



The EURACT Medical Education Conference 2018

September 21st-22nd 2018

**“Family medicine education in the real world:
from theory into practice”**

ABSTRACT BOOK



Table of contents

Preface	3
About this conference	4
Program overview	5
Oral communications	7
Session 1	8
Session 2	13
Session 3	19
Session 4	24
Session 5	30
Session 6	36
Session 7	40
Workshops	
Session 1	46
Session 2	50
Session 3	54
Session 4	58
Session 5	62
Session 6	66
Session 7	69
Posters	73
Keynote lectures	108
Euract Prices and the Prof. Jan Heyrman Award.	109
Index	110
About ACHG	112

Preface

I would like to welcome you on behalf of the European Academy of Teachers of Family Medicine/General Practice [EURACT] to our second educational conference. This is being held in collaboration with the Academic Department of Family Medicine of the Katholieke Universiteit here in Leuven and is part of the Department's celebration of its 50th anniversary.

The conference organising committee is delighted with the response to the call for abstracts. There is a wide range of abstracts and they address all the conference themes. You will find that the programme reflects the breadth of work being done across Europe and will highlight not only the many things we have in common, but also the difficult challenges facing some of our colleagues.

EURACT exists “to foster and maintain high standards of care in European General Practice by promoting general practice by learning and teaching”. The EURACT courses for teachers of Family Medicine are run regularly and are well attended. In addition we are aware of the importance of continuing to question everything that we do as teachers, following the maxim: *Teaching without testing is like cooking without tasting*. Through these biannual conferences, EURACT recognises the importance of supporting and disseminating the good educational research being done in Family Medicine.

I would like to thank Professor Jan Degryse and his colleagues at the Academic Department of Family Medicine of the Katholieke Universiteit Leuven for hosting this conference and for the generous provision of administrative support. The conference would not have been possible without them.

The conference offers you an opportunity to meet colleagues and exchange ideas, and we hope will help you to continue the development of Family Medicine Education in your own country.



Jo Buchanan
President EURACT

About this conference

The European Academy of Teachers in General Practice (EURACT) is originated in 1974 within the Leeuwenhorst Group. In 1992 the EURACT was established to “foster and maintain high standards of care in European General Practice by promoting General Practice as a discipline by learning and teaching “. Within a turbulent period in Leuven with demonstrations, strikes and police interventions the Academic Centre of General Practice (ACHG) was born in 1968 at the KU Leuven. We train medical students and general practitioners and provide support to all healthcare stakeholders. We will play an innovative and prominent role in the policy and organization of care in Belgium and the world at large, with the aim of offering patients qualitative and respectful care in a healthier society. Through innovative education at different levels, undergraduate and postgraduate, we try to improve the quality of our medical students and general practitioners. Together with all Flemish speaking universities we made a curriculum for more than 900 general practice trainees to maintain a high level of education and quality of care in Flanders.

One of our predecessors, Prof.Dr.Jan Heyrman was the director of the ACHG, KU Leuven for more than 20 years and as the editor, responsible for the first educational agenda of EURACT in 2005. For many years the EURACT was hosted at our university. Given these many similarities we are very proud to welcome all the participants at our university and town full of history. As the Englishmen would say: The EURACT is coming home”.



Professor Bert Aertgeerts,
director of the ACHG, KU Leuven

Friday the 21st of September

Session Overview			
Date: Friday, 21/Sep/2018			
8:15am - 5:00pm	Registration desk: Registration desk is open during the whole conference		
9:05am - 9:50am	Keynote Lecture 1: Teaching and learning Evidence Based Medicine in General Practice Location: Auditorium BMW2 Prof. Roger Damoiseaux - Universitair Medisch Centrum Utrecht (The Netherlands)		
10:00am - 11:15am	Oral presentations 1: Novel teaching models and learning experiences Location: Auditorium BMW2 Chair: Adam Windak	Workshop 1.1. Location: Room Hippocrates 1 <i>Structured feedback workshop.</i>	Workshop 1.2. Location: Room Hippocrates 2 <i>Self-determination theory in practice: how to motivate your students</i>
		Workshop 1.3 Location: Room Hippocrates 3 <i>Hackathon: Let's hack complex health problems in an interprofessional team together with patients. How to implement this in our daily professional practice.</i>	Workshop 1.4 Location: Room Hippocrates 4 <i>Training GPs to improve triggering and delivery of palliative care in the community: use of active learning methods, and educational material based on core competencies in primary palliative care</i>
11:15am - 11:45am	Coffee & poster viewing		
11:45am - 1:15pm	Oral presentations 2: Curriculum development and evaluation Location: Auditorium BMW2 Chair: Nele R.M. Michels	Workshop 2.1 Location: Room Hippocrates 1 <i>Training Programme for GP Mental Health Consultations in Islamic Culture.</i>	Workshop 2.2 Location: Room Hippocrates 2 <i>The clinical examination: an opportunity to teach clinical reasoning to medical students.</i>
		Workshop 2.3 Location: Room Hippocrates 3 <i>Establishing and integrating Health Promotion in core medical curricula: the implementation challenges and opportunities</i>	Workshop 2.4 Location: Room Hippocrates 4 <i>How do we keep our GP trainee's resilient and work engaged? Framework and tools to optimize their resilience and well-being at work.</i>
1:15pm - 2:00pm	Lunch		
2:00pm - 2:30pm	Keynote Lecture 2: Generic Competencies: Translating words into actions Location: Auditorium BMW2 Dr. Meiling Denney, Chief Examiner for the Royal College of General Practitioners' MRCGP licensing exam in the UK		
2:45pm - 4:00pm	Oral presentations 3: Teaching about care for older people Location: Auditorium BMW2 Chair: Ruth Kalda	Workshop 3.1 Location: Room Hippocrates 1 <i>Family Medicine and Primary Care at the Crossroads of Societal Change.</i>	Workshop 3.2 Location: Room Hippocrates 2 <i>A practice format of proficiency testing for admission to the postgraduate family medicine education</i>
		Workshop 3.3 Location: Room Hippocrates 3 <i>Creating a mindful practice. How to teach and practice mindfulness in family medicine.</i>	Workshop 3.4 Location: Room Hippocrates 4 <i>Data through the looking glass: a focus group discussion on how audit and feedback can add to continuing professional development.</i>
4:00pm - 4:30pm	Tea & poster viewing		
4:30pm - 6:00pm	Oral presentations 4: Multiprofessional teaching and learning Location: Auditorium BMW2 Chair: Jo Buchanan	Workshop 4.1 Location: Room Hippocrates 1 <i>How to train a General Practice clinical trainer to become a skilful role model?</i>	Workshop 4.2 Location: Room Hippocrates 2 <i>Introducing clinical reasoning in (under-)graduate training: discussion of experiences and future.</i>
		Workshop 4.3 Location: Room Hippocrates 3 <i>The best possible curriculum in family medicine for Europe.</i>	Workshop 4.4 Location: Room Hippocrates 4 <i>Using quality improvement projects to develop potential leadership skills of learners in the workplace – an example of an educational intervention in GP training</i>

Saturday the 22nd of September

Date: Saturday, 22/Sep/2018				
9:00am	Debate: Three years or five years of speciality training in Family Medicine?			
-	Location: Auditorium BMW2			
9:30am	Chair: Nele R.M. Michels			
-	Organized by The EURACT ST committee			
9:40am	Oral presentations 5:	Workshop 5.1	Workshop 5.2	Workshop 5.3
-	Selected topics of interest	Location: Room Hippocrates 1	Location: Room Hippocrates 2	Location: Room Hippocrates 3
11:10am	Location: Auditorium BMW2	Educational training requirements in Europe, fine-tuning the content of a EURACT document.	Workplace based assessment of clinical communication in General Practice.	Teach as a leader... Lead as a teacher...
-	Chair: Mario R Sammut			
11:10am	Coffee & poster viewing			Workshop 5.4
-				Location: Room Hippocrates 4
11:30am				Patient, clinical expertise and evidence: on teaching and learning EBM in practice.
12:45pm	Oral presentations 6: Career planning of students, empowering trainers and self care for trainees and trainers.	Workshop 6.1	Workshop 6.2	Workshop 6.3
-	Location: Auditorium BMW2	Location: Room Hippocrates 1	Location: Room Hippocrates 2	Location: Room Hippocrates 3
Chair: Denise Alexandra Cunha Velho	Blended learning material in family medicine education - now!	How to teach Active listening?	Video-training family medicine education: get more out of it!	
12:45pm	Lunch			
-				
1:30pm				
2:45pm	Oral presentations 7: Miscellaneous topics	Workshop 7.1	Workshop 7.2	Workshop 7.3
-	Location: Auditorium BMW2	Location: Room Hippocrates 1	Location: Room Hippocrates 2	Location: Room Hippocrates 3
Chair: Martine Granek-Catarivas	Awareness on Burnout.	Cinema-education: Teaching medicine in the real world using films.	Leadership training in family medicine.	
2:45pm	Keynote Lecture 3: Teaching Family Medicine in the real world: The view from Three Continents			
-	Location: Auditorium BMW2			
3:30pm	Prof. Yonah Yaphé School of Health Sciences of the University of Minho in Portugal			
3:30pm	Closing ceremony			
-	Location: Auditorium BMW2			
3:45pm	Awards for the best presentations and posters.			

Oral presentations

01.01 A training game for family physician students: educational project report

Van Rossem Inès¹, Devroey Dirk², De Paepe Kristien³, Puttemans Francis⁴, Petit Pascale⁵, Schol Sandrina⁶, Deridder Sander⁷, Vandevoorde Jan⁸

^{1 2 6 8} Department of Family Medicine and Chronic Care, Vrije Universiteit Brussel, Laarbeeklaan 103, B-1090 Brussels, Belgium

^{3 4} Department of Pharmaceutical Sciences, Vrije Universiteit Brussel, Laarbeeklaan 103, B-1090 Brussels, Belgium

⁵ Study Guidance Centre, Vrije Universiteit Brussel, Laarbeeklaan 103, B-1090 Brussels, Belgium

⁷ Department of Chemical Engineering, Vrije Universiteit Brussel, Pleinlaan 2, B-1050 Brussels, Belgium

Background

Medical schools have a growing interest in making pedagogical shifts in their curricula, using new learning tools, such as skills labs, small-group sessions, etc. On a different note, some students feel that they are not fully prepared for real life practice at the end of their studies. Simulation-based medical education (SBME) could form a pedagogical approach for this problem [1].

Aim

A SBME training game based on the Groningen Institute Model for Management in Care Services (GIMMICS) [2] was introduced in the curriculum at the Department of Family Medicine at the Vrije Universiteit Brussel in 2010. The aim of the game is to prepare medical students for their complex tasks as family physicians, based on the CanMEDS framework [3], by addressing and integrating each and all of the seven roles.

Methods

GIMMICS is a training game that simulates real life situations, in a structured and supervised setting, offering students the possibility to practice clinical, practical and communicational skills. At the premises of the university, students specialising in Family Medicine install and manage their own group practices. They hold consultations with simulated patients, participate in several assignments and collaborate with pharmacy students. A specific assessment model for the students was developed.

Results

Feedback sessions showed that the training game is well-received by students and considered as very useful but intensive by staff members. A self-assessment questionnaire filled out by the students, comprised of 23 questions on major aspects of the seven CanMEDS roles, showed significantly higher scores at the end of the game for 21 questions ($p < 0.05$, Wilcoxon signed rank test).

Conclusion

GIMMICS can be a valuable linking pin between the different learning methods in medical education and clinical practice, helping students to improve themselves in the CanMEDS roles. However, simulation-based medical education requires a significant time and resource investment.

References

- [1] Okuda Y, Bryson EO, DeMaria S Jr, et al. The utility of simulation in medical education: what is the evidence? Mt Sinai J Med. 2009;76:330-43.
- [2] GIMMICS: Groningen Institute Model for Management in Care Services. Accessed February 4, 2018.
- [3] Frank JR, Danoff D. The CanMEDS initiative: implementing an outcomes-based framework of physician competencies. Med Teach. 2007;29:642-47.

01.02 GP STAT: A General Practice Standardised Teaching Assessment Tool for Small Group Learning

O1

Rory Stewart¹

¹School of Medicine & Biochemistry, Queens University Belfast, 97 Lisburn Rd, Belfast BT9 7BL, UK

Background

Small Group Work is a commonly used teaching method which is now ubiquitous across different fields of teaching including General Practice (GP). It has a broad structure which takes many different forms. General practice teaching has become more dynamic and recent times have seen a move towards a focus on a small group structure to learning.

Good quality teaching is important for trainee doctors. It is necessary to allow them to build on their skills and develop new skills within the context of the overall goal of improved patient outcomes.

Good teaching requires teachers to reflect and receive feedback. The importance of this is fundamental in improving their teaching skills, while helping them adapt their teaching style in a manner that is suitable to the group. There is a move towards quality assurance in all fields of Medicine. Medical education now faces the need to adapt to this in order to gain validation so as not to remain quiescent.

Aim

As such, this study set out to develop a teaching assessment tool for small group work in general practice teaching – GP STAT (General Practice Standardised Teaching Assessment Tool).

Method

The tool was based on the evidence taken from the literature, which was synthesised by an experts panel of Medical Educationalists (using a modified Delphi process) in order to form a unique, purpose built, teaching evaluation tool for small group work in GP training.

Results

The modified Delphi process resulted in consensus around a list of 25 small-group teaching assessment outcomes for general practice. They were grouped into 8 themes. This was formulated into a tool - the GP STAT evaluation tool.

Conclusion

This may prove to be an invaluable tool for GP training schemes seeking to evaluate their teaching practices in the future.

01.03 Diagnostic reasoning in medical undergraduate curriculum: good practice of an instructional strategy

Van Royen Paul, Adriaenssens Niels, Coenen Samuel, Debaene Luc, Van Peer Werner, Van Puymbroeck Hugo, Van den Ende Jef

Department of Primary and Interdisciplinary Care, Faculty of Medicine and Health Sciences, University of Antwerp, Antwerp, Belgium

Background

In the diagnostic process we distinguish three phases: the initiation phase requiring communication skills, the refinement phase and the final definition phase requiring more analytical tools. Diagnostic reasoning and subsequent medical decision making is a core competence for all future physicians, that should be taught in an integrated way throughout the medical undergraduate curriculum.

Aim

To integrate an instructional strategy to improve undergraduate students' diagnostic reasoning competence in the medical undergraduate curriculum.

Methods

We have developed an instructional strategy based on a three step model: 1. from reason for encounter to diagnostic panorama, 2. from diagnostic panorama to diagnosis, and 3. from diagnosis to threshold action. It uses visuals: a diagnostic panorama displays the differential diagnosis, and a diagnostic diagram displays the diagnostic reasoning process, and rather than math, uses language built on eight concepts: a diagnostic panorama, pre-test and post-test probability, confirming and excluding diagnostic findings, power of diagnostic findings, (a)symmetry of findings, categories of power, the diagnostic diagram and thresholds. We gradually integrated the strategy into the medical undergraduate curriculum, first in the senior (master) and recently in the junior (bachelor) years.

Result

To date the instructional strategy has been integrated in different modules of the Antwerp undergraduate medical curriculum for almost ten years. Currently an introduction and 3 seminars are given to the 3rd year bachelor students (9 hours). In the 1st and 2nd master year, the model is applied in problem-oriented teaching workshops and in seminars to address diagnostic errors, respectively. The model is also integrated in the communication and consultation skills training throughout the medical curriculum. We also developed a handbook¹ and online learning platform.

Conclusion

This instructional strategy provides a stepwise learning approach to medical diagnostic reasoning. It takes the advantages of a prescriptive, rather than a normative or descriptive model. Students and practitioners are encouraged to adopt the model and to apply it when appropriate, e.g., to overcome cognitive biases and acknowledge the factors influencing thresholds to different (diagnostic) actions.

References

[1] Van den Ende J et al. Klinisch redeneren - van model naar competentie. Acco 2018. ISBN 9789463447133

O1.04 Supporting students with Electronic Health Record-embedded learning aids: A mixed method study

O1

Sanne Peters¹, Geraldine Clarebout^{2,3}, Bert Aertgeerts¹, Jimmy Leppink², Ann Roex¹

¹Academic Center for General Practice, Department of Public Health and Primary Care, KU Leuven, Kapucijnenvoer 33, 3000 Leuven, Belgium.

²School of Health Professions Education, Maastricht University, Universiteitssingel 60, 6200 MD Maastricht, the Netherlands

³Center for Instructional Psychology and Technology, KU Leuven, Dekenstraat 2, 3000 Leuven, Belgium

Background

Students often perceive workplace-based learning as disconnected from what they learn in medical school. Interventions that deal with this issue regularly involve feedback and/or learning aids. Feedback has frequently been encouraged in previous research, while the use of aids is less understood.

Aim

This study aims to investigate the added value of learning aids in making the connection between medical schools and workplace-based learning.

Methods

First-year students in post-graduate general practice training participated in a mixed method study. Within a quasi-experimental design two conditions were investigated: (1) Students having access to Electronic Health Record (EHR)-embedded learning aids and feedback and (2) students only receiving feedback. Interviews were also conducted.

Results

Students used the aids frequently and found them useful. They appeared to stimulate transfer of learning, self-confidence, reflection and interaction between student and supervisor. Given that the aids were familiar to students and contained practice-based instructions in easily accessible format, they were perceived as feasible to use during workplace-based learning. Yet, no significant difference was found between the two conditions.

Conclusion

Access to EHR-embedded learning aids seemed to offer additional support during, but also before and after, patient encounters. The aids can be easily implemented into workplace-based learning.

01.05 Continuity of care and chronicity in medical student's experience: "adopt" a chronic patient

Bonfatti Marco¹, Preci Cecilia¹, Padula Maria Stella¹, Romani Alessandra¹, Fiandri Paola¹, Venturelli Antonio¹, Aguzzoli Martina¹, Garuti Caterina¹, Andreoli Mimmo¹, Corbelli Luca¹

¹University of Modena and Reggio Emilia, Via del Pozzo 71, 41124 Modena, Italy

Background

Chronicity is nowadays one of the most frequent aspects doctors have to deal with. In the complexity of their disease, chronic patients require a continuative approach, not only pharmacological, aimed at the relieve of daily symptoms, that seems achievable by the integration of continuous-care intervention with a multi-professional support.

Aim

The purpose of the project is to make the students know, understand and learn the clinical, relational, social and managerial aspects of chronicity and changes that the disease causes in patient, family and in the doctor himself.

This has become possible inserting the student in a territorial environment for a long period, making him try different dynamics, and complexity of management. Particular attention is placed on social, familiar and psychological aspects, often neglected by health professionals.

Methods

The project was born in the University of Modena and Reggio Emilia, within the course of family medicine. At their 3rd year students can voluntarily join the project, that will be completed at their graduation. Students are followed by a Family Doctor, in taking care of "their" patient and of his family: during the ordinary visits; during meetings with health professionals and people involved in patient assistance and in hospital, in case of hospitalization. It is asked to keep an updated diary, participate at the periodical revision of the clinical story and write an end-report.

Meeting with tutor	Key messages	reflections
Meeting with family and patient	Key messages	reflections
Meeting with health professionals	Key messages	reflections
Trimestral debriefing with tutor	Key messages	reflections
Trimestral debriefing with tutors and students	Key messages	reflections

To facilitate the observation and the updating of data, it has been prepared a logbook with precompiled check lists and tables and guided moment of reflection. Everything is discussed during moment of debriefing with other students and tutors.

Results

At the end of the 2nd year of the project, the participating students have analysed data of their work. Clinical evolution of the disease, mental and body changes and the diagnostic and therapeutic future planning have been shown trough the narration of living experiences.

Conclusions

A prospective change in the student's thought seems to be achievable through a continuous training guided by tutor. The acquisition of the importance of a continuous relationship and of the figure of the doctor as therapy is the main goal. Although, the project also aims to teach the conduct of a more human medicine to the future physicians and to improve the skills needed in a complex and delicate relational environment including that of chronic disease.

02.01 Designing a curriculum to address barriers and facilitators to integrating Physician Associates into the General Practice workforce: a grounded theory approach.

Benjamin Jackson¹, James Gray², Michelle Marshall³

^{1,2}Academic Unit of Primary Medical Care, University of Sheffield Samuel Fox House, Sheffield S57AU.

³Academic Unit of Medical Education, University of Sheffield, Beech Hill Road, Sheffield S102RX

Background

Workforce capacity has created problems accessing family practice (FP) in the UK with Physician Associates (PAs) seen as part of the solution (1). How effective this will be is unclear. To inform curriculum development for our PA course, a grounded theory study of stakeholder opinion was undertaken

Aim

To investigate the barriers and facilitators to the integration of Physician Associates into the General Practice workforce

Methods

Stakeholder interviews informed a theoretical framework tested with Family Practitioners (FPs), Advanced Nurse Practitioners (ANPs) and Patients (Pts). Emergent themes generated a final conceptual model used to inform curriculum design [Figure 1].

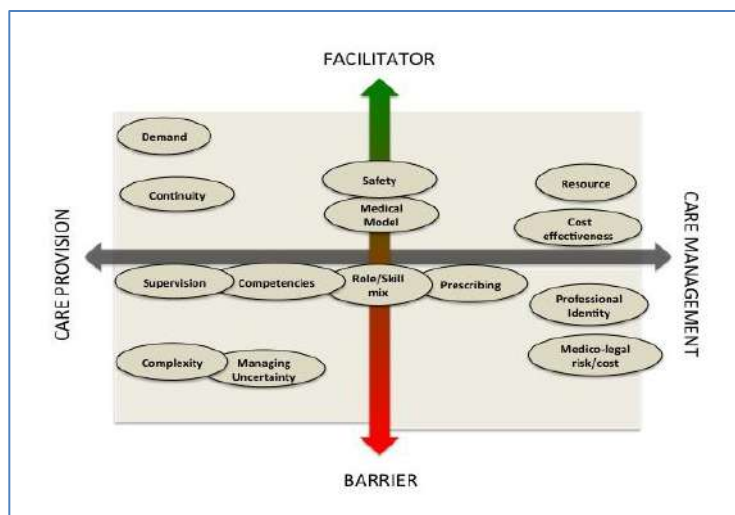


Figure 1: Conceptual Model of the Barriers and Facilitators to the integration of PAs into the FP workforce.

Results

FPs expressed concerns about PAs managing medical complexity and uncertainty, non-prescriber status, supervision and medico-legal implications. Pts were unconcerned as long as supervision was arranged. ANPs reflected on their experiences and the need to support PAs against prejudicial attitudes.

Conclusion

Contextual factors were found as both barriers and facilitators to the integration of PAs into FP in our region. A conceptual model is presented with a discussion of potential curricula adaptations and wider implications.

References

- [1] Health Education England - Primary Care Workforce Commission. The future of primary care Creating teams for tomorrow. 2015.

02.02 How do Dutch trainees judge the quality of their GP speciality training program?

Simon van Grootheest¹, Bastiaan van Nieuwenhuizen², Ronald Batenburg^{3,4}, Elize Vis³

¹GP speciality training, Radboud university medical centre, Nijmegen, the Netherlands

²GP speciality training, Academic Medical Centre, Amsterdam, the Netherlands

³ Netherlands Institute for Health Services Research, Utrecht, the Netherlands

⁴ Department of Sociology, Radboud university, Nijmegen, the Netherlands

Background

Since 2004 every few years the NIVEL (Netherlands institute for health services research) investigates how Dutch trainees value their training program. The results provide rich data about the satisfaction of GP trainees and the strengths and points of improvement of the Dutch training program. This program usually exists of two years in general practice and one year in hospital, chronic care and psychiatry with one release day each week.

Aim

To investigate how Dutch trainees value their GP speciality training program and what they think could be improved.

Methods

An online questionnaire was sent to all Dutch trainees in the first months of 2018.

Results

After a short introduction about the Dutch GP speciality training program we will present the results of the questionnaire. The results are at this moment preliminary and have not yet been published, but will be at the conference. We know from the former evaluations that most GP trainees value their training as good or very good. We will explain which aspects of the training scheme contribute to this positive evaluation and what aspects need further improvement in the view of trainees. This trainee-based information can be very interesting for GP training schemes in other countries.

Conclusion

GP trainees in the Netherlands are very positive about their training program but there is also room for improvement. Other training programs can profit from this information.

02.03 The active role of patients in university formation and care management: the Modena experience

O2

Maria Stella Padula¹, Francesca Rossi¹, Gabriele Amati¹, Andrea Balbarini¹, Francesco Rioli¹, Luca Antonini¹

¹Corso integrato di Medicina Generale e Cure Primarie nel corso di laurea di Medicina e Chirurgia, Dipartimento di Scienze Biomediche, Metaboliche e Neuroscienze - Via Campi, 287 - 41125 Modena, Italy

Background

Nowadays new therapies have increased life expectancy and consequently the number of chronic patients. Moreover, there is strong evidence that between 50-80% of patients do not respect their prescribed treatments.

From this data, it seems obvious the need to increase the trust in the physician. The University of Montréal, for this reason, has decided to act from the initial training of medical students through the introduction of patient-partners during university lessons. Drawing inspiration from this innovation, the University of Modena and Reggio Emilia has also introduced patient-partners.

Aim

The aim of this study is to evaluate the impact of patient-partners on medical students in the university of Modena and Reggio Emilia.

Methods

In 2016, 15 chronic patients were recruited following specific criteria. The patients began an educational programme in order to learn the correct way to communicate their disease experience to medical students (Figure 1). In 2017 the third year's Family Medicine lessons were organized with the participation of both the teacher and the patient-partner. At the end of the lessons the students (n=39) were given a satisfaction survey to evaluate the impact of this new approach.

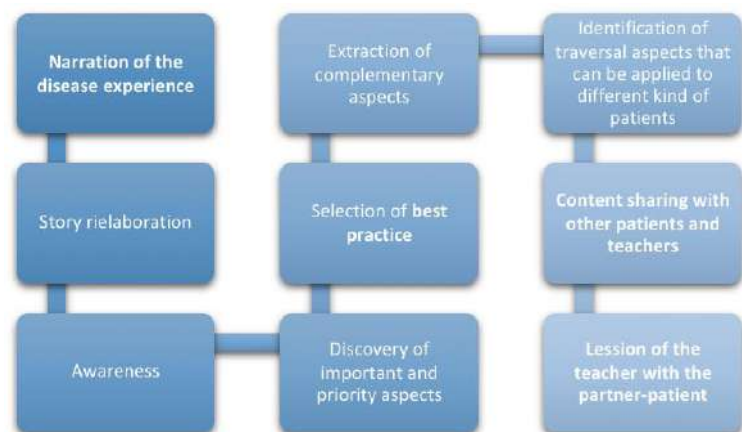


Figure 1: flowchart of patient-partners formation.

Results

The surveys showed that:

→ Students believe that the participation of the patient-partner has taught communicative and relational aspects (94,5%);

→ The presence of the patient was useful to recognize and respect patients' experience and perception (56,4%), as it addressed aspects different from clinical to biological ones (28,2%) and because the patient's story was a real experience (12,8%);

→ The participation of the patient was useful to improve the clinical and relational approaches by acquiring the patients' point of view (30,8%), by establishing the priorities based on the patient's necessities (12,8%), by learning the aspects that can reduce the therapeutic compliance of the patients (12,8%) and by learning the patient's expectations (12,8%);

→ The majority of students have appreciated the presence of the patient-partner during the lesson (Average Assessment: 3,9/5,0) and the method used (Average Assessment: 4,1/5,0).

Conclusion

These results suggest that this new way of teaching could complete the formation of the future physicians.

02.04 How to attain better supervision for residents in primary health care- A regional plan in process

Eva de Fine Licht¹, Christina Vestlund¹, Karin Hed ²

¹Family Medicine Residency Program Directors Unit, Research and Development Center, Södra Älvsborg, Sven Erikssonplatsen 4, 503 38 Borås, Västra Götaland Region, Sweden

²Family Medicine Residency Program Directors Unit, Research and Development Center, Södra Bohuslän

Background

In 2015 Sweden got a New National Regulation for Doctors' specialist medical training issued by the Swedish National Board of Health and Welfare (Socialstyrelsen). These new regulations contained enhanced assessment and documentation requirements. Supervision should be continuous as support and guidance, based on the curriculum. The supervisor should have specialist training in Family Medicine, be trained as a supervisor and should serve in the same clinic as the resident. Supervisor should assess the resident's skills continuously. The analysis should be known in advance and be performed with agreed methods. The assessment should be documented and form the basis for the certification as specialist in family medicine. Shortcomings should be addressed.

Aim

Our aim was to find out what our trainees and supervisors felt was good supervision and how the new regulation could be part of this. Also how we as directors of clinical education can support them. Furthermore we aimed to formulate Regional routines according to our findings, to produce a common "tool-box" for assessment and educate our supervisors and trainees in these methods

Methods

Directors of clinical education in two areas in Västra Götaland Region collaborate in this study. Altogether 186 residents and 120 supervisors in Family Medicine are included. A Delphi Process was used as means of investigation. Residents and supervisors receive the same two questions:

1. Which elements are included in a good tutoring?
2. What elements do you think your supervisor further needs to improve / you as a tutor need to improve in supervision?

Results

In our "top ten" elements of good supervision both trainees and supervisors stressed the need of assessment, feed-back and structure. We could accordingly feel safe to introduce the enhanced assessment and documentation requirements stipulated by Socialstyrelsen without resistance and we followed our aim to educate the region in the new methods. All Directors of Clinical Education in the region took part in this work.

Conclusion

When introducing new routines and tasks it is preferable if you can engage the trainees and supervisors from the beginning and show that the enhanced structure meets a felt need among them.

02.05 Design, development and implementation of a 5 week family medicine course for undergraduate medical students

Dominique Manhaeve¹, [Jan De Lepeleire](#)¹, Mieke Vermandere¹, Sylke Van Dierdonck¹, Carmen Claeys¹, Marc Van Nuland¹, Martine Goossens¹, Bert Aertgeerts¹, Birgitte Schoenmakers¹

¹Department of Public Health and Primary Care, KU Leuven, Kapucijnenvoer 33, 3000 Leuven, Belgium.

Background

Undergraduate medical education in Belgium has recently been transformed from a 7 to a 6 year program according to the European agreement on master programs. This transformation resulted in the development of a new credit course for students (6th year of basic training) applying for the family medicine advanced master program.

Aim

The aim was to develop a course preparing students within a limited time frame for the first day of the family medicine internship. The course is evaluated by measuring students' perceived and factual level of "preparedness": how prepared do they feel and how well do they master the starting goals.

Methods

The course was designed following the four-component instructional design (4C/ID) model, and was developed by the teaching staff according to the plan-do-check-act (PDCA) cycle. Detailed student and teacher feedback on the course content is obtained after completion for each student group and monitored by a steering committee. Students are surveyed on their perceived level of "preparedness" using a validated questionnaire at different intervals. The GP trainers are questioned on the level of preparedness of the GP trainees shortly after starting the internship. In addition, the result of the proficiency test for the advanced master's program is compared with the uptake of the credit course.

Results

Approximately 60 students have already completed the blended learning course consisting of 3 themed modules (figure 1) with increasing complexity. An online learning platform supports the credit course. The platform offers tailored e-learning, completed according to the student's individual learning needs. The building blocks (e-learning, tasks, lectures, workshops and communication trainings) of each course module cumulate in an "integrated consult" session where students integrate knowledge, skills and attitudes in a realistic consultation setting. Students alternate roles (GP, patient, observer) with observers using a specifically designed observation list. Students provide peer feedback and experienced GPs facilitate each session. Preliminary feedback of students and teaching staff is predominantly positive, particularly concerning the integrated consults and students indicate they feel more prepared for their internship.

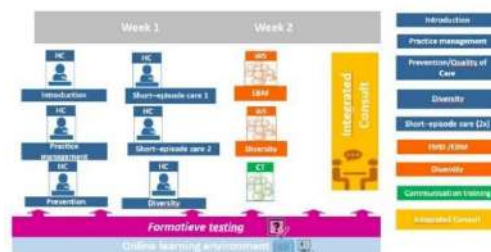


Figure 1: example of a course module

Conclusion

The course is well received and assessment results are continuously being used for its further development.

O2.06 Securing social accountability in family medicine education (includes the presentation of a family medicine curriculum for health equity)

Dominic Patterson¹

¹Health Education England, United Kingdom

Background

This presentation will describe ways in which the education of family doctors can reduce health inequalities and demonstrate social accountability. Social accountability in medical education refers to the concept that the planning and delivery of medical education should address the needs and priorities of the population being served. Work has taken place at undergraduate level describe how medical schools can move towards demonstrating social accountability, but there has been very little exploration of how postgraduate education, particularly in family medicine, can do so. A key part of responding to the health needs of a population is addressing health inequalities. Differences in health outcomes exist between individuals and population groups and in many cases, these are avoidable and unjust. Healthcare systems should work to identify and reduce inequalities and family doctors are at the heart of this. How we plan and deliver education to current and future family doctors has the potential to influence and address such unfair differences in health outcomes.

Aim or research question

How can the education of family doctors be socially accountable?

What do family doctors need to learn in order to tackle health inequalities?

Methods

A literature review will be presented. A Delphi survey was performed which explored the thoughts and opinion of twenty-eight UK based experts, practitioners, and patients. They were initially asked without guidance to describe the knowledge, skills, and attitudes required of practitioners to help reduce health inequalities. From the responses, learning outcomes were drafted and subsequent survey rounds refined these into a final curriculum, which included a list of desirable attitudes, values and characteristics of practitioners.

Results

The final curriculum for health equity will be presented at conference. Incredibly rich data was returned by participants and allowed for the production of a broad curriculum, presented in a concise and accessible form with clear learning outcomes. Practical examples of education to attain social accountability will also be shared.

Discussion and conclusion

Socially accountable medical education can affect and improve patient outcomes. It has the potential to alter the way that healthcare is delivered to disadvantaged groups, improve outcomes for patients, and adds momentum to the growing movement that is advocating for change to healthcare funding and policy to address inequalities.

03.01 Learning with GP Trainees by practice based research - some SAGE advice - experience and results from a project in GP Specialty Training on improving advocacy for people with frailty / complexity in GP Training Practices

Anna Martin¹, Ealga Beary¹, Elizabeth McCarron¹, Leanne Hanrahan¹, Olivia Murphy¹, James Larkin², Pádraig Ruane³, Bibiana Savin³, Claire Collins², Aisling Ni Shuilleabhain^{1,4}

Brendan O' Shea^{2,4}

¹TCD/HSE GP Training Scheme, Institute of Population Health, Tallaght, Dublin 24, Ireland.

²Irish College of General Practitioners, 4-5 Lincoln Place, Dublin 2, Ireland.

³Sage - Support & Advocacy Service, 24 - 26 Ormond Quay Upper, Dublin, Ireland.

⁴Department of Public Health and Primary Care, Trinity College Dublin, Ireland.

Background

Learning by conducting research is valued in medical education^{1,2}. Effective research is complex, requiring a blend of relevant experience, skills and support. Improving care for complex frail individuals is important³. This study describes process and outcomes from a pragmatic study in 5 Training Practices, involving collaboration between ICGP Research, a GP Training Scheme, a University Department of Primary Care, and an NGO agency (SAGE)³ tasked with providing support and advocacy to vulnerable/older adults across a range of care settings including the community.

Aim

The aim of this study was to ascertain if it is acceptable and feasible to establish a referral pathway for complex frail elderly individuals to an agency providing trained advocacy services, in 5 GP Training Practices. A secondary aim was to undertake this as a GP Trainee Study, as collaborative learning, involving several agencies.

Methods

Observational study (n = 28) examining referral of complex frail elderly individuals to a trained advocacy service, ascertaining feasibility and acceptability by look back survey among people referred to the service, and with referring GPs.

Results

During a 6 month period, 28 referrals were made, and reasons for referral noted; 16 referrals were from one practice. High levels of acceptability were evident from those referred to SAGE. Good acceptability was evident among GPs, with 7/9 indicating they would make further referrals.

Conclusions

While aspects of the study were satisfactory, number of referrals was disappointing, with referral patterns uneven among participating practices. Results were encouraging in terms of supporting concept, but the study team were disappointed with aspects of the study. While reassured no negative clinical consequences were observed, the study does not demonstrate convincingly that the concept was sound. At best it might be considered a pilot for a larger study. In terms of study supervision, we conclude closer supervision during the study period, with more consistent feedback, would have increased more appropriate referrals. Effective studies involving GP Trainees are complex, requiring several pre conditions for success. Direct access to trained advocacy services for older frail people appear acceptable, but a further study is required to prove this conclusively.

References

[

A complete list of references can be found on the website www.euract2018.org

03.02 Teaching Geriatric Medicine to undergraduate students on Medical Faculty in Ljubljana Slovenia

Janez Rifel¹, Marko Kolšek¹

¹Department of Family Medicine, Medical Faculty, University of Ljubljana, Poljanski nasip 58, 1000 Ljubljana.

Background

On the medical faculty in Ljubljana a new curriculum for undergraduate students is implementing. In the academic year 2020/21 a new course Geriatric medicine will be presented for the first time in the 6th and final year of medicine undergraduate school.

Aim

Promote integrated, patient-centered care of multimorbid, frail geriatric patients. Prepare future doctors for the challenges in the future.

Methods

Curriculum for the course Geriatric medicine was prepared as a project in Leonardo III Euract course in Malta and Solun, Greece in 2017 and 2018.

Result

Geriatric medicine will have three credits in the 6th year of medical school, which is equal to 90 hours in one semester. Students will attend 15 hours in small group seminars, 30 hours of clinical practice and 45 hours of individual work. Course will be prepared and presented in the cooperation of the departments of family medicine and internal medicine.

Conclusion

Students will acquire knowledge, skills and attitudes of specific geriatric syndromes, coordinated care and working in teams. Paradigm shift from following guidelines to patient-centered care will be most important learning outcome.

References

[1] T. Masud, A. Blundell, A. L. Gordon, K. Mulpeter, R. Roller, K. Singler, A. Goeldlin, A. Stuck, European undergraduate curriculum in geriatric medicine developed using an international modified Delphi technique. Age Ageing, 2014 Sep;43(5):695-702.

03.03 Innovative teaching of geriatrics in Russia: competitiveness, motivation, efficiency

Elena Frolova¹, Anna Turusheva¹

¹Department of Family medicine of North-Western state medical University named after Mechnikov, Kirochnaya 41, ST-Petersburg, Russia

Background

The first and so far only epidemiological study of the health status of the elderly in Russia, Crystal, launched in 2008 and completed in 2013, gave us a clear understanding that health care for the elderly should be improved immediately. Thus, the big amount of GP and nurses should be trained on geriatric in relatively short time.

Aim of research

The aim of the project was to develop a format for a training event that would help to prepare in a short time a group of leaders who can act as teachers and promote the ideas of modern geriatrics.

Methods

We have developed the format of the educational event on the principle of blended learning [1]. The selection of students was based on the competition of applications, which took into account the proportion of older people in the population, served by a General practitioner, his interest in participation, recommendations from peers. The first step of complex event was an online course on comprehensive geriatric assessment, 36 hours of distance learning, included video lectures, video cases, tests. Among those who completed the course with the best grades, 25 people were selected for the free participation in the second stage: an international workshop with teachers invited from different countries. The international workshop also included an online component of the forum discussion, homework, clinical cases discussions (<http://tp.nkonp.ru/forums/>). The evaluation of workshop was made using competency questions with answers on Likert scale [2]. The third stage of the educational event was teaching activity on the work places of participants or in regions, which was registered using the teaching portfolio on the site of Spring School (<http://tp.nkonp.ru/#>).

Results

According to the self-assessment of learning effectiveness, the average score was 50 ± 5 (min-39, max-60) from 65, that means that 83% of materials was efficiently learned. The best learned topics were “unmet needs of the elderly” 93.6%; “assessment of risk of falls” 96.7%; “development of preventive measures for the elderly” 90.7%. Participants pointed as the most difficult for learning: neurological assessment, diagnosis and care of delirium and depression; cognitive disorders – more than 50% were unsure about this topic. We also asked to value the most useful teaching methods. According 97% participants opinion there were clinical cases and homework, The advantages and benefits of forum discussions and video were noted by 65% of participants. Participants of the School, which for two years had 60 people, held 97 training events (seminars, lectures, round tables, conferences), using materials of Schools.

Conclusion

Learning at Spring school in geriatrics was effective because it was linked to practical needs, students have a personal desire to learn, learning process was interesting, active and combined different methods.

References

- [1] Curtis J. Bonk (ed.) and Charles R. Graham. THE HANDBOOK OF BLENDED LEARNING: Global Perspectives, Local Designs. Publisher: *JohnWiley & Sons, Inc.* Pfeiffer March 2006 Pages: 624
- [2] Evaluation Cookbook : A practical guide to evaluation methods Editor Jen Harvey. The Learning Technology Dissemination Initiative is funded by the Scottish Higher Education Funding Council.

03.04 Primary Care Physician and geriatric frailty: definition of a standardized diagnostic method for the assessment of frailty and comparison with other risk stratification tools currently used.

Colucci G, Robusto F, Desiati C, Zamparella M, Anelli F, Lepore V¹.
General Practitioner, ¹NeuroPsichiatria, "Mario Negri".

Background

Frailty is a chronic condition with increased risk of poor health outcomes and progressive disability, high impact on health care and corresponding costs. Risk stratification tools can be useful in screening, but GPs have key role in defining and diagnosis.

Aims of the study

Development SVaFra (standardized method for defining frailty among old population in Primary Care setting), comparison with other risk stratification tools. Evaluation of application SVaFra to clinical endpoints.

Materials and methods

scientific board composed by General Practitioners, biomedical engineers and other health workers identifying 4 critical areas: clinical complexity; disability; family context; managing complexity. 98 GPs of 4 Italian Regions were involved in observational prospective study: they filled a questionnaire expressing 4 critical areas. A subcohort of patients was selected and stratified applying Charlson Comorbidity Index (CCI) and Drug Derived Complexity Index (DDCI) to administrative databases. Health care in population stratified with SVaFra in year after application was confronted with a control population with same clinical and demographic characteristics.

Results

1305 frail geriatric patients were identified (Males 36.0%; mean age 83.1 ± 8.52 years). Most frequent results: moderate-severe clinical complexity (54.4%); managing complexity (47.9%); disability (47.0%); family context (24.9%). GPs noticed severe frailty in 165 patients (12.6%), more highly correlated with clinical complexity and disability. Record linkage with administrative databases was possible in 102 cases. Subcohort results are:

- CCI score >0 was found in 20 patients (15.3% of the frail population selected by the GPs)
- High DDCI score in 88 patients (86.3%)

Finally, health care utilization and costs significantly decreased in selected frail patients compared with general populations with same clinical and demographic characteristics, particularly emergency hospitalizations.

Conclusions

SVaFra is a simple tool in application for screening and assessment of frail patients. CCI has underestimated conditions of majority of selected population, DDCI has shown more accuracy with high score in majority of frail patients. SVaFra lead to a significant decrease of health care cost in emergency hospitalizations. SVaFra can develop relevant diagnostic-therapeutic routes and a careful and proper management of frailty syndrome.

03.05 Brokering between research and care by clinical-scientists in general practice and elderly care medicine

Marie-Louise Bartelink¹, Yvette Baggen², Diede Stevens², Martin Smalbrugge³, Nynke Scherpbier⁴, Roger Damoiseaux¹, Esther de Groot¹

¹Julius Centre for Health Sciences and Primary Care, Department of General Practice, University Medical Centre Utrecht, Utrecht University, Universiteitsweg 100, 3508GA Utrecht, The Netherlands

²Department of Educational Sciences, Utrecht University, Heidelberglaan 1, 3584CH Utrecht, The Netherlands

³Department of Eldery Care Medicine, VU Medical Centre, De Boelelaan 1109, 1081HV Amsterdam, The Netherlands

⁴Department of General Practice and Elderly Care Medicine, Radboud University Medical Centre, PO Box 9101, 6500HB Nijmegen, The Netherlands

Background

Clinician-scientists (CSs), physicians combining clinical practice with research, may act as brokers who perform clinically relevant research and disseminate evidence in clinical practice. There is no data available on CSs in general practice or elderly care medicine brokering activities and the perceived barriers and facilitators. For training in programs installed for CS training more insight about brokering skills needed is important.

Aim or research question

To identify the brokering activities of CSs in GP and elderly care medicine and the barriers and facilitators they come across whilst sharing knowledge and connecting people in the worlds of research and care.

Methods

Qualitative interview study among 17 Dutch CSs. Interview data were audio recorded, transcribed verbatim and thematic interpretative analysis was used to identify themes.

Results

CSs facilitate collaboration between researchers and practitioners. They exchange knowledge on both sides, make use of extensive networks and constantly and actively involve care and research in their daily work. Some barriers and facilitators are at the individual level whilst others are related more to the job context and workplace.

Conclusion

Strengthening awareness of the brokering role of CSs and what they need to function effectively in demanding work settings is important for the future impact on the fields of GP and EM. The skills future CSs need to be effective brokers should be developed or strengthened during CS training. This might enhance the programs currently installed for CS training.

04.01 VPMed: The development of an interprofessional virtual patient

Avtarovska M¹, Sobocan M^{1,2}, Klemenc-Ketis Z^{1,3,4}

¹Faculty of Medicine, University of Maribor, Taborska ulica 8, 2000 Maribor, Slovenia

²University Medical Centre Maribor, Ljubljanska ulica 5, 2000 Maribor, Slovenia

³Ljubljana Community Health Care Centre, Metelkova 9, 1000 Ljubljana, Slovenia

⁴Department of Family Medicine, Faculty of Medicine, University of Ljubljana, Poljanski nasip 58, 1000 Ljubljana, Slovenia

Background

Interprofessional collaboration can offer solutions when addressing the multiple factors that influence individuals, families and communities. Collaboration in health care has been shown to improve patient outcomes. Virtual patients (VPs) as interactive computer-based programs that simulate real-life clinical scenarios, are excellent low-cost educational tools for teaching clinical medicine, developing decision-making and improving clinical competency. Therefore, the use of an interprofessional VP can allow learners to emulate the roles of all health care providers, consider each other's unique perspectives and fields of expertise in making decisions to provide the best patient care.

Aims

To develop an interprofessional VP with a pedagogic value which explains the benefits in treating patients with Diabetes Mellitus type 2 in the primary health care setting throughout collaboration of a nurse practitioner and a family physician.

Methods

Ten undergraduate students from different studying areas (medicine, nursing, psychology, pedagogy and software engineering students) collaborated in the development of an interprofessional VP. Each students' field of approach in treating patients with Diabetes Mellitus type 2 has been considered, roles assigned, analysed and implemented in a detailed and staged scenario for providing quality health care of the VP.

Results

The VP scenario is composed of a step-wise protocol with multiple-choice questions in all steps of examining, diagnosing and treating the patient. The scenario includes common complications in patient treatment also including referral to different medical specialists. The scenario contains videos, photographs, scans and diagnostic results. Each stage has a message for the user, which describes and explains the correct answers in every stage. A score counter is included indicating the current user's score. The VP is developed in Slovenian language.

Conclusion

The VP will be finalized by the end of June, 2018. Health professionals (including medical students, nursing students and interns) will test and evaluate if all the stages covered topics were relevant to everyday patient care. They will evaluate the VP usability, the complexity and level of knowledge gained throughout each stage. An important part of the evaluation is also the perceived benefit of the interprofessional approach in treating the patient.

04.02 An educational module on interprofessional collaboration for family physicians and other health care professionals: development and participant evaluation

O4

Tsakitzidis Giannoula¹, Timmermans Olaf^{2,3}, Callewaert Nadine⁴, Truijen Steven⁵, Meulemans Herman⁶, Van Royen Paul¹,

¹Department of Primary and Interdisciplinary Care, Faculty of Medicine and Health Sciences, University of Antwerp, Antwerp, Belgium

²Department of Nursing and Midwifery Sciences, Faculty of Medicine and Health Sciences, University of Antwerp, Antwerp, Belgium

³HZ University of Applied Sciences, Vlissingen, The Netherlands

⁴Department of Health Sciences, Artesis-Plantijn University College of Antwerp, Belgium

⁵Department of Rehabilitation Sciences and Physiotherapy, Faculty of Medicine and Health Sciences, University of Antwerp, Antwerp, Belgium

⁶Department of Sociology and Research Centre for Longitudinal and Life Course Studies, Faculty of Social Sciences, University of Antwerp, Antwerp, Belgium

Background

Interprofessional collaboration (IPC) is considered a key-factor to deliver the highest quality of care. IPC assumes a model of working together, in particular with awareness of the process of interprofessional collaboration, to develop an integrated and cohesive answer to the needs of the client/family/population. Educational modules are developed in response to a perceived need to improve IPC for the benefit of patientcare. Up until 2005 no explicit module on interprofessional collaboration existed in the education programs of the Antwerp University Association (AUHA).

Aim

To develop a module on IPC in the education programs of future health care professionals and to evaluate it by its participants

Methods

An 'Interprofessional Collaboration in Healthcare (IPCIHC) - module' was developed for future health care professionals: physicians including family physicians, physiotherapists, occupational therapists, nurses, midwives, dieticians, speech therapists, social workers, pharmacists and bachelors in psychology. The curriculum was competency oriented and contained colleges, workshops coached by one teacher and practical sessions for case studies and creation of care plans. One group, post-test design was used to gather data from the participating students using a structured questionnaire. Data was collected from participating final year students in healthcare educational programs.

Results

5381 (84 % overall response) students evaluated the IPCIHC module from 2005 up to 2017. Over 80 % of the participants were convinced the IPCIHC increased their knowledge and changed their understanding that it will impact their future professional relationships, and felt a greater understanding about problem-solving in healthcare teams.

Even though the results indicate that the goals of the IPCIHC module were achieved, less than 60 % of the participants experienced a change in attitude towards other professional groups.

Conclusion

Despite the positive outcomes, the challenge remains to keep on educating future healthcare providers and specifically family physicians in IPC in order to achieve an increased interprofessional behavior towards other professional groups. Research is needed to investigate the effectiveness of undergraduate programs on the quality and safety of patientcare.

References

[1] Tsakitzidis G, Van Royen P. To learn to collaborate interprofessionally in health care. De Boeck 2015 - ISBN 978 90 455 5509 6

04.03 Factors associated with attitudes towards professionalism in medical students at Faculty of Medicine Ljubljana, Slovenia

Polona Selič¹, Anja Černe¹, Davorina Petek¹ & Vesna Homar¹

¹Department of Family Medicine, Faculty of Medicine, University of Ljubljana, Poljanski nasip 58, 1000 Ljubljana, Slovenia.

Background

Due to numerous warnings that lack of professionalism may lead to damaging patients' welfare and health as well as physicians' morale, professionalism is becoming one of the main competencies that all medical students should develop^[1].

Aim

The aim of this study was to explore factors associated with attitudes towards professionalism in medical students and identify if they were mainly associated with basic personal traits (i.e. heredity) or were due to study process (i.e. social learning).

Methods

This is a part of a six-year longitudinal pragmatic research, taking place at the Faculty of Medicine in Ljubljana, Slovenia. In this cross-sectional data collection, a sample of 210 students (of 418 enrolled (50.2%)) in the fourth and sixth year in the academic year 2016/17 voluntarily participated. The big five personality test (BFQ)^[2], the Personal Values List (LOV)^[3] and the Professionalism assessment scale^[4] were administered together with the set of basic socio-demographic data. In multivariate modelling, the association between demographic characteristics, LOV, BFQ and attitudes towards professionalism were analyzed.

Results

There were 66.5% female students who scored significantly higher on attitudes towards professionalism (total PAS score; $M_{\text{women}}=93.4\pm5.1$, $M_{\text{men}}=89.1\pm9.8$, $p=0.001$). Participants significantly differed from Slovenian norms in four of five personality traits, i.e. in Energy ($p<0.001$), Friendliness ($p=0.024$), Emotional stability ($p<0.001$) and Openness ($p<0.001$). The most important preferences declared were self-esteem ($z=0.36$) and freedom/independence ($z=0.32$), the least beauty ($z=-0.35$) and children ($z=-0.49$). In a multivariate modelling, 34.5% of variance was explained ($R^2=0.345$, $F=2.450$, $p<0.001$). Male gender ($\beta=-0.16$, $p=0.038$) and rural origin ($\beta=-0.23$, $p=0.006$) were negatively, friendliness ($\beta=0.34$, $p<0.001$) and the values food ($\beta=0.24$, $p=0.006$), home ($\beta=0.24$, $p=0.009$), work ($\beta=0.19$, $p=0.021$), freedom ($\beta=0.19$, $p=0.021$) and power ($\beta=0.24$, $p=0.006$), respectively, were positively associated with attitudes towards professionalism.

Conclusion

At this phase, attitudes were found to be associated with both, hereditary and social factors, the last ones possibly influenced by study process. Given that, decision makers at the Faculty of Medicine in Ljubljana, were warned to reconsider the curriculum and capacity building in mentors, since interactive learning was widely accepted and recognized as a factor that could affect values and attitudes.

References

- [1] J Papadakis MA, Paaup DS, Hafferty FW, Shapiro J, Byyny RL, Perspective: the education community must develop best practices informed by evidence-based research to remediate lapses of professionalism, *Acad Med* 2012, 87(12), 1694–8
- [2] Caprara GV, Barbaranelli C, Borgogni L, Bucik V, Boben D, Hruševar-Bobek B, Krajnc I, Zupančič M, Horvat M, Model "velikih pet": pripomočki za merjenje strukture osebnosti: priročnik. 3. dopolnjena izd. Ljubljana, Center za psihodiagnostična sredstva 2012
- [3] Pogačnik V: Lestvica osebnih vrednot - LOV : priročnik. Ponatis. Ljubljana, Center za psihodiagnostična sredstva 2013
- [4] Klemenc-Ketis Z, Vrecko H. Development and validation of a professionalism assessment scale for medical students, *Int J Med Educ* 2014, 5:205-11

04.04 Integrated clinical pharmacology and therapeutics for medical students: multidisciplinary approach for flipped classroom using video resources.

O4

JeanLuc Belche¹, Thida Kang¹, Valérie Massart¹, Didier Giet^{1,2}

¹General Practice Department-University of Liège, Belgium

²Institut de Formation et de Recherche en Enseignement Supérieur (IFRES), University of Liège, Belgium

Background

The impact of polypharmacy is well recognized for patients with multimorbidity. Integration of therapeutics from various medical specialties needs to be part of education of each future doctors. Meaningful and active learning activities are well recognized as strong motivators for students. The flipped classroom using video as content delivery was the chosen method.

Aim

To design, implement and evaluate a method of clinical pharmacology and therapeutics (CPT) multidisciplinary learning through a motivating approach for final-year medical students.

Methods

Each CPT lesson followed the same scheme.

Each student:

- visualizes about 15 videos available 15 days before D-day
- participates, on D-day, in:
 - a workshop of 15 students: 3 clinical cases of multimorbidity are discussed followed by 5 multiple choice questions (MCQ) per case, individual answers on an electronic teaching platform
 - a plenary session: answers to MCQ and feedback of a multidisciplinary teachers' team

Videos conformed to a pedagogic-determined format :6 to 9 minutes, talking head with expert, slides in the background. Each lesson was coordinated by a multidisciplinary medical team that reached consensus on each CPT video's topic and feedbacks.

Results

46 experts produced 64 videos. 4 CPT lessons for 200 students targeted 4 domains: pediatrics, geriatrics, internal medicine, women's health medicine. We observed 95% of video visualizations and MCQ answers, heterogeneous attendance at workshop and average attendance of 50% at plenary session without any incentive. Students were highly satisfied about videos, clinical cases and plenary sessions. Lack of time and lack of teacher's consensus during debriefing were seen as weaknesses. Teachers were enthusiastic about creating video supports and participating to whole process of flipped classroom, although time- and money-consuming for the initiation.

Conclusion

The multidisciplinary approach represents an innovative way to tackle complexity of CPT and bringing integrated answers for patient with multimorbidity. The produced framework is an innovative method for participants, generating motivation for students and teachers. Time for effective student's preparation and diversified CPT resources should be introduced according to flipped classroom method.

04.05 Competencies for primary secondary care collaboration, a Delphi study among physicians

Nynke Scherpbier¹, Marijn Janssen², Lia Fluit³, Jacqueline de Graaf²

¹Department of Primary and Community Care, Radboudumc, PO Box 9100, 6500 HB, Nijmegen, the Netherlands

²Department of internal medicine, Radboudumc

³Radboudumc Health Academy, Radboudumc

Background

More and more the overview and management of patients with multimorbidity takes place in primary care. To successfully manage these patients, primary and secondary care physicians require specific collaborative competencies. To successfully develop and implement education between primary and secondary care physicians, essential collaborative competencies should be defined.

Aim

To define essential competencies for collaboration between primary and secondary care physicians, according to the views of physicians.

Methods

We used a Delphi technique to obtain consensus on the opinions of experts, through a series of structured questionnaires. We included GPs and GP trainees and medical specialists and trainees in different specialties. Round 1 was used for idea generation by open ended questions. Answers were analyzed using content analysis on a manifest level with predefined prefixes: knowledge, skills and attitudes. In the second round we provided the participants with a list made of their answers from the first round, organised in groups: 1. knowledge, skills and attitudes for the GP, 2. knowledge, skills and attitudes for the specialist and 3. not directly patient related knowledge, skills and attitudes for both groups. They scored the items on a scale from 1 to 10. This was analyzed using descriptive statistics. For inclusion in the final list consensus was defined as: $\geq 75\%$ scores a 7 or higher and $\leq 5\%$ scores a 3 or lower for exclusion: $\geq 75\%$ scores a 5 or lower and $\leq 5\%$ scores a 8 or higher. We performed T-test and Ancova to determine if opinions between different groups (medical specialists, GPs, trainees) differed. Round 3 was used to gain consensus over the items over which no consensus was reached after round 2. This was analyzed using descriptive statistics. An item was included in the list if more than 50% answered yes. Ethical approval was obtained from the Netherlands Association of Medical Education (nr. 620)

Results

63 participants completed all 3 rounds. It resulted in a final list of 91 items (knowledge, skills and attitudes) that were divided in specific moments (referral/consultation initiated from the GP; treatment in secondary care; discharge from secondary to primary care) and generic skills (roles and responsibilities; professionalism and reflexivity; knowledge about the organization of collaboration; skills and attitudes to promote the organization of collaboration)

Conclusion

A rich list of collaborative competencies was defined by a rigorous approach. This can be the starting point individual learning goals and for on- and off-the-job educational interventions

References

[1] R.A. Green. The Delphi Technique in Educational Research, Sage Open, 2014

04.06 Learning collaboration between primary and secondary care trainees: how to benefit more from primary care trainee hospital placements?

Natasja Looman¹, Nynke Scherpbier-de Haan¹, Esther de Groot², Mariëlle van Wijngaarden³, Lia Fluit³

¹Department of Primary and Community Care, Radboudumc. Geert Groteplein Noord 21 (r149), 6525 EZ Nijmegen, the Netherlands ²Julius Center for Health Sciences and Primary Care, UMC Utrecht. P.O. Box 85060, 3508 AB Utrecht, the Netherlands ³ Department for Research in Learning and Education, Radboud Health Academy Radboudumc. Gerard van Swietenlaan 4 (r43), 6525 EZ Nijmegen, the Netherlands.

Background

The increase in the number of patients with multimorbidity and chronic illness has a direct impact on all health professionals involved with a single patient. Concurrently, healthcare service provision is moved from secondary care to primary care. The transitions at the primary-secondary care interface involve an increased risk of errors. Collaboration between doctors in primary and secondary care is not always effective.^[1] Primary-secondary care collaboration (intraPC) could be enhanced by interprofessional education.^[2] However, the logistics needed to educate trainees from different disciplines together are often a hurdle.^[3] GP-trainees have a six-month hospital placement in their second year. This placement could form a natural workplace setting for trainees from different medical specialties to learn primary-secondary care collaboration through intraprofessional education. It is unknown whether and how learning of intraPC informally takes place during these placements.

Aim

To study whether and how learning of intraPC takes place during hospital placements.

Methods

An ethnographic non-participatory observational study in the hospital during placements to study whether and how intraprofessional learning takes place, followed by in-depth interviews with primary care trainees, secondary care trainees and supervisors from the observations. The interviews focus on how trainees learn concerning IntraPC, what helps, what hinders and where they see chances to learn more about intraPC.

Results

Even in this promising setting where primary and secondary care trainees work together in the same department, IntraPC receives only limited attention as a competency to be learnt. GP-trainees often adjust to the role of Hospital Specialist-trainee and hardly tend to share their primary care knowledge. Engagement is promoted when there is a collaborative culture in the workplace, not too much hierarchy with power imbalances; dedicated time for intraPC and support from the supervisor.

Conclusion

Trainees and supervisors indicate that intraprofessional education is essential and requires more formal attention. In order to actually benefit from the opportunities that are available during hospital placements, adjustments in the set up of these placements is necessary.

References

- [1] A.J. Berendsen, G.M. de Jong, et al. Transition of care: experiences and preferences of patients across the primary/secondary interface - a qualitative study. BMC Health Serv Res 9:62, 2009.
- [2] WHO. Framework for action on interprofessional education and collaborative practice, 2010.
- [3] Meijer, L.J., de Groot, E., et al. Intraprofessional collaboration and learning between specialists and general practitioners during postgraduate training: a qualitative study. BMC Health Serv Res 16:376, 2016.

05.01 The bigger picture of direct observation during residency: general practice supervisors' views

Chris BT Rietmeijer¹, Daniëlle Huisman², Annette H Blankenstein³, Henk de Vries⁴, Fedde Scheele⁵, Anneke WM Kramer⁶, Pim W Teunissen⁷

^{1,2,3,4}VU university medical center, Department of General practice and elderly care medicine De Boelelaan 1109, 1081 HV Amsterdam, the Netherlands; ⁵ Department of obstetrics and gynaecology, OLVG west, Jan Tooropstraat 164, 1061 AE Amsterdam, the Netherlands; ⁶ Department of public health and primary care, Leiden University, Hippocratespad 21, 2333 ZD Leiden, the Netherlands; ⁷ School of Health Professions Education, Maastricht University, Universiteitssingel 60, 6229 ER Maastricht, the Netherlands

Background

Direct observation (DO) of residents' performance, despite the importance that is ascribed to it, is infrequent and the quality of observation may be poor. DO tends to be seen as just a means to gather information on the performance of residents for purposes of feedback and assessment. We explored the possible complexity of DO in workplace learning.

Research question

What are the manifestations, meanings and effects of DO in developing post-graduate training relationships?

Methods

Constructivist grounded theory informed our data collection and analysis. Data collection involved focus group sessions with clinical supervisors in Dutch general practice. Prompt questions were on manifestations of DO, the supervisor's thoughts and feelings with regard to observing his or her resident, the assumed thoughts and feelings of residents with regard to being observed by a supervisor, the importance and benefits of DO, the initiative to observe, and the influence of the relationship between supervisor and resident on DO and vice versa. Theoretical sufficiency was achieved after 4 focus groups with a total of 28 participants being included. A theoretical framework was developed through a process of constant comparative analysis.

Results

Supervisors strongly connected DO to not observing directly (NOD). We found five patterns: initial planned direct DO sessions, NOD, resident-initiated ad hoc DO, supervisor-initiated ad hoc DO and prolonged planned DO sessions. Different patterns of DO/NOD related to a multiplicity of varying meanings and effects, all of them concerning the training relationship, patient safety and/or residents' learning.

Conclusion

DO, to supervisors, meant much more than gathering information for purposes of feedback and assessment. Planned, mostly bi-directional, DO sessions were an important routine during the initiation phase of a training relationship. Continued planned bi-directional DO sessions, although infrequently practised, potentially combine most benefits with least side-effects of DO. Ad hoc DO, although much relied upon, was often hampered by internal tensions in supervisors, residents or both. Our findings help us understand why simply requiring more frequent DO for purposes of feedback and assessment can lead to tensions that hamper learning rather than promoting it.

References

Please consult the website www.euract2018.org for a complete list of references

05.02 Improving health care through GP learning groups

Niels Kristian Kjær^{1,2} Lone Grønbaek², and Karl Martin Lind²

¹Research Unit of General Practice, Institute of Public Health, University of Southern Denmark, Odense,

Denmark ² Association of General Practitioners, Department of Continuing Medical Education, Copenhagen, Denmark

Background

Denmark has introduced mandatory systematic continuous professional development (CPD) for GPs. The programme is based on a consensus-based curriculum, which enrolled several stakeholders including GPs, GP researchers, hospital consultants, GP educators and administrative staff. A part of this new curriculum is treatment of patients with multi morbidity. Introduction of mandatory non-sponsored CPD for all GPs is however an organizational challenge and it has been necessary to develop new educational concepts. Small group learning has been an important and widespread part of Danish GPs CPD for more than 20 years. It has therefore been natural to explore whether the GP group learning tradition could be integrated in systematic CPD.

Aim

To explore the feasibility and impact of small group learning in training the treatment of patients with multi-morbidity in general practice.

Methods

We developed a concept with four sessions. It dealt with topics such as medical competences, psychosocial issues, patient empowerment, collaboration and clinic organization. The concept included experience exchanges and new knowledge input in a problem-based-learning set-up. It was pilot tested in two GP learning groups. Based on questions generated by the discussions in the pilot groups, we developed educational videos with expert statements and additional educational material addressing the identified questions. The process was tested in six new GP learning groups (8 -14 GP members). The sessions were evaluated by telephone interviews with participants from first four groups. The remaining group sessions were evaluated through a questionnaire collecting ratings and open-ended questions. The interviews were performed after a semi-structured guide. Two researchers analyzed the obtained qualitative data using systematic text analysis.

Results

The GP group learning format was highly valued. The participants experienced the sessions improved their professional capacity and expected the sessions would have a positive impact on their future clinical practice. A mutual professional understanding was developed during the sessions. All the participants felt professionally stimulated.

Conclusion

GP group learning seems to be a feasible format for training treatment of patients with multi morbidity. It can be assumed to have a positive impact on the quality of patient care if high quality educational material is available.

05.03 Reflexivity in disguise

Martin Class¹, Chloé Delacour¹, Hubert Maisonneuve²

¹ Department of General Practice, University of Strasbourg, 67000 Strasbourg, France

² Primary Care Unit, Faculty of Medicine, University of Geneva, Geneva, Switzerland

Background

Research in Primary Care lacks investigators. Studies have shown that participating to a study protocol during medical school encourage the participation to further ones.

In order to motivate students, we decided to explore the benefits they may gain from their participation to a study protocol in primary care.

In a preliminary study, we had identified that collecting data was inducing reflexivity on practice. Reflexivity has an impact on professionalism, one of the major competences residents have to develop.

Aim

To explore family medicine residents reflexivity processes in action when participating to a research protocol.

Methods

Qualitative research using a phenomenological approach to analyse reports written by residents participating to a clinical research during their rotation in family medicine practices. A deductive thematic analysis using the theoretical frame of Nguyen et al [1] was performed. A second analysis, inductive, was performed to explore the clinical research context.

Results

Our analysis has identified reflexive processes in every report. The integrality of the processes described by Nguyen were present in half of the reports. Those marks of reflexivity were spontaneous and authentic, considering the reports had not been directed to demonstrate reflexivity. The source documents are the principal limit of the study because of their variety and the fact that they bring indirect information about residents thoughts. Some elements of the context seem to have enhanced resident reflexivity: the existence of the study protocol, the writing of the report, value conflicts generated by the experimentation, the emotional experience, the research environment and the interaction with clinical tutors. Encouraging residents to question their own practices in research may help them to develop clinical competences indirectly. Clinical tutors may also benefit from interacting with their students during a research protocol.

Conclusion

Our results advocate for a better integration of research into Family Medicine residency.

References

[1] Nguyen QD, Fernandez N, Karsenti T, Charlin B. What is reflection? A conceptual analysis of major definitions and a proposal of a five-component model. *Med Educ* 2014;48:1176–89.

05.04 Pre-graduate students dealing with uncertainty and questions arise about liability: how teachers can foster reflective attitude without anxiety?

Humbert de Freminville MD., Ph.D.¹

¹Family Physician Department-University Claude Bernard Lyon 1
University of Lyon

Background

Pre-graduate students are dealing with uncertainty in medical practice curricula. The real clinical situation sometimes confronts the student with ethical issues or dilemma which can lead to liability fear.

Aim

How teachers can foster reflective attitude without chronic anxiety.

Methods

The family physician department propose two optional workshops per year during three years in the curricular to pre-graduate students in general practice. Each student presents a real clinical case he/she was involved in and then, asks a question arise during the consultation. The teacher organizes thematic purposes, and create small student groups to initiate answers. One leader of each group summarize for the community, and then discussion occurs.

Results

6 groups of 15 students talk about the mandatory certificate, the end-of-life dilemma and ethical issues like facing euthanasia, family violence, the victim, and intimate partner. They cannot reflect enough to withdraw their anxiety by a lack of consistent knowledge on legal rules.

Conclusion

Fostering a reflective attitude among medical students in the workshop need split classroom methods to palliate lack of knowledge on legal rules.

05.05 Military medicine: principles of teaching on post-graduate courses for family doctors

Oleksandr Katerenchuk, Viacheslav Zhdan¹

¹Cathedra of Family Medicine and Therapy, Ukrainian Medical Stomatological Academy, Shevchenka str., 23, 36011 Poltava, Ukraine.

Background

Military aggression of Russian Federation against Ukraine started in 2014 resulted in needs to train family doctors in military medicine preparing them to be ready to provide medical help in the case of large-scale war conflict. From 2014 till now training in military medicine are present in the academic plans of all post-graduate courses for family doctors.

Aim or research

To analyse and improve educational methods in military medicine training process for family doctors based on own experience obtained during last 3 years.

Methods

Complex analysis of training methods used on lectures, seminars and practical lessons on military medicine courses during last 3 years.

Results

Lectures on military medicine cover the main topics devoted to the principles of military-medical forces structure and functions, urgent medical help on the battlefield during the fire attacks, principles of medical care on different stages (red-yellow-green zone), basic themes on medical evacuation, differential diagnosis in the cases of poisoning with radioactive agents and chemical substances. Theoretical training includes the modern views on the different types of hurts caused by different types of weapons. Also, we provide information in the field of nuclear medicine and radioactive impairments as well, as chemical weapon and intoxications. Practical training consist of improving skills in delivering medical care in bleeding, impairments of different parts of human body caused by different types of weapon, shock treatment, pneumo - and hemotorax treatment, immobilization. We improve skills in medical sorting. Also we provide seminars in psychological rehabilitation of victims.

Conclusions

Training in military medicine is necessary in modern politically unstable world. In Ukraine we encountered with problem of family doctors' low level of readiness to deliver medical help in the case of war. It was a consequence of, as non-sufficient training in military medicine of medical students and doctors during 2000th, as in provided implementation of new (as for Ukrainian doctors) NATO principles of organization of military and medical forces into organizational structure of Ukrainian army. The current situation in Europe requires family doctors training in principles of military medicine, so the experience of Ukraine in this field may be useful.

05.06 ‘The ABC of family medicine research’ – does a trans-national training course for early career family doctors make a difference?’

P. Kolesnyk¹

¹Uzhgorod National University, Ukraine

Background: Some European countries do not have courses on research methodology that are relevant to their young family doctors (FDs).

Research question

How effective is a transnational family medicine research course for early career FDs? Should we encourage similar courses for other individual countries or institutions?

Methods

“Approaches to family medicine research”, the first in a series of three transnational two-day courses in family medicine research (the “ABC” courses), was piloted in 2017 in Ukraine, a country with little experience of primary care-based research. This introductory course was led by experienced FD researchers: PK (Ukraine) ensured that the course was relevant for local FDs, and MH (UK) provided an international primary care research perspective.

Evaluation was by pre- and post-course administration of two previously validated questionnaires: the ‘Research Self-Efficacy Scale’, and the ‘Stages of change questionnaire’.

Results

Fifteen early career FDs took part in the course. All 11 items of the ‘Research Self-Efficacy Scale’ demonstrated an increase in mean scores, with particular increases in: ability to design and implement a strategy for collecting data; choosing a research design that will answer a research question; designing the best data analysis strategy.

Most items in the ‘Stages of change questionnaire’ showed an increase in scores after the course, in particular the number of delegates that had discussed increasing research with colleagues, and that had spoken about it in a formal meeting.

Conclusion

This evaluation demonstrates that a transnational model of research courses for FDs is effective and feasible. As well as giving early career FDs the opportunity to learn about family medicine research, it has strengthened closer working relationships between two European countries.

06.01 A multi-country study on students' career choices: towards a balance between the need for general practitioners and what students choose

Peter Vajer¹, Ferenc Ficzer¹, Peter Torzsa¹, Joey Jarmohamed², Marta Velgan³, Ruth Kalda³, Nele Michels²

¹Department of Family Medicine, Medical Faculty, Semmelweis University Budapest, Kutvolgyi ut 4., 1125, Budapest, Hungary

² Centre for General Practice, Department ELIZA, Faculty of Medicine and Health Sciences University of Antwerp - CDE, R3.14, Universiteitsplein 1, 2610 Antwerp, Belgium

³Institute of Family Medicine and Public Health, department of family medicine, University of Tartu, Estonia

Background

In many European countries the shortage of general practitioners (GPs) is a well-recognized and growing problem [1]. Various efforts have been made to promote general practice as a specialization, but without the expected results. Insight in the process of students' choice of career will assist educational and political departments to effective attempts to deal with this challenge.

Aim

This multi-country study aimed to investigate career choices/preferences in undergraduate medical students. It aimed to determine characteristics of students' interest in specialties and the factors that influences their choices.

Methods

A survey was designed on the base of two previous used surveys [2,3], discussed in an expert panel, and spread to all Flemish, Hungarian and Estonian undergraduate medical students (N=13248). Data were analyzed by descriptive statistics (SPSS version 22). Answers on open-ended questions were qualitatively analyzed and coded (data-driven).

Results

N=1962 students (≈15%) completed the survey. A surgical specialty (23,5%), internal medicine (15,1%), and pediatrics & neonatology (12%) were the most preferred specialties by average. Ten % of the students wanted to become a GP; another 19% do not exclude to become a GP, although they have other priorities. "Intellectually challenging work", "positive experiences with doctors or trainers", "communicative skills are required" and "the combination of communicative and technical skills" were rated as most important factors when choosing a specialty. About 60% of the students never received advice on which specialization to choose. 88,4% felt they would need more information and advice. Students' (change of) choices were influenced by internships, courses, information, and positive experiences with other doctors, trainers and assistants. Students have a positive opinion about the role of GPs in the health care system. Reasons to become a GP are the relationship with patients, the professional independence, and the variance in patients, pathology and job content.

Conclusion

Early and correct information on job content and characteristics of the different specialties, high-quality internships and positive role models could shift the students' interest more towards GP. Further analysis of the results can help to obtain a right balance between what is needed in health care and what students choose.

References

[1]Marchand C and Peckham S. Addressing the crisis of GP recruitment and retention: a systematic review. Br J Gen Pract 2017; 67 (657): e227-e237.

[2]Vergouw DPJH, Batenburg RS. De Keuzemonitor Geneeskunde: Een nationaal en longitudinaal meetinstrument voor het volgen van specialisatievoorkeuren en het ondersteunen van specialisatiekeuzen van geneeskundestudenten in Nederland. 2015

06.02 Early contact of medical students in primary health care and its effect on the choice of specialty

Emmanouil Smyrnakis, Panagiotis Stachteas, Magda Gavana, Aikaterini-Vasiliki Touriki, Eleni Lagouia, Marina-Triantafyllia Kotzamani, Alexios Benos

Laboratory of Primary Health Care, General Practice and Health Services Research - Medical School, Aristotle University of Thessaloniki, Greece

Background

Many medical students have a delayed and limited involvement in Primary Health Care (PHC) due to traditional hospital-based curricula. Moreover, the low General Practice (GP) prestige leads a limited number of them to choose to work in PHC as GPs. Aristotle University of Thessaloniki Medical School introduced in 2015 a pilot program for year 1 to 3 medical students entitled “Introduction in Clinical Skills and PHC” following the new trends in medical education¹.

Aims

The purpose of this study is to record medical students' views on early PHC education and to find out whether their involvement affects the thinking about their future specialty.

Methods

All 50 undergraduate students who finished the three-year pilot program, were invited to participate in an anonymous online evaluation. Among the main topics covered were the benefits gained from the early contact with PHC, with real patients and their thoughts on possible future carrier in PHC. The data were quantitatively and qualitatively analyzed.

Results

Thirty students responded to the questionnaire (60% responsiveness). Regarding what they gained from their early contact with PHC settings, 21 (70%) reported the practice of basic clinical skills, 20 (66.7%) focused on early contact with real patients emphasizing their familiarisation, exonerating feelings of anxiety and shame, as well as practicing communication skills. A significant number of participants (11, 36.4%) referred to their knowledge of PHC and the way it works. Eleven of the participants (36.4%) consider it quite likely that they will work in PHC in the future, supporting their preference for good working conditions as well as for a familiar and cooperative atmosphere between the doctor and the patient. However, 19 (63.4%) wouldn't like to deal with PHC. Their wish for a different specialty, the limited number, variety and difficulty of clinical cases, as well as the increased bureaucracy were the main mentioned reasons.

Conclusions

Profits from the early exposure in PHC are multiple, contributing decisively to a better information and a conscious final choice of specialty to follow. If we would like to increase the number of inspired graduates working as GPs², we should reform medical curricula strengthening education in PHC settings.

References

- [1] J. Frenk, L. Chen, Z.A. Bhutta, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. A Global Independent Commission. Lancet 376 (9756): 2010, 1923–1958.
- [2] V. Wass. By choice — not by chance: supporting medical students towards future careers in general practice, Health Education England and the Medical Schools Council, London 2016.

06.03 Educational experience of two Workshops about Doctors' Burnout in Portugal – for trainers and trainees

Marta Marquês¹

¹Unidade Saúde Familiar Cova da Piedade, Av. Rainha D.Leonor, 2, Piso 7, 2805-009 Almada, Portugal

Background

The theme of doctors' burnout is transversal to both young and experienced doctors. Being able to address this theme in general practice/ family medicine (GP/FM) training seems relevant for doctors' professional and personal wellbeing.

An educational workshop was developed to address the theme's importance to a population of GP/FM trainers and trainees. It was presented for GP/FM trainers - November 2015, in Sintra, Portugal - and for GP/FM trainees -April 2016, in Almada, Portugal.

Aims

1. Raise awareness on the theme. 2. Use interactive and participative andragogic methodology. 3. Discuss pertinence of this educational module on continuous development of GP/FM trainers and trainees. 4. Evaluate the workshops.

Methods

The trainers workshop was developed in the context of Euract course Level 3 final work and presented for a convenience sample of trainers in a health care practice where doctors showed interest on the theme. The trainees workshop was presented after an invitation from a local GP/FM trainees association for presentation at their annual convention. The 1,5 hour duration workshop methodology included: ice-breaker, buzzgroups, short lecture, application of a burnout questionnaire, small group tasks and workshop evaluation. The methodology for the workshops evaluation was a two step process: an informal conversation at the end of the workshop and a written pre and post-test with knowledge about the theme multiple option questions and development questions about workshop expectations and results.

Results

The workshops were presented respectively for 13 GP/FM trainers and 19 trainees. We had 10 pretest and 11 post test trainers' responses and 19 pretest and 14 post test trainees' responses. There was an increase in the correct answers on the multiple options questions in both workshop groups (trainers: 62,3% to 80,3%; trainees: 68,4% to 83,0%). Regarding workshop's future improvement suggestions it was transversal in both groups that longer duration was required.

Conclusion

The educational module created seems to address actual needs of both trainers and trainees. The learners seem to have gained further knowledge on the theme. A possible improvement strategy would be to increase the time duration of the workshop to increase the time for small group tasks.

06.04 Social Media Educational Use among Primary Health Care Professionals

George Tzanis, Kleomenis Politis, Ourania-Ioanna Fotopoulou, Emmanouil Smyrnakis
Laboratory of Primary Health Care, General Practice and Health Services Research
Medical School, Aristotle University of Thessaloniki, Greece

Background

In recent years, social media have been widely used in health care. Literature describes posting behaviors [1], main benefits and limitations of social media [2,3]. However, research is focused mainly on communication between patients and health care providers.

Aim or research question

This study evaluates the attitudes associated with the use of social media education groups formed by Primary Health Care professionals.

Methods

A questionnaire consisting of 12 questions was distributed to five Greek Facebook® groups related to primary health care in May 2018.

Results

A total of 77 responses were received. 89.6% (n=69) of the participants were physicians, mainly GPs (n=68). Social media were mainly accessed by smartphone (58.4%, n=45) and the most used social media platform was Facebook® (94.8%, n=73). In accordance with other research studies, 53.2% (n=41) of the participants frequently used social media groups for reading posts, while percentages of frequent question or informational posts were significantly lower (9.1%, n=7 and 15.6%, n=12). Participants had a neutral-positive attitude versus the communication, feedback and educational opportunities provided by the groups. However, the education benefits were the least favored probably due to the belief that the main limitation was the reliability of information (64.9%, n=50).

Conclusion

Health care professionals believe that social media educational use can provide a variety of benefits. However, the reliability of information, as well as other limitations, pose strong challenges that have to be resolved.

References

- [1] K. Rolls, M. Hansen, D. Jackson, D. Elliott. How Health Care Professionals Use Social Media to Create Virtual Communities: An Integrative Review. *Journal of Medical Internet Research*, 18(6), 2016.
- [2] S.A. Moorhead, D.E. Hazlett, L. Harrison, J.K. Carroll, A. Irwin, C. Hoving. A New Dimension of Health Care: Systematic Review of the Uses, Benefits, and Limitations of Social Media for Health Communication. *Journal of Medical Internet Research*, 15(4), 2013, e85.
- [3] W.S. Chan, A.Y. Leung. Use of Social Network Sites for Communication Among Health Professionals: Systematic Review. *Journal of Medical Internet Research*. 20(3), 2018, e1.

07.01 General practitioner trainers prescribe fewer antibiotics in primary care:

Evidence from France

Louise Devillers^{1,2}, Jonathan Sicsic², Angélique Delbarre², Josselin Le Bel^{3,4}, Emilie Ferrat^{5,6}, Olivier Saint-Lary^{1,2}

¹ Department of Family Medicine, Faculty of Health Sciences Simone Veil, University Versailles Saint-Quentin en Yvelines (UVSQ), Montigny-le-Bretonneux, France.

² CESP, University Paris-Sud, UVSQ, INSERM U1018, University Paris-Saclay, Villejuif, France.

³ Department of Family Medicine, University Paris Diderot, Sorbonne Paris Cité, Paris, France.

⁴ UMR 1137, INSERM, IAME, Paris, France.

⁵ University Paris-Est Créteil (UPEC), School of Medicine, Primary Care Department, Créteil, France.

⁶ University Paris-Est Créteil (UPEC), DHU A-TVB, IMRB, EA 7376 CEpiA (Clinical Epidemiology And Ageing Unit), Créteil, France.

Background

Antibiotic prescription is a central public health issue. Overall, 90% of antibiotic prescriptions are delivered to patients in ambulatory care, and a substantial proportion of these prescriptions could be avoided. General Practitioner (GP) trainers are similar to other GPs in terms of sociodemographic and medical activities, but they may have different prescription patterns.

Aims:

Compare the antibiotic prescribing rates between GP trainers and non-trainers.

Methods

This observational cross-sectional study was conducted on administrative data claims from the French National Health Insurance. The antibiotic prescribing rate was calculated. The main independent variable was the training status of the GPs. Prescribing rates were adjusted for the various GPs' characteristics (gender, age, location of the practice, number of visits per GP and the case-mix) in a multiple linear regression analysis.

Results

Between June 2014 and July 2015 the prescribing patterns of 860 GPs were analysed, among which 102 were GP trainers (12%). Over the year 363,580 patients were prescribed an antibiotic out of 3,499,248 visits for 1,299,308 patients seen over the year thus representing around 27.5% of patients. In the multivariate analyses, being a trainer resulted in a significant difference of 6.62 percentage points (IC 95%: [-8.55; -4.69]; $p < 0.001$) in antibiotic prescriptions comparing to being a non-trainer, corresponding to a relative reduction of 23.4%.

Conclusion

These findings highlight the role of GP trainers in antibiotic prescriptions. By prescribing fewer antibiotics and influencing the next generations of GPs, the human and economic burden of antibiotics could be reduced.

07.02 Online micro-CME: an efficient way of education in family medicine?

Nele Michels^{1,3}, Jonathan Rees², Elena Andreeva³, Jachym Bednar³, Jo Buchanan³, Vesna Homar³, Pavlo Kolesnyk³, Razvan Miftode³, Radmila Ristovska³, Péter Vajer³, Herman Stoevelaar⁴

¹Centre for General Practice, Department ELIZA, Faculty of Medicine and Health Sciences
University of Antwerp - CDE, R3.14, Universiteitsplein 1, 2610 Antwerp, Belgium.

²Backwell Medical Centre, Bristol, United Kingdom.

³EURACT Council-CME Committee

⁴Centre for Decision Analysis and Support, Ismar Healthcare, Lier, Belgium.

Background

In the comprehensive field of family medicine, keeping abreast of new scientific information and best practice is challenging and time-consuming. A recently developed online concept for Continuing Medical Education, consisting of weekly cases with direct feedback ("micro-CME"), proved to be successful in specialist care.^[1]

Aim

To explore the feasibility of the micro-CME concept in family medicine.

Methods

An online survey was conducted amongst a sample of general practitioners (GP) in 9 countries. Nine EURACT-CME Committee members were asked to invite around 20 colleagues to participate. The survey contained 5 short cases (100-150 words) on voiding problems presented to a GP. For each case participants had firstly to indicate the most appropriate treatment choice or most likely diagnosis (multiple choice, 4-7 options). Thereafter the opinion of an expert panel was presented, together with a summary of the evidence from clinical studies and/or international guidelines. Participants were then asked to reconsider their initial answers in light of the available evidence. The survey also contained questions on the relevance of the cases and news value of the evidence, and on the usefulness of the micro-CME concept for family medicine.

Results

Ninety-three surveys were fully completed. The majority of participants (81%) came from eastern and southern Europe, the remaining 19% from western Europe. Two-thirds were female, 60% had ≥ 10 years of experience as a GP. The mean percentage of correct answers increased from 36% [range 10-68%] to 67% [range 53-85%] after showing the recommendations and related evidence (Fig. 1). The increase of correct answers was higher if the initial score was lower ($PCC = -0.45$, $p < 0.001$). Seventy percent of participants considered most cases to be relevant for their practice, 61% reported that $\geq 50\%$ of the information was new to them. Around 75% found the cases and concept of micro-CME to be very useful.

Conclusions

The results of this interactive survey suggest that a case-based approach with targeted feedback may help improve physicians' knowledge and clinical decisions. The concept of micro-CME was very positively received by the participants.

References

^[1] H. Stoevelaar, J. Yperman, W. De Loore, R. Rijnders, B. Tombal, One year experience with micro-CME in prostate cancer: less is more? Presented at the 5th Global Congress on Prostate Cancer. Lisbon, 28-30 June, 2017. $PCC = -0.45$, $p < 0.001$

07.03 Cross-sectional descriptive study protocol about the Family Violence Curricula in Europe (FAVICUE)

Raquel Gómez Bravo¹, Gene Feder², Robert Reuter³, Claus Vögele¹

¹Institute for Health and Behaviour, Research Unit INSIDE. University of Luxembourg – Campus Belval. Maison des Sciences Humaines. 11, Porte des Sciences. L-4366 Esch-sur-Alzette

²Centre for Academic Primary Care, Bristol Medical School, UK.

³Research Unit ECCS. University of Luxembourg – Campus Belval. Maison des Sciences Humaines. 11, Porte des Sciences. L-4366 Esch-sur-Alzette

Background

Family violence (FV) is a widespread public health problem of endemic proportions and serious consequences. Doctors may be the first or only point of contact for victims who may be hesitant or unable to seek other sources of assistance, and they tend not to disclose abuse to doctors if not specifically asked. A comprehensive health care response is key to a coordinated community-wide approach to FV, but most of the practicing physicians have received either no or insufficient education or training in any aspect of FV. Training of medical students concerning FV is often delivered in an inconsistent or ad hoc manner.

Aim

The main aim of this project, Family Violence Curricula in Europe (FAVICUE), is to (1) describe current FV education delivery in European medical universities (undergraduate period) and during the specialist training in General Practice (GP)/Family Medicine (FM) (postgraduate residency programme), and (2) compare it with the World Health Organization (WHO) recommendations for FV curriculum.

Methods and analysis

This is the protocol of a cross-sectional descriptive study consisting of two self-report online surveys (for undergraduate and postgraduate training, respectively) with 40 questions each. For both surveys, general practitioners, residents, medical students and professionals involved in their education from countries of the European region will be identified through the European Regional Branch of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA Europe) and will be invited to provide information regarding their training on FV. Descriptive tests will be carried out and a thematic analysis will be conducted on the open-ended questions.

Ethics

Ethics approval has been obtained by the University of Luxembourg (ERP 17-015 FAVICUE).

Results

The results will provide important information concerning current curricula on FV, and can be used for mapping the educational needs and planning the implementation of future training interventions. Preliminary results will be shown at the conference.

Conclusions

There is an urgent need to establish a structure curricula regarding Family Violence during the undergraduate and postgraduate period and the results of this study will support it.

07.04 EURACT Level 1H courses for trainees of all specialties - the Portuguese experience

O7

Luís Filipe Gomes¹, Denise Velho²

¹ Department of Biomedical Sciences and Medicine, University of Algarve, Portugal

² Santiago Family Health Unit, Leiria, Portugal

Background

Since 2007, Portuguese EURACT members have cascaded the Leonardo Teachers Courses. After dozens of courses for General Practice/Family Medicine Teachers, colleagues from other specialties showed an increasing interest to participate. Facing innumerable solicitations, after careful reflection and minor adaptations of the course materials, we decided to include all specialists in level 1 courses. We have called them level 1H courses.

Aim

To share our experience in opening the level 1 EURACT course to teachers of all specialties.

Methods

Cross-sectional study including every level 1H course organized, describing the number of participants, specialties of participants, course assessment by participants and faculty with a Likert-type scale and verbal comments at the end of each course.

Results

So far, we have organized a total of three level 1H courses. The first one was in Coimbra, in 2016, the second in Leiria, in 2017, and the third, in 2018, in Ponta Delgada, Azores. We will present the total number of participants, the percentage of family doctors and the percentage of doctors from other specialties. All three courses were very successful with high scores on the Likert scale throughout. Specialists from the other disciplines gave an added perspective to the course enriching everyone's experience. The results of the participants' and faculty's assessment and impressions of the courses will be presented. We already have three more level 1H courses scheduled for 2018, in Viana do Castelo, Aveiro and Madeira.

Conclusion

The level 1 course materials are successfully adaptable to all medical teachers. Having a diverse group of participants allows colleagues from different specialties to share their experiences and strengthen their bonds improving the quality of medical teaching and even medical care itself.

07.05 Structured, empowering Inter-vision for Medical Practice Trainers

Sabine De Weirdt

Interuniversity Center for Training of Family Physicians in Flanders, Belgium (ICHO vzw), Kapucijnenvoer 33, 3000 Leuven, Belgium.

Background

When family physicians in Flanders, Belgium, start training young colleagues in their clinic, they receive a thorough training about the necessary, basic didactical skills. But all trainers, whether experienced or not, run into personal flaws and limitations, blind spots, frustrations, discouragement, or/and (feelings of) powerlessness in the process.

Aim

Knowing that structured inter-vision among peers has proven to be one of the better methods for adult learning, we have set up a number of groups in different regions in Flanders, to explore the idea of organizing peer groups for trainers of family physicians to provide learning opportunities and discuss difficulties in this area of personal functioning as a trainer.

Methods

Over the course of 4 years (2014-2018) one specific type/form of structured, empowering inter-vision has been introduced, explored, and refined in different types of small groups (15; staff, train-the-trainer, trainers) within the practice training program for Family Medicine in Flanders. Different approaches have been explored (ex.: with or without case preparation, with or without thematic introduction, etc.), with varying results.

Results

The method shows potential for great results. In all groups, most participants went home after every inter-vision with a specific, useful piece of (practical) advice. In general, MDs were satisfied with the results of their investment of time and effort. Special attention needs to be given to diligent personal training and follow-up of each group facilitator: working with correct learning questions is usually new; guiding a group through different phases of exploring a delicate subject is challenging; the method initially requires frequent, patient repeating of the procedure. The presence and regular support of a trained inter-vision coach seems highly recommendable.

Conclusion

Through this exploration, we became greatly convinced of the need and surplus of guided reflection with peers/colleagues about personal functioning during practice training. It seems recommended to include this preferred method of adult learning in all support programs for practice trainers in (Family) Medicine.

References

- [1] F.Bannink, *Positieve Supervisie en Intervisie*, Amsterdam: Hogrefe Uitgevers, 2012. ISBN 978-90-797229-68-5
- [2] M. Boer, M. Hoonhout, J. Oosting (red.), *Supervisiekunde. Meerperspectivisch*. Deventer: Vakmedianet, 2015. ISBN 978 94 6276 0349

Workshops

W1.01 Structured Feedback Workshop

Marta Marquês¹, Rita Viegas^{1,2}, Susana Medeiros³

¹Unidade Saúde Familiar Cova da Piedade, Almada, Av. Rainha D.Leonor, 2, Piso 7, 2805-009 Almada, Portugal

²NOVA-Medical School, Lisboa, Portugal

³Unidade de Saúde Familiar Alpha Mouro, Av. Infante D. Henrique, 39, Piso 1, 2635-367 Rio de Mouro, Portugal

Background

The ability to provide proper feedback is one of the bases for effective teaching. This is even more so when talking about the teaching of family doctors, where communication skills are the baseline for every day's work. Structured feedback aims to improve the learner's self-assessment, which is not always accurate, addressing aspects of the learner's specific behaviour relevant to his clinical competence and professionalism and therefore allowing for continuous improvement.

Aims

This workshop aims to 1. remember the principles, advantages and obstacles to effective feedback, 2. provide a simple organized framework/ guideline for applying structured feedback in clinical teaching, 3. allow participants to practice giving and receiving feedback and 4. allow reflection on the relevance of this skill.

Proposed method

We propose an interactive and participative methodology, with: ice-breaker, brainstorm, facilitator's brief presentation and task oriented small group work.

Expected outcome

Allow contact with a step by step structured feedback framework, allow practice of this framework between group participants, allow reflection on the importance of giving and receiving structured feedback in clinical teaching.

W1.02 Self-determination theory in practice: how to motivate your students?

W1

SSL Mol,¹ MI Vermeulen,² FJM Grosfeld³

¹Julius Center for Health Sciences and Primary Care, University Medical Center Utrecht Universiteitsweg 100, 3584 CG Utrecht, the Netherlands.

²Julius Center for Health Sciences and Primary Care, University Medical Center Utrecht, postgraduate GP-training, Broederplein 43, 3703 CD Zeist, the Netherlands

³ Skills training department, University Medical Center Utrecht, P.O. Box 85060, 3508 AB Utrecht, the Netherlands.

Background

Sometimes a student is obviously not interested in your lesson. Or even worse, the whole group is unmotivated. The causes vary: student factors (fatigue, purpose not clear), the content of the education material (not appealing), teacher factors (the way of teaching) etc. How can one organise one's lesson in such a way that students are optimally motivated? We use Ryan and Deci's Self-determination Theory (SDT) as a theoretical framework.[1] This theory describes how the three basic psychological needs – autonomy, relatedness and competence - contribute to intrinsic motivation.



Figure 1: SDT three basic psychological needs

Aim

Learning how to motivate students optimally based on the SDT on 3 stages of Millers' pyramid (know, knows how, shows how).

Proposed method

We will alternate theoretical background and practical exercises in 4 cycles. The first exercise is about getting to know one another as an example of the importance of "relatedness" with students. In the second exercise we use case vignettes of students to understand in which stage of motivation a student is. Then participants learn to recognize which psychological needs are met in vignettes of teaching methods we present. And as a last exercise, participants apply the SDT-knowledge to a self-selected lesson.

Expected outcome

Participants learn to differentiate between the various stages of motivation and gain insight in to which degree the basic psychological needs are met. They apply this knowledge to optimize their own teaching practice. In addition, participants will learn from each other by exchanging teaching experiences.

References

- [1] R.A. Kusurkar, G. Croiset & O.Th.J ten Cate, Twelve tips to stimulate intrinsic motivation in students through autonomy-supportive classroom teaching derived from Self-Determination Theory. Medical Teacher, 2017 33:12,978-982

W1 W1.03 Hackathon: Let's hack complex health problems in an interprofessional team together with patients. How to implement this in our daily professional practice.

Natasja Looman¹, Nynke Scherpbier¹, Sigrid Pullen¹

¹Department of Primary and Community Care, Radboud University Medical center
Geert Groteplein Noord 21 (r149), 6525 EZ Nijmegen, The Netherlands

Background

In several curricula in Nijmegen, the Netherlands, we are looking for innovative educational methods to organise interprofessional education with explicit patient participation. We want our students and trainees to experience their individual strengths and weaknesses in a team, to experience the benefits of interprofessional collaboration and to feel that they have a potential to change traditional patterns in collaborative healthcare.

The Radboud University Medical Centre and the university of applied sciences (HAN) are working with 'Hackathons': an innovative and interprofessional interactive method in education and collaboration. The word Hackathon is formed by the words 'hacking' and 'marathon'. Hacking means that we are trying to find a solution for complex (health) problems with an experimental approach. The word marathon stands for the (relatively short) amount of time in which a lot of energy is invested in solving the problem. This method has very positive trainee evaluations.

Aim

We would love the participants to experience the benefits of this educational innovation.

Proposed method: During this interactive workshop participants will experience a part of this Hackathon-method in immediate presence of patients and/or caregivers. We also will have a brief discussion about how we apply the Hackathon at Radboud University Medical Center. Participants reflect on the potential of this educational innovation in their own educational setting. Finally, we will discuss and tackle the translation of this method to our own GP practice, in terms of efficiency and efficacy.

Expected outcome

Participants experience an innovative educational method of teaching interprofessional collaboration in health care education with patient participation (Hackathon) and think of ways to implement this method in education and practice in the best possible way.

W1.04 Training GPs to improve triggering and delivery of palliative care in the community: use of active learning methods, and educational material based on core competencies in primary palliative care

Sébastien Moine^{1,2}, Scott A Murray^{2,3}, Jordi Amblas^{2,4}, Esther Limon^{2,4}, Xavier Costa^{2,4}, Pierangelo Lora Aprile^{2,5}, Maurizio Cancian^{2,5}.

¹Health Education and Practices Laboratory, University of Paris 13, France

²European Association for Palliative Care [EAPC] Primary Care Reference Group

³Primary Palliative Care Research Group, University of Edinburgh, United Kingdom

⁴Chair UVIC/ICO/CCOMS in Palliative Care, University of Vic, Spain

⁵Italian College of General Practitioners, Coneglio, Italy

Background

General practitioners (GPs) have a major role to play in triggering and providing palliative care in the community. These activities, which can otherwise be termed primary palliative care, are a crucial component of their practice. If started in a timely manner, they can help make a significant difference to the well-being of people living with life-threatening conditions, their caregivers and their family^[1].

In this respect, training should be tailored to meet GPs specific education needs and be consistent with usual professional constraints in primary care. Therefore, it should remain predominantly in line with the fundamental missions of general practice^[2], and rely on the core competencies already defined for GPs, and those identified for the development of primary palliative care^[3].

Aim

This workshop is aimed at GPs educators, GP trainees and GPs working in primary care. It intends to focus on three main core competencies in primary palliative care: early identification of patients with potential palliative needs; multi-dimensional assessment of palliative needs; future care planning

Proposed method

Various active learning methods will be used during this workshop: small group activities; structured clinical vignettes; production of a metaplan.

A brief video on Early palliative care will be screened and used as a basis for group discussion.

Expected outcome

At the end of the workshop each participant should be able to:

- understand the concept of illness trajectories, and its epidemiology in general practice
- use simple clinical tools for early identification of people with potential palliative needs
- anticipate the evolution of palliative needs over the course of illness
- initiate future care planning conversations with patients in primary care

The content of this workshop can be used to offer a specific training module on primary palliative care in university departments of general practice, or to facilitate group discussions with GPs.

References

^[1] Murray SA, Kendall M, Mitchell G, et al. Palliative care from diagnosis to death. BMJ 2017; 356: j878.

^[2] WONCA Europe. The European Definition of General Practice/ Family Practice (accessed on February 26, 2018, at: <http://www.woncaeurope.org/sites/default/files/documents/>)

^[3] <http://www.eapcnet.eu/Themes/ProjectsTaskForces/EAPCReferenceGroups/PrimaryCare.aspx>

W2.01 Training Programme for GP Mental Health Consultations in Islamic Culture

Enda Murphy¹, Fatma G. Cihan²

¹Asst Programme Director, GP Training Scheme, Ireland. Faculty member, Center for Global Health, Harvard University, USA.

²Assoc. Prof., Necmettin Erbakan University Meram Medical Faculty, Family Medicine Department, Konya, Turkey

Background

80% of people who develop the most common mental health difficulties will have their GP as their only professional health resource. This is especially true of practitioners in Islamic culture where access to professional services is limited and has led to an over reliance on the prescription pad in mental health consultations. The National Institute for Clinical Excellence (NICE) has stated that 'Cognitive Behavioural Therapies (CBT) are the principal evidence based psychological treatment recommended for common mental health problems'. Research suggests that to manage their mental health, most people merely need two things; information and support. When combined, outcomes are extremely good. The vast majority of people can be helped to overcome their distress through 'low intensity' interventions delivered by GPs.

Aim

This workshop demonstrates a model of CBT which translates complex psychodynamics into a simple framework where specific problems can be easily identified and treated. This provides a proven method that can be easily learned and applied within the constraints encountered in the health care services of Islamic cultures facilitating a change in the recurring nature of consultations. These interventions are highly effective in treating anxiety, depression and most common mental health problems being treated by GPs in Islamic culture today.

Proposed method

Participants are encouraged to bring with them clinical case histories, for presentation and discussion. The workshop is fully interactive and is designed to encourage lively debate and debate.

Expected outcome

- 1) Identify complex mental health issues and put them into a simple 'jargon free' framework from which specific problems can be identified.
- 2) Provide practical CBT skills which can be used in treating these problems.
- 3) Demonstrate how best practice principles can be easily translated into Islamic culture providing a more focused approach to difficult problems leading to more effective outcomes.

W2.02 The clinical examination: an opportunity to teach clinical reasoning to medical students.

Arabelle Rieder¹, Marie-Claude Audétat¹

¹Unité des Internistes Généralistes et Pédiatres (UIGP), Medical School, Geneva University, Rue Michel-Servet 1, 1206 Genève, Switzerland.

Background

Medical students usually learn the physical examination as a list of skills they must master. Physical examination textbooks and online resources are organized by organ system and favour a systematic examination and recording of clinical data. This “head-to-toe” tradition of examination is not consistent with the diagnostic reasoning that medical students are expected to demonstrate at the end of their studies. Therefore, medical students should be encouraged not only to generate and verify hypothesis during history taking, but also during the clinical examination. This allows them to develop, early on in their training, reasoning skills that are essential in the busy clinical settings of in and outpatient medicine. Thus, to effectively supervise medical students who are learning physical examination skills, clinical supervisors need to explicit the 2 types of clinical reasoning that expert clinicians use. Medical students should learn from their supervisors to choose the examination skills that will help forward their clinical reasoning.

Aim

Understand the processes of clinical reasoning during history taking and examination of the patient
 Know how to teach medical students to apply clinical reasoning during the physical examination
 Know on how to teach a clinical examination skill to medical students

Proposed method

- 1) Small group and large group discussions: expectations of the participants:
- 2) Video of a medical student who examines a patient with a medical complaint. The participants analyse the encounter. Group-discussion.
- 3) Review of the literature: Background and best practices of clinical supervision of the physical examination. Reminder of the basic principles of clinical reasoning: pattern recognition and hypothetico-deductive reasoning.
- 4) Work in small groups to prepare the feedback to the student.
- 5) Role-play: feed-back to the student.
- 6) How to teach a clinical or technical skill: two different methods will be presented to the participants. Role-play.
- 7) Conclusions. Lessons learned. Next steps for the supervisors.

Expected outcomes

Understand the processes of clinical reasoning during history taking and examination of the patient
 Know how to teach medical students to apply clinical reasoning during the physical examination
 Know on how to teach a clinical examination skill to medical students.

W2.03 Establishing and integrating Health Promotion in core medical curricula; the implementation challenges and opportunities

Ann Wylie

School of Population Health & Environmental Sciences, Faculty of Life Sciences and Medicine, King's College London

Background

Primary care and general practice (GP) have been championing Health Promotion (HP), identifying risk factors and where possible addressing them, conducting screening, early disease detection services and being proactive in disease prevention such as travel advice and immunisations. GPs support behaviour change eg smoking cessation, some GPs have engaged in local advocacy and the development of social prescribing. However, there are many variables, inconsistencies and fragmentation. Yet the increasing prevalence of non-communicable disease and the influence of social determinants of health on patient populations, it seems imperative that HP should have a significant place in medical curricula for medical students and in preparing and supporting their GP clinical teachers. GP.(1)

Aim

HP is a broad term, it can be contested, poorly evidenced and difficult to define as there are other terms such as behavioural sciences, population and public health and single issues such as smoking cessation. Current clinical teachers will have limited formal education in these topics and curriculum developers need to have defined learning outcomes and assessment modalities. The aim is to allow time to explore the opportunities and challenges of applied health promotion teaching in GP, how is HP being defined and being assessed: what teacher development is needed to align with medical school requirements; what influence should GP teachers have on medical school curricula and expectations; what can students learn through experiential methods and be potential contributors to the practice patient population.

Proposed Method

Participants will share their experiences of HP teaching, what terms are used, when it happens, is it core or optional, what challenges they encounter. We will look at the current King's approaches and some background, and the challenges faced. We will take a global perspective possibly the Canadian CAMs model and or the development of Japan's curricula to consider what can be learnt and applied in European context.

Expected outcome

By the end of the session participants will have:

- Considered their learning needs, in their context, for Health Promotion curricula content
- Considered what is feasible, sustainable, and assessable, for their clinical teachers and students
- Discussed variables such as resources, priorities and evaluation

References

[1] Wylie A, Leedham-Green K. Health promotion in medical education: lessons from a major undergraduate curriculum implementation. *Education for Primary Care*. 2017:1-9.

W2.04 How do we keep our GP trainees resilient and work engaged? Framework and tools

Charlotte Haarsma¹

¹ Freelance trainer for Doctors4Doctors (Belgium), Freelance trainer for ICHOvzw

Background

GP trainees and GP's in Belgium and foreign countries are at risk of burn-out [12]. This affects our healthcare: more mistakes occur and patients are less likely to persevere in treatment [3]. Treatment of burn-out and prevention of overstrain, for GP (trainees) themselves, are essential.

Besides treatment and prevention, we should focus on 'amplition'^[4], through increasing work engagement and resilience. By doing this, we help professionals to feel optimistic, be pro-active^[5], let them use the relevant resources etcetera^[6]. But more importantly: we let them perform better^[7].

Aim

This workshop aims to give a framework for supporting GP trainees in optimizing their resilience and work engagement. From treatment of burn-out, to prevention of overstrain, to amplition. The latter will be the core of this session.

Proposed method

We will start with a short theoretical framework and their own good practices. We will add tools for treatment, prevention and especially amplition.

Expected outcome

Participants will get to know a framework that includes tools of treatment, prevention and especially amplition.

References

- [1] Z. Attrichine-Kachi, J. Goedhuys, L. Pas, Burn-out bij huisartsen in opleiding, Masterproef Huisartsgeneeskunde, 2016, 1-97.
- [2] L. Godderis, H. De Witte, S. Vandenbroeck, E. Van Belle et al., Onderzoeksrapport: een onderzoek naar burn-out en bevlogenheid bij artsen en verpleegkundigen in Belgische ziekenhuizen. Iov de FOD Volksgezondheid en de FOD Werkgelegenheid, KULeuven & Idewe, 2012, 1-63.
- [3] B.L. Fredrickson, The value of positive emotions. American Scientist, 91(4) 2003, 330-335.
- [4] E. Ouwenel, W.B. Schaufeli, P. Le Blanc, Van preventie naar amplitie: interventies voor optimaal functioneren, Gedrag & Organisatie, 22 (2) 2009, 118-135.
- [5] W. Schaufeli, T. Taris, P. Le Blanc, M. Peeters, A. Bakker, J. De Jonge. Maakt arbeid gezond? Op zoek naar de bevlogen werknemer. De psycholoog, 36 2001, 422-428.
- [6] Bakker & Bal, 2009 in A. Bakker. Een overzicht van 10 jaar onderzoek naar bevlogenheid, Gedrag & Organisatie, 22 (4) 2009, 336-353.
- [7] S. Christian, A.S. Garza, J.E. Slaughter, Work Engagement: A Quantitative Review and Test of Its Relations with Task and Contextual Performance, Personnel Psychology, 64 (1) 2011, 89-136.

W3.01 Family Medicine and Primary Care at the crossroads of societal change: looking back at the future.

Jan De Maeseneer¹

¹ Department Family Medicine and Primary Health Care, Ghent University, Corneel Heymanslaan 10, 9000 Gent, Belgium.

Background

The book: "Family Medicine and Primary Care at the crossroads of societal change" analyses the development of family medicine since the second half of the 20th century and the first two decades of the 21st century. Different dimensions of the daily practice of family medicine and primary care are examined: dealing with social determinants and diversity, the need for a paradigm-shift towards Goal-Oriented Care, the importance of decision-making in care and the critical assessment of the complexity of prevention; the role of pharmaceutical industry; the quality of care and the care for quality, the importance of appropriate training of family physicians and the health care professionals for the 21st century; the need for policy change from care for individuals and families towards accountability for a population and the importance of appropriate payment systems in the broader international context.

The analysis and the viewpoints of the author are the starting point for the debate.

Aim

Starting from the analysis made by Prof. Jan De Maeseneer in his book "Family Medicine and Primary Care at the crossroads of societal change", 3 critical interviewers will question the author, in interaction with the audience, in order to understand what the actual challenges are and how (the training of) family physicians can respond to these challenges, building on the insights from the last 4 decades.

Proposed method

The 3 interviewers question Jan De Maeseneer about his insights and the proposals for future changes. The contextual viewpoints start from the training of future family physicians, fit for purpose in the 21st century in a changing primary care system. The interviewers chose 3 to 4 topics from the book and in each of the topics, the public is invited to contribute to the debate.

Expected outcome

The aim is that participants leave the room with a broader insight in challenges of family medicine, and how training of family physicians may anticipate to address those challenges.

References

[1] J. De Maeseneer, "Family Medicine and Primary Care at the crossroads of societal change". Book. www.lannoocampus.com ISBN 9789401444460.

W3.02 Presentation/workshop: A practice format of proficiency testing for admission to the postgraduate family medicine education

Birgitte Schoenmakers

Department of Public Health and Primary Care, Kapucijnenvoer 33, box 7001, Leuven, Belgium

Background

In the last two decades family medicine transformed into a full discipline and plays a major role in medical education and in health care. It is although, a specialty dealing with his very own particularities. Nevertheless, admission to the advanced master in family medicine is not, as in hospital disciplines, commonly regulated. Above, most traineeships are mainly organized in a hospital setting. Students therefore come hardly in contact with family medicine and are highly unaware of the required capabilities and competencies in this discipline. Health care in general and family medicine in particular evolved in in a profound way. Consequently, the health care system puts more emphasis on primary care and on the role of the family physician. This medical professional is more than other care professionals confronted with the complex reality of chronic care. Above, related to medical and societal developments, patients request more participation and sharing of decision making. These evolutions require a well-trained family medicine with more than only medical expert skills.

To meet the above conditions, in Flanders, a three-phase admission program is developed and implemented by the collaboration of the four involved universities.

Aims

The development of an admission procedure is challenging and depending on many factors: logistics, ethical and juridical conditions, acceptability by all stakeholders, etc. The admission procedure starts from the education framework, the learning objectives and the formal work related requirements. The development of this procedure is challenging. To give participants handles to deal with these challenges, this workshop will focus on both development, content and outcome of the Flemish procedure. Concrete, a three-phase admission procedure was developed and implemented. Phase 1 consisted of the formal admission requirements phase 2 comprised a multicomponent, machine assisted test and phase 3 referred to the structured jury exam addressing students who failed the multicomponent test.

Methods

In the workshop/presentations the development, implementation (logistics and juridical implications) and test results of the procedure will be demonstrated. A practice formal will be offered and participants are guided through this procedure by a SWOT-analysis.

Results

The expected outcome is that participants know how/show to develop, test and implement an admission program.

W3.03 Creating a mindful practice. How to teach and practice mindfulness in family medicine

Dr. Michael Kaffman ^{1,2}, Dr. Michal Shaked ³

¹Department of family medicine, Clalit Healthcare Services Haifa and West Galilee district Israel

²Bruce and Ruth Rappaport faculty of Medicine the Technion Haifa Israel

³Maccabi health services northern district Israel

Background and Rationale

As busy family medicine practitioners we meet many challenges that influence our daily practice, such as: Difficult communication issues, time management, life work balance, dealing with uncertainty, bureaucratic load, that may cause, burnout, empathy decline less patient centeredness and more medical errors. Mindful and reflective practice can help in creating a more resilient, empathic, and patient centered comprehensive attitudes and behaviours (1,2,3) and might decrease medical errors (4). In this workshop we shall discuss and experience methods to teach and create a mindful and reflective practice, by using the participants experience, and my own experience which partially is based on the university of Rochester school of medicine curriculum guides.

Methods

Short introduction, experiential exercises of mindfulness (formal short meditations and small exercises) discussion, narratives and reflective inquiry

Expected outcome: at the end of the workshop the participants will:

- Experience and have a taste and understanding of formal and in-formal mindful practices.
- Be able to explain the actual experience of being mindful and its relation to their practice
- Discuss and be able to create different methods of teaching mindfulness (in small group as well as workplace base (in the office and hospital settings)
- Consider how to implement mindfulness teaching in their curriculum.

References

1. Shapiro SL, Schwartz GE. Mindfulness in medical education: Fostering the health of physicians and medical practice. *Integr Med*.1998;1:93–94
2. Novack DH, Suchman AL, Clark W, et al. Calibrating the physician. Personal awareness and effective patient care. *JAMA*. 1997;278:502–509.
3. Krasner MS, Epstein RM, Beckman H, et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA*. 2009;302:1284–1293.
4. Borrell-Carrió F, Epstein RM. Preventing Errors in Clinical Practice: A Call for Self-Awareness. *Annals of Family Medicine*. 2004;2(4):310-316.

W3.04 Data through the looking glass: a focus group discussion on how audit and feedback can add to continuing professional development

Dorien van der Winden¹, Nynke van Dijk¹, Mechteld Visser¹, Jettie Bont¹

¹Education and Training Research Group, Department of General Practice, Academic Medical Centre, Meibergdreef 15, 1105AZ Amsterdam, The Netherlands.

Background

Recently, a shift has been initiated in the perspective on audit and feedback (A&F) in general practice. Often it is seen primarily from a quality assessment perspective. Instead of stimulating the intrinsic motivation of professionals to improve their practice, this can result in a tendency towards control and window dressing. General practitioners (GPs) are therefore asking to put the emphasis of quality improvement policies such as A&F, back on personal learning and professional development. A&F gained its place as an important evaluation tool on professional performance and is an often used form in continuing professional development (CPD) in general practice as well as in secondary care settings [1]. A&F interventions are heterogeneous, but always based on the principle of gathering data on professional performance (audit) and providing the practitioner with a summary of the data (feedback), comparing it with set professional standards or other professionals [2]. In order to make optimal use of the learning possibilities that A&F offers, it is key to have excellent understanding on what, and more importantly, how professionals can learn from A&F. Ideally, this means stimulating and making optimal use of their intrinsic motivation to be the best possible doctor they can be.

Aim

This workshop aims to encourage and inspire participants to look at A&F from a medical education perspective and explore possibilities to use A&F in continuing professional development (CPD) settings.

Proposed method

There will be a short introduction in which we will discuss some examples of methods in which A&F can be deployed to aid CPD. We will share results of a focus group study and other studies we performed with GPs to their experiences of an A&F intervention. We then stimulate discussion among participants and discuss their views on how A&F can be a valuable form of CPD, using a topic list.

Expected outcome

Participants will have a general idea on the possibilities of A&F as a learning tool in CPD and how to apply this in their own settings.

References

- [1] Ivers N, Jamtvedt G, Flottorp S, Young JM, Odgaard-Jensen J, French SD, et al. Audit and feedback: effects on professional practice and healthcare outcomes. The Cochrane database of systematic reviews. 2012(6)
- [2] Colquhoun HL, Brehaut JC, Sales A, Ivers N, Grimshaw J, Michie S, et al. A systematic review of the use of theory in randomized controlled trials of audit and feedback. Implement Sci. 2013;8:66

Ria Jochemsen- van der Leeuw^{1,2}, Kees van der Post¹, Nynke van Dijk²

¹ Department of General Practice/Family Medicine, Academic Medical Center, University of Amsterdam, PO Box 22700, 1100 DE Amsterdam, Netherlands

² Network of GP specialty training institutes in the Netherlands, Utrecht, Netherlands

Background

In Family Medicine, patients expect their General Practitioner (GP) not only to be competent in performing a physical examination, but also to be competent in exercising diagnostic or therapeutic procedures. Consequently, a GP trainee must grow into a competent skilful family physician by learning all the necessary clinical procedures during their family medicine educational training, primarily from their clinical trainers. However, are GP clinical trainers themselves competent in performing medical skills? Moreover, are GP clinical trainers performing as skilful role models [1] for their GP trainees? As complicating factors, many new and more complex medical skills have been added in recent years, either by task shift from the hospital to general practice or by new technological developments. Furthermore, recent studies showed new ways of developing post graduate curricula and teaching medical skills in clinical practice [2,3]. In addition, it has been shown that the number and type of medical skills basic doctors indicate to master, does not meet the expectations of family medicine educators [4]. Lastly, the current way of training the GP clinical trainers has not always appeared to be beneficial for the GP trainees [5].

Aim

To develop effective educational programs for GP clinical trainers to become skilful role models for their GP trainees

Proposed method

After an interactive presentation with an overview of the literature on role modelling and clinical skills training, medical educators (medical educational program developers, medical educational teachers, GP clinical trainers, GP trainees) first face the difficulties of transferring a medical skill through own experience. Afterwards, small groups work together to design a teaching program for clinical trainers to become competent skilful role models for their GP trainees, to apply later in their own setting. Finally, ideas will be discussed plenary.

Expected outcome

New ways of effective teaching of GP clinical trainers, beneficial for their GP trainees in becoming competent skilful GPs.

References

- [1] Jochemsen-van der Leeuw HGA, Van Dijk N, et al. The attributes of the clinical trainer as a role model: A systematic review. *Acad Med.* 2013;88:26-34.
- [2] Nicolls D, Sweet L, et al. Teaching psychomotor skills in the twenty-first century: Revisiting and reviewing instructional approaches through the lens of contemporary literature. *Med Teacher* 2016;38:1056-63.
- [3] Rekman J, Gofton W, et al. Entrustability Scales: outlining their usefulness for competency-based clinical assessment. *Acad Med.* 2016;91:186-90.
- [4] Dickson GM, Chesser AK, Woods NK, Krug NR, Kellerman RD. Family medicine residency program director expectations of procedural skills of medical school graduates. *Fam Med.* 2013;45(6):392-99.
- [5] Jochemsen-van der Leeuw HGA, Van Dijk N, et al. Educating the clinical trainer: Professional gain for the trainee? *Perspect Med Educ.* 2014;3:455-73.

J. Van den Ende¹, P. Van Royen¹, L. Debaene¹, Rina Triasih², A. Henriquez-Trujillo³, P. Basinga⁴.

¹Faculteit Geneeskunde en Gezondheidswetenschappen, Universiteit Antwerpen, Belgium

²Faculty of Medicine Universitas Gadjah Mada/Dr. Sardjito Hospital Yogyakarta, Indonesia

³Facultad de Ciencias de la Salud, Universidad de Las Américas, Quito, Ecuador.

⁴Bill and Melinda Gates foundation. Nigeria country office.

Background

In the seventies Pauker and Kassirer translated clinical decision making into everyday clinical work with their concept of the therapeutic threshold, later extended to the test and test-treatment threshold [1,2]. Kahneman and Tversky stressed the importance of heuristics for clinical reasoning, pushing Bayes' theorem more or less to backstage [3,4]. In the eighties Sackett caused a small revolution bringing clinical epidemiology to clinicians, advocating replacing sensitivity and specificity with likelihood ratio's and predictive values with posttest probability [5]. Building on the above mentioned paradigm shifts, we brought these ideas together in a clinical reasoning model we first developed in the Institute of Tropical Medicine, Antwerp, Belgium. Together with the first steps in undergraduate training in Belgium, field experiences concerned Ecuador, Bolivia, Laos and Rwanda, where workshops were organized for practicing clinicians. After several years of training and feedback it became clear that teaching should start in universities, before heuristics and intuition become the only and gold reasoning standard in routine clinical work. From 2002 on, we set up undergraduate courses based on this instructional strategy (three steps model, using visuals and built on eight concepts) in different countries and also in Belgian Universities, both in undergraduate and graduate training [6].

Aim

To identify an appropriate content of training in clinical reasoning, to report ways of introduction and difficulties encountered in earlier experiences and to formulate advice for the future.

Proposed method

After presentation of experiences by the authors and other participants, an interactive session will focus on difficulties experienced and on future developments.

Expected outcome

The workshop will be an opportunity for participants to share teaching cases, curricula, learning objectives, and evaluation measures. This can lead to a model of content and a timeline for future introductions of clinical reasoning in (under)graduate curricula and training.

References

[1] Pauker SG, Kassirer JP. Therapeutic decision making: a cost-benefit analysis. *N Engl J Med* 1975; 293(5):229-234.

[2] Pauker SG, Kassirer JP. The threshold approach to clinical decision making. *N Engl J Med* 1980; 302(20):1109-1117.

[3] Tversky A, Kahneman D. Judgment under Uncertainty: Heuristics and Biases. *Science* 1974; 185(4157):1124-1131.

[4] Kahneman D. Thinking, fast and slow. New York : Farrar, Straus and Giroux, 2011.

[5] Sackett DL, Haynes RB, Guyatt G, Tugwell P. Clinical Epidemiology: a basic science for clinical medicine. 2 ed. Boston: Little, Brown and Company; 1991.

[6] Van den Ende J et al. Klinisch redeneren - van model naar competentie. Leuven: Acco. 2018

W4.03 The best possible curriculum in family medicine for Europe

Helena Karppinen^{1,2}, Ilse Hellemann^{1,3}, Francesco Carelli^{1,4}, Milena Cojić^{1,5}, Mira Kiš Veljkovic^{1,6}, Valentina Madjova^{1,7}, Mario R Sammut^{1,8}, Natalia Zarbailov^{1,9}

¹The Basic Medical Education Committee of EURACT,

²EURACT council member of Finland

³EURACT council member of Austria

⁴EURACT council member of Italy

⁵EURACT council member of Montenegro

⁶EURACT council member of Serbia

⁷EURACT council member of Bulgaria

⁸EURACT council member of Malta

⁹EURACT council member of Republic of Moldova

Background

The Basic Medical Education Committee of EURACT initiated a process to establish standards for the undergraduate curriculum in family medicine in 2018, as a response to a WONCA statement recommending this in 2017.

Aim

The aim of this workshop is to develop undergraduate curriculum standards in line with the WONCA Europe statement, and together with a wide range of experts.

Proposed method

A preliminary proposal for minimum standards of undergraduate curriculum in family medicine will be presented. An overview of some examples of curricula is available to understand the heterogeneity in Europe. Participants will discuss the suggested items in smaller groups and they may improve and justify them. The participants are then invited to vote for emerging suggestions regarding the (1) learning goals of undergraduate teaching in family medicine, (2) the timing and duration of such teaching, (3) if and how practice visits in family medicine should be used, and the recommended (4) teaching modalities and (5) assessment methods. The workshop is facilitated by EURACT council members (European Academy of Teachers in General Practice/Family Medicine). The Basic Medical Education Committee of EURACT is responsible for strengthening undergraduate education in family medicine in Europe and has issued a number of statements and papers (www.euract.woncaeurope.org).

Expected outcome

After the workshop the shape of minimum standards for the undergraduate curriculum in family medicine is ready to be launched as a statement of EURACT.

W4.04 Using quality improvement projects to develop potential leadership skills of learners in the workplace – an example of an educational intervention in GP training.

ML Denney ^{1,2}

¹ Royal College of General Practitioners, 30 Euston Square, London NW1 2FB

² NHS Education for Scotland, 102 West Port, Edinburgh EH3 9DN

Background

Quality Improvement (QI) activity is increasingly seen as an essential part of the role of the family medicine doctor yet it is less often included in GP training in the surgery setting. QI project involvement will soon become a mandatory part of GP training in the UK, giving the trainee an opportunity to learn leadership at practice level, team working skills, and an understanding of change management. GP educational supervisors will be expected to support their trainees doing project work, and give feedback on their performance.

Aim

The aim is to give primary care educators an introduction to supporting GP trainees embarking on a quality improvement project in the workplace. Participants would be encouraged to share experiences of training and quality improvement, develop project ideas as training material, and to evaluate project ideas against a set of acceptability criteria.

Proposed method

A short presentation will give an overview of the educational intervention piloted in the final year of GP training. Participants will work in small groups to look at examples of project suggestions that trainees might bring to supervisors and discuss the strengths and weaknesses of these. The workshop will be interactive, and participants will be given time to discuss how QI processes and concepts could translate into their own training situations.

Expected outcome

Participants will be able to share ideas about the practical application of quality improvement in the training environment and work place. They should leave with an appreciation of the possible challenges involved when making decisions about the suitability of a trainee's project and how they might best support a trainee to do a feasible project, mindful of the constraints of available resources.

W5.01 Educational training requirements in Europe, fine-tuning the content of a EURACT document

EURACT specialty training committee. Nynke Scherpbier¹, Nele Michels² Martine Granek- Catarivas³, Roar Maagaard⁴, Peter Prydz⁵, Eva de Fine Licht⁶, Sonata Varvuolyte⁷

¹Department of Primary and Community Care, Radboudumc, PO Box 9100, 6500 HB, Nijmegen, the Netherlands. ² Centre for General Practice, Department ELIZA, University of Antwerp, Universiteitsplein 1, 2610 Antwerp, Belgium ³Department of Family Medicine, Sharon- Shomron District, Clalit Health Services and Sackler Faculty of Medicine, Tel Aviv University, Israel, ⁴ Centre for Health Sciences Education, University of Aarhus, Denmark. ⁵

Norwegian Medical Association, Dept of Education, Hammerfest, Norway. ⁶ Family Medicine Residency Program Directors Unit, Research and Development Center Södra Älvsborg, Västra Götaland County, Sweden.

⁷Vilnius University Faculty of Medicine Institute of Clinical Medicine Clinic of Internal Diseases, Lithuania

Background

The EURACT Specialty Training committee collected all documents that have been written on educational training requirements for GP/FM trainees. This resulted in a document called 'Educational Training Requirements'^[1] (ETR). The implementation of these requirements will vary between countries.

Aim

To get feedback on the ETR document. To enrich and fine-tune the ETR document based on input from the various countries.

Proposed method

A presentation will be given about the content of the ETR document. Then we will divide the group into three subgroups. These subgroups, chaired by members of the EURACT Specialty Training Committee, will focus on the implementation of the ETR document by looking at it through three lenses:

1. From teacher oriented to learner oriented learning.
2. From time framed to competency based education.
3. From workplace based working to workplace based learning.

Each subgroup will get one lens, through which to look at the teaching and learning methods, as suggested in the ETR document. Are they adequate? Do they want to add other methods?

We will end with a wrap-up and group discussion.

Expected outcome

The results of this workshop will be used to enrich and fine-tune the ETR document in relation to the situation in various European countries and in relation to actual educational insights. It will also inspire the participants to implement the document in their country. The final document will be published in the end of 2018.

References

^[1] N. Michels, N. Scherpbier, R. Maagaard on behalf of Specialty Training Committee of EURACT. European Training Requirements. To be published on EURACT website end of 2018.

Geurt Essers¹, Noelle Junod Perron², Marc Van Nuland³

¹ Network of GP Specialty Training Institutes in the Netherlands, Orteliusslaan 750
3528BB Utrecht, The Netherlands

² Institute of Primary Care, Geneva University Hospitals and Unit of Development and Research in Medical Education, Geneva Faculty of Medicine

³ Department of Public Health and Primary Care, KU Leuven, Kapucijnenvoer 33, 3000 Leuven, Belgium

Background

Recently medical education has shown a movement away from class room based simulations to more workplace based training and assessment of clinical competencies. This movement aims to bridge the gap between classroom learning and 'real life' clinical practice. However, workplace communication assessment generates new and context-specific challenges for medical educational practice, including an adjusted assessment practice. Various concepts and specific tools have been developed to provide solutions to these challenges.

Aim

To provide participants both some theoretical background and an experiential learning session related to the workplace based assessment of communication in the general practice setting.

Proposed method

After a short plenary introduction to the workshop, the concepts and the theoretical background for workplace based assessment will be addressed in an interactive way. Next, participants will work in small groups (3-5 pers.) to identify context factors in the clinical workplace in which they aim to assess communication. Their results will be discussed in plenary and related to known context factors in general practice. Then participants will assess a junior doctors' communication skills in a real life, videotaped clinical consultation. Assessment results will be discussed with the plenary group. Finally, participants will be asked to formulate at least one take-home message and tell other how they plan to work with that in their work situation.

Expected outcome

Participants will be able to: 1) describe approaches to assessing communication in the workplace, 2) identify the impact of context influences on communication, and 3) apply new ideas and experiences in addressing assessment of clinical communication in the workplace.

References

[1] Kiessling C, Tsimtsiou Z, Esser G, Van Nuland M, Anvik T, Bujnowska M, Hovey R, Joakimsen R, Junod Perron N, Rosenbaum M, Silverman J, General principles to consider when designing a clinical communication assessment program, Patient Education and Counseling, Vol 100, 2007, p1762-1768

[2] Esser G, van Dulmen S, van Es J, van Weel C, van der Vleuten C, Kramer A. Context factors in consultations of general practitioner trainees and their impact on communication assessment in the authentic setting, Patient Education and Counseling, Vol 93, 2013, p 567-572

W5.03 Teach as a leader ... Lead as a teacher...

Nikolaos Georgiannos^{1,3}, Eva De Fine Licht², Christina Vestlund², Spyridon Klinis³

¹Närhälsan Fristad Public Primary Healthcare Center & Educational Unit, Tärnavägen 6, 51333 Fristad, Västra Götaland County, Sweden.

²Family Medicine Residency Program Directors Unit, Research and Development Center Södra Älvsborg, Sven Erikssonplatsen 4, 50338 Borås, Västra Götaland County, Sweden.

³Hippocrates Association of General Practitioners and Family Doctors in Greece, Educational Committee, 27 Mihalakopoulou Str, 11528 Athens, Greece.

Background

Primary health care faces challenges in a continuously changing global environment. Family Medicine is expected to contribute significantly to the quality, efficiency and safety of health care and the establishment of a universal health coverage (health for all, everyone and everywhere - WHO 2018). Flexibility and creativity, exchange of educational experiences and international collaborations, transformation of family doctors' education and harmonization of educational standards worldwide can be necessary. Family medicine tutors can lead the way to successful innovation.

Aim

"Family doctors-leading the way to better health" is WONCA's key theme for 2018. Identifying and highlighting the leadership component and acknowledging its impact in the educational process, motivating and inspiring existing and future leader-tutors could be crucial for the future development of family medicine and health care.

Proposed method

A variety of methods and workshop techniques will be used to facilitate participation and interaction and reach the expected outcome. Workshop is based on the project "Teach as a leader... Lead as a teacher..." which has been developed within Leonardo EURACT Course Level 3 for trainers in Family Medicine (2017-2018).

Expected outcome

At the end of the workshop participants will be able to understand the common qualities between a leader's and a tutor's task, identify leadership opportunities and acknowledge the significance of implementing leadership skills for enhancing the impact of tutoring process, intentionally and flexibly use different concepts, methods and styles of leadership in order to create and secure appropriate educational environment and culture for further development of family medicine and health care worldwide.

W5.04 Patient, clinical expertise and evidence: on teaching and learning EBM in practice

Marie-Louise Bartelink¹, Roger Damoiseaux¹

¹Julius Centre for Health Sciences and Primary Care, Department of General Practice, University Medical Centre Utrecht, Utrecht University, Universiteitsweg 100, 3508GA Utrecht, The Netherlands

The need to use scientific evidence to support daily clinical decision making in primary care is widely supported by GP supervisors, GP trainees and medical students. Unfortunately, teaching the principles of evidence based medicine (EBM) is often experienced as a burdensome undertaking since its clinical use is often not directly clear to students. Moreover, integration of EBM in daily patient care is often not well implemented and the gap between theory and practice remains. This workshop will focus on teaching and learning EBM in the workplace and on the role of the supervisor.

Students often regard what supervisors tell and show them as the truth (eminence-based medicine), but do not always know how decisions are made by supervisors in practice. To be aware of the role and importance of the evidence, the clinical expertise and the patients' expectations behind decisions is essential in learning and teaching EBM. In practice, supervisors and students should make the implicit explicit and discuss and question why they act as they do. In this workshop we will explore together what is needed, what possibilities lie in observations of consultations and how to use tutorial dialogues to achieve that students learn how to apply EBM in clinical practice.

W6.01 Blended learning material in family medicine education - now!

Martine Granek-Catarivas¹, Natalia Zarbailov², Helena Karppinen³, Francesco Carelli⁴, Nino Kiknadze⁵, Milena Cojić⁶, Maja Račić⁷, Mira Kis Veljkovic⁸, Radmila Ristovska⁹, Pavlo Kolesnyk¹⁰.

EURACT Task Force on the Provision of Educational Material.

¹ MD, Dept. of Family Medicine, Clalit Health Services & University of Tel-Aviv, Israel

² Assoc.Prof, Family Medicine Dept, State University of Medicine and Pharmacy "Nicolae Testemitanu", Moldova

³ MD, Dept.of General Practice and Primary Health Care, University of Helsinki, Finland

⁴ Prof.of Family Medicine, University of Milan, Italy

⁵ Assoc.Prof, Tbilisi State Medical University, Georgia

⁶ Assist.Prof, Medical Faculty Podgorica, University of Montenegro

⁷ Assoc.Prof, Dept.of Primary Health Care and Public Health, University of East Sarajevo, Bosnia & Herzegovina.

⁸ MD, General Medicine Dept, Medical Faculty University of Belgrade, Serbia

⁹ MD, Center for Family Medicine, Ss.Cyril and Methodius University, Skopje, Macedonia

¹⁰ Prof, Educational and Training Center of Family Medicine, Uzhgorod National University, Ukraine

Aim and background

Blended learning methods are widely accepted in medical education. Blended learning comprises a combination of e-learning and face-to-face teaching. However, there is a scarcity of blended learning material for teaching the core competencies needed in family medicine. In addition, teachers may have mixed feelings about their abilities to develop blended learning in family medicine.

The aim of this workshop is to get inspired in blended learning. Participants will experience various tools to implement the core competencies of family medicine into medical education.

Material and methods

Both beginners and experienced teachers in family medicine are warmly invited to share in common, wishes and experiences in order to teach special competencies needed in family medicine, such as a holistic approach, treating multi-morbidity, health promotion, or decision-making based on prevalence and incidence. In the workshop, members of a task force of the European Academy of Teachers in General Practice and Family Medicine (EURACT) will launch a tool, "roadmap", to help initiate blended learning. Based on this workshop, educational material produced by EURACT task force will be revised and then made available to the participants. Further ideas and possible teaching material will be shared during group discussions, in order to be added later to the pool. Additionally, some examples of blended learning modules for family medicine will be illustrated.

Expected outcome

Shared ideas and experience will amplify knowledge and skills, and influence attitude towards blended learning, thus bringing theory to practice in family medicine education in the real world.

Conclusions

There is no need to have mixed feelings about blended learning. Join this international workshop and be inspired!

W6.02 How to teach active listening

Radmila Ristovska¹, Riste Sekuloski¹, Valentina Risteska Nejashmijk¹, Jáchym Bednář², Pavlo Kolesnyk², Vesna Homar², Elena Alexandrovna Andreeva², Nino Kiknadze²

¹Center for Family Medicine, Medical Faculty of Ss. Cyril and Methodius University, 50 Divizija 6, Skopje, R. Macedonia

²EURACT Council-CME Committee

Background

"Active listening" is one of the most important parts of Communication. Listening is more than the physical process of hearing. It is a matter of attitude and also an intellectual and emotional process. According to Hunsaker and Alessandra [1], when people are listening, they can be placed in one of four general categories, i.e., non-listener, marginal listener, evaluative listener, and active listener. Active listening is the highest and most effective level of listening, and it is a special communication skill [2].

Aim

Discuss the skills of communication and focus on the art of listening. Have an increased understanding of the techniques of effective listening.

Proposed method

There is a necessity for the development of strategies to create more awareness among doctors, concerning their active listening skills, which will lead to improved communication with patients, increase in doctors/patient satisfaction, reduction of medical errors, and increase in patient safety. During 90 minutes, devoted exclusively to Active listening, participants are introduced to different aspects of this skill. This workshop will use slides, Communications Activities, Icebreakers, and Exercises. Attendees will identify issues and participate in group exercises to help them to understand this important clinical skill. The workshop will be led by the CME group of EURACT.

Expected outcome

This workshop will enable participants to share experiences, understand and use the techniques of effective listening.

References

[1] Hunsaker PL, Alessandra T, Alessandra AJ. The new art of managing people, updated and revised:

Person-to-person skills, guidelines, and techniques every manager needs to guide, Direct, and Motivate the Team. Simon and Schuster Inc; New York NY, USA: 2008.

[2] Gonzalez TD. PhD thesis. University of Phoenix; Arizona, USA: 2009. Impact of active listening training at a California state hospital: a quantitative study

W6.03 Workshop: Video-training family medicine education: get more out of it

Birgitte Schoenmakers¹

¹Department of Public Health and Primary Care, Kapucijnenvoer 33, 3000 Leuven

Background

Since many years, teaching and training in communication skills are cornerstones in the medical education curriculum. Although video recording in a real-time consultation is expected to positively contribute to the learning process, research on this topic is scarce. Above, video training as teaching and assessment method is still not widely used. Third, both students and teachers are particularly feeling burdened by this teaching and assessment method. In the family medicine education in Flanders, it is believed there are more opportunities in video training than the mere individual training and assessing of the individual student. We therefor developed a video-training concept on four levels: assessment of the individual student, videos of students used as teaching material, videos as the base of roleplaying, videos used to assess and reflect on the training practice.

Aim

In this workshop, we will demonstrate how video-recorded consultations of students are used in family medicine education.

At level one, videos are used as training and assessment and instrument with the focus on the individual student. Students are evaluated by peers and teachers and are trained to give feedback. At level two, videos of students are used as supportive teaching material in workshops or seminars. Here, the focus is not on the student but on the intrinsic content of the consultation. At the third level, videos are used to support roleplaying. Here, students train to adapt their vocational skills based upon exemplary real life consultations. Fourth, videos are used to get more insight in the training practice. Students discuss on all aspects of practice management.

Proposed method

Participants will be guided through the digital video-platform we created and will be demonstrated how to implement this 4 level use of videos of students. This will be supported by a SWOT analysis.

Expected outcome

Participants will know/show how to develop and work with this 4 level concept of video-based teaching.

W7.01 Raising Awareness on Doctors' BurnOut Workshop

W7

Marta Marquês¹

¹Unidade Saúde Familiar Cova da Piedade, Almada, Av. Rainha D.Leonor, 2, Piso 7, 2805-009 Almada, Portugal,

Background

The theme of doctors' burnout is transversal to both young and experienced doctors. Being able to address this theme in general practice/ family doctors (GP/FM) training seems relevant for doctors' professional and personal wellbeing.

Aims

This workshop aims to: 1. Raise awareness on the theme of doctors' burnout/ doctors' wellbeing; 2. Apply a simple self-test regarding burnout levels; 3. Discuss burnout prevention measures applicable to everyday practice; 4. Provide simple communication techniques to improve doctors'/ teams' wellbeing; 5. Allow participants to practice one of these communication techniques with each other.

Proposed method

Interactive and participative methodology with: ice-breaker, brainstorm, facilitator's brief presentation, task oriented small group work and workshop evaluation.

Expected outcome

Raised awareness and reflection on the theme of doctors' burnout. Reflection on practical measures to prevent burnout.

W7.02 Cinema-education: Teaching medicine in the real world using films

John Yaphe¹

¹University of Minho School of Medicine, Braga, Portugal

Background

Fictional stories from films, books, and plays can be used effectively to teach medical students and family medicine trainees about the real world.

Aim

By the end of this workshop, the participant will know how to use film clips to explore key issues in medicine using brief clips from popular commercial films. These include the definitions of health and disease, the role of the family in coping with illness, the potential for behavioural change, the influences of gender on health, and end of life issues.

Proposed method

Following the screening of each five-minute film segment, the participants will be asked to engage in discussion of the subject of the film by defining health and disease, by drawing the genogram of the characters portrayed, by exploring their own models of behavioural change, and by assessing the needs of the characters.

Expected outcome

Participants will value ways that these films can be used to complement the teaching and training we do in our own settings and share new ideas for other applications of the arts in teaching medicine.

References

[¹] Yaphe J. Moving pictures, moving hearts and moving minds: using cinema in medical education. Rev Port Med Geral Fam 2014; 30: 11-2.

W7.03 Leadership training in family medicine

W7

Fatma G. Cihan¹, İsmail Sevinc²

¹Assoc. Prof., Necmettin Erbakan University Meram Medical Faculty, Family Medicine Department, Konya, Turkey

²Assoc. Prof., Necmettin Erbakan University Public Administration Department, Konya, Turkey

Background

Leadership training has a direct impact on the ability of medical directors to make continual system improvement. The nationwide shortage of primary care providers contributes to the lack of qualified physician-leaders, and, as a result, many physicians are recruited to these roles without leadership training beyond that provided in traditional residency or fellowship programs. A blueprint five-step call to action has been proposed: (1) build horizontally and vertically integrated collaborations between academic medical centers and community health centers, (2) increase opportunities for trainees in underserved primary care settings, (3) offer leadership training for physicians committed to care for the underserved, (4) create a national program to provide longitudinal training and mentorship for potential primary care physician-leaders, and (5) identify new funding mechanisms for medical education in community health centers. [1]

Aim:

Most family physicians lack a clear understanding of the specific role of the medical director. The aim of this workshop is to plan an education program for developing and building leadership skills in primary care for underserved settings.

Proposed method

Participants will discuss the strong and weak parts of leadership training in family medicine among their national settings and mark out an ideal training program.

Expected outcome

Innovative programs in leadership training for primary care physicians focused on serving underserved populations are necessary to provide equity and optimize access in a universal health care system. Leadership training and support for trainees who are likely to serve in community health centers will prepare students with strong leadership.

References

[1] Markuns, Jeffrey F. MD, EdM; Culpepper, Larry MD, MPH; Halpin, William J. Jr. Commentary: A Need for Leadership in Primary Health Care for the Underserved: A Call to Action, *Academic Medicine*: 2009 - Volume 84 - Issue 10 - p 1325-1327

POSTERS

P01 Developing Effecting Continuing Medical Education [CME] for Isolated Family Doctors

Jáchym Bednář¹, Elena Alexandrovna Andreeva², Vesna Homar³, Ruth Kalda⁴, Nino Kiknadze⁵, Pavlo Kolesnyk⁶, Radmila Ristovska⁷, Peter Vajer⁸, Biserka Bergman Marković⁹

¹Institute of General Practice, First Faculty of Medicine, Charles University, Praha 2, Albertov 7, 128 00, Czech Republic.

²Department of Family Medicine, Northern State Medical University, Troitsky ave 51, 163000 Arkhangelsk, Russia.

³Department of Family Medicine, Medical faculty, University of Ljubljana, Poljanski nasip 58, 1000 Ljubljana, Slovenia.

⁴Institute of Family Medicine and Public Health, department of family medicine, University of Tartu, Puusepa 1a, Tartu, 50406, Estonia.

⁵Tbilisi State Medical University, 33 Vazha Pshavela Ave, Tbilisi, Georgia.

⁶Director of Educational Research Training Center of Family Medicine, Postgraduate Faculty, Uzhgorod National University, Kapushanska 161, Uzhgorod 88000, Ukraine.

⁷Center for Family Medicine, Medical Faculty of Ss. Cyril and Methodius University, 50 Divizija 6, Skopje, R. Macedonia.

⁸Department of Family Medicine, Medical Faculty, Semmelweis University Budapest, Kutvolgyi ut 4. 1125, Budapest, Hungary.

⁹Department of family medicine, Medical school University of Zagreb, Academy of Croatian Medical Science, Dr. Ante Šercera str. 28A, 10 000 Zagreb, Croatia.

Background

Many family doctors work in isolation. It is well recognised that continuing professional development is enhanced by contact with fellow professionals which facilitates reflection on one's practice and provides the opportunity to discuss specific dilemmas. Finding cover for one's practice to attend courses can also be challenging. Isolated doctors have particular problem accessing CME, these will be addressed in this workshop.

Aim

To explore the issues of relevance to the CME of isolated family doctors

To describe existing models for the delivery of CPD to this group

To identify alternative ways in which to meet the needs of this group

Proposed method

The workshop will be led by the CME group of EURACT and will provide the opportunity to discuss isolation in family doctors and the challenges this provides in delivering effective CME. Examples of different approaches to this area will be described from several countries. Time will be spent in small groups exploring possible approaches to a range of specific learning needs including those related to disease management and communication skills. This will enable participants to share experiences and explore how to use different approaches.

Expected outcome

This workshop will enable participants to share experiences and explore how to use different approaches for CME for isolated doctors.

P02 Continuing Medical Education in Croatia Association of Teachers in General Practice / Family Medicine (ATGP/FM)

Biserka Bergman Marković^{1,2,3,4}

¹GP's medical office "prof. Biserka Bergman Marković, MD, PhD, family med. spec."

²Department of Family Medicine, Medical School University of Zagreb, Croatia

³Croatian Academy of Medical Science

⁴Association of Teachers in General Practice / Family Medicine (ATGP/FM)

Background

"ATGP / FM was founded in 1988 as an association for teaching of teachers, for the last ten years, has also been engaged in continuous medical education (CME) of all GPs in Croatia, and last two years especially for GPs in rural region and island by electronic workshops

Aim

Presentation of CME in Croatia through work of ATGP/FM.

Results

Number of GPs in Croatia 2238, active workers 1775. All ATGP / FM activities can be categorized as teaching, researching and publishing. 1. Teaching – one Symposium, nine congress (number of participants: 2015 - 566, 2016 - 678, 2017 - 576 and 2018 - 562, total 2382), a lot of workshops in four region of Croatia (number of participants: 2015 - 128, 2016 - 327, 2017 - 686 and 2018-154, total 1295) with evaluating list between 4.5 and 5.0. 2. Researching - six projects (basis for six doctoral theses and for more than a dozen papers published in Current Content journals. 3. Publishing activity - "Family Medicine" library was established with six books, proceedings of the congress with published all lecture in extensor - serve as teaching text too. Last two years, we have devoted workshops in electronic format, elaborating more than thirty themes, this year we started with electronic module of CME such as panel discussion of specialist of family medicine with clinical specialists for example about patient with multi morbidity and / or debate also with clinical specialist on default theme. The plans for the future are on-line discussions with active participants

Conclusion

Systematic and organized CME is required especially for rural and isolated region and island. Result for electronic education will be published until September 2018.

P03 Train-the-trainers: an educational path for all Flemish GP supervisors

P

Eveline Boogaerts¹, Gabie Thijs¹, Nele Michels¹

¹ICHO vzw, Kapucijnenvoer 33, 3000 Leuven, Belgium.

Background

A good clinical doctor is not necessarily a good trainer. Nevertheless, adequate "teaching skills" are essential in a high-quality training of general practice (GP) trainees [1]. These teaching skills are not standardly included in GP training and in continuous medical education.

Aim

To train and coach GP supervisors in Flanders, Belgium, from novice towards expert-teachers [1]. To form a learning community of enthusiastic, motivated, driven, and qualified GP supervisors.

Methods

To be recruited and selected as a GP supervisor, candidates need governmental approval. Specific criteria were formulated by law: follow one introduction-session and, once selected, a minimum of two train-the-trainer sessions each year. ICHO (Interuniversity Centre for the Education of General Practitioners, Flanders) formulated additional criteria: once approved and accepted, the GP supervisor start an educational path which brings them from a novice to a competent, a proficient or even an expert teacher. Regional coordinators, assisted by didactic experts, are responsible for content and training. The first two years 3 didactic trainings should be followed mandatory (from novice to competent). Additionally, a regional coordinator offers user-oriented coaching e.g., by a SWOT analysis of the GP practice. In a later stage, to become a proficient teacher, GP supervisors can follow a diversity of trainings (learner-need-oriented): workshops where specific didactic competences are explored, information sessions, peer review sessions in small-groups, seminars... Every year a central "GP supervisor Day" with international speakers is held. GP supervisors also achieve personal feedback by practice visits. Finally, some of the GP supervisors can become an expert teacher by following an advanced personal educational path.

Results

We just started this renewed educational path: 326 GP supervisors stepped in as novice teachers, 1012 are already experienced several years and follow the trainings on proficient level. Quality is mostly evaluated by short surveys after the training. GP supervisors indicate to learn a lot by discussing educational themes with peers.

Conclusion

A clear educational path helps GP supervisors to know the training conditions. In this way we can qualify our GP supervisors and in mean time build a learning community, which is working together to provide a highly qualitative GP training.

References

[1] J. Allen, E. Price, I. Svab, A. Windak. Framework for Continuing Educational Development of Trainers in General Practice/Family Medicine in Europe.

P04 Opinions of Supervisors on Vocational Training of General Practitioners in a Hospital setting in Flanders.

Riet Breesch MD¹, Johan Buffels MD, PhD¹, Nele Michels MD, PhD²

¹Department of Public Health and Primary Care, KU Leuven, Kapucijnenvoer 33, 3000 Leuven, Belgium.

²Centre for General Practice, University of Antwerp, Belgium

Background

The curriculum of the vocational training of General Practitioners (GP) in Flanders (Belgium) is being reformed. In the second of three years of training every GP trainee will have to be trained in hospital during 6 months. This creates the need for a large number of new supervisors. The large majority of these hospital staff members does not have any experience in supervising GP trainees. We hypothesized that views and experiences of existing supervisors could be useful to new candidates.

Methods

A convenience sample of hospital GP supervisors has been selected. After agreement they were invited for a semi-structured interview, focusing on experiences and opinions about training future GPs in their hospital ward. The results were manually analysed and summarized.

Results

The supervisors mentioned that training future GPs is inspiring and educational. They noticed that GP trainees use different guidelines and emphasize other points in their daily routine compared to specialists trainees. It gives the opportunity to compare guidelines of GPs and specialists, to know each other better, and to improve the collaboration between primary and secondary health care providers. As GP trainees have at least one year of clinical experience in GP practice, they can complete a full anamnesis and clinical investigation, which is an important benefit. However, a punctual supervision is needed: GP trainees do not have the same specialized knowledge and professional experience as the supervisor, which is a delicate issue in taking care of hospital patients. Providing specialist guidelines before the hospital training starts, will be important. As hospital training will now be mandatory, commitment and enthusiasm of GP trainees could be questioned. All supervisors agreed that teaching very specialized technical skills is not useful. Internship coordinators (experienced GPs) should perform hospital visits in order to have a clear view and understanding of the setting, the particularities of the workplace and the educational possibilities.

Conclusions

All supervisors agreed that hospital training of future GPs is inspiring and improves collaboration. The former clinical experience in GP practice creates new opportunities. Support from the university by the internship coordinator is an important added value.

P05 Creating New Standards for Training of Future General Practitioners in a Hospital Setting

P

Johan Buffels¹, Riet Breesch¹, Nele Michels²

¹ Department of Public Health and Primary Care, KU Leuven, Kapucijnenvoer 33, 3000 Leuven, Belgium.

² Centre for General Practice, University of Antwerp, Belgium

Background

The curriculum of the Master Degree in Family Medicine in Flanders (Belgium) is being revised. In the second of three years vocational training every future general practitioner (GP) will have to perform 6 months in hospital training. This new setting creates the need for a large number of new supervisors. The large majority of these hospital staff members does not have any experience in supervising GP trainees. This paper describes the process of creating valuable training facilities in a hospital setting.

Methods

As a first step, we aimed to explore the opinions and experiences of hospital staff members already involved in supervising GP trainees. Furthermore, we explored expectations and ideas of other stakeholders: faculty members of the 4 universities involved, GP trainees and undergraduate medical students. Based upon these findings we constructed a model of possible tasks for future GPs during their in hospital training. Learning goals were defined based (1) upon the CanMEDS framework for the generic part and (2) upon the specific learning goals for specialists in training in the various disciplines, but adapted to needs for GPs. Finally, we constructed an introductory course for candidate supervisors. An invitation was sent to all hospital staff members in Flanders by various communication channels, including medical press. The target was set to obtain 160 valuable training facilities for future GPs.

Preliminary results

The learning opportunities and the training methods showed a large variation between different hospital wards and services. To date, 185 candidate supervisors followed the introductory course. This course focused on various items: the properties of GP trainees after their first year of vocational training, the differences of reference frames between primary and secondary care, the possible tasks for GP trainees in the hospital, the need for coaching and for counseling time by the trainer, and practical issues. We experienced a lot of enthusiasm among the candidates. Emergency units and geriatric services were most often represented.

Conclusion

The construction of training facilities in hospital for GPs in vocational training in Flanders is work in progress. Until now, it is a very promising and exciting project.

References

[1] EURACT Statement for Hospital Posts used for Training in General Practice/Family Medicine. Graz, Austria 5 April 2013. Accessible by www.euract.woncaeurope.org.

P06 International exchange during vocational training: a benefit for future family doctors?

Indra Van Hoorick¹, Johan Buffels²

¹Department of Family Medicine and Primary Health Care, Ghent University, Campus UZ -Ghent - 6K3, De Pintelaan 185, 9000 Gent, Belgium

² Department of Public Health and Primary Care, KU Leuven, Kapucijnenvoer 33, 3000 Leuven, Belgium.

Background

Today, family doctors not only need to stay up-to-date about new scientific insights and fast changing technology, they also have to face socio-economic changes with globalization as an important driving force. Internationalization of the curriculum can be seen as one of the educational responses to the phenomenon of globalization [1]. International student mobility including exchange programs, global health and intercultural competency are approaches to achieve this internationalization in the discipline of medicine [2]. At the moment, a standard exchange program in the Belgian vocational training for family medicine doesn't really exist. The resident often depends on the willingness of her clinical supervisor with whom she works to let her take part in an extracurricular exchange.

Research question

In order to be able to promote international exchange among family medicine clinical supervisors in Belgium, it's important to know what their ideas, concerns and expectations are regarding the subject.

Methods

Twelve semi-structured interviews with clinical supervisors with different background and working in different setting were performed and analysed as a qualitative survey. The analysis was executed using the software program Nvivo 11 Pro and a second independent researcher analysed 4 interviews to ensure intercoder reliability.

Results

The main themes identified during analysis were the ideal exchange program from the viewpoint of the clinical supervisor, learning opportunities and objectives, concerns and expectations regarding exchange and the feasibility to implement a standard exchange program in the Belgian curriculum in the near future. Most clinical supervisors are enthusiastic about exchange. Moreover, they would all like to take part in it themselves. Most of them see learning opportunities abroad for the residents they train and for themselves. They underline the importance of defining learning objectives at an individual base before leaving. Concerns are primarily practical and also about the quality of education abroad.

Conclusion

Clinical supervisors in Belgium have in general a positive attitude towards international exchange for family medicine residents though solutions to fill the gap between the ideal exchange program and a feasible variant have to be thought of. Further qualitative research describing the viewpoint of residents themselves and the departments of family medicine in Belgium is needed in order to be able to proceed to actual implementation.

References

- [1] B. Leask, C. Bridge, Comparing internationalisation of the curriculum in action across disciplines: Theoretical and practical perspectives, *Compare*, 2013, 43: 79-101.
- [2] A. Stutz, W. Green, L. McAllister, D. Eley, Preparing medical graduates for an interconnected world: Current practices and future possibilities for internationalizing the medical curriculum in different contexts, *J Stud Int Educ*, 2014, 19: 28-45..

P07 Towards supervised independent learning in the Flemish (GPs) Context of Continuous Medical Education

P

Julie De Groot¹

¹Domus Medica, Lange Leemstraat 187, Antwerp, Belgium

Background

Domus Medica is one of the largest players in the field of continuous medical education for general practitioners in Flanders and Brussels. The scientific association strongly focuses on the development of new, more efficient and didactically stronger forms of continuous education. GME providers must take into account that learners have different learning needs, methods and learning preferences (Gardner, 1983).¹ We aim to provide qualitative continuous education, meeting the needs of our members. New teaching methods in the field of combined learning, e.g. combining group sessions with in situ demonstrations and practical learning, and online/offline teaching (e.g. e-learning) are being developed.

Aim

To develop strong teaching methods, keeping GPs up to date with the latest developments in the field of medicine and at the same time meeting individual learning needs. This conference poster gives you an overview of the different teaching methods Domus Medica has on offer, the advantages and disadvantages of each method, and it also provides the first results of the survey on e-learning, encouraging further debate.

Methods

Starting from learning objectives we search for the most suitable combination of online or offline activities, in order to support the different learning activities. We aim to combine web-based technology to achieve a specific educational goal (Van de Put, s.d.).² However, in order to do so and to evaluate quality, we must question our target audience by means of a survey among our members, GP's in training and educational specialists. Being aware of the expectations of our members considering continuous education is important given the imminent changes in the accreditation system, which will strongly emphasise personal development and personal learning objectives.

Results

Short surveys at the end of each session indicate that members are satisfied with the way in which subject matter is introduced. However preliminary surveys also indicate that the members are open to new methods. The imminent changes in the accreditation system offers a challenge, but thanks to this preparatory thinking we are able to meet expectations.

Conclusion

This poster gives an overview of the different options of continuous learning we provide mentioning the advantages and disadvantages of the (new) teaching methods. It is also an invitation to exchange ideas that will support the development of continuous medical education in family medicine (in Flanders and Brussels).

References

[¹] H. Gardner, Multiple Intelligences. The Theory in Practice. New York: Basic Books. 1993

[²] L. Van de Put, Van e-learning naar geïntegreerd blended learning. Leuven: School of Education.

P08 What are the characteristics of high achieving trainees from the training programs of General Practice and Elderly Care Medicine? And how do they learn? An interview study from the perspective of their trainers and teachers.

F. Frederiks¹, S.C. van Rhijn¹, M.R.M. Visser¹, M. Smalbrugge², J. Bont¹, A.D. Diemers³, J.W.M. Muris⁴, N. van Dijk¹

¹Department of General Practice, Academic Medical Center, Meibergdreef 15, 1105 AZ Amsterdam, The Netherlands

²Department of General Practice & Elderly Care Medicine, VU Medical Center, Postbus 7057, 1007 MB Amsterdam, The Netherlands

³Department of General Practice, University Medical Center Groningen, Huispostcode FA20, Postbus 196, 9700 Groningen, The Netherlands

⁴Department of General Practice, Maastricht University, Postbus 616, 6200 MD Maastricht, The Netherlands

Background

The training to become a medical specialist mainly takes place in the clinical workplace (workplace based learning). Some postgraduate medical trainees are identified by their supervisors as high achieving in comparison to their peers [1]. To our knowledge, the characteristics of high achieving postgraduate trainees from the training programs of General Practice and Elderly Care Medicine and how they learn during their training, from the perspective of their trainer and institute teachers, are unknown. Knowledge on this subject is important for two reasons. Firstly, the focus of the training programs is generally on supporting the weak and not on the high achieving trainees. Knowledge on characteristics of these high achieving trainees can provide insights in how they can be identified, to be able to train them, more than now, to their full potential. Secondly, it is important to gain insights in the way they learn, because they may benefit more from workplace based learning than their peers. With this knowledge, methods could be developed to improve the training program for all trainees.

Aim

Through this interview study, we primarily want to identify what trainers and teachers identify as characteristics of high achieving postgraduate trainees. Secondly, we want to identify which learning behaviour they observe within these trainees.

Methods

At this moment we are still conducting semi-structured interviews with trainers and teachers at three Departments of General Practice and at one department of Elderly Care Medicine. The interviews are audio-recorded, transcribed verbatim and analysed subsequently using MAXQDA using thematic analysis [2].

Results and conclusion

Up to now we conducted 10 interviews. We expect to achieve data saturation with approximately 15 interviews. A first analysis shows, in addition to a wide range of characteristics, different cultural considerations coming forward, when identifying high achieving trainees. At the time of the Euract congress in September 2018, the data collection and analysis will be complete and the final results can be presented and discussed.

References

- [1] M. Oerlemans, P. Dielissen, A. Timmerman, P. Ram, B. Maiburg, J. Muris and C. van der Vleuten. Should we assess clinical performance in single patient encounters or consistent behaviors of clinical performance over a series of encounters? A qualitative exploration of narrative trainee profiles. *Medical Teacher*, volume 39, number 3, 2017, 300-307.
- [2] V. Braun, V. Clarke. Using thematic analysis in psychology. *Qualitative Research in Psychology*, volume 3, number 2, 2006, 77-101.

P09 EURACT courses in Portugal and beyond

Luís Filipe Gomes¹, Denise Velho²

¹ Department of Biomedical Sciences and Medicine, University of Algarve, Portugal

² Santiago Family Health Unit, Leiria, Portugal

Background

EURACT has developed four Leonardo Teachers Courses: level 1 (competent educator), level 2 (proficient educator), level 3 (educational expert) and the assessment course. The first edition of the equivalent to the EURACT level 1 course in Portugal was an international edition, in Monchique, Algarve, in 2006. The Portuguese participants of that edition translated all the materials from English to Portuguese and began to cascade the course at a regular and steady pace to this date, even going beyond frontiers to Brazil and Catalunya.

Aim

To showcase all courses organized by Portuguese EURACT members in the last eleven years.

Methods

Cross-sectional study including every EURACT course organized by Portuguese EURACT members.

Results

We will present the total number of courses, locations and participants.

Conclusion

In Portugal, we have worked very hard to spread "EURACT's word" and we believe any country can achieve this. We hope our poster inspires members from other countries to start cascading the EURACT courses and thus contributing to the improvement of General Practice/family Medicine teaching around the globe.

P10 Multidisciplinary Approach To The Effects Of Shrapnel Parts

Meside Gunduzoz¹, Berrin Telatar²

¹Department of Family Medicine, Occupational Diseases Hospital Ankara, Osmangazi Mahallesi Atlılar Caddesi No:45 06280 ,Ankara , Turkey.

² Department of Family Medicine,Bilim University Istanbul Büyükdere Cad. No:120 34394 Esentepe Şişli , İstanbul, Turkey.

Background

Shrapnel pieces that remain in the body after the conflict may produce local and systemic effects. In this study, we analysed, in a multidisciplinary approach, on 150 patients the chronic effects of shrapnel pieces that remained in the body for averagely 20 years.

Research Question

Do the shrapnel parts in the body make a local or systemic effect?

Methods

150 patients applied to the Ankara Environmental and Occupational Disease Hospital for examination with shrapnel and bullet in the body. All the examinations were done in a family medicine clinic in a secondary care hospital. Toxicological analyse and radiologic imaging results were obtained from hospital database (FONET). Toxicological results were evaluated according American Conference of Governmental Industrial Hygienists (ACGIH) threshold values. The results of all the analyses were taken into the relevant branches in the family medicine clinic

Results

Illness diagnoses received 100 psychiatric illnesses. 65 of these are post-traumatic stress disorder, 50 patients are depressive epizote. 10 patients were diagnosed with sensorineural hearing loss. 150 patients was exposed to heavy metals and solvent: ^[1] ^[2] 25 patients' urine arsenic levels, 2 patients' blood cadmium levels, 39 patients' blood antimon levels, 35 patients' blood manganese levels, 30 patients' urinary 24 hours copper levels, 7 patients' blood cobalt levels, 14 patients' blood nickel levels, 3 patients' blood molybdenum levels, 21 patients' urine solvent levels were higher than ACGIH threshold values. 20 patients' liver enzymes (Alanine Aminotransferase and Aspartat Aminotransferase), 58 patients' LDH enzymes (Lactic Dehydrogenase), 16 patients' CK (Creatine Kinase), 16 patients' prolactin hormone, 15 patients' parathyroid hormone were above laboratory reference range and 16 phosphor element were below laboratory reference range. 50 patients' Total IgE and 45 were patients' homocysteine above laboratory reference.

Conclusion

When toxicological analysis of patients with multiple exposure of shrapnel parts are done not only a single metal would be analysed but a panel of these metals should be assessed. The physical examination and analysis towards the potential organ damages should be performed. The patients should be followed for future effects of these toxic metals. So they should be examined thoroughly by clinicians concerning these risk factors.

References

- ^[1] Squibb KS, Gaitens JM, Engelhardt S, et al. Surveillance for long-term health effects associated with DU exposure and retained embedded fragments in US veterans. JOEM. 2012;54:724–732.
- ^[2] Quigley KS, McAndrew LM, Almeida L, et al. Prevalence of environmental and other military exposures in Operation Enduring and Operation Iraqi Freedom veterans. JOEM. 2012;54:659–664.

P11 The ultrasound diagnosis of Frozen Shoulder by the Family Physicians, and a comparative Randomized Controlled Trial among High-Intensity Lasertherapy (HILT) versus Low Power Lasertherapy (LLLT) associated with Steroid Joint Injections in the treatment of the shoulder adhesive capsulitis.

Mihai IACOB

Department of Research in Primary Care, Ultrasound Working Group / EUVEKUS, Timisoara/Vienna, Capitan Damsescu street, No. 40, 300150, Romania

Background

Frozen shoulder is an often condition characterized by stiffness and pain in the shoulder joint, those cause problems both, patients by long periods of inactivity with suffering, and physicians regarding management of this pathology. This study aims to present the results of LLLT, with 685/830nm wavelength, 1800mW power, compared with the results after treatment with HILT in infrared emission 1064nm wavelength, 12W power.

Research questions

What investigation can diagnose Frozen Shoulder, and which type of therapy is more effective?

Methods

The diagnosis of Frozen Shoulder was determined by ultrasound criteria. Inclusion criteria were patients with the frozen shoulder in different stages. We conducted a prospective unblinded trial (RCT) over five years, on 750 patients, using two laser devices (semiconductor source). The steroid used in Joint Injections (SJI) was Dexamethasone. Cases studied were divided into three groups: First as Control Group includes patients with classic medication, the second included patients treated with LLLT, and the third group included patients treated with HILT, both associated with SJI. Elements evaluate each patient were: pain on a visual analog scale (VAS), a motion-functional scale (MFS) of the shoulder disability, and the Shoulder Pain and Disability Index (SPADI).

Results

Our healing rate was only 40% in the first, 77% in second and 88% in third group with significant pain reduction. All these data were entered electronic database designed by us. Analysis of risk and data obtained on patients by VAS, SPADI, and MFS scales, before and after treatment, within each group was compared by Student's t-test, and among all three groups after the final evaluation of patients by ANOVA, $p < 0.001$. The results of „2x2 Contingency-Tabel” were: -Relative Risk (RR): 0.46 (Benefit), Odds Ratio (OR) = 0.30 - between LLLT versus Control Group and RR: 0.20, 95% CI = 0.13-0.29, Odds Ratio = 0.11, between HILT versus Control, $p < 0.0001$.

Conclusions

The combination of HILT and SJI significantly improved the outcome with 48% compared to conventional therapy and may be considered the most effective treatment. HILT combined with joint steroid injection proves to be more effective than LLLT in the frozen shoulder management.

References

A full series of references is available on our Website www.euract2018.org

he Applications of "Point of Care Ultrasonography" (PoC-US) in Family Medicine: an experimental FOCUS (Focused Cardiac UltraSound) Screening or Basic Cardiac Ultrasound for non-cardiologists known under the acronyms of: Rapid Cardiac Assessment (RCA), RACE (Rapid Assessment Cardiac Echocardiography) and FADE (Focused Assessment Diagnostic Echocardiography).

Mihai IACOB, Ana REMES, Madalina STOICAN,
Department of Research in Primary Care, Ultrasound Working Group / EUVEKUS, Timisoara/Vienna, Capitan Damsescu street, No. 40, 300150, Romania

Background

FOCUS is a complement of the clinical exam, for the evaluation of cardiac function, in the hemodynamic critical patient. These concepts of ultrasonographic examination of the heart, performed as a diagnosis documentation after physical examination in cardiac care by non-cardiologists, have gained many followers over the past two decades.

Aim

FOCUS can be recommended for patients with a very high cardiovascular risk, which presents after clinical examination the suspicion of cardiac pathology, common in outpatient practice such as cardiomegaly, valvulopathy, pericarditis, endocarditis, congenital malformations, aneurysms, and arrhythmias.

Methods

The RCA can be done in a few minutes, and traditionally involves the following five views: Subxiphoid view, Parasternal long or short axis, Apical four-chamber view, and IVC assessment. Within each view, there are several cardiac sections, that can be evaluated according to the orientation of the probe. We conducted an Experimental FOCUS Screening on 1780 patients with very high cardiovascular risk. Patients at high risk, identified on inclusion criteria, were first examined by a family doctor with expertise, is subsequently compared with ultrasound review by cardiologists, to determine the accuracy of this application. We have developed a Computerized Diagnostic Algorithm of the cardiac pathology detected by non-cardiologists.

Results

We identified 585 patients with cardiac pathology at FOCUS performed by the family physician, and subsequently confirmed by the cardiologist. We did the descriptive statistical analysis of the echocardiographic cases detected. The accuracy of FOCUS screening in primary care was 96.07% with a sensitivity: 95.12% and a specificity: 96.57%, $p < 0.001$, for all 1780 emergency patients that were subsequently confirmed by the cardiologist as the "Gold-Standard" method. The combination of multiple ultrasound techniques greatly increases the precision of the method, as evidenced by AUROC. The prevalence of cardiac pathology was 34.55% with 95% CI: 32.34% at 36.81%.

Conclusion

Early diagnosis of many cardiac conditions, by FOCUS, can save the lives of patients in primary care, based on concepts and guidelines of good clinical practice. Being an operator-dependent method, we only propose it, as a complementary or as a further guidance tool for the clinical examination of the cardiac patients, and we recommend referral to the cardiologist.

References

The full series of references is available on our website: www.euract2018.org

P13 General Practice at the Deep Ed in Yorkshire & the Humber, United Kingdom

Liz Walton¹, Ben Jackson¹, Tom Ratcliffe², Dom Patterson²

^{1,2} Academic unit of Primary Medical Care, University of Sheffield, Sheffield S5 7AU.

^{3,4} Health Education England working across Yorkshire and the Humber, Leeds LS2 9JT

Background

General Practice and the 'Deep End' (Yorkshire and the Humber) brings together Family Practitioner's (FPs) caring for patients in the most deprived communities. The movement links medical education, academia, the voluntary sector and social care (1).

Aim

Our overall aim is to tap into the incredible passion and commitment among clinicians in Family Practice to help tackle the region's stark and worsening health inequalities.

Methods

The group's four key objectives were agreed at meetings in October 2015 and March 2016. - Workforce, Education and Training, Advocacy, Research (W.E.A.R.)

Results Workforce

Identified our own inverse-care law of established training practices and provided incentives to counter this. Established a Trailblazer Scheme and a Regional Workforce and Training Hub to add to the practice workforce in deprived areas.

Education & Training

Launched "Fairhealth – health equity action and learning" for GP trainee's, run CPD sessions including the topics of unexplained symptoms, diversity, caring for new migrants and infectious disease. Surveyed UK medical schools on learning on Health Inequity. Developed 'Deep End' clinical Undergraduate Placements.

Advocacy

Worked with community groups on social prescribing. Taken positions within the emerging NHS structures where we can raise the matter of health inequity within the systems.

Research

Established a Research cluster of 'Deep End' Family Practitioners and a patient participation research group. Carried our research into FP resilience, self-management, FP supply and views of trainees.

Conclusion

Passionate clinicians work hard across the region daily to address health inequity, and we hope the Deep End movement brings these colleagues closer together and raises the profile of their work and challenges. We will continue to nurture and build this network. Deep End General Practice has extraordinary potential to improve lives and we wish to play our part in helping this become a reality. We continue to keep our blog up to date <https://yorkshiredependgp.org/>

References

[1] Walton L, Ratcliffe T, Jackson BE, Patterson D. Mining for Deep End GPs: A group forged with steel in Yorkshire and Humber. Br J Gen Pract. 2017;67(654):36–7.

P14 Development of an innovative training intervention in GP Vocational Training Scheme of Central Makedonia Region in Greece

Dimitrios Karanasios¹, Athanasios Symeonidis²

¹Coordinator of GP training in AHEPA Hospital, HIPPOCRATES Association, Michalakopoulou 27, 11528 Athens, Greece.

²General Coordinator of GP training in Central Makedonia, HIPPOCRATES Association, Michalakopoulou 27, 11528 Athens, Greece.

Background

Differences of GP trainees' competences in chronic disease management, are quite obvious in our region. The General Coordinator's Office of GP Training, realizing the inequalities in training between several Primary Health Care Units and Hospitals, scheduled an intervention to harmonize teaching and learning.

Aim

To develop and evaluate an innovative training intervention for the total number of Central Makedonia Region's GP trainees, for 2017-2018

Methods

26 GP Tutors of Hospitals and Health Centers, put in practice five daily workshops, with a mean number of 120 GP trainees as participants. The educational themes were selected by the assembly of Tutors. A theoretical background of every theme was presented at the beginning of the day by trainees. Group working in case studies and clinical skills laboratory with mannequins was following, in groups of 8-10 GP trainees with a couple of Tutors as facilitators. There was a guidelines-based checklist of the same specific questions and issues for all the groups, followed strictly by the facilitators in every group discussion. Key points of group discussions were presented in plenary afterwards. Finally, feedback was given by GP trainees to the plenary for this educational procedure.

Results

From September 2017 until June 2018, 120 GP trainees were trained in five workshops, following the same method in the same place at the same time, in chronic disease management. An evaluation of the procedure will be done in the clinical setting of GP trainees by their Tutors with the beginning of the new academic year.

Conclusions

Access to such training interventions for the total of GP trainees of a region in Greece, gives the opportunity to an equal and harmonized training in several topics which were absent or educationally hospital-oriented. It is expected that such training interventions will be implemented to the rest regions in Greece.

P15 Blended Learning in Family Medicine: Coordination, Comprehensiveness, continuity of care

Authors: Nino Kiknadze¹, Francesco Carelli²

¹EURACT Country National Representative of Georgia.

²EURACT Country National Representative of Italy.

Background and objectives

E-learning teaching modules in medicine are widely used with students and medical doctors of all specialities. Traditional E-learning modules are disease or symptom oriented. In Family medicine teaching core competencies need different approach and blended learning – combination of e-learning modules and face-to-face teaching seems to be optimal for this. Literature about experience in E-learning modules specific for family medicine competences is insufficient and better understanding is needed to determine effective and acceptable modules both for teachers and students.

Aim

Use blended learning modules of principles of Family Medicine in practice, assess and improve them.

Methods

3 Teachers of family medicine piloted blended learning module in Family Medicine (Continuity, comprehensiveness and coordination of care) with 30 6y. Undergraduate students. E-learning part was in Google form or by e-mail, students submitted forms and next day they had traditional class. All students after finishing both part of module were asked to fill short Questionnaires about module. There were 2 groups of Questions: 1. preferable learning methods, 2. Satisfaction with the course content with rating from 0 to 10. Also Teachers gave their feedback.

Results

For students 3 most preferable learning methods were Work/Practice based learning 67%, reading 57%. E-learning modules – 53%, and they found blended learning module helpful for their educational needs and rate content of module 8 out of 10. They wish technologically more advanced online part of module. Students were, in general, satisfied with the course, giving a rating of 7.5 out to 10. Teachers found split of module time saving and modern.

Conclusion

Online medical education becomes more and more popular. Blended learning of main principles of family medicine is effective for students and acceptable by teachers as a time saving and effective method. E-learning modules in Family Medicine can assist in the distribution of learning opportunities in the undergraduate learning program. Technical support is needed to do modules more easy to use and with appropriate navigation.

References

- [1] Eric P. Skye, MD; Leslie A. Wimsatt, PhD; Tara A. Master-Hunter, MD; Amy B. Locke, MD. Developing Online Learning Modules in a Family Medicine Residency. Family Medicine MARCH 2011 • VOL. 43, NO. 3 pp 185-192
- [2] E-learning for health professionals.Vaona A¹, Banzi R, Kwag KH, Rigon G, Cereda D, Pecoraro V, Tramacere I, Moja L., PMID: 29355907 DOI: 10.1002/14651858.CD011736.pub2
- [3] THE EUROPEAN DEFINITION OF GENERAL PRACTICE / FAMILY MEDICINE WONCA EUROPE 2011 Edition

P16 Problem-based learning in postgraduate family physician education process.

Iryna Klymas¹, Liudmyla Khimion¹

¹Shupyk National Medical Academy of Postgraduate Education, Family Medicine Department, 9, Dorogozhytska St., Kyiv, 04112, Ukraine.

Background

One of the most important tasks of postgraduate family physician's education is development of clinical thinking and wide range of competencies, needed for the further independent work. The most effective way to combine all above mentioned knowledge with the clinical tasks for the learning process is learning on working place and uses the simulated clinical situations with the step by step approach to resolve clinical cases with the help and the teacher supervising. In this regard the problem-based learning (PBL) technology considered to be the most effective way.

Aim or research question

To evaluate the knowledge survival after PBL and traditional methods used in the postgraduate family physician education process.

Methods

The study was conducted at the Family Medicine Department of the Shupyk NMAPE in 2017. 98 residents in "General Practice - Family Medicine" were divided into two groups during 2 weeks of teaching themes "Acute coronary syndrome", "Rheumatoid arthritis". The first group used PBL methods (in small groups) and second – used only traditional methods (lectures, seminars, patients' demonstration). For PBL residents were offered a few written scenarios, reflected the most frequent and typical clinical situations on above mentioned themes (first level) and further – a few more difficult clinical situations (second level). All proposed clinical problems were discussed in small groups according to the written tasks and questions under teacher guidance. The written control tests with multivariate answers were performed in each group of residents after 7 days (current), and 6 months (final).

Results

In general, residents from first group demonstrated better knowledge surveillance in 7 days and 6 months after learning comparing to the second group: 94-96% of the correct answers comparing to 86-92% in 7 days and 82-94% comparing to 73-80% in 6 month.

Conclusion

Use of PBL technology in postgraduate training of family physicians helps to develop longer lasting knowledge comparing to traditional learning. PBL requires more intense work from both resident and teacher is more time-consuming during preparing phase (for teacher) but is more effective for information survival.

P17 What is more sustainable late after family doctor's training: academical knowledge or motivation to change the performance?

Ivanna Shushman¹, Pavlo Kolesnyk¹, Kenez Yevgenia¹

¹Postgraduate Faculty of Uzhhorod National University; Educational and Scientific Training Center of Family Medicine, 88000 Uzhhorod, Ukraine.

Background

The Ukrainian primary health screening program has not been based on evidence. We need to increase family doctors' (FDs') motivation to introduce a new, evidence-based screening system into their clinical practice. The traditional system of continuous medical education in Ukraine places FDs in the role of passive listeners. There have been no studies on the effectiveness of interactive methods for training Ukrainian FDs in terms of increasing their motivation to adopt evidence-based screening into their practice.

Research question

How effective are interactive training methods in changing Ukrainian FDs' knowledge and motivation to adopt evidence-based screening into their clinical practice?

Methods

During 2016-7, as part of the World Bank Project, we organized twenty 8-hour training courses on "Evidence-based prevention, screening and management of cardiovascular risks among patients in FDs' practice". Over 600 Western-Ukrainian FDs took part. We evaluated changes in their knowledge by using 20 multiple choice questions administered before, immediately after, 3 and 12 months after training. We also assessed changes in their attitudes using a 25-question "Motivation to change practice" scale (adapted from an IDEA Health and Fitness Association questionnaire¹), in which a score of 1-10 indicates low motivation to change, 11-20 indicates moderate motivation, and more than 20 indicates high motivation.

Results

FDs' level of knowledge in the topic was low before the training, with a mean of 6.1 (S.D. 1.8) correct answers out of 20, but it increased significantly after training to 14.7 (S.D. 2.3; $P < 0.001$). Three months later the mean number of correct answers had decreased to 9.94 (S.D. 3.27); this was still higher (though not significantly) than at the beginning of the training. The proportion of FDs who were highly motivated to change their practice increased significantly from 9.3% before the training to 37.3% immediately afterwards. Three months later, 29.7% of FDs were still highly motivated. The 12th months results after training survey is in progress and will be presented on the Conference.

Conclusions

The interactive training model was effective as a method for increasing the proportion of Ukrainian FDs who were highly motivated to adopt evidence-based screening into their clinical practice. While their knowledge initially increased significantly, this increase was not sustained.

References

[¹] IDEA Health & Fitness. How to Motivate and Retain Your Clients. San Diego, USA: IDEA Health & Fitness Association, 2002.

P18 Learning by narratives about emotions during pre-clinical years in Helsinki Medical School

Liisa Kuikka¹, Helena Karppinen¹ and Kaisu Pitkälä¹

¹ Department of General Practice and Primary Health Care, P.O.Box 20, 00014 University of Helsinki, Finland.

Background

A narrative is a powerful learning tool. Interviewing enables one to understand people, their emotions and what they have experienced. Understanding of normal psychological development was lacking in medical curriculum in University of Helsinki, Finland.

Aim

We wanted to expose our medical students to narratives of people of various ages. The period is a part of primary health care course that aims to improve knowledge of psychological development, and how people experience their lives and suffering at different ages.

The aim of this research is to evaluate how the students observed and understood emotions and life-course perspective that were evoked by narratives of different people.

Methods

Since 2007 the second-year medical students visit nurseries, homes of older people, centres of disabled people and centres for people recovering from life crisis like drug addiction. The students interview one person during each four visits trying to perceive a narrative of the person's life, and they write a learning diary later. Emergent themes from the diaries have been analysed qualitatively (thematic content analyses).

Results

The visits were eye-opening experiences for many students. One emergent theme was respect towards all kinds of people, and importance of discussion with patients. Many were concerned about resources.

Excitement among toddlers, future plans among rehabilitees, and resilience among older people were reported often in the learning diaries.

Conclusion

The second-year students showed an improved understanding towards people coming from various life contexts. Narratives allow students to have more immediate emotional experiences. These experiences can help them to understand future encounters with similar patients. Furthermore, narratives are a safe way of processing emotions evoked by different life stories.

P19 Educational ups and downs in rural primary health care settings - the voice of EURIPA IAB

Donata Kurpas ¹, Kateřina Javorská ², Beata Blahova ³, David Halata ²

¹ Chair of IAB, EURIPA; Wrocław Medical University, Poland; ul. Syrokomli 1, 51-141 Wrocław, Poland

² IAB, Euripa – Czech Republic; Working Group on Rural Practice of the Czech GP Society, Sokolská 490/31, 120 00 Prague 2, Czech Republic

³ IAB, Euripa – Slovak Republic; SZU Bratislava, Limbova 12, Slovakia

Background

EURIPA is a representative network organization founded by rural family doctors to address the health and wellbeing needs of rural communities and the professional needs of those serving them across Europe irrespective of location, culture or resource. It represents a growing network of rural practitioners and organizations across Europe working together to disseminate good practice, initiate research, develop rural education, and influence policy. The purpose of the IAB (International Advisory Board) is to be a direct contributor to EURIPA's main goals as well as to develop cooperation between rural family doctors and primary care experts across all European countries. By working together within EURIPA we support not only our members in their scientific projects, but also share practical information suitable for the everyday diagnosis and treatment of our rural patients as well as supporting our colleagues and their patients in the most remote areas.

Aim

The purpose of this workshop (WP) is to present the most urgent issues regarding undergraduate and postgraduate training needs of general practitioners in rural and remote areas in countries of EURIPA IAB members.

Proposed method

The 10-minutes presentations of EURIPA IAB members will be followed by a discussion panel which will be guided and summarized by moderators.

Expected outcome

Our WP will allow for the identification of problematic and common issues regarding undergraduate and postgraduate training needs of general practitioners in rural and remote areas. The WP will provide useful insights into perceived priorities for future educational projects. The WP may inspire participants faced with the challenges of rural medicine training to tackle the differences between rural and urban areas by focusing on the needs of trainees and young doctors in rural and remote areas.

P20 Motives and expectations of mentors on categories of general medicine of the medicine faculty in Belgrade

Branka Lazić¹, Vesna Janjušević¹, Vesna Mandrapa¹, Lila Apostolska¹

¹Healthcare centre Old Town, Simina 27, 11000 Belgrade, Serbia

Background

In the Republic of Serbia, the specialization program for general practice implies that a doctor specializes in an office with a mentor for 24 months by acquiring knowledge, mastering skills, adopting attitudes and becoming more competent. By joining the General Medicine Unit of the Serbian Medical Society in EURACT 2004, we got the opportunity to attend training courses for mentors. All colleagues who, with the kindness of EURACT, attended one of the courses, in return, had an obligation to repeat the same in Serbia. Mentoring is completely voluntary.

Aim

We examined the motives and expectations of mentoring work in the group of doctors of the course participants. Strengthening the network of mentors in GP / FM in the country is a prerequisite for a quality primary health care system.

Methods

During EURACT Leonardo 1 course in april 2018.at Medicine faculty in Belgrade we conducted a survey of 40 participants by anonymous questionnaire with 8 questions about: age, gender, work experience, on their motives and expectations for dealing with mentoring work and final assessment for specialization of general practice.

Results

In the group of 40 participants there were 31 (77.5%) females, 25 (62,5%) were under 55 years old. Analysing the years of service, in the group of 16-35 there were 29 (72,5%) . A far as the specialist work experience is concerned, there were 20 (50%) with 5-15 years of experience. Most of them 29 (72.5%) considered that the motive for mentoring was complex and selected all three offered answers: transfer of experience, creating a model of behaviour and encouraging young colleagues to improve their competences. In the group younger of 55 years, 21 (52.5%) noted that they expected material compensation for mentoring work; and 8 (20%) expect recognition in professional status and self-realization ($p<0,05$). It is interesting that everyone answered yes to the last question whether the mentor's assessment should be decisive during a specialist exam.

Conclusion

The motivation for most of participants for mentor work are complex. The expectations half of them are material compensation and for 85% are recognition in professional status, self-realization and material compensation.

References

- [1] Zarbailov N., Wilm S., Tandeter H., Carelli F., Brekke M. Strengthening general practice / family medicine in Europe-advice from professionals from 30 European countries. BMC Fam Pract. 2017; 18 (1): 80.
- [2] Selection of General Practice / Family Medicine (GP / FM) Trainers / Practices and Implementation of Specialist Training in GP / FM European Academy of Teachers in General Practice / Family Medicine, EURACT, Jerusalem, Israel, 23 March 2012
- [3] Allen J., Schwab I. Framework for Continuing Educational Development of Trainers in General Practice in Europe (CEDinGP), EURACT, Krackow, Poland, 2012.

P21 Have you tried www.BRADFORDVTS.co.uk?
the free GP training resource for everyone, not just Bradford

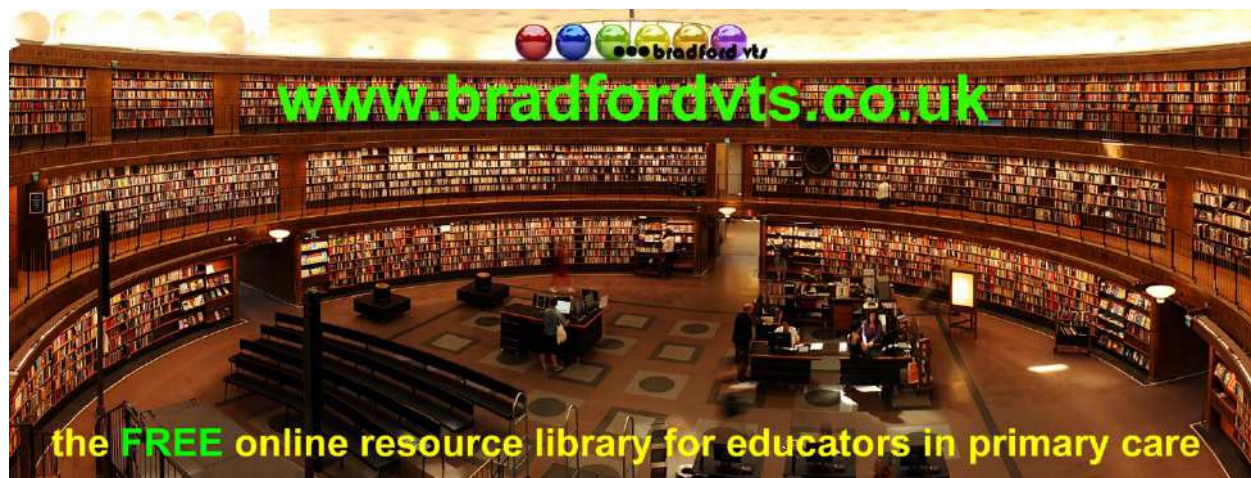
P

Dr. Ramesh Mehay¹

¹Ashcroft Surgery, Bradford, UK

Background

Back in 2001, when the author became a Programme Director for the Bradford GP Training Scheme (UK), he went to a meeting on how we teach audit. He was surprised at how all GP Educators had a PowerPoint on audit, developed individually by themselves, and yet they all said more or less the same thing! He asked the question why we didn't share resources to stop us from reinventing the wheel and instead help us progress educational material to the next level. Hence the website - a central FREE repository of donated educational material from GP educators all over the UK.



Bradford VTS is a FREE online library of primary care educational resources for everyone.

Aim

The structure, function and usage of the website will be described.

Methods

The website provides:

- 1) Free educational resources for both GP educators and trainees. Hundreds of documents, PowerPoints and videos to help with tutorials and training. And it's constantly growing!
- 2) Free templates - like evaluation forms, personal development plans etc.
- 3) Lots of web pages on GP training in general.
- 4) Buckets of information for the MRCGP. Top tips for AKT, CSA and WPBA.

It is used because it's free! Free GP training resources to make life EASIER for GP Educators. Why re-invent the wheel? The online library allows participants to use, modify and play with downloaded material. No advance permissions necessary. Although targeted at UK Primary Care, most of the resources (communication skills, leadership etc.) are equally useful for primary care educators outside the UK.

Results

Figures indicate Bradford VTS gets over 10,000 hits PER MONTH. A third are from Europe.

Conclusion

The Bradford VTS website was created in 2001. Since then it has grown rapidly in popularity and is now UK's number one training website for GP educators and GP trainees. Website statistics would suggest there is a wider audience than just the UK.

P22 Can we pool our efforts to deal with GP shortage in Europe?

Nele Michels¹, Peter Vajer², Ruth Kalda³, Adam Windak⁴, Eva Jurgova⁵, Marta Velgan³, Markku Sumanen⁶, Torunn Bjerve Eide⁷, Ryan Prince⁸

¹Centre for General Practice, Department ELIZA, Faculty of Medicine and Health Sciences

University of Antwerp - CDE, R3.14, Universiteitsplein 1, 2610 Antwerp, Belgium

²Department of Family Medicine, Medical Faculty, Semmelweis University Budapest, Kutvolgyi ut 4., 1125, Budapest, Hungary

³Institute of Family Medicine and Public Health, department of family medicine, University of Tartu, Estonia

⁴Department of Family Medicine, Jagiellonian University Medical College, Poland, Krakow, ul. Bocheńska 4

⁵Slovak Society of General Practitioners, Líščie údolie 57, Bratislava, Slovakia

⁶Faculty of Medicine and Life Sciences, University of Tampere, Finland

⁷Institute of Health and Society, Department of General Practice University of Oslo, Oslo, Norway

⁸National GP Recruitment Office, St Chad's Court, 213 Hagley Road, Birmingham B16 3RG

Background

Current research on shortage of general practitioners (GPs) in Europe is rather descriptive and local. If we want to deal with this issue, pooling of data will be necessary and interventions, both educational and political/societal, should be set up. Collaboration is needed and a (research) network on European primary care workforce could be helpful. First steps to create a network are already taken.

Aim

Aim of the workshop is to generate ideas on collaboration and extension of a (research) network.

Proposed method

First, we will frame the objectives and the challenges primary care is facing. Second, we will use the GPS brainstorm method to generate ideas and initiate collaboration projects. This method starts with working in duo's/small groups and ends in plenum. As such we end up with a plenary conclusion on (and with) concrete steps to move on.

Expected outcome

In this structured and interactive way, participants who want to be involved in a (research) network on primary care workforce shall have a clear view on what to expect from future collaborations and how they can be realized.

P23 Challenges in the implementation process of a new family medicine curriculum in Romania

Andrea Elena Neculau¹, Viorela Enăchescu², Adela Iancu³, Liliana Marcela Rogozea⁴, Gindrovel Dumitra⁵

¹Associate professor of family medicine, Department of Fundamental, Clinical and Prophylactic Sciences, Transilvania University Brasov, 56 Nicolae Balcescu street, 500019, Romania

²Professor at the Department of Family Medicine, Craiova Faculty of Medicine, President of the Family Medicine Advisory Board of the Romanian Ministry of Health, 2 Petru Rares street, Romania

³Associate professor at the Department of Family Medicine, University of Medicine and Pharmacy, Bucharest, 37 Dionisie Lupu street 030167, Romania

⁴Professor, Department of Fundamental, Clinical and Prophylactic Sciences Transilvania University, Brasov, 56 Nicolae Balcescu street, 500019, Romania

⁵Gindrovel Dumitra, Vicepresident of the National society of Family Medicine, 10 Ionel Perlea street, 010209, Bucharest

Background

Family Medicine is a recognized specialty in Romania since 1991. Since then, generations of GP's have graduated a vocational program led by the Departments of Family Medicine from the 11 Faculties of Medicine. The initial vocational program had two main problems: it was excessively centered on Hospital Rotations (21 months of Hospital rotations in comparison with 15 months of GP practice), coordination of trainees was led by specialist from other clinical fields and the final evaluation was (and still is) based on clinical cases in Hospital settings, not adapted to the practice in the community. In 2016, a new curriculum was developed by a group of GPs' coordinated by the Advisory Board of the Ministry of Health together with the Departments of Family Medicine from all Universities. The length of the program was extended to 4 years, with half of the time spent in the GP's office. As a novelty, 2 weeks of rural rotations were introduced, also a communication module, evidence-based medicine and an ultrasound interpretation module. The implementation phase requires coordination from both the Ministry of Education and Health.

Aim of research

The purpose of this research is to give an answer to the following questions: what the regulatory and organizational needs are to put in place a network of accredited GP practices, how to follow residents during hospital rotations, how to implement an online log book.

Methods

Medical Universities representatives, Ministry of Health representatives, GPs active in family medicine department, tutors in family medicine, representative members from professional organizations will meet in a series of focus groups. The paper is focusing on a SWOT analysis of the problems in the implementation process of the new curriculum.

Conclusion

Results are to be presented to a joint committee from both ministries of Education and Health.

P24 Educational needs of medical students with a special interest in family medicine.

K. Nessler¹, J. Hrabia², A. Krztoń-Królewiecka¹, A. Windak¹.

¹Department of Family Medicine, Jagiellonian University Medical College, Bocheńska 4, 30-061, Krakow, Poland.

²Family Medicine Interest Group, Department of Family Medicine, Jagiellonian University Medical College, Bocheńska 4, 30-061, Krakow, Poland.

Background

Early exposure is a method that can be utilized in order to attract students to a certain field. Among medical students, specialty interest groups are a means through which this early exposure can be attained. One such interest group is the Family Medicine Interest Group (FMIG), and it is currently the third largest specialty interest group at Jagiellonian University Medical College (JUMC).

Aim

Aim of the study was to explore the educational needs of medical students with special interest of family medicine.

Methods

An anonymous online questionnaire was sent to all FMIG members, either through e-mail or Facebook. A gentle reminder was sent after five days, requesting the students to take part in the survey. The questionnaire was made up of two parts; the first consisted of five demographic questions, while the second consisted of eight questions regarding the students' needs and expectations of the FMIG. Namely, the students were asked about their reasons of joining the FMIG, their organizational preferences, their most favourable method of work and forms of contact, and finally, which areas of family medicine they would like to learn more about. The answers to some questions were based on the Likert scale, which consisted of the following options: strongly agree, agree, neither agree nor disagree, disagree, and strongly disagree.

Results

The study group consisted of 56, who are members of FMIG, both in Polish and English medical programme. 45 students responded (response rate 80%), 63% from JUMC's English program. Approximately 58% of participants are considering family medicine as their future specialty. The main reasons of joining the FMIG were to get more clinical experience (77%) and understand better the nature of family practice (74%). The most preferred form of students' activity reported by 95% of the study participants was having the possibility of joining family doctor in the office when available. More than 55% of respondents was interested in working on scientific project. Additionally, the study showed that clinical skills training was the students' most favourable method of work (81%). Finally, nearly two-thirds of respondents (65%) confirmed that their membership in FMIG has increased their interest in family medicine.

Conclusion

Our study revealed that an improvement of clinical skills is the members' main expectation of the FMIG. They thus view the FMIG as a group through which they can learn more practical knowledge, especially that of the work of a family doctor in every day practice.

P25 Designing an immunization e-course for healthcare workers in cooperation with family medicine trainees

Marje Oona¹, Janne Haar², Sander Heidmets², Pirje Hütt², Kristina Kesküla², Marge Pihu², Marika Talumäe², Triin Marandi³

¹Associate professor, Department of Family Medicine, University of Tartu, Puusepa 1a, Tartu 50406, Estonia.

²Trainee in family medicine, Department of Family Medicine, University of Tartu, Puusepa 1a, Tartu, Estonia.

³Instructional designer, Lifelong Learning Centre, University of Tartu, Ülikooli 18, 50090, Estonia.

Background

In Estonia every family medicine trainee has to conduct a supervised research project within residency. There was a keen interest among family medicine trainees to conduct research in immunization topics. According to the Estonian legislation, every healthcare worker (HCW) administering vaccines has to attend a special continuous medical education (CME) course every 5 years according. Small number of courses consisting of uniform auditory lectures had been provided so far. There is a large number of HCWs administering vaccines in Estonia: family doctors, family nurses, school nurses, midwives, etc. HCWs' learning needs are diverse depending on their specialty, working place and how experienced they are. The needs for immunization training were not covered neither by course content nor by learning opportunities available.

Aim

The study had a dual aim: the first, to guide family medicine trainees in their research project, the second, to develop a pilot e-course for HCWs. For the second aim we specifically aimed to identify HCWs needs for filling gaps in their professional knowledge and skills regarding immunizations, to identify key characteristics of learners (previous knowledge, learning context and access to technology) and learners' attitudes, preferences and expectations towards the immunization e-course.

Methods

Group discussions with family medicine trainees, as well as with future teachers of the pilot e-course and with instructional designer for designing future research and pilot e-course were conducted. Family medicine trainees performed focus group studies involving different key professionals providing immunizations (family doctors, family nurses, and school nurses) and online surveys among HCWs using professional societies e-mailing lists.

Results

Altogether 6 family medicine trainees were involved in the design research project. Main themes and preferred methods for an e-learning course emerged from focus group studies and online surveys. An e-course consisting elective e-modules which are instructor led and facilitated was developed. Altogether 91 HCWs took part in the pilot e-course and the feedback was generally very positive.

Conclusion

Designing an e-learning course with elective modules in close cooperation with key stakeholders incl family medicine trainees is feasible.

P26 Enabling transfer of learning at the workplace: The validation of a tool for medical students and supervisors

Sanne Peters¹, Geraldine Clarebout^{2,3}, Bert Aertgeerts¹, Nele Michels⁴, Peter Pype⁵, Lorette Stammen², Ann Roex¹

¹Academic Center for General Practice, Department of Public Health and Primary Care, KU Leuven, Kapucijnenvoer 33, 3000 Leuven, Belgium.

²School of Health Professions Education, Maastricht University, Universiteitssingel 60, 6200 MD Maastricht, the Netherlands

³Center for Instructional Psychology and Technology, KU Leuven, Dekenstraat 2, 3000 Leuven, Belgium

⁴Center for General Practice, University of Antwerp, Universiteitsplein 1, 2610 Wilrijk, Belgium

⁵Department of Family Medicine and Primary Health Care, Ghent University, De Pintelaan 185, 9000 Ghent, Belgium

Background

It is often unclear who is responsible for enabling transfer of learning during workplace-based learning experiences. In order to increase learning opportunities, it is important that expectations are discussed and alignment is reached between the student's and supervisor's expectations.

Aim

This study aims to validate a tool that could be helpful in facilitating this conversation between student and supervisor, enabling them to find an alignment after making their expectations explicit.

Methods

The validation focused on reaching consensus about representativeness, clarity and relevance of the tool across four medical schools. A modified Delphi approach was conducted over three rounds of inquiry. Round one was an online questionnaire. In round two group discussions were held and round three consisted of final comments on the revised tool.

Results

Students, supervisors and coordinators validated the tool. The tool was perceived to help in clarifying expectations of students and supervisors, finding alignment and making agreements about responsibilities for enabling transfer of learning. Only small adjustments to the tool were required and consensus was reached about the revised tool.

Conclusion

The tool was perceived as very useful for workplace-based learning and can easily be implemented in medical training, as well as in other contexts.

P27 The impact of using a semi-structured computerized mental health interview on the self-rated confidence & competence of medical students

Bennett Quinn¹

¹Blackheath Medical Centre Wirral & University of Chester, UK

Background

Primary care views the diagnosis of mental health disorders such as anxiety, depression and eating disorders as falling within their remit but the evidence suggests that primary care fails to recognise mental health symptoms and, even when it does, responds with a low level of diagnostic accuracy. Goldberg, Howe & Smith all question how well equipped primary care is to provide adequate mental health care to their patients.

Research question

This research assesses the impact of using the Global Mental Health Assessment Tool (GMHAT) on the self-rated confidence & competence of third year medical students in undertaking mental health assessments in UK primary care.

Methods

Students were trained in the use of GMHAT. Training included practice interviews, refinement of questioning techniques and guidance on assessment of symptom presence & severity. Students interviewed patients using the tool during their attachment. Students completed a self-rating at the start and end of their attachments. They were also interviewed to explore their opinions on semi-structured support tools in general and GMHAT in particular. The recordings were thematically analysed.

Results

The students varied considerably in their experience of mental health assessments and in their initial self-rated confidence & competence. There was a clear improvement in their self-rated assessments at the end of their attachments. Analysis of their exit interviews underlined the improvement in their confidence & competence in undertaking mental health assessments.

Conclusion

The evidence suggests that primary care is under-equipped to care for patients with mental health disorders even though their prevalence exceeds the combined prevalence of hypertension & diabetes. This research shows that training students in the use of a semi-structured tool which they then use in their clinical practice increases their self-rated confidence and competence in undertaking a mental health assessment. This approach has the potential to facilitate undergraduate teaching and improve the skills of future primary care physicians.

P28 Risk factors for voiding disorders in children

Valentina Risteska Nejashmijk¹, Radmila Ristovska¹, Katarina Stavrikj¹

¹Center for Family Medicine, Medical Faculty of Ss. Cyril and Methodius University, 50 Divizija 6, Skopje, R. Macedonia

Background

Voiding disorders in children may present with a wide range of symptoms which can include: difficulty in emptying bladder, urinary hesitancy, slow or weak urine stream, urinary urgency, urinary frequency or dribbling of urine, nocturnal enuresis, diurnal enuresis etc. These disorders are often accompanied by other symptoms that may be associated with the underlying cause of the disease. There are more risk factors for difficulty in urinating in children, and therefore careful and thorough medical history and physical examination is needed.

Aim

To develop online and contact continuing medical education (CME) courses, and short guides for primary care physicians, by using case based approach with targeted feedback for managing voiding problems in children.

Methods

We will present 7 cases with voiding problems, due to various etiological causes, delivered from everyday practice. Cases were selected as representative for the whole group of children with similar symptoms. Each case of a child with voiding problem processed in a specific scenario. In each scenario step by step approach in management is included, depending on the existing symptoms.

Results

Data analysis has found that the most frequent risk factors for voiding disorders in children in Primary care practices are: phimosis in boys, constipation and vulvovaginitis in girls, helminthiasis, unstable bladder and hydronephrosis which are not so frequent but have to be earlier recognized as a complication of VUR and nephrolithiasis.

Conclusions

Voiding problems in children can be result of a wide range of different diseases, and therefore, an up to date knowledge is needed, because only in that way the children will have benefit from the treatment. Interactive CME courses, with short guides, could influence outcome of learning and improve health quality, followed by regular quality check.

P29 Enhancing mentoring in medicine – Combining novice mentoring with peer and near-peer mentoring: a thematic analysis of mentoring programs between 2000 and 2017

Samuel Yong Siang Lim¹, Eugene Yong Hian Koh¹, Benjamin Jia Xing Tan¹, Ying Pin Toh^{2,3}, MBBS, MRCPCH, Lalit K. R. Krishna^{1,3,4,5}, MBChB (Liverpool), FRCP (Edin), FAMS, MA (Ethics), MA (Medical Education), PhD (Singapore)

¹Yong Loo Lin School of Medicine, National University of Singapore

²Family Medicine Residency, National University Hospital Singapore

³Division of Palliative Medicine, National Cancer Centre Singapore

⁴Duke-NUS Graduate Medical School

⁵Centre for Biomedical Ethics, National University of Singapore

Background

Excellent mentorship is essential in training the next generation of family physicians. Novice mentoring helps develop the professional and personal domains of mentors and mentees in Family Medicine. However, novice mentoring programs continue to face personnel, financial, and practical obstacles. Combining novice mentoring with near-peer and peer mentoring (C-NP mentoring) has been touted as a potential solution despite being unproven, poorly understood, and diversely practiced.

Aim

The review seeks to identify the benefits and viability of C-NP mentoring programs through scrutiny of accounts of its use and to proffer a framework for a C-NP mentoring program for eventual implementation in the training of family physicians.

Methods

Four reviewers carried out independent literature searches on C-NP mentoring in medicine using Embase, ERIC, PubMed, and Scopus databases for articles published between 1st January 2000 and 31st December 2017. The Best Evidence Medical Education (BEME) collaboration guide and the STORIES (STructured apprOach to the Reporting In healthcare education of Evidence Synthesis) statement were used to develop a narrative from the thematic analysis of the articles selected.

Results

3913 citations were identified, 21 full-text articles were reviewed, and 15 full-text articles were thematically analyzed. Thematic analysis was employed to circumnavigate mentoring's context-specific nature and 10 semantic themes were identified including the need for C-NP mentoring, mentee and mentor participation, the matching and mentoring processes, mentee and mentor training, obstacles to C-NP mentoring, outcomes measures of C-NP mentoring, and proposed improvements to C-NP mentoring.

Conclusion

C-NP mentoring is part of an evolving mentoring landscape and based upon an expansion of novice mentoring to meet the growing demands for personalized and timely mentoring of mentees. Understanding that C-NP mentoring's success comes from balancing flexibility to provide individualized mentoring support whilst maintaining its structure that promises consistency in mentoring approaches and compliance with accepted codes of conduct and professional standards of practice helps build a C-NP mentoring framework that can guide its consistent and effective use. The framework will allow better understanding and longitudinal and holistic study of the mentoring process. Such insights provide a consistent platform for further growth of C-NP mentoring in Family Medicine.

P30 The satisfaction of vocational training in general practice, as quality indicator of postgraduate education

Victoria Tkachenko, Yana Maksymets

Shupyk National Medical Academy of Postgraduate Education, Kiev, Ukraine

Background

According to principle of democracy, quality improvement principles and standards of ISO 9001:2015 the estimation of educational process has to be done by trainees (consumers) independently, that is one of the quality indicators of educational process.

Aim

To analyze the satisfaction of trainees in general practice after postgraduate vocational training at the Institute of Family Medicine.

Methods

Trainees' self-government developed the questionnaire to conduct the survey between GP trainees for estimation their satisfaction of vocational training, if postgraduate education is suitable to expectation. 101 GP trainees took participation in the survey. The respondents were asked to estimate the importance and value of each question in 5 points rang. The statistical analysis was done with Excel 2007, SPSS.

Results

The most important for GP trainees (4 or 5 points) in their training were the organization of self-education (86.1%), abidance to timetable of classes (86.14%), the results and motivation of their own training (84.2%), the accessibility of information and materials for exam preparation (85.2%), the relevance and novelty of the educational materials (83.2%), the qualitative work of teaching staff (82.2%), sufficient time for preparation to STEP-3 (82.2%), observance of legislative and regulatory requirements (82.2%), and less important were the quality and number of practical skills during residency (79.2%) and the time for clinical work (76.2%). At the same time, they were most satisfied with observance of legislative and regulatory requirements (92.1%), the quality of work of teaching staff (86.1%), sufficient time for preparation to STEP-3 (85.1%), the relevance and novelty of the educational materials (83.2%). Equally, 78.2% of respondents were satisfied with the quality and quantity of practical skills, the organization of self-education and the sufficiency of information and materials for exam preparation. 80.2% were satisfied with the results and the motivation of their study and indicated that the education was suitable to their expectation.

Conclusion

According to the results of survey the quality improvement has to be directed to increasing the time for self-education and preparation to exams that was not expected.

P31 Quality of vocational training for general practitioners in Ukraine

Victoria Tkachenko, MD, PhD, DMSc, Assoc. Prof.
Shupyk National Medical Academy of Postgraduate Education, Kiev, Ukraine
wtk@ukr.net

Background

In the conditions of educational and health system reformation in Ukraine the postgraduate education of general practitioners (GPs) needs estimation and control.

Aim

to analyze the quality of postgraduate education for family physicians in Ukraine.

Methods

the systematic review and qualitative and statistical analysis of features of vocational training and survey between trainees were conducted.

Results

GPs training over the Europe leads at least 3 years. In Ukraine the GPs training is carried out in two-year internship, according to the typical curriculum approved by the Ministry of Health of Ukraine in 2015, which envisages 50% of academic hours at the departments and 50% hours at primary clinics. Unfortunately due to the economic difficulties in country it is impossible for government to prolong the duration of GPs training to 3 years. In this situation, the quality of GPs' training is being improved through the use of European modern educational methods - clinical cases, structured clinical examination of the patient, training in small groups, role-playing games, standardized patient methodology, method of problem-oriented learning, introduction of distance learning, continuous professional training in different variants. The WONCA Global Standards for Postgraduate Family Medicine Education (2016) are tried to be implemented in Ukraine. In accordance with the quality requirements of ISO 9001:2015, the quality control of GPs training is constantly monitored through questionnaires, knowledge control, monitoring of the results of exams. The level of GP-trainees' knowledge according to international STEP-3 exam is in average 84-89%. The satisfaction of education is in average of 90-98% according to result of survey and it is increased after implementation of modern educational methods on 26%. The good quality of education was confirmed in 2017 by the certificates of ISO 9001:2015 from professional auditors from DQS Company and by Certificate "Recognized Excellence" from the European Foundation for Quality Management.

Conclusion

Despite the difficulties in ensuring the quality of GPs' training in current conditions in Ukraine, the Institute of Family Medicine of Shupyk National Medical Academy of Postgraduate Education takes all possible measures to ensure the high quality of vocational training.

P32 Step by step: modern approaches to specialist training of general practitioners in Ukraine

V Vataha, L Khimion, T Sytiuk, O Alekseichenko

Family Medicine Department, Shupik National Medical Academy of Postgraduate Education, Dorohozhytska Street 9, 04112 Kyiv, Ukraine

Background

The problem of specialist training quality of family doctors is one of the main problems in medical education and an integral part of the modern health care system reform in Ukraine. According to the recommendations of WONCA, EURACT and UEMO a new program of internship (specialization) for higher medical educational institutions graduates in the field of "General practice-family medicine" was approved in 2015 in Ukraine, based on the principle of using not only nosological, but complex nosological-syndromological approach.

Aim

To analyse the effectiveness of implementing a new internship program in the specialty "General practice-family medicine" at the postgraduate level in higher medical institutions of Ukraine for 2012-2017.

Methods

Statistical reports on the results of the licensing exam "Step 3" (assessment the level of professional competence of qualified specialists with higher education at the stage of graduation from internship) in the field of "General practice-family medicine" for 2012-2017 have been analysed. The statistical analysis was done with the help of Microsoft Excel 2010, Statistica 6.0.

Results

During 2012-2017 the license test "Step 3" in the field of "General practice-family medicine" was passed by 5532 interns, of which before 2015 (2012-2015) - 3689 persons, after 2015 (2016-2017) - 1843 persons. The average results of the licensed exam "Step-3" among interns for 2012-2017 are shown in Fig. 1. The highest results were shown in 2017 (85.3%), the lowest in 2012 (73.0%). Among the interns who studied under the old program (until 2015 inclusive), the "Step 3" did not pass 20.8% compared with 9.87% ($p < 0.0001$) interns who studied under the new program (after 2015), which indicates an increase in the level of professional competence of interns at the stage of graduation from internship.

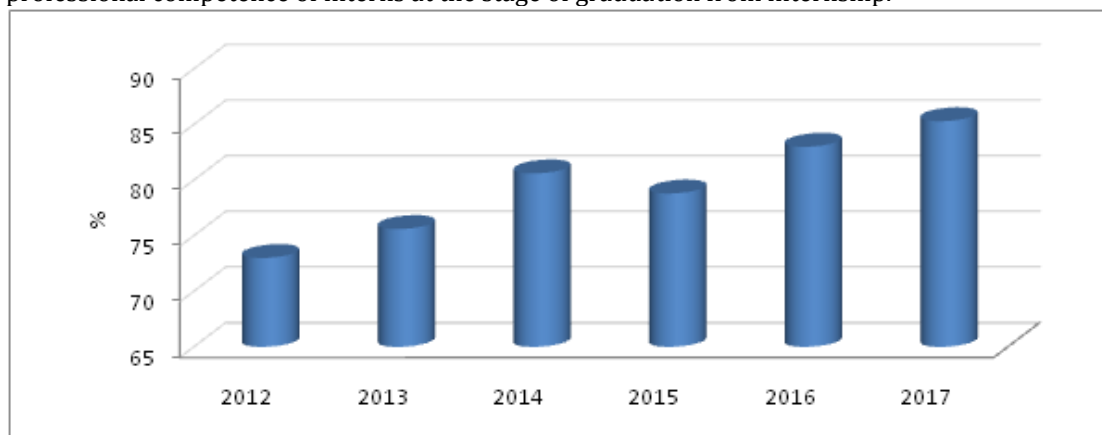


Figure 1. The average results of the licensed exam "Step-3" among interns for 2012-2017

Conclusion

The conducted analysis showed a great success of the "Step 3" exam among the interns who studied under the new program, which testifies to the effectiveness and promising use of a complex nosological-syndromological approach in the curriculum on the specialty "General practice-family medicine", which most fully corresponds to modern the international requirements for the preparation of family doctors, as close as possible to their practical activities and provides an integrated approach to the management of patients. Cannabidiol – Practical Experiences and Perceptions of the Effects after Administration as an Additional Therapy in Different Health Conditions

P 33 The quality of vocational training for general practitioners in Ukraine

P

Dr Irena Vitanovska¹

¹ Doctor for Family Medicine Specialist, a family medicine educator at the Medical Faculty in Skopje, FYROM - Republic of Macedonia.

² Private healthcare clinic "IHTUS REMEDIUM", address: Kukuska 8; 1000 Skopje, FYROM - Republic of Macedonia

Cannabis (hemp) is among the oldest used plants in various traditional folk medical treatments. Cannabidiol (CBD) is one of the major non-psychotropic cannabinoids in cannabis, with expressed therapeutic potential and positive effects at various conditions, manifested in a numerous investigations and clinical studies. With the amendments of the legislative in our country, the use of cannabis products for medical purposes has been enabled and various and different pharmaceutical dosage forms of Cannabidiol were registered as borderline products, and available on the market.

In order to review the effects of the application of Cannabidiol (CBD) as an additional therapy in the available pharmaceutical dosage forms in the FYROM - Republic of Macedonia in patients with various health conditions according to the instructions in the Patient information leaflet, 36 patients with different health conditions were monitored in outpatient and stationary conditions in private health institution of the primary health care, as well as a private institution for elderly persons care for the period of 20 days, in the period from January 2017 until June 2017.

For monitoring the effects of the administration, the following key points have been taken into consideration: the basic disease and the current health condition of the patients, concomitant diseases, the basic therapy, the physician's assessment for the benefit from the use of Cannabidiol, and the acceptance by the patients comprehensively in accordance with the guidance in the Patient information leaflet.

The considerations of the effects from administration are systematized on the basis of the qualitative changes in the symptoms of the health condition status, assessed by the physician and by the patient.

In all stationary treated patients, there is a perception of improving the general health condition, the quality of life and improvement of the observed symptoms.

Outpatient treatment in patients is shown as special cases with certain positive effect. The limiting factor for perceiving the effect of outpatient treatment in patients is the adherence to treatment and the possibility of its prolongation.

Generally, the observations noted by the physicians and patients in terms of improvement of the quality of life and the manifested positive effects.

References

A full list of references is available on the website : www.euract2018.org.

P34 'Next Generation GP' - A leadership programme for Newly Qualified GPs to ENERGISE - ENGAGE - EMPOWER

¹Karen Wallace, ²Nishma Manek, ³Arla Gamper, ⁴Jemma Batte, ⁵Peter Thompson

¹Severn Deanery, Leadership & Excellence Extension GP Trainee, Bristol, England.

²National Clinical Fellow, Cambridge GP Trainee, England

^{3 4 5} Severn Deanery GP trainee, England

In the face of unprecedented pressures, the landscape of the NHS is changing rapidly, with the centre of gravity rapidly shifting towards primary care. This represents an exciting opportunity for GPs to be involved in improving frontline services for our patients. But with the largest curriculum and the shortest amount of time to learn it all, many of us are starting out without a clear understanding of the system we'll be working in, or the tools to lead change effectively. We are five GP trainees, who will share our experience of establishing 'Next Generation GP: a fully-funded program which took a novel approach to leadership development. Our aim was to energise, empower and engage future GP leaders, through a 6-month evening program based in London. Our participants were 49 selected GP trainees and newly qualified GPs. We designed each event to consist of two elements: a workshop to inform participants of the wider system structure and the tools needed to implement change, and an interview with an inspirational GP leader, including the previous Chair of the RCGP and the Director of Primary Care at NHS England. We will present the qualitative and quantitative impact data collected from the program. This included a pre and post course evaluation, which explored the extent to which participants' felt it influenced their knowledge of the wider system and likelihood of taking up future leadership roles. We will demonstrate the value of educating and inspiring emerging GP leaders through an innovative, peer-led program of leadership development.



An example of the impact of the program in front of parliament in London, England

P35 The nurses' role in the family medicine practice – shall we teach the same curriculum as doctors?

P

Natalia Zarbailov

State University of Medicine and Pharmacy « Nicolae Testemitanu »,
Republic of Moldova, natalia.zarbailov@usmf.md

Aim question

The study is aimed to identify the availability of the nurses in the primary care to actively participate in the whole range of activities assigned to the family doctor's team and to take over some of the imported activities in the absence of the family doctor.

Methods

The questionnaire, included items related to different aspects of the services provided by primary care team, considering team work and leadership, was proposed to nurses from the Primary Care Health Centres, participants at continuous medical education courses. The simple descriptive analyses applied to 211 respondents.

Results

Interviewed nurses expressed readiness and awareness about capacities and skills to ensure long-lasting relationship with different categories of patients, based on community needs, including preventive services and health promotion. The less accepted aspects were related to managerial skills such as activity planning based on performance indicators, leadership and coordinated care.

Conclusion

Traditional curriculum for nurses includes mostly medical topics focused on the diseases and patient care, despite the fact that epidemiology, statistics, practice management, health economy etc. became a part of doctors' curriculum. So, shall we think about the creation of the congruent curriculum?

Keynote presentations

K1 Teaching and learning Evidence Based Medicine in General Practice

Prof. dr. Roger Damoiseaux, Universitair Medisch Centrum Utrecht

The 5 steps of EBM (ask, acquire, appraise, apply and assess) are mainly focussed on the use of evidence. The role of the clinical experience of the General Practitioner and the preferences of the patient are not sufficiently integrated in these 5 steps. When teaching EBM teachers mostly focus on the first three steps. The last two steps should be learned in the workplace of General Practice. Little is known of how this learning takes place. What trainees have to learn has been discussed more often. EBM competencies in General Practice have been defined. These competencies should offer a framework that can guide learning of EBM in the workplace. How they can learn this is not clear and should be explored in the workplace first. The role of the clinical trainer and his/her attitude to EBM could be important. Knowing the mechanisms of learning of EBM can stimulate the learning of EBM in the workplace.

K2 Generic Competencies: Translating word into actions

Dr. Meiling Denney, Chief Examiner for the Royal College of General Practitioners' MRCGP licensing exam in the UK

How can we move from the theory of generic professional capabilities into our curriculum, assessment, and the practical aspects of training? Reflections on the role of workplace based assessment and experiences from a pilot with trainees and supervisors.

K3 Teaching Family Medicine in the real world: The view from Three Continents

Professor Yonah Yaphe School of Health Sciences of the University of Minho in Portugal

Family medicine may be taught as an academic discipline in 'ivory tower' settings, but family practice is done with patients in the real world. In this talk, I will share some of my experiences with teaching and learning family medicine on three continents and provide research evidence to support the methods used.

Prizes for Posters and Oral Presentations

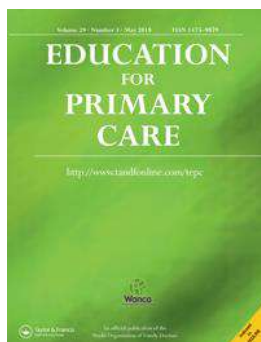
During the conference all posters and oral presentations will be assessed and scored according to a clear set of criteria. The three best posters and oral presentations will be presented with a certificate. The authors of the best poster and the best oral presentation will be given a voucher entitling two of the authors to free registration at EURACT's next conference in Graz, 2020.

In addition on the occasion of the 50th anniversary of GP/FM teaching at the KU Leuven, Belgium a special Award will be issued: The **Professor Jan Heyrman award**. The poster or oral presentation that will be selected for this award will offer scientific insight into how to teach the core competencies required for the development of a *generalist approach* to patient encounters. This work will be congruent with the EURACT mission statement: *to foster and maintain high standards of care in European general practice by promoting general practice as a discipline by learning and teaching*.



Education for Primary Care

We are pleased to announce that the conference has continued to collaborate with 'Education for Primary Care'. Following the conference a selection of abstracts will be selected for publication in the digital version of the journal. The authors of the selected articles will be contacted for consent to publish. There will be an accompanying editorial in the paper journal. The editor of the journal Professor Val Wass will be present at the conference.



Index

Avtarovska, 24
Bartelink, 23, 65
Bednář, 73
Belche, 27
Bergman Marković, 74
Bonfatti, 12
Boogaerts, 75
Breesch, 76
Buffels, 77
Cihan, 71
Class, 32
Damoiseaux, 110
de Fine Licht, 16
de Freminville, 33
De Groot¹, 79
De Maeseneer, 54
De Weirdt, 44
Denney, 61, 110
Devillers, 40
Essers, 63
Frederiks, 80
Frolova, 21
Georgiannos, 64
Gomes, 43, 81
Gómez Bravo, 42
Granek-Catarivas, 66
Gunduzoz, 82
Haarsma, 53
IACOB, 83, 85
Jackson, 39, 87
Kaffman, 56
Karanasios, 88
Karppinen, 60
Katerenchuk, 34
Kiknadze, 89
Kjær, 31
Klymas, 90
Kolesnyk, 35
Kuikka, 92
Kurpas, 93
Lazić, 94
Looman, 29, 48
Manhaeve, 17
Marquês, 38, 46, 69
Martin, 19
Mehay, 95
Michels, 41, 96
Moine, 49
Mol, 47
Murphy, 50
Neculau, 97
Nessler, 98
Oona¹, 99
Padula, 15
Patterson, 18
Peters, 11, 100
Quinn, 101
Rieder, 51
Rietmeijer, 30
Rifel, 20
Risteska Nejashmikh, 102
Ristovska, 67
Robusto, 22
Samuel Yong Siang Lim, 103
Scherpbier, 29, 62
Schoenmakers, 55, 68
Selič, 26
Shushman, 91
Smyrnakis, 37
Stewart¹, 9
Tkachenko, 104, 105
Tsakitzidis, 25
Turusheva, 21
Tzanis, 39
Vajer, 36
Van den Ende, 59
van der Leeuw, 58
van der Winden, 57
van Grootheest¹, 14
Van Hoorick, 78

Van Rossem, 8
Van Royen, 10, 25, 59
Vataha, 106
Velho, 81
Vitanovska, 107

Wallace, 108
Walton, 87
Wylie, 52
Yaphe, 70, 110
Zarbailov, 109



Responsible editor: Prof.J.Degryse ,
KUL / UCL

jan.degryse@kuleuven.be

&

Jean-marie.degryse@uclouvain.be

About ACHG

The Academic Centre for General Practice (ACHG), Department of Public Health and Primary Care, KU Leuven.

The ACHG is a clinical department of General Medicine at KU Leuven. Most staff members are general practitioners who are employed part-time and carry out clinical work in their own general medical practice. As an academic department, the ACHG mainly conducts research into diagnostics, care for the elderly, implementation strategies and research into education. As of 2018, the department will be responsible for a three-year Advanced Master's programme in General Medicine (540-600 students), training more than half of all Flemish students in General Medicine. In recent years, we have also made a very important and substantial contribution to the basic curriculum. The ACHG also has substantial social responsibility for its profession, that of the general practitioner. Finally, the ACHG also has an important impact on the first line through major projects such as the Centre for Evidence-Based Medicine (CEBAM), the CEBAM Digital Library for Health (CDLH), Health & Science, EBMPPracticeNET and INTEGEO, a computerised continuous registration network of GPs.

Our mission statement

The ACHG, KU Leuven undertakes to carry out excellent and relevant research. We train medical students and general practitioners and provide support to all healthcare stakeholders. We use an interactive network for this to play an innovative and prominent role in the policy and organisation of care in Flanders and the world at large, with the aim of offering patients qualitative and respectful care in a healthier society. The ACHG seeks to improve the quality of care, to introduce innovation, to strive for an interplay of its partnership with other professions, research groups, patient empowerment, etc., and seeks to become one of Europe and the world's General Medicine centres of excellence. We want to train doctors who are excellent clinicians, who strive for qualitative care, whose basic attitude is geared towards lifelong learning, who work together efficiently with all care providers, who allow the patient to play a more prominent role (ethical perspective), and who take responsibility for the health of a segment of the population.