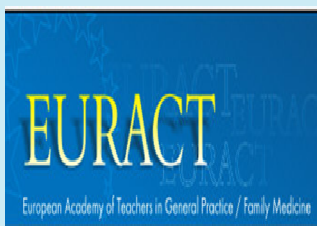




EURACT Newsletter



Dismantling Family Medicine

By Francesco Carelli

We are facing a really dangerous and dismantling situation. We see some kind of coordination as time and ways to marketing the Health Systems, giving them in different ways to any willing provider.

In primary care, we are facing increasing efforts to force changes based, depending on the country, on diktat, on managerism, on bureaucracy, on avoiding doctors' opinion and discussion.

These efforts on untested reforms are proceeding much too quickly, contested, going as a crazy jeopardized system, filling the GPs' burn-out.

Today we clearly see that the system and its supporters are attempting to replace the doctor-patient relationship, as typical in general practice where the prevalence is for emphatic values and personalization of care, with a doctor-structure relationship, based on illusion that sharing clinical information through informatics could replace the peculiar and intimate patient-family doctor relationship.

Competition based on prices rather than quality is on the horizon also in Italy with a system named CReG (Chronic



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Related Group) just similar to DRG (Disease Related Group) in hospital setting, care for chronic patient based on low price offers by different providers ("any willing provider" as Clare Gerada underlines in her letters to RCGP members) already not only GPs but mainly coming from the market, from groups outside primary care and NHS itself. A way for killing primary care, the opposite to what indicated in the European Definition.

This opening up of healthcare boundaries, destroy opportunities for collaboration between primary and secondary care and the new system will exacerbate inequalities because more developed practices (as area and as management systems) will be the only ones, as primary care, if they succeed on any other willing provider, to work the system in this marketing way.

The input is on privatizing and commercializing, funding and delivery with new structures (nationally named in different ways... but logic and aim seem to be the same...) modelled on those of the US healthcare industry. Impositions for every kind of bureaucracy, marketing and competition place 'disease' at the centre, lead to vertical organization with fragmentation of care and lead to disparate quality - cherry picking.

In abolishing the duty to secure and provide comprehensive healthcare for all and with equity, the NHS and family medicine are abolished.

We are worrying about future quality of education and training funding and management when Family Medicine will be so under-professionalized as specialty and seen as managerism to be just supported for this aim by new providers of NHS services, diverting educational resources into services funding and educational contents shadowy shifted to pursue marketing and their directive aims.

Also, it is strong evidence the attempt to hospitalize the family medicine, applying to this dimension the elements and procedures that are typical for hospital medicine and sectorial specialized medicine. We can see that many administrators

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do ignore the clinical practice in family medicine, where diagnosis is instrumentally finalized and centered on patient, not really at all to get a codification; they ignore that it is contextual aspects (continuity, person-centeredness, community orientation and holistic) and not disease orientation.

This mystification on family medicine's practice, explains the obstinate willingness on trying to exchange the specialist medicine's categories where the prevalence is for technical standardized and codified elements, instead of the existing elements of listening, narrative, waiting and deciding inside the patient's dimension context.

There is a willingness to change and simplify the communication between doctors, key element for the therapeutic process, to a different system just codifying nosographic entities only for bureaucratic and control purposes, and really not to transfer necessary information to define diagnostic doubts and find agreed therapies.

These are for control logical, also clearly useless, because passed data are not at all suitable for the governance: so they are not passed on citizens' own interest, because, according to the necessity's principle, personal data have to be treated only when such a treatment would be absolutely necessary to the pursued aim.

Last but not least we must consider how the political body and health authorities are paradoxically spurring the pro-consumistic aspects in the access to family medicine services.

Increasing the offer according to the future estimated mega-structured-organization, it will increase greatly the inappropriate demand in such a context where we all should be asked to reduce lot of interventions that are useless or anyway not supported by valid evidence on the field, so to grant the supportability in an universalistic health system.

If we read carefully and with detachment at several recent scientific papers, we can see that in the family medicine's setting, mainly when concerning big "chronic-social" pathologies, it is rare to find interventions with convincing evidences on relevant clinic end points and with adequate temporal horizons.

Evidences supporting interventions, are not at all automatically exchangeable, also if they would be coming from studies or from literature's reviews, because these just never refer to populations as we meet in the common daily clinic practice, but to selected groups, free from the comorbidity's complexity and strongly motivated to agree with protocols.

If we read carefully and with detachment at several recent scientific papers, we can see that in the family medicine's setting, mainly when concerning big "chronic – social" pathologies, it is rare to find interventions with convincing evidences on relevant clinic end points and with adequate temporal horizons.

By trivializing the access to family medicine and by replacing doctor-patients relationship with a doctor-structure relationship, we will surely and greatly increase the demand coming from the 20 per cent of patients just today consuming the 80 per cent of resources, worsening efficiency and equity, failing to bring benefits to the patients and increasing bureaucracy so withdrawing resources from clinic and assistance.

Family doctors in different European countries should work together in this

dangerous situation for family medicine itself. We have to fight against compelling all GPs, also by diktat with fixed and crazy dates, to be just clerks, administrative and so on, or just disappear at all for any other willing provider.

We must slow down, get discussion and collaboration and allow for every agreed system to develop iteratively and based on evidence and learning to secure integral responsibility for all health problems people face.

GPs know best the matter and they must not be turned from talented clinicians into medical managers, or worse to be marketers or disappear.

We all must use the WONCA, EURACT, RCGP Definitions and Statements on Family Medicine, ask for professionalism, for using our core competences, discourage fragmentation of primary care leading to vertical organisation and perverse incentives "cherry picking" driving patient flows where costs are lower but quality not the same and personal care not at all, ask for extending the duration and scope of vocational training so to be real specialists in a really good for patients NHS.

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Country Report

Development of Family Medicine Specialization in Turkey

By **Esra Saatci**

Turkey has a population of 73.722.988 million and covers an area of 815 000 km². Administratively it is divided into 81 cities. The first Faculty of Medicine was established on the 14th of March 1827 during the Ottoman Empire. The first five specializations were internal medicine, surgery, gynecology & obstetrics, ophthalmology and dermatology. In 1923, the Republic of Turkey was founded by Mustafa Kemal Atatürk. In 1928, the number of specializations increased to 15 and in 1947 to 22; one of them was “general practice (GP) specialization”. However, in 1955, the number of specializations was increased to 37 while “GP specialization” was cancelled and then re-accepted in 1983 with the name “family medicine”. The primary health care services were provided by the directorate of health in the cities and by the government doctor in the towns after 1913. In 1924, in rural areas “Examination and Treatment Centers” with 5-10 beds were established. In 1930, the minister of health Refik Saydam decided to establish a new PHC model based on the integrated preventive and curative services after his visit to the

United States of America (USA). In 1946, the minister of health Behçet Uz established a population-based system: one “health center” for every 40 villages (approximately 20.000 people). From 1947 to 1955 the idea of primary care with a special training was supported. Training of GP specialists with a rotation program of two years in internal medicine, general surgery, obstetrics & gynecology, and pediatrics was the integral part of the initiative. This project was abandoned in 1955. The GP specialization was cancelled and the residents were directed to become a specialist in any of those four main disciplines.

The most important initiation in primary care in Turkey was the “Socialization of Health Care Services” by the Law number 224. The Law was prepared by Nusret Fisek, the undersecretary of the Ministry of Health and the pioneer of public health and was brought into force on the 5th of January 1961. The Law proposed “health houses” (with a midwife only) for each 2000 inhabitants in the rural areas and for 2500 in the urban areas and a “health centre” for each 5.000-10.000 inhabitants in rural areas and for 50.000 in urban centers. At least one practitioner without any specialization training, nurse, midwife, health officer/technician, and secretary would work in a health center. In the Law, the job de-

scription of health centers was defined in 252 items. The system would be financed by taxes. It is interesting that Turkey took this great step for the improvement of community health and primary care even before the rest of the world. The dates of the Law 224 (1961) and the Alma Ata Declaration (1978) can be considered as an evidence for this statement. The health centers were established all over the country reaching a total number of 6000 health centers and 12000 health houses. However, Fisek described the factors causing the Law to fail after 1966. These were among others the lack of support from high-level managers, the lack of health personnel, the inconsistency between the training and job definition of the health personnel, the lack of coordination between the health centers and the hospitals, the lack of primary care teams, underuse in urban areas and the lack of allowances.

The family physician and his/her role were first cited in Turkish medical literature by Velicangil and Cakmakli in the mid-1970s. The official recognition and inclusion of the family medicine specialization in the regulation on medical specialization happened on the 5th of July 1983 with a minimum duration of the specialization training for three years after graduation. The family medicine specialization training was initiated in nine Training and Research Hospitals of the Ministry of Health in three big cities of Turkey. In 1989 the Health Sector Master Plan Study was initiated. The Turkish Family Physicians’ Association (TAHUD) was founded in 1990. The association holds annual national scientific congresses with family medicine departments.

In 1993, the Higher Council of Education recommended the establishment of family medicine departments in the universities. On the 17th of September 1993, the first department of Family Medicine was established and specialization training was initiated in the Trakya University Faculty of Medicine in Edirne. In the same year



(September 1993), specialization training was initiated in the university hospitals. A year later, in 1994, teaching family medicine in Basic Medical Education was initiated in the Cukurova University Faculty of Medicine Department of Family Medicine in Adana. In 1994, a family medicine specialist was appointed for the first time to the Department of the Eskisehir Osmangazi University. The Turkish Grand National Assembly enacted the Law on Pilot Implementation for Family Medicine in November 2004. In March 2005 retraining of primary care physicians (having no vocational training) was initiated in Duzce (Black Sea Region) and this pilot study covered the whole country (81 cities) by the end of 2010. However, the list is not person-based, it is district-based and only very few family doctors are family medicine specialists. They are medical school graduates attending ten days training to become a family doctor. Strong debates focused on financial issues and the rights of family medicine specialists. The governmental policy is a short-term solution. The problem with the outpatient clinics of the family medicine departments has not been solved yet. As each citizen is in the list of a family doctor, there is no population of the outpatient clinic of departments. The problem has been discussed with the Ministry of Health but no improvements have been recorded until now. The situation has significant impact considering the educational opportunities missed by medical students and residents in family medicine. This has created a great conflict with the new regulation for the specialization training in family medicine which was put into implementation on 18 July 2009. The detailed regulation which was announced on 7 September 2010, stated that the residents will have 18 months (half of the specialization training) in the primary care setting to gain knowledge, skills and attitudes for the core competencies of this discipline. The other 18 months will be five months in Pediatrics, four months in Internal Medicine, four months in Gynecology & Obstetrics, two months in Psychiatry, one month in Surgery, one month in Cardiology and one month in Chest Diseases. However, it is obvious

Turkey is a big country and has several problems related to family medicine as a health care service delivery model.

that this 18 months period will not be very efficient with very few patients in practice. 2017 was the deadline to be announced by the Ministry of Health for the medical school graduates to be able to practice as a medical doctor without any postgraduate training but has not been announced yet.

However, the institutionalization of primary care services and the specialization of family medicine training were problematic and still are. Several meetings have been organized with the representatives of the Ministry of Health, universities, TAHUD and the Turkish Medical Association. The Turkish Medical Association, practitioners working in primary care (without any postgraduate training) and academicians working in public health departments oppose family medicine because they regard it as private enterprise, money-based and unsuitable for the economic situation of Turkey.

Today, there are 44 departments out of 71 Faculties of Medicine. They have played an important role in undergraduate and postgraduate education. The chairpersons were not family physicians in the past years but today many departments' chairpersons are family physicians. There are 13 full professors, 68 associate professors, approximately 100 assistant professors, 2000 specialists and 400 residents in family medicine. Until now, there were no family medicine academics in the Training and Research Hospitals of the Ministry of Health. The residents were under the direction and coordination of the chief doctors of other specializations in which the residents work during their hospital rotations. However, after April 2010, chiefs, assistant chiefs or senior specialists in family medicine were appointed to the Training and Research Hospitals of the Ministry of Health, four chiefs in An-

kara, one assistant chief in Izmir and two in Istanbul.

There are 963 Community Health Centers, 6391 Family Health Centers and 20.236 primary care doctors (including both family doctors and family medicine specialists). The projection for the year 2023 is 44.600 family doctors. The mean list size is 3507 persons. The target is 1800-2000. The mean number of patients seen daily is 46. The patient satisfaction rate is 85%. The health budget is 5.27 % of the total budget. Some demographic and health indicators for Turkey are : urban population 75.5 (%), crude birth rate 17.8 (‰), crude death rate 13.2 (‰), infant mortality rate 13.1 (‰), maternal mortality rate 20 (‰), life expectancy at birth (years) women 76.5, men 71.5, hospital outpatient clinic visit/person/year: 4.07, primary care clinic visit/person/year: 2.72, total number of physicians: 118.641 (specialists: 60.000, residents: 37.000, practitioners: 22.000).

Both the patients and the physicians are quite satisfied with the new system. The drug prices were reduced and the salaries of the primary care team members were increased significantly. Physicians working in the Family Health Centers use the buildings of the old health centers. They work together with a nurse or midwife or a health technician. They provide laboratory service from a central laboratory. Family medicine specialists have some advantages when appointed by the Ministry of Health. The number of residents is still too low and the residency is not being encouraged enough. The department outpatient clinics are in great trouble as they have no list of population and have very low patient numbers per day and experience serious problems in basic medical education and specialization training. The problem has even been getting worse after the change in the legislation for specialization training which stipulates 18 months in primary care. There is no mandatory referral chain yet. Family physicians have some limitations in prescriptions caused by the legislations of the Social Security Institution.

The associations in family medicine in Turkey are as follows: TAHUD, Academy of Family Medicine, Family Medicine Training and Research Association (AHEAD), and Turkish Foundation of Family Medicine (TAHEV). The National Congress in Family Medicine is being organized every two years since 1993 by TAHUD. The Family Medicine Summer School is being organized each year since 2007 by TAHEV having Chris Van Weel, previous Wonca President, as the honorary president for the last two years.

In conclusion, Turkey is a big country and has several problems related to family medicine as a health care service delivery model. However we, as the members of this new discipline, have hope for the future.

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A real General Practice environment for our medical students The new Medical School in Algarve

By Luis Filipe Gomes

The reasons

In Algarve, we felt the need to create a medical school.

Algarve is the Portuguese most southern region, with a population of 700.000 inhabitants – increasing to 1.800.000 during the touristic “season”. And the nearest medical school was in Lisbon – 300 kilometers away!!! There is an international airport in its main city, Faro, with direct connections to all of Europe. That allows easy inter-connection with other universities.

The ideas

As we had the chance to design the curriculum from scratch, and as we were conscious of the increasing importance of primary

care and general practice in teaching, we decided to go for a new kind of medical school. So we designed a four-year course based on three aspects (separately developed in other courses):

- Graduate entry (like in Warwick, UK, as an example);
- Problem Based Learning (in fact, “pure” PBL, as in Maastricht, Holland);
- Primary care based (as in James Cook University, in Australia).

We recruit our basic sciences teachers from out of more than 200 scientists in the biology field (University of Algarve, Ualg), and clinical teachers from out of 280 specialists in General Practice/Family Medicine and 400 hospital specialists in the region. Of course, others came and will come from different universities – we

have been successful in attracting some...

Starting from their very first week, our students have close contact with patients and health services in a General Practice setting during their first and second year, moving to hospital rotations only in their 3rd and 4th year – when they will still have their General Practice/Family Medicine (GP/FM) rotation.

Students are placed in a GP/FM setting *not* because we want them to become General Practitioners/Family Physicians (GP/FP) – even if we believe and wish that some, more than usual, will choose GP/FM – but because we are sure that *all* future doctors will greatly benefit from a deep contact with GP/FM and primary care – and their future patients will surely feel the difference!

This model was made possible by the existence in Algarve of a very well trained and quite enthusiastic group of GP teachers and trainers (most of them already involved in GP Specialist Training and/or CME/CPD).

Our medical school has no departments or disciplines; all the pedagogical issues (andragogical, actually) are dealt with by a core group of teachers: Professor José Ponte, the course director, from Kings College (an anesthesiologist); two general practitioners, one internist, one pediatrician and researcher, one surgeon, one physiologist, two researchers (regenerative medicine, molecular biology) and one computer systems professor who meet regularly. There are also regular meetings with all the GP Tutors.

The students

Our students come from different backgrounds – nursing, of course, but also biology, psychology, occupational therapy, pharmacy, dental medicine, veterinary... and even agronomy. They are all graduates, many of them have master degrees in their previous fields and some have PhDs. They bring an outstanding capability and the desirable diversity to the course.

The selection

The selection of students is very thorough. Candidates are first assessed (by specialists) in English language and cognitive skills (abstract, numeric, verbal). Academic degrees, age, serial classification, previous voluntary work (with patients, children, elderly) and belonging to the UAlg are also taken into account.

After finishing that process, the best 72 are picked out and submitted to Multiple Mini Interviews - MMIs (a kind of “selection OSCEs”) where, in 10 stations of five minutes each, candidates are assessed in domains like problem-solving ability, self-appraisal ability, ability to relate to others, motivation to study medicine, learning styles, and others.

We became quite effective in doing these interviews: 720 in two days, with no confusions or time lost. We use actors to simulate situations, and different professionals as observers – GPs and other doctors, of course, but also other teachers, nurses, other health professionals, journalists and patient representatives.



Fig 1: MMI – reading the scripts

Briefing before each section, debriefing afterwards, comparing/discussing grades (varying from “bad” to “excellent”) when divergent, explaining/discussing all extreme grades – that finalizes the process and at the end 32 students are selected.

Until now we had a lot of candidates – 1080 in 2009, 760 in 2010, 780 in 2011. And we think and hope it will continue like this. After some opposition in the beginning, the new course now is known and respected countrywide – even if some members of the medical profession and some teachers from the “classic” schools still criticize it from time to time...

The course

The course is developed in 6 modules:

1. Problem Based Learning (pure PBL)

Well tried methodology pioneered by McMaster University in the 1960s, PBL favors the acquisition of **knowledge** in basic and clinical sciences. It is self-directed, under the guidance of tutors, with extensive

use of specific educational software packages and resources available on the internet.

Students are divided in groups of 8, and meet regularly with a (previously trained) PBL Tutor (GPs, other doctors or other teachers and researchers). PBL tutorials are scheduled for 3,5 hours, twice a week. A set of problems or cases (the fully developed, proven curriculum was purchased from St. Georges Medical School in London University, translated and adapted to Portuguese reality) is the base. The cases include anatomy, biochemistry, biology, physiology, pathology, doctor-patient relationship, family and social problems... in brief, all domains of medicine.

Assessment is done through MCQ – actually, PPI (Personal Progress Index). All examinations involve all domains of medicine – and the level obtained increases with the progress of the student in the course. The same PPI is used at the same time for similar courses in McMaster (Canada) and Limerick (Ireland), allowing us to compare our results. And our students are doing well!



Fig 2: A PBL tutorial

2. Skills Lab

The skills lab is where the students develop their **skills** – in models, with tutors (practical short introductions to techniques). We also train our students in communication techniques - with the patients, their families, other doctors or teams, and even... with the press!

Assessment of this module is done through OSCEs – most of them are stations with simulated patients. We use the same group of actors that help us with

the MMIs – they are quite enthusiastic about their work, and carefully learn with us their roles!

3. Clinics

This module is exclusively based on the GP setting for the first two years of the course; it's designed in order to allow students to develop their **attitudes**, namely by interacting with real patients and with their tutors (their role-models). All GP tutors undergo training as teachers - namely through EURACT courses (EURACT Course for Trainers in GP, EURACT Assessment Course) and Group-leader Courses.

Working one-to-one with their GP tutors in a real environment allows students to progress from interviewing patients and practicing limited physical examination to higher levels of communication, finding common grounds, arriving at mutual decisions and designing plans with the patients.

The assessment is done by the GP tutors – every week, using a specific tool.

4. Seminars

In addition to PBL, there are seminar based programmes in Pathology and in Pharmacology throughout the first two years of the course.

Other seminars provide support to students' educational needs in different areas like Cell Biology, Physiology and others. Every week, however, we have "inspirational" seminars, where our students have the possibility to meet with important and charismatic personalities and discuss subjects on the edge of medical progress and knowledge.

Just to refer to some of the international speakers that visited us, in the field of General Practice we had seminars on Patient Centeredness (David Misselbrook), Addiction (Fergus O'Kelly), Geriatrics (George Spatharakis), Disease-mongering (Ray Moynihan), Matters of Life and Death (Iona Heath), Sustainable and Responsible Preventive Medicine (Linn Getz and Johann Sigurdsson). And, of course, many other issues, provided by our own teachers or teachers from other Portuguese universities have been addressed in these seminars.



Fig 3: "Attentive listening" and "Touching in the Consultation" - Seminar "The Consultation", designed by LF Gomes

To assess the students in this module, we ask them to choose a seminar and to create a poster for it; the poster is then assessed by a jury.

5. Students Selected Modules (SSM)

SSMs support the core curriculum and allow students to learn about and begin to use research skills, to develop their self-directed learning skills.

Every year each student selects a topic of his or her own particular interest to study in depth, outside the core curriculum.

This helps students in developing greater confidence in their own skills and abilities and to eventually consider potential career paths.

SSMs can be theoretical/bibliographic, laboratory/clinical-based or educational. The students present the results of their work in writing, and the report is assessed by a jury.

6. Clinical follow-ups

The long term clinical follow-ups provide a unique opportunity for students to understand the problems of managing (a) chronic disease in the community (b) dependent patients, and to observe the interaction between the patient and his/her family. Following up the second half of a pregnancy and the first few months of a baby's existence within the family provides essential insights into the problems of (c) managing the medical problems of childbearing and the common problems of the first 6 months of life.

Pairs of students follow up the three different situations (one in each of their first

three years of the course). Each pair prepares a presentation of their work, to be attended by every other student and assessed by a jury; the students prepare also an individual report for assessment, carrying their own views and critic remarks on what they have witnessed during the process.

Outside General Practice setting - Rotations

By the end of their second year, students are introduced to very short one day rotations in departments of their choice, where some of our teachers work – an imagiology clinic (to see the anatomy doctors see), a pathology service. But only in their third year will they really start their rotations in the different hospital specialties and in public health. But they will be back to a GP setting for their general practice rotation (with different purposes and a different program). By then we are sure they will be quite prepared to meet the big hospitals "milieu", and stay sensible to the problems of the patients and we hope that they will have developed the knowledge, the skills and the attitudes that will allow them to become humane doctors, practising a person centered approach – whatever their specialty of choice will be!

GPs in the course

Meanwhile our course is going quite well and we are proud to have a Medical School where General Practitioners/ Family Physicians are involved in designing the curriculum, in management, in selecting the students, in teaching in PBL, Skills Lab and Seminars, in tutoring Students Selected Modules and Clinical Fol-

low-ups, in being the role-models and tutors in clinical setting, in taking part in all assessment procedures, and in preparing the future GP Rotation (all the while already thinking of the future elective periods – ten weeks to spend outside Algarve in the students' 4th year - mostly, we hope,

outside Portugal) – in fact, GPs are effectively present in all steps of the way. Which, of course, all members of the Algarve Medical School think is quite a progress!!!

Thesis Report

'Challenging the patient centered paradigm, designing feasible guidelines for doctor-patient communication.'

Thesis by Wemke Veldhuijzen, University of Maastricht, June 2011

Reviewer Yvonne van Leeuwen

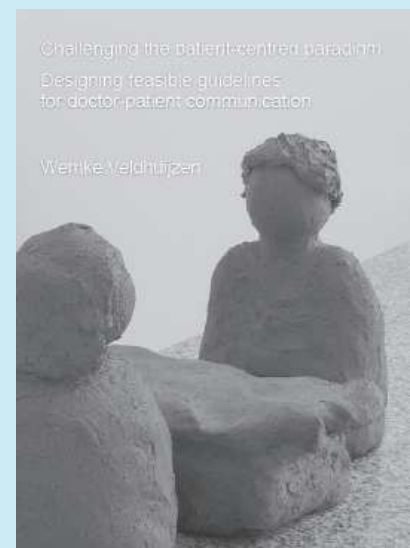
This very interesting thesis reports a (mostly) qualitative study on the educational goals of doctor patient communication training. One of the research questions is: do these goals correspond with the doctors' goals for d-p-communication in a practice setting. Surprisingly, doctors have other ideas about the usefulness of communication guidelines than educators. Their communicative behavior appears to be closely related to the aim of each specific consultation: e.g. reassure the patient, discover serious illnesses, 'keep it short'.

The author advocates goal related guidelines in order to enhance compliance and

to be of real help to doctors. The study is an example of good and revealing research in this field. It shows the sense of entering the crawl space of the communication building. It answers many puzzling longstanding questions like: why is there so little progress in communication skills during training, why do doctors seldom apply the highly recommended guidelines. Worth reading is also the personal account of the author of her learning process in doctor patient communication.

In short: every educator in this field should read this thesis and experiment with goal related communication training.

To download the thesis, click <http://dissertaties.ub.unimaas.nl> > search for Veldhuijzen



Literature Reviews



EBM (Evidence Based Medicine) in Professional Training; why, how to do it, and how to assess it

Reviewer Brendan O'Shea

Thomas A, Saroyan A, Dauphinee WD. Evidence-based practice: a review of theoretical assumptions and effectiveness of teaching and assessment interventions in health professions. Adv in Health Sci Edu 2011;16:253-276, DOI 10-1007/s10459-010-9251-6

Summary

This is a (presumably) commissioned review article, chiefly originating from Magill in Canada, and coming from the discipline of Occupational Therapy, which has long been regarded as a strong and rational discipline in Canada.

It commences with a theoretical review of the foundations and rationale underlying Evidence Based Medicine, together with its importance in Teaching, which appears clear, logical and in terms of its extent, appears to this reader to be in 'the Goldilocks zone,' ie neither too long nor too brief, but just sufficient.

In this initial part of the review, it is asserted that while many entities within the professional teaching and practice domains acknowledge that Evidence Based Practice should now be an essential and omnipresent value in Teaching and in Practice, but also that the reality varies, and there is no uniform and accepted system of teaching or practice where this value is adequately or consistently

The review examines concepts of expertise and superior performance, and places them practically in the context of evidence based approaches. It moves from the historical development of such constructs, into the recent available research literature which examines the objective efficacy of programs which were set up to integrate an evidence approach into higher professional teaching, and from there, it moves to a consideration of how this process can be assessed within the educational process.

This critical progression from first principals to current challenges in teaching includes the definition of many areas of uncertainty where additional formal reflection and research would be desirable and helpful. The review also comprises several clearly laid out schemes or process maps which appear relevant if one is faced with the task of establishing an improved process of learning or assessment in one's own programme.

The conclusion section commences by baldly stating that 'consumers of health services expect the best....' And goes on to assert that the uniform in-corporation of EBM into learning and practice is highly relevant to delivering on this aspiration. The references comprise a particularly rich source of additional background reading.

Comments

In key respects, the value of Evidence Based Medicine

to realize systematically in the context of daily practice, and in teaching.

This review, emanating from a strong centre of excellence, expands on the history and theory of EBM, and on its teaching. Though written with especial reference to the discipline of Occupational Therapy, it is also written to be applicable to any medical discipline, and certainly appears relevant to the teaching of General Practice.

Reading it thoughtfully challenges your own teaching. Reading it in detail will deliver many suggestions for critically appraising what and how you teach the learners for whom you have a responsibility. If you were considering a formal study (eg MSc, MD or PhD) on some aspect of either EBM or Professional Teaching, it is probable that this review would be of especial use as a seminal paper to consider.

Implications for training

If you consider that your own program is deficient in the teaching and learning of EBM, you can easily checklist its pedagogical characteristics against the elements outlined here. The most difficult challenge which is perhaps not practically addressed here, is how to reconcile the uniform desire for best practice in every consultation with the pragmatic realities of delivering high volume service given finite and frequently scarce resources in clinical practice. Perhaps we in EURACT might find an

Literature Reviews

Assessment for selection: complicated and difficult

Reviewer Francesco Carelli

Prideaux: et al. – Assessment for selection for the health care professions and specialty training. Consensus statement and recommendations from the Ottawa 2010 Conference – Medical Teacher, 2011;33:215-223.

Summary

The areas of consensus on assessment for selection are small in number. There is little evidence about the predictive validity of school leaver scores. Interviews have not been shown to be robust selection measures. Studies of multiple mini-interviews have indicated good predictive validity and reliability. Little evidence exists on the effect of non-traditional measures in widening access.

Recommendations for future action focus on use of multi-method programmatic approaches, development of interdisciplinary frameworks and utilization of sophisticated measurement models.

Comments

This paper is really important because it analyzes the different methods by an extensive international authorship and it enlarges the horizon to a political view.

It looks at selection as “assessment for selection“. The paper deals with the question of widening access to medical and health professional courses to include greater representation of ethnic minorities, low socio-economic or disadvantaged groups or indigenous people.

This way of dealing with selection has a value with strong local and political dimensions: political validity. The paper analyzes and confronts MCAT, GAMSAT, UMAT, UKCAT, MMI.

Implications for training

This paper is very interesting if you focus on students' selection at the beginning of undergraduate courses.

The position does not make the man, the man makes the position; or the right man for the job?

Reviewer Elena Frolova

J. van der Zwet, P. J. Zwietering, P. W. Teunissen, C. P. M. van der Vleuten, A. J. J. A. Scherpbier. Workplace learning from a socio-cultural perspective: creating developmental space during the general practice clerkship. Adv in Health Sci Educ 2011;16:359–373.

Summary

Workplace learning in general practice setting is a powerful workplace to learn about aspects of medicine like chronic and minor illnesses, communication skills and dealing with uncertainty. Students also learn here to develop their individual consultation style. Research has underlined the importance of the role of the supervisor in general practice learning.

This article describes the qualitative research devoted to learning experiences in general practice of 44 fifth-year undergraduate medical students. The main research tool was the group interview. Researches

stressed the social-cultural experience of each learner, because what and how medical students learn during clerkships depends on the nature of their experiences and activities and the meaning that they, and others, attach to these experiences. From this point of view learning environment - including community, the interaction between the learner(s) and cultural tools - including the language, physical artifacts and local rules are really important.

The researchers used a phenomenological approach to construct a conceptual framework. There was a voluntary participating with tutor's permission, and seven sessions were conducted. All 44 participants gave a structural interview and additional questions were asked to clarify the nature of knowledge.

The results showed that both contextual and socio-emotional elements had an influence on the developing of professional identity, having effect on three activities: independent consultations, conversations about consultations, and observation of GPs.

Comments

Development of family medicine as a discipline starts from curriculum writing, choosing the place for training and tutors or supervisors. In spite of many documents that can help prepare this process, in some countries the training of new family physicians starts in hospitals. The learning environment in a hospital is absolutely different: trainees are



dependent on the hospital staff, nobody gives them responsibility, nobody recognizes them as doctors.

At the time the Department of Family Medicine in St-Petersburg's medical academy for postgraduate study was opened, a new family medicine office was launched. This office serves as a learning place for residents and trainees. In Russia this was the first experience with this way of working and due to this approach the Department of Family Medicine takes a leading place in the formation of family physicians in Russia.

The General practice team is a living organism that includes all members from the registrar till the head of office. All members have been of influence on the growing of young GPs. The patients' community is a very important factor of a trainee's development. The relationships patient-trainee are complex, "adult". Learning from patients' feedback is a meaningful component of the training process.

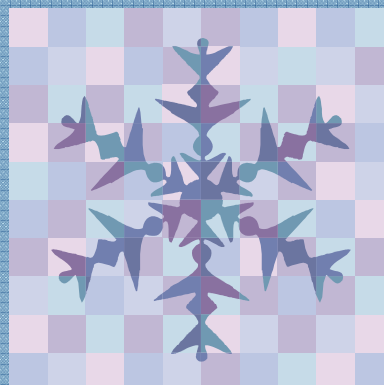
I strongly agree with the results of this interesting qualitative study. It could be very interesting to reproduce this study in

my GP office and how much more interesting it would be to reproduce this research in different countries and then to compare results.

Implications for training

It is very important not only for a physician's training but also for supervisors and tutors.

WE WISH YOU
A MERRY CHRISTMAS
AND A HAPPY 2012



Agenda

EURACT

21-23 March 2012

Euract Council Meeting
Jerusalem, Israel

November 2012

Euract Council Meeting
Adana Turkey

WONCA – Europe

04-07 July, 2012

Vienna, Austria
Theme: “The Art and Science
of General Practice and Family
Medicine”
www.woncaeurope2011.org

EGPRN

10-13 May 2012

Ljubljana, Slovenia
Quality improvement in the
care of chronic disease in
family practice : the contribu-
tion of education and re-
search

18-21 October 2012

Antwerp Belgium
The theme for this meeting is:
“Research on patient-centred
interprofessional collabora-
tion in primary care”.

OTTAWA CONFERENCE

9-13 March 2012

Kuala Lumpur, Malaysia
OTTAWA conference on
assessment of medical
competence

AMEE

25-29 August 2012

Lyon, France
The theme for this meeting is
« *The Continuum of Education in
the Healthcare Profession* »



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