



EURACT Newsletter



Editorial: EURACT and the spirit of Alma Ata

by **Francesco Carelli**

Thirty years ago, the "Declaration of Alma Ata" defined health as a "complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" and stated that the access to basic health services was a fundamental human right. The model adopted to provide health care services was "primary health care".

Two really important documents have tried to make the Alma Ata ideals a practical reality for patients. The WONCA Europe Definition has set out the range of skills required to practice the kind of primary health care envisaged in the Alma Ata declaration. The EURACT educational agenda seeks to equip future generations of doctors in the same way.

Local care facilities will need to be enhanced as well as the provision of primary care, reaffirming the role of family doctors. The growth of Family Medicine is of great importance, because the challenge for medicine in the third millennium is to achieve the right balance between modern technologies and interpersonal relations, rethinking the issue of humanization/ dehumanization, with all its underlying physical, psychological, cultural and relational aspects.

Family doctors are in a privileged position, because Family Medicine is the place where medical sciences merge with other disciplines, particularly sociology, economics, philosophy and law. The Alma Ata declaration statement that health is not merely the absence of disease renewed the meaning of the concept of care, transcending a restrictive view of care simply as treatment. A shift was made, from patient to person, from treatment to giving care, with the human being viewed as part of a network of relationships. Treatment thus becomes more of a social process; attention is given to paradigmatic circumstances, such as diseases affecting children, the elderly and women.

EURACT supports fully the Alma Ata philosophy by defending high levels for teaching and learning health promotion, by looking for mandatory specific training, an adapted undergraduate curriculum and early exposure to clinical experiences within the primary care setting and by promoting a clear selection of teachers and practices.

EURACT's values were inspired by the Alma Ata Declaration, taking into consideration a community's orientation, understanding

the potentials and limitations of a community. The ethical and moral responsibilities of general practitioners could lead them to try to influence health policy in a community, reconciling the health needs of individual patients and of a community, in balance with available resources. To be able to do this, general practitioners should be allowed contractually to act as advocate for all their patients and a whole community. To be successful, general practitioners need to learn in the basic curriculum and in the vocational training the interrelationships between health and social care, the impact of poverty, ethnicity, inequalities, the structure of the health care system in which they live and in which they work (Educational Agenda 2004).

The increasing role of the patient as a determining factor in health care and its provision, compels us to start organizing an approach to implement a social model truly consistent with the human nature, which ought to foster the interaction between health care providers and patients and between the different professionals involved in the treatment and care who intend to work for the good of the single person and the community.



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The grey epidemic in Europe and its consequences on primary care doctors' training and function

"Geriatrics is not recognized as a medical speciality or sub-specialty in certain countries"

by George C. Spatharakis & Elena Frolova

Humanity for the first time in its history is faced by an unprecedented "grey epidemic" alias an important demographic senescence. This phenomenon started presenting itself in the midst of the 20th century and it continues to progress steadily. Demographic projections point out that it will continue to accentuate and will acquire on the European soil critical, if not explosive, dimensions somewhere between 2035-2050.

This phenomenon poses unique problems on all levels of social activities. Health services are among those who receive the big-

gest burden as advancement in age is often related to comorbidity – multimorbidity, frailty, polypharmacy, atypicality of clinical manifestations, iatrogenic adverse reactions, disability, solitude, emotional and/or mental disturbances, financial problems, etc.

On the other hand the global state of preparedness of the medical world seems not very high on this behalf:

1. The number of certified Geriatricians is low and tendencies in some countries are towards a decline rather than an increase in their number.
2. Geriatrics is not recognized as a medical speciality or sub-specialty in certain countries.

3. The model of education in medical schools still largely relies on the Pasteurian one, that is that one infectious factor (microbe) > one pathological image > one set of precise and well defined clinical symptoms > one diagnosis > one treatment. This model that has worked perfectly for infectious and/or acute diseases and has contributed a lot to the development of medical science, is de facto incapable of permitting the understanding, assessment and management of multimorbid frail elderly and their complex bio-psychosocial problems.

While the number of specialized Geriatricians seems



not to keep up pace with the number and increasing needs of the elderly population, the number of available General Practitioners / Family Doctors (GP/FDs) and that of Community / Primary Health Care Nurses seems to be at least stable, if not progressing in some cases (countries). The important number of GP/FDs, their proximity to the living places of the elderly, their community orientation and integration as well as the use of the Engelian “bio-psycho-social” modelling in the approach, assessment and management of health care and psycho-social problems make them the privileged interlocutors in the process of maintaining frail elderly at home, thus decreasing health costs and increasing elderly quality of life.

Nevertheless the “geriatric” education and training of GP/FDs in many European countries still seems insufficient and/or inadequate to cover all these needs and all the multiple and complex aspects of community geriatric care, as far as knowledge but especially as far as the acquisition of skills is concerned. GPs in Europe are trained in organ- and disease-based approaches and may lack knowledge about the concepts, tools and instruments required to manage complex health problems in an ageing population.

Nursing home care that also often implicates GP/FDs is still an open, hard and unaddressed issue, different in many aspects from that of the community geriatric care. The problem of sharing responsibilities between the geriatricians and GPs also still exists. An example of such failing collaboration was shown on the Geriatric Congress in July 2009 in Paris. The session devoted to the role of GP in the geriatric care was absolutely insufficient with no examples of successful collaboration, not containing any practical points, and finally being boring and unintelligible.

Moreover the efficiency and the cost-effectiveness of the services/approaches offered by GP/FDs to manage the needs of an ageing population are failing to make much impact. The case for routine comprehensive screening for unmet health needs in the older population has, for example, collapsed following the Medical Research

Council (MRC) trial’s demonstration that there are few or no benefits to quality of life or health outcomes for older people. In addition to the above, primary care services are often reactive, fragmented, and poorly adapted to the management of older patients with high levels of dependency and comorbidity, leading to enthusiasm for ‘case management’.

“One of the solutions to the problem of teaching on frailty could be the introduction in the vocational training of all GPs/FDs of a 3-6 months rotation in geriatric establishments of different kinds ”

On the other hand, the Intermediate model of care of Dutch GPs and nurses in the Dutch Easy Care Study demonstrated cost-effectiveness as well as multi-dimensional assessment. But in order to demonstrate the influence of such models of assessment or interventions on clinical or health related outcomes we need more real scientific research focused on the primary level. The leading role in such research should be carried out by the General Practice research centres really informed about the needs of primary care. Two interesting projects were started in 2009: BELFRAIL in Belgium led by the Family Medicine Department of Leuven University (Belgium) and Crystal led by the Family Medicine Department of St-Petersburg’s Medical Academy for postgraduate study (Russian Federation) The goal of both research projects is to understand the frailty concept and its impact on the health of community dwelling people above 64. This population is under the responsibility of GPs. The study’s results will help to elaborate new principles of collaboration between the geriatrics and GPs, to enhance the sharing

of responsibility and to create relevant input in the teaching of new GPs.

One of the solutions to the problem of teaching on frailty could be the introduction in the vocational training of all GPs/FDs of a 3-6 months rotation in geriatric establishments of different kinds (acute care units, rehabilitation ones, long-term care institutions, nursing homes, day care centres -geriatric or psychogeriatric-, home aid mobile units, etc.). Another idea might be the introduction of specific teaching modules including vignette (case) analysis and acquisition of specific skills, composites of the comprehensive geriatric assessment [MMSE, Geriatric Depression Scale-30, Mini Nutritional Assessment -short and full form-, Timed Get Up and Go Test, Tinetti test, ADL of Katz (Activities of Daily Living), IADL (Instrumental Activities of Daily Living) of Lawton, etc.]. Furthermore the teaching modules should not only address the diagnosis, assessment and management of specific diseases (e.g. Alzheimer’s disease, denutrition, osteoporosis, depression, etc.) or syndromes (e.g. falls, incontinence, frailty, etc.) or conditions (e.g. Polypharmacy) but should also be focused on prevention, reducing iatrogenesis and promoting function.

For the already existing GPs/FDs working in the field, the solution might be the organization of Continuing Medical Education/ Continuing Professional Development activities promoting the very same goals and focusing mainly on acquisition of skills and attitudinal change. Some of these courses may be presented in electronic format, for implementation through EURACT.

These new needs and challenges for the health care systems in Europe will demand a concerted action/effort of all of the family physicians, geriatricians and nurses in primary care. In particular, in addition to the need for more intensive training there is an

increasing need for more intensive research in primary care. Public health officials, politicians and local authorities' representatives should also intensely and thoroughly be informed, updated and lobbied the interests of the proposed approaches and strategies, especially using as contact points the notions of cost-effectiveness and the possibilities for large scale economies, through such concerted actions of education, training/retraining and reorganization/changing of philosophy of primary/proximity services in primary health care of the community dwelling elderly.

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Family medicine in Estonia: historical background and newest trends

"92% of those who had visited their family physician during 2007 were satisfied with the service and the share of satisfied patients had risen by 9% since 2001"

by **Ruth Kalda**

Prior to the independence, the Estonian Primary Health Care (PHC) System was based on the Soviet Semashko model. PHC services were mainly provided in polyclinics and health centres owned by the municipalities. There was no specialist training in family medicine and the specialty did not exist. Polyclinics were staffed by therapists, paediatricians, gynaecologists and other specialists.

Following independence, PHC reforms were introduced in 1991. The reforms aimed to develop a family medicine centred PHC system and to establish family medicine as a medical specialty. In 1993, family medicine was designated as a medical specialty in Estonia – the first Post Soviet country to do so. New postgraduate training

programmes were introduced, including a three-year residency programme for new graduates and an in-service training programme for retraining of specialists who were working in PHC – especially therapists and district paediatricians.

In 1997 significant health reforms were introduced in primary health care, which required Estonian citizens to register with a family physician (FP) and family physicians to become independent contractors. As independent contractors, family physicians were able to conclude a contract with the Health Insurance Fund (HIF) to provide primary health care services to their registered population and be remunerated according to a new mixed payment system comprising capitation payment, fee-for-service, a

basic practice payment and additional allowances. Since 2006 a special fee for quality of care (quality bonus system) was established. This bonus system wants to stimulate preventive activities, the follow-up of patients with chronic diseases as well as the provision of more comprehensive care.

Partial gate keeping was introduced as part of the PHC reforms. Family physicians have a gate keeping function and control to a large extent the access to specialist care. Generally patients need a referral from the FP to see a specialist and to be admitted as an inpatient (except for acute emergency cases when ambulance services may be used).

Access, accessibility and quality of primary care are monitored by the Ministry



Estonia is a small country with 45,226 sq km, population about 1,33 million. In Estonia we have only one Medical Faculty, which is located at the Tartu University, the oldest in the Baltic Sea region (founded in 1632).

Medicine has been taught at the University of Tartu since 1632 when the king of Sweden, Gustav Adolf, gave orders to found a university here. The Faculty of Medicine offers basic courses, residency training and degree courses.

In 2008 there were 4504 physicians in Estonia (excluding dentists and pharmacists). This means that there were ~338 physicians per 100 000 inhabitants. According to the official data, there are 940 certified family doctors today in Estonia, but the number of trained family doctors is somewhat higher (~1050). Some of them retired, went to work abroad or work in other areas.

My contact address is: Department of Family Medicine, University of Tartu, Puusepa 1a, 50406, Estonia - phone: +3727319211

My current position is: since the 1st of Sept. 2009 I am professor of the Department of Family Medicine. I am chair of the Estonian Society of Family Doctors and I am working as part time family doctor in a group practice (5 doctors together).

of Social Affairs and the Estonian Health Insurance Fund. Surveys show that, overall, 92% of those who had visited their family physician during 2007 were satisfied with the service and the share of satisfied patients had risen by 9% since 2001. The satisfaction with family doctors is even higher than the satisfaction with other specialist services (86% of the patients were satisfied with specialist in 2007). Accessibility of family physicians is generally good – more than 40% of patients surveyed in 2007 were able to see their family physician on the same day, 33% during 1-2 days and only 2 % of patients waited for more than week. However, compared to the period 2001-2002, the number of patients seen on the day of attendance has decreased. In 2002 this number was more than 60%. The decrease is mainly due to the growing work-load and responsibilities of family physicians in every day work. Compared to 2001, significantly more problems are solved at primary care level today.

During the last years several new developments took place in Estonian primary health care, but also in health care as a whole. First, the Estonian Society of Family Doctors worked out a collection of standards describing acceptable levels of family medicine practice organisation and clinical work. The document consists of written text, a table of indicators, an

example of the patient questionnaire for feedback and a digitable table in the Society's intranet for voluntary comparison of practices and doctors. The quality guide has 4 parts : access to practice, organisation of the practice, quality of clinical care and practice as the base of teaching and research. Quality management systems will be soon linked to the practice contracts and certain incentive systems.

A second change occurred when the Estonian Society of Family Doctors started to create a distant learning environment for family physicians, called as SVOOG. At the moment SVOOG includes about 120 different topics and lectures which family physicians can listen to and read without leaving their every day practice.

The third very important development is related to the nationwide e-health system. During the last decade, Estonia became well known as a country with advanced e-services, not only in the business sector (especially banking), but also in e-Government services (electronic tax board, state commercial, car and shipping registers, e-voting, e-school, e-ticket etc.). Other IT-solutions such as digital signatures and ID-card authentication are recent innovations, and their use is comprehensively regulated by national law.

The idea of e-Health and a national e-health information system already emerged in 2002. The purpose was to develop a nationwide framework (database) using different medical documents in a digital format that facilitates the exchange of diffuse health information, which was available only in local databases and information systems that were not able to communicate with each other. Implementing e-Health projects resulted in the Estonian health information system that was launched on December 17th 2008. The gradual development of the system will continue until 2013. From the September the 1st of 2008 the health care service providers



are obliged to forward medical data to the health information system. The rules for data usage state that only the health care employee (the attending physician) currently associated with a patient's treatment has the right to make enquiries about this patient's data, i.e. the patient's attending physician or a medical assistant.

Patients have the right to set restrictions of access to their data. In this case the patient will be informed by the information system at the time of setting the restriction that it is dangerous to his/her life and health to provide health care services based on insufficient information. There will be no access allowed to initial docu-

ments even in the emergency situation and the patient will take full responsibility regarding possible consequences that may arise from banning access to data.

The Estonian health information system is globally unique for the fact that it encompasses the whole country, registers virtually all residents' medical history from birth to death, and is based on a comprehensive state-developed basic IT infrastructure.

"Compared to the period 2001-2002, the number of patients seen on the day of attendance has decreased. In 2002 this number was more than 60%. The decrease is mainly due to the growing work-load and responsibilities of family physicians in every day work."

Literature Reviews



Defining and assessing professionalism – a blueprint

Reviewer Monica Lindh

Wilkinson TJ, Wade W, Knock D. *A Blueprint to Assess Professionalism: Results of a Systematic review. Academic Medicine 2009; 84(5):551-558.*

Summary

There are many and varying definitions of professionalism, no agreed consensus, and views on professionalism may change over time. Many attempts have been made to develop tools to measure professionalism.

The purpose of this article is to match assessment tools to definable elements of professionalism and to identify gaps where elements of professionalism are not well addressed by existing assessment tools.

Literature reviews of definitions of professionalism and of relevant assessment tools were made. This was done within Medline and then expanded through manually checking for further publications.

The findings have been clustered into five clusters of professional-

ism. Predominantly professionalism is about what someone does, rather than what he/she knows. And nearly all definitions include some elements of reflectiveness and/or self-monitoring. Nine clusters of assessment tools were identified. Findings are presented in tables including an overall table "Professionalism Assessment Blueprint".

Professionalism can be assessed using a combination of assessment tools such as mini-CEX, P-MEX, MSF, patients' opinions, paper-based tests, simulations, measures of research and/or teaching activities, and scrutiny of self-assessments compared with assessments by others. Portfolio is seen as having a role of collecting evidence but not as the source of that evidence. More tools need to be developed to measure some of the attributes for example reflectiveness, dealing with uncertainty and advocacy.

Comments

This is a new article from 2009. The first author is the associate dean in medical education at University of Otago, New Zea-

land. It is a thorough and well-described literature review leading to interesting and valuable findings.

However some assessment tools commonly used are not included (why? because there are no studies published?), for example repeated video-recorded consultations with real patients seen in real/actual practice. The Assessment Blueprint (table 3) does not include assessment by the supervisor (the most common assessment tool/model in for instance Sweden where the supervisor might have been supervising that trainee for 5 years or more, working in the same workplace). Also the portfolio could be used as the source of evidence for assessing for example completion of tasks, time management, punctuality, and taking responsibility.

Implications for training

Interesting to read for those involved in assessments, especially for directors of training and assessment, trainers' course organizers, medical departments etc.



Medical teacher as the hero of nonfiction literature

Reviewer Elena Frolova

Sutkin G, MD, Wagner E, Harris I, PhD, and Schiffer R, MD. What Makes a Good Clinical Teacher in Medicine? A Review of the Literature. Acad Med. 2008; 83:452-466.

Summary

The purpose of this review was to find the key features of a good clinical teacher. Methods used are discussions with clinical teachers on their own experiences, framing the question (what are the qualities of a good clinical teacher in medicine), and searching for the literature pertinent to this question. Between July and December 2006 titles from Index Medicus, Pubmed, PubMed related articles and referenced articles were reviewed. Chosen articles were then read in their entirety and those that described specific characteristics of clinical teachers were included. Qualitative analysis was used to identify themes. From 4914 titles 68 articles were selected for analysis. Four hundred eighty descriptors were identified and grouped into 49 themes, which were clustered into main categories: physician, teacher and human characteristics. Non-cognitive characteristics dominated the descriptions and themes. The conclusion is that inspiring, supporting, actively involving and communicating with students characterize excellent clinical teaching. Therefore faculty development programs and future research should focus on development of the non-cognitive attributes of clinical teachers, as well as the knowledge and skills associated with effective teaching.

Comments

During the previous meeting of EURACT Council members we discussed very actively this question. We did not come to any conclusion and did not finish the discussion. I am sure that it is the same discussion that can be heard in any department and/or offices of General practice. The question is not only the consequence of curiosity. It reflects the growing interest of the public and society for the quality of health care and correspondingly for the quality of teaching. Is a good teacher the product of education? Can we foster him or must he have inherent personal features which make him so good in teaching?

If the authors' view is followed, we should believe that non-cognitive characteristics are prevalent among others and thus they make out a good teacher. This position is one that is close to my heart. But what to do with people who want to teach or who must teach because of their clinical position, but were not awarded by fairies during birth with such brilliant features as patience, good sense of humor, and other qualities, listed in the appendix?

I do agree that we can create a good model of teaching behaviour, and to learn this model is to become a good teacher. I do agree that a teaching style may exist and that we can improve it. But some of the statements (quoted in the appendix) that were used as the basis for determining the characteristics are contradictory.

Can we accept this approach to elaborating a good clinical teacher model? I am not completely sure, because despite of the systematic literature review method the first step (framing the question in the discussions with the clinical teachers) was subjective. We also have to be careful whet-

her this model is internationally acceptable. In countries where the paternalist style of teaching is still popular, for example, not all the characteristics mentioned would be accepted by both teachers and students or trainees. Anyway, this article is very interesting and stimulating for our own search: how to make a teacher good?

Implications for training

This article may be very useful for discussions with faculties, with students and trainees, and also for including some of the characteristics proposed into faculty development programs. Finally it may be a starting point for generating a good clinical teaching features list (as Good Clinical Practice for example).

Globalization in medical skills assessment

Reviewer Yvonne Van Leeuwen

McKinley RK a.o. Development of a tool to support holistic generic assessment of clinical procedure skills. Medical education 2008; 42 619-27.

Summary

The article describes an attempt to globalize checklists for procedural skills. The main reason is because skills increase as well as the variety of performers. A very careful and elaborated procedure, with both qualitative and quantitative elements, is introduced to assess reliability and validity of the checklists. Moreover, non technical aspects are introduced, which position the skill in its context. Test validity is mainly assessed by consensus-techniques, reliability with generalizability estimated, resulting in a certain mini-

conclusion is that globalizing checklists contributes to feasibility.

Comments

Before arguing, I want to state that I have tried to escape being taken into custody because of an attempt to administer a lethal dose of cyanide to a patient by intravenous injection. I doubt whether an assessor using only his checklist, would have caught me.

This illustrates the difficulty of globalization: specific elements like checking the content of the bottle are left out, because the skill could also be suturing a dermal wound. In my opinion, the preferred instrument depends highly on the desired feedback. A beginning surgeon wants feedback on the exact stitches he makes, not (only) on the performance as a whole. See also the literature of Eriksson on deliberate practice - training for hours to perform one music scale well, or a backhand volley in tennis. Secondly, globalization assumes that you have assessors who know the skill rather well.

This having said, I appreciate the careful and elaborated approach to construct an instrument which is really needed. See only the many checklists (51) assembled, which must have cost a lot of time to construct. It may be an idea to start with the G (global) list and add specific items if needed fitting the focus of feedback.

My last question concerns the weighing. Being considerate towards patients and skillful technique, should not be mutual exchangeable as far as scoring is concerned. Students should score sufficiently well on both.

Literature Reviews

Teacher as a patient? No, patient as a teacher!

Reviewer Sandra Gintere

Jha V, Quinton ND, Bekker HL, Roberts TE. What educators and students really think about using patients as teachers in medical education: a qualitative study. Med Educ 2009;43 (5):449-456.

Summary

This is an explorative study using qualitative methods with the aim to find out the benefits and drawbacks of patients as educators for the medical students. It is a qualitative study with semi-structured focus groups set at the university and hospital of Leeds, UK. A purposeful sample of 46 participants divided into 4 focus groups of clinician, non-clinician teachers, patient-educators and medical students of each study year were used. Semi-structured focus group interviews followed by thematic content analysis.

The main themes were: the role and the impact of the patient-educator including the patient as a storyteller as well as mechanisms explaining the patient-teacher role in the medical training. Most of the time the participants of the above mentioned focus groups had similar views on the topics.

Patients-educators might be helpful in consolidating the theory into practice as well as giving close insight into patients' feelings and perceptions of an illness.

However, the major problem indicated were the repeated narratives of the traumatic illness experiences of the

patients and the way students would perceive them emotionally. In addition, the quality of a study process of such type needs to be constantly monitored.

Focus group participants did not accept the patients' involvement in the curriculum development and formal assessment.

Both educators and students see the value of patients being educators though with some potential pitfalls related to the quality assessment of the learning process as well as emotional involvement of both students and patients.

Comments

In my opinion, the purpose of this study is to inform medical educators who have already been working with patients-educators of the potential strengths and drawbacks of the particular education format.

Overall, it is a very well designed study with explicitly explained methodology as part of the study.

The evaluation of the particular parts of the paper follows :

The abstract represents the full article with exception of conclusions that are not linked with the results part. In addition, no clear conclusions are given on the main part of the paper answering the question of the title of the paper - "what people involved in the education really think about patients-educators?".

As a result, the usual format of main themes with some

typical quotations is used which is very helpful in order to get insight in the work of the focus groups.

Though the discussion of the results by each participant group is missing, I would expect some differences in views, e.g., between the group of non-clinicians and clinicians or medical students of non-clinical years compared to the ones from the clinical years (for instance on the theme of the emotional impact of the patient-educator on the students).

The group of patients-educators is missing in the part describing the results (this group is only mentioned the chapter "Sample size").

The discussion part gives a very good summary of the main topics discussed which probably could be emphasized also in a more condensed manner in the separate chapter "Conclusions". Too little is said on the potential biases and problems related to the study (except the selection bias).

The last 2 questions in the list of questions for the focus group (Appendix 1) on the 'expert-patients' and the effects on doctor-patient relationships are extremely interesting though not discussed in the paper.

Overall, this paper is a very good example to learn how to carry out a good quality research in a qualitative manner. However, in my view, the readers would also expect some 'tips' or suggestions on how to use this format more efficiently

or advice in what setting and in what circumstances the patient-led learning sessions would benefit the students most.

Implications for training

As mentioned here above under comments, the implications/drawbacks cannot be drawn very clearly from the paper. In my view, the patient-led-education can be used in some non-clinical years as an example when discussing issues related to communication skills, but for clinical years this format could be used more frequently involving the development of the clinical knowledge as well as communication with the patients. The main drawback of the particular format is the complicated way of standardized training of patients-educators as well as the assessment standards following such sessions.

Portfolios can support and assess competence development in medical education

Reviewer Bernhard Rindlisbacher

Driessen E, van Tartwijk J, van der Vleuten C, Wass V: Portfolios in medical education: why do they meet with mixed success? A systematic review, Med.Ed. 2007;41:1224-33.

Summary

The study is a systematic literature review on the effectiveness of portfolios ("reports on work done, feedback received, progress made and plans for improving com-

petence”) in supporting and assessing competence development in undergraduate, postgraduate and continuing medical education. It shows that portfolios are in fact effective to support learning and feasible for assessment if they fulfil certain important criteria. These are decisive in the successful use of a portfolio.

The recommendations, based on the studies containing empirical data, are as follows:

- Clearly introduce the goals of working with a portfolio to learners and teachers
- Combine the two goals learning and assessment (if portfolios are not formally assessed, other summative assessment instruments tend to be prioritised by the assessment-driven students and the use of the portfolio is tailed off)
- Integrate the portfolio into other educational activities in the curriculum
- Provide clear guidelines about the procedure to follow, the format and the content of the portfolio but keep the format flexible and avoid being overly prescriptive about the content
- Use a hands-on introduction with a briefing on the portfolio’s purpose and the procedures
- Avoid too much paperwork
- Be cautious of possible problems of the users with information technology
- Provide mentoring by teachers, trainers, supervisors or peers to enhance learning
- Use assessment panels of 2-3 assessors depending on the stakes of the assessment and train the assessors (in high stakes exams a satisfac-

tory reliability can so be achieved)

- Use holistic scoring rubrics (global performance descriptors) to allow for learners’ preferences
- It may be a good choice to combine the portfolio assessment with an interview.

Comments

This is an important study by authors who for a long time already work in this field. They have published themselves quite a few scientifically well based articles on the use and effect of portfolios.

A bias might be that they support, based on their studies, the use of portfolios in medical education.

Implications for training

For general practice portfolios are an especially important tool as they allow for a holistic and integrated approach in education and assessment and they can support reflective practice. So a portfolio may well be used to support the development of competence in more complex fields like person-centred care, comprehensive and holistic approach to the patient.

“PBL is like sex: more fun than IVF but not more effective” (quote from G. Norman)

Reviewer Yvonne Van Leeuwen

Norman G e.a. Predicting doctor performance outcomes of curriculum interventions: problem bases learning and continuing competence. Med.Educ. 2008;42:794-9

Summary

The article compares alumni from Mc Master (PBL curriculum) and Canadian conventional

schools on keeping up to date with new medical knowledge and on performance according to peers. On neither issue the ex-PBL-students performed better.

In spite of the study limitations the conclusion is warranted that PBL is not the major asset it was assumed to be.

Comments

It causes a kind of grief to see ‘proven’ that a learning method which is so attractive to students is not as promising as it was supposed to be. Thus, the sex metaphor is very appropriate: more fun, not more kids (than IVF).

It is, however, still worthwhile to look for other valuable outcome measures e.g. the ability for teamwork. If nothing works: fun is very important too and the amount of drop-outs being so small is a kind of efficacy anyway.

To be aware of romantic and pseudo-self evident gain, is an important message to retain from this article too!

Implications for training

Go more for evidence based education.

Does the presence of medical students affect quality in general practice consultations experienced by patients?

Reviewer Mladenka Vrcic-Keglevic

Price R, Spencer J, Walker J. Does the presence of medical students affect quality in general practice consultations? Med.Educ. 2008 42;374-81

Summary

Previous studies have

has looked at the effect of students' presence on conventional UK general practice consultations.

This study aims to measure the quality of the consultation as experienced by patients when students are present, to explore patients' attitudes to the presence of medical students, and to look at the relationships between these factors.

A cross-sectional questionnaire study was conducted in general practices in north-east England. General practitioners (GPs) from practices teaching fourth and final year students administered questionnaires to patients who were seen in either teaching or non-teaching consultations. The questionnaire comprised previously validated measures of empathy and enablement as measures of quality, attitudinal statements regarding the presence of students, a scale rating pertaining to the patient's degree of acquaintance with the doctor, and items on demographic data.

Results showed no significant differences in enablement scores between the 2 groups. Consultations with students present, last longer. Empathy scores were significantly lower in the 'students present' group, but the size of the difference was small. Attitudinal statements regarding the presence of students showed a high proportion of positive responses, and some groupings of negative ones. Further analysis demonstrated some significant links between attitudinal statements and enablement and empathy scores.

The quality of general

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practice consultations was not adversely affected by medical students' presence. However, significant numbers of patients who agreed to be seen with a student present were resistant to the students' presence.

Comments

The study has several strengths. Firstly, the research topic is highly relevant to the general practice as an academic discipline as it concerns an important teaching resource in undergraduate medical education. It is important to emphasize to various stakeholders that "The quality of general practice consultations was not adversely affected by medical students' presence". Secondly, the topic was put into a well elaborated framework, enabling the reader to make conclusions on the added value of this study. Thirdly, several already validated instruments (PEI, CARE, patient-doctor acquaintance, length of consultation...) were used to measure the quality of a consultation from the patients' perspectives, which leads to valid conclusions. Fourthly, a large number of the patients were involved. Fifthly, several different statistical methods, (chi-square test, Mann-Whitney, Spearman correlation, multiple regression and factor analyses) were implemented to get a deeper insight into variables and their associations. Sixthly, the results are presented in a simple and readable manner and the discussion is

organized along with the results and in comparison to the results of other studies.

The study has some limitations. One of the limitations mentioned by the authors is that they were unable to relate the patients to a particular GP. Another limitation is the possible effect of the study on the GP's behaviour (the same as usually) and the fact that attitudinal statements are presented to the patient with students present at the consultation.

Implications for training

Further study would be very valuable to see why a certain number of patients were resistant to having the students present : what are their reasons ? What are their suggestions ?

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The education and training of rural doctors

Reviewer Sandra Gintere

Story M. *The rural doctor shortage: two aspects of an international issue.* *Med Educ* 2008;42:552-3.

Summary

This is the summary of and commentary on two studies on the topic of education and training of rural doctors: the retrospective study by Wright and Woloschuk on

data from one medical school in Australia (1) and the meta-analysis of 12 studies by Wilkinson et al. (2). The summary of both studies is given as well as discussions on potential challenges in implementing the novel method of videoconferencing suggested by Wilkinson et al.

Comments and implications for training

I agree with the author of the commentary on the potential financial challenges related to videoconferencing as well as to addressing this issue of rural doctors in general. In addition to the training itself, the selection procedure during the admission process to medical schools can be reviewed. This is in contrary to videoconferencing a low-cost way to ensure the admission of a higher proportion of students from rural areas.

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Teaching complexity is complex

Reviewer Yvonne Van Leeuwen

Cook DA e a. *Introducing resident doctors to complexity in ambulatory medicine.* *Med Educ* 2008;42:838-48.

Summary

The article constitutes an original study to test e-learning on complex medical cases among 1-3th year medical residents.

Complex cases were presented to residents and experts of different fields (e.g. endocrinologist and general practitioner). Residents compared their answers to a complex written case with those of experts. The aim was to have the residents learn from the comparison, to attract them towards the diversity of approaches. The residents however, suffered more than they enjoyed from this presented complexity. It is suggested that it may be better to slowly increase complexity and present it in fragments.

Comments

The study itself as well as the outcome and the theory presented are interesting. The complex cases are cases often presented to GPs, in the Netherlands. Our residents learn day by day to tackle such complexity, having one hour per day to discuss these with their teacher. American students seldom have this opportunity, so looking for means to show how diverse problems and solutions are, is sensible. I can well imagine the residents' wish to discuss on these patients live with a forum of experts. I doubt whether the overwhelming information should be reduced and presented in fragments. Why not podcast the reaction of the experts and present this on the e-learning environment, asking the students to react toward these comments? One more comment: It is often the identity of the patient that structures the knowledge about the pa-

tients. Presenting a face and perhaps a little film may help against overload and increases commitment.

Implications for training

It may be worthwhile to try this out in undergraduate training with all kinds of IT-facilities.

What is professionalism and how to train it in medical education? – The theory of planned behavior (TPB) model

Reviewer Monica Lindh

Archer R, Elder W, Hustedde C, Milam A, Joyce J. The theory of planned behavior in medical education: a model for integrating professionalism training. Medical Education 2008;42:771-7.

Summary

There is no common definition of medical professionalism. This paper discusses various definitions of professionalism. Some of the factors that influence behaviors of professionalism are identified. The current indirect methods used to teach professionalism in medical schools are not adequate to affect change in learners' attitudes and skills, which may lead to a poor relationship between the attitudes taught and their corresponding behaviors.

The paper describes a model based on the theory of planned behavior (TPB) which originates in the social psychology literature. In TPB behavior is predicted by intention which is influenced by three factors: attitude towards the behavior, subjective norms and perceived behavioral control. The TPB has been used to successfully predict a variety of health-related behaviors including smoking and exercise. The suggested model is predictive of

professional behaviors. Limitations of this proposed model are also described.

In conclusion: Successful implementation of this model in medical education curricula should increase positive professionalism attitudes, alter institutional social norms and increase the perceived behavioral control of students.

Comments

This is an interesting paper from the Department of Family and Community Medicine, University of Kentucky, USA. It introduces and describes a model that originates in another scientific field, social psychology. The abstract part might be a bit "too" theoretical but the full article clarifies the topic, describes the model and is well-written.

Implications for training

According to the authors, the TPB best serves the purposes in medical student education. To me the content of the paper seems to be useful for trainers/educators involved in ST-training as well as to doctors and facilitators involved in CPD activities, even if the model as such might not be implemented.

Is it Fashionable? Yes! Is it simply and easy? No! Is it useful and valuable? Yes!

Reviewer Elena Frolova

Deketelaere A, Degryse J, De Munter A, De Leyn P. Twelve Tips for Successful E-tutoring of Electronic Portfolios. Medical Teacher, 2009

Summary

E-tutoring of a digital portfolio allows for personal guidance in a context in which regular face-to-face contact between supervisor and student is difficult. In medical training an e-portfolio can be a handy tool during long periods of clinical clerkships in peripheral contexts. However, implementing e-tutoring in practice is not always straightforward. Tutors do not always get round to posting e-feedback regularly. In this article authors present twelve tips which can increase the chances of successful e-tutoring of electronic portfolios. The tips are based on the authors' own experiences with e-tutoring, on interviews with 14 tutors of an e-portfolio and on questionnaires answered by 107 students who have experienced the e-tutoring.

Comments

Nowadays to implement e-learning is a very fashionable trend. But how often a crash of plans follows because of unskillful hasty efforts! Unfortunately people think that every thing linked with E (e-learning, e-portfolio, e...) will make everything easy. And how disappointing the results may be!

It is a pity that an appropriate number of publications on this topic can not be found. Both the mentoring and the tutoring are not too popular in publications. From the 1988 onwards only 27 articles were published about mentoring (Pubmed resources) and not more than 100 from 1966 about tutoring.

An interesting point is the differentiation of mentoring and tutoring and the detailed explanation of what these

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words mean. This may be most important for countries which only start to be members of the educational community and of course it is of the utmost importance to have a common ground for our efforts to improve teaching. Differences between countries in terminology and in programs, curriculums still

exist. The idea even crossed my mind to adjust (or to extend) the vocabulary of EURACT pages according to this paper: tutoring, teaching, mentoring, e-learning, portfolio.

Personally it was very useful to learn some things about the implementation of e-

portfolio step by step during the year. I agree totally with the delicate position of the authors as far as the relation of tutor and students is concerned. And what else did I get from this article? Practical things which could be special directions to act.

Do you think that it is too easy to be e-tutor? Tell us!

Implications for training

Very useful for creation of e-learning and implication of portfolio method. My proposal is to open a discussion about these tips on the EURACT website.

Agenda

EURACT

April 2011

Euract council meeting
TARTU (Estonia)

November 2011

Euract council meeting
FARO (Portugal)

WONCA – Europe

8-11 September 2011

Europe Regional Conference
2011 Warsaw, Poland
"Family medicine, practice, science and art".

EGPRN

www.egprn.org

4-17 October 2010

Zürich-Switzerland
The theme for this meeting is:
"Motivation in Medical Education and Patient Communication"
Deadline for abstracts is the
30th June 2010

5-8 May 2011

Nice – France
The theme for this meeting is:
"Relevant Outcome Measures in General Practice Research into Chronic Diseases".

AMEE

27-31 August 2011

AMEE 2011,
Vienna, AUSTRIA

9-13 March 2012

OTTAWA conference on
assessment of medical
competence
Kuala Lumpur, Malaysia



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