



Editorial: *A holistic way and debate*



by Francesco Carelli

A holistic approach means that we can employ many allies in the effort to bring better health to people. The tradition of social medicine, of physicians who help to demonstrate how social conditions can impact health and work to ameliorate them, is an excellent example.

The EURACT European Definition (3), at point k, stipulates that family medicine treats health problems in their physical, social, cultural and existential dimension.

The discipline of family medicine has to recognise all these dimensions at the same time and has to be able to give the right weight to them. Illness and pathologies are modified by these dimensions and interventions not able to solve the core problem, may cause a lot of suffering.

In chapter 6 of the Educational Agenda by EURACT (3) Holistic Modelling is clarified.

Holistic thinking has been applied to various levels of medical care, and the challenge is not *whether* to apply holism, but *which* holism (4).

The definition of holism that is widely accepted for medical care, implies "*caring for the whole person in the context of the person's values, his family beliefs, their family*

system, and their culture in the larger community, and considering a range of therapies based on the evidence of their benefits and cost".

Holism, as Pietroni states, involves a "willingness to use a wide range of interventions... an emphasis on a more participatory relationship between doctor and patient; and an awareness of the impact of the 'health' of the practitioner on the patient" (5).

Further holistic care can only be interpreted in relation to an individual's perception of holism. If we accept that holism will always be individualistic, then even therapies or inter-

Holistic thinking has been applied to various levels of medical care, and the challenge is not whether to apply holism, but which holism

ventions offered to the patient will have a different meaning to different people. This is the reason why it relates so closely to family medicine.

From a medical point of view it incorporates systemic holism, and as a person-centred discipline it gives a central role to whole-person holism. The holistic view acknow-

ledges objective scientific explanations of physiology, but also admits that people have inner experiences that are subjective, mystical and for some religious, which may affect their health and health beliefs (6).

Development of the biopsychosocial model

The recognition that all illnesses have both mental and physical components and that there is a dynamic relationship between components of systems (general systems theory) led to criticisms of the biomedical model and to the development of the biopsychosocial model of modern medicine (7). The position of the biopsychosocial model was spelt out most clearly by George L. Engel (3,4) who argued that for psychiatry to generate a fully scientific and inclusive account of mental disorder, bio-reductionist accounts should be superseded.

Understanding the illness (not disease) as a process, which gives equal importance to biological, psychological and social determinants for pathogenesis, diagnosis and therapy, forms the holistic approach with its consequent implementation into practical measures.

Using a biopsychosocial model as the basis for cure

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influence that can be handled by one person in a therapeutic environment. Examples of factors may be:

- natural disposition, including elements of gender, genetic constitution and typology.
- micro-social environment such as the family and the macro-social environment, including the local community and the wider community with all its cultural elements.
- health beliefs and life experiences that make a person the entity that it is at a given moment.
- health-maintaining factors in a person, like the understanding of events, the acceptance of meaning, the autonomy that leads to the conviction that life is manageable.
- personal experiences including past illnesses, medical and social contacts.

Using a biopsychosocial model as the basis for cure and care implies the acceptance that many factors influence our understanding of what it is to be human

As the list of factors could grow unlimited, it is also important to stress that a basic awareness and understanding of one's own limitations as a doctor are crucial. Keeping in mind the fundamental autonomy of the patient, there is a limited opportunity for the family doctor to intervene occasionally and rather "tangentially", with an interesting but very scarce knowledge of the person's history, feelings and priorities. At the same time, the integration of influencing factors is crucial and constitutes the added value. This refers to system approach, where the whole is considered more than the sum of the parts.

Consequences for educational methods

A wide variety of methods can be used for teaching a holistic approach, starting with theoretical considerations of and discus-

sions about the holistic understanding and different levels of holism. Clarification of the biopsychosocial model, based on reading, lectures and seminars, should form the basis for the use of other methods. To be able to handle a large variety of fields in an integrative way, further teaching and learning should be largely based on case studies, narratives and patients' histories, the global context that can be taught and learned in the practice context.

Specific methods to achieve this include:

- case studies, single case descriptions and presentations,
- videotaped interviews, video analysis of clinical encounters, simulated patients,
- group discussion, one to one discussion,
- field visits, observation in practice, supervision in tutor practices.

Consequences for the assessment of holistic modelling

Central to the assessment of this chapter's competences are case presentations, direct observation of consultations, video recording analysis and the evaluation through long-term tutor assessment, observation in teaching practice, and peer assessment. The conceptual parts can be assessed by case simulation in an oral examination, and even by MCQ. Written reports, essays on specific focuses and aspects may also be considered very useful for the evaluation of the learner's ability to take into consideration various factors and integrate them into the health care process.

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Country Report

Family Medicine in Israel: A National Overview and Examples from Ben-Gurion University in the Negev

By Howard Tandeter

Physicians' Statistics

Israel is a small country with a population that almost doubled itself in the last 30 years (3.5 to over 7 million people), mainly due to immigration. It has a large number of physicians/ population (460/100.000), and only 45% of them are board certified as a specialist in any discipline (data from 2004, with the proportion of board certified growing every year). One third of the physicians employed in 2004 immigrated to Israel after 1989. Almost 60% of all the physicians in the country are employed in hospitals and the rest in the community. At present, training (a formal residency program or postgraduate course) is not a prerequisite to become a primary care physician (although the trend is changing).

The System

Israel has a well-developed primary care system with clinics located in the community, all around the country (urban, suburban, and rural). About 97 per cent of the population has medical coverage through a National Health Insurance, and they can choose one of four Health Maintenance Organizations as their health services' provider.

Family Medicine in Israel

The last 30 years have witnessed a process of renaissance of primary care in Israel, which developed on two main tracks: medical education throughout all its stages, and the organization of medical care in its various aspects. FM developed



as a new discipline in Israel in the seventies, achieving independence from other disciplines. The first official residency training program was initiated in 1977, and today there are 11 departments around the country; each affiliated academically with one of the four universities' with medical schools, offering residency programs in Family Medicine (Ben-Gurion University, Tel-Aviv University, and the Technion in Haifa and the Hebrew University in Jerusalem). A fifth medical school in the city of Zefat is expected to begin its activities in 2012. FM is a well-acknowledged discipline in this country and it is now recognized by the National Scientific Council as base for sub-specialization in geriatrics, infectious diseases, and emergency medicine.

The Residency Program

After 1 year of internship, residents enter a national 4-year's program composed of hospital and community rotations. Hospital rotations include a year in internal medicine, 6 months in pediatrics, 3 in psychiatry, and 6 in elective rotations (two 3-month rotations chosen from a list of sub-specialties such as

ENT, dermatology, ophthalmology, gynecology, surgery, orthopedics, and emergency medicine). Community rotations are performed in approved teaching practices, with 9 months under direct supervision of an instructor (1: 1 teaching/ stage 1), followed by 12 months of independent work (not under direct supervision/ stage 2). The clinic in which stage 2 is performed is expected to become the definitive practice of this doctor after certification. Last year, the Syllabus committee of the specialty decided to change the proportion of time spent in each stage, expanding stage 1 from 9 to 15 month while reducing hospital rotations. In addition, residents participate in a weekly course over six semesters in which they discuss the theoretical background of their work and learn communication skills. Evaluation consists of two examinations: a multiple-choice examination 24 months into their residency, and a final oral examination -for the Board of Family Medicine mandatory examinations- about different areas of knowledge (clinical cases, family presentation, and practice organization). These programs produce about 60 board certified physicians per year.

A Flower in the Desert (Department of FM at Ben Gurion University)

The Negev is the desert region of southern Israel covering a surface of over 13,000km². It covers 60 percent of Israel's landmass and is inhabited by only 13 percent of its population.

Family physicians throughout the Negev provide integrated curative and preventive care to all the inhabitants of the area, including urban, rural and semi-nomadic Bedouin tribes. Neighborhood and rural clinics are spread all over the Negev, so that patients can get to a clinic within walking distance from their homes. Each family physician has about 1500 listed patients, which are 250-350 families, under his or her care. The clinics are well equipped with modern facilities and use a

common computerized file communicating with the Soroka University Medical Center, central laboratories, and other resources.

The major responsibility of the Department of FM is a four-year residency program which, at the moment, numbers about 50 residents. This program was initiated in 1980.

The palliative care service and a pain clinic

The palliative care system in the Negev consists of a home palliative care service (HPSC), a mobile palliative care unit, an ambulatory and inpatient consultation service and Ma'agan – a community support center for cancer patients and their families. The HPSC was established in 1990, and currently employs nine family physicians, nine nurses, and one social worker. The Home Hospice is on call for 24-hours a day all year. Serving in the HPSC is an integral and required part of the residency training at BGU. Residents must spend at least six months at the HPSC in Beer-Sheva, in addition to their regular responsibilities at the primary care clinic. They have full responsibility for at least one terminally ill patient along the entire 6-months period, including an on-call duty for the HPSC. However, for the time being, this unique experience has become a part of the residency training only in BGU. The main objectives of this experience are to provide the residents with an opportunity to accompany a family in crisis and to learn end-of-life care.

The didactic course

In 1988, a year after the Family Medicine Department was founded it commenced a unique annual course for the residents, a day per week. This course emphasizes the patient-centered medical model and the family-oriented primary care. During the first year of the residency, the emphasis is placed on doctor-patient relations and communication skills and a family-oriented care concept; in the second year the family-oriented care course is based upon case presentations and discussions;

in the third year the course uses "simulated patient" techniques, whereby role playing of doctor-patient encounters are analyzed and discussed. In the last year, each resident is videotaped in his or her practice; the videotape is presented to the group for analysis and discussion with the tutors. All these classes are taught in small groups of 10 to 12 residents by a family physician and a social worker, modeling the importance of team work.

Additional topics in the program provide insight into medical problem solving and the decision making process and stress frontiers in clinical issues. Also included are updates in epidemiology, pharmacology, psychiatry, medical ethics and law, preventive medicine, and women's health as they apply to family practice. The fourth year residents have an additional individual program tailored to their needs, which may include practice organization, analysis of videotaped encounters, Balint groups, and preparation for the final specialty examination.

Research

The Department of FM has developed into the most productive and successful among all the departments of family medicine in Israel in terms of publications and attracting research funds. All residents are required to perform a mandatory research project during their residency training. This requirement was first introduced in Beer-Sheva and was later adopted in other family medicine departments in Israel. Research instructors are members of the Department who supervise the residents through all the phases of their research projects. Some of these projects have been presented in national and international conferences, and published in peer reviewed journals. There has also been an increase in funding residents' projects. Sial Research Center provides the support for residents and faculty in their research projects. Conducting research in the community setting is an ongoing challenge. Physicians face many difficult barriers such as very broad spectrum of medical problems, personal involvement with patient and families, high practice demands, high sense of ongoing responsibility,

low professional status and lack of research culture. The Sial Research Center for Family Medicine and Primary Care was established to remedy this deficiency and provide the needed support and assistance for research.

Undergraduate training (The FM Clerkship)

In order to improve the level of primary care in Israel, it is important to increase the number of medical graduates who choose primary care specialties. The decision to choose or not primary care as a career is greatly influenced by institutional, legislative, and market pressures. At an *institutional* level, the four medical schools in Israel differ greatly in their attitude toward primary care (regarding the length of primary care exposure in each of them).

While BGU presents community-oriented care as a key component of its undergraduate training, and has a defined 6 week clerkship during the sixth year of studies, in other institutions, there are only between 2-4 weeks' rotations in family medicine in the sixth year of their programs. Students may acquire distorted images of the primary care specialties as they learn in academic settings that are essentially hospital-based. For a country in which 20% of its physicians are expected to work in the community, even the good example of BGU –dedicating only 10% of the clinical years to teach primary care specialties - shows to be insufficient.

In 1974, the Ben-Gurion University of the Negev in Beer-Sheva, established a new medical school, with a primary objective of emphasizing community medicine and primary care¹³. Today, students at the Joyce and Irving Goldman Medical School at Ben-Gurion University, have a six year program, with a six-week clerkship in Family Medicine that moved lately from its fifth to its sixth year. Following is a description of the Family Medicine clerkship at our university, with special emphasis on the developments that took place during the last 10 years of the program. Every year,

after completing their clerkships in Pediatrics, Internal Medicine and Psychiatry, students arrive to the family medicine clerkship, and are divided into three groups of about 20 students each. Different to what happens in hospital based rotations each student is assigned to one family physician in a community clinic, on a one-to-one teaching format. During the first two weeks of the clerkship, students regularly see patients with their preceptor. Later on, they start working more independently, involving the preceptor in the decision-making process at the end of each patient's encounter with the student.

Once a week, students assist in lectures and seminars at the medical school. Some of these meetings serve for self-prepared presentations, mostly of the approach to a common medical problem or a prevention strategy. In preparation of their final oral exam (patient presentations), students also perform home visits in order to meet the patient's family, and to assess their home environment.

Conclusions

FM developed and grew for the last 30 years in Israel making a great impact in the

delivery of primary, community-oriented care. During this time family medicine developed as a separated discipline who took responsibility for the health in the community, separating from the hospital. Today, FM in Israel has advanced to be one the most developed systems of primary care in the world thanks to its academic development and the adoption of the National Health Insurance, which ensures equity in health delivery. And in this process, the Department at BGU plays an important part.

A description of training of GP trainers in Flanders, Belgium

By Lieve Van den Block, Carl Stubbe, Guy Gielis

Introduction

To become a general practitioner (GP) in Flanders, Belgium, 3 years of training are required after graduating as a medical doctor. More specifically, the fourth year of the master in medicine is currently also the first year of the Master-after-Master or Advanced Master of Family Medicine. In Flanders, the Catholic University of Leuven, Ghent University, Antwerp University and the Vrije Universiteit Brussels are closely collaborating to organize the final two years of training of these **GP trainees** i.e. to obtain their Advanced Master of Family Medicine. These four universities have founded the ISHO – Interuniversitair Samenwerkingsverband voor Huisartsenopleiding – or interuniversity collaboration for training in general practice – and outsource the daily organization of the Advanced master to the ICHO – Inter-universitair Centrum voor Huisartsenopleiding – or interuniversity center for training in general practice.

The most essential part of the training of the GP trainees in this Advanced Master concerns their two years on-the-job training – employment contract with a weekly time schedule of 38h to 48h (including work and study activities) – within the

practice of established GPs further referred to as **GP trainers**. Since increasing attention has been paid during the past decades to providing training to these GP trainers in order for them to become “teachers” and not only “physicians”, this article describes the training of the GP trainers in Flanders, Belgium, as organized by the ICHO and ISHO, in terms of the competences to be attained and the educational curriculum. Currently (academic year 2010-2011), 312 GP trainees follow the Advanced Master of General Practice, and they are trained by 301 GP trainers in approximately 209 practices in Flanders.

“In order for a GP trainer to become a competent GP trainer, a number of skills, personal traits and knowledge characteristics have been identified in previous research”

Competences of GP trainers to be attained

In order for a GP trainer to become a competent GP trainer, a number of skills, personal traits and knowledge characteristics have been identified in previous research (1

-5). Across the different projects, different themes and categories have been described to categorize these competences. In Flanders, a core set of 40 key competences to be attained by the GP trainers is used in the organization of the training of the GP trainers, categorized into 4 separate domains (6). This framework can be summarized as follows:

Domain 1: general practice competences – based primarily on the Can-Meds Roles Framework (7): medical expert, communicator, manager, health advocate, scholar, and professional. Next to being a competent physician, the GP trainer is expected to be a competent teacher, coach or trainer for the GP trainee, as described in the following 3 domains.

Domain 2: organization of the GP practice as an educational practice – the GP trainer organizes his or her GP practice in such a way that the GP trainee can work and learn effectively, having a separate consultation room and the necessary equipment and access, using a flexible “work and educational planning” that organizes when and how GP trainees can work and learn. The GP trainer is working as a GP for minimally 5 years, is acquainted with the rules and expectations of the program, and knows how to

effectively disperse educational expertise within his own group practice or network.

Domain 3: educational, didactic competences – the GP trainer has teaching knowledge, teaching skills, and a teaching attitude. He is aware of being a role model, is able to maintain a professional relationship with the GP trainees, is apt in verbal and nonverbal communication skills knowing how to stimulate learning and self reflection of the trainee, can observe and evaluate skills, competences and knowledge of GP trainees and is doing this on a regular basis. He reports daily concerning all the GP trainee's work and he organizes weekly more in depth case discussions or other coaching conversations e.g. focusing on evaluating progress in the trainee's 'learning agenda' and professional functioning. He also coaches the master's thesis and works together with other professionals involved in the training of the GP trainees.

Domain 4: personal functioning and personal development – the GP trainer is prepared to make critical reflections on and introspections of his personal competences, he is open minded concerning feedback and self-development, and he is aware of his personal strengths and limitations. The GP trainer aims to enhance his teaching and coaching competences on a regular basis, shows respect for the GP trainee and incorporates the different roles (educator, GP, colleague, employer) in a flexible manner.

Curriculum of GP trainers

To attain these competences, the ICHO organizes several different educational and coaching encounters for GP trainers.

Basic GP trainer curriculum

The **basic curriculum** of all GP trainers aims to inform new GP trainers and train them in attaining basic educational skills as a teacher and coach of a GP trainee and encompasses:

- Minimally 2 *introductory sessions* of 3 hours each for interested GP trainers, focusing on the practical and organiza-

tional issues of the GP trainees' and GP trainers' training, on minimal criteria, on relevant medical and educational/didactic models used throughout- the curriculum, and on preparing the candidate GP trainers for the next concrete steps before becoming a registered GP trainer.

- After the introductory sessions, candidate GP trainers are *visited* by a staff member of the ICHO staff group of GP trainers – consisting of GPs and psychologists who are charged with the task of "training the GP trainers", coaching and supporting them – who assist them in attaining the core competences of competent GP trainers. During this first visit, the GP trainers are coached to reflect upon their own practice in terms of core competences and to identify crucial strengths and also weaknesses to enhance in the future. A limited number of GPs is refused to enter the GP trainers' program on the basis of stipulated exclusion criteria such as performing alternative medicine.
- After being officially recognised as a GP trainer by the ICHO and by the Federal Ministry of Health, the GP trainers are appointed for 2 years. During these first years, 5 days of 4 hours training are organized focusing on acquiring basic educational skills. These trainings are provided by psychologists and GPs of the ICHO staff group, organized in group sessions of approximately 20 GP trainers. The content of the basic educational training focuses on:
 - * Having a flexible and transparent "work and educational planning"
 - * Organizing daily and weekly meetings and educational encounters with GP trainees
 - * Daily reporting of all patients seen by the GP trainee: training the GP trainer to perform a time and output-efficient daily reporting of all consultations
 - * Clinical decision-making in GP practice: an overview of recent conceptual frameworks and concepts such as sensitivity and specificity, diagnostic landscapes, probability diagnoses, dealing with uncertainty and ascending to certainty, diagnostic thresholds etc

- * Case discussions concerning the trainee's clinical decision-making skills – using general coaching skills and basic communication skills aimed at facilitating the GP trainees in finding their own solutions and attaining goals themselves
- * Case discussions concerning socio-emotional, developmental or ethically charging consultations – using a problem-solving oriented approach
- * Coaching the GP trainee's "learning agenda", which is a combination of different learning objectives identified by the GP trainee and trainer, and how these objectives are best tackled and planned; how to coach the trainee's portfolio

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The educational methods used throughout these basic training sessions focus on interactive teaching and role-playing

- After these first two years, the progress of the GP trainers is evaluated and their appointment can be extended for 4 additional years. At the end of the first two years, GP trainers formulate specific personal learning aims for themselves as a trainer/coach.

Continuous GP trainer curriculum

While the basic curriculum has been set up for new GP trainers, experienced GP trainers are expected to attend **3 half day trainings each year** as part of their continuous curriculum. These educational meetings are organized in different regions in Flanders and are facilitated by the ICHO staff members who are called "**coaches**" for the GP trainers. GPs are organized in regional groups, attended by 15 to 30 GP trainers. The objectives of these meetings are:

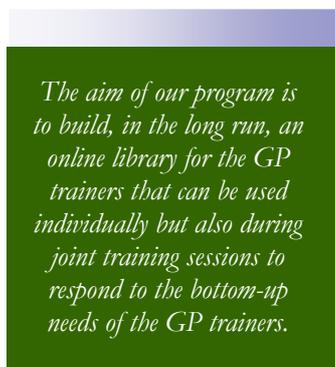
1. to educate and train the GP trainers in terms of the identified competences described above
2. to inform GPs about recent developments in the GP training and the training of GP trainees
3. peer review, to provide consultation and advice on specific problems where needed
4. to provide a forum for GP trainers to come into contact with other professionals involved in the training of the GP trainees.

The first objective consumes the largest part of these trainings and concerns the training of advanced competences covering all 4 competence domains, primarily focusing on the educational and personal development domain. Training is usually organized over a whole year encompassing a specific theme. For example, during one year, the GP trainers might receive training about their own consultation skills, learning how to observe the skills of their trainees by using video-taping on-the-job, providing feedback to GP trainees on their communication and consultation style, and making evaluations at the practice; these video tapes are also used during the training sessions as input for the competence training. For each meeting, a specific scenario is developed in consensus with all ICHO staff members.

The aim of our program is to build, in the long run, an online library for the GP trainers that can be used individually but also during joint training sessions to respond to the bottom-up needs of the GP trainers.

The educational methods used throughout these training sessions also focus on interactive teaching and role-playing. Additionally, GP trainers are visited by their ICHO coach, educational dialogues between the GP trainer and trainee are videotaped and analysed in the GP's practice; these video tapes are also used during the training sessions as input for the competence training. For each meeting, a specific scenario is developed in consensus with all ICHO staff members.

The aim of our program is to build, in the long run, an online library for the GP trainers that can be used individually but also during joint training sessions to respond to the bottom-up needs of the GP trainers.



Additional training options for GP trainers

Firstly, all the GP trainers, GP trainees and staff members have online access to specific materials supporting all training activities via the ICHO website www.icho.be. Using this website, network learning is facilitated via the possibility of exchanging texts, case descriptions, presentations, master's thesis, reflections etc.

Specifically with regard to the personal development as a teacher (domain 4) the ICHO has created an **online portfolio** for the GP trainers which they can use freely to follow-up their own progress as a teacher or coach. GPs can make an online inventory of their training needs, write reflections about educational encounters, access specific tools to evaluate their own behaviour and competences on a regular basis, and ask for feedback of their personal ICHO coach. However, these tools are not obligatory for all GP trainers and are only used by a limited number of experienced GP trainers.

The ICHO also organizes several **ad hoc workshops** each year. These workshops are optional for all GP trainers and concern themes that GPs have indicated to be of interest for them. They are provided by the ICHO coaches and by other external faculty members, in groups of about 15 GPs. Themes of these trainings can be related to the functioning of GP practices (e.g. the use of electronic medical files) but can also focus on case discussions, daily reporting, self

-evaluation or other competences. These workshops are supplemented with specific **e-learning packages** that can be used for distance learning.

GP trainers can also register to follow the training sessions that are specifically developed for GP **trainees** concerning specific skills or competences related to the GP profession (competence domain 1). They can also be directly involved in the final examination of the GP trainees, organized by the ICHO, via observation and evaluation of trainees' skills and competences during simulations and role plays.

With regard to **personal coaching**, the GP trainers are supported by the ICHO staff in case they have specific questions, training or coaching needs, or in case they need help in coaching their GP trainee or in conflict management. Finally, the academic promoter of the master's thesis of the GP trainee will indirectly facilitate the GP trainer, in case the trainee's master thesis concerns a quality improvement project in the GP's practice – which is often the case.

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Health Centers in Serbia in Transition: a personal reflection

By Snezana Djordjevic

After World War II, the formation of community health centers throughout Serbia started on a big scale. The idea of bringing doctors and pharmacists closer to patients had been given form earlier through the - so called - health cooperatives but these were largely insufficient on a personal and technical level and especially in numbers.

Community health centers really put a doctor at a patient's disposal in the closest possible way. Apart from the main, central building that is located in a community or a town center, there are numerous branches: health stations and outpatient departments. According to the number of inhabitants that use the services of these stations, an adequate number of doctors will be at work there. In some cases, only one doctor working only a couple of days a week is necessary while on other days an educated nurse with a lot of experience and who cares for the patients, gives first aid, and consults with the doctor on the phone when needed. Usually a pharmacy will be open in the same building when the doctor is available.

Anyone who has not worked in such a station has not experienced the true charm of general practice. After climbing snow-covered village roads, cleared through remote areas that seem still visited by forest fairies, one reaches the warm health station where a steaming cup of coffee awaits you and a spot next to the furnace, reserved especially for the doctor. As the fire is crackling, the patients start to arrive. They are quiet because, in these areas, it is considered very rude to interrupt the doctor and the staff as they are drinking coffee and having a short rest after the jour-

ney. No one will object no matter how long the wait lasts and when the door opens and the village doctor appears, a sense of deep respect as if for royalty invades the scene. As the doctor passes through the narrow corridor towards his office, tough highlanders used to all kinds of hardship, stand up and greet him as if he were their savior, teacher and adviser. They have heard of the great city doctors but the opinion of these specialists is never convincing enough if opposed by the village doctor's opinion - no matter how inexperienced he is. After all, the city doctors are far away. The doctor that saves is nearby, equipped only with basic diagnostic tools, guided by his heart, by a love and devotion as only the young can show. It is in these craggy areas that the golden pages of medicine are written that are later woven in tradition and retold among patients and colleagues. These are the days that a doctor holds dearest in memory and no matter how far he progresses in his career later, he will never reach these heights again.

Community health centers really put a doctor at a patient's disposal in the closest possible way

As time goes by, such a doctor will be transferred for specialization to one of the city stations so that after passing the specialist's exam he can get a position in the central building and no longer spends his time on the road. Serbia has several large health centers. Apart from the general practice department, the health center in Niš for example has a pediatric department, a de-

partment of dentistry with dental surgery, a mouth disease department and numerous specialist departments equipped for diagnostic and minor interventions: ophthalmology, gynecology, otorhinolaryngology, dermatovenerology cosmetic studio included, internal medicine department, the majority of surgery branches, etc. A radiology diagnostics department is available as well as a laboratory with a separate section for pregnant women and for diabetics and a section specialized in cases of epidemics. A department for physical medicine and therapy, sports medicine with recreation, neurology, psychiatry, and psychology are also part of the health center. Additionally numerous counseling offices - for newborn infants, for pre-school and school children, for dietary advice for healthy and ill persons, for diabetics, for contraception, and for young people and pregnant women - can be consulted. There is a preventive center for patients' education, for advice on giving up smoking and for risk factor estimation. Visiting nurses offer their services in the field by visiting young parents and educating them how to nurse their children or by visiting patients with diabetes and chronic diseases so that regularity of therapy and risk factor corrections can be checked.

The service of home care and treatment is in charge of handicapped and blind persons and other serious cases and these patients are visited according to previously devised schedules or, if necessary, on call. Within this service, a region doctor with a nurse is available. If needed a specialist of a particular department can be consulted or gerontology nurses who help the households to function doing minor domestic works can be put at work.

In a health center organized in such way, a patient is completely examined on short notice and at only one location. The doctors' work is significantly simplified and diagnostics and consultations are beyond comparison more accessible than in the field.

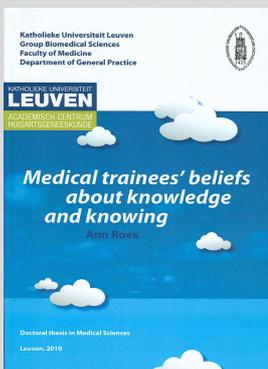
But time brings about change, including changes in the organization of primary healthcare. Plans are made to suspend these large systems, to make the transition to the capitation formula and to abolish the majority of the specialists' services within the health centers in the aim to bring the system closer to European standards. The decision to implement the system of one chosen doctor for each patient is now being implemented. Although the majority of people always preferred to visit one and the same physician, in the last few years, this system has been aggressively insisted on, with numerous com-

plaints of patients as a result. In the meantime, voluminous administration has been imposed on doctors. The completion of these plans is getting nearer including an expectation that patients will give doctors simple answers to model questions with little space left for warm, human talk. Patients' rights protector posters are smiling from waiting room walls.

While writing this report, scenes from seasons long ago flash through my memory. I remember cold winter days, how we used to push through blizzards and worked from the heart and how we used to treat the patients then. Summer brings the noise from the quarry in Sićevo gorge - near Niš -, the sun, the dust and the refreshingly cold smell of the geranium flower. I see myself on the bus home when half way on my way back a bewildered woman asked for help from a doctor. So the bus stopped for me to get off and help her and waited with all other passengers on board for me to finish this

unexpected home visit - that was never charged and up till now was never documented in any way - before continuing my way home. I remember a spring and me thinking about our city station, the end of my shift and my new dress. Then, a moment later, my colleague and I kneeled over a patient, giving her CPR and heart massage in turns. We fought for a human's life and nobody had to give us a reminder of any sort. Autumn brings back memories of a home visit long ago, a late sunbeam over the bed of a patient without hope of healing and a dry hand caressing the brim of my white coat. If these are only a few of my personal memories, they can be supplemented by a lot of other doctors' experiences that are being told and retold. And then I fear not the transition but that I will start believing that being a doctor is just a job, the same as any other job. And I fear for the fairies, the good fairies inside us.

Literature Reviews



Medical trainees' beliefs about knowledge and knowing

Reviewer Yvonne van Leeuwen

Rarely one encounters a thesis that is crucial to the development of a domain. This is one of them. Not in its outcome but in its hypotheses: a brilliant and courageous work concerning the question: is the performance of doctors – in its broadest sense - influenced by their appreciation of knowledge. The overview of the literature is valuable in itself: a good account of the development of expertise and a.o. the difference between an experienced clinician and an excellent (superb performing) physician. It is shown that there are many factors influencing medical expertise. Beliefs about knowledge, epistemological beliefs, could be one of them.

Two different aspects are discerned:

1. do we regard knowledge as 'absolute'; the ultimate answer to questions about reality or can we accept that all knowledge is fallible?
2. how do we justify our knowing "I have read this, thus, it is true", or can we again take a certain 'doubt' for granted?

The difficulty begins with the operationalization of epistemological beliefs. A questionnaire was designed reflecting the two aspects. With factor analysis an attempt to identify traits for aspect 1 and 2 was made.

Only for aspect 2 a typical answer pattern was identified. On the basis of the questionnaire one could make out that there were GP trainees who were quite absolute in their statements about 'the truth' and others who allowed a certain doubt.

Furthermore, as they emerged from the questionnaire, the different groups were linked to a.o. their background variables, their 'culture' (French and Flemish speaking), their scores on the knowledge test, their self-assessment.

No striking correlation has been found. On first sight this is disappointing, but the discussion section shows how many more specified questions and hypotheses come up in view of the (negative) results. Apparently, it is even more complex than we thought. But every experienced - and surely the superb performing medical teacher - will assure you that the attitudes of students towards knowledge and knowing make all the difference!

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Literature Reviews



Evaluation of three short-listing methodologies for selection into postgraduate training in general practice

Reviewer Mladenka Vrcic-Kegelevic

Patterson F, Baron H, Carr V, Plint S, Lane P. Evaluation of three short-listing methodologies for selection into postgraduate training in general practice. Med Educ. 2009 Jan;43(1):50-7.

Summary

This study aims to evaluate the effectiveness and efficiency of three short-listing methodologies used in selecting trainees for postgraduate training in general practice in the UK.

The study is exploratory, designed to compare three short-listing methodologies. Two methodologies – a clinical problem-solving test (CPST) and structured application form questions (AFQs) – are already in use for selection purposes. The third, a new situational judgment test (SJT), is evaluated together with the live selection process. The evaluation was conducted on a sample of 463 applicants for training posts in general practice in the UK. Applicants completed all three assessments and went to a selection centre that uses work-related simulations at the final stage selection. Applicants' scores on each short-listing methodology were compared with scores at the selection centre.

The results indicate that the structured AFQs, CPST and SJT are all valid short-listing methodologies. The SJT was the most effective independent predictor. Both the structured AFQs and the SJT add incre-

A combination of the CPST and SJT represents the most effective and efficient battery of instruments as, unlike AFQs, these tests are machine-marked. Importantly, this is the first study to evaluate a machine-marked SJT to assess non-clinical domains for postgraduate selection. Future research should explore links with work-based assessment once trainees are in post to address long-term predictive validity.

Comment

The study has several strengths. It is well designed and put into the proper contextual framework. The research questions are clear and the methods used are appropriate to answer these questions. The results as well as the discussion are clearly and understandably presented. The limitations of the study are also specified.

But, besides limitations mentioned in the study, several others should be taken into account. For readers outside the UK, even outside the field of selection practices, what looks like phase 1 of selection, is unclear. Why are these applicants not included in the sample? Stage 3 of the selections (work-relevant simulations) is also not clear. Which performance was used as an outcome measure? „Results demonstrate that the strongest predictor of the Selection Centre – stage 3 performance is a combination of all three measures“. It is well documented that the combination of several assessment methods will have added value and reliability.

Implications for training

The main concern relating to this study remains how far we are to go into psychometrics. Does using complicated statistical formulas add new values to something which could be called 'common sense'? Is it still readable for an ordinary reader? Another concern is the predictive value of the described assessment/selection procedure on the outcomes of a training process (success, length, drop out...) or the outcome of real work as a general practitioner, the quality of care?

Narrative reflective practice as small group learning in family medicine residents

Reviewer Monica Lindh

Clandinin DJ, Cave M-T. Creative pedagogical spaces for developing doctor professional identity. Medical Education 2008; 42:765-770.

Summary

The paper reports on a Canadian study of residents that used a reflective practice approach to develop their identities. During 10 weeks 4 medical residents wrote 10 parallel charts that were discussed at bi-weekly meetings with 2 researchers. Residents' experiences include "learned to be a doctor in one cultural setting, into another cultural setting", "affirms a relational way of practicing medicine", "begins to see the complexity of attending to patients' experience". The process shows the importance of creating pedagogical spaces that give doctors opportunity to individually develop their own stories.

Comments

This is an interesting study concerned with an important topic. The study group is small: 4 residents. A bigger group might have resulted in richer results.

Both researchers were educators which might influence the results differently as compared to the case where one of them had been a family practitioner/medical doctor.

Results could partly have been presented in another format, making it more readable and accessible. The conclusion is far too long.

Implications for training

Reflection on one's patients/consultations is a good learning tool for small groups. It may also be used at trainer – trainee sessions. If computerized files are used, it is easy to make copies and less time-consuming. The model used in this study is probably far too expensive for most countries.

Methodology and Outcomes of a Family Medicine Research Fellowship; experience of the Department of Family Medicine and Community Health, University of Pennsylvania

Reviewer Mladenka Vrcic-Keglevic

Cronholm PF, Straton JB, Bowman MA. Methodology and outcomes of a family medicine research fellowship. Acad Med. 2009 Aug;84(8):1111-7.

Summary

There has not been a strong tradition of training researchers to provide the great amount of new evidence needed for the practice of family medicine. Few models for creating suc-

cessful family medicine researchers have been presented in the literature.

The authors report on the methodology and outcomes of a faculty development research fellowship in the University of Pennsylvania's Department of Family Medicine and Community Health. The fellowship focuses on the two domains - intensive research training and academic career development - and frames them with course-work in a content-appropriate master's degree program and clinical practice in an underserved community. Fifteen fellows have completed the program, which began in 1997. Most fellows' research work has been related to primary care and health disparities. Program completers have been the principal investigators on 39 funded studies and coinvestigators on 24 funded studies. They have, at the time this article was written, described their work in 236 publications, 114 of them peer reviewed. All but one program completer hold academic faculty positions, and 12 practice in underserved areas. In a research-intensive institution, the fellowship program successfully trained family physicians to be independent clinical researchers and leaders who have substantially contributed to the national effort to mitigate health disparities through practice and research. The authors suggest that the outcomes strongly support the development of similar training opportunities in family medicine departments in other resource- and research-rich institutions.

Comments

The article is very valuable. It is very important for all

EURACT Council Members, to read a story of success due to faculty development, to know how to support young researchers and future teachers, the corner stone in the academic development of general practitioners.

Very briefly: the several facts important for the success:

1. Well designed and structured curriculum - three parts: intensive research training, career development and clinical practice and practical experience as medical educator – lasting 2 (3) years – 55% full time equivalent for program coordination.
2. Small numbers of fellows – 2 or 3 per year.
3. Reserved, protected time for mentors – 70% full time equivalent – divided between 5 mentors.
4. Well founded, multiple sources.
5. Free choice of the research topics and mentors.
6. Active methods of education: a) mentorship-regular one to one meeting with immediate feedback, b) research seminars – every other week, focused on academic productivity.
7. Last but not least – a clear vision and enthusiasm of the founders of the program.

Self-assessment of communication skills – a learning tool for surgical & non-surgical residents

Reviewer Monica Lindh

Symons AB, Swanson A, McGuigan D, Orange S, Akl E A. A tool for self-assessment of communication skills and professionalism in residents. BMC Medical Education 2009;9:1.

Summary

The article comprises a study to evaluate residents' self-assessment of their communication skills and professionalism in dealing with patients, and to evaluate the psychometric properties of a self-assessment questionnaire. 130 residents in 23 surgical and non-surgical training programs were involved. Two groups of items relating to developing interpersonal relationships and to conveying medical information to patients were used. As far as explaining things is concerned, males and surgical residents rated themselves higher. For listening to patients, graduates of medical schools outside U.S. rated themselves higher. To conclude, this article presents an internally consistent and reliable tool for residents' self-assessment. Some demographic differences are clear.

Comments

This is an interesting study which “promotes” a patient-centered consultation model. When looking at the results it is important to note that the study includes both surgical and non-surgical students, and that 55% are in year 1-2. Only 22% are doing year 4 or more. That is – most residents are not very experienced.

It would have been useful if at least some of the questions used had been included in the article.

Literature Reviews

Some of the figures and statistics could have been excluded.

Implications for training

The tool for self-assessment of communication skills and professionalism seems to be a good learning tool but is not made for evaluation purposes.

Medical students' opinions of psychiatric illness in primary care

Reviewer Mladenka Vrcic-Keglevic

Summary

Previous research has shown that general practitioners (GPs) hold negative attitudes towards patients with schizophrenia, which do not simply reflect the nature or chronic aspects of the illness. This study aims to describe the attitudes and predicted behaviour of medical students towards patients with mental illness in a primary care setting and to investigate whether these are affected by the students' level of training. A sample of 1239 students from the University of Birmingham Medical School were each given one of four case vignettes, all of which were identical except that the patient involved was described as having a previous diagnosis of, respectively, schizophrenia, depression, diabetes or no illness. Students rated their level of agreement with 12 attitudinal statements relating to the vignette.

A total of 1081 (88%) students responded to the questionnaire. Students were generally less favourable in

their responses to patients with either schizophrenia or depression. They would not be as happy to have them on their list, believed these patients would consume more time and considered they would be less likely to comply with advice and treatment. The students expressed more concern about the risk of violence, the potential welfare of children and the possibility of illegal drug and excessive alcohol use. General clinical and psychiatric training had little effect on these reactions.

Patients with mental illness provoke less favourable responses in medical students, which are not altered by furthering education. Undergraduate primary-care-based mental health education should be re-evaluated to ensure that students develop an empathetic and positive approach to mental health patients and their treatment.

Comments

This study has several strengths. First and foremost, the importance of the topic of mental illness is highlighted and set into a clear conceptual framework in the introductory paragraph. The way of thinking on the topic is clearly stated in the study, exhaustively enough, with a clear description of the "social exclusion of mentally ill people, negative attitudes of medical profession similar to the general population and attempts to change this views through the medical education". Other strengths are the substantial bulk of literature on the topic and the magnitude of the sample of respondents accounted for

(88% of the students responded and 68% of undergraduate medical students from one school, Birmingham Medical School).

However there are several limitations to this study. Firstly, related to the topic of the study, according to the psychological literature, this is not exactly a question of attitude. It is more a question of opinions. Nowadays, semantic differentials are the most valid and reliable method to measure attitudes, not simple statements using the Likert scale. But this way of measuring attitudes is very commonly used in medical education literature. Secondly, related to the cross-sectional design of the study : to investigate the association of the level of training with the attitudes of medical students a longitudinal study would be necessary to obtain more information on possible changes. Furthermore, it is not clear from the description of the procedure whether the different groups of students were confronted with different case vignettes or each group with only one. Although the groups of students did not differ according to the socio-demographic variables, there was no proof that their attitudes were not influenced by other, co-founding variables. It could be more appropriate to compare the attitudes of a particular student toward 4 entities : schizophrenia, depression, diabetes, and good health and then draw conclusions. The weakest element of the paper is the measurement, the Lawrie questionnaire, used instrument to investigate the

attitudes. It is comprised of 10 statements, 8 of which cannot be traced to negative attitudes/opinions since they express realities concerning mental illnesses. For instance: the students' perception that mentally ill patients will take up more time is real, because there is evidence that these patients have a higher consultation rate. The situation is the same with statement number 3 (You would refer this patient to a hospital specialists), with number 4 (This patient is more likely to be violent than most patients), number 5 (She is unlikely to comply with advice or given treatment) etc. Two statements are indifferent, not relevant to opinion/attitudes f.e. Would you advise her to eat more healthy ? Only three statements are expected to measure opinions/attitudes : statement 1 (You would be happy to have this patient on your list) and 2. (She arouses your sympathy). In conclusion: how can valid results be expected if no valid method of measurement is used ?

Implications for training

The authors' suggestion for future research (to use another educational method : autobiographical case studies to reduce stigmatization of the mentally ill patients by health professionals) is doubtful. The limitations of any method to change attitudes (including medical education) are well documented. Attitudes are established in early childhood due to families' and societies' attitudes. There is however literature about changes in professional behavior. More concentration on

*"Careful: work in progress!"
Experimenting with e-tutorial*

Reviewer Yvonne van Leeuwen

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

Summary

The authors give 12 tips to colleagues who plan e-tutorials on the basis of portfolio-learning. Each tip is soundly based on realistic arguments and personal c.q. common experience. The tips are clear and easy to implement. They should be part of a handbook for e-portfolio learning and assessing.

Comments

Real research-evidence on the effectivity of e-tutorial is inevitably not abundant, because it is still scarcely available. Although the authors are fully aware of the danger of the portfolio-hype, there may be even more fundamental questions concerning value and implementation. For example: Do we have enough evidence that portfolio-learning effects/changes learning in the individual? Is it not only visualizing what was already there? If so, we should regard it and use it in another way.

Some say that women have more advantage of the portfolio system than men, because of their greater verbal expression culture. To me that seems very plausible. Men normally dislike this sort of 'exercise'. Would it be possible to use the portfolio only in the atmosphere: proud to be assessed? So: let the student boast of all he/she does well. The variety in products may make them think. Pass/fail assessment is

done by other means, in this option. My personal impression is that this medium is very good for the very good student, for others much less. I would very much like to see refined research on this subject. Nevertheless: the authors contribute very much to better use of portfolio-learning.

Developing medical professionalism by studying contemporary sociological literature?

Reviewer Monica Lindh

Martimianakis MA, Maniate JM, Hodges BD. Sociological interpretations of professionalism. Medical Education 2009;43:829-837.

Summary

This paper reviews a range of approaches used in sociology, from the 1920s and onwards. The approaches include professionalism "as a list of traits and behaviours", "as a role played in society", "as a social construction" and "as means and affect of social control". Medical educators primarily frame professionalism as a list of characteristics or behaviours. But a focus on this alone is insufficient as a basis on which to build further understanding of professionalism. Sociologists have argued that focusing on any normative definitions of professionalism (trait-based, behaviour-based or role-based) leads to an over-emphasis on codes of behaviour and misses the influences of context, institutions and socio-economic and political concerns in the creation of the definitions. Freidson E, for example, showed that the culture and values of the institutions in which a new graduate doctor practised were much more important determinants of his

or her professional behaviour than the training he or she had received in medical school. A central question concerns whose standards students are conforming to. The most significant issue concerns not what constitutes professionalism, but who is able to decide on the definition and why.

There is a growing awareness that professionalism is too complex to be reduced to a simple checklist of characteristics and behaviours. Instead we can think about professionalism as something that is socially constructed in interaction.

Teaching professionalism should make clear that the construct of professionalism is central to the identity of the doctor; that factors constituting professionalism are not static; it is a nexus of power with dimensions of gender, race and class; and that actions of professionals have far-reaching consequences.

A conclusion is that contemporary sociological literature on professionalism should have greater prominence in medical education.

Comments

This is an interesting paper from the Wilson Centre for Research in Education and Departments of Paediatrics, Medicine and Psychiatry, University of Toronto, Ontario, Canada. The paper starts with "a common clinical scenario" in which a doctor performs a vaginal examination in an open hallway in the emergency department of a hospital. The following discussion and the historical review of approaches to professionalism used in sociology, relate to the case-study. Although it describes a clinical situation far from family medicine practice and the principles of family

medicine, this paper is still valuable for learning family medicine.

Implications for training

In agreement with the authors it is clear that contemporary sociological literature ought to be more emphasized in medical education, especially in the field of family medicine. This paper could be used in discussions/coursework on issues such as development of professionalism, both at undergraduate- and postgraduate level.



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".

4-7 July 2012

Europe Regional Conference
2012 Vienna, Austria

WONCA – World

25-29 juni 2013

"Care for generations"
Prague Czech Republic

EGPRN

19-22 May 2011

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

13-16 October 2011

Krakow, Poland
Theme: *"Infectious Diseases in
Primary Care; Managing the
interface between the person and the
community"*. Deadline to send in
abstracts: 30 June 2011

AMEE

27-31 August 2011

AMEE 2011,
Vienna, AUSTRIA

25-29 August 2012

AMEE 2012
Lyon, FRANCE

9-13 March 2012

OTTAWA conference on
assessment of medical
competence
Kuala Lumpur, Malaysia



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