objectives, methods of teaching, organization and timetable.

Postgraduate education - Vocational training

Postgraduate education is a part of vocational training (organised teaching), but it can finished with master deegre. Vocational Training, specialization, was not started this spring as we expected, but our minister promissed nex autumn (not believe to the polititians). As I described in previous reports, the profession and the departments of GP/FM are ready to accept a large number of trainees. It is planned to have about 150 trainees per year. This year, 5 courses for trainers were carried on and 145 finished thar basic training course. Additionally, one CME workshop for trainers was held during the Conference.

CME

Is going on regular basis, as a part of recertification procedures.

Other news

"A. Stampar" School of Public Health was nominated as WHO Cllaborative center for training in PHC, and me as Director, and I was also taken resposibility as Head of The Depertnment of Family Medicine.

CZECH REPUBLIC

BME

There are no core changes in BME since May 2003. General practice is the subject of teaching at all seven Medical Schools in Czech Republic but in different extend and in different school years.

VT

The system of VT is the same. What is important is the conclusion of wide discussion about the institution of Family Doctor. This discussion was running among professional bodies in General Practice, Ministry of Health, GPs and patients. Common statement is as follows:

- current system of divided primary care with divided competencies and age categories of patients will still exist in near future. It means – GPs for adults, GPs for children, gynecologists in primary care.
- the institution of Family Doctor will be developed as a new discipline for:

- 1. those GPs who are interested in it and need it for their work in some regions (e.g. rural regions)
- 2. making possible free movement of physicians in countries of EU
- 3. having measurement for FDs from countries of EU

There is no social order from patients and no professional necessity from the side of GPs and GP societies to establish FD via retraining all GPs in short time now. The level of providing primary care is not bad, it is comparable to this in European countries. We must also respect the wishes of patients. In many families each member has his/her own different GP and parents are used to go to GPs for children with their child. Despite, we will start with working on VT for FD soon.

CME
High level of all educational activities assigned by credits and certificates. Big interest of GPs. Still no recertification system.

Some main problems

- no gate keeping
- assessment of quality of care on professional level is missing
- easy access to secondary care
- expensive care
- less of money to primary care
- primary care is the basis of health care but (it seems) in written statements only

What I have done as a Euract Council member in the last period

- translation and distribution of Wonca Document to all Medical Schools and to important persons as the basis for teaching
- leading the discussion via e-mail about this document with other Euract members and GP teachers
- information about Euract working agenda to all Euract members
- preparation of regular Annual meeting of all GP Departments Representatives in the end of September in Brno
- preliminary preparation CZ-SL meeting in Spring 2005 and consultation with important person in this matter
- distribution of CME booklets
- general promotion of Euract as organisation and its importance for teaching GP/FM in CR when the institution of FD is still missing (Conference in Brno in September)

DENMARK

Basic Medical Education

No recent major changes since last meeting.
3 medical Faculties in DK (Copenhagen, Odense and Aarhus).
The student intake at the 3 Universities have been augmented by about 80 % because of prognosis telling about lack of doctors in DK for the next 10-15 years. Many of these extra students are from Sweden – and many of them drop out early in the study making planning difficult – so some overbooking is now taking place.
A new thing will be: from 2004 the University in Odense stops with the « normal » examination with long written exams – a 2 day OSCE examination is introduced!

Continuing Medical Education
No compulsory CME – but our national bodies (Danish Medical Association and GP's Union) propose that every GP should be able to document 200 hours CME over a 4 year period. A web-system for registration of your CME is provided by the Danish Medical Association. The registration is your personal and can't be looked by others.
PLP (personal learning plans) is now promoted for GP's.
"A new deal" for GP's by April 1'st 2003 is increasing the reimbursement for GP's CME by about 75 % over the next 3 years.
A discussion will take place: should the College be more responsible for CME-courses instead of our Medical Association?? If so it may have harmful influence on our relationship to consultants and young doctors – but there are also benefits. No answer yet.

Vocational training

There is – in autumn 2003 - one big educational issue (still) going on in Denmark: specialist training for all 37 specialities has to bee dramatically changed from 2004 (1 year delay). Changes in regard to: length of training period / all trainees having a mentor / new blueprints and curricula for all specialities / more focus on training instead of "just work" / more formalised evaluation / "course-organisers" in all specialities / research training for all doctors.

The changes in VTS for General Practice are going to be very big!

And we have started (as the first speciality, of course): Sept. 1'st was the day! 4 counties started this date. – I gave a little presentation the same day about our new training scheme at the AMEE conference in Bern, Switzerland.

The process with writing this new blueprint has been very successful – and very expensive! The new European definitions have been built into it.

We have also created an electronic blueprint – on the web – and built together with this is our new **electronic logbook (also on the web)**: all trainees "have their own" logbook – and their tutor can recognize/sign competencies in the logbook.

The challenge right now: to mobilize enough practices (esp. in Copenhagen area) to become training practices – this process is running right now – some problems have been solved – but more practices have to be recruited, yet.

The yearly meeting in the College October 3'rd (guest speaker Arthur Hibble, UK) will focus on Education and is part of this putting focus on education in GP.

Health Care

A new deal between GP's union and national health authorities has been negociated with success – it went in action by April 1'st. We as GP's are rather satisfied…. (total: extra 15.000 Euro per GP over the next 3 years – and many new smaller improvements).

A big issue in Danish health care is the lack of specialized doctors in the future – also in GP. It is a very dark cloud in the horizon. As many as 25 – 33 % of GP's may be lacking in 10 years time. A new initiative has been taken by the College and the GP Union to seek out how to improve recruitment to GP (especially in more distant parts of Denmark) and how to persuade GP's to retire at a later age than intended (I take part in this task-force). Many ideas have been taken forward – no final plans made yet. It seems that a major issue for young doctors is being afraid of the big finances, they have to put into buying a practice.

There is a fear among GP-organisations that the Government will put Primary Care under the "Social System" instead of the "Health System" – and so make a division between Primary and Secondary Care. This will be a major drawback for GP we all think and fear. Discussion will stop in 6 months and a decision will be taken (not by us – but by "them"!).

What have I done in my country as a EURACT Council member?

1. Facilitate a link and seek support from their national college or association.

I am still a member of the Board of the Danish College of GP's – so a very tight connection is established.

2. Facilitate the development of links with academic departments of family medicine in medical schools.

We have 3 departments/medical schools. I have close connection to Aarhus (work part-time there!) – and also close connections to Odense and Copenhagen because of my post as chair of the Educational Committee of the College of Danish GP's.

3. Facilitate and develop links with national representatives of other European bodies (eg UEMO, EQuiP, EGPRW, European Society and other European organizations in family medicine).

In Denmark the College has "an international committee" – and in this committee the national representatives of EURIPA, EQuiP, EGPRW and EURACT have seats together with other GP's. So a very tight connection is established. Meeting next week!

4. At the time of election council members should inform their local WONCA organization and seek their support for the successful candidate.

I will certainly do so!

ESTONIA

On September 14th Estonia votes for membership in EU. There have been hot discussions on all spheres of life, including health care. One of the questions where there have been several opinions is how many Estonian doctors and nurses will move to the other European countries and how many unemployed doctors from EU countries will come to Estonia.
In medical education no major changes since May 2003. The current year is the first year when graduates from the University started their residency training just after 6 years of studies as there is no internship-year any more between undergraduate studies and specialist training. Therefore the competition for the residency posts was quite heavy this year.
In health care the accessibility to the specialist care is decreasing which puts an additional pressure to the primary health care system. Government has changed the system of compensation for drugs with the aim to use more generics and increase patients` own co-payment.

At the beginning of October 2003 the Baltic conference of Family Medicine will be organised in Tartu. In September 2004 there will be an international research training course Forum Balticum also in Tartu- this is a Scandinavian-Baltic meeting held every second year since 1994. So there are several activities going on to keep everybody busy.

FINLAND

Basic medical education
Most striking news is the modifying education (this is not an official term), where nurses are educated to be doctors. This politically made decision gave permission to 25 nurses to start tailored medical education at the University of Turku. The nurses have to have three years experience within health care; and the education takes 6 years (as for medical students). Nurses have their own entrance examination and finally the applicants are even interviewed. The first class will start this fall. The reputation of our university may have suffered among other faculties and medical students. Most medical people think this does not solve our problems and is an expensive way of education, even the nurses will probably become good doctors after tailored education. According to the politicians this will solve our shortage of doctors!
Medical student intake has been increased. Anyhow, among general practise teachers there seems to be good spirit and even competition which one of the five faculties makes the best reforms. It is also officially decided to move medical education out of the university hospitals as much as possible.

Specialist training
General practice is doing well among all the specialties, even the causes for general practice oriented reforms are mainly manpower problems. Every specialist in all disciplines has to be trained in general practise for 9 months. This is much, but it has to be remembered there are no real internships included in the basic medical educations.
All specialist training will be partly moved out of the universities. Half of the training in most disciplines (except neurosurgery and such specialties) has to be performed out of the university hospitals.
There are also some new economical benefits for specialist training in family medicine.

Continuing medical education
Last year there was a countrywide project to help our health care. Experts within this project gave a recommendation to force the employers (municipalities) to organise continuing medical education to all workers within health care. Doctors are waiting now what will happen. There is a law in planning concerning this issue.
A Nordic Conference in Family Medicine was just held in Helsinki with 450 participants. It was successful and problems common in all Nordic countries were discussed.

What I Have Done For Euract
I have tried to get new members among the general practise teachers, but haven't had success. Unfortunately I have lost two members. The key question seems to be the fact that there are not much member services available for members in countries where general practise is already advanced.

FRANCE

No report received

GERMANY

Basic Medical Education

The new federal regulations (Approbationsordnung, ÄAppO) for BME became effective for all medical faculties on October 1st, 2003. General Practice will have a stronger role in most medical faculties. It will play a role in integrated teaching in epidemiology, health economics, ethics, prevention, geriatrics, complementary medicine and other subjects, but the actual role in each Medical School depends on the willingness of other subjects to co-operate and share and on the engagement of the GP-teachers in that respective Medical School. There is now an obligatory term in teaching practices of one to two weeks, usually in the 4th or 5th year of the curriculum, and General Practice can be an elective of four months in the 'practical year', the 6th year. As all subjects now are obliged to give grades to the students at the end of each course, discussions started on adequate assessment procedures. A national workshop at the Department of General Practice in Kiel on May 16-18, 2003, discussed different ways to answer to this challenge (German materials: www.degam.de/s_2/material/index_material.htm) This discussion will be continued during the coming months and in a 2nd workshop next spring. German members of EURACT play a central role in this process. Different from other European countries, there is no experience with OSCE and on-site assessment in general practice teaching so far.

Vocational Training

After years of discussion and dispute, the 106th 'Deutscher Ärztetag', the parliament of all doctors in Germany, in May 2003 has finally decided to melt the vocational training of general practitioners, general internists and specialised internists into a common trunc. Both disciplines will have a compulsory VT of 5 years; at least two years of internal medicine are mandatory. VT leads either to a specialist in 'Internal Medicine and General Practice', who will be the only primary care physician (besides pediatricians and gynecologists) in the future, or to specialties like gastroenterology or cardiology. The primary care track will require at least two years in general practice; surgery was thrust into the background. Up to now GPs and general internists compete in primary care; patients can choose freely which one to consult. As VT legislation is federal legislation, these new regulations need further approval and adaption in the Federal Chambers of Physicians and in Federal Governments which will be done in Spring 2004. The camp of the internist has sworn to undo the melting process on that level - I will report.

The German Association for General Practice and Family Medicine (Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin (DEGAM)) (the scientific society) has published a booklet about planning and establishing general practice VT rotations in co-operation of hospitals and GP practices ('Verbundweiterbildung zum Allgemeinarzt'; author: N. Donner-Banzhoff). There is no rotation scheme in general practice VT in Germany; future GPs have to 'patchwork' their combination of posts.

CME

Politics is putting growing pressure on the Federal Chambers of Physicians to take action in the field of recertification, saying that voluntary CME alone is no sufficient prerequisite for competence of doctors. The planned new regulations ('Gesundheitsreformgesetz') agreed upon by both, Government and opposition, see mandatory and regular CME probably with credits controlled by the Federal Chambers as a practicable way. Denial of individual doctors will lead to financial punishment and finally to extinction of the licence. DEGAM has installed a task force on 'CME and re-certification' in September 2003, led by N. Donner-Banzhoff and S. Wilm, to develop answers going beyond CME to maintenance of professional competence and CPD.

What have I done as EURACT representative in Germany?

The 13 German EURACT members will meet during the next workshop of the German Association of University Teachers in General Practice in Cologne on November 21, 2003, to exchange ideas especially in the field of assessment. At least twice a year members get a report of EURACT activities and new documents; via e-mail they are immediately informed about new developments.

During national assemblies, congresses, workshops and task force meetings, in DEGAM and the teachers association German EURACT members influence the discussion about and progress of general practice medical education very much.

GREECE

General

Since national elections approache all political parties are talking about major and fundamental reforms on the health system which is going to be based (one more time) on a strong primary health care. Unfortunately, we

experience the strange phenomenon according of which even if everyone agrees and supports the idea of a strong PHC nobody is doing something for it. I'm afraid that PHC is not a good idea!!!

BME
No changes at all!!

Specific training
The most remarkable evolution is that in a big number of training hospitals, the trainees supported by their tutor and assisted by the Association, organised a training programme tailored according to their needs. It seems that we experience a more demanded generation of trainees.
It is planned to develop a special course for the tutors aiming to a harmonisation of the specific training in different regions of the country.

CME
The most recent evolution is that the Association is trying to implement a credit system for the CME activities.

What have I done as a council member

Promotion of Euract courses and conferences. Preparing the participation and contribution of Euract at the Wonca Europe 2005. Preparing a Euract School of training in Greece!!

HUNGARY
No report received

IRELAND

There is little change to report since our last meeting.

Basic Medical Education

There are four University medical schools and one independent medical 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 eleven independent GP training programmes with a total intake of 84 trainees. It is hoped to expand the intake to 150 over the next few years. This might need a radical revision of how training is organised! More about this in future years.
For the last ten years places on the training schemes are highly prized and training schemes have attracted the highest calibre of graduate. Following a national conference held to discuss the expansion of numbers in training and the length of training, many of the schemes are now extending training to four years. The additional year will be spent in the Community, i.e. in general practice. The official policy of the Irish College of General Practitioners (ICGP) 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. In the interim all schemes will go to four years by 2005.

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. Quality assurance programmes are to be introduced by the Medical Council this year for each of the different craft groups within the profession.

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 then enjoyed a much-improved financial situation for seven years, however the medical infrastructure is still 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. Funding is now again tight and so developments are again on the long finger.

Personal notes

I am a general practitioner for the last 25 years and am director of the Dublin GP training programme. I am also a part-time lecturer in the Department of General Practice, Trinity College Dublin. My daughter Siobhan qualified this year in Medicine and has started her Intern Year – a future EURACT member?

ISRAEL

This has been a quiet summer in Israel on the family medicine education scene since the Vilnius meeting. However there are some interesting developments to report.

BME

The Tel Aviv University faculty of medicine is undergoing reform of the undergraduate medical program. It will now have a vertically integrated curriculum based on teaching by systems. The clinical departments will have input in both the pre-clinical and clinical years. The program starts with an extensive program in behavioral medicine called "Medicine, the Person and Society" which was developed in part and is taught by many family physicians. The department of family medicine has a new chairman, Prof. Michael Weingarten who has returned from a sabbatical year in Oxford. Two deputy chairmen will assist him: Dr. Shlomo Vinker and Dr. Yonah Yaphe.

VT

The Ministry of Health has granted recognition to the three new postgraduate departments of family medicine in the centre of the country. The move is to smaller departments that are more manageable educational units. There are now eleven departments in the country including a new department run by the Israel Defense Forces that will fund training posts in civilian hospitals and military primary care clinics. Most departments now have a research requirement for trainees. New research units have sprung up. The Afula department has recently held a successful research day for presentations by trainees.

CME

A successful national program for training in doctor-patient communication using actors as simulated patients is now going into its second year. The Tel Aviv department played a key role in developing this program. A study testing the efficacy of the program is also underway. There was good representation by 17 GP's from Israel at the WONCA meeting in Ljubljana this summer including active participation in seminars, workshops, oral presentations and posters.

What I have done as EURACT council member

A faculty development workshop was held in Tel Aviv based on the material developed at the Bled course on medical errors last year. Participation in the EURACT sessions at the WONCA meeting was encouraged. I participated actively in the Bled course on ethics earlier this month. Preparations are underway for the annual meeting of the Israel Society of Teachers of Family Medicine where I will present EURACT activities.

ITALY

Basic Medical Education

First steps for basic medical education are now organised in Italy. Now, we have signed agreement between University of Modena and Italian College of General Practitioners (and another one with University of Bari) and a structured course is organised since last November 2002, for students on sixth year. A course to prepare Tutors specifically for this topic was organised in Modena, medical journals

wrote about, a specific book for Tutors (the first one in Italy, printed by Italian College) is on the tables, one chapter is mine. The topic is matter of discussion, finally, and it'll open the way forward (signed in Genova, at beginning in Milan, where I hope to contribute discussing all details about a teaching agenda for students). Big work, also, on teachers' selection. A conference in Modena, on 20th September will try to put a national political basis for BME in Italian General Practice. I was asked to underline the point of view of EURACT.
I was invited as lecturer and member of EURACT Council National Representative at several meetings during this period in University of Milan and Parma, to speak about teaching, accreditation, research (EGPRW), guidelines with specialists, and all concerning EURACT's acitivities.

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. It'll be since next course, beginning in October 2003. Teachers are paid for seminars, tutors are paid monthly, coursists are paid at lowest level for hospital doctors, not yet (differently from previous years) obliged to refuse by law every contemporary other work.

Continuing medical education
It is obligatory for National Contract with NHS , to take 40 (before it was 32) hours of CME , (20 with Health Local Authorities , 20 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, 150 credits to collect in five years.
After a period of prove, between January and December 2001, we are now going, since 01 April 2002, to real credit points. but .many colleagues involved in teaching and research and the biggest Scientific Society (Italian College of General Practitioners) are not satisfied and they are studying to arrive to a system accrediting also curricula, active participation at congresses, and distance learning systems (more difficult to organise and value). Italian College is realising this having changed its bylaws with a system with membership and fellowship.
Generally, 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 (April 2001), there was a change in Minister and a change in the Government, after political elections. After strong fighting, Scientific Societies are taken again in discussion, but, really, CME by Internet accreditation is not working and points are attributed automatically not seriously, with problems on getting real control on providers, different credit – points just attributed to the same event in different cities, no real consideration about professional quality… Debate is spreading and CME in difficulties with Italian College trying to put on the table his point of view, very similar at EURACT's point of view.

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: on 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 strong debate…!

Life as Council Member
The EURACT Council National Representative was invited at several meetings during this year also in University of Milan and Parma and Modena, to speak about teaching, accreditation, research (EGPRW) and all about EURACT's activities.
Several different medical associations and societies and medical schools published a translation of the New Definition, using formats of different length. WONCA was usually believed to be the real author: I had to underline the role of EURACT with seasons spent on drafting and on getting consensus at Barcelona Conference.

I got six papers of mine published these months: EJGP June issue (Mediterranean medicine: Malta consensus), B.J.Gen.Pract., September issue (New Contract and Career Development), EJGP September issue (tutor and practice selection) , BJGP January 2003 issue (New Contract and the New Definition), EJGP April 2003 (Good co-operation from all European countries without barriers), BJGP April 2003 (Why still a medical student wants to become a GP)., BJGP July 2003 (Special non clinical interests).
Seven electronic letters were published on British Medical Journal.
All were signed as EURACT Council Member, and, except the first one, they all were based on EURACT's concepts and documents. So EURACT was known in large population of GPs, the same for Italy, with translations and presentations.
EURACT – Italy is involved in co-operation with EGPRN for Workshop in Verona (19-21 October 2003). Some members are involved with University of Maastricht on palliative care
I'm now appointed in the Editorial Board for the International Journal of Medicine, in London and I invite colleagues to send contributes to be published.
A lot of new members for EURACT are continuously coming, all from different geographic areas and from different GPs Societies (Csermeg, Snamid, SIMG , local P.C. schools). They need now a big work of secretary by me and my wife and my daughter and I'll ask again EURACT Council to realize real benefits for EURACT full members.
A bad situation was discovered when I realised that somebody organised a meeting with some of the scientific societies and trust organisations to organise the scientific committee for WONCA 2006 in Florence, without inviting EURACT because....not representative (!!). EURACT Executive and WONCA Europe President got informed by me of the situation. EURACT- Italy members also. The situation, on this topic, is unchanged till now.

LITHUANIA

Basic medical education**.**
Still introduction to family medicine starts on the 6th year of undergraduate studies. Now duration of the course is 2 weeks, basics of general practice are introduced during the course. We have some hope that after EURACT meeting in Vilnius, where some very important academic persons was present, we might try to introduce some training based on primary care earlier in the curriculum.

Vocational training.
Since this year vocational training for Family Medicine is 3 years. Vocational training programme still needs to be more based on ambulatory care rather than hospital-based training, but in this aspect no major changes are announced yet. The big problem in Universities now is the very limited amount of young researchers and physicians which want to start their academic career, mostly due to the poor financial situation. Also each year less and less young doctors choose the vocational training in Family Medicine.

Continuous professional development.
Some important steps have been taken during last year to limit enormous amount of one-drug conferences in Lithuania. Now only conferences and seminars which are organized by Universities can give doctors credit points for licensing. That was attempt to control information on medications as well as aggressive promotion of drugs.

NETHERLANDS

Basic medical education
The Visitation Committee has visited all Medical Schools and the final report is expected shortly. Direct verbal reports after each visitation indicate that the committee will focus on two topics in general:

- the presence of clinical encounters with patients in the first years of the curriculum
- (again) the clerkship

Several new curricula are now in year 3 or 4 of their 6-year programme. The focus is now the construction of year 6 which can become something of an internship. The student (it will still be a student) will get more responsibility.
Some specialties see this period as a pre-specialty training.

Postgraduate training.
All departments are very active with the implementation of the new curriculum.

The number of available positions for GP's in training has been increased and there were enough applicants.

CME/HPT
No changes/no news.

Health Care
The current economic situation forces the government to cut in the budget. On September 16, the Queen will officially announce the Government plan. Among them will be removal of physical therapy out of the health insurance fund. Women of 21 and older will have to pay for contraception. Couples will have to pay for their first IVF attempt by themselves.
It is not clear if the government will put money available for the practice nurse in general practices. If not, there will be much turmoil to come.

What have I done as Euract Council member.
I had several discussions regarding the WONCA 2004 meeting and the role of Euract.

NORWAY
No report received

POLAND
Undergraduate education:
No major changes in the field of BME. New law about minimum curriculum in family medicine is still somewhere in the desks of civil servants. At the moment each school provides its own programme.

Postgraduate education:
There is a shortage of training places. This situation lasts already since several years. Ministry of Health stopped financial support for the training centres nearly two years ago. Most of them (at least biggest ones) belong to the universities, which are not keen to devote large amount of money for the training of family physicians. So, although both technical possibilities and surplus of candidates exist, nothing can be done.

Continuous Professional Development:
There is no formal regulation in this field. The Chamber of Physicians issued some kind of suggestions, however without any practical solution for it. CME is completely voluntary. The College of Family Physicians in Poland runs the CME school which provides workshops and seminars for GPs in whole country. This initiative is well admitted and on average two to three hundreds doctors attend each training session. There are two or three of them organized each week in different places. The fees of pharmaceutical companies, which want to have a booth on the conference, support the school. The work on the distance-learning programme is in progress.

What I have done in my country as a EURACT Council member
EURACT was presented during the plenary session of the National Congress of Family Medicine, attended by twelve hundreds of doctors. The Board of the College of Family Physicians in Poland was informed about the rolling course plans.

PORTUGAL
In general
The new Primary Care Law, which was published some months ago, is not yet in the field – the need was felt to create a Commission to accompany its implementation. We hope some of GPs arguments are to be given some credit.

BME
Universities are now starting to change their General Practice programmes – following what's already being done in two of the newly created, sixth year is to be more practical, residential. We hope the GP Departments are to be stronger.

VT
There are winds of change, too, in what comes to Vocational Training. Our Minister of Health just produced a new law, changing the former Internate (we had 2 years of General Residency). We'll possibly have two branches – Medicine and Surgery – of a 1 or 2 years residency period, followed by 3 or 4 years of specific training. The College is now studying the law (so are the GP Association, Syndicates, and ADSO), and will soon pronounce for or against it. Most of us are for the end of the general residency, and for the 4th year GP training.

We have, for 2004, 182 new training places for General Practice. It's more than in 2003 (147), but only about 20 % of the total. All the other specialties increased too.
CME
Nothing new to report.

Work done as a EURACT Council member
New Portuguese members have joined EURACT (a total of 3, including another "old" member reconnecting). Fees of these members have been paid to the National Representative, and will be taken to Leicester.

Institutional contacts have been finally made with EGPRW(N).

I was present at one important GP meeting (Sesimbra), and made another conference on New Definitions and Patient Centeredness. There was, as usual, a distribution of a text explaining all about EURACT. Plans are being made to induce replication of workshops on these matters – but only in Algarve, for the moment.

The EURACT/EQUIP CPD booklets were not enough; therefore there was the need to copy them. After that I sent them to 46 destinations, including: all Portuguese EURACT members; all the members of the College council; all the members of ADSO Executive Board; reference persons in all the Universities with GP Departments (all that have Medical Schools – 6). The last ones received 4 booklets each, to allow easier divulgation. Contacts were made with the EQUIP representative in Portugal (Dr. Luís Pisco), in order to initiate translation and further wider distribution of the document.

Documents on EURACT were prepared and sent to Madeira Authorities and to Merck Foundation, looking for support to the next 2004 Madeira Meeting.

Addenda
I have the painful duty to communicate the death of one of the first Portuguese EURACT members – Professor **José Guilherme Jordão**.

One of the initiators of Family Medicine in our country, Jordão was for long time the Director of the Portuguese Institute for General Practice (South).
A highly respected Professor in the Lisboa University (FML) GP Department, he was also a practicing GP, and the President of our Teachers and Trainers Association (ADSO).

In his early fifties, he passed away the 23 of August – sudden death.

All his friends and colleagues, and the Portuguese General Practice as a whole will miss him deeply.

ROMANIA
Basic Medical Education
The undergraduate study of the Family Medicine seems to be neglected. Even there are courses and practical activities scheduled, most of the time the content has nothing to do with the discipline. Most of the teachers in Family Medicine have other specialities and most of the time the students are not spending any time in practices. The curriculum is based on the rehearsal of some clinical knowledge from other specialities.

Postgraduate specialist training
The rules for admission into the residency had been changed. Still there is a national exam but it is organized upon specialities in different medical universities. The doctors have to choose from the beginning the speciality for which they are competing. The bibliography has also been changed-for the first time some foreign medical literature has to be studied. There are 600 places for residentship in Family Medicine this year.

Continuing Medical Education

The National College of Physicians is planning to introduce "the doctors'log book" in order to keep a better evidence of the participation to CME and of the credit points gathered. It will contain diplomas from courses, conferences and seminars, copies of the articles or books written and published, subscriptions from medical journals.

Family Medicine

In July, a national conference of the family doctors took place in Iasi; there were more than 800 participants from all over the country. It was the first conference where most of the papers presented were made by family doctors and not by other specialists. Also for the first time, the National Centre for Studies in Family Medicine presented the 5 guidelines that are developed in the QualyMed project. Important matters concerning the statute of the family doctors were also discussed.

What I have done in my country as a EURACT Council member

As national representative I prepared a report of the Vilnius meeting for the Romanian EURACT members and I kept them informed about the Bled course and about the General Meeting held in Ljibliana asking those who were there to participate.
I tried to bring new members by one to one discussions with the trainers in family medicine.
I presented the new definition as a EURACT initiative at The National Conference of the Family Doctors held in Iasi.
I published an article concerning the new definition in the magazine of the Medical University in Craiova.
As for CPD document, I had to translate it in Romanian in order to make it more accessible and understandable for the recipients.

SLOVAKIA

Health care

The Slovak health care system is in a permanent process of transformation in the last 12 years.
one of the most recent step of the reform is a new rule, approved by the Slovak Parliament, that each patient has to pay at each visiting of the primary care doctor a sum of 20,-Sk - (0,5 Euro).
There does not exist a rational reason for this. It does not help the doctors financialy at all, and the patients are angry and irritated, as for the last 50 years they were used to have the whole healt care service free of charge.

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 yet no Departments of General practice and Family medicine, but teaching of General practice and Family medicine became a compulsory part of undergraduate educational at all of them. Medical students are obliged to spend 1 or 2 weeks at an accredited primary care teaching practice.

Postgraduate education

Vocational trainig 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 why the last mentioned condition is not always fulfilled in reality. The process of accreditation of teching practices is in progress.

Continuous Medical Education

The model of obligatory continuous medical education: „CREDIT POINT SYSTEM CME IN GENERAL PRACTICE" is now accepted with real respect. GP´s are obliged to prove their attendance of educational activities by collecting certain number of credit points (200 points per year). The evaluation is in the competence of the elected representatives of the Regional Medical Chamber and is provided every 5 years as **„recertification"**. Recertification will be one of the conditions for renovation of GP´s contract with the Health insurance companies.

What I have done in my country as a Euract council member
October 2002 - I was elected to be a vicepresident of the Slovak Society of GP/FM - the most representative institution of GP/FM in Slovakia, with 1 400 voluntary GP members (the total number of GP´s in Slovakia is 2 150). In this Society I am also responsible for the international relationships and activities: I was nominated to represent the Slovak Society in the European Society, WONCA Europe, EURACT, EUROPREV and EURIPA . Slovakia is not yet represented in EQUIP, EGPRW. The process of our application to the UEMO is undergoing.
November 2002 - The New Definition of GP/FM has been published in my article in the wide- spread medical journal „Health Care News".
January 2003 - I have had a Presentation with title „New European Definition of GP/FM" at the Slovak Conference of GP/FM - with live discussion.
February 2003 - I was reelected as the regional president of the second most important institution of GP´s, the Association of Private Physicians of Slovakia
April 2003 - an other of mine articles was published in the „Health Care News" medical journal, with title: „Core competencies of GP in Europe."

SLOVENIA

Undergraduate education

Over the summer, I have managed to make a final proposal for the curriculum reform to the dean. It is a very difficult task, because nobody wants to change anything. I am seriously considering to resign from this job.

We are preparing some innovations to the family medicine curriculum in this academic year, which starts in October. It is a major revision.

Vocational training
The first round of vocational training workshops has ended. It was a huge task to start an entirely new programme which has demanded a lot of resources. The next round will start in a few weeks and we are considering improvements to the programme.

CME
I am writing that just before leaving for the Bled course. This year we are going to have a bit smaller audience than last year, but for the first time in history of the course, we have managed to get a participant from United Kingdom to attend.

The WONCA conference in Ljubljana is over, as you all know. The feedback we have got from the participants, was very positive. Reports from the conference have appeared in many journals, even in the British Journal of General Practice. I would like to thank all of you who participated and helped in making it a successful event.

What have I done for euract
I have organised the Bled course and the WONCA conference where EURACT was promoted as the key organisation of teachers in family medicine in Europe.

SPAIN

Basic Medical Education
No recent major changes since the last report. Most undergraduate students from the different universities must spend some time in Primary Health Care settings as part of their undergraduate education, but the recognition of the universities to that task is in general not satisfactory for most of the primary care tutors involved. Tutors that teach students in the health centres are not paid, have not more protected time and only a very few proportion become an academic nomination. Also the time spent by the students in the health centres is too short and mostly at the end -last year- of the basic medical education

Vocational Training
The new program has been presented in different forums but still it has not been implemented, for different reasons (other specialities also want a longer program, increment of costs, shortage of tutors, next year we have regional and general elections, and who know.).

Continuing Medical Education
In Spain CME is still not compulsory but still the different medical bodies are very active and the opportunities very high for they that want to do it. The National Society (semFYC) and also the regional federated societies are offering a very high number of courses, workshops for their members, and usually the participation is very high. Expert GP's in the different topics are key speakers in almost all courses and they are very much "primary care oriented".
Specific meetings for course organisers and clinical teachers are running also all over the country.

Health Care
Spanish health care seems to have a lack of doctors: specialists and also GP's. The Catalan Society of Family and Community Medicine and the Teaching Units are doing a survey to know the professional trajectory of the trainees that have finished our specialty in the last five years.

What did I do as EURACT Council member?
The New Definition of GP/FM has been distributed in its original version (English) to the council of semFYC and also to the federated societies, and also to all Course Organizers all over the country (we call them Coordinador de Unidad Docente). It has also been presented in different forums. Now it has been translated in Spanish and I have done the last overview of the translation. And it starts to appear as bibliographic reference in some of the last articles published in our journals.

SWEDEN

Many official national GP organisations support a new proposal on the organisation of general practice in Sweden (PROTOS). It implies a more structured establishment with a list system, a defined assignment, a well organised CME , salary both by capitation and result. A system like this was recently successfully carried through in Norway and that structure is very much a model.
A lot of the general information on what is going on in Sweden is published on the website of SFAM (Swedish Association of General Practice) www.sfam.se (an English version is available)

Undergraduate teaching
The impact of general practice in the undergraduate curriculum is increasing mainly in the early stages of the training. In Umeå, a university town in the northern part of the country a new theme "professional development" has been developed. All through the years in the undergraduate teaching a thread of "communication", "doctor's role", "clinical skill", "personal supervision"," humanities" is running and the different activities are organised by the division of general practice. The same structure will be organised in other universities.
In Göteborg the Erasmus/Socrates student exchange programme is getting more compre-hensive. We have had students from Germany, Holland and the UK that has made clerkships in Sweden (learnt Swedish in advance!) and this academic year new students will appear.

Vocational training
The European exchange programme for trainees (Hippokrates) has been introduced for Swedish trainees and an English version is created which I enclose below (from the website www.sfam.se). The presentation of the Swedish health care is also included and some of the host practices are presented - if you have any plans of sending/exchanging trainees to/with Sweden!

Hippokrates - Official introduction
Hippokrates is a European Exchange Programme for Medical Doctors specializing in General Practice/Family Medicine supported by WONCA region Europe-the European Society of General Practice/Family Medicine through EURACT-The European Academy of Teachers in General Practice. The aim of the programme is to encourage exchange and mobility among young Medical doctors in the course of their professional formation as General Practitioners providing a broader perspective to the concepts of Family Medicine at both professional and personal levels.
The participants of the programme will acquire insight of the context of General Practice in the Primary Health Care of the European Countries gaining knowledge that will inspire to take an active part in the development of European Family Medicine as well scientifically as structurally. Furthermore the programme will enhance collaboration among the National Societies of General Practice/Family Medicine and recruit young professionals to these important tasks.

At the individual level the acquisitions are numerous: an international experience in a vocational setting, improving knowledge and skills, inspirational introduction to methods of professional development for lifelong learning, improving language skills, creating new friendships.

Structure
Hippokrates is launched at the 6th European Conference on General Practice & Family doctors in Vienna, Austria July 2-6, 2000. In the pilot phase of the programme there are 5 participating countries: Czech Republic, Denmark, Netherlands, Spain, United Kingdom
In each country the programme is based in the National College of General Practitioners and there is a Country Coordinator in charge of the programme.
In the participating countries a number of General Practitioners and their Practices have been selected to be Host Practices. These practices are the cornerstones of the programme inviting visiting Medical doctors specializing in General Practice/Family Medicine from the other participating countries.

The duration of an Exchange Study Visit is two weeks. During this time the visitor will obtain a brief, broad introduction to the aspects and the role of General Practice/Family Medicine in the respective country by taking part in all activities of the Host Practice. The visitor will also meet, follow and exchange views with the local trainees specializing in General Practice/Family Medicine and will be encouraged to gain insight in local resources and quality improvement activities as well as local health care planning and health insurance.
Where possible private accommodation can be arranged.
In this catalogue the Country Coordinators and the Host Practices are presented not only with informational data but also with a short presentation of the specific Host Practice.

Financing
In the pilot phase of the programme there is no central funding. Grants supporting innovative initiatives will have to be found locally. As the programme develops and proves its justification and success it should be elaborated and made suitable for EU-funding through the EU mobility programmes Socrates/Erasmus or Leonardo da Vinci.
By all means intentions are to keep costs at a minimum through the pioneer spirit of the participants.

Procedure
The programme is designed with a very flat structure relying on the activity and creativity of the participants. Thus through the principles of ownership enhancing the likelihood of success and sustainability.
The Country Coordinator makes the programme known among the Medical doctors specializing in General Practice/Family Medicine and distributes this catalogue.
A Trainee wanting to exchange takes direct contact to the practice of choice in the country of choice and makes preliminary arrangements for a study visit.
It relies then on the Trainee supported by the local Country Coordinator to find and apply for appropriate funding and to carry the exchange study visit through.

Evaluation
After the successful completion of an exchange visit an evaluation form will have to be completed. These forms will make up the basis for an annual report to the WONCA/EURACT-council on the progress of the programme.

Language
The common language is English however it is an asset if the visiting Trainee is capable of speaking the language of the hosting country.

Legal aspects
For legal reasons the visiting Trainee must take no independent active part in the examination and treatment of patients of the Host Practice.

On the following pages you will find a brief introduction to the organisation of General Practice/Family Medicine as well as presentations of the Country Coordinators and of the Host Practices from each participating country.

National presentation Sweden
Health care structure

Sweden has a population of about 9 million. The Swedish health care system is a public sector responsible for providing and financing health services for the entire population Responsibility for these services rests primarily with the 21 county councils.
Primary health care in Sweden is since the late 1960´s organized in health centers which has facilitated teamwork. Most family doctors are salaried employees, and it is most common to work in a health center, side by side and as a team with nurses, midwives and physiotherapists, but there are also some private alternatives. There is no long Swedish tradition in doctors listing patients; the doctors working in a health center hold responsibility for the people in the most nearby area. The last ten years though there has been some dynamic in the Swedish system of primary care, and there is now more diversity in the way of organizing local primary health care in different parts of the country. A law that states that every citizen in Sweden has the right to choose a doctor who has qualified as a GP as their own family doctor, which has led to a more prominent position for Primary Health care in swedish society. In 2002 the government also put resources into the Family Medicin Institute, which has as its main purpose to enhance the position of Primary health care in Sweden on all boarders.

Education and training
Medical school, basic undergraduate medical education, is 5 1⁄2 years, in which general practice occurs on the curriculum throughout the education. Internship is 18-21 months, of which 6 months in General Practice. Successful completion of this programme gets the doctor a license to practice (full registration). Specialist training is at a minimum 5 years, and is carried out in a salaried position with medical responsibility. There are nationally stipulated goals for what knowledge and skills the trainee shall acquire to become a specialist in family medicine, and an individual plan for training is designed for each trainee. The whole time in training the registrar has her personal supervisor, with whom the progress in skills and knowledge is continually evaluated and reflected upon.

Tasks in general practice
Primary care in Sweden provides all basic healthcare that does not demand medical and technical facilities of a hospital. That includes preventive and rehabilitative care, child- and maternity-health care services, healthcare in schools as well as medical care of the very oldest in the community. The referral rate from general practitioners to specialists is less than ten percent.

Country coordinator for Sweden:

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Sweden
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Sweden - HOST PRACTICE
Arlövs Vårdcentral, Svenshögsvägen 6, 232 38 Arlöv
Phone:+46 40536900 , fax:+46 40435211

Welcome to our general practice in Arlöv!
Geography: Our clinic is situated in the small community of Burlöv, which is located between the larger towns of Malmö and Lund in the south of Sweden. A good location with a mixed population who generally visit their clinic before trying other health providers in the nearby towns with large hospitals and abundant private practices. Also nearby are airports (Sturup and Kastrup), the Oresund Bridge joining Sweden to Denmark and making travelling to the centre of exciting Copenhagen just thirty minutes by train or car.
Doctors: We are a fairly large clinic with nine GP´s working in the clinic, some part-time some full-time. Most of the time there are 1-2 young doctors training in family medicine and 1 young doctor at preregistration level. At times we also have medical students in the clinic.
Staff: The staff consists of over twenty employees ranging from nurses, secretaries, occupational therapists, physiotherapists to lab technicians.
Clinic: We run a well equipped modern clinic with a full computerised filing system. We service an area containing approximately 15.000 inhabitants.
Preferred visiting periods: Avoid in general the months of June, July, August and December.
Accommodation: There is plenty of low-cost accommodation available in the nearby towns of Malmö and Lund.
Please contact us for more information:
Dr Tommy Jönsson **jonsson.i.lomma@gamma.telenordia.se**

Sweden - HOST PRACTICE
Dr Mats Rydberg, Bäckagårds vårdcentral
Bäckagårdsvägen , 30271 Halmstad
0046-35-134306, 0046-35-134304

Welcome to Bäckagårds health center
Bäckagårds health center is in the city of Halmstad on the west coast of Sweden. The city is situatuated in a beautiful landscape with miles of sandy beaches. Halmstad is a popular summer resort, known for it's good opportunities for bathing in the shallow water and in the sun, and in the summer there is far more than the usual 80 000 inhabitants living in the city and the near surroundings. The city is easy accessable by plane, car or train. The nearest larger airports are in Gothenburg and Copenhagen.
Our surgery, which is recently renovated, is in the outer part of the central city, close to the sea in a well-situated area, where the majority of the inhabitants live in self-owned houses. The health centre serves about 5500 people. We also serve two geriatric wards, and a special-housing for healthy elderly people. As for all primary care health centers we take care of the preventive child care in our area. The surgery is well equipped: ECG-registrator, defillibrator, spirometer, eye- and ear-microscope. There are also facilities and equipment for gyn exams, procto- and rectoscopy examanitions and for chirurgia minor.
Three GP´s are working here: dr Mats Aili, who is also a pediatrician , dr Ulf Peber and dr Mats Rydberg. The staff also holds three nurses, secretaries, assistant nurse, physiotherapist and occupational therapist. There are district nurses as well.
The best time to come here is april-june or august-september. Please contact us for more information:
mats.rydberg@lthalland.se
Most welcome to Halmstad!

Sweden - HOST PRACTICE
Jämjö vårdcentral, Hammarbyv 6, S-373 00 Jämjö
Tel 0046 455 735600

Welcome to Jämjö vårdcentral
Our practice is located in the Souteast corner in Sweden where the migraiting birds leave Sweden in the autum and return early in the spring. Karlskrona the closest town is situated 25 kilometers to the west and has a long military history, now part of the worlds heritage. The area is rural and costal with a few inhabited islands.
The practice was established in the early 70`s. The population is about 7000. We are three Family doctors who have worked here at least ten years: Elisabet Jernby, Börje Carlsson och Ingemar Lilja (. Most of the time we also have a trainee. At the clinic there are also three nurses, two auxiliary nurses and two secretaries.
Our priorities are the old and sick with a high degree of accessibility and no waiting list.
We are all interested in palliative medicine and we have time put aside each week to visit our sick and dying patients in their homes.This is done with the close cooperation of our district nurses who also take care of our child health care.
You are welcome to visit us all year around and we can provide accommodations in our homes or according to your wish. Please contact us for more information!
The Family doctors in Jämjö!
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Sweden - HOST PRACTICE
Mölndals vårdcentral, Bergmansgatan 5, 431 30 Mölndal.
Tfn 0046-31-87 84 00

Welcome to Mölndals vårdcentral
Mölndals Vårdcentral is situated on the beautiful Swedish west coast,in a small suburban city just outside Gothenburg. We are five doctors and six nurses working here, and two secretaries.
Jacob Wennberg, Inger Dagnell and Dimitri Edin Zylberstein have been fellow workers since the start of the practise in 1994. Kenth Wikhager and Katarina Järbur came along in 2002 when the practise expanded.
We serve close to 10.000 inhabitants in Mölndal and we are responsible for several nursing homes for elderly and handicapped in our neighbourhood. We have a special child welfare clinic in our practise too. Normal reception time is between 8.00 am to 5.00 pm but on Mondays, Wednesdays and Fridays we recieve patients in the evening up to 8.00 pm.
We have a psychologist working with us too, to better help our patients with psychiatric problems.

We are all very interested in teaching, and we like to supervise both medical students and doctors under education.We do look forward to introducing a colleague from another country to the Swedish family practise. We also look forward to learn and be inspired by other ways to do the work of a family doctor in another country, culture and system. Please contact us for more information
Welcome!
Contact: Katarin Järbur **katarina.jarbur@svenskhalsovard.se**

Sweden - HOST PRACTICE
Rens Hälsocentral
Our health center, Rens Hälsocentral, is situated in the small town of Bollnäs, in the midst of Sweden, in a beautiful landscape of forests, mountains and lakes. Here is wildlife experience right at your doorstep. Quality of life is top priority.

At our health center are five GP's and two doctors in training. There are also nurses, assistant nurses, occupational therapists, chiropodist and physiotherapists working in the clinic. We provide basic health care as well as child healthcare for a population of 9000 people. We use modern technology in our daily work, and in communicating with our patients; our website has all information about the health centre, and patients can contact us by e-mail. The patients can even book their own consulting time at their doctor on the web. The webaddress is **www.renshc.nu** . Please take a look, and see the staff and the premises.

Most welcome!
Please contact Maria Öhrner at **maria.ohrner@lg.se** for more information.

Continuous medical education (CME)
The most relevant and updated presentation of Swedish CME is given by Dr Anders Lundqvist from Örnsköldsvik in northern Sweden. In an international correspondence on CME (to the BMJ) he gave the following answers to some appropriate questions.

Dear Rana Khodadoust!
I am a GP in a small community in the northern parts of Sweden, and at the same time chairman of the CME-council at the Swedish Association of General Practice. I will try to give you some answers to the questions you are asking. First you need a little background: (warning - long message follows!)
GPs in Sweden are nowadays subject to a period of five years of vocational training. They are for the most part salary-paid and work in health care centres. Single practices are rare. About 20 percent work in a more entrepreneur-like fashion on a contract negotiated with the health authorities. Primary health care in Sweden developed after the great expansion of hospitals in the fifties and sixties, and has had quite a hard time of establishing itself as a natural point of first contact in the health services. Only about 20 % of the doctors (at the specialist level) are in fact GPs. The all too many hospitals in this country make it difficult for politicians to allocate the needed amount of resources to primary health care. Shifting the balance in favour of the GPs has proved to be a really difficult task, but in the last few years the Government has expressed a strong political will to make this shift come true. A national plan for primary health care was launched in 2001, and evaluation by the National Board of Health Care proceeds until 2008. A special institute called Fammi has a facilitating function in this process. There is still a lack of GPs in the countryside and the number of trainees really needs to grow to make a difference. Slowly its becoming more popular to be a trainee in General Practice, so we are now beginning to look forward to a brighter future as opposed to the dismal years of the nineties. There is still a lot of work to be done!

To the questions:
1. How much CME do GPs have to do (hours/year)?
There is no formal requirement at all!
The attitude to CME from the employers varies greatly within the country. From a "laissez-faire" tradition where the pharmaceutical industry is the main provider, to an organized system with local bodies of professionals in a supporting, coordinating function where the employers ask for personal developmant plans.
2. Who pays for CME and how much do they pay?
Usually every health care center has a budget for professional development. A substantial part of that goes to the GPs. Money is really not the problem. Time is.
In my region we have a personal account of 25 000 kronor a year which covers travelling, hotel, course fees, litterature and so forth. My income is the same as if I was working in my practice. Those who work on a contract usually have to allocate extra resources to cover loss of income. CME-wise we are considered to be a progressive region.

3. Who are the CME providers ?
Sadly the pharmaceutical industry still dominates the scene, but for those who feel reluctant about having the industry as the main provider there are good alternatives.

On the local level we have a system of small CME groups (50% of GPs participate), mentoring functions and Balint groups are options in some places. Regular monthly meetings (4 hrs) with CME-activities for all the GPs in a specified area is the standard in most regions.

On the regional level we have special Pharmaceutical committees responsible for making a list of recommended substances to be used in the health care services. They also arrange theme-oriented CME-activities to all prescribers about 2-4 times a year (8 hrs on the average). One or two doctors in the regions work as EBM-facilitators and visit practices or groups o colleagues at meetings. In some regions there are local professional bodies that arrange indepedent CME based on needs expressed by their GP-colleagues. The range of that varies from occasional activities to 8-10 days a year. Hopefully this is a growing phenomena.

On the national level we have Kursdoktorn (The Course Doctor) an organisation partly funded by the above mentioned Fammi and partly by the 1 million size Västra Götaland region (incl Gothenburg) which offer a catalogue of activities available to all GPs in the country. For this year about 35 activities are scheduled ranging from 1-5 days. We also have a fund in one of our unions responsible for about ten 3-5 days activities per year. SFAM the Swedish Association of General Practice arranges annually a 3 day congress for its members, which is becoming increasingly popular. We also arrange various activities for special interests-groups during the year.
SFAM has a policy on CME since 1993. We want CME for GPs to be self-directed, based on adult-learning theory and independent. Small CME groups, mentoring, Balint groups, and personal development plans are the cornerstones in the CME we wish to encourage. We also want to provide our members with commercially independent course activities of good quality on a national, regional as well as local level. Our CME-council is the driving force for that purpose and we meet 4 days a year. Recently we have formed (helped by fammi) a national network of CME-coordinators consisting of 60 GPs all over the country. We meet two days each year and communicate in the e-group format. The Nordic countries has started a small network for key persons.
4. Do Gp´s use any English language online CME-services?
Apart from reading BMJ do you mean? Your magazine is quite popular here but I dont think the average GP spends a lot of time reading English magazines or books. Very few I believe take part in any interactive CME-activities online.
5. Is language a barrier?
Shouldn´t be really. The amount of information available in Swedish is really enough for most GPs however.
6. Does online CME have to be in Swedish?
No, not really, but I think maybe a few more GPs would be interested if that was the case. Online CME has yet to be discoveerd for most of us.
7. Do they offer gap assessment and a Personal development plan?
I´m not really sure what you mean by Gap assessment, but as far as revalidation goes this has yet to become an issue here. The health authorities are keeping a low profile in this matter. As I told you before SFAM wants to encourage personal development plans, but nationwide this has not been a success. In some places doctors were given bonuses to present PDPs, but once the bonuses stopped the production of PDPs ceased. A lot of the CME-activities taken by GPs are not deeply reflected on beforehand so to speak.

SFAM has a voluntary form of assessment procedure called ASK see abstract below.
If you want some more information feel free to ask again! It was interesting hearing from you!
Kindest regards,
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What I have done
In different national general practice meeting I have informed about EURACT. A direct link to EURACT is now on the web site of Swedish Association of General Practice/Family Medicine (see above). The Wonca definition has been referred to in various reports and publications. The Swedish members have been informed of the different activities that EURACT organises.

SWITZERLAND

Basic medical education

For political reasons the reform of the 4.-6.th year is stopped. So we will continue in the old way for the next years, waiting for the next accreditation. The only thing we are going to change are the lecture blocks because the students don't appear anymore in usual lectures.
It might be that they are not interesting enough, but we think as well that learning attitudes of the students have changed. So a new program has to be elaborated by the faculty where we as GP's contribute only a few. As I mentioned already in previous reports there are no important changes for GP during BME.

Postgraduate education

We had this year a great number of trainees that failed in the final GP exam. For this there are different reasons. As we have no structured VT, every doctor can try the exam. So we had a lot collegues which failed in other specialities who tried to become a GP. Or our mostly inhospital training is an insufficient training for the later GP-profession. So we are quite happy with the situation as we can show that our training doesn't work well, and that it's not so easy to become a GP when you failed somewhere else.
On the other hand no important changes within the system although we think to have proved the weakness of it.

CME

No news, we continue by supporting the local "quality-circles" (6-14 GP's), either for CME or for research.

Politics

The idea that raised in politicians heads is to form but one "medical school Switzerland" that means a go together of all the 5 faculties. For the first step we will reduce from 5 to 3 schools but no one knows how this should go. So the is great incertitude within all the faculties.

What have I done as a EURACT-member

As the time between Vilnius and Leicester was very short, I have not done a lot of things as I have to admit. Distribution of information about our meetings and about the EURACT courses.

TURKEY

Health reforms including in developing the primary care and family practice are being implemented very slowly because of resource insufficiency.
Annual conference was held last week in Sivas. The main topic of the conference was "mental health in primary care".

Basic Medical Education

The number of the Departments of Family Medicine has reached to 34 out of 43 Medical Schools in our country. GP/FM is the subject of teaching at 21 Medical Schools with different extend. But practical training in general practice is organised only in a few universities. There are now 66 teachers in the departments of FM in Turkish Universities. 56 of them are family physicians and 10 from other specialties, all full teachers, no associated teacher. There are nine professors at the departments, two of them family physician.
Relations between the departments were discussed in a separate session in the last annual conference. The aim of the session was to inform the departments each other about their activities in the universities and to establish a similar content of teaching for all departments. A national workshop on the role of the departments of FM in medical education was decided to be held in near future.

Vocational Training

For long time we proposed a limitation of the number of clinical specialist training places and an increase of the number of family medicine training places. Last spring the Ministery of Health asked the departments of FM in the universities for how many trainees they could accept each year. The departments declared that they were ready to accept a large number of trainees. We need about 2000 family medicine training places per year. Now it is planned to be reached to this number within two years, beginning with 600 new trainees this year. Besides university departments the Ministery of Health has 11 teaching hospitals having family medicine specialist training schemes. If it is carried on this will be a big opportunity for developing the departments with a demand and pressure from the Ministery of Health to the Higher Educational Council; new academic places and new resources for the established 34 departments and new departments in the other universities.

Retraining the practitioner physicians

The development about family medicine trainee places was also a prerequisite for retraining of practitioner physicians in a transitional period. Since last council meeting the most important development on family medicine teaching has been the debate on the retraining program. A structured training for the physicians practicing in primary care and having not specific training was not in the agenda of the Ministery of Health in the process of reorganization and quality improvement in primary care. But Turkish Association of Family Physicians (TAHUD) was insistent on a structured retraining program. This was discussed and adopted during the two workshop held in the beginning of 2003 and organized by TAHUD. We prepared projects and presented them to the MoH.
Last June Primary Health Care Directorate of MoH establihed an Advisory Committee on Family Medicine. It was composed of family medicine academicians, TAHUD representatives, Turkish Medical Association representatives (practitioner physicians) and officials of MoH. The Committee was held three times during the summer months and prepared some proposals on the issue. The main proposal is a retraining program of one year lasting for seven years. The training will be implemented with a joint effort of the interested parties provided that the university departments being in the center.
We, as departments of family medicine and EURACT teachers, are now working in details of the program and waiting for the decision of the MoH.
CME
There is noting new. The department of FM in the Republic University in Sivas organised an annual conference last week in collaboration with TAHUD.

What I have done as EURACT representative in Turkey?

I have close links to the Turkish representatives of EGPRN and EQuiP. They are all EURACT members.
As I mentioned in Vilnius report, as Turkish EURACT members we carried out the 8th EURACT course in Ankara in Last May. There was 33 participants.
EURACT is well-known by all family physicians, university departments, practitioner physicians and even by the Ministery of Health. I have three new candidates for EURACT membership.

UNITED KINGDOM

There is an increasing emphasis on multi-professional education and a new development is the setting up of an organisation called the NHS University. This has to be called the NHS-U at present as it has not been through the appropriate legal processes to be granted the title of “university”. It is hoping to provide personal development courses for all NHS staff, from cleaners to consultants. It has been given lavish funding, but is coming into conflict with other higher education providers, and made a play to take over postgraduate medical education. This has not progressed recently, but as it has the personal backing of the Prime Minister, it is not going to go away!

Our Secretary of State for Health resigned earlier this year, for “personal reasons”. This phrase is usually used before some scandal breaks, but so far he seems to have been squeaky clean, and nothing has emerged. He had been in post since Labour came to power, and has been responsible for many of the structural changes in the NHS, and probably felt in need of a break.

The new GP contract was launched shortly before our last meeting, to be voted on by all GPs. As I mentioned last time most doctors would have faced a significant drop in income, given the figures that were presented. The vote was postponed and whole thing renegotiated; my colleagues from our union, the GPC, had several all night sessions, and looked very frail! However the negotiations were successful and the contract was voted in by a substantial majority. The main change is that GPs can negotiate three levels of service – core services, additional services (such as chronic disease management to local guidelines) and extended services (providing special services such as cardiac clinics). Some GPs will only work at the first level, the majority at level 2, and some at level 3. For the first time the responsibility for out-of-hours provision has been moved away from GPs to their management organisations, and most, if not all, will opt out of this by April next year. We are currently trying to get teaching recognised as a level 3 service, but this is low on the priority list for most management organisations.

Basic Medical Education
As I mentioned last year, as part of the continuing drive to increase the number of doctors, there are new medical schools being created, particularly for a 4-year graduate entry programme. Students who have completed a

science based first degree can apply for places in one of these new schools. As they are predominately clinically based they will increase the pressure on placements in general practice for medical students – in my own area new student placements will represent a 30% increase in numbers, a welcome development but not without its problems.

Specific training

The new management structures for postgraduate medical education in England, the Workforce Development Confederation, was created in 2001 (the one for my area was only created in April 2002). During this year there have been major attempts to abolish them, and merge them with what are called Strategic Health Authorities. These have responsibility for health care provision and one could see a major conflict of interest developing in which money for education could be diverted to prop up failing services. Fortunately a degree of wisdom has prevailed and local arrangements can be continued if they are working well; which is useful for us in this area because the processes are working very well indeed.

The reorganisation of SHO training continues to be developed, with pilot programmes being established all over the country. There are many organisational issues to be resolved, not least of which will be our capacity in general practice to provide educational placements for medical students, doctors on foundation programmes, as well as those commencing specialist training for general practice, undergoing innovative training programmes based in general practice but with experience in secondary care, and their final general practice placements. The organisation of British training practices may have to change radically to adapt to this new situation.

I am planning a new style of GP training scheme in which two years will be spent in the training practice and only one year in further hospital-based training. It will be designed to follow on from the two-year Foundation Programme we are developing here in Leicester. I will keep you posted on progress as it will not be starting until August next year.

Continuing professional development

The new general practitioner contract is also going to change the funding arrangements for CPD. The GP Directors no longer have responsibility for quality assuring CPD programmes, and the move towards practice based learning and personal learning plans continues apace. The appraisal process is now established with an annual interview being carried out by trained appraiser. However there is little quality control and the GP Director has been given responsibility for this process; another poisoned chalice! The link with the identification of underperformance is still unclear and a major source of dispute; particularly unclear process by which patient viewpoints are to be incorporated, as they are currently not part of the appraisal process.

"What have I done for EURACT?"

Since our meeting in May most of activities have been concerned around EURACT centrally rather than nationally. I represented you at the European society executive in Ljubljana where we also had a general meeting, and meetings with presidents of the other two networks and with the organisers next year's conference in Amsterdam. Apart from that my time has been taken up in preparing for this conference and council meeting.