Annex 1

Review of national educational activities after EURACT Council meeting in Eilat, 2000

EURACT Council meeting
October 19 – 21, 2000
Kusadasi, Turkey

AUSTRIA

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Pregraduate Education

The new medical curriculum will be totally different to the old one and a lot of work is put into the development. Education will be offered in a block-line model and all traditional subjects are integrated into these blocks. The study time will be 12 semesters – 2 semesters the first part and 5 semesters the second and third part. The GPs, who are lecturers at the university of Vienna are included in the development of the curriculum. One of the aims of the curriculum is, that the student should have the basic knowledge of a G.P. at the end of the studies.
Status of the G.P.s at the Vienna university: General Practice is a part of the Institute of Pre-and Postgraduate Education.
The new curriculum might start with the winter-semester 2001 and would be offered to about 1400 students in Vienna. The 2 other universities (Graz and Innsbruck) are also developing a new curriculum.

Further changes:
Students will have to pay for their studies... about ATS 10.000.-(EURO 8oo.-) per year from the next year on. Protests have just started.

Postgraduate education

We are hoping that the trainees will be able to come to the G.P.teaching practices also at the beginning of the vocational training. There is a new political discussion about it.
Until now the trainees are fulfilling their teaching practice training in the ambulatory care units of the hospitals.
The waiting time for V.T. is about 2 years in Vienna and less in the countryside.
Theoretical courses for traines are organised, but they are not obligatory.
The final exam of the V.T. is well accepted. The G.P.s of the Austrian society of G.P.and the Doctors Chamber are organizing it (written short answer questions).

CME

The WONCA Conference in Vienna in July 2000 was a big success. 2400 participants from 68 countries all over the world met in the Wiener Hofburg. The contributions were very good (500 abstracts) and the whole conference was very inspiring. We were told, that it was one of the best conferences WONCA ever had.

All over Austria Quality Cercles are now established and training for the cercle-leaders are offered.

The International classification of primary care-2 book is now translated into German . Austria was working together with Switzerland and Germany. The book will be available by the end of the year.

Politics

We are happy that finally the EU-sanctions against Austria are over.
Saving money (Sparpaket) is important and so there are a lot of discussions about changes in the health care:
°more care offered outside the hospital and payment for patients, who use ambulatory care
°chip-card
° G.P.s as coordinators and offering more preventive care
°allowance of group-practices, which is still forbidden... etc.

BELGIUM

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Undergraduate education

The positive message from our French sister university, the UCL (Université Catholique de Louvain) goes on: a second "research professor" is nominated, Dominique Paulus, a young female doctor with a good background in epidemiology. This is really the first time that also the French speaking universities introduce in the academic structure a normal department for General Practice. Let's hope the other two universities will follow.
A negative point: the career of GP is loosing a lot of interest for the young medical students. We are still 4 years before the point that there will be a numerus clausus : only 180 GPs will be allowed in GP-specialist training at the Flemish side, and we could this year only attract 160 new trainees. One of the possible reasons is that, in view of the impending "limitation of specialist posts", large opportunities are offered for specialist training in all different hospital wards. But probably there is more: is the young generation still interested in a hard working lifelong career with a lot of personal involvement for a low level of income ? Did we overemphasise the complexity of GP, so that the new generation is afraid of it? Or is it mainly because of the lack of properly structured primary care. Still 80% of GPs are solo, and young graduates don't want to practice this way.

Postgraduate specialist training

Our new Leuven curriculum, based on the social constructivistic paradigm raises a lot of new positive energy, with students as well as teachers. In a 3-year planning scheme, we want in the department to completely renew our training curriculum to a strong IT supported and selflearned pathway for learning. Next year course texts only on the web, for each topic a specific learning traject that ends with a specific selfdirected test or exam. It keeps us busy and young !

Health Care
Last time, I mentioned the « listing of patients with a nominated GP ». It started as a success with those over 60. Almost 1 million of older people chose a personal GP. The planning is to evaluate and to enlarge it in 2003, but the minister included earlier than planned the over 50: it will start from January 2001 on. This includes amongst other that the complete responsibility for breast screening programs and for prostate screening comes in the hands of the GP. Including in future also the younger till the age of fourteen are included in the planning, but raises a lot of difficulties with the pediatricians. Officially the government still wants, from 2002 on every citizen to be offered a personal GP as the « official medical record keeper ».
A negative point : the government plans to support primary care by creating an official legal status, so that structural financing becomes possible, get a lot of negative or at least hesitating reactions from the GP's itself. A fear for change, for new challenges, or just a feeling of « I don't want to change anymore my life routines ».

BOSNIA & HERZEGOVINA

No report received.

CROATIA

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There are several news:

1. A new **student's book** of General Practice / Family medicine was published,
2. Undergraduate education is going on as usually, but we tried, through discussion in the group of tutors, to list **clinical teaching methods** employed during GP clinical crearkship.
3. Vocational training is almost stoped. This year there is **no one new trainee** in whole Croatia.
4. In this situation a **lot of effort is put in CME**, organising different courses and woorkshops (Care of terminaly ill patients, How to deal with strong emotions?, Balint's group, How to deal with difficult patients?, How to deal with most frequent sexual problems?, Using small technologies in GP, The role of public nurse).
5. A **new course**, basic of pedagogy, for younger medical teachers is going on at Medical School University of Zagreb and Department of GP participate a lot.

CZECH REPUBLIC

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General Practice Teaching in the Czech Republic in 2000

One decade of free development of economic, social and scientific life influenced the system of medical care provided by general practitioners and, in particular, the ways of teaching of GP, too. That is a reason to have a deeper look at the general practice education in the Czech Republic. There are three main types of institutions responsible for education of general practitioners in our country.

1) **Medical faculties at universities** – subordinated to the Ministry of Education

Currently, medicine is being studied at seven medical faculties (university medical schools). Teaching of general practice was provided at none of them during the totalitarian regime. Nowadays, family medicine or general practice teaching is performed at all the medical faculties in the Czech Republic on the undergraduate level. However, the extent, form and demands vary from school to school. There are no central directives to regulate undergraduate education in general practice/family medicine. The subject "family medicine" is being taught at four medical faculties, "general practice" at three of them. The ways of organizing the education and the teaching methods employed are changing significantly with time. E.g., a new, independent "Department of general practice" was established at the Medical faculty in Olomouc recently, while a former "Department of family medicine" at the Medical faculty in Brno was transformed into a "Department of gerontology, nursing and general practice". Currently, there is only one medical faculty, namely, one of the three medical faculties in Prague, at which there is no institutional basis for GP/FM teaching.

Medical faculties are responsible for undergraduate education only, not for a special postgraduate training or for CME. However, some of the medical faculties also participate on continuing medical training of GP's, although it is not a direct duty of theirs.

2) **Institute for Postgraduate Training** – subordinate to the Ministry of Health
This non-academic educational body is responsible for the contents of postgraduate training and for examining of future GP's. It also participates in CME by organizing thematic courses for GP's within the framework of CME.

3) **Czech Chamber of Physicians**
The responsibility for CME was handed over to the Czech Chamber of Physicians – although, the splitting of competence among the Ministry of Health, the Institute for Postgraduate Training and the Czech Chamber of Physicians is still being discussed and hence, obviously, is not understood in the same way by each of the parties involved. Nevertheless, the interest of physicians in CME has grown substantially during recent years, the Czech Chamber of Physicians taking the main credit for that.
The Czech Chamber of Physicians is, to a certain degree, responsible for education of physicians in general, therefore, for a special postgraduate training as well. The scheme of GP's special postgraduate training being in effect so far was accepted more than two decades ago and has not reflected the changes induced by new social conditions. The whole curriculum comprises only two and half years. There is a universal agreement that the existing time limit allocated to special training of GP's is far too short. The Czech Chamber of Physicians in fact accepted a decision recently to more than double the length special training of GP's. However, this prolongation has not been implemented yet due to several reasons: Among others, no adequate measures have been worked out to compensate for a few year's gap in producing new GP's which would result from a sudden prolongation of the time of their professional preparation. Also, the question of financing this extension has to be solved. The Ministry of Health and the Institute for Postgraduate Training have not yet publicly presented their opinions on how the proposed extension of GP's special training ought to be realized. Only future development will test the feasibility of such drastic measures in the time of transformation of the health care system.

Outline and Perspectives
Undergraduate education has been subject of the most remarkable progress during the last decade. Teaching of general practice is being performed at all the medical faculties and includes both workshops as well as rotations at GP's surgeries. Unfortunately, there seems to be a lack of genuine interest of central authorities and medical faculties to improve it significantly in the near future.
Postgraduate special training did not change substantially during the last decade. It is centralized and academic bodies are not involved in its realization. Intentions to decentralize it and to prolong of its duration have been proclaimed repeatedly.
Continuing medical education used to have no organizational basis in the past and flourished recently. However, no clear rules have been recognized and opinions of responsible bodies about this topic differ a lot. Particular features specific to general practice are not sufficiently taken into account while the pharmaceutical companies grabbed their opportunities to profit by the duty of the physicians to take part in CME.

DENMARK

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Summary:
General practice managed to get a cease fire in BME – and is probably winning a battle in PST.

Pregraduate education (BME)
The Institutes of General Practice were close to being squeezed out of the medical faculties as independent institutes (with a specific budget) in accordance with new regulations form the Ministry of Education. An effective and efficient lobbyism succeeded in postponing the instalment of regulations.
At the same time curricula are revised inviting general practice to engage as teachers of communication skills from first year of medical school.
The study period of medical school has been reduced to at total of expected 6 years (from 6½ years).

Postgraduate specific training (PST)
Shortage of doctors in almost all specialities is apparent. The struggle to get the candidates is ongoing.
The number of training posts in specific training for general practice has been expanded with 25% to 140. The revision of the national programme has been effected, making 1½ years of 5 to be spend in training in clinical general practice.
Furthermore plans are progressing of defining a training period for general practice of 5 years following the internship (of 1½ years); 2½ years of the 5 years will be situated in general practice training practices reducing the hospital training period (from now 4 of total 5 years).
The theoretical part of the training is undergoing revision, adapting the curriculum to modern general practice trainees.

Continuous Medical Education (CME)
At this very moment very much energy is put into debating the role of the pharmaceutical industry as sponsor of CME – and strict rules are supposed to appear, regulating the relationship between doctors and industry. Compulsory CME (with no funding) is part of the discussion.
Still GP CME is a story of success. More than 90% of GPs utilise their money in the CME fund and 98% of all GPs are included in at least one (local) small group, defined by geography, interest, theme etc. The small groups are going to become focus of change with facilitators (a new creation sponsored by the quality assurance fund) workshopping with the groups to implement guidelines etc.

ESTONIA

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The Estonian Ministry of Social Affairs is on the position that the primary health care reform has been mostly completed, family medicine as a new speciality has been established and by 2003 family doctors in all regions of Estonia will provide most of the primary care. For training this means that there will be quite an extensive retraining program for the next 2-3 years, thereafter new family doctors will enter their job only after completing 3-year vocational training after their undergraduate courses.

A new health care organization law is in parliament, giving legal support also for the changes in primary health care. List system, compulsory vocational training and independent contracting with sick funds are the basic keywords for family medicine in the new law.

Family medicine has become the largest medical specialization in Estonia with the largest number of trainees in vocational training. Still we have a competition for the residency posts.
At the beginning of October I participated on behalf of WONCA-Europe at the conference in Minsk where representatives of 10 CIS countries discussed general practice education. This was a very interesting meeting and we should be aware of the reality that all these countries nowadays redesign

their primary health care systems, that medical schools have opened chairs of general practice and that in 1999-2000 in most of these countries GP-associations have been established.

FINLAND

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Health Care

An increasing shortage of general practitioners is the main topic in discussions about health care in Finland today. Even if we now have more doctors than ever before, there is a shortage of GPs in the health centres, but also of many other specialists in public hospitals. General practitioners haven't been participating in any demonstrations yet, but e. q. more than half of the anaesthesiologists of the Turku University Hospital are intending to withdraw their work in the hospital and to move to the private sector. It can be guessed that media has been very interested in negotiations around this topic. The burn out of doctors as a consequence of the overloading work is being held as the major cause of shortage in general practice. The new population-based idea of organising the work in health centres has not helped in the situation, maybe the effect has been into the opposite direction. To help, the authorities are willing to increase the annual student intake, but at the same time give only minor resources to the faculties to survive in the new situation.

Basic medical education

General practice has a stable position in basic medical education of all the medical faculties. All the faculties have established departments of general practice with full professors. General practice is in most curricula involved in the education very deeply, but of course the medal has the other side as well. Some representatives of other disciplines talk about the metastatic Carcinoma of General Practice in medical education. There are good news as well. The Medical Faculty of Turku has got a new, scientifically very competent professor, Sirkka-Liisa Kivelä from the University of Oulu. Earlier we have put a lot of emphasis on education, now it will come the time for research as well. At the same time, of course the professor chair in Oulu is now open.

Specialist education

General practice is a specialty in Finland, since the 70s. It is very popular among the young doctors. The program consists of six years training after BME, including health centre and hospital service, theoretical education, assessment and training, and a written national examination. After the new law on specialist education in 1998, we have started with more individual training with personal tutors, guidance and mutual assessment, logbooks, more structured education based on trainees' needs etc. There are no real problems in this specialist education today. The state is even paying subsidy to those health centres and hospitals which participate in the training.

Continuing medical education

This is a hot topic as well. There is no real structure in CME/CPD. Universities, educational trustees, professional associations as well as medical industry are willing to take their part of CME. There is neither obligatory CME nor recertification. The medico-legal authorities have a right to stop the practice of a doctor who is not competent enough, and may order the doctor to participate in CME. These sanctions are nearly never used. The doctors are responsible with their own CME, and most doctors participate voluntarily in. The burden of work has maybe diminished the participation during the last years. A positive solution for these problems is discussed very lively today.

FRANCE

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1. Health Care System

There is always a specific convention between GPs and national health insurance, but no convention with specialists. The situation is worse for them: the national insurance decided, with the accord of the government, to decrease the price of some technical services because they exceeded the rate of care expenses.

The telematic transmissions with the health insurance system is now effective: more than 50% GPs have this electronic contact. But the system is always free access for the patient who pays for each consultation. The agreement between the patient and his GP for 1 year "medecin referent" in which the patient doesn't advance the fees, is not successful (no more than 10% GPs). The elections for the Professional Unions (who are composed by members of trade unions) give the majority to the trade union who doesn't sign the convention: no change actually but what happens now ?

A decree about individual and collective assessment of medical practice was published: each doctor can be evaluated in his office according to a voluntary process.

2. Teaching and training in general practice

The planned reform of medical studies is delayed for technical problems, but the process is on the way. Each faculty discusses about new BME, the cursus of specialised study in general practice (like for the other specialities) is programmed and the 3 years of vocational training will begin in November 2001.

There are now 51 GPs associated teachers in the French universities: 21 professors and 30 lecturers. All the universities have now an associated teacher but none of them a full teacher !

3. Continuing medical education

The obligation is still not applied. The law expected is not yet published by the government: the project plans 3 ways of evaluation: 35 hours of education each year, a periodic examination or a personal record of activities.

4. French National College: CNGE

The CNGE school organises 12 sessions for 2000 for GP trainers and teachers. The annual workshoop with EURACT is scheduled in November about "How to teach prevention". Dr. L. Pas and M. Samuelson are the trainers. There are actually 15 participants from 10 different countries.

The College prepares its First National Congress, instead of his annual meeting, in November 1999, in Brest, about Clinical Competencies. The goal is to interest a large audience beyond the teachers and to have the support of all the profession for academisation of general practice. The College started work on a big research project about chronic pain with 200 GPs. The journal EXERCER has some difficulties with his sponsor and the future is not clear.

GERMANY

No report received.

GREECE

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General
The last six months we have been experiencing the negotiations on the reform of the health system. The main points of the reform are: 1) the decentralisation of the health services of the Ministry, 2) the replacement of the existing administration board of the hospitals with managers of health services, 3) new way of funding of health services in combination with the unification of different health funds, 4) development of the PHC mainly in urban areas(in non urban areas has been already developed), 5) implementation of the family doctor based on a list system; gate keeping is under negotiations, 6) increasing of the number of posts of specific training in GP in combination with a on job retraining programme (under the responsibility of ELEGEIA).
It is clear that there are big problems with the hospital doctors; they don't like the reforms at all. The negotiations are going to finish till the end of October. According to the plans of Ministry till the end of the year the new law is going to be voted; so, the new changes are expected by the new year. It is now a matter of political will and power. The positive point is that the Minister believes and has the will to do it.

Specific training
No changes concerning the curriculum and the content of the specific training. A new initiative taken by the Greek Association of GPs (ELEGEIA) must be reported; last June, ELEGEIA organised a meeting of the Coordinators of GP from all hospitals of the country in order to discuss with them the problems they meet and to activate them to better coordination and training of the trainees. We had rather poor results, since the majority of them are specialists with no interesting in GP. We have to work hard on it.

CME
Next week the members of the education committee of ELEGEIA have a meeting on CME; this will be the first organised effort to plan CME activities for the next two years. I think at the next council meeting I'll be able to present the complete programme.

HUNGARY

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General information
Slowly and uncertainly is the structure of the national health service being restructered. Unfortunately there are a lot of new laws accepted, which are difficult to apply and make the everyday work of physicians even more complicated.

The privatization of primary health care has started.
The conditions of financing is underway.

Graduate teaching
The Department of Family Medicine at Semmelweis University organized its Empathy Course for the first time in summer, where 25 students in their I.-IV.academic year had the opportunity to get familiar with the everyday practice of a family physician and improve their emphatical ability through situational experience.

Students could identify with the feeling of being ill by taking up the role of patients suffering from various diseases and disabilities. Their experience was later worked out in small group discussions assisted by specialist and experts. They visited people living in different social circumstances.

At the University of Pécs in the frame of the education reform teaching family medicine starts at an earlier stage of the academic curriculum. After the first academic year they participate in a one-week summer course of family medicine aiming to improve their communication skills and providing a possibility to get an insight in the everyday work of a family physician. In the third year they get acquainted with the theory and practice of family medicine in the frame of small group sessions, while in the fifth year they take part in a two-week practice course of family medicine.

At other Faculties of Medicine the reform is under preparation.

Postgraduate teaching
The number of residents of family medicine has unfortunately been reduced by the Ministry over the past year, so instead of a 100 only 75 residents started their studies.

WHY WAS LAST YEAR'S WORKSHOP CANCELLED?
Despite the preliminary survey the number of both Hungarian and international applicants was so small, that the course could have been organized with considerable debit.
In finding out the reason for the unexpectedly small number of applications in Hungary, we concluded that due to the change in the marketing policy of pharmaceutical companies sponsoring postgraduate education so far it is virtually impossible to find sponsorship for the same purpose, which means applicants should have covered the expenses. Considering the average income of Hungarian physicians today, very few of them can afford it.
Consequently our task in the future may be to find other sponsors and sources to organize courses very useful for us, minimising the expenses of participants.

IRELAND

No report received.

ISRAEL

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It is impossible to report on activities in Israel without reference to the current increase in tension in our area. We hope that common sense will prevail and we will soon see an end to violence and a return to negotiation.
The period since the Council meeting in Eilat has been marked by continued academic activity in family medicine. This summer the AMEE conference was held in Be'er Sheva and we enjoyed presentations and workshops with our colleagues in medical education from Europe.

In September we held a successful national meeting of the Israel Society of Teachers in Family Medicine (HEIMAR). A look at a selection of the titles of the presentations gives a sense of the direction of academic family medicine in Israel. The were lectures on the use of narratives in medicine, the teaching role of medical consultants in family medicine clinics, the effectiveness of preparatory courses for specialization exams, a study of a new tool for assessing communication skills in trainees, a program of educational cooperation between geriatricians and family doctors and workshops on problem-based learning and coping with uncertainty.
Howard Tandeter and Aya Biderman from Be'er Sheva report on a successful course on scientific writing of research papers for family physicians, a joint workshop with the Ben Gurion University faculty of education on motivation in teaching and meeting educational goals and a new project with Columbia University in the US teaching family medicine to American medical students in Israel.
Eli Kitai from Tel Aviv reports on an exciting distance learning project that the University has started with internal medicine, pediatrics and family medicine in the lead. Each department will prepare a series of CME seminars for interactive broadcast to multiple electronic classrooms around the country. Tel Aviv continues to invest in faculty development. Seminars on EBM, conducting focus groups and setting learning objectives have been given to local groups of teachers. The integrated 6-year behavioral science curriculum in the Tel Aviv medical school, led by Michael Weingarten continues to develop.
Arthur Furst reports from Jerusalem that the successful early clinical exposure course for medical students in family medicine continues this year. The final year clerkship and vocational training schemes are functioning. There are hopes that the new dean of medicine in Jerusalem will create a more favorable climate for academic development of the profession.

ITALY

No report received.

LITHUANIA

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Training of family physicians is going on, and until now about half of GPs , required for primary health care in Lithuania, has been trained, others are in the process of training (or re-training).
First group of family physicians –independent contractors, are starting their activities with the support of EU Phare project. As independent contractors are expected in future to be the main providers of PHC services, it is very important that this group of GPs would become an example in family medicine as well as be financially successful so that other GPs would like to establish their practices too.
International workshop in research training in primary care, 4th Forum Balticum, was held in Klaipeda 7-9 September, 2000. Purpose of this workshop was to encourage young researchers to start their own research projects and help them with methodological issues. We think that this was a siccessful meeting and next one will be in Klaipeda again after 2 years.
Now Governmental Sickness fund is evaluating new scheme of financing of health care institutions. The main idea of new system is combination of capitation fee (70%) and fee for service (30%). The main purpose of this change of payment to PHC institutions is to stimulate GPs to provide the wider range of services in general practice and by that to save the money used in Secondary care level. This means more responsibility for GPs as well as more paperwork too.

Our doctors agree that in the current situation of restricted financing, the time for implementing the new system is not the best, but the final decision depends upon the Ministry of Health. After elections to the Parliament and new Government now we are going to get new leaders of the MoH too.

MALTA

No report received.

NETHERLANDS

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National items

They are more or less the same as in my Eilat report.

The main issueat present is the mounting awareness of the (experienced) unacceptable workload of GPs. This leads to a complete revolt.

The general feeling is that the government does not pay adequate attention to this issue and that not enough money is made available for the GP. The feelings have risen so high that a national strike of GPs is planned on Tuesday 17th October ! They will all travel to the Hague, where the government is located, to join in a huge protest meeting. This is a unique happening in the history of dutch general practice.

What is the background ?

Quality expectations and costs of the practice have increased. More work is directed to the GP, because of shorter stay in the hospital and increased turn over. Patients, the profession and the insurance companies expect more and better quality. But the working conditions have not been improved accordingly. The premises are too expensive to buy and/or to maintain, and the same applies to assistance in the practice.

The capacity of the medical schools and the vocational training programmes is insufficient with regard to the demografic ('greying' population) and societal changes (more women, more parttimers, less working hours). The number of trainees has to grow dramatically. Thirty percent of the GPs is older than fifty and eighty percent older than fourty years. Being on call is experienced as demotivating and stressfull. This is one of the reasons for many GPs to fall ill, to retire earlier; and for young doctors not to start the training at all. Moreover, the extra hours of being on call are not adequately paid for (less than 4 euro per hour).

One of the initiatives to counter this problem is the establishment of central GP call centres for large areas (up to 150.000 patients), sometimes integrated in the emergency post of a hospital. The latter is the case in Maastricht. The experiences as well for the patient as for the GP are unexpectedly positive. The workload of the GP decreases and the patient can always call the same telephone number or go to the same place. A proper and decent reimbursement is requested from the government as these posts are rather expensive.

In my view this period is crucial for the position of the GP and general practice in our country.

The **other items** are mentioned in my previous report and remain unchanged: quality systems initiated by the College and the Association of GPs; higher professional training, basic medical education and academic practices. Progress is made.

Netherlands (Bernardina's report of the European Network of Teaching Cancer Care in General Practice).

Hot news

In the Netherlands general practitioners come into action. GPs are concerned that under the current circumstances the profession of "general practitioner" is at stake.

Yesterday, October 17th, 1000 GPs demonstrated in the Hague in order to stress the need for:

- More GPs. There is an urgent need for more general practitioners. GPs who follow vocational training schemes should be better paid. Comparable to the payment for other specialists in training.
- The on call system. More and more GPs organise their on call from a central place in a town or region. Reasons for this are; - a growing number of patients ask for help outside the normal hours. These demands are often not based on acute situations, but the patient finds it more practical to call the doctor on this time; - a growing aggressiveness. Especially in the bigger towns; - the doctors experience more and more that working during the week and for the on call hours is a great burden. There is obviously a change from the 24 hours availability in one person to a delivery system in the hours outside the normal working hours. GPs want money in order to be able to organise the different on call system
- Money. There is a discrepancy between the heaviness of the job and the money you earn. GPs want the government to address this issue seriously.

I assume Harry Crebolder will describe the development in the specific fields of training in general practice in our country.

ENTCCGP

The network is coming to an end, with regard to the Europe Against Cancer project. All national projects will be finished by now, and reports are being written. We asked all countries to write their report as a draft for an article, in order to prepare already the step for publication.

During the past half year we presented our work on an international level as three workshops on the WONCA in Vienna. We developed our cooperation with the ESO (European School of Oncology) in the START project (State of the Art, a network facility for doctors about cancer) and in a consensus project on "good palliative care in Europe". One of our members will be one of the workshop leaders in the coming international workshop in Barcelona in November.

We are reflecting on options to continue as a network in the future. The uncertain future was the reason that we did not make a web page to be linked to the EURACT page as yet.

I am afraid that the ending of the network in this organisational form will also mean the end of my role as observer in the EURACT.

As to me personally. Palliative care, my area of interest and work, is an important issue in the Netherlands at the moment. There are a lot of initiatives to improve the opportunities for health professionals to consult experts in this field. My activities in this exist of the following items:

- I am developing a national educational programme for general practice consultants in palliative care. The course will take 1 ½ years in total. It is planned that the GPs who followed this programme will be working in the following ways; they will be available for consultation in this field for their GP colleagues at a regional level. Together with their colleague consultants they will provide of a 24 hours availability on a national level. They will have a responsibility on a regional level to organise and provide of CME in this field.
- the peer group project that I developed in the Europe against Cancer project will be starting in several other regions in the Netherlands. Two projects are running, and three more will follow in the year 2001.
- I am developing a training programme for consultation teams. The first training will take place in November and will be given to the several health professions together. The raining will be focussing on consulting skills, cooperation and team building.

NORWAY

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National level

- Still the most important subject in Norway, is the discussion and making plans how to create a patient-list- system in Norway.
  First all should have been prepared until January the 1st 2000, then the limit was January the 1st 2001 and it seems to be a reality that this great reform will be established at June the 1st 2001.

- The lack of GP/FP seems to be about 800, before this reform can be a reality.

- This is a major problem that a lot of districts and health centres all over the country does not have enough GP's/FP's.

- The new reform will be named something as a "firm patient-doctor-reform", or a "firm doctor reform".

- A major subject is also how to communicate with the patient. The model developed in Bergen in contact with the Leuven University is rather popular.

POLAND

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Undergraduate education:
No major changes have occurred. Family medicine is still taught at all medical university schools but number of teaching hours differs significantly. The Board of Higher Education – an independent body consisting of representatives of universities and attached to the Ministry of Education, consider two projects of so called minimal standard of basic medical education. The standard contains the minimal number of teaching hours, which should be allocated to the given subject. When approved by the Board must be followed by all the universities. First project gives 120 hours during the whole basic medical education for family medicine, second only 20. The projects are complex proposals, so other solution (e.g. 60 hours) is hardly possible. At the moment it is unclear which project has higher chances to accepted.

Postgraduate education:
New law about postgraduate education of physicians from 1999 is strongly criticized. There are advanced works on its renewal. Some disadvantageous regulations about GP education could be removed. Still the discussion is going on and the results are uncertain.

Continuous Professional Development:

The College of Family Physicians in Poland has started School of Tutors. Over 200 FDs have applied but only 100 have been accepted. The school has three modules of three teaching days each. Basic information about the CPD are taught as well basic theory of Quality Assurance. Graduates of the school are expected to be leaders of peer-review groups of 10 – 12 physicians. The groups are going to conduct qualitative projects as well as participate in educational activities.

Other issues:
There is further deterioration of financial arrangements for family physicians. This trend however is common for all the parts of health care system.

PORTUGAL

No report received.

ROMANIA

No report received.

RUSSIA

No report received.

SLOVAKIA

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Undergraduate education
There are still no Departments of General practice and Family medicine at two out of four Medical schools in Slovakia, but teaching of General practice and Family medicine is a compulsory part of undergraduate educational at all four Medical Schools. At the Medical schols without Departmetns of GP/FM teaching is provided by the Internal medicine Departments. General practitioners are involved as lecturers and also in the practical part of teaching. Education curriculum contains three parts:
l. lectures (f.e. introduction to primary health care, teaching PHC principles)
2. workshops (f.e. teaching communication skills, preparation of project in health promotion)
3. visiting teaching practices.
All medical students are obliged to spend at least one week in accredited primary care practice.
Untill now there was not pointed any professor of GP/FM in Slovakia.

Postgraduate education
The duration of the Vocational trainig for General Practice is 3 years. Future GP must spend two years on various hospital departments (1 year Internal medicine, 3-4 months Surgery and Traumatology, 1-2 months ENT, Emergency, Dermatology, Neurology, Urology, Psychiatry or Gynecology, etc.), than 6 months in different „policlinic out door surgeries“ and finally there is a request for 6 months in a Teaching practice. Beacuse of lack of teaching practices, the last

mentioned condition is in many cases only a theory, but the process of accreditation of teching practices is well in progress, so finaly also the stay in Teaching practice is becoming a reality.

Continuous Medical Education

The recent model of obligatory continuous medical education is called:
„CREDIT POINT SYSTEM FOR CME IN GENERAL PRACTICE“, introduced in January 1998 as an inniciative of Slovak Association of Private Physicians. Later on it was accepted and supported by the Slovak Postgraduate Academy of Medicine and the Ministry of Health.
This mocel of CME is recently accepted with real respect from most of the GP´s.
Different courses and lectures are organised by Slovak Postgraduate Academy of Medicine in Bratislava, Regional medical educational bodies or Pharmaceutical companies. Attendanding accredited lectures and courses is bonused by certa
in number of credit poits, and GP´s are obliged to prove their attendance of certain number of educational activities, by collecting certain number of credit points, to the elected representative of the Regional Medical Chamber.
Collecting certain number of credit poins per year is one of the main conditions for the renovation of GP´s contract with the Health insurance companies, which is essencialy important for further financial existence of health care centre.
Paradoxly, the most requested courses organised in CME were those focused on Practice management, Health financing, Cost effective drug prescription and Primary care development.
Courses focused on clinical practice (f.e. cardiology, diabetes mellitus, astma bronchiale, etc) are becomming more interesting only in last few months, expecially according to the introduction of new diagnostic and treatment guidelines.

SLOVENIA

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Undergraduate education

This autumn we have introduced a major change in the undergraduate curriculum: the exam in the end will be changed from an oral one to a three part exam, including a MCQ, OSCE and an oral exam. We have worked hard on it, and we are all anxious to see how it goes.

Vocational training

Fortunately, the vocational training scheme is progressing well. Afetr many years of standstill the Medical chamber has accepted our vocational training scheme. There is still a lot of negotiations that have to take place, but fortunately there is a group of mcollaborators that manages to deal with this in an excellent way. The new scheme will start this autumn. We have successfully piloted it this spring and although a lot of work remains to be done, the major decisions have been taken. I was also asked by our medical chamber to find out about the position of trainees and trainers in general practice in some European countries, so I will probably be bothering some of you with questions regarding that issue.

CME

The Bled course was (as always) a success. The theme was “learning and teaching about evidence based medicine in general practice”. Next year we are going to celebrate the 10^{th} anniversary of the course and we are especially anxious to get as many foreign participants as possible. We are also looking for interesting themes and I would like to have suggestions from the EURACT board as well.

This year we have had a special ceremony which included planting a vine near the health centre of Bled. The mayor of the town was there and he presented me with a flag of the town. But this was just a pilot for next year!

OTHER
I have finished the work on the BME paper and have sent it to the European Journal of General Practice. Let us hope it gets accepted.

SPAIN

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REVIEW OF NATIONAL EDUCATIONAL ACTIVITIES
There haven't been important changes in the health and education regulations.

Undergraduate education
In Barcelona has taken place a course on problem based learning with the participation of a great number of nursing high school teachers and clinical tutors of different medical specialities. It is difficult to understand and much more difficult to implement that new system.
Surprisingly not one university professor attended the meeting.
The medical schools don't cat down the number of new students and for the next year 4.383 students will start the basic medical education.

Postgraduate education
In all over the country next year, 5.791 graduate will start their postgraduate education, and about 2.000 of them will go to family and community medicine.
A new revision of the national programme of our speciality just started and it will be outlined for a length of four instead of three years. The biggest problem will be financial, because in Spain the most part of the residents are paid by the state. In our program at least of 15 months are spent in community based health centres and now the debate is if that additional year must be used to extend the time spent in the hospital or in he health centre. In our program the residents are evaluated by their tutors (summative) after each year and at the end of the residency. The problem is that depending of the place the qualification was too high (80-100% of excellent) and of course it was not uniform all over the country. Because of that the Health ministry decided to develop a test to confirm the excellency! Last summer a first voluntary group of new "excellent" specialists in family and community medicine went trough an examination of clinical competence (OSCE), and from the 362 candidates, 80% (289) past. How can we interpret these results? What is to be done with the candidates who fail the examination? What it has happened is that the failed candidates became the qualification "outstanding". The most part of clinical tutors over the country are against that kind of evaluation, and for the next year the ministry has stopped the OSCE for that purposes.

Continuing medical education
Still not mandatory. Every one can do what he likes. The different medical organisations are trying to leader the process and the offer of courses, seminars, is very high and of good quality, and reaches different fields (quality improvement, cost effective prescription, practice management, financing, and also different clinical fields including clinical interview).

SWEDEN

No report received.

SWITZERLAND

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Basic medical education

For the first time in Switzerland a GP is the head of commission organising the clinical curriculum at one of our Universities,we hope to get many steps forward.So slowly after the latest accreditation ,as I mentioned in my last report ,things beginn to move. PBL is now established at all our five universities in preclinical studies and in many of the clinical curriculums. On the other hand a lot of our plans fail because of financial problems.(e.g. a 4 weeks block in a general practice during the 5th year).In Basel a system with a singel tutor (1 GP for 1 student) has great success.

Postgraduate education

A new system of competence certifications is introduced by more and more specialist`s associations which augments the endless quarrel between GP`s and Specialists.We try to include these certifications directly into our postgraduate education so that GP`s dont loose more and more competencies.
Because of lack of training places in general practices the project of the obligatory ½ -year training cannot be established by 100%.But we try hard.Our system has been shown at the WONCA-congress in Vienna.
Final exams are obligatory from the next year on.

CME

For the whole country 4 major events take place reglularly which form the basics of CME for GP`s: the annual congress of the swiss GP society, and 3 other 2-day congresses at Montana , Magglingen and Lucerne.On the other hand we encourage the formation of local Quality-circles and we train their leaders.

TURKEY

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Health Care System

Some information on current health care system: 'Socialisation reform' of 1961 clearly described the definition of the population for whom the practice is responsible, definition of priorities by identifying community health problems, community involvement, equity in health care services, continuity of care, integrated services, establishment of referral chain, and the concept of team work. The basic health care units in primary care are health centres and health posts at the village level. Health posts serve a population of 2500-3000, and the service provider is a midwife. Health centres provide

healthcare services for a population of 5000-10,000 in rural areas, whereas the size of population can go up to 50,000 in urban areas. These centres are staffed by a team consisting of at least one physician (general practitioner with no vocational training), nurse, midwife, etc.
The need for change: Over time the state budget allocations for primary care stagnated. A well-running system of referral could not be established. The health care indicators are not satisfactory compared with Turkey's socio-economic development level. The healthcare system experiences equity problems. The demographic trend implies a need for change in the planning of health care services. Finally primary care doctors are not motivated to PHC services.
Healthcare reform: The proposed healthcare reform has the following main headings: service provision reform; restructuring of the PHC services and development of GP/FM; decentralisation of hospitals and healthcare financing reform, implementing the general health insurance scheme.

Undergraduate education
Thirty-nine medical schools have admitted 4547 first year students in 2000. The departments of Family Practice have been established at 25 medical schools. Twelve departments are chaired by certified Family Physicians, four of whom are associate professors. Other departments are chaired by other specialists, nine of whom are professors, with the largest support from Public Health academicians. The departments have 34 certified family physician academic staff and are becoming more heavily involved in undergraduate and postgraduate teaching programs.

Postgraduate education
The most criticised aspect of the vocational training program is lack of training in general practice. However the departments at the universities have been establishing their own teaching centres outside the university hospitals. At present five departments have completed the establishment of such centres. There are lack of trainers in general practice settings as well. We are preparing 'Teaching courses' for training the interested family physicians in primary care. One of them will be held just before the council meeting in Kusadasi.

Continuous Medical Education
Nothing has changed since last March.

UKRAINE

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By this I am sending you the following information which will reflect the latest activities of the Ukrainian Family Medicine Association, in response to you request to throw light at what is going on inside our society.

IIIrd Ukrainian Scientific-Practical Conference
"Current Issues of Family Medicine"
Odessa 2000

"On the 19-20th of October the Ukrainian Family Medicine Association convened its IIIrd Ukrainian Scientific- Practical Conference in Odessa. The general topic of the conference was "Current Issues of Family Medicine". The conference was attended by 216 participants from Kiev, Lvov, Dniepropetrovsk and other towns of Ukraine as well as by our foreign colleagues. The discussions both during and between sessions were lively. The program dealt with the issues related to the

organisation of family medicine in Ukraine, pre- and post-diploma training of family physicians, diagnosis and drug therapy in practice of family doctors, non- medicinal treatments, etc. The lecturers were highlighting the important issues concerning current challenges and future issues of the organisation and introduction of family medicine in this country, a reorientation of the prime medico-sanitary service to a service built according to family principle, role of family medicine in a general health care system, adjustment of various regional (for rural areas, in particular) models for family medicine functioning, perfection of the training of family doctors; exchange of the experience within a framework of the American international health care association, with colleagues from The Netherlands and Germany.

Recognizing the need to strengthen the capacities of this country in establishing family medicine, the delegates decided:

- to actively promote the implementation of Cabinet of Ministers' resolution #989 of 20 June 2000 "About the complex measures pertaining to an introduction of family medicine in public health care system" and the order of Ministry of Health #214 of 11 September 2000 "About the adoption of a plan on the stepwise transition to a family-based prime medico-sanitary service";
- work be continued on the trial, scientific substantation and practical application of family medicine models in Ukraine, with an account being taken of national and regional conditions and recommendations of the Ukrainian Institute for Public Health;
- to continue working in order to perfect a system of pre- and post-diploma education of family physicians;
- to develop the programs for pre- attestational cycles for family physicians, for postdiploma specialization of family doctors assistants, medical nurses;
- to promote research and seminars for exchange of experience in issues of family medicine; and
- to plan a next conference."

UNITED KINGDOM

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The NHS Plan

For was the third time in ten years the National Health Service is to undergo another major reform. Criticism of the government's management of the service was gathering pace in the early part of this year, with a widespread recognition that it was significantly underfunded. Out of the blue the Prime Minister announced a major injection of resources to bring health care spending in the United Kingdom up to the average spending in the European Union-it would appear that one of the chief catalysts for this move was widespread publicity on the different levels of spending throughout Europe, on television and the newspapers.

Unfortunately there is a catch, and yet another major reorganisation is imminent. In a lengthy policy document which contained very little in the way of detail, a lot of changes have been proposed. Amongst these is the abolition of the Joint Committee, in a merger with the equivalent specialist authority - a proposal that may seriously weaken the position of general practice. There are welcome proposals to increase the number of doctors, particularly in hospital practice, and to a less extent in general practice as well. In the short term the plan is to recruit from overseas - it will be interesting to see from where. The whole basis of traditional general medical practice is under threat. It is suggested that nurses should carry out much of the work of general practitioners, and that GPs should all develop specialist skills to reduce the demand on secondary care. At the same time there is a move to more community based health service management with the establishment of primary care trusts. Finally the

basis of the general practitioner contract with the health service is being steadily eroded, with an inexorable progress towards a more managed and salaried service.
It is not clear how all proposed changes are to be achieved nor what is the proposed time scale. All in all it is a confusing time to be practising medicine in the United Kingdom, and an early effect has been a rush to early retirement.

Doctor shortage

One thing that is already clear is that the proposed changes will require an even greater increase in the number of doctors and is currently planned. Recruitment difficulties to fill practice vacancies are increasing, but there has been a recovery in the numbers seeking to train in general practice.

Basic Medical Education

One of the proposals for increasing the output of medical graduates is to increase graduate entry, and graduate medical schools are being developed in three universities. One of the more bizarre suggestions in the NHS Plan was that the basic medical education curriculum should be shortened to four years. This proposal seemed to appear out of the blue, with no prior discussion, and would of course contravene the requirements of the European Directive 93/16. It is also unclear what part of the present curriculum for basic medical education would be discontinued.

Funding changes for Postgraduate General Practice Education

As was mentioned in my last report, the funding for all general practice postgraduate education has been transferred to the GP Directors from the 1st April. This has, as predicted, resulted in the development of a large number of innovative training schemes. Many GP Directors have moved the funding to allow eighteen months to be spent in general practice. New types of combined hospital posts have also been developed, with some being based in a general practice setting. In my own deanery every GP registrar can apply for an extra six months of funded training in which they spend two days per week working in their training practice, and the remaining time on a period of in-depth study. This can be in order to acquire specific skills, such as performing endoscopy is, or in developing teaching and research skills. They are supervised by a GP trainer, have to produce a learning plan for the proposed a deep study, and the whole process will be subject to evaluation. This voluntary extra training has been taken up by more two-thirds of the registrars completing training this year.
The number of training places has been capped, and there is now a national appointment system so that all GP training places are advertised at the same time and there is a uniform process of application and appointment, organised at Deanery level. It is hoped that this will prevent the appointment of doctors to training places when they are not likely to be suitable to work in general practice.