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"AMSE Newsletter" is a newsletter of the Association of Medical Schools in Europe. The purpose of AMSE is to share experience between European Medical Faculties in the fields of education, research and management.

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"AMSE Newsletter" welcomes contributions in the form of questions, opinions, statement of problems, and also data concerning the faculties. Contributions and all correspondence should be sent to the editor, to the following address: Professor Sergio Curtoni - Department of Genetics, via Santena 19 - 10126 Torino - Italy. Telephone: +39-11-6706668 / 6336511. Fax: +39-11-6336529, e-mail: curtoni@molinette.unito.it

According to art. 1 of the Constitution, "Each Medical School in Europe is eligible for full membership and may be represented normally by the Dean or an appropriate representative. Any person who is not the Dean or the recognised representative shall require a certificate of authority from the faculty in order to register with AMSE as a full member and have the right to vote." and art. 5 states that "On payment of the annual subscription membership of AMSE is valid for that calendar year." **The representatives of Medical Schools who are not already members of AMSE may become members paying the membership fee of 200 US$** to the:
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AMSE AND DISCRIMINATION

The Executive Committee of AMSE, meeting in Prague on 8 April 2000, was informed that the Medical Faculty, University of Vienna, had produced a document stating its opposition to all forms of social discrimination based on race, religion, gender and religion.
The members of the Executive Committee declared their full agreement with this approach and believe that colleagues from all European countries should join the Austrian academic community in expressing their opposition to any kind of social discrimination . The Executive Committee further believes that this process is assisted by ensuring that staff from Austrian medical faculties continue to participate in international, and that European colleagues continue to attend meetings organised by Austrian faculties

AMSE ANNUAL ASSEMBLY 2000

The annual assembly of AMSE will be held in the Medical School of the University of Porto on Monday 4 September 2000 at 17.00.
Two members of the Executive Committee, Professor Helmut Gruber (Vienna) and Professor Henk Huisjes (Groningen) are at the end of their second term, and cannot be re-elected. Therefore two new members will be elected. The candidates proposed by the E.C. are Professor Alfredo Salerno (Palermo) and Professor Wolfgang Schutz (Vienna).
According to the AMSE Constitution (see http://histolii.ugr.es/AMSE) " Nominations for election to membership of the Executive Committee may be made only by members of AMSE in good standing. Nominations shall require the signature of two members. The Secretary shall be the returning officer. The Secretary shall receive in writing the agreement of the nominee to stand for election. The nomination shall be notified to the Executive Committee at least one month before the General Assembly."
Therefore more nominations can be proposed to the AMSE Secretary (Professor Helmut Gruber, see address above) until 4 August 2000

NEWS FROM THE EUROPEAN MEDICAL STUDENT ASSOCIATION (EMSA)
During its last annual congress, EMSA elected a new executive council. The new EMSA President is:
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The e-mail address emsa.president@emsa-europe is permanent and will always stay the address of the EMSA president. In addition, the permanent address of the EMSA European Board (including all the other EMSA officials) is emsa.eeb@emsa-europe.org.

The most updated information about EMSA can always be found at the homepage of EMSA. You can find the EMSA homepage at http://www.emsa-europe.org

The addresses of the EMSA European Board can also be found there. You can find the addresses at http://www.emsa-europe.org/eeb.html

CONTINUING MEDICAL EDUCATION

Reports presented at the annual AMSE congress 1999 (Jerusalem, 5-7 September 1999)

1. CONTINUING MEDICAL EDUCATION IN EUROPE

Uno Erikson – Uppsala (Sweden)

In the past and sometimes even now a university degree meant a sufficient knowledge for the rest of the coming professional life. The academic professionals had to take care of their own development of knowledge.
The very rapid increase in scientific knowledge has also led to a short halftime life of for example a doctor's knowledge. The professionals therefore ask for an organised continuing medical education (CME) and since most of the teachers are at the universities, the universities now have to realise that they cannot stop teaching at the point of the final degree, but have to offer full professional life learning. How to offer and why was discussed during the meeting of AMSE in Jerusalem in September 1999. The experiences will be summarised in the following.
The EU plans to introduce standardised and harmonised CME-programs for the EU members. Already today, there is a certain international competition, since some countries do perform CME on either voluntary or obligatory basis.

The view of Ireland and U.K as well as the organisation of UEMS (Union Européenne de Médecins Spécialistes) was presented by Dr. Hurley from Dublin, Ireland, who has represented the professionals in radiology towards EU and also the European Association of Radiology (EAR).
Dr. Hurley set out the positions of UEMS Radiology Section and Board and EAR regarding Continuing Medical Education (CME). Both bodies have drawn up and harmonised requirements for CME for European Radiologist. The objective is to guarantee the maintenance and upgrading of knowledge, skills, and competence following completion of post graduate training. CME is an ethical and moral obligation for each radiologist throughout his/her professional career in order to maintain the highest possible professional standards. EAR and UEMS Radiology Section and Board act as promoters and facilitators of CME in Europe and encourage the specialist radiology boards in each country to establish CME on a regular 5 year cycle in order that a comprehensive re-education programme is achieved within that time scale.
A credit system is recommended. Category 1 credits may be earned by attendance at courses, conferences, lectures, scientific meetings, workshops etc, where the course has undergone to prior assessment of course content and relevance by EAR/UEMS Radiology Section and Board or by the National Authority, Board or College or its delegate radiological speciality body which organises radiological CME. Attendance at management courses relevant to organisation of radiology services and radiology departmental management also earn Category 1 credits. Category 2 credits are awarded for self directed learning, hospital and locally based educational activities as well as teaching, audit, published work etc. A maximum of 125 Category 2 credits would be accepted in a 5 year cycle. In all 250 credits are required over 5 years i.e. 50 credits per annum. Documents supporting attendance at courses and other CME activities are retained by each Radiologist as evidence for validation.
These requirements have been in place for European Radiologists since January 1 1998. CME activity is still voluntary in most countries but is becoming mandatory in some countries as part of a re-accreditation process.
The number of Irish and British radiologists (as well as the specialists of other disciplines) /million of inhabitants are about 25 % of the number in other western European countries, but however the education resources are quite proportional.

The German way to organise the CME is new in Europe and Dr Otto Pohlenz in Hamburg with his colleagues has created an academy.
The German academy of CME in diagnostic radiology is based on the fact that out of 357000 medical doctors in Germany about 2 % are radiologists about 7000. Of these,

5000 - 5500 are active radiologists, the others are either retired or practise a non-radiological professions or are unemployed. The German radiologists are represented by 2 major societies:
- German x-ray society (DRG) with about 5 000 members.
- Professional society of German radiologists (BDR) with about 1 500 members.

There is a overlapping between the two societies.
By German law the doctor has to pass through continuing medical education all his/her professional life and the doctor himself is responsible for quality assurance of his/her professional work. The doctor has to show proof of the CME towards the Medical Chamber. In all Germany's 16 states there is a Medical Chamber. The introduction of obligatory CME in Medicine has been under discussion several times in the past years. The EU plans to introduce a standardised and harmonised CME-programs for the EU members. Already today, there is a certain international competition, since some countries do perform CME on either voluntary or obligatory basis. In Germany other medical specialities Anaesthesiology, Neurology, Dermatology etc undertake already CME on a voluntary basis.
With this background it was found of a great value to create an academy for continuing medical education in radiology and such an academy was founded in October 1998. The goal of the Academy was to offer CME for the participants on a voluntary basis in order to meet the legal demands.
The definition of demand and supply for CME activities nationwide is well balanced within and between the single regions and states
An actual “calendar of events” is regularly published in the well known radiological journals in Germany.
CME activities are subdivided in categories (I or II), as follows (note that different CME activities, as lectures, courses, meetings, congresses etc, can be certified).
Category I (1 hour activity = 1 point “CME-1-credit"):

- workshops
- categorial courses
- refresher courses
- symposia
- state-of-the-art-lectures
- special-focus-sessions
- lectures lasting more than 30 minutes

Category II (1 hour activity = 1 point “CME-2-credit”):

- short-term-lectures
- mixed topics
- case conferences/local activities
- meetings of or with other disciplines
- clinical-radiological-pathological conferences
- self education (printed, CD-ROM, Tape, Online-CME)

At the end of the activities evaluation is mandatory. Evaluation is considered a key instrument for quality control as well as for feed back (for organisers, teachers, and for the academy).
It is recommended not to include nor certify for CME:

- programmes dealing with theoretical research and science primarily
- mainly commercial activities
- meetings with purely financial intentions
- health politics

In order to get an annual certificate, the participant has to achieve:25 CME-1-credits and 25 CME-2-credits per year. 25 % of both categories are transferable from one year to another. Teaching and lecturing gives an extra bonus but limited to a certain percentage. Events in other countries, already credited and certified by another authorised scientific institution, will be recognised by the German Academy on the basis 1: 1.
The diagnostic radiological curriculum (doctor's knowledge at the time of final boards) should roughly be covered by a CME program over a time span of 5 - 6 years (= one

"cycle") for polishing, repetition, refreshing and actualisation. Interdisciplinary activities are encouraged, since the Radiologist is a consultant for many different specialists. CME is provided also for radiographers and medical technicians, as important partners of the radiologist.
After foundation of the Academy all the above rules were published and the active work was started in March 1999. Within 9 months almost 25 % of all active radiologists signed in for participation in the programme.

The current direction of CME in Israel was presented by Prof. Weingarten, Tel Aviv. The Israeli universities are active in this aspect of CME and have responsibility. It should be considered as satisfactory if about at 40 – 50 % of the doctors accept CME. There are many reasons for not taking part in CME: economical reasons, or the doctor was alone in his/her practice and could not be replaced. Prof. Weingarten, underlined that a doctor who did not take part in CME was not a second class doctor, but one who perhaps considers that he could handle this subject himself.

Conclusion
The CME, the continuing medical education, is of increasing interest for doctors, patients and universities. The universities have responsibility for education and it should be accepted that the university has responsibility for the undergraduate and postgraduate education, including CME

2. THE CHALLENGE OF CME WITHOUT RE-CERTIFICATION

Michael A. Weingarten - Tel-Aviv (Israel)

A fifteenth-century Hebrew paraphrase of the Hippocratic Oath contains a significant addition to the original: “Above all, the physician should accustom himself to continual learning in order to help the body to health, and should never weary of referring to books.”(1)

By the eighteenth century the knowledge explosion was already overwhelming and the review was invented as a new form of medical literature, first in Germany then in Britain, where the first quarterly review journal was published in 1737.(2) I owe this information to Iain Chalmers of Oxford, the driving force behind the Cochrane Collaboration, an international group founded in the twentieth century, devoted to collecting all the evidence on medical interventions that is based on methodologically sound research and disseminating regularly updated systematic reviews of that evidence to practitioners throughout the world, using CD and Internet technologies.(3)
So the technology of CME has moved from books to periodical reviews to electronically published systematic reviews. Newly acquired medical knowledge has, in this way, become more readily accessible, more complete, more accurate, perhaps, and more open to critical appraisal by the reader. The time lag between the creation of new knowledge and its arrival at the practitioner has also shortened remarkably. Only the expense never seems to go down.
New technology will soon bring to the individual practitioner the possibility of going beyond reading about new advances, to interacting personally with those who compose the reviews. Lectures, perhaps the most popular form of CME, are really just having the author read out the review rather than reading it for yourself - rather like having a bed-time story read to you as a child, which is much more fun than reading the book. There can never be enough opportunity for a significant number of the audience to engage the lecturer in conversation. But the new distance learning technologies do allow the learner to interact in a limited way with the material, in a sort of question and answer mode which might be more effective in achieving information retention, or even with a lecturer and his assistants who may be questioned in order to clarify issues and thus intensify understanding of the new material.

But all of these information transfer technologies do not address the issues of incorporating the new advances into practice, as David Davis and his colleagues have shown.(4) The greatest challenge for CME is changing established behaviours by implementing newly acquired knowledge. It seems that to do this we need to meet each other and discuss what we are each doing and what other options are open to us. Small groups allow, encourage, or instruct doctors to meet regularly to discuss specific clinical issues in order to reach a common understanding which will lead to a consensus about reasonable clinical practice in the light of current research findings. This is the sort of process that led Dutch and Icelandic GPs to stop using antibiotics for acute otitis media in children. Was it that the scientific evidence was so strong as to lead inevitably to the conclusion that clinical practice must change, or was it that the presenters of that evidence were so eloquent, persuasive, and authoritative that the local practitioners responded positively to their propositions? Initial evidence suggests that they were indeed right, but doctors in other countries are still waiting to see what happens before changing their own habits.

Small group meetings, which are also known as quality circles in the German speaking world, are essentially a social interaction, and it is the nature of the power relationships among the peers that determines who is influenced by whom. For this reason, some CME authorities have proposed an alternative to small group discussions, in the form of a personal, one-to-one, mentor system. The mentor system is designed to select carefully a cadre of doctors who are skilled, not so much in data retrieval and critical appraisal, but rather in the philosophy and techniques of adult education. The power remains firmly in the hands of the learner, who remains responsible for the whole cascade of learning - from needs identification and definition (perhaps by keeping a diary of what he/she does not know(5)), to location of learning resources(6), then on to critical appraisal and finally to the decisions concerning clinical practice. The mentor's task is to facilitate all of these stages. In this context it is appropriate to rename CME as Continual Professional Development (CPD) (7).

Turning now to some of the contextual constraints that encourage or discourage doctors to engaging in CME, or CPD, there is sometimes a confusion between demonstrating competence to practise and demonstrating that you are fulfilling your professional obligation to remain up-to-date. It seems irrational to insist on repeatedly requiring a doctor to demonstrate that he or she is competent to practise. (I am talking here about basic licensure, not specialist status). If you have any confidence in your initial licensing procedures, then you should safely be able to assume that the doctor will remain minimally competent to practice throughout his/her career, unless some catastrophe intervenes to impair his/her competence, such as addiction or illness. There is solid empirical evidence to show that elderly practitioners retain fully their grasp of the core elements of medical knowledge (8). It is only rarely that advances in medical science actually prove previous habits to be harmful, so that even though the doctor who neglects CME will be unlikely to provide his/her patients with the best available advice, he/she is also unlikely to be incompetent to practise. So recertification does not need to be contingent on a competency test. On the other hand, it does seem reasonable to require a practising doctor to demonstrate fulfilment of the obligation to engage in perpetual study. Thus many states have instituted statutory requirements that doctors accumulate CME credit points in order to remain in practice, or to maintain the validity of a specialist certificate. The problem with this is that attendance at CME activities is not necessarily equivalent to benefiting from them - either because the teacher was at fault, or because the learner slept, talked or left early, or because the topic was irrelevant. So what is needed is an appropriate structure for the accreditation of CME activities, using for example the Dundee CRISIS criteria on the teaching side (9), and for demonstration of learning on the participant's side. This formulation is equally applicable to all methods of CME, including lectures, multimedia distance learning and personal mentoring.

In this analysis I have narrowed down the field of statutory regulation to the extent that even in the absence of recertification legislation it should still be possible to satisfy the public that the profession is behaving responsibly and taking CME seriously. Legislation is often difficult to introduce politically, and difficult to regulate administratively. A voluntary system of CME points may be satisfactory even in the absence of the threat of non-recertification, if sufficient positive reinforcement is provided, either by means of financial advantage or in increased professional status for doctors who are able to demonstrate perpetual learning in accredited CME activities.

This is the current direction of CME in Israel. The Education Committee of the Israel Medical Association (IMA) grants accreditation to CME courses which can show bona fide academic credentials (excluding, for example, purely commercial CME). It maintains a computerised record of every one of its member's CME credit points, and the IMA Central Committee is at present in negotiation with the government over the nature and size of the financial incentives which will be included in the salary of doctors who accumulate sufficient credit points. At present the system is fairly loose, accepting without external verification the claims of the CME course organisers who apply for accreditation, and of the participants applying for credit points. When we become accountable to the public purse, for the financial incentive payments, then we will develop the verification and quality assurance components.(10)
Meanwhile about one-third of Israel's community based physicians have voluntarily accumulated enough credit points to gain a Certificate of Update. Our task is made much easier, in the salaried sector, by the protected time for CME provided for in the work contract, of 24 half-days per year. Many more physicians avail themselves of CME than apply for credit points, though we do not know exactly how many. There remains, however, a major challenge in ensuring CME among the growing private sector, to which the public health services are contracting out an increasing proportion of their clinical load. Without contractually protected CME time, and without the possibility of incentive payments, it is difficult to devise a system of voluntary CME in this sector. Meanwhile there is, perhaps, enough professional pride and cooperation in the salaried sector at least, to progress to the next stage where governmental involvement might eventually lead to re-certification.

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3. THE ROLE OF THE MEDICAL SCHOOL IN CONTINUING MEDICAL EDUCATION

Antonio Campos – Granada (Spain)

After a very long and productive career, the painter and printmaker Francisco de Goya, close to the end of his life, drew a self-portrait which he entitled, significantly, “Aún aprendo” (I can still learn). I think this is a good attitude for anyone who wants to make sure that his work remains creative and does not become routine. I think everybody would agree that Goya's determination to learn should be present throughout a physician's life whether one is devoted to clinical care, research, or teaching.

In addition to this deep personal feeling, we should be aware that Medicine is continuously changing as a result of three major influences. These influences are: first, changes in society and the health environment; second, scientific progress; and third, political and administrative changes. Factors that contribute to changes in society include aging, emigration, appearance or reappearance of diseases (TB / AIDS) and communication strategies between doctors and patients, physician colleagues, and doctors and society. Some elements that form the basis of scientific progress are new diagnostic and therapeutic technologies and advances in basic scientific knowledge.

In the political and administrative sphere, the major factors are patients' demands and patients’ rights charters, strategies for team work and cost concerns.

Among these influences I would like to emphasize the importance of aging, the human genome project, the possibility of predictive medicine, and the increasing tendency to work in multidisciplinary teams.

What, then, do we really mean by continuing medical education? Continuing Medical Education, as we understand it today, is the set of educational activities aimed at maintaining or improving professional competence (knowledge, skills and attitudes) after the basic or specialty degree has been obtained.

What are the goals that we are trying to reach with Continuing Medical Education?

The objective for the physician are to maintain and improve professional competence.

For society, the goal is to maintain and improve the level of health.

As a result of changes in Medicine due to scientific progress, and changes in society and administration, and also as a result of individual motivation and the needs of society, we can now say that Continuing Medical Education is taking form as a specific institutional and academic activity. As a result, recent years have seen the development of Continuing Medical Education through different approaches in different countries. The main tendency has been to create a true system for Continuing Medical Education at various official levels.

What are the goals of a system for Continuing Medical Education? Basically, there are four of them:

* The first is to analyse local, national and international needs.
* The second is to establish a common framework for accreditation that will provide for recognition of equivalent training under equivalent circumstances.
* A third goal is to coordinate continuing medical education with the health care system. This will ensure that Continuing Medical Education becomes an integral part of the health care system.
* The fourth goal should be to guarantee reciprocity between different countries of the European Union, Mercosur and other trans-national organisms. Because of the increasing mobility of users and providers of medical care, we should strive to guarantee a similar level of quality care.

How is Continuing Medical Education organized in Spain? In Spain a National Commission for Continuing Medical Education has been created, and its members come from The Ministry of Education, The Ministry of Health and the Autonomous Regions. In addition, advice is received from the National Conference of Medical Schools Deans, the National Commission for Medical Specialities, the Federation of Scientific Medical Societies, and the professional organizations for physicians. This National Commission is responsible, in addition to the four goals just mentioned, for constituting the National Accreditation Committee. The Accreditation Committee oversee both

activities and institutions. In the second case, the criteria for accreditation to implement Continuing Medical Education are mainly to have documented experience in Continuing Medical Education and to be committed to applying the national criteria for accreditation. Of course a similar model is used in each Autonomous Region.

As we have seen, we have a number of players in search of Continuing Medical Education, like in Pirandello's famous work. How can Medical Schools contribute to Continuing Medical Education as one of the possible players?

In a Medical School there are three basic components: basic science, clinical science and medical education. Naturally, all three are part of undergraduate education. My feeling is that a new role for Medical Schools is emerging: Continuing Medical Education.

Why do I see such a clear role for Medical Schools? Mainly because Medical Schools already perform the first step in Continuing Medical Education by stimulating the motivation for self education throughout one's professional life. In addition, Medical Schools are best situated to perceive changes in medicine, as explained above. And finally, Medical Schools are, by virtue of their structure, able to offer integrated programs incorporating basic and clinical science within a medical education framework.

What are the advantages for Medical Schools if they get involved in Continuing Medical Education? First, feedback on the undergraduate curriculum is extremely useful for efforts to make sure that undergraduate education actually satisfies current needs. Second, Continuing Medical Education provides a link between the medical schools and all other health and professional institutions. And third, because it offers the possibility of increasing financial support for medical education. Of course there are also some disadvantages of having to work hard. There is a risk of imbalance with respect to the basic goal of a medical school, and of restricting the curriculum to problems selected by Continuing Medical Education. A further consideration is the increased cost if Continuing Medical Education is not an item in the budget.

At what level should the Medical School try to implement Continuing Medical Education? Implementation should occur within the Medical School Area, through interuniversity exchange programs, and by participating in regional, national or international programs in collaboration with medical societies or professional organizations. At all three levels our experience in staff and student mobility could be useful.

In practical terms, how can a Medical School introduce Continuing Medical Education in its structure? This is just a possible approach that needs to be considered in each particular Medical School. Provisionally, we could introduce a Committee for Continuing Medical Education or a vice deanship responsible for these activities.

This Committee should take into account a number of sources of information. It is important to identify local, regional, national and international needs, and to assess the needs of targeted learners. Also, advice should be obtained from both basic and clinical departments, and hopefully from the Department of Medical Education. The challanges for Deans are these: do we have a vision of Continuing Medical Education on the horizon of Medical Schools? Or do we turn away from this challange and leave it in the hands of other players? Will Deans stay on well known roads, or will they catch the train towards Continuing Medical Education?

I have tried to show that Medical Schools have a role in this enterprise. I sincerely hope that AMSE will play a leading role in stimulating Continuing Medical Education as a part of our increasing responsibilities.

Of course the work will be hard for deans, as symbolized in the Velazquez's painting Forge of Vulcano: where deans are hard at work over the forge of change and progress, in the presence of the spirit of Continuing Medical Education.

Nevertheless, I suggest that we should take the advice of the modern Spanish writer Antonio Muñoz Molina: "It is time to do only those things which we find impossible".

Report presented at the annual AMSE congress 1999 (Jerusalem, 5-7 September 1999)

DOCTORS AS MANAGERS AND LEADERS - DREAM OR NIGHTMARE

Jenny Simpson – The British Association of Medical Managers

Is it a sign of the times that the role of the doctor in management features is prominently in conferences and events. It is also a major breakthrough in thinking. For years, small numbers of doctors in the UK have been banging the drum about the crucial role of the doctor in running healthcare services.

Now it is clear that not only is a role in leadership and management a bona fide career option for doctors, but that educating doctors for this role is a major challenge to be tackled head on.

Providing skills to today's senior doctors is of no value whatsoever unless it is underpinned by commitment to educating our doctors of the future. It seems as if much of what is currently in place is remedial, a "sticking plaster" approach for senior doctors – but this does not make sense for the long term. Tomorrow's doctors must be fully equipped to take on the management role and to do it well.

In the late 80's and early 90's it became clear that the National Health service simply would not work unless doctors and managers worked in harmony. At the time the modus operandi amounted to guerrilla warfare, with the managers undermining what clinicians were trying to do and clinicians vetoing – largely by table-thumping and digging-in of heels – what the manager wished to achieve.

The managers in the system were - and still are -accountable through various levels of hierarchy to the politicians, ultimately to the Secretary of State for Health- The medical profession, however, has a flat, collegial organisation governed by professional standards, codes of practice and ethics. The sheer degree of antagonism and conflict between the two sides had rendered the system unworkable. Yet individuals on both sides of the fence could see that doctors and managers should be aiming at precisely the same goals - efficient effective healthcare, delivered to the highest quality possible, given a finite pool of resources.

The building blocks for today's concepts of doctors in management were laid by Sir Roy Griffiths in 1983 who, in his report to the Government on NHS management said that "the nearer the management processes get to the clinical processes, the more important it is for doctors to be seen as the natural managers"(i)

In this statement Sir Roy encapsulated the huge divide between professionals and management and the fundamental need to break down the barrier, if clinical services were to be delivered effectively. The doctor's role in management is one that crosses every geographical boundary. Colleagues in the USA, Australia, Scandinavia and other European countries all face identical challenges -no matter how the service is delivered, the tensions and complexities of the professional/managerial interface is common to all systems.

One of the problems experienced by doctors in management roles is that for any reasons, things are not always what they seem to be and there is often a distinct lack of straight talking. This paper attempts to describe some of the issues that must be confronted and particularly the steps that should be taken to better prepare the doctors of the future for their wide-ranging management responsibilities.

Consider the realities of being a doctor/manager. Firstly, it is important to explore the organisation in which these individuals need not only to survive, but to excel. The dream is that these organisations, be they hospitals or primary care practices, will be driven and led by clinicians, that all decisions will be taken on the basis of clinical need rather than either political or financial imperative. Clearly this is only feasible within whatever the financial constraints may be, but nevertheless the driving force behind decision making, in the ideal health care organisation would be a clinical one. The reality, however, is often a long way from this. In many cases the true driving forces will not be at all clear -either to those using the organisation as patients or indeed to those working inside it.

True involvement of clinicians means a real commitment on the part of the leader of the organisation to devolve decision making authority to those providing the service. This happens only in a small number of organisations.
There is a small number of organisations in the UK where this does not happen in any shape or form. Most organisations in the NHS sit between these two extremes, many expressing a genuine determination to reach a properly devolved system, others less committed. It is the strong leader who can devolve decision making authority and power and yet still lead the organisation.
Most doctors, whilst keen to play a role in management, do not wish to do this full time, however. Most prefer to retain some degree of clinical activity and to take on roles which might involve half-time commitments as medical or clinical directors -that is either heading up a clinical service in a particular specialty or, as Medical Director, taking on the responsibility far the quality of clinical practice far the entire organisation.
Some non-medical Chief Executives see the involvement of doctors in management as a threat to their power and control, whilst others realise that, unless the clinical professionals take responsibility far managing the quality of service themselves, it simply will not be managed at all.
In reality, the degree of involvement of clinicians in management really depends on the skills and talents of the Chief Executive and of the clinicians themselves. It is the culture, set at the very top of the organisation that either makes or breaks the chances of creating a truly clinically led set-up.
Regrettably there are a number of organisations in the NHS where the doctor/manager nightmare exists. These are very uncomfortable places in which to work. They are characterised by clinicians very obviously in management roles -on paper. The real decision making, however, takes place 'underground', and is generally held centrally, so that edicts are handed out to clinical teams, who then have the responsibility to implement them, but have no true managerial platform which contribute to the process.
So, what are the issues confronting these doctor managers, who typically have had considerable experience as a consultant or at a senior level in primary care and have developed an interest in management. Are they appointed to a managerial position because of their skills and interest? Are they doing it because they would rather not see someone else doing the job or because it is just their turn? Are these individuals the champions of the clinical service or are they doing the bit the Chief Executive finds unpalatable?
Is this a real career step or a job, the individual feels obliged to take on for a couple of years before handing over to someone else?
Perhaps a more fundamental question is -are these doctors leaders or managers? Are they strategic players, in key positions in the organisation?
Or are they simply figureheads with their name at the top of a budget, with responsibility for ensuring the budget is not overspent, but no real managerial power to do anything it if it is?
In the early days, many doctors were appointed or persuaded to take on management positions on the basis that this was tokenistic, a passing fad, something to go on the CV. However, what we have seen over the last few years has been truly remarkable. It is a testimony to the sheer dedication and determination of doctors to make sure that the services provided for all patients are as good as they possibly can be, given the constraints.
What has happened is a gradual but developing realisation that part of a doctor's duty is to make sure that their management tasks are performed as responsibly as their clinical duties. The simple fact is that excellent clinical skills and knowledge are worth nothing if the system itself is shabby and increasingly doctors are becoming enthusiastic to take on their management responsibilities with interest and commitment.
The concept of the doctor in management as the eccentric, often maverick individual has changed. Now it is the bright doctor, at the top clinically, who turns his or her attention to management duties because of their fundamental commitment to improving quality of care, through the improvement of the management systems. In parallel with this development, the clinician in management no longer takes on the role as a manager, but as a leader.
So, what is the difference between management and leadership? Levicki describes management as being about "consistency and order" whereas leadership is about "constructive or adaptive change". Management is about keeping things steady, control, not rocking the boat. Leadership is about understanding and elevating the motives and values of others. Leaders inspire others to

give their best, to go the extra mile, to innovate. Managers are required to set standards and monitor performance against them.

Leaders set the tone, the culture and the attitude of an organisation. Managers work within the culture and attitudes of an organisation.

In reality, doctors must both manage and lead -the environment in which they find themselves delivering clinical services, demands this. It is one of constant change, and constant raising of expectations -of patients and professionals alike. Technological advance races on, way ahead of the services' ability to keep up with it. Alongside this, the public's understanding and knowledge of clinical conditions and their treatment has risen dramatically with the advent of the world wide web.

This is not the environment in which the "keeping a lid on things," "not rocking the boat," mentality will survive and thrive. Clinicians of the future, whilst needing to know something of management process and skills, must primarily be educated and developed to take on leadership roles -and this is where we have to some extent failed today's clinicians.

Educators have a duty to tomorrow's doctors -to ensure that their skills in leadership and management are developed, not at age 40 and 50, as is currently the case, but from the word go, as soon as talented individuals enter medical school -as happens in other professions and disciplines.

Teaching leadership skills is, however, more complex than reading books and giving lectures. It involves developing an individual's set of qualities and values. These are described by Levicki as tenacity, stamina, long term wisdom, emotional intelligence, judgement -what is worth fighting for and what is not, equanimity, character, capacity to inspire fellowship and love for fellow human beings.

Leaders must have the confidence to learn about themselves, to be honest about their shortcomings, their skills and talents. Young doctors must be taught how to build on their own strengths and how to overcome their weaknesses. They must be developed to have the ability to inspire ordinary people and to make a profound and enduring difference to the organisation.

There are many different theories and opinions on whether leaders are made or born, educated or developed. Most likely, is that some individuals are better placed to develop into leaders -by dint of their personality, upbringing and schooling, but that the particular skills and knowledge can be developed in most individuals. The challenge is to create a culture within our educational bodies and institutes in which leadership skills are recognised at an early stage, rewarded and developed -as a precious resource.

There are many different approaches to developing leadership skills, ranging from coaching, to learning in groups, to taking on specific assignments, to tackling challenging problems in a challenging environment, to learning at the side of excellent leaders. This is clearly not as easy as preparing a course with a finite set of facts to be learnt and skills to be achieved –but nevertheless by no means impossible.

It is encouraging to see medical schools taking an innovative approach to teaching students - many of our medical schools do in fact generate a culture of leadership, even although it is not identified as such. What we need to build on is the way that individuals are developed, on rather a broader scale than happens currently, so that a cadre of clinical leaders may be generated who will take on their roles in running and delivering the service, in contributing to shaping of healthcare policy, right from the top, with skill, sensitivity and an excellent knowledge base.

It is the organisations and individuals responsible for the training of our future doctors to whom we look for confidence that there will be a significant emphasis on management and leadership skills in their curricula and programmes, so that in time we will be able to deliver far more in the way of dream organisations than the nightmare and mediocre variety.

REFERENCES

1. Griffiths, Roy. Letter to Secretary of State, NHS Management Inquiry 1983

Communication presented at the annual AMSE congress 1999 (Jerusalem, 5-7 September 1999)

BIOETHICS IN MEDICAL TEACHING

Radzisław Sikorski, Małgorzata Sikorska - Lublin (Poland)

Progress in medical science is so enormous that ethical roles of medicine are threatened. This causes concern that commercialisation may endanger fundamental human rights. Technical development, economisation of life and the emerging multimedial reality result in situations which were not predicted by the classical ethics. This is why bioethics developed as a child of our time (Trevenot). Bioethics is a reaction to a technical development which produced a great gap between what can be done and what should be done. Professional independence of a physician is endangered as are his/her authority and the patient′s rights. Mass-media, public opinion, politics and sometime unionists try to weaken the physician′s omnipotence. The state as a fund-provider takes part in medical dialogue and to some extent interferes with patient′s rights. The patient′s privacy in invaded by the computer techniques. The above mentioned dangers make teaching bioethics to medical students and physicians an important addition to the professional training.

Of special concern are problems such as in vitro fertilisation with all its moral, familial and legal aspects, transplantology from the point of view of both the host and the donor, medical engineering facilities enabling the scientist to modify the human genome and to combine it with animal genes, passive and active euthanasia.

There is one more serious moral problem regarding the physicians and their job – a pressure they often undergo to take part in the immoral politics and to perform immoral experiments.

These problems have parallel cultural, political, economical, legal and religious aspects.

The spectacular successes of medicine and other biologic disciplines may produce serious danger for the individuals as well as for the communities. Opportunities and tendencies may emerge towards dehumanisation of man, manipulating with human reproduction, controlling his physiologic and social behaviour, altering human cognitive functions and interfering with justice.

Noble Prize Winner of 1969, American biochemist Nirenberg says that we should stop extensive medical research on humans until modern man possesses adequate wisdom and ethical level, which would help him to use the gained knowledge for the benefit of human kind.

A dynamic development of many of the knowledge branches produces almost every day problems of legal and ethical nature.

Medical ethics has been developing without major problems since the Hypocrites times until the middle of the 20 century when it neither focused special interest nor it caused any specific emotions.

In the last two decades, ethical problems in medicine have reached the social consciousness with increasing intensity. FIGO, the most important world-wide organisation of gynaecologists and obstetricians, states in”Recommendations on ethical issues in obstetrics and gynaecology” published in 1970: “achievements in medical knowledge and technical developments have created ethical dilemmas concerning the good and the evil, the life and the death, as well as those of justice and individual preferences”. Thus, biomedical ethics raises the problems of patient′s rights which are to guard his/her well-being and to promote the patient′s independence.

The development of medicine changes the patient-physician relationship but at the same time it influences the social structures and the health politics. This is why health politics forces the changes in basic medical ethics on local, national and international levels.

Medical problems in obstetrics in gynaecology have created an hitherto unknown and unexpected interest in certain aspects of human procreation.

Some of the most prominent bioethical problems associated with procreational medicine at its present level of development are:

- substitutional motherhood;

- choosing the gender of a baby;
- anencephaly and transplantology;
- scientific research in the preembrionic period;
- selective foetal reduction in multiple pregnancy;
- prenatal diagnosis of foetal disorders and the ethical aspects of the pregnancy termination when congenital malformations have been diagnosed;
- problems associated with the utilisation of embryonic and foetal tissues for therapeutic applications;
- genetic material donation for reproductive purposes;
- altering human genome;
- ethical aspects of the HIV infection in procreational medicine.

Euthanasia remains a special problem.

WHO in its statement of 1950 described euthanasia as an unacceptable procedure „under all circumstances". In its „Declaration of Patient′s Rights" (Lisbon, 1981), the WHO accepted the right of a patient to die with dignity and to refuse to be treated. The Venice Declaration (1983) states that a physician is obliged to treat and ease the suffering constantly respecting the basic interests of a patient.

Catholic morality is against euthanasia yet accepting the right of a human being to die with dignity.

Protestant morality does not divide the respect for life while at the same time accepting the indispensable right of a human to die with dignity.

Jewish morality forbids the termination of human life.

Muslim morality does not permit the termination of life regardless of the cause.

Guido Gerin of Trieste (Italy), the Head of the International Institute of Human Rights, said that rapid development of scientific research as well as technological progress do not give firm answers which would remain unaltered for a longer period of time. Seeking for knowledge produces opinions and answers of relative importance which are valid only at the time they are given. Gerin thinks that bioethical problems not only are of interest for scientists but also focus a concern of governments.

Henri Anrys from Brussels writes that ethics requests from the physicians not only a respect but also a protection of the patient′s rights against their violation by non-humanitarian treatment experiments and the limitation of the medical care availability for economic reasons. Anrys writes: that first of all we should accept the independence of physicians facing danger for both a patient and the doctor′s position when mass-media, public opinion and the political power centres and sometimes even workers unionists act together to weaken the physicians′ plenipotence. One should not expect the physicians to effectively treat the patients and respect their rights if doctors are forced to be health care officers strictly fulfilling political instructions where the system manipulates with patient′s rights. The state provides the funds and by that becomes a party in the medical dialogue interfering to some extent with the patient′s rights and, according to Anrys, invading patients privacy by means of computer techniques.

The imperfect funding of medicine results not only from the prolongation of average life time especially in terminally ill patients but also from the explosion of diagnostic and therapeutic facilities in recent years. This is why a physician faces the demand to reduce the availability of medical services which may sometimes influence his/her income. Anrys writes: one may have an impression that diminishing the availability of medical services, especially when expensive therapeutic procedures are concerned, as well as more or less intensive propagation of euthanasia result from searching for an ethical alibi for economical problems. Thus medical ethics is trapped between patient′s rights and limitations in medical care availability.

Rabin Albert Guigui from Paris writes that progress in medical science is so enormous that it may cause a moral rules disaster. This causes concern especially because the run for rapid profits endangers fundamental human rights.

A physician, educated to protect life, cannot perform or justify acts of euthanasia neither as an act of mercy nor on the patient′s request. From the point of view of humanistic ethics legalisation of euthanasia as an act"justifiable by a social benefit" should be considered unaccepted. "Social benefit" which to some extent translates into the financial benefit, cannot overweigh a value of

human life including the life of physically or mentally handicapped individuals who are socially useless or even troublesome (8).
In the developed countries such as Australia, Ireland, Japan, Canada, USA or UK, a vivid discussion takes place on the “right to die” policy which turns into the discussion on the “right to be killed”. This debate gathers physicians working on the intensive care wards, and psychiatrists as well as lawyers and ethicists. Questionnaire studies were performed among intensive care doctors and psychiatrists. Questions concerned their opinions on patient′s rights: to refuse to be treated, to commit suicide, to a mercy killing. Studies included also elder patients treated in the internal medicine wards. Most patients answered that they would refuse to undergo an intensive therapy if doctor′s evaluated their status as terminal.
Among psychiatrists opinions as for the patient′s rights varied considerably. Most of them think that suicidal tendency reflects mental disease and as so, the patient′s preference should not be considered as decisive. In contrast, intensive care specialists would accept in a terminally ill patient, to stop the reanimation procedures or not to reanimate such patients at all. They agree however that the law at its present state, does not effectively protect the patients against the possible abuse of euthanasia. It is quite commonly stated that patients should be fully conscious at the moment of decision making.

We are convinced about the importance of the assimilation by the academic teachers of the elements of bioethics and the transfer of these ideas to the students.
Human thought is like a wind, it could have destructive force but it could also be beneficial, it ruins but it can also vitalise. A need exists to provoke during lectures and seminars discussions concerning problems to be met by students during their professional life. Our students should get familiar with various bioethical problems and be stimulated to think bioethically.

AMSE'2000

2000 Annual Conference of the
Association of Medical Schools in Europe

Porto, Portugal, September 3-5, 2000

175th Anniversary of the Medical School of Porto

Organising Committee

Prof. M. Miranda Magalhães
President of the Directive Committee, Medical School of Porto

Prof. M. Amélia Ferreira Tavares
Vice-President of the Scientific Committee, Medical School of Porto
Member of the AMSE Executive Committee

Prof. J. Pinto-Machado
Ex-Dean of the Medical School of Porto
Member of the AMSE Executive Committee

Ana Antunes
Association of Medical Students, Medical School of Porto

AMSE 2000 is sponsored by ROCHE

Welcome Message

The Medical School of University of Porto is honoured to host the 2000 Conference of the Association of Medical Schools in Europe, in Porto, Portugal, September 3-5, 2000. In 2000, we are celebrating the 175th Anniversary of the Medical School of Porto and this meeting will be one of the most important celebrating events occurring throughout the year.
We will be very pleased if you consider to attend the meeting, bringing your experience and research interests in Medical Education. We are sending you the second announcement of the Conference with the registration, abstract and accommodation forms, to stimulate you to attend an exciting scientific program with important and up-dated topics in Medical Education. We welcome your participation!

The Conference will take place at the city of Porto which has a unique charm, easily traced as the romantic old historic centre, awarded UNESCO World Heritage in 1996. We hope that you take this opportunity to join us in AMSE'2000 to present your experience and research and that your stay will be most instructive and pleasant.

Looking forward to welcome you in Porto,

M. Miranda Magalhães
Dean of the Medical School of Porto

J. Pinto-Machado
Ex-Dean of the Medical School of Porto

PROGRAMME
Sunday, 3rd September 2000

15:00h-18:00h Registration at "Ordem dos Médicos"

18:30h Welcome cocktail at "Ordem dos Médicos"

Monday, 4th September 2000

SESSION I - "What is the Profile of the Undergraduate when Leaving the Medical School and How to Evaluate it?"

9:00h – 9:15h – Dale Dauphinée – Executive Director, Medical Council of Canada - *Linking the Educational Plan with the Assessment Process: Key Considerations in the Validation of the Students' Educational Experience.*

9:15h – 9:30h – Ralph Bloch – Institute for Medical Education, Faculty of Medicine, University of Bern, Switzerland - *Mission, Goals, Objectives and Controlling the Management of Learning.*

9:30h – 9:45h – Henk Huisjes – Dean of Medical School of Groningen, The Netherlands - *Student Profiles: a virtual matter.*

9:45h – 10:00h – Luiza Cortesão – Faculty of Psychology and Educational Sciences, University of Porto. – *How and Why to Define a "Profile"?*

10:00h-11:00h Group sessions

11:00h-11:30h Coffee Break

11:30h-12:30h Panel and general discussion

12:30h Official Opening Cerimony

13:00h-14:30h Lunch Break

SESSION II - "Knowledge Transfer from University Research to Practical Use: The General European Research Policy"

15:00h – 15:20h – Jonathan Knowles – President of Global Pharma Research, Member of Executive Committee ROCHE – *The Future of Medicine and the Implications for Medical Schools*

15:20h – 15:40h – Chief Manager of ROCHE – *The Administrator Perspective of Knowledge Transfer.*

15:40h – 16:00h – Luis Magalhães – President of Foundation of Science and Technology (FCT), Portugal – *Technology Transfer and Innovation Policy in Portugal.*

16:00h – 16:30h – General Discussion

16:30h – 17:00h – Coffee Break

17:00h-18:00h – AMSE General Assembly

20:30h Dinner at Taylor's Port Wine Cellars

Tuesday, 5th September 2000

SESSION III - "Results and Experiences of the EU Programmes on Exchange of Students and Teachers"

9:00h – 9:15h – Mireille Bellet – Director of International Relations for Medicine, University of Bretagne Occidentale, Brest, France - *Experiences and Results of the Exchanges of Medicine Students between France and Europe.*

9:15h - 9:30h – J.M. Nascimento Costa – Pró-Rector of Coimbra University, Portugal – *The University of Coimbra University: from ECTS Pilot Project to the Socrates Exchange Programme.*

9:30h – 9:45h – Igor Barjakterovic – Director of the "Standing Committee on Professional Exchange (SCOPE) da International Federation of Medical Students Association (IFMSA) – *Experiences and Results of the Exchanges Programmes of the IFMSA.*

9:45h – 10:00h – Ana Antunes – Association of Medical Students of the Medical School of Porto, Portugal – *Evaluation of the Portuguese Experience on the Exchange Students Programmes.*

10:00h-10:30h Panel discussion

10:30h-11:00h Coffee Break

SESSION IV – AMSE/AMEE Workshop

11:00h-12:30h - “Toward a European Core Curriculum?” – Joint Project of AMSE and AMEE
Chair: H.J. Huisjes, University of Groningen, The Netherlands (on behalf of AMSE) and L.N. Bouman, University of Amsterdam, The Netherlands (on behalf of AMEE)
12:30h-14:00h Lunch Break

SESSION IV – Posters and Medical School Presentations

14:30h-15:30h Poster Session
15:30h-16:30h Presentation of Medical Schools
17:00h Executive Committee Meeting at the University Club of Porto.

Registration Fees	**Until June 16, 2000**	**After June 17, 2000**
AMSE members	❑ 40.000 PTE (200 EUR)	❑ 48.000 PTE (240 EUR)
Non members	❑ 50.000 PTE (250 EUR)	❑ 58.000 PTE (290 EUR)
Students	❑ 20.000 PTE (100 EUR)	❑ 28.000 PTE (140 EUR)
Accompanying persons	❑ 25.000 PTE (140 EUR)	❑ 25.000 PTE (140 EUR)
AMSE membership fee	❑ US $200 (in a separate cheque)	

Fees for PARTICIPANTS include:

- Participation in sessions
- Two lunches
- Coffee during breaks
- Welcome cocktail on Sunday
- AMSE Conference Dinner on Monday
- The printed material of the Conference

Fees for ACCOMPANYING PERSONS include:

- Welcome cocktail on Sunday
- AMSE Conference Dinner on Monday
- Tours planned to coincide with the sessions:

  September, 4th , 2000 - *Porto, World Heritage (14:00h/17:30h)*

  Admire the beautiful landscape of our city from Serra do Pilar. The view is wonderful. Crossing Luis I bridge, built by a student of Eiffel we will find the Fernandinas Walls. Go down the Barredo stairs and find the river. You are at Ribeira. Enjoy the colourful market, the Bacalhoeiros wall. Going up the Infante street we will find the Stock Exchange Palace with its magnificent Arabian room. Passing through Mouzinho da Silveira street we will find St.Bento Station. After visiting the heart of Porto and some of the most commercial streets of our city, a stop at Majestic Cafe to have an afternoon tea. We will finish the visit in one of the many Port Wine Cellars. Opportunity to taste the wonderful Port Wine. Return to the hotel.

  September 5th, 2000 - *Return to the Past (09:00h/13:00h)*

  Departure from Porto heading to Guimarães, known as "the Cradle of the Portuguese Nationality". Visit of the historical centre including the Castle and "Paço dos Duques". Return to Porto and lunch at Chez Lapin restaurant.

Cancellation Policy

Refund of Registration Fees will be made as follows:

Post-marked prior to June 16, 2000 – full refund less 8.000PTE (40EUR) handling fee
Post-marked from June 17, to August 4, 2000 – 50% refund
Post-marked after August 4, 2000 – no refund

Conference Secretariat

Please address all correspondence to:

AMSE'2000
ACRÓPOLE, Lda.
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4470-090 MAIA - Portugal
Phone ++ 351 22 9412406 Fax. ++ 351 22 9412407
E-mail – acropole@esoterica.pt

TRAVEL AND ACCOMODATION

ICITOURS, Travel Agency, Lda is the official travel agent for the Conference
(Contact: Patrícia Costa)
Address: Rua Oliveira Martins, 167 - 4200 – 429 Porto, Portugal
Phone: ++ 351 22 507 30 30 Fax: ++ 351 22 509 75 16
Email: icitours@mail.telepac.pt Internet: www.icitours.pt

HOTEL INFORMATION

Hotel Carlton Porto ★★★★★: Iocated in the Praça da Ribeira in the heart of the historical centre of Porto, built on a section of the mediaeval city wall, the Porto Carlton Hotel occupies part of a group of buildings that date from the XVI, XVII and XVIII centuries. The hotel offers luxurious accommodation comprising 3 suites and 45 double rooms, a restaurant where guests can enjoy an excellent meal accompanied by fines wines, a bar and four meeting rooms.

Hotel Porto Palácio ★★★★★: With a total of 253 rooms including luxury standard rooms and suites, all equipped with satellite TV, direct telephone, air-conditioning and mini-bar. An excellent choice of menus and ideal setting.

Hotel Vila Galé ★★★★: Close to the commercial district in the traditional Porto, integrated in the "Porto Centre", a complex with a shopping centre, restaurants, offices and a bus terminal. This is the newest Porto hotel, offering all the confort of spacious and luxurious furnished rooms. Parking facilities, restaurant and bar, health club with indoors heated pool, gymnasium, and sauna.

Hotel Beta★★★★: Close to the Conference venue this hotel has 126 rooms and suites with all facilities. Health club and heated swimming pool, solarium, gymnasium. Garage and parking facilities.

AMSE'2000

2000 ANNUAL CONFERENCE OF THE ASSOCIATION OF MEDICAL SCHOOLS IN EUROPE
PORTO, PORTUGAL, SEPTEMBER 3-5, 2000

REGISTRATION FORM

Please complete and return this form, together with your payment, to:
Secretariat, **AMSE 2000 Conference**
ACRÓPOLE, Lda. - Avenida Mouzinho da Silveira, 16
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Identification

Please complete this section accurately; the information you provide will allow us to correspond with you efficiently, and it will also be used for your delegate badge at the Conference.

Participant (Please TYPE or PRINT IN BLOCK LETTERS)

Surname _____ Initials _____

First Name _____

Title ❑ Prof. ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms.

Address for List of Participants' Purposes:

Institution _____ Department _____

Nº Street _____ Suite/Apt. _____

City _____ State/Province _____ Country _____ Postal Code _____

Email address _____

Mailing Address If Different From Above:

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City _____ State/Province _____ Country _____ Postal Code _____

Accompanying persons

List only those individuals registering for the Accompanying Persons' Program:

Surname	First name	Title
Surname	First name	Title
Surname	First name	Title

Registration Fees

Please check in the appropriate box/s

	Until June 16, 2000	**After June 17, 2000**
AMSE members	❑ 40.000 PTE (200 EUR)	❑ 48.000 PTE (240 EUR)
Non members	❑ 50.000 PTE (250 EUR)	❑ 58.000 PTE (290 EUR)
Students	❑ 20.000 PTE (100 EUR)	❑ 25.000 PTE (140 EUR)
Accompanying persons	❑ 25.000 PTE (125 EUR)	❑ 25.000 PTE (125 EUR)
AMSE membership fee	❑ US $200 (in a separate cheque)	

Payment:

Please indicate amount enclosed and ensure that you send your fully completed registration form together with your payment:

Total fees: _____ PTE (EUROS)

Method of payment

Option 1: Bank Transfer – with your name and address indicated on the reverse. If payment is made for more than one person or by a company please make sure all names are indicated and send fully completed registration forms together with a copy of the bank transfer. Please make drafts payable to: Faculdade de Medicina do Porto - AMSE 2000 and send them to Caixa Geral de Depósitos – Balcão Areosa – NIB 003501030002712353030. Bank charges are the responsibility of the payee and should be paid at source in addition to the registration fees.

Option 2: Cheque made payable to: Faculdade de Medicina do Porto - AMSE 2000

Enclosed cheque number: _____ Bank: _____

Please include fully completed registration form.

Date _____ Signature _____

AMSE'2000

2000 ANNUAL CONFERENCE OF THE ASSOCIATION OF MEDICAL SCHOOLS IN EUROPE
PORTO, PORTUGAL, 3-5 DE SETEMBRO, 2000

ACCOMODATION FORM

This Accommodation Form is to be completed and returned to the following address:

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Please be so kind and fill in your name in block letters or use the typewriter:

Family name: _____ First name: _____
University of: _____ Title: _____
Address: _____
_____ Country: _____ Code: _____
Phone: _____ Fax: _____ Email: _____
Accompanying person(s) _____
Arrival: _____ Departure: _____

Accommodation has been reserved at different hotels. Kindly note that all capacities are limited and all requests will be considered in order of receipt. Prices are in PTE per room and night including breakfast

Hotel Carlton Porto *****			
	Single room (view city)	PTE 18.000	Nº Rooms_____
	Double room(view city)	PTE 21.000	Nº Rooms_____
	Single room (view river)	PTE 20.000	Nº Rooms_____
	Double room (view river)	PTE 23.000	Nº Rooms_____
Hotel Vila Galé ****			
	Single room	PTE 14.000	Nº Rooms
	Double room	PTE 14.000	Nº Rooms_____
Hotel Porto Palácio *****			
	Single room	PTE 20.000	Nº Rooms
	Double room	PTE 22.000	Nº Rooms_____
Hotel Beta *****			
	Single room	PTE 11.400	Nº Rooms
	Double room	PTE 13.550	Nº Rooms_____

Cost includes: room, breakfast, taxes and VAT. A deposit for 1 night is necessary for reservation.
For students we have rooms at lower prices at "Students Houses". For more information please contact the Secretariat.