

**1ST ANNUAL MEETING OF TEACHERS IN FM/GP.
AT THE CROSSROADS OF THE EDUCATION.
Kranjska Gora, September 10-11, 2004
ABSTRACTS**

**AT THE CROSSROAD OF EDUCATION DURING THE
VOCATIONAL TRAINING IN GENERAL PRACTICE**

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Dragica Nikolic, Primary Health Centre "Dr Milutin Ivkovic" -
Belgrade
Serbia and Montenegro.**

In 1981, the Department of General Practice School of Medicine, University of Belgrade was established.

By the decision of representatives of School of Medicine, a new chief of the Department of General practice as well as new members of the department were elected, in 2002.

Specialization in general practice lasts for 3 years.

The topics in the part of education organized by general practitioners used to be oriented to clinical medicine. In last two years some topics, which were not present in previous period, were incorporated.

These topics, prepared by two authors of this text, were: Medical errors in general practice, Ethics in general practice, Communication skills in general practice and OSCE.

Topics were presented as one-day workshop and included previous preparation of the participants, mini-lectures, small group work, plenary, group presentations... Workshops were organized and led by one general practitioner.

In previous period, classic lecture-based learning and passive way of teaching were present.

In last two years, some attempts were made towards active learning.

But, that is not enough, we are quite aware of that.

Which direction should we choose now?

Some changes have to be done.

How to do it?

New approach should be incorporated in our teaching, active learning should be implemented, exchange of experiences must exist, international collaboration: participation in courses, Conferences, international organizations (WONCA, ...),

collaboration between (national and international) Departments of General Practice/Family Medicine, publishing in international journals...

To be(come) member of big family General Practice/Family Medicine.

SPECIALIST TRAINING OF SLOVENE FAMILY PHYSICIANS

Mateja Bulc, Igor Švab, Danica Rotar Pavlič, Marko Kolšek, Katedra za družinsko medicino, MF Ljubljana.

The development of family medicine in Europe in the sixties of the last century was marked by the introduction of obligatory specialist training. Slovenia is one of the countries with a long tradition of family medicine specialist training, but till 2002 specialist training had not being elaborated or conducted by peers in general practice/family medicine. When socialist system started transforming due to the reform of political situation, the country started to modify its system in order to meet the criteria of the European Union. One of the changes was the introduction of a new health care system with an influential medical chamber, which was responsible for postgraduate training of physicians.

A new model for vocational training for family physicians was established in 2002, following the recommendations of UEMO (European Union of General Practitioners). According to the new programme, which lasts for four years, trainees spend half of the training in hospital setting and half in general practice, where they are supervised, by a trainer in practice.

We describe the new form of specialist training in Slovenia and its contents, comparing it with specialist trainings in other UEMO countries.

MIDDLE-SIZED PRIMARY HEALTH CENTRE AS AN OPTIMAL ENVIRONMENT FOR LEARNING MEDICINE?

Rade Iljaž, ZD Brežice.

Background: Community based learning is a very hot topic in all developed societies and health care systems at all.

Slovenia has officially became a developed nation by World Bank standards in March this year(STA march 17-1). Consequently we are faced with similar dilemmas and worries about medical education as developed countries are. Slovenian's socialistic heritage, still deeply grounded in authorities' health care delivery approaches, has a strong influence on a medical education processes, its feasibility and final implementation in primary care settings. The aim of this article

is to present some possibilities to learn medicine in primary health care centre, based in Slovenian countryside.

Methods: Description of the typical Primary Health Care Centre in Slovenian countryside and its fundamental health services. Presentation of current teaching stuff and teaching methods.

Conclusions: **General description:** Slovenian primary care is a bit fragmented among different specialities as well between public sector and »private« health care providers. Primary Health Centres were founded in early sixties of the 20th century in all Slovenian communities. Their basic purpose was to enable and practice comprehensive and quality health care adjusted to real needs of each communities' population. These Centres incorporate dentistry services, general practices and different medical specialities in (so called) dispensary departments. Typical specialists included in these departments were paediatrician, gynaecologist, psychiatrist and specialist in labour and sport medicine. Private practices either solo or group, were replaced completely, and health planning and managing have been put in local authorities' hands. In the last decade, approximately a third of all primary care specialists decide on private practices again. Significant number of them stayed in same settings, that proves successful in ensuring continuity of care at primary level. Continuity and comprehensiveness in health care are influential factors for successful education too.

Primary Health Centre presentation:

Employed physicians: 6 specialists in general practice + general practitioner, two specialists of labour and sport medicine, one internist, gynaecologist, paediatrician, and psychiatrist + four dentists. All physicians and dentists are employed for full working-time.

In the same Centre are placed surgeries of three private practitioners, well equipped laboratory, urgent service with our own ambulance cars, pharmacy, home nursing service and centre for treatment and prevention of illicit drug addiction – all of it in the same building.

Two lady-physicians are tutors for postgraduates and two younger physicians are tutors for medical students.

All of them agree about work overload and shortage of time as main barriers to implement more efficacious education in their practices. At the moment, an average number of consultations is over 50 per working day. All tutors recognized our urgent service as significant opportunity for students and postgraduate learners. At the second place three of us placed well equipped laboratory. Proximity of community hospital was denoted by one physician.

Students' comments and observations:

1. B: Work in urgent ambulant is very useful and dynamic. J needed more time for history taking and examination. Administrative overload had a strong influence on my working motivation.

2. G: There are too much paper work in GPs' office. Some of these administrative tasks seems to be completely unnecessary. It is very difficult to work efficacious in such a time shortage.
3. M: IT is very interesting and very stressful work, especially when you are "urgent doctor" at the same time. I'm not sure general practice could be the choice of my professional career.

Educational methods:

Undergraduate and postgraduate curriculum of Medical faculty in Ljubljana are adjusted to general EU standards and recommendations. Undergraduates are obliged to spend 7 weeks in general practice settings during last year of their study. This period is divided into four principal sections followed by final tutor's assessment of student's work, knowledge and acquired skills which should be made in a written form. Family medicine study has been included in Medical Faculty curricula since year 1995.

However, postgraduate study or specialization in FM, consists of two main parts. »Clinical learning« which lasting about two years is anticipated for the first half of postgraduate study. Family medicine study is planned to be learnt as a combination of work in outpatients settings and attending courses and workshops organized by Family medicine department. Specialization in family medicine has been established in actual form since the second half of year 2000.

A general practitioners who were involved in medical education of students and residents hasn't been paid for that work at all, till recently. Consequently , their motivation for those tasks to be done properly was low. Any relevant study about satisfaction of teachers/ tutors and students/learners as main participants in educational process, hasn't been carried out in Slovenian primary care in the past. However, it's well known that meaningful complaints of Slovenian's general practitioners were about workload and high frequency of outpatient's visits(ref.)

TEACHING AND LEARNING IN THE CLINICAL SETTING: PATIENT CONTACTS ON SOUND EDUCATIONAL PRINCIPLES IN UNDERGRADUATE MEDICAL EDUCATION.

Ramon PG Ottenheijm and Job FM Metsemakers, Maastricht University, Department of General Practice, The Netherlands.

Context: The way of teaching at the Medical Faculty of the Maastricht University (the Netherlands) features a problem based learning approach. The Medical Faculty offers its students a six-year curriculum. In September 2001 the medical curriculum was revised (Curriculum 2001) with the aim to intensify the student-patient contacts in several practical settings.

Aim: In respect of Curriculum 2001, according the aim to intensify the student-patient contacts, we decided to review our undergraduate medical programmes based on student-patient contacts. Among other things we focussed on the educational principles of the programmes. We wanted to turn to a set of guiding principles based on evidence, or at least on long term successful experiences. Inspect this, we asked ourselves two questions:

- Why are patient contacts in practical settings so important (Why)?
- What criteria do such contacts have to fulfil (How)?

Method: Literature review

Results: Why: Patient encounters in medical teaching are important to integrate theory and practice in order to develop medical expertise. Therefore, continuing exposure to patients is important. How: An active role of students is essential; supervision and feedback play a central role; clinical teachers should be trained. There are also several important practical points: lack of time and space, and financial rewarding.

Conclusion: These educational principles and practical points have consequences for constructing or rebuilding medical education in general and student-patient contacts in particular.

TEACHING ABOUT FAMILY IN THE FAMILY MEDICINE DEPARTMENT IN LJUBLJANA

Janez Rifel, Katedra za družinsko medicino, MF Ljubljana.

Teaching family medicine is getting bigger importance in the curriculum of the medicine faculties. Family is in the centre of interest in family medicine but there is a lack of basic data on teaching about families as a specific issue.

On the medical faculty in Ljubljana teaching family medicine consists of lectures, seminars, work in small groups and practical work in family medicine practices. During the seven weeks of the course each student prepares a family report describing a family which he visited at least twice. Family report consists of three parts: family tree, family profile and family problem list. Family tree in a schematic way presents family members, their age, sex, marriages, divorces, important relationships and most important health problems. Family profile depicts family type, phase of the family cycle, family APGAR score, describes relationships between family members and the role of each member, ethnic and cultural background, spending free time and describes family environment, economic status of the family and relation to the health and health service. Family problem list is a list of health related problems for each family member for the last three years. Previous medical measures and future plans are written for each problem. Family report deals with at least three generations whether or not all generations live together. Family medicine is taught in Ljubljana in such way for 10 years and such program is quite simple to execute. The patients, and family physicians are satisfied with the program, there were no major complaints. At the end of the course students evaluate it in short questionnaires, where they generally express enjoyment over the course.

SELECTION FOR GP TRAINING IN UK

Roger Price, Deputy director postgraduate General Practice, UK.

Over the last 5 years our postgraduate deanery, in conjunction with 2 others, has developed a system of selection for entry to vocational GP training. It is based on the competencies found to be desirable for work as a proficient general practitioner in the UK. The selection process, from advertisement to eventual placement in a training programme has been, and continues to be, the subject of a university research-based evaluation. This has led us to conclude that the traditional approach to recruitment to training programmes in the UK is open to question and that our

methodology could result in a more robust selection process with the potential for an output of doctors “fit for purpose” as GPs in the UK. The process consists of a structured application form, followed by an assessment day in which applicants undergo an MCQ, a group exercise, and consult with a simulated patient. This process has gradually been taken up in part by several other UK deaneries and it is likely that a national approach to recruitment will result in single route to appointment as a vocational trainee in general practice in the UK within the next 3 years. This process is underpinned by an explicit understanding of equal opportunity and diversity awareness. It does not compromise, nor favour, non-UK graduates. It does however demand an expectation that successful applicants will be able to demonstrate the competencies that research has shown to be needed as a UK general practitioner as a basis for acceptance on our training schemes.

During this workshop the methodology will be described in detail, and then participants will be invited to apply some of the techniques required in a group setting. Handouts will be provided giving further information.

ROLE OF EVIDENCE BASED MEDICINE (EBM) IN THE CONTINUOUS FORMATION IN MEDICINE

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***Medico di famiglia, Dipartimento di Neuroscienze AIMEF**

*Nell’Almansuri, Al-Razi(841-926 d.C) definisce la medicina come “...l’arte che si occupa di preservare la salute delle persone, di combattere le malattie, e di ripristinare lo stato di salute negli individui malati...”
(Broawe EG. ”Arabian Medicine”)*

We can find first rules on doctor education as far ago as 800 years BC, written by Persian doctor Al-Razi. His work, called Continens, was one of the greatest encyclopaedias of ancient medical science, composed of 22 volumes. It was used also by French Universities in teaching young doctors.

Therefore the need of training is for a doctor a need that roots far in the past.

Continuing medical education is very important also for family physicians. The main objectives of our work are setting diagnosis, provide care in a narrow timeframe, we have, care for the patients in an effective and efficient way.

These objectives can only be achieved by a correct methodological process of teaching, especially in continuing education, which should proceed through three main characteristics of learning:

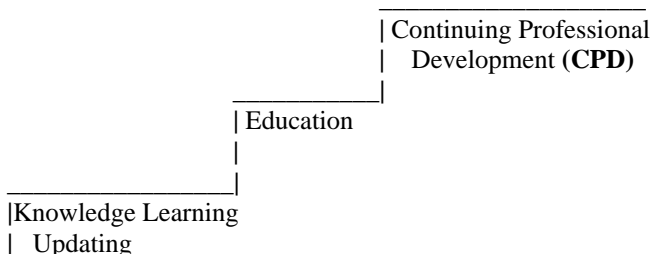
- To know
- To know how to perform
- To know how to be

Tab1. Characteristics of Continuing Medical Education

CHARACTERISTIC	COMPONENTS	SPECIFIC OBJECTIVE
To know	<i>Cognitive</i>	Basic knowledge
To know how to perform	<i>Practical skills</i>	Specific competences
To know how to be	<i>Emotional relational affection</i>	Professional performance

Teaching is an educational process of transmission of knowledge from a teacher to the student in a defined field. The actual objective of Continuing Medical Education is a combination of knowledge, skills and performance to assure an appropriate and quality care. On the other hand it corresponds to the British Continuing Professional Development=CPD. On the value scale this represents the highest degree.

Fig. 1



So that continuing professional development is an important and indispensable requisite for practising evidence based medicine, which allows a professional improvement in accordance with the clinical context.

Most often used definition of EBM is “Use of concise and explicit guidelines of best available evidence to support doctors in making decisions relevant each patient” (Ann McKibbin – *Il Pensiero Scientifico Editore*) describes at the best, what we accept as EBM which became using the words of David Sackett, father of EBM – science, which combines everyday clinical practice with the best available scientific evidence.

There is a question if doctors know how to use EBM, if they know the model, if they have systems to uptake the rapidly growing body of medical evidence in a way which enables them to use the knowledge in an appropriate and effective way in the best interest of their patients.

From that viewpoint there is an growing tension to promote EBM in the process of Continuing Medical Education with all the benefits, obstacles and possible errors. Legal and ethical aspects of EBM should also be addressed. There are important limitations of EBM in the field of paediatric and obstetric care. Multimorbidity and everyday practice cannot always be covered by the results of RCT.

Selection of most useful evidence for daily practice is the first step to promote EBM in FP.

There are many dilemmas regarding practice of EBM in FP which should be addressed by continuing medical education.

Our sensitivity and knowledge shall suggest how to positively exploit what seems a limit in order to create instead an original path which cannot and shall not follow “tout court” EBM but try to reinterpretate and humanize it using its undoubtable qualities without being forced to the use of it.

RURAL PRACTICE IN SERBIA

Snežana Jnaković, Department of General Practice of the Faculty of Medicine University of Belgrade.

Health care of the population living in rural parts of Serbia is carried out through health care system on all three levels: primary, secondary and tertiary level.

Primary health care level is carried out in Health Centers with all their services, their employees either medical or not:

- general practice department (with patronizing service, that could be within some other department);
- home care service (it exists either autonomously or within the department of general practice);
- pre-school children health care service;
- school children health care service;
- occupational and environmental medical service;
- dental health care
- specialist services (with diagnostic service that can be within some other service or department or autonomously);
- emergency service (except in big cities where it operates as a separate institution: Belgrade, Nis, Novi Sad);
- pharmacy (or within the pharmaceutical institution);
- general affairs service.

Continuing responsibility of rural population health care, according to present Laws and regulations, is managed by Health Centers, through their special organizational units, such as:

- health stations (number of services varies);
 - dispensary or ambulance.

Health Centers in Serbia are managed in two ways:

- they may be autonomous or
- Within the greater Health Centers.

Management and decision making is centralized, under the continuous supervision of the Ministry of Health of Serbia. There is a decentralization tendency and transfer of management to local levels.

Patients that belong to this population group have their medical records in the Health Centers organization units with their physician according to the territorial principle. This does not exclude the possibility of them having their medical records in the Health Centers in towns.

In most of the rural settlements there are Health Stations or Ambulances with its teams. In some of them, mostly in the mountains, far from cities, physician and nurse do not work every day. They work according to needs of the local population. Living conditions and hygiene mostly differ and are directly correlated to the level of settlements development. There are highly developed settlements / villages, with advanced infrastructure and with modern way of living. On the other hand, there are highly underdeveloped settlements, without roads, water supply, even without electricity, with very difficult living conditions.

The current way of data gathering and current means of reporting on functioning of these services, it was not possible to get data on morbidity and mortality of this part of the population in Republic of Serbia. Acquiring this information would be very important for this gathering.

At the end, one should stress the point that small settlements in Serbia are getting older. Village settlers easily make decisions to move to cities, if they get a chance, due to easier and more comfortable way of life. In order to evaluate the health status of this population it is essential to modernize the information system of Serbia. Only then we would be able to evaluate the results of our work and experience. Then, as well, we would be able to enforce adequate strategies to improve our practice.

TEACHING MEDICAL STUDENTS IN GENERAL PRACTICE: THE PATIENTS' VIEW

**Asist. Nena Kopčavar-Guček, MD, Outpatient Clinic Zdravje,
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Education in medicine is a permanent and never ending process. Teaching in primary-care settings is and will be used for undergraduate and postgraduate studies.

The concept of patient centered care should be appreciated even in a teaching setting. An active role of the patient, rather than a passive stance, greatly improves the effect of the educational, as well as the medical aspect of the consultation. If properly prepared and with respect to official issues the teaching process in general practice can be an enjoyable and profitable experience for the patients as well as the students. A few studies have been conducted to prove that patients can even benefit from participating in the teaching process. Developing communicating skills is essential for effective verbal and non-verbal relating to patient. Respect, candor and empathy remain the cornerstones of successful interacting with the patient.

Teaching in general practice differs greatly from the teaching in hospitals, but is inevitable and invaluable; the patient has to remain in the center of care.

Respecting patients' rights is the essence of teaching, therefore respecting the principles of medical ethics is mandatory.

Communication is the basis of patient – physician relationship and plays a major role in the teaching triad patient – doctor – student.

Patients should be treated with respect, genuineness and empathy, whereby teachers act as role – models for the learners.

The results of some studies suggest that the teaching process in medicine can be a positive and enjoyable experience for the patients as well as the learners and their teachers.

TEACHING AND LEARNING IN GENERAL PRACTICE: THIRD YEAR STUDENT-PATIENT ENCOUNTERS

**Ramon PG Ottenheijm, Paul J Zwietering, Job FM Metsemakers.
Maastricht University, Department of General Practice, The
Netherlands.**

Context: In September 2001 the medical curriculum of the Maastricht University was revised. The aim of the curriculum is that students can handle increasing independence and responsibility in their role of medical doctor. The third curricular year has chronic disorders as central theme, and is divided over four clusters of ten weeks, each focussing on a particular subject area. Students have patient encounters on a weekly base. These patient encounters take place at several settings, mainly in outpatient clinics and in general practices.

Objectives: To describe the general practice part of the programme and to report some early evaluation results.

Design: Every student visits one family physician eight times (twice each cluster) and meets patients with problems relevant to the subject area of the present cluster. During each visit the student takes a history from and performs a physical examination of at least two patients and pays attention to chronic generic themes. The student writes a structured report (SOAP) to which Elaboration and Learning goals have to be added. He receives subsequent feedback from the coaching general practitioner. At the faculty, the written reports are used in tutorial groups.

Results: Students, family physicians and the faculty teaching staff are enthusiastic. On average students see two patients a day and most of them receive subsequent feedback. We face some organizational problems, e.g. providing enough participating family physicians.

THE CURRENT POSSIBILITIES AND CHALLENGES IN MANAGEMENT OF HYPOTHYROIDISM IN PRIMARY CARE.

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Introduction.

Developing, distributing and implementing guidelines is a major challenge for general practitioners and their organizations and academic departments. One of the most important part of this process is an education. Different tools are used to bring the information to the individual doctor and to ensure the highest possible compliance with the guideline. The small group sessions moderated by local GP opinion leader and facilitated by an academic GP have been shown to be effective.

Topic of the workshop.

The hypothyroidism is the second most common endocrine disorder in western population with higher prevalence in women and in elderly. It is a chronic disease which can be easily diagnosed when considered and for which there is an effective treatment when taken continuously. The diagnosis and treatment have usually a great impact on a quality of life and a prognosis of a patient. On the other hand the symptoms are often nonspecific and may be confused with those of other clinical conditions. There are some controversies concerning management of subclinical hypothyroidism, sense of screening for hypothyroidism in risk groups and in general population.

Method.

The workshop will be organized as a *small group session* – a part of a national CME programme on Quality Improvement in Management of Hypothyroidism in Primary Care.

Local GP, a session moderator, will introduce a tutor, an academic GP, who will give a brief expert lecture. Then the questions will be raised by moderator as a base for discussion and feedback control for session participants and presenter.

The participants will be provided by a simple session assessment form.

Conclusion.

Small group session is a widely used CME tool. The added value of the workshop is possibility to discuss practical management of chronic disorder based on evidence with the international insight on a problem.

DEVELOPEMENT OF CURRICULUM FOR FAMILY MEDICINE FOR NEW MEDICAL SCHOOL IN MARIBOR

Ksenija Tušek-Bunc, Janko Kersnik, Katedra za družinsko medicino, Medicinska fakulteta Maribor.

After many years of effort, we can say that our dreams have come true. We got a Medical School in Maribor and of course the Family Medicine Department will be also established. The Program Family Medicine will be run in the course of second, fifth and sixth academic year. The content and requirements will be adjusted to the expected level of students' needs and understanding. The program of the subjects according to the hours and the form of the studying, will be divided in the course of three years which means, six semesters and lectures, seminars and exercises. The lectures will be held by the university professors and visiting professors. The number of lessons will be limited to the minimum that is necessary to present the main content of subjects. Seminars that will be organized in the form of monitored workshops and small groups will be led by teaching assistants and visiting professional guest speakers. Drills will be organized an implemented by mentors, physicians and teaching assistants. In the course of second year they will be held in the form of the monitored groups and run by the teaching assistant. In the fifth and sixth academic year the students will attend the sessions individually, run by mentors, trained in the surgeries. Tests if knowledge will be carried out continuously in the form of seminar papers, 50 surgery charts in the medical file, case presentation, permanent evaluation by the mentor. Communication, work in the surgery(offices) and knowledge tests in the form of, practical, written and verbal exam after six academic year. (OSCE station).

There are new challenges ahead of us. We are ready to face them with enthusiasm. Above all we are committed to keep in touch with the Family Medicine Department at the Medical School in Ljubljana, where we made our first steps, ourselves.

SLOVENE FAMILY MEDICINE SOCIETY - SLOVENIAN MEDICAL
ASSOCIATION

DEPARTMENT OF FAMILY PRACTICE, UNIVERSITY LJUBLJANA

DEPARTMENT OF FAMILY PRACTICE, UNIVERSITY MARIBOR

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Assessment in FP/GP in Europe

Kranjska Gora, Slovenia, September 23 – 24 2005

Call for abstracts and registration form

AIMS OF THE CONFERENCE:

The conference is aiming at the educators in primary care who are involved in teaching at university or practice level and will be held in English. The main aim is to exchange the experiences and to propose effective strategies, models, curricula and methods of teaching GP/FM at undergraduate and postgraduate level with special emphasise on the assessment in GP/FP. During the conference there will be a mixture of invited key note lectures, presentations, panel discussions, poster presentations and group work. The modules produced during the 15th international course will also be presented to the conference audience.

GENERAL INFORMATION:

The conference will be held in Kranjska Gora, Slovenia. Kranjska Gora is a tourist resort in the Northwest of Slovenia and is easily accessible by car, train or plane. The conference fee is 150 EURO + V.A.T. and will include organisation of the course, conference attendance, refreshments during coffe brakes, lunch during Saturday lunch brake, reception and gala dinner. We have chosen an array of interesting keynotes and have invited distinguished speakers to cover these issues. We invite you to send an abstract for the poster or oral presentation or for the workshop. Three presentations will be covered by the products of the course on learning and teaching about comorbidity. We suggest an early room booking through the main registration office by letting them know you are participating the conference and/or the course: **Hotel Larix**, Borovska cesta 99, 4280 Kranjska Gora, Tel.: +386 4 5884 100, Fax: +386 4 588 44 70, E-mail: info@htp-gorenjka.si. Detailed programme will be available on the Society web page <http://www.drmed.org/novica.php?id=442>

ABSTRACTS:

Presentations and workshops on the topic of the conference are welcomed. Abstracts for the presentations and workshops not exceeding 250 words should be send in word format by e-mail to the programme committee by the June 20. The address is janko.kersnik@s5.net.