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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.

AMSE website: <http://histolii.ugr.es/>

“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 Uno Erikson, Dept. of Radiology, Uppsala University Hospital, SE-751 85 Uppsala, Sweden.

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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 repre-

sentative. 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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## CONTENTS

Purpose and organization	2
Knowledge transfer from university research	2
Administrator perspective	3
Session III	6
Session IV	6
Even more medical students?	8
Conflict between healthcare production and education	9
Tuning educational structures in Europe	11
AMSE annual meetings since 1992	13
Addresses of AMSE-EC members	14
AMSE Executive committee meeting in Uppsala	16
2001 Annual conference	17
Programme	18
Abstract form	22
Registration form	23
Application form	24

## THE PURPOSE AND ORGANIZATION OF AMSE

AMSE creates a forum for European Medical Faculties to share experiences in the fields of education, research and management. AMSE seeks to stimulate co-operation between Medical Schools in Europe and to initiate and sustain relations with other professional, governmental and non-governmental organisations in education, research and health care. AMSE organises an Annual Conference on topics of particular interest to Deans and other Staff members of Medical Faculties.

The Society is registered in Vienna as an incorporated non-profit society. It operates through the General Assembly and the Executive Committee. The Executive Committee manages the affairs of the Association and together with a Local Committee organises the Annual Conference in one of the Universities in Europe. The Chairman of the Execu-

tive Committee serves as President of the Association.

One main issue of AMSE at present is to define the outcome of undergraduate medical education in Europe in order to attain to European core objectives for a medical doctor. The aims of this project are (I) to enhance the quality of undergraduate education, and (II) that patients and authorities were reassured that medical graduates were fit for supervised clinical practice in the different countries of Europe. In recent years the debate has moved from trying to create a common core curriculum towards defining an agreed outcome at the time of graduation, i.e. defining standards of knowledge, skills, and attitudes required by the graduates. However, the choice of the curriculum design will remain open to each Medical School. Such freedom is essential if developments and innovations are to be encouraged.

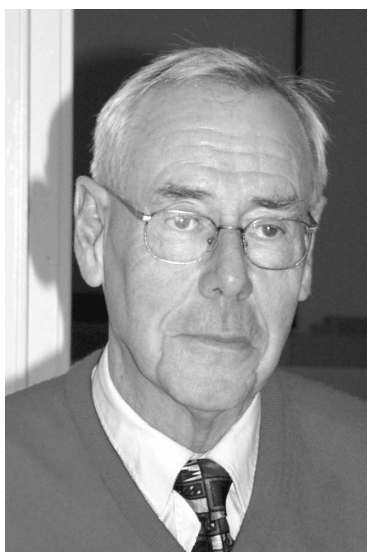
## KNOWLEDGE TRANSFER FROM UNIVERSITY RESEARCH TO PRACTICAL USE. THE GENERAL EUROPEAN RESEARCH POLICY

By **Uno Erikson,**  
Uppsala University Medical School

If you look back about 50 years, the universities and the business world lived apart. Only some transfer of knowledge to the industry from universities occurred from the departments of pre-clinical medicine and chemistry to; e.g. the product of dextran (Macrodex, Pharmacia), Xylocain (Astra), and high quality steel (Sandvik). The university educated engineers were employed by the companies for their own development, e.g. Ericsson and ABB. This was the situation in Sweden as well as all over Europe.

In the U.S. a change began to evolve when the Faculties of Science and Technology were approached by the company, when the rapidly growing basic science in physics, chemistry and physiology showed a promising market future, e.g. transistors, vaccines, nuclear magnetic resonance and technique. In some well-known universities like UCLA, Caltech, MIT, and Stanford, the co-operation became much closer than earlier, and the atmosphere to create small science based companies more favourable. Thus, the ground was prepared for a later concentration in areas like Palo Alto, the Silicon Valley and the Research Triangle in South Carolina. During the early IT-era, these developments impressed the world. Very soon the focus came on the IT-world and nowadays it has changed to a focus on medicine and hospital-related areas.

All around the world, now, governments speak about and sometimes even promote university scientific transfer, e.g.



within the U.K., Switzerland, Sweden and Singapore. In Sweden the political mentality has changed from a hostile attitude (do not allow scientists to be rich), to a more friendly (now we are equal to the U.S. and want to share in the scientific discoveries). The development of new products now seems to need more knowledge than earlier and to an increasing degree. Company employees need greater knowledge in e.g. solid-state physics, electronics, computer science, as well as physiology and molecular biology.

All this has changed the approach in departments of basic science and medicine from the relatively calm, far-sighted research procedure in early days — from a mighty wide river — to the current

hectic production of PhD's — coming like fish from a fast-flowing stream.

Now the state wants to have rapid return on its investment, regardless of what venture capitalists want. The organisation of the old universities was considered to be a hindrance, i.e. the professors and the former graduates of Ph.D. were considered slow to react. A general spring-clean was necessary — the new trendsetters tell us. Look to the U.S. — Suddenly the sun rises in the west. It has always been the professors and the associate professors, who have had the skill to do research and the research was often done by graduate students (young and healthy, and unmarried, to cope with days of 12 – 15 hours work). The chairman him/herself and his team took part in the research and the administration burden

was a relatively small problem. The output was sufficient to meet the needs of society, i.e. companies, schools and the universities own demand for competent people. These were of good quality, and the number of Ph.D. degrees was related to the demand – even if we take into consideration that in some organisations a Ph.D. was looked upon as a useless high-brow person who had just inflated his own ego. The sudden need of industrially employed Ph.D.'s has created a new response from the universities. The research foundations, which sometimes have had an increase in research funds, dictate the conditions under which faculties have to work. The Ph.D. exam must be produced within a period of four years, including both training and experimental work and of course under full payment. This is a heavy burden for a department and beyond that, the result of the effort must be ready for a rapid grant application and hopefully contribute to employment while also creating experts within their field of research. The academic life is far away from that of an artist in their atelier or a composer. The basic and profound searching is no longer promoted – particularly in relation to theoretical experiments.

The research within the Swedish medical faculties is soon to be investigated by a noble elite of hand picked researchers (selected by a mighty board, which includes a former Prime Minister, as well as other prominent public persons). From

a full freedom of choice, the universities have now entered a limited freedom to act within proscribed limits are always focused to a certain chosen area which will be given to the universities as their research area. The aim is to create excellence and to stay in the international front line. The appointed people will put the searchlight upon the supposed obscure corners of the universities. Very little opposition is heard. Another problem has, however, appeared. In Europe there is a tradition, that the teacher/researcher owns his/her ideas and the outcome of the patents, products, specialities. This makes the researcher independent, and in a few cases wealthy and the wealth he can dispose by himself. Among Swedish politicians, business people and also among university administrators and professional economists the opinion is now spreading that the researchers are paid by the society and therefore their research results should belong to the society (i.e. the university). It is also considered and taught in some courses that the researcher should not handle their own affairs. At Uppsala University, this has been thoroughly discussed and the old European law is still valid. In case a researcher agrees to and needs assistance from the university, he gets 70 % of the income, when the expenses are taken into account. The remaining 30 % will go to the university – but the agreement is voluntary. Many researchers prefer their own private solution.

During the Porto meeting of AMSE in September 2000, some problems were discussed. The AMSE meeting provided an excellent forum for this discussion, and the lectures from this appear hereafter in shortened versions.

## THE ADMINISTRATOR PERSPECTIVE OF KNOWLEDGE TRANSFER

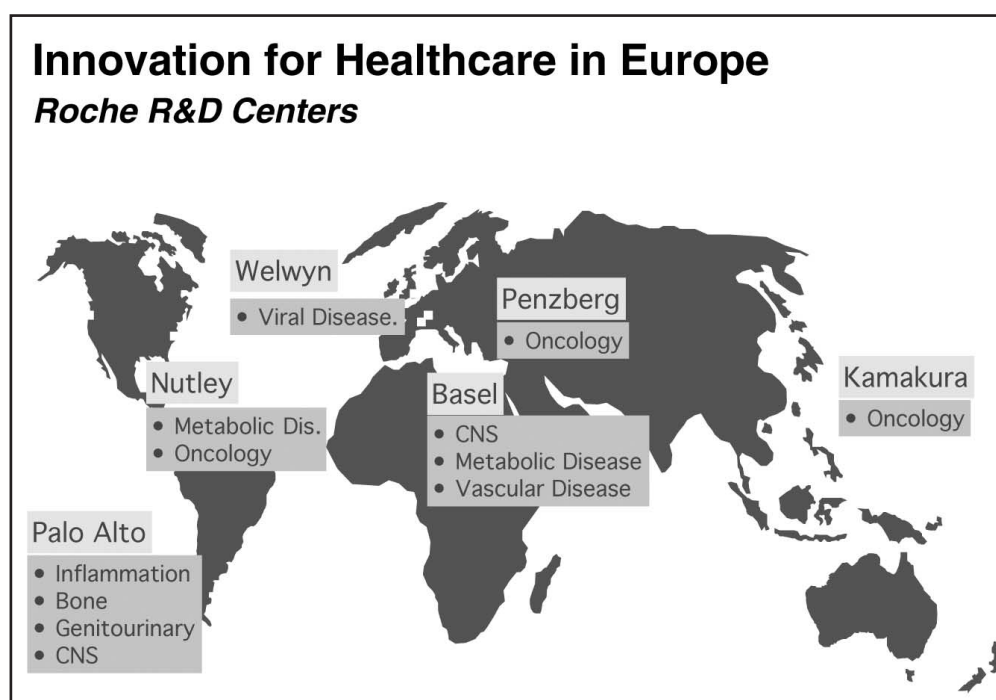
By **Adriano Treve, ROCHE, Lisbon**  
**The Roche contribution to the country of Portugal's research in Coimbra and Porto.**

Welcome to Portugal. It is a pleasure to have this opportunity to speak to you. I will start with a short overview on Roche, the Swiss based pharmaceutical company and I start where it actually all begins - in research and development.

Roche runs 6 Research Centers worldwide.

They are in:

- Palo Alto
- Nutley
- Welwyn Garden City
- Basel
- Penzberg
- Kamakura.



We have concentrated our research in 7 major areas which are

- Central Nervous System
- Genitourinary Disease
- Inflammatory Disease
- Metabolic Disease
- Vascular Disease and Lipids
- Oncology and Viral Disease

The area for development is structured in a similar way. On a worldwide basis we employ a staff of approximately 1800 people with development expenditures of USD 900 million.

Overall, in 1999 the Group increased its R&D spending by 11% to 2.4 billion USD of which 900 million USD for development. Worldwide, Roche currently employees some 3,200 people in pharmaceutical research, 1,220 of them in Basel. We have the critical mass to take advantage of opportunities and cope with the risks inherent in pharmaceutical research and development.

Comparing R&D investment with other pharmaceutical companies, Roche ranks 2nd.

We are competing successfully in an environment dominated by continuous change in both the scientific and commercial world. The competitive pressures to discover new molecular entities quickly, to flood pipelines with new medical therapies, to efficiently move compounds through clinical testing and to achieve rapidly high level of peak sales, are mainstays of the environment in which we operate. Roche is as a matter of fact conducting at present more than 150 clinical trials worldwide and with that in contact with many academic centers.

On the next slide you are able to see the different phases of the research and development process. Before a product enters into the commercial life cycle, in other words, before the product is made available to patients, it spends the first 12-13 years of its life within Research and Development. The remaining patented time of 7-8 years is the time to make the money necessary to continue funding research and development, or, in other words it is the time to recoup the investments which today amount to approximately 300 - 350 mio USD to develop a new product. By shortening the development cycle time we can both extend patent protected product sales and create 18-24 months of time savings within which we can generate sales, enter markets early, grow those markets quickly and invest in future R&D initiatives.

Being capable of completing Phase I to III clinical programs faster than competition allows to achieve a strong competitive advantage in today's intense marketing environment. After all drug development is not only about rapid registration, but also about rapid commerciali-

## Innovation for Healthcare in Europe R&D Investment Pharmaceuticals

Leading Pharmaceutical Companies by R&D Expenditure as % of Drug Sales in 1998

AstraZeneca	19.8%
Roche	19.1%
Eli Lilly	18.8%
SmithKline Beecham	18.1%
Novartis	18.0%
Aventis	17.4%
Pfizer	17.3%
Glaxo Wellcome	14.6%
Bristol Meyers Squibb	12.5%
Merck	11.9%

Pharmabusiness and Julius Bär Brokerage (BusinessWeek 12/99)

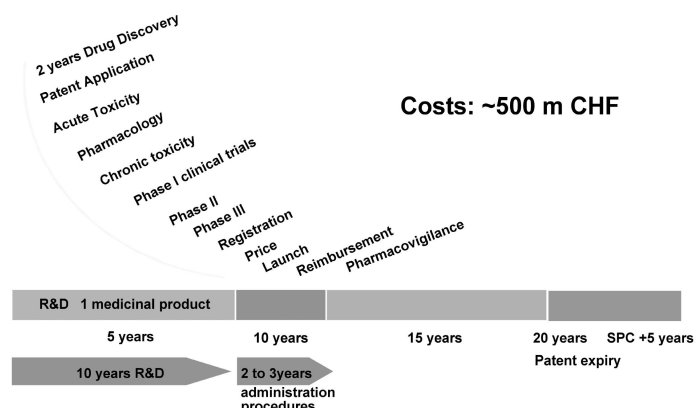
sation.

This was a brief overview to show how R&D is organized at Roche, but also a try to emphasize once more how much time and effort it takes, to take a product to the market. This is important, since the output of the global research and development organization is as well a driving force for the local sales and marketing organizations in the countries. As a matter of fact and as in other industries the sales and marketing organizations live of the R&D output, but with all these commercial aspects we should not forget the main goal which is to improve the quality of medicine for patients.

Before talking about the commercial aspects of the business, let me say this:

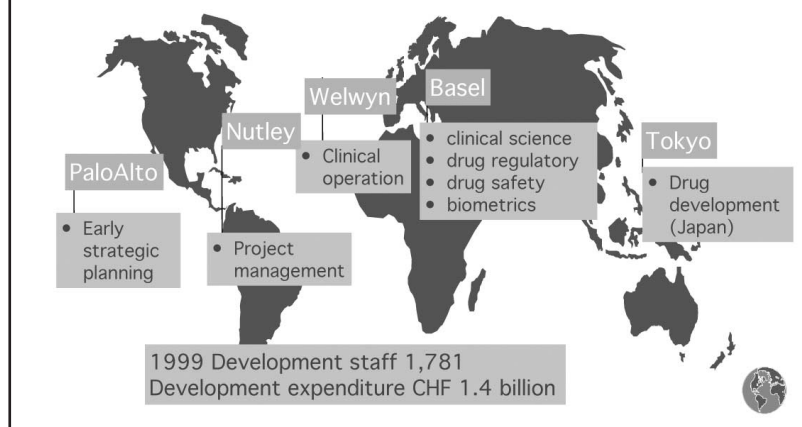
The cooperation and partnership we have Internationally and locally with the Medical community is a backbone of our business. As a drug company we have no direct access to patients and this is why a pharmaceutical company like Roche needs collegial partnerships and collaborations with the medical profession to provide and test new medicines. The medical profession has the expertise and know-how to deal with the patients and we complement that with either new innovative products or different treatment options. We

## Innovation for Healthcare in Europe Phases of R&D Process





## A worldwide organization with global development principles decentralized functional leadership



establish treatment hypotheses and in collaboration with you we analyse the outcomes. Such a collaboration is essential, then only together we can transform biological knowledge into effective medicines for patients.

However, the cooperation has changed in the last years. It has become more complex and complicated. The guidelines for clinical studies are more tight and everything has to be done faster, since every extra day before registration of the product costs money.

The number of patients to be included has increased. Depending on the substance and indication a company needs a couple of thousands of patients for clinical testing.

It is interesting to watch the process of how these partnerships between the pharmaceutical industry and the medical schools are established and how they work together. In most of the cases the top clinical research is done in major teaching hospitals which are affiliated to medical schools. The relation is usually with, what we call thought or opinion leaders. Most of the time the industry has excellent relations with the thought leaders or the respective department involved in the research. Sadly enough none of these relations transition locally to the medical schools. Also, looking at programs of medical schools we hardly find courses for clinical trials, regulatory affairs, drug safety or pharmacoeconomics or other courses related to activities of the pharmaceutical industry. It seems it is the duty of pharmaceutical industry to provide such know-how.

The industry as such should not only be considered as a provider of funds, but also as a partner to improve health. It is important for all to build long-term relationships where both can benefit from each other. In Portugal for example we have some tools that we use to strengthen these relationships and to transfer and share know-how.

For example not long ago we have created the Roche foundation with the goal to communicate to the medical profession about local scientific Roche events and activities. Through the Roche foundation we support the best students for a traineeship at Roche and sponsor post-graduate education as

well.

Other main contributions are:

We provide and sponsor local and international education at congresses.

We organize and support participation at local scientific events for all those who cannot participate in international events. Sometimes we sponsor foreign speakers to come to Portugal to share their experiences on ongoing clinical trials or on products that are already available in their market.

In terms of clinical trials we are also working together with Ordens dos medicos, the official body of the Portuguese physicians, to build expertise on clinical trials.

We give training on how to perform clinical trials to achieve good clinical practice.

We also sponsor major medical events and public education programs such as the Congress of Cardiology, the Oncology day, AIDS related events and Dermatology.

We work together, usually on a part time basis, with medical consultants from major portuguese hospitals to share expertise on products already available in the market. This partnership also reinforces the concept of pharmacovigilance in which we monitor a drug on a continuous basis when it is commercialised.

Last but not least important we use in Portugal the internet extensively where physicians and consumers can access our local portuguese homepage and seek for information

The discovery and development of new medical solutions is, and will continue to be, the motor driving Roche's business. But the fact is, we are just one company – albeit a one – in a very large industry. An industry whose value and contributions society, I believe, are too little known, understood and appreciated. Robust sales not only mean that our industry is doing well, but that our patients are doing even better.

It is a challenge for all of us to improve all the time the way we do things. The aim is to become even more professional, to produce results based on Good Clinical Practice which result in high quality data for filing New Drug Applications which leads to faster introduction of new innovative products for patients and better health.

**Conclusion:** The universities display an increasingly important role in the company's life. In Europe and like elsewhere, therefore the demand of useful research results may interfere with the free research and thus a traditional intellectual life at the universities. The governments like to control the boards of the universities by demanding to chose a chairmen as well as other board members of the universities, and in many aspects this has changed the attitude to the universities and to the university freedom.

## SESSION III:

### RESULTS AND EXPERIENCES OF THE EU PROGRAMMES FOR EXCHANGE OF STUDENTS AND TEACHERS.

Moderators: Colette Creusy, Eduardo Rodrigues Pereira, Madalena Patricio:

Speakers: Mireille Bellet, J.M. Nascimento Costa, Igor Barjaktarevic, Ana Antunes.

All the speakers, deeply involved in Exchanges of students, presented their point of view on this topic.

For the Academic year, 1998 – 1999, in France a national survey has been undertaken concerning the Exchange of students for undergraduate students through a questionnaire. Nearly all the French medical schools belong to the Socrates programme, half of them co-operate out of Socrates with western as well as with eastern European schools.

About 400 students went abroad world wide, 18 % in Europe, essentially thanks to Socrates for hospital practice. The average mean duration time of the stay abroad is three months, usually during the summer season.

In Portugal, experience of student exchanges, has been regarded by the Association of Medical Students. The main part of the student's mobility is organised by the students association.

The stay abroad is essentially for hospital practice for one month in summer time. Students can participate abroad in a research programme when involved in a specific project.

Although only French and Portuguese experiences have been discussed during this session, many European countries have student exchange programmes. The duration time abroad within the Socrates Exchange Programme, can vary from periods of 1 to 3 months, to longer periods of stay abroad, for one semester or even a whole year. This has been possible by using the ECTS system for evaluation.

The discussion pointed out the importance of ECTS, guaranteeing mutual recognition of validation of exams between medical faculties.

The most difficult aspect to solve relates to the differences of curricula between European countries.

There was general agreement that, in our Faculties, the responsible for student mobility have to be very flexible to facilitate the student exchanges. It was also accepted that students can take great advantage of those mobility programmes (different approaches to medicine, to different cultures, as well as sharing new experiences).

## SESSION IV:

### AMSE WORKSHOP

Hendrik J Huisjes, Herman JM van Rossum and Janke Cohen-Schotanus  
Faculty of Medical Sciences, University of Groningen, the Netherlands

#### Student profiles, a virtual matter?\*

Usually, if the title of a presentation contains a question, the answer is given at the conclusion. After considering all the relevant data, I shall not follow that good custom. I choose to start with the answer: 'a student profile is by no means a virtual matter. It is hard necessity.'

#### Definition of profile

First of all, my definition. I consider the profile of a student as his or her professional properties or qualities at the end of his or her initial medical education. In Europe usually after six years. This regards cognitive and other qualities. For example: what skills did he master? What knowledge does she possess? What are his or her attitudes? In the 'Dutch Blueprint' the term chosen is: objectives, or final objectives of the undergraduate medical training.

I propose that, before being able to design a curriculum, one needs to choose the profile of the student at the time of graduation, in terms of the objectives of the curriculum. Therefore, the profile and the objectives determine the curriculum and not the other way round. This seems obvious, but it is not.

#### The subject-curriculum

For centuries, curricula have been designed by allocating varying amounts of time to each of the existing disciplines, from anatomy and biochemistry to surgery and psychiatry. In this way the curriculum is a collection of disciplines. The student must be able to integrate them in his own mind before being able to function as a doctor.

There are several disadvantages: firstly, it's not easy. It is, for example, particularly difficult to integrate communicative skills and cognitive skills. E.g. how to transfer what you know, to a patient who does not. Secondly, the relevance of an extensive knowledge of basic theory for medical practice is not evident in itself. Many students tend to forget their theoretical knowledge of anatomy when they need it later in surgery. Finally, the students do not like it. There is little moti-

vation in having to learn (bio)chemistry when the reason for choosing the study of medicine is the wish to help sick people.

The advantage of a subject curriculum is, that the various disciplines and their epistemology are readily recognisable, so that the construct of medicine, as a collection of areas of knowledge becomes clear to the student.

### **The problem oriented curriculum**

During the last decades, problem based learning (PBL) in medicine is becoming more and more popular. In contrast to the traditional subject-based approach, in PBL any problem with which a doctor may be confronted while practising medicine, can be the point of departure for learning. This can be problems in written form. Or, as we have chosen in our Faculty it is patient-demonstration by the teachers. The advantages are clear: integration of disciplines from the beginning, the relevance of basic sciences is immediately apparent and most students prefer this approach. The drawback is that the various disciplines lose some of their identity, in particular the basic sciences.

In conjunction with this rising popularity of PBL there has been an increasing awareness of the need to define the profile of the young doctor when leaving medical school. Until the second half of the 20th century, the student had to learn more or less what there was known of medicine, and this determined what he knew when starting his career. Specialisation improved his skills more than his knowledge. Skills were not a particularly important aspect of undergraduate study, let alone attitudes. In the past decades, the amount of knowledge available rose tremendously and attitudes were deemed increasingly important. A selection had to be made because students couldn't learn everything.

At first, this was done by reducing the lecture-time offered to the various disciplines. The professor had to decide for himself what was important. The curriculum still offered a constellation of disciplines and the endresult was the sum of these. But, along with the acceptance of the concept of PBL, grew the recognition that a curriculum could be, or rather should be, defined not by the abilities of the teachers but by the expected abilities of the doctor. In other words by the question what kind of problems one could expect him to solve, instead of by an accumulation of subjects. In the Netherlands, this resulted in the Blueprint 1994: Objectives of undergraduate medical education.

### **The Dutch Blueprint**

In the second part of my presentation, I will discuss in some detail this Blueprint, which has received a certain amount of appreciation in Europe and, as I have understood, has been considered to serve as a basis for the development of a European medical curriculum, when this was still a viable project.

Firstly, the most important aspect of the Blueprint, perhaps even more important than its contents, is its history. The second aspect to be discussed is of course its contents. The

third aspect is its consequences.

### **The history of the Dutch Blueprint**

In 1990 the need was felt to better define the common objectives of the medical training programmes in the eight medical Faculties in the Netherlands. This recommendation was received by unanimous consent of all the Deans of the medical faculties. The Deans, of course, did not decide that they would all have the same curriculum. What they did decide, however, was that the final objectives of all eight curricula would be the same. How to reach these objectives was a matter of choice for each Medical Faculty.

The work was begun in 1991 and it ended on January 1, 1994. There was a Steering Group in which all the Faculties and the students were represented, and a Project Group for the execution of the work. In the Steering group were delegates of the Royal Dutch Medical Association and a representative of the Ministry of Health. They had an advisory part.

In my opinion, the commitment from the beginning of all concerned parties: faculties, ministry, students and the medical association has been vital to the success of the project.

### **The contents**

The blueprint starts with a general profile of the doctor. It contains the following items:

- medical problem-solving
- knowledge and skills
- scientific education
- attitudes
- flexibility
- responsibility

It is clear that such an archetypal and general description of the doctor cannot be of much help in programming a curriculum. It is like a mission statement and more details are needed. Therefore on the second level of the Blueprint the general objectives are formulated. These are classified as follows:

- medical aspects
- scientific aspects
- personal aspects
- aspects related to society and the health care system.

A presentation like the present one cannot show all the ramifications forming the essence of the blueprint. Therefore here follows the categorisation of the medical aspects as an example:

- man in somatic, mental and social respect
- problem recognition and description
- history-taking
- physical examination
- problem analysis
- additional investigation
- further problem analysis
- management
- attending (the patient)
- reporting and making records
- prevention

Each of these aspects is analysed further. For example evaluation of the results of treatment involves such aspects as addressing the patient's needs, assessing the achievement of the intended effect, side-effects, complications, compliance, planning of follow-up et cetera.

The physician is expected to deal with the patient's problems. Therefore the last level of dissection of the curriculum in the Blueprint is the list of some 350 problems. They are used as starting points for training.

A substantial appendix, of 90 pages, which is more than the size of the actual Blueprint, is devoted to discipline-related objectives. This appendix contains the clinical problems and skills, arranged by discipline, which the student should be able to handle. The level of required competence varies with each item. It is now thought by many teaching staff in the Netherlands that too many details are presented in the appendices. Students, however, like the lists because they can be used for self-assessment.

### **The application of the Blueprint**

The Blueprint offers a clear definition of the objectives of the medical curriculum in the Netherlands. It can be used and is being used as a guideline, not only for designing curricula in the Faculties of Medicine, but also for designing clerkships and final examinations. In the quality assurance system, in which all faculties are visited and judged every four years, the Blueprint is used as a standard for assessment. The Blueprint has also been incorporated into the legal structure to determine what can be expected of doctors. As such it has been a success.

Of course, there are problems. As the objectives become

more detailed (from the general objectives to the detailed lists of problems and skills), the risk of inaccuracy grows. It is clear that in a list of 350 problems, close reading will reveal that some of the problems are of no great importance, or that other, important ones are missing altogether. That is what actually has happened: there have been over 30 reactions from medical scientific organisations and disciplines indicating omissions. They are currently being dealt with by a new working party set up by the medical faculties to revise the Blueprint. The results will be available in the summer of 2001.

Another problem is the position of the basic sciences. There are no explicit objectives for them, because these are considered implicit in the problem oriented approach. The student needs basic knowledge to be able to solve clinical problems and in the final objectives both basic and clinical knowledge and skills are included. Perhaps this is inherent to the essence of medicine. Medicine is basically a profession built on a variety of sciences (from philosophy to molecular biology).

However, in general, my feeling is that the grasp on the medical curriculum has much improved. There is a basis for discussion on what should be in and what may be left out. The initial commitment of the Faculty Deans, and the subsequent incorporation in the legal structure have resulted in a Blueprint that is there to stay, albeit not in any fixed and unchangeable form. It will have to be adapted to changing opinions and newly developing trends in medical education. Hopefully, it will be of use in developing not a European curriculum (because curricula should be variable and reflecting the profiles of the Faculties), but in developing European objectives.

## **EVEN MORE MEDICAL STUDENTS?**

The UK is increasing medical student numbers - yet again. The recent government announcement confirmed that there will now be a further 1000 students in England in addition to the similar increase agreed only two years ago. These figures represent a 40% change in admissions to medicine. The UK with a population of around 60 million will shortly produce 7000 doctors annually. Given all the complexities of workforce planning, do these figures represent a sustainable growth in the number of doctors in the UK or a short term political fix for deeper seated problems within the British National Health Service (NHS)?

While there seems good evidence to support the argument that the UK has been under-producing doctors for some years, the country annually attracts and employs substantially more overseas doctors than UK graduates. The General Medical Council, the UK medical licensing body, registers around 10,000 overseas doctors each year. No doubt many come for postgraduate training and have no wish to work permanently in the UK. Nevertheless they undertake a very substantial and important part of the clinical service. Indeed without their help, the NHS could not maintain even

the current level of service - widely perceived as inadequate to meet patient needs in the 21st Century.

From a UK perspective it does appear that the increase in UK medical graduates is both necessary and, at least for the foreseeable future, sustainable. The government is, however, seeking a number of additional but linked changes. There is a suggestion that the length of the undergraduate medical course should be reduced from the six years or 5,500 hours "under the supervision of a university" established by the European Medical Directive. Without changing that Directive, the only way in which time spent as a medical undergraduate could be reduced would be by accepting other university qualifications to contribute towards the medical degree. Of course that has been happening to a limited extent for some time. Dentists wishing to become doctors have not been required to repeat all the courses in the basic sciences and similar arrangements have been made for some graduates in the biomedical sciences. In the near future a number of UK medical schools will initiate shorter courses for other groups with prior experience outwith the biomedical sciences. It seems inevitable that those accepted as medical stu-



dents in the UK will come not only directly from school but from a number of different jobs and will bring with them a wide variety of previous experiences. With such diversity in those admitted to study medicine it is even more important that medical schools and universities define clearly the standards and competencies required of graduates. At a time when society expects high standards of doctors, universities must in their turn recognise that high academic standards are necessary but are not in themselves sufficient for our future doctors. Our graduates must be fit to practise - and that means having high ethical standards as well as clinical skills.

Within the UK, four entirely new medical schools are to be developed in addition to innovative curricular developments

in established schools. While many of these initiatives are to be welcomed they will succeed in changing the practice of medicine only if accompanied by supportive changes in postgraduate training, hospital and general (family) practice. Many of our students will still be practising medicine beyond the year 2040. So rapid are the changes in the biological and social sciences that our universities must ensure graduates have a secure undergraduate education and, in addition, are well equipped for a lifetime of continuing education. Nothing else will provide doctors with the motivation to improve their clinical practice - and nothing less will help them meet the increasingly high expectations of their patients. Is this not an important role for the Medical Schools in Europe?

## THE CONFLICT BETWEEN HEALTHCARE PRODUCTION AND EDUCATION IN A CLINICAL DEPARTMENT.

By: Professor Olle Nilsson Uppsala Sweden

Increasing demands on production and cost-effectiveness in the short-term perspective has become a serious threat to clinical education as well as clinical research. This development has been brought about by a combination of factors, the most important being reduction in hospital funding and increasing demands on production.

The challenge to provide a top class clinical education in an environment where the productivity is a high priority is the subject of this paper. The need for new strategies in teaching has become apparent by the developments and changes in medicine and in the health care systems worldwide.

In order to create an organization that can provide a high-class clinical teaching we will have to analyse the developments and challenges that we will encounter in health care, teaching and the society in general in order to be able to organize our institutions according to these challenges. We can expect major changes to occur in a variety of fields, the most important being:

- ✓ Healthcare
- ✓ Attitudes and needs of students and young doctors – the next generation
- ✓ Biomedical knowledge

### 1. Current health care trends:

Rapid development of new knowledge:

New methods and modes of treatment are emerging while others are becoming obsolete. The list of new methods for diagnosis and treatment can be made very long, new imaging techniques such as MR and PET, and minimal invasive surgery are two examples. In fact, in most parts of the world lack of resources, not of possibilities, is the most important restriction to an effective healthcare.

Changing spectrum of disease:

The success in treatment of for example some infectious disease and gastric ulcers has made some conditions disappear

with new medications, while other diseases such as AIDS have appear. This has resulted in a changing spectrum of disease - which puts new demands on the flexibility on the educational systems. While trauma and infectious diseases are still the number one killers in the world important changes in pattern and treatment have occurred – and even more profound changes will come in the close future. In several ways knowledge will become transient – and our organizations will have to change accordingly.

New and more advanced technologies also necessitates a higher degree of specialization. This can be exemplified by MR, PET and interventional radiology, but also laparoscopic surgery, applied gene technologies in oncology and medicine etc. The rapid development of these techniques in combination with the high demands of specific knowledge in their handling makes the need for continuous learning obvious to all.

The increased specialization is obvious in all fields of medicine as a result of the expansion of the mass of knowledge and skills. The advantage is a deeper knowledge and increased experience in a certain field, but the disadvantage being fewer generalists and less flexibility.

Shorter working hours will become a problem in areas of medicine which are based on skill. The time spent in actual surgical training is diminishing for most surgeons as well as in many other similar situations.

Increased demands of cost-effectiveness is certainly a reality that affects all aspects of health care, teaching and research in most hospitals.

### 2. The new generation

Changes in the group of young students that are the coming generation of doctors and researchers are no less profound than that of medicine itself. The new generation of students in general have much less interest and respect for accepted

truths, their minds are not burdened by previous experience, and they do not fully understand the significance of the mountains of published material. But they have different eyes, they are critical and they may have the ability to see the problems from a different angle. They have energy and often believe they know better. These features are very important assets that must be preserved. In addition, many of the young generation are also part of the new IT revolution. They know how to handle computers and to gather information on the net. Their attitudes are also different from that of previous generations in that they wish to live a more flexible life with shorter commitments. They are more prone to accept new challenges within their profession, or to change their professional career.

### 3. The explosion in medical knowledge

- resulting in curriculum overload - has led to fundamental problems in the teaching of medicine in order to include relevant knowledge in the core curriculum.

Which implications does these developments have on the organisation of a University Hospital?

No doubt we need strategies to improve learning and teaching at all levels and to maintain the quality of health care. Such strategies include:

1. Improvements in the teaching of medical students. The clinical teacher has to be both well acquainted with the clinical medical treatment, recent scientific developments, and professional teaching. A strict division between clinical production and teaching does not favour good clinical teaching.
  - Teaching based on current pedagogical knowledge, i.e., a teaching based on active participation of the students such as in problem based learning.
  - Student-run clinical wards.
  - A more strict division between clinical positions and teaching/research positions.
2. CME is one key event and it is clear that learning will have to be life long. The importance of professional development and life-long learning in medicine is receiving increasing attention. All parties involved will have to join forces in order to establish a functional CME that covers all aspects of medicine. In the long perspective we would also like the education of specialists and the requirements of CME to become harmonized between different countries - so that free movement among physicians becomes a reality. CME should involve regular reading of medical literature, study visits, postgraduate courses and congresses. However, the most important aspect of CME is the educational climate for CME in the department especially the occurrence of regular internal meetings, discussions of problems and cases, and allocated time for professional development. In conclusion, it is essential that physicians develop ways to keep pace with the advancements in medicine. The quality of health care and the personal development of the individual physician will require life long learn-

ing by CME. Several important issues will have to be addressed before CME has become a reality. The responsibility for CME implementation rests within the profession and its professional organizations, while employers must assure the practical and economic conditions for professional development.

3. Define goals - and measure how we manage to reach them.
4. Develop mentorship programs - to improve transfer of knowledge and skills, and to help the student to enter the role of a physician.
5. Devote resources (time & money).
6. Health Care organisation changes will have to be considered:
  - Sub-specialization to ensure adequate training in difficult and demanding diagnostic procedures and treatments.
  - Concentration of low-frequency procedures to acquire a reasonable number to assure enough experience.
  - Concentration of high-tech procedures to decrease investment costs.

### The role of the Universities

The University hospitals play an important role not only in science and education but also for the development of healthcare. Some aspects of medicine are very significantly dependant on the universities and the university hospitals.

1. **Advances in basic research:** The transfer of basic research to clinical practice becomes more rapid. Thus, it is important even for the clinically working physician to follow the developments in for example cell biology. For example, gene technology will soon become everyday practice in oncology. In order to practice most fields of medicine you will have to know the basics of cell biology and physiology.

To be a decent orthopaedic surgeon you will have to know how these cells, the osteoblasts are regulated. How a signal may be transduced to different responses as proliferation or differentiation as shown here. By recent developments bone forming cells can be modulated by a Bone Morphogenetic Protein and other cytokines to form new bone which is important knowledge in fracture treatment. This proliferative and modulating effect can in the future be used to generate new tissues such as seen here in a rat.

Also, the turnover of the skeleton is regulated by a number of mechanical, hormonal and paracrine factors that are the focus of intense research, and developments in these areas are of importance in everyday clinical practice since they will affect the treatment of common conditions such as osteoporosis.

2. **Multidisciplinary developments:** Important new developments occur in between different disciplines. Actually, many of the old disciplines are becoming redundant and new are forming. For example much of the develop-

ments in anatomy occurs by new imaging techniques in radiology.

Another example is interventional cardiology that is affected by advances in biomaterial research, as well as in cardiology.

**3. Evaluation and Validation of new methods:** New knowledge is generated in the successful testing of a hypothesis with relevant scientific methods. This is one cornerstone of the Universities, the other being teaching. All good teaching will have to rely on a sound scientific basis. Naturally these objectives can be met outside the Universities, but the Universities have through the years collect and expertise in science and scientific methods.

**4. Teaching in teaching:** New methods to handle the increasing amounts of knowledge that is emerging in medicine are developed and tested at the Universities. Such developments include utilization of IT technologies, implementation of problem based learning, and application of new results from pedagogic research and research in communication. Not all of these new developments will be suited for use in teaching in medicine but the experience obtained at the Universities might be of value in CME.

Naturally, the leadership of a highly professional organisation such as a university hospital is a very important issue. In my opinion the choice of any leader must be made in order to meet the crucial challenges to the organisation, and to reach the goals. In the case of a university hospital the purpose is to develop the three cornerstones: teaching, research and the practice of medicine. The rapid developments in all these three areas put high demands on the University hospitals to

maintain a high quality. Changes will have to occur continuously. In order to foresee the development and to guide the development a thorough knowledge in all these fields is necessary. In general, the leadership of professional groups is a challenging task. The group, or groups are characterized by a high degree of professional skill, a high level of ambition devotion to the specific area of interest and in the case of medicine to the treatment and care of patients. However, in my experience the medical profession is not especially prone to change or to restrictions. Thus, the leader will have to have high credibility and the knowledge to scrutinize different arguments in order to be able to induce any changes. Other aspects of leadership, i.e., economic knowledge, personnel administration and other important aspects of hospital organisation will have to be added by experts in these fields. However, the most important issue is the ability to motivate and direct the organization to continuous developmental changes and improvement of the quality of medicine.

I would like to argue that the requirements on the leader of a department in a university hospital, and probably on the leader of the hospital, are best met by a person well acquainted with teaching, research and medicine, in most instances a doctor of medicine.

The importance of professional development and life-long learning in medicine is receiving increasing attention. All parties involved will have to join forces in order to establish a functional CME that covers all aspects of medicine. In my view the Universities can contribute significantly in this process, naturally in close collaboration with the individual, the professional organizations and the employers.

## TUNING EDUCATIONAL STRUCTURES IN EUROPE

The Project 'Tuning Educational Structures in Europe', submitted to the European Commission at the end of the year 2000, is intended to be a two year Pilot project. It is co-ordinated by the University of Groningen in The Netherlands with the assistance of the University of Deusto in Spain.

Important developments are taking place in the European labour market, on the one hand, and, on the other hand, the Bologna process is determining quite fundamental changes in the Higher Education sector and the educational systems at large.

Intensive debates are going on concerning the educational structures as well as the ways study contents are organised and offered, but actual exchange of opinions between foreign institutions does not really seem to take place on an issue that is of European-wide relevance.

The political decision underlying the Bologna process implies that convergence between the different educational systems

in Europe will occur with the necessary adaptation of curricula in terms of structures, contents as well as the phrasing of competencies or learning outcomes as a starting point.

The 'Tuning' Pilot project aims at pooling together and capitalising on available experience and recent developments in several of the Member-states and a number of study areas, particularly from previous and on-going European co-operation in the context of the Socrates programme.

ECTS (European Credit Transfer System) has been facilitating mobility and recognition of study periods abroad, but there is the need to evolve towards a European credit accumulation and transfer system, which will enable to measure workload and the adaptation to the new and dynamic configurations of the labour market and its requirements in terms of learning outputs (professional profiles and needs of society).

The Pilot project aims at enabling European universities to make a joint reflection and debate on these issues, enabling comparative analysis, building upon their experience

and conferring a European dimension to the undertaking. It focuses on five Pilot groups, which are representative of university studies and methodologies in general and which regard the areas of : Mathematics, Geology, Business, History and Educational Sciences.

In addition, certain other study areas will contribute to the 'Tuning' Project as synergy areas: Chemistry, Physics, Languages, Humanitarian Development, Law, Medical Sciences, Engineering and Veterinary Sciences. These synergy areas were selected on the basis of the work already accomplished in the context of the ERASMUS Thematic Networks action concerning ECTS, quality assurance, definition of core curriculum and minimum requirements.

**The main objectives of the project are:**

- To bring about a **high level of Europe-wide convergence** in Higher Education in the five main subject areas (Mathematics, Geology, Business, History and Educational Sciences) by defining commonly accepted professional and learning outcomes.
- To **develop professional profiles and desired outcomes**, in terms of knowledge, skills and competences in the five subject areas.
- To **facilitate transparency** in the educational structures and to further innovation through communication of experience and identification of good practice.
- To **create five European networks** that can present examples of good practice, encouraging innovation and quality in the joint reflection and exchange, also for other disciplines.
- To **develop and exchange information** in relation to the development of curricula in these five areas, and **develop a model curriculum structure** for each area, enhancing the recognition and European integration of diplomas.
- To **build bridges** between this network of universities and other appropriate qualified bodies in order to **produce convergence** in the five main subject areas.
- To **elaborate a methodology for analysing** common elements and areas of specificity and diversity, and how to tune them.
- To **associate other subject areas** where a similar process can be incorporated through synergy. Among the areas, where related projects are already underway, are Languages, Humanitarian Development, Chemistry, Law and Physics.
- To **act in a co-ordinated manner** with all the actors involved in the process of tuning of educational structures (Ministries, Conferences of Rectors, and Universities).

**The anticipated outcomes of the project are:**

- A **methodology to move forward** in Europe-wide tuning of educational structures in these particular fields, which can in the future be applied to other areas.
- A **set of general and more specific competencies** or learning outcomes of teaching of the five selected disciplines, which are also very useful in a wider perspective.
- **Identification of the major obstacles in the process of convergence** at the level of structures and possible ways forward.
- A **common methodology for measuring student workload** at European level in relation to professional profiles and learning outcomes including knowledge, competence and skills.
- A **platform for discussion with professional bodies** on these issues.
- A **final report giving the experience of five subject areas**, in their efforts to tune and converge European educational structures.
- A **set of recommendations** to be offered to the Ministries, the Conferences of Rectors, Universities and the European Commission.

Following a call for expressions of interest in joining the project and participation in its implementation, launched via the National Agencies, the project has been generating great interest among the European Higher Education Institutions.

The Steering Committee of the 'Tuning' project comprises representatives of the main partner institutions (University of Groningen, NL, University of Deusto, ES, LUISS Guido Carlo, IT, Fachhochschule Osnabruck, DE, Université Libre de Bruxelles, BE), representatives of the synergy areas, of the Association of Rectors and Confederation of Rectors Conferences and Commission representatives (DG EAC).

There exists an 'inner circle' of partners composed of about 70 universities that are directly contributing to the implementation of the project (about 15 per each of the five main study areas) and an 'outer circle' of partners consisting of all other interested higher education institutions. Communication between the 'inner' and the 'outer circle' will take place via an electronic newsletter, a 'Tuning' Project website including a discussion forum (on the Europa Server) and hyperlinks to the partners' websites. In addition, national Rectors Conferences will provide inf

Regular meetings will take place throughout the 'Tuning' Project, culminating in a final meeting which is foreseen in June 2002.



## AMSE ANNUAL MEETINGS SINCE 1992

### TOPICS

- 1992 Dundee AMDE attended the AMEE Meeting
- 1993 Utrecht (April)
1. AMDE: Future perspectives and Constitution.
  2. Relationship between Medical Schools and Teaching Hospitals.
  3. A European Medical Curriculum?
- 1993 Lublin (Sept.)
1. Student Selection Rate and Reason for Drop-outs
  2. Exchange of Students and Staff Programme
  3. Career Perspectives for Clinical Researchers
- 1994 Perugia
1. Medical Education and Medical Practice in Europe. The Policies of the European Commission and their Effects on Medical Education and Medical practice in Europe
  2. Health of Medical Students
  3. Training of clinical Researchers
  4. Report from the working group (Lameire): Student and Staff Exchange
- 1995 Vienna
1. Information Technologies and Computer-assisted Education
  2. Scientific Integrity in Medical Research
  3. Complementary Medicine: Is there a Place for Complementary Medicine in Medical Schools?
  4. Report from the working group (Curtoni): Selection of Students
- 1996 Granada
1. Specialisation and GP Training: Should Differentiation Start in Medical Schools before Graduation
  2. Is Free Research in the Medical Schools under Threat? The Influence of Research Funding Agencies
  3. Is there a Role for University Hospitals in the Future?
  4. Report from the working group (Harris): Scientific Integrity and Research Misconduct
- 1997 Uppsala
1. The Importance of a Research Environment for Medical Education
  2. What is the Role of an Academic Physician in Research?
  3. What is the Role and Responsibility of a Dean of Medicine?
- 1998 Prague
1. Relationship between University and University Hospitals
  2. How to Encourage Staff Members Towards Excellence in Teaching and How to Assess Educational Qualification of Teaching
  3. When Researchers in a Medical Faculty are Not Medically Trained – is this a Problem?
- 1999 Jerusalem
1. Who Should be the head of a Clinical Department/Service: A Medical Professional or an Administrator?
  2. MD-PhD Programmes: Researchers for the Next Generation
  3. Teaching Bio-ethics in the Clinical Setting
  4. Continuing Medical Education
- 2000 Porto
1. What is the Profile of the Undergraduate When Leaving the Medical School and How to Evaluate It?
  2. Knowledge Transfer from University Research to Practical Use; The General European Research Policy
  3. Results and Experience of the EU Programmes on Exchange of Students and Teachers
  4. Toward a European Core Curriculum: A Joint Workshop of AMSE and AMEE
- 2001 Ghent
- 2002 Lille
- 2003 Izmir

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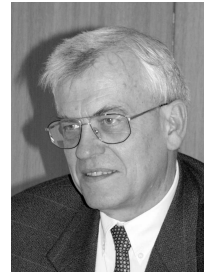
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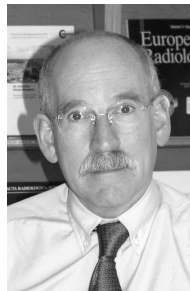
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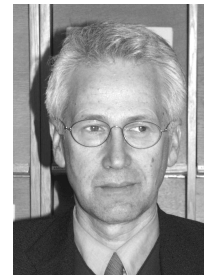
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**PARTICIPANTS IN THE AMSE EXECUTIVE COMMITTEE MEETING HELD IN  
UPPSALA DURING APRIL 21 – 22, 2001.**



**From left to right:**

1. Professor Wolfgang Schütz, University of Vienna, School of Medicine, Austria
2. Professor Uno Erikson, Uppsala University, Medical Faculty, Sweden
3. Professor Colette Creusy, Faculte Libre de Médecine, Lille, France
4. Professor Petr Hach, First Faculty of Medicine, Charles University, Prague, Czech Republic
5. Professor Mireille Bellet, Faculté de Médecine, Brest, France
6. Professor Graeme Catto, Vice Principal's Office, King's College, London, U.K.
7. Professor Antonio Campos, Institute of Health "Carlos III", Madrid, Spain



# 2001 ANNUAL CONFERENCE OF THE ASSOCIATION OF MEDICAL SCHOOLS IN EUROPE

FACULTY OF MEDICINE, UNIVERSITY OF GHENT  
UNIVERSITY HOSPITAL, GHENT

GHENT, BELGIUM - SEPTEMBER 6 - 8, 2001

## AMSE Executive Committee

Prof. Dr. A. CAMPOS, Madrid, Spain, president  
Prof. Dr. W. SCHUTZ, Vienna, Austria, secretary-treasurer  
Prof. Dr. G. CATTO, London, United Kingdom  
Prof. Dr. U. ERIKSON, Uppsala, Sweden  
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Prof. Dr. A. SALERNO, Palermo, Italy

## Local Organizing Committee

Chairman: Prof. Dr. N. LAMEIRE  
Renal Division, University Hospital, Ghent, Belgium  
Co-Chairman: Prof. Dr. P. VAN CAUWENBERGHE,  
Dean, Faculty of Medicine, University of Ghent, Belgium

**The meeting is hosted by the Faculty of  
Medicine, University of Ghent and the  
University Hospital Ghent**

## THE AMSE 2001 ANNUAL CONFERENCE IS SPONSORED BY

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## IMPORTANT DATES

DEADLINE ABSTRACTS:  
JUNE 30, 2001  
DEADLINE PRE-REGISTRATION:  
JULY 1, 2001  
DEADLINE REGISTRATION:  
JULY 15, 2001  
DEADLINE HOTEL REGISTRATION:  
AUGUST 1, 2001

## Welcome message

The Medical Faculty of the University of Ghent is honoured to host the AMSE 2001 Conference in Ghent, Belgium, September 6-8, 2001.

We cordially invite you to attend this meeting which will cover very important topics of interest to every Medical Faculty in Europe.

We hereby submit the Second Announcement of the conference, together with the registration form, the accommodation form and the abstract form, to invite you to participate.

We also include the membership-application form to join the Association of Medical Schools in Europe (AMSE), in case your faculty is not yet a member of this association.

Ghent is a lovely, old medieval city, which offers a great number of cultural and tourist opportunities. We hope to meet as many colleagues and students as possible from Medical Faculties all over Europe.

Looking forward to welcoming you in Ghent.

N. LAMEIRE  
Chairman AMSE 2001 Conference

P. VAN CAUWENBERGHE  
Dean Faculty of Medicine, University of Ghent

## THEMES OF THE CONFERENCE:

**IMPACT OF FEMINIZATION ON  
THE MEDICAL PROFESSION**

**HOLISTIC MEDICINE IN A  
UNIVERSITY HOSPITAL**

**ROLE OF THE MEDICAL SCHOOL  
IN ACCESS TO MEDICAL  
PRACTICE IN EUROPE**

# SCIENTIFIC AND SOCIAL PROGRAMME

THURSDAY, SEPTEMBER 6, 2001

## 18.30 h **OPENING CEREMONY - Auditorium C - University Hospital**

N. LAMEIRE, Chairman AMSE 2001 Conference  
University of Ghent  
Rector, University of Ghent  
P. VAN CAUWENBERGHE, Dean,  
Faculty of Medicine, University of Ghent  
L. BRACKE, Head of the Department International  
Affairs, University of Ghent  
A. CAMPOS, President of AMSE,  
Institute of Health "Carlos III", Madrid  
R. RUBENS, University of Ghent

**"From philosophy to evidence  
based medicine or *experientia  
docet*"**

## 20.00 h **WELCOME RECEPTION - Faculty Room - University Hospital**

FRIDAY, SEPTEMBER 7, 2001

## 9.00 - 11.00 h **SESSION I**

### **IMPACT OF FEMINIZATION ON THE MEDICAL PROFESSION**

Chairman: C. CREUSY (Lille, France)  
Co-chairman: N. LAMEIRE (Ghent, Belgium)

9.00 - 9.30 h IMPACT ON ACADEMIC MEDICINE  
speaker: I. Kerremans (Ghent, Belgium)

9.30 - 10.00 h IMPACT ON PRIMARY CARE  
MEDICINE  
speaker: J. Denekens (Antwerp, Belgium)

10.00 - 10.30 h THE FEMALE RESEARCH STUDENT  
speaker: M. Ramklint (Uppsala, Sweden)

10.30 - 11.00 h THE FEMALE MEDICAL STUDENT  
speaker: S. van der Velde (Groningen,  
Netherlands)

11.00 - 11.30 h COFFEE BREAK

11.30 - 11.50 h DISCUSSION

11.50 - 12.50 h GENERAL ASSEMBLY

12.50 h - 14.15 h LUNCH

## 14.15 - 15.30 h **SESSION II**

### **HOLISTIC MEDICINE IN A TERTIARY CARE HOSPITAL - IMPACT ON UNDERGRADUATE EDUCATION**

Chairman: H.J.M. VAN ROSSUM (Groningen,  
Netherlands)

Co-chairman: R. RUBENS (Ghent, Belgium)

14.15 - 14.35 h PATIENT EXPERIENCE IN A  
UNIVERSITY HOSPITAL  
speaker: D. Crane (Aberdeen, UK)

14.35 - 15.00 h SHOULD THE ACADEMIC FAMILY  
MEDICINE DEPARTMENT TAKE  
THIS RESPONSIBILITY?  
speaker: J. De Maeseneer (Ghent, Belgium)

15.00 - 15.30 h SHOULD THE ACADEMIC  
INTERNAL MEDICINE  
DEPARTMENT TAKE THIS  
RESPONSIBILITY?  
speaker: F. Follath (Zurich, Switzerland)

15.30 - 16.00 h COFFEE BREAK

16.00 - 16.20 h MEDICAL ONCOLOGY: AN  
EXAMPLE OF A TERRITORY  
PROBLEM  
speaker: S. Van Belle (Ghent, Belgium)

16.20 - 16.40 h THE POINT OF VIEW OF THE  
ORGAN SPECIALIST  
speaker: M. Moens (Bonheiden, Belgium)

16.40 - 17.15 h HOW CAN THE MEDICAL SCHOOL  
SOLVE THE TERRITORY  
PROBLEMS? IMPACT ON  
TEACHING, ETHICS AND PATIENT  
CARE.  
speaker: G. Catto (London, UK)

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**SATURDAY, SEPTEMBER 8, 2001**

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**9.00 - 11.00 h SESSION III**

**ROLE OF THE MEDICAL SCHOOL IN  
ACCESS TO MEDICAL PRACTICE IN  
EUROPE**

Chairman: I. VÄLIMÄKI (Turku, Finland)  
Co-Chairman: J. DE MAESENEER (Ghent, Belgium)

9.00 - 10.10 h OVERVIEW OF DIFFERENT  
EUROPEAN COUNTRIES

- I. Scandinavian countries - 10'  
speaker: C. Twomey (Dublin, Ireland)
- II. Eastern European countries - 20'  
speaker: V. Grabauskas (Kaunas, Lithuania)
- III. Germany - 10'  
speaker: W. Breipohl (Bonn, Germany)
- IV. United Kingdom - 10'  
speaker: G. Catto (London, UK)
- V. Spain - 10'  
speaker: J. Vinas (Lleida Spain)

10.10 - 10.40 h THE RECOGNITION OF MEDICAL  
QUALIFICATIONS IN EUROPE

Mr. A. Rodriguez-Perez, Internal Market  
Directory General, European Commission,  
Brussels, Belgium

10.40 - 11.00 h DISCUSSIONS

11.00 - 11.30 h COFFEE BREAK

**11.30 - 12.30 h PANEL  
DISCUSSION**

**THE CONTINUUM OF UNDERGRADUATE  
AND POSTGRADUATE MEDICAL  
EDUCATION - A EUROPEAN VIEW ON  
ACCESS TO MEDICAL PRACTICE**

Chairmen: H. HUISJES and N. LAMEIRE

Panel: P. Van Cauwenberghe (Ghent, Belgium),  
A. Rodriguez-Perez (EU, Brussels, Belgium),  
J. De Maeseneer (Ghent, Belgium),  
E. Molina (Parma, Italy),  
G.O. Peker (Izmir, Turkey),  
M. Ramklint (Uppsala, Sweden)

12.30 h - 14.00 h LUNCH

14.00 - 16.30 h FREE COMMUNICATIONS

Abstracts on the themes of the conference

IMPACT OF FEMINIZATION ON THE MEDICAL  
PROFESSION

HOLISTIC MEDICINE IN A UNIVERSITY HOSPITAL

ROLE OF THE MEDICAL SCHOOL IN ACCESS TO  
MEDICAL PRACTICE IN EUROPE

THE CONTINUUM OF UNDERGRADUATE AND  
POSTGRADUATE MEDICAL EDUCATION - A  
EUROPEAN VIEW ON ACCESS TO MEDICAL  
PRACTICE

are invited for oral presentation.

All abstracts should be typed on the enclosed abstract form according to the instructions. One original with the name of the author and institution plus three copies, without name or institution, should be submitted to the secretariat of the local organizing committee not later than

June 30, 2001

Abstracts may be faxed, but should always be followed by an originally typed copy. Additional abstract forms are available at the local secretariat (address see page 9). Speakers will be notified by JULY 20, 2001 at the latest. Mailing address for abstracts:

Prof. Dr. N. Lameire  
Renal Division, University Hospital  
De Pintelaan, 185  
B 9000 Ghent  
Belgium  
Fax: 32 9 240 45 99  
E-mail address: Ingrid.Verslycken@rug.ac.be

**PROJECTION**

Available in Auditorium C:  
PowerPoint presentation - MS OFFICE 2000 / Windows  
98 - diskette or CD-ROM only  
35 mm European Standard slide projection  
Overhead projection

## GENERAL INFORMATION

### CONFERENCE VENUE LOCAL SECRETARIAT - AUDITORIUM C

PROF. DR. N. LAMEIRE  
Renal Division, University Hospital Ghent  
De Pintelaan, 185  
B 9000 Ghent  
Belgium  
Tel 32 9 240 45 24  
Fax 32 9 240 45 99

E-mail: Ingrid.Verslycken@rug.ac.be

## REGISTRATION

A registration form for participants is enclosed in this announcement.

### REGISTRATION FEES

Before July 15, 2001	After July 15, 2001
Member AMSE 8.000 BEF/200 EURO	10.000 BEF/250 EURO
Non-Member AMSE 10.000 BEF/250 EURO	12.000 BEF/300 EURO
Students 4.000 BEF/100 EURO	6.000 BEF/150 EURO

### Participants:

Registration fee for participants includes:

Participation in the sessions, lunches, coffee breaks, Welcome Cocktail on Thursday, participation in the AMSE Conference Dinner on Friday evening at the reduced price of 1.000 BEF/25 EURO, Congress Map, conference free coach service.

The registration counter is located on the first floor in front of Auditorium C

Thursday, September 6	17.00 hr - 18.30 hr
Friday, September 7	08.00 hr - 16.00 hr
Saturday, September 8	08.00 hr - 10.00 hr

Participants will receive their documents at the conference venue. Admission to the conference facilities will not be allowed without registration badge.

### Accompanying persons:

Should also be registered (free registration - see registration form). Opening ceremony and Welcome Reception are free. Dinner on Friday evening at 2.000 BEF/50 EURO (see registration form). Conference coach service for Welcome and Dinner is free.

An Opening Ceremony at Auditorium C of the University Hospital on Thursday, September 6, 2001 at 18.30 followed by a Welcome Reception at the Faculty Room is offered to all participants and accompanying persons (see registration form). Conference coach service to the hotels after the Reception is provided.

Conference Dinner is organized on Friday, September 7, 2001 at 19.30 hr at the CASINO, Ghent. Coach service from and to the hotels is provided. Registration at 1.000 BEF/25 EURO per participant and 2.000 BEF/50 EURO per accompanying person (see registration form).

## METHOD OF PAYMENT

Payment should include: registration fee for the participant, registration fee for dinner on Friday evening for the participant and accompanying person(s).

The registration form should be accompanied either by:

- a cheque made payable to AMSE in Belgian francs or EURO

Please mention distinctly the name of the registered person as well as the Euro Card number on the back of the cheque! Personal cheques cannot be accepted.

- a copy of the remittance slip, if paid by bank transfer in Belgian francs or EURO to:

AMSE  
De Pintelaan, 185,  
B-9000 Ghent, Belgium  
account number: 441-7047991-22  
Bank address:  
KBC, Koolmeesstraat, 2,  
B-9000 Ghent, Belgium  
Bank sorting code: KRED BE BB

### Cancellation policy:

In case of cancellation the following fees become due:  
- before August 15, 2001: 600 BEF/15 EURO  
- after August 15, 2001: not refundable

## FOOD AND BEVERAGES

Coffee breaks and lunches (sandwiches, soup, cold and warm drinks) are offered to the participants of the conference.

Coffee breaks are served on the first and second floor in front of Auditorium C. Lunches are served in the University Hospital facilities - Conference restaurant.



## ACCOMMODATION

The organizing committee has made room reservations in five downtown hotels in Ghent at advantageous rates. Only bookings made through the official Travel & Housing Agency TRAVEL CLUB, licence A 1791, will secure this and will be accepted as such by these hotels. A selection was made of first class and advantageous tourist class hotels, all located in or close to the City Center and/or the University Hospital.

All hotel reservations are on a first come, first serve basis, depending on availability. As the month of September is a very busy convention and congress period, we recommend reservations as early as possible and before July 15, 2001. Reservations after July 15, 2001 will be considered but reduced rates and accommodation close to the congress venue cannot be guaranteed. Requests will be processed as far as possible.

Please complete the enclosed 'Accommodation registration form' and indicate your hotel preference. Tick a first and second choice.

## HOTELS

Information and rates - per night including taxes, service charges and daily buffet breakfast

IBIS CATHEDRAL - Superior Tourist class  
Downtown/historic centre - distance to the venue: 8 km  
Rate: 3.050 BEF/75.61 EURO single  
3.350 BEF/83.04 EURO double

IBIS OPERA - Tourist class  
Downtown/historic centre - distance to the venue: 8 km  
Rate: 3.050 BEF/75.61 EURO single  
3.350 BEF/83.04 EURO double

BEST WESTERN CHAMADE - Tourist class  
Railway station downtown - distance to the venue: 3 km  
Rate: 3.300 BEF/81.80 EURO single  
3.800 BEF/94.20 EURO double

EUROPA HOTEL - Tourist class  
Railway station downtown - distance to the venue: 4 km  
Rate: 2.750 BEF/68.17 EURO single  
3.200 BEF/79.33 EURO double

CARLTON HOTEL - Tourist class  
Railway station downtown - distance to the venue: 3 km  
Rate: 2.400 BEF/59.49 EURO single  
2.900 BEF/71.89 EURO double

For all inquiries please contact Travel Club  
TRAVEL CLUB  
J. Eggermontstraat, 12  
B 9050 GENT  
Belgium  
Tel: +32 9 230 40 40  
Fax: +32 9 231 75 88  
E-mail: [congress@travelclub.be](mailto:congress@travelclub.be)

## TRAVELLING TO GHENT

### By air:

All international flights are arriving at Brussels National Airport, situated approximately 60 km from Ghent. From the airport to Ghent, there are fast direct trains every hour. Indirect trains, via Brussels Noord Station, twice per hour to Ghent (direction Oostende or Knokke/Blankenberge). Travelling time is approximately 1 hour.

Price per ticket:

First class	870 BEF/21.57 EURO
Second class	570 BEF/14.13 EURO.

### By train:

All international trains connect all major European cities with Brussels Midi Station, connecting trains to Ghent Sint Pieters (direction Oostende or Knokke/Blankenberge).

Timetable:

See website <http://www.b-rail.be/E/index.html>

### By car:

Ghent is located near the intersection of E40 and E17 motorways. The easiest way to reach the University Hospital is by leaving the motorway at the 'EXIT 9 - 'UZ''. From there please follow the signs 'H/UZ' - 5 minutes.

### Taxis:

Taxis are available at the Ghent Sint Pietersstation - main exit.

10 minutes to the University Hospital - price approximately 250 BEF

10 - 15 minutes to the City Center - congress hotels - price approximately 300 BEF.

### Public transport:

Ghent Sint Pieters station, Ghent City Center and the University Hospital can be easily reached by public transport.

### Conference free coach service is offered:

- on Thursday evening after the welcome reception from the University Hospital to the hotels
- on Friday morning from the hotels to the University Hospital
- on Friday evening from the University Hospital to the hotels, from the hotels to the Casino and from the Casino to the hotels after dinner
- on Saturday morning from the hotels to the University Hospital.



## ABSTRACT FORM



### INSTRUCTIONS FOR AUTHORS

TITLE: type in capitals

NAME AUTHORS: start new line, use lower case, underline name of the presenting author

INSTITUTION: start new line, use lower case, mention name of institution, city and country

TEXT: type degree: minimum 10 point / maximum 12 point

NAME:

Institution:

Address:

Postal code

City

Country

Tel

Fax

email address

SEND TO:

PROF. DR. N. LAMEIRE

Renal Division,

University Hospital

De Pintelaan, 185

B 9000 GHENT

Belgium

Fax 32 9 240 45 99



# REGISTRATION FORM



Please type in capital letters and write the names as they are to appear on your badge

Prof.  Dr.  Mr.  Mrs.

NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

INSTITUTION \_\_\_\_\_

ADDRESS \_\_\_\_\_

POSTAL CODE \_\_\_\_\_ CITY \_\_\_\_\_

COUNTRY \_\_\_\_\_

TEL \_\_\_\_\_ FAX \_\_\_\_\_

Email address: \_\_\_\_\_

The above-mentioned address is my institution address  my home address

### REGISTRATION FEE

		BEF	EURO	
Member AMSE	before July 15, 2001	8.000	200	.....
	after July 15, 2001	10.000	250	.....
Non-Member AMSE	before July 15, 2001	10.000	250	.....
	after July 15, 2001	12.000	300	.....
Student	before July 15, 2001	4.000	100	.....
	after July 15, 2001	6.000	150	.....

I will attend

Opening Ceremony / Welcome Reception on Thursday, September 6, 2001	number of persons: .....	free
Dinner on Friday, September 7, 2001	number of persons: .....	
	1.000 BEF/25 EURO per participant	.....
	2.000 BEF/50 EURO per accompanying person	.....
Lunch - on Friday, September 7, 2001		free
- on Saturday, September 8, 2001		free

**TOTAL AMOUNT DUE** ..... **BEF /** ..... **EURO**

MY PAYMENT IS MADE BY

**CHEQUE INCLUDED** (please mention the card number on the back and YOUR NAME), made payable to AMSE, De Pintelaan, 185, B-9000 Ghent, Belgium

**BANK TRANSFER IN BEF or EURO** to the account number 441-7047991-22 of AMSE, De Pintelaan, 185, B-9000 Ghent, Belgium. KBC, Koolmeesstraat, 2, B-9000 Gent. Sorting code: KRED BE BB



## APPLICATION FORM

First: ( )      Renewal: ( )

The Medical School / Medical Faculty / Medical Academy of the

University.....

Street.....

City.....

Country.....ZIP Code:.....

E-mail.....

which is represented by the Dean or other authorized Representative, who is

(Name):.....

applies for Membership of AMSE for the year 2001.

The **Membership Fee of US Dollars 200.-**

(excluding bank charges)

will be paid to the Account of AMSE:

Account no. 0521-05335/00 (AMSE)

Creditanstalt Bankverein Wien

Swift Code: CABVAT WW

Bank Code: 11000

Address: Schottengasse 6-8

A-1010 Wien, AUSTRIA

Signature:.....

Date:.....