Annex 5

Group Discussion Reports

EURACT Council meeting
May 7–10, 2003
Vilnius, Lithuania

Group I, Core competencies 1 & 3

The task force met in Vilna with Yonah, Roar, Gertraud, Job, Okay, Francesco, Bernard and Andreas in attendance. The first task was to divide the work on the chapters into two groups. Roar, Gertraud and Yonah (lead and editor) will write chapter 1.1 on primary care management and Bernard, Andreas and Okay (lead and editor) will write chapter 1.3 on problem solving. Francesco and Job agreed to contribute to work on both chapters.

Two principles were agreed on:

1. Keep the educational agenda PERFORMANCE BASED.
2. Keep it focused on the ENDPOINT of VOCATIONAL TRAININIG

The following matrix was proposed as a structure for each chapter:

1. Aim: "The doctor will be able to:…"
2. Specific learning objectives: "This will require…" (List knowledge, skills and attitudes objectives)
3. Teaching and learning methods: " Methods to achieve this include…"
4. Assessment: "The doctor will show…"

For example, the structure of chapter 1.1 might appear like this:

Chapter 1.1 Primary Care management

Aim: The doctor will be able to manage primary contact with patients, dealing with unselected problems

Specific learning objectives: This will require

1. A knowledge of the epidemiology of problems presenting in primary care (see also Chapter 1.3)
2. An "open door" approach to unselected problems
3. An ability to prioritize problems

Methods: Methods of teaching and learning to achieve these aims include:

1. Direct observation by the learner of the trainer performing in general practice
2. Performance of general practice tasks by the learner during a general practice attachment.
3. Simulation of general practice tasks with feedback on performance

Assessment: To demonstrate competence the learner will show how they perform required tasks in simulations. To demonstrate successful performance of tasks in actual practice the GP tutor will observe patient care by the learner through direct observation or by video review of recorded consultations.

Central issues

Each chapter will contain a discussion of three central issues arising from the core concept. These discussions will be written by experts in the field who will be invited to contribute by the chapter authors.

Mandate for the expert contributions

1. Three page document (maximum)
2. Citations to relevant literature on the topic.
3. Implications of the issue for teaching and learning in general practice
4. Future agenda and directions on this issue.

List of issues and authors responsible for inviting experts:

Hypothesis generation in GP problem solving- Bernard
Emergency services in primary care - Andreas
Information management in primary care - Gertraud
Dealing with uncertainty - Yonah
Pattern recognition - Job
The generalist orientation - Francesco
Rational Use of Resources - Roar (task completed - Frede Olesen agreed)

Timeline: We hope to complete our drafts by the Leicester meeting in September 2003.

Group II, Core competencies 2 & 6

Domain 1.6 Holistic Modelling

Prepared by Egle

Jan Heyrman's notes after the Vilnius sessions on the topic. To be further addressed by Egle in the first place, by the all working group in a later phase (Fergus, Bernardina, Juliana, Paula, Filippe, Adam, Stefan ..)

6. Holistic modelling
-use a bio-psycho-social model taking into account cultural and existential dimensions.

Introduction to the topic

1. Defining wholisme

Medicine is a part of a larger culture It is based on a set of shared beliefs and values, as with any cultural practice. Holistic thinking has lately been applied to various levels of medical care, and the change is not *whether* holism, but *which* holism (2). Holism has many interpretations of the term in medical practice, including alternative or complementary practices, often used in literature. Unless the term holism is made clear within a piece of work, the author may attach one meaning, and the person reading the article has a totally different understanding of the term (4).

The definition of holism that is widely accepted for medical care, and will be used in this document, implies *caring for the whole person in context person's values, his family beliefs, their family system, and their culture in larger community, and considering range of therapies based on the evidence of their benefits and cost* (1). Holism involves, by definition of Pietroni (1987) "willingness to use a wide range of interventions… an emphasis on a more participatory relationship between doctor and patient; and an awareness of the impact of the "health" of the practitioner on the patient (5, cit. by 4).

And there is more. Holistic care can only be interpreted in relation to an individual's perception of holism. If we accept that holism will always be individualistic, then even therapies or interventions offered to the patient will have a different meaning to different people. That's a reason why it relates so closely to family medicine.The holistic view acknowledges objective scientific explanations of physiology, but also acknowledges that people have inner experiences that are subjective, mystical and for some religious, which may affect health (6, cit. by 4).

2. Defining the bio-psycho-social model

Several different levels or approaches to holism have to be considered when setting educational standards in teaching family medicine. Basis in biology defines organismic holism, from a medical point of view it incorporates systemic holism, and as a person-centred discipline it gives a central role to whole-person holism (2). The latter is mainly defined as bio-psycho-social model, taking into account cultural and existential dimensions.

To be expanded, with some good literature, by Stefan ??

3. Defining the factors and the integration of them

Using a bio-psycho-social model as the basis for cure and care implies to accept that many factors influences the present presentation. Family doctors accept a large diversity of factors to be of influence. Still there is always a limitation to a set of influence that can be handled by one person in a therapeutic environment. Examples of factors are

-the natural disposition, including elements of gender, genetic constitution, typology.
-the macrosocial environment, including the family, the small and the big society with the cultural elements in it.
-the health beliefs and life experiences that makes a person the entity that it is now
-the salutogenesis, putting focus on the healing power, and the health maintaining factors in a person, like the understanding of events, the acceptance of meaning, the autonomy that leads to the conviction that life is manageable. This is seen as a balance and a complement to the pathogenesis, that leads to illness and disease.
As the list of factors could grow unlimited, it is important to stress that a basic feeling of the own limitations is crucial : keeping aware of the fundamental autonomy of the patient, the limited opportunity for the family doctor to intervene occasionally and rather "tangential", with an interesting but very scarce knowledge about personal history, feelings and priorities.

The integration of influencing factors is crucial and constitutes the added value. This refers to system approach, where the whole is considered more than the sum of the parts. This refers to circular reasoning as counterpart for linear-causal reasoning, where listing all vulnerable and changeable influencing factors is considered more useful in a therapeutic relation than the search for the one principal and dominant causality that started the process .

Objectives

- Ability to understand patient as a bio-psycho-social whole
- Attitude to patient's beliefs and *his* understanding of holistic approach;
- Skills to transform holistic understanding to practical measures
- Ability to cooperate with other team members in providing holistic care
- Tolerance and understanding to other patients' experiences of subjective nature that may affect health.

Consequences to methods

To train to handle a large variety of fields in an integrative way, different focuses should lead the set of used methods. The basis is the case study, the use of narratives and patient stories, the focus on simulated patients with complete stories and defined life histories.

1. Opportunities :
- use the practice environment and the home visits to focus on life circumstances, housing conditions, family relations and the stories that are told by it.
-Use the chronic patient to focus on meaning of disease in a lifetime, on life conditions, on reactions to value and beliefs, on coping behaviour, on support systems from family and friends
2. Instruments
-the genealogy trees, the family plots with relational elements, and the doctor in it, with reference to strategic consequences of the reinforcement or the change of positions.
-the complete patient report, with different elements to obligatory inventarise.
-the narrative descriptions
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3. Models :
-chronic disease models,
-focused concepts like stress, somatisation, coping behaviour, support systems
-life cycles and family cycles from developmental psychology
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4. Enabling factors
-communication style, patient centred focus, awareness for bio-psycho-social cues.

5. Evidence base
The specific set of data on bio-psycho-social models

Consequences to assessment

Assessing the specific theoretical models used within the training program to

Case-based assessment by reports, by MEQ that start from the case situation

By following and reflecting process and progress.

Consequences to setting and timeframe

In BME, the biomedical model should be balanced by the broader bio-psycho-social framework.
A scientific basis of psychology, sociology, anthropology and ethics should be related to its application in patient care
Early patient contact should enlarge the narrowing disease focus, and keep the context in relation

In specialist training there will be a need of remodelling the dominance of a biomedical model in the larger framework of the biopsychosocial dimensions.

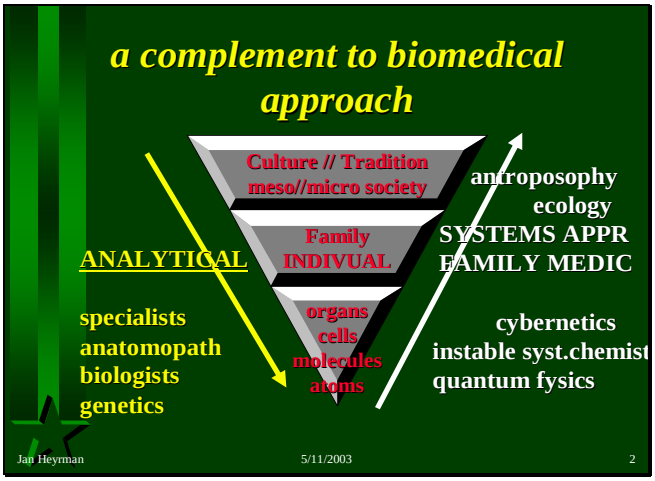
Overview framework

Discussion elements

The 3 BOX TOPICS

We did not discuss this in the group. As far as I'm concerned, I would like to input here two topics, others can be added

1. The system approach
a complement to the analytic approach



2. Salutogenesis
a complement to the Pathogenesis

Reference to Antonowsky, the Sence of Coherence scale,
All the elements of autonomy, of coping and support
The medical healer literature