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

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FROM THE EDITOR

Since the start of the medical profession the male dominance has been most pronounced. At universities and hospitals the superior positions have by tradition always been appointed to male doctors. During the last years, we have had a discussion on how to change the male predominance in higher positions and under debate and different correction means have been suggested. Slowly and finally, in many European countries, we now have more than 50 % of the medical students who are female. AMSE has therefore considered it of interest to devote one of the sessions at the Ghent meeting to discuss the impact of feminization within the medical profession. Aspects on this topic were given by a professor of surgery, Prof Kerremans, a doctor of primary care medicine Prof Denekens, a psychiatrist and PhD student Dr Ramklint and a medical student, who because of an accident could not attend but sent her report.

The second session was devoted to holistic medicine and during this session a blind patient with long experience from hospitals in both UK and Belgium gave her report.

The third session commented on the role of medical schools of Europe in access to medical practice followed by a panel discussion.

In this issue of AMSE Newsletter a selection of reports and summaries are published.

Uppsala on the 30th of April 2002

Uno Erikson



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 Executive 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.

FROM THE GENERAL SECRETARY AND TREASURER:

News from the Executive Committee

The Executive Committee is proud to report that over the last years AMSE has faced a significant increase in the number of member institutions, from 23 Medical Schools in 1999 to 42 institutions at the end of 2001. This development also has a positive side-effect concerning AMSE's financial situation. Member institutions comprise Medical Faculties from all over Europe plus one Medical School in Louisville, Kentucky. The increasing popularity of AMSE is strengthened and promoted by AMSE's Internet presence (on <http://histolii.ugr.es/AMSE/>) where relevant, up-to-date information is made available to the interested public. The AMSE website is maintained by the Department of Histology at the University of Granada.



The popularity of AMSE is also reflected by the overall success of the past Annual Conference in Gent in September 2001 which attracted 73 participants from Medical Schools all over Europe as well as one representative from a US University. The Conference reports are printed on the following pages of this Newsletter.

Over the last years, AMSE has intensified collaboration in the form of conference attendances and joint projects with organizations involved in the field of medical education, like EMSA, IFMSA, AMEE and MEDNET - to name but a few - and will reinforce these cooperations in future.

The Executive Committee holds regular meetings at least three times a year to discuss important issues and to prepare the upcoming Annual Meeting. This year's Conference will be held in the lovely city of Lille in Northern France on September 5-7, 2002, following an invitation by Prof. Colette Creusy from the Faculté Libre de Médecine (Institut Catholique de Lille). The two faculties of medicine of Lille, the Faculté de Médecine (Université Droit et Santé - Lille 2) and the Faculté Libre de Médecine (Institut Catholique de Lille) will act as Conference hosts and organizers. The First Announcement is scheduled for publication by the end of January 2002 and will be made available to the public immediately thereafter. We are strongly optimistic that the conference with its attractive scientific and social programme will be an overwhelming success and will again attract attendants from member countries and institutions all over the globe.

The year 2001 brought about several changes in the composition of the Executive Committee. Much to our regret, Prof. Antonio Campos from the University of Granada resigned as AMSE President and was succeeded by Prof. Petr Hach from Charles University in Prague. The members of the Executive Committee wish Prof. Hach all the best for his new responsibilities and promise to support him to the best of their abilities. We equally regret the withdrawal of Prof. Gadi Glaser from Hebrew University in Jerusalem and of Prof. Graeme Catto from King's College in London from their position as EC-members and we herewith express our sincere gratitude to Prof. Campos, Prof. Glaser and Prof. Catto for their valuable contribution to serve the purposes of AMSE and wish them all the best for their professional and personal future.

The Executive Committee gladly welcomes three new members to its group: Prof. Gonul O. Peker from Ege University in Izmir and Prof. Juan Viñas Salas from the University of Lleida as new co-opted members and Prof. Maria Rosa Renoll-Brunet from the University Rovira I Virgili in Reus as new AMSE auditor. We are looking forward to future fertile cooperation with our new colleagues!

On behalf of the Executive Committee I would like to express my gratitude to all members and supporters of AMSE and I herewith take the opportunity to wish everybody a successful and happy year 2002.

Wolfgang Schuetz
AMSE Executive Secretary and Treasurer

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

CONFERENCE REPORT - SESSION I

IMPACT OF FEMINIZATION ON THE MEDICAL PROFESSION

The Impact of Feminization on Academic Medicine

I. Kerremans (Ghent, Belgium)

Introduction

Women in many European countries now comprise over half of first undergraduate students not only at the faculty of medicine. However, this has been a relative new phenomenon, and they still remain a minority of second-degree postgraduate students, particularly students studying for a doctorate, the "feeder pool" from which future academics are likely to spring.

Situation at Flemish Universities

Like in European and Northern American universities more than 50% of the undergraduate students are female but with an important discrepancy at the level of senior lecturer up to full professor. (Diagram I)

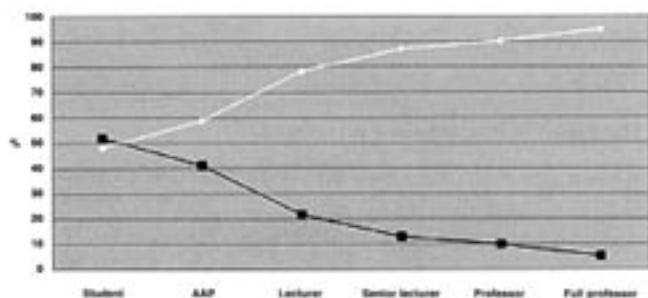


Diagram I. Percentage men and women on different levels

Why aren't there more women leaders in Academic Medicine? Is it a Glass Ceiling or Sticky floor?

The term *glass ceiling* has become a popular way of referring to the scarcity of women at the top levels of organizations. The phrase suggests that invisible factors- as much as, or more than, overt discrimination- keep women from rising to the top. It also assumes that those hidden influences are unlikely simply to disappear over time, a ceiling is not a structure that evanesces. Finally, the term suggests that women's job performance is at least the equal of their male peers; a ceiling is something that keeps people down despite their competence.



In terms of academic career, individualism is a myth while male support systems are the reality, in the process disadvantaging women who do not take to the former and are excluded by definition from the latter.

How do academics make their way through the academic career?

Studies have found academic careers dependent on the support of colleagues and superiors, and on the extent of collaboration.

Success is achieved through personal contacts, friendships and cooperative work with key players in the field.

Therefore, it is contended that women's marginal status in science is due not to their lack of technical skills, but their failure to display the mastery of the indeterminate skills of the job.

Self-promotion is essential to an academic career. Women are less willing to play the game and therefore it can be seen to privilege men and disadvantage women.

Women are strongly disinclined to treat the knowledge and wisdom they have acquired in the academic world as "a kind of trading commodity".

This is not just naivety but also a rejection of the "idea that playing games to advance themselves is necessary."

Nevertheless, women need to know that they have to promote themselves, and need to be actively encouraged to do so.

In 2001 the *Association of American Medical Colleges* published the results of interviews conducted with 34 chairs and two division chiefs in five specialities during the years 1998-99.

The chairs' responses centered on the constraint of traditional gender roles, manifestations of sexism in the medical environment, and lack of effective mentors.

Highlighting constraints imposed by social forces outside medicine, 28 out of the 34 responding chairs cited traditional gender roles, such as taking care for the children and family,

	LECTURER			SENIOR LECTURER			PROFESSOR			FULL PROFESSOR		
	M	V	T	M	V	T	M	V	T	M	V	T
KULv	120	34	154	173	23	196	156	21	177	352	8	360
UG	145	36	181	127	12	139	120	9	129	114	11	125
VUB	64	19	83	61	14	75	56	11	67	76	11	87
UIA	14	1	15	44	6	50	19	2	21	45	2	47
UCA	17	7	24	19	3	22	26	0	26	20	1	21
UFSIA	11	4	15	34	8	42	34	2	36	34	1	36
LUC	6	4	10	12	4	16	19	2	21	37	3	40
TOTAL	377	105	482	470	70	540	430	47	477	651	37	688

Tab. I. Male/Female distribution at different levels in Flemish universities.

	WOMEN			MEN		
	TOTAL	Total part time	% part time	TOTAL	Total part time	% part time
KULv	139	68	48.9	1150	457	39.7
UG	85	24	28.2	627	163	30.0
VUB	87	41	47.1	444	236	46.8
UIA	19	10	52.6	193	91	47.2
UCA	12	3	25.0	110	34	28.2
UFSIA	18	3	16.7	164	58	35.4
LUC	20	11	55.0	114	47	41.2
TOTAL	380	160	44.4	2802	1086	38.7

Tab. II. Faculty members of Flemish universities in full time or part time tenure. Tab. II demonstrates that a higher percentage of part time tenure by women is not an explanation for the important discrepancy illustrated in diagram I.

as posing a major barrier to women's advancement. Where men tend to pursue linear career paths, women's career paths are more likely to be cyclical as they adapt to changing family situations. Women's role in the family often preclude them from devoting essential time and energies to achieving milestones that are central to promotion, and these roles limit the geographical mobility that is often necessary to advance in profession.

Women are no longer satisfied with a few part-time opportunities, for which Medical Women's Federations campaigned for decades, but want a much more fundamental restructuring of working hours. Medical resistance to women doctors also at the university now centres on the issue of part-time work. It is argued that part-time work interferes with continuity of care and inevitable reduces its quality.

Men value "traditional" work schedules as part of a process of building up cultural capital. Women are less concerned about capital and just want the job be done as quickly and efficiently as possible. Hence there is a fear that, should the profession become female dominated, medical time will be less valued and medical work demystified.

The problem reflects our society as a whole. We do not value parenting. We do not value teaching. We do not value children. So the roots of the problem of the gender roles lie beyond the institutional boundaries of the faculty of medicine but even than has the faculty the means to counteract the effects of these forces.

Overall situation in the USA Women faculty by department 1998

	Women faculty	Associate professors	Full professors
Anatomy	429 (25 %)	119 (23 %)	129 (18 %)
Biochemistry	505 (22 %)	129 (25 %)	121 (12 %)
Microbiology / Immunology	415 (25 %)	110 (25 %)	114 (16 %)
Pathology (includes Clinical)	1.328 (28 %)	366 (28 %)	213 (14 %)
Pharmacology	338 (20 %)	82 (22 %)	84 (12 %)
Physiology	356 (20 %)	89 (19 %)	89 (10 %)
Other Basic Sciences Department	487 (27 %)	117 (27 %)	84 (14 %)
TOTAL	3.858	1.012	834

Tab. III. Basic sciences

	Women faculty	Associate professors	Full professors
Anesthesiology	1.162 (27 %)	206 (23 %)	63 (11 %)
Dermatology	200 (32 %)	42 (29 %)	22 (12 %)
Emergency medicine	218 (23 %)	20 (15 %)	4 (7 %)
Family practice / Community / Preventive medicine	940 (34 %)	123 (21 %)	52 (15 %)
Internal medicine	4.860 (24 %)	901 (19 %)	384 (8 %)
Neurology	604 (23 %)	118 (18 %)	61 (9 %)
Obstetrics / Gynecology	1.308 (38 %)	188 (26 %)	80 (11 %)
Ophthalmology	361 (23 %)	71 (21 %)	35 (8 %)
Orthopedic surgery	128 (9 %)	23 (7 %)	5 (2 %)
Otolaryngology	190 (21 %)	33 (15 %)	22 (9 %)
Pediatrics	3.655 (40 %)	735 (33 %)	348 (18 %)
Physical Medicine	330 (38 %)	52 (30 %)	16 (15 %)
Psychiatry	2.382 (34 %)	385 (27 %)	171 (13 %)
Public health	464 (38 %)	106 (35 %)	64 (19 %)
Radiology	1.182 (22 %)	240 (19 %)	127 (9 %)
Surgery	875 (12 %)	156 (9 %)	74 (3 %)
Other clinical departments	34 (25 %)	5 (19 %)	5 (9 %)
TOTAL	18.893	3.404	1.533

Tab. IV. Clinical sciences

Men's career advancement depends in many cases upon sacrifices on the part of their wives.

So, men who want to play a more active role in child-rearing while advancing their careers will constitute a potent force for pervasive changes in the workplace, making it more responsive to both men and women with family responsibilities.

Adequacy of Mentors: Do Women have distinctive needs?

Prospects for advancement in academic medicine are enhanced significantly by the guardianship of an effective mentor.

Mentors can play a key role in addressing several of the barriers to advancement: the constraint of traditional gender roles, the by-products of early socialisation, the cumulative effects of sexism and bias and the scarcity of senior role models in academic medicine.

Should the mentor be a woman or is it better to promote a gender-blind mentoring?

If same gender professional partnerships (female mentor and female protégée) are important, how can their benefits be achieved in light of the scarcity of women in leadership positions who are available to serve as mentors?

A single institution cannot solve this problem so the Office on Women's Health within the U.S. Department of Health and Human Services created the National Centers of Lead-

ership in Academic Medicine, which launched a nationwide effort to develop model demonstration mentoring programs for men and women in academic medicine.

These programs have two goals:

1. To foster gender equity in medicine
2. To promote the leadership advancement of junior faculty, both women and men, into senior faculty positions.

The following seven program activities were chosen:

1. Training and education, including faculty development workshops
2. A formal mentoring program (connections between senior faculty, campus and organizational resources)
3. The establishment of a faculty leadership council
4. Special events for the community
5. Academic performance counselling
6. Creation of a website for the National Centers of Leadership in Academic Medicine
7. Extensive resource development.

Important is to provide the visibility for women's accomplishments and leadership. Women must have a substantial presence as speakers at medical grand rounds and the major annual departmental educational conferences.

Promotion depends also on publishing. Most studies show fewer publications for women, particularly women faculty with children.

Academic productivity among male and female faculty members

Academic Productivity	MEN (N=2661)	WOMEN (N=1293)	Unadjusted mean difference (95% CONFIDENCE INTERVAL)	p VALUE
Publications and lectures (no.)				
Unsolicited article				
First author	10.2	5.6	4.6 (3.8-5.3)	<0.001
Last author	7.1	2.5	4.6 (3.8-5.5)	<0.001
Sole author	2.2	0.8	1.4 (1.1-1.7)	<0.001
Book chapter	6.0	3.0	3.0 (2.2-3.8)	<0.001
Book review	1.1	0.5	0.6 (0.4-0.9)	<0.001
Solicited article	2.7	1.2	1.5 (1.1-1.9)	<0.001
Named lecture	1.0	0.4	0.6 (0.4-0.9)	<0.001
Factor score for publications and lectures*	0.16	-0.25	0.41 (0.34-0.48)	<0.001
Grants (no.)				
Principal investigator	3.4	1.9	1.5 (1.2-1.9)	<0.001
Co-principal investigator	1.4	0.8	0.6 (0.4-0.8)	<0.001
Consultant	0.6	0.3	0.3 (0.2-0.4)	<0.001
Factor score for grants*	0.13	-0.19	0.32 (0.25-0.39)	<0.001

*Factor scores are aggregate scores that were calculated by summing scores on standardized-item components.

However women and men faculty without children have similar rates of publication. Furthermore, Sherrie Kaplan and colleagues found that the most productive women faculty had less institutional support for research than did the man. This, in turn, may influence the number and quality of publications that women can produce, particularly the types of research that will be published in the some of the more prestigious journals. But how are women represented on the Editorial Boards of Major Journals?

The *Annals of Internal Medicine* was the only journal that had more women on the editorial board than there are

JOURNAL	No. on editorial board	No. (%) of women	No. of men	Editor
JAMA	26	2 (7.7)	24	Woman
New England Journal of Medicine	35	3 (8.6)	32	Woman
American Journal of Psychiatry	20	3 (15.0)	17	Woman
Journal of Family Practice	34	7 (20.6)	27	Man
Annals of Internal Medicine	33	12 (36.4)	21	Man
Pediatrics	28	5 (17.9)	23	Man
Obstetrics and Gynecology	18	5 (27.8)	13	Man
Surgery	52	7 (13.5)	45	Man
Neurology	47	6 (12.8)	41	Man
Ophthalmology	26	4 (15.4)	22	Man
Journal of the American Academy of Dermatology	84	28 (33.3)	56	Man
Ear, Nose and Throat Journal	54	3 (5.6)	51	Man

Tab. V. Numbers of women and men on the editorial boards of two general and ten speciality medical journals

women physicians in the field, the *American Journal of Psychiatry* and the *Journal of Pediatrics*, had the largest disproportion of women represented on their editorial boards versus women physicians in their specialities.

Being on the editorial board may also assist in the advancement of women academically by increasing the articles being accepted for publication that are written by women.

Academia values reputation above all, which is heavily dependent upon integration into formal and informal networks in the research community. Women are less likely to have access to these networks. In this male-dominated, patriarchal environment, men do not have to create networks for themselves, but can take advantage of ready-made ones.

Women academics need to challenge the academic process to make universities places for women. Unless women set up their own "sisterhood", women's success is dependent on the men in power who are largely working to maintain their and other men's position. Therefore women must promote each other and themselves strategically. Women must systematically and strategically include themselves in all gate-keeping activities in academia. They must be brought into the power structure of medical schools by recruited to dean, chair, and unit heads and being asked to serve on important administrative committees.

Remedies: Shatter the Ceilings, Polish the Floors

A successful long-term program was developed at the John Hopkins University School of Medicine.

Together with the *American College of Physicians* and also the *Association of American Medical Colleges* they appointed a committee to design an effective program.

The task of the committee was:

1. Identify the problem by interviewing women faculty about their perceptions of the department.
2. Developing and implementing procedures to eliminate problems that appeared to be gender-based.
3. Evaluating the success of the program by examining the changes in the promotion of women and changes in women's attitudes.

A monthly meeting was begun to provide women faculty with concrete information about how to move through their

professional career and how to handle different problems that might arise.

Another change was to provide senior faculty with explicit information about how to mentor, in an effort to eliminate disparities in treatment of junior men and junior women.

Within five years, the program was extremely successful. In 1990 there had been only four women associate professors; 1995 there were twenty-six. The improvement was not due to changes in promotion criteria. What did change was women's knowledge of what was required for promotion. In 1990,

only 26% of the women reported that they were advised about the criteria, but 1993, 46% reported being advised.

The John Hopkins program demonstrates that institutions can, with major efforts, significantly improve the status of their female employees.

Such initiatives, supported by elbow grease from men and women, will help to shatter the glass ceilings and polish the academic floors for women faculty.

The impact of feminisation on general practice.

J. Denekens (Antwerp, Belgium)

Feminisation in figures:

The number of women.

For centuries the medical world was exclusively a male domain. This is gradually changing all over the world. Until 1960 women made up only 12% of medical graduates in Belgium. At the end of the 60s an expansion set in thanks to the democratisation of university education. Women have outnumbered men since 1992. Six out of ten young general practitioners (younger than 35) are now female.

The feminisation of general practice has an important impact on "service volume".

It has been suggested that because of shorter working hours, lighter patient loads, and higher numbers of career interruptions, women physicians will produce fewer medical services than men. It also seems that fewer and fewer doctors are interested in taking the course "general practice". This decline is greatest among men. A study in the south-west of England suggested that increased workload, out of hours work and erosion of professional autonomy were seen as deterrents. Furthermore research revealed that many young doctors leave the profession within 5 years after graduation. This trend is more apparent for women than for men.

All these factors mean that there will soon be a lack of general practitioners in many countries.

Increase in femininity:

Are women changing primary health care?

Female doctors have been placing specific emphases in health care. They demanded reliable contraception, abortion if the former failed, fought to have victims of violence and sexual abuse recognised and drew attention to the dangers involved in medicalising women's lives. Female general practitioners focus more attention on prevention, health information and education.

Female physicians have shown that male bodies are used to set the standard in medical research. Sex differences in diagnosis and treatment of ischaemic heart disease have received most attention. The results confirm the picture of



under-diagnosis and under-treatment of ischaemic heart disease in women.

The curriculum's main and minor courses consistently fail to address the difference between men and women in epidemiology, etiology, presentation, of complaints, treatment and outcome of illnesses which at first sight appear to be gender neutral (16,17). Female physicians

have demonstrated that there is a need for "gender centered" medicine.

Do women have a different interaction style?

Societal changes in the past decades have affected health care and power relations between doctors and patients. The doctor-patient relationship has changed as a result. Today, respect tends to be based on a patient's appreciation of his/her doctor's knowledge, technical know-how and social skills.

Compared to their male colleagues, women doctors attach much more importance to a good doctor-patient relationship and communication, to "talking instead of handing out pills". This finding is rooted in large-scale research carried out in the Netherlands which revealed that women doctors prescribed far less drugs and give more counselling and information. They interact more closely with their patients and on a much more equal basis. It is extremely important to note that a doctor-patient relationship directly influences the extent to which the patient will follow the doctor's instructions and comply with his/her prescriptions: i.e. the "compliance" phenomenon or "adherence" as defined more precisely in recent literature.

Research has revealed that male and female doctors have different communication styles. Men tend to focus on a patient's symptoms or complaint whereas women tend to focus more on the actual patient. When a problem is involved, men concentrate on seeking a solution whereas women are more likely to discuss things. Women are more process oriented whereas men are more task oriented.

As men and women receive the same training with the same standards, norms and rules the differences can be attributed mainly to different male/female social interaction styles which remain largely unaffected by professional interaction styles. Research suggests that training tends to have a homogenising effect, i.e. that feminisation is mitigated by the traditional model.

Impact at the organisational level:

Type of practice.

In the 70s approximately half of women worked as solo in the Netherlands. At the beginning of the 80s there was an abrupt change. From that moment on only 20% of women work as solo. Although this pattern also holds for men, it developed more gradually.

This evolution clearly shows that women are leading the way when it comes to more humane working conditions for doctor families.

Conclusions.

As a result of feminisation and other factors there will be a shortage of general practitioners in the future. This is a serious problem because many countries have placed responsibility for primary care with general practitioners.

General practitioners play an important role in the health care system as gatekeepers.

It is extremely important to note that by using anamnesis, clinical examination and a minimum of technical tools general practitioners are able to solve 7 to 9 out of 10 of patient problems and this has important public health and economic implications.

It means that general practitioners have a considerable impact on the effectiveness of care and as a result have to guarantee high levels of quality.

Medical literature contains a number of recommendations for medical faculties.

Faculties can integrate the social and scientific relevance of general practice in their mission thus changing the culture and the decision-making of the medical schools so that the members understand the competencies and underlying content of primary care disciplines and value the role of primary care in the nation's health care system, in the education of medical students, and in the furtherance of medical knowledge.

We must build the credibility of primary care departments by providing full-time, tenured appointments for general practice as for the other specialities, with the same remuneration.

The faculties can request government and health organisations to allocate significant money for training and research

in primary care and for the careful and continual study of medical education.

The curriculum should be more community-based. Students need a course on the health care needs of society and the organisation of the health care system and the role of the different physicians. General practice departments should offer a longitudinal learning route with compulsory internships and practical training for all students.

The faculties can play a role in advising policy-makers to take measures to ensure that general practice is financed at a similar level as specialised medicine in the health care system.

This will make general practice a more attractive option, for male and female students alike and redress the quantitative balance between men and women.

How can faculties increase femininity? The key issue here is whether women contribute to the introduction of favourable developments in medicine.

Until now female physicians have been unable to influence medical training courses or the formal specifications of the medical profession in general. In addition, they have not played any great role in the process of defining the quality of good medical practice and the setting up of formal and informal quality requirements.

A number of provisions are needed to give women access to power positions at universities and professional organisations: improved child care, pregnancy leave and parental leave, for men as well as for women. Training needs to become more flexible: possibilities for part-time training programmes need to be stepped up.

Research has to focus more attention on "gender" differences and their potential for change in terms of the way work is organised, the characteristics of the doctor-patient relationship and specific female values. Although the quality of this kind of research is increasing, there is still room for improvement particularly as far as methodology is concerned.

Increasingly, society is questioning the medical establishment and the physician's role today.

In a rapidly changing society the physician is contributing towards a different medical culture.

The added value of feminisation is brought about by adding to the male medical culture female values which are important for all doctors and strongly appreciated by the modern patient, who is on search for a good companion to guide him or her to a healthier life.

The ultimate goal for faculties for the future is: restoring the balance on a quantitative and a qualitative level and deliver doctors for the 21 century that have female and male values in equilibrium.

Impact of feminisation on the medical education-truths and myths. The female research student perspective.

Mia Ramklint (Uppsala, Sweden)

Truths and myths, my subtitle, try to stress the need of knowledge in this area. This topic, feminisation, commonly evokes strong emotional reactions. We have a lot of beliefs, but what is really known?

What do we really mean when we talk about and use the word feminisation? Is there any broadly accepted definition? How many women are needed to make this "feminisation" change happen? Is there an inverse relationship? Does a critical proportion of men start a "masculinisation" of women? Which changes are referred to as feminisation? According to Webster's New World Dictionary, "feminine" is having qualities regarded as characteristics of women and girls. However we probably don't mean that our male colleagues are becoming more feminine? We could mean that increasing numbers of women medical students and women medical doctors might have an impact leading to changes in the psychosocial job environment, or the learning environment? And the total number of female research students has increased. However there is a continuous drop in the numbers of women at each level of the academic ladder. Therefore the female impact at the top positions afflicted with authority, seems to be relatively low.

This conference is concerned with the female impact on an organisation, education and profession traditionally dominated by men. However the problematisation in official documents, such as in the European Commission's "Action plan to promote gender equality in science", is the opposite. In these documents the concern is the masculine impact on female scientists.

We know that women leave their academic careers to a far greater extent than their male colleagues do. However we don't know why! There are studies that try to shed light on why. These studies use different models. Some models focus on social factors and examine structural and organisational circumstances that might discredit women. Other models focus on individual factors and are based on the assumption that through socialisation women and men become different. Women have different values. As long as there is a conflict between female gender-identity and the traditional way of accomplishing an academic career, women will exclude themselves. There are also studies using both perspectives.

Let us look at some truths.

In Sweden the female high school students even have higher grades than male students do. Therefore it is relevant to conclude that both women and men have the same qualifications for academic studies. There are equal numbers of males and females that graduate with doctor's examination. This implies that women succeed as well as men with their scientific work at the PhD level. There is no difference in reported activity level between male and female research students. The study funding is similar between the sexes.



Let us look at some of the myths.

Women are less motivated and career-oriented than men are. If women are less motivated they will not be as assiduous in applying for positions and grants. It's a common belief that women because they mostly take the main responsibility for their home and children have less time for scientific work,

therefore are less productive.

Are there any studies that scientifically evaluate if these myths are true?

Several studies have shown that both women and men rate the quality of men's work higher than that of women when they are aware of the sex of the person to be evaluated, but not if the same person's gender is unknown. In a Swedish study by Agnes Wold and Christine Wennerås they examined whether the peer-review system of the Swedish Medical Research Council evaluates women and men on an equal basis. It was published in Nature 1997. The study was converted in 1995. There were 114 applicants for the 20 post-doctoral fellowships, 62 men and 52 women. Finally four women (7.7%) and 16 men (25.8%) were awarded post-doctoral fellowships. Did the men and women with equal scientific productivity receive the same competence ratings by the Medical Research Council reviewers? No! Women suffered discrimination due to gender. The most productive group of female applicants, with 100 total impact points or more, was judged as competent as the least productive group of male applicants. This analysis of peer-review scores for post-doctoral fellowships applications strongly suggests the system cannot judge scientific merit independent of gender.

According to models focusing on individual factors there might be a conflict between the female gender identity and the demands from the academic career. However in more than 15 studies female scientists with children have been shown to produce just as many scientific papers and succeed just as well or even better with their careers than female colleagues without families.

Summing up the female research student perspective of the feminisation of medical education; **there is no problem!** The problem shows up at a higher level of the academic ladder. There might be many causes to why women leave their academic careers. However both women and men need postdoctoral fellowships and study funding to be able to proceed with their scientific work after the PhD level. It must be very hard to go on with science without any time or any money for it.

CONFERENCE REPORT - SESSION II

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

Reports from the chairmen:

HMJ van Rossum (Groningen, Netherlands)
R. Rubens (Ghent, Belgium)

M. Morrison (Aberdeen, UK)
Patient experience in a university hospital.

The session started with a poignant communication by Mrs. Morrison from Aberdeen (UK). Mrs. Morrison has been treated as well in the university hospital in Aberdeen (Scotland) as in the university hospital Saint Luc in Brussels. As she suffers from a chronic condition she could compare the approach towards the patient in both countries. The important difference is the communication towards the patient, it being very different in the UK from the Continent. The patient in Brussels gets more information than in Scotland. The increased amount of information however was not improving her well being as it caused her much more concern over the treatment.

F. Follath (Zurich, Switzerland)
Should the academic internal medicine department take this responsibility?

Speaker is head of a department of general internal medicine in Switzerland. Based upon the in hospital epidemiology Prof. Follath claims that the department of general internal medicine is the expert department to deliver a holistic care to the patient in the university hospital. The broad approach and the basic broad knowledge, including all specialties of internal medicine, typical for the general internist make him the key figure in a patient centred approach in the hospital. Furthermore it is the general internal medicine department, which is the basic training place for the different hospital-based specialties. General internal medicine is the pivotal service for the emergency division of a large hospital. He finished his talk by stating that general internal medicine should go neither in necrosis, nor apoptosis, nor just fade away. On the contrary to build up a humane medical care in a large institution as a university hospital a strong department of general internal medicine is necessary.

S. Van Belle (Ghent, Belgium)
Medical oncology an example of a territory problem.

Medical specialisation evolved out of the increased knowledge in the XIXth century. The medical oncologist started with the increased knowledge in clinical cancerology of the fifties. In 1970 the first society for clinical oncology was founded. In 1975 a European association for clinical oncology was made. In 1977 the first guidelines for the training of clinical oncologists were drafted in the USA. In 1988 the integration of the European and American model for clinical oncology was performed.

The different medical specialties are based upon two axes: (I) the organ or system axis: e.g. cardiologist, pneumologist, (II) the more holistic axis: oncology, infectiology.

The expert for the treatment of the cancer patient can thus be the medical oncologist (eventually to be subdivided in pneumology, gastro-enterology etc.), radiotherapist, the hematologist, and the surgical specialist with interest in oncological surgery. The dispute and territory problem only exist if the physician becomes the centre person of the treatment. If the patient is the centre of the problem then a personal approach is the rule with a smooth collaboration between different experts and a qualitative better treatment. The latter should be the rule.

M. Moens (Bonheiden, Belgium)
The point of view of the organ specialist.

The division of medical specialists is based on two possibilities: (i) the "modality" specialist: e.g. surgeon, radiotherapy or (ii) organ specialist e.g. urology, gynaecology, gastro-enterologist etc. In tertiary care both kind of specialists must be present. The treatment of the patient should remain holistic, meaning the gynaecological oncological patient not only is diagnosed by the gynaecologist but will also be treated by the gynaecologist. Only in the disciplines where oncology is rare (e.g. E.N.T.) a referral to the medical oncologist is necessary. A holistic treatment does not only involve skills, knowledge but also a notable amount of "professional wisdom". The organ specialist with his experience in the pathology is the key figure to the latter approach.

How can the medical school solve the territorial problem? Impact on teaching, ethics and patient care.

Graeme Catto (London, UK)

Problems.

As ever, the problems are more easily identified than resolved. The complexity of modern medicine has resulted in increased specialisation with the result that there are fewer “generalists” able to take a broad view of the needs of the individual patient. Patients and the lay public have a much greater understanding of the potential benefits and disadvantages of modern medicine and their expectations of doctors have changed over the last few years. Not unreasonably, they expect better information and the ability to develop a partnership with their doctors. On the other hand, the increasingly workload and compartmentalisation of medicine sometimes leaves the doctor somewhat isolated, with insufficient opportunities to discuss difficult problems with colleagues. The increase in litigation has perhaps inevitably introduced a defensive attitude to some aspects of medical practice.

Potential Advantages of the Medical School.

The medical school may be able to help resolve some of these problems. Academic staff are often the leaders in complex specialties and many treatments now regarded as routine began in university departments. The nature of a medical school results in colleagues from other specialties working in close proximity and all academic staff have considerable experience in research and in evaluating evidence. Inter-disciplinary working is common in academic departments and the collegiality that still exists allows individuals to discuss complex cases in an open and constructive way.

Potential Disadvantages.

Some clinicians, however, will perceive disadvantages in working more closely with academic colleagues. University staff may, for example, be thought to have less time for clinical work and some may be even considered to be less clinically competent than their health service colleagues. It is true that academic staff have a number of commitments and the increasing pressures of research, teaching and administration may cause them to be less available for immediate clinical consultations.

On balance, however, the medical school generally has access to sufficient and relevant expertise to help resolve some of the problems posed by providing medical care in a tertiary care hospital. Its staff are generally of sufficient seniority to focus attention and resources on complex problems and have robust links with primary and social care. Working constructively with health service colleagues, usually in the

local university hospital, medical school staff are frequently able to indicate areas of “best practice” and in many cases are able to lead by example.

Management of Health Services.

Changes in clinical practice are being mirrored by improvements in the management of health services. Academic staff no longer manage hospitals or indeed clinical services in the way that they once did. They still, however, have an important leadership role both locally and through their national and international connections. Their influence on managers, both medical and non-medical, remains substantial.

Teaching.

The types of organisational change currently being experienced by health services in all countries inevitably have an impact on teaching. The increasing specialisation of hospitals and the decrease in the length of patient stay do not, on the whole, benefit undergraduate medical education. Increasingly, undergraduate teaching and learning will move from the acute hospital to the community and primary care. Clinical care and teaching are likely to become increasingly patient-centred, focusing on the journey of care that patients with both acute and chronic conditions require. Postgraduate medical education, on the other hand, is likely to benefit from increasing specialisation within large academic clinical centres and there is much evidence to indicate that patient care has improved in a teaching environment. Within the UK medical students have indicated a preference for being educated in smaller hospitals and with general practitioners. Although the logistics are complicated, that preference does create opportunities for improved and relevant multi-disciplinary learning.

Ethics.

Ethical issues are now being much more widely discussed than was the case even a decade ago. Greater involvement of members of the public, patients themselves and members of the other healthcare professions helps create an open and unthreatening environment for medical students and doctors. Many of the questions debated are matters for society to resolve, doctors have a duty to raise awareness of these issues.

Future.

So how are these matters likely to be resolved in the future? Medical schools with their academic staff and breadth of experience should, I believe, initiate the debate. The starting point, as ever, is the individual patient’s needs. Meeting these in the most constructive way is likely to involve better links both within the hospital setting and between hospital and community care. The generalist and the general practitioner are likely to have a more important role in the years ahead.

Should the academic family medicine department take this responsibility?

J. De Maeseneer (Ghent, Belgium)

Holistic medicine can be defined as the art and science of healing the whole person - body, mind, and spirit, in relation to the person's community and environment. It can be questioned whether or not a tertiary care hospital and holistic medicine are not a "contradictio in terminis". Results from patients' feedback, indicate that there is very often an important information gap for patients treated in tertiary care hospitals. So there is a need for better communication, co-ordination, continuity, and contextual orientation of the care in tertiary hospitals and patient's participation should be improved. One could even question if a tertiary care hospital is the place to be for adequate undergraduate medical education. A tertiary care hospital deals with a disease oriented approach, with pre-selected patients, very often in severe conditions, and uses a (super) specialised diagnostic and therapeutic approach. Therefore many undergraduate curricula move towards more community oriented teaching and teaching in secondary care hospitals.

The basic characteristics underpinning family medicine (comprehensiveness, patient centred approach, problem solv-

ing strategy, community based) may be useful for the development of a more holistic approach in tertiary care hospitals. Nevertheless it is difficult to imagine how an academic family medicine department could take the organisational (structural) responsibility, because family medicine is most of the time not involved in the decision making process in tertiary care. Nevertheless increasing attention to the participation of family doctors in multidisciplinary teams at the tertiary care level stimulates the inclusion of contextual information in the medical decision making process. Family medicine could certainly take an educational responsibility in the development of a holistic approach in tertiary care hospitals: its links with the contextual disciplines (sociology, psychology, anthropology, environmental health, health economics), its expertise in skills training (medical decision making, communication, multidisciplinary co-operation) could contribute a lot. Illustrations from the new medical curriculum at Ghent University make clear how these contributions can be organised.

The conclusion is that the need for a holistic approach reduces the contribution of tertiary care hospitals to undergraduate medical education. Family medicine departments cannot substitute for the structural deficiencies in tertiary patient care but may contribute to training, skills and attitudes required for a more holistic approach.

CONFERENCE REPORT - SESSION III ROLE OF THE MEDICAL SCHOOL IN ACCESS TO THE MEDICAL PRACTICE IN EUROPE

EASTERN EUROPEAN VIEWS

Vilius Grabauskas (Kaunas, Lithuania)

Structure of the presentation.

Presentation is based on information received by standard questionnaire from eight EU candidate countries.

General information about medical education.

Information on the process of obtaining medical qualifications.

Information on the process of employment of medical staff.

Traditions and possibilities of medical practice in public/state or private health care sector.

Role of state (MOH or MOE), medical school and professional medical societies in obtaining medical qualifications and in medical practice.

Some thoughts on how the role of medical schools in medical practice might be optimized.

Conclusions.

Why such a structure?

The major objective for medical school is education-training-research while employment facilities of medical staff are limited (except university hospital).

However, access to medical practice in principle might be influenced by:

Quality of education/training.

Process of obtaining medical qualification (residency training programmes, continuing medical education).

Process of seeking the balance between training and demand of medical staff which requires close collaboration with health care system.

EU candidate countries that reacted to standard questionnaire.

Bulgaria
Hungary
Latvia
Lithuania
Poland
Romania
Slovakia
Slovenia

Population by country from 2 mln in Slovenia up to 40 mln in Poland.

Total enrolment of students in medical schools from 1000 in Slovenia up to 20 000 in Poland.

Access to medical practice (1).

COUNTRY	LICENSE REQUIRED	EMPLOYMENT POSSIBLE		ADMISSION PLANNED IN RELATION TO DEMAND	UNEMPLOYMENT
		AFTER GRADUATION	AFTER RESIDENCY		
BULGARIA	No	Yes	Yes	±	Yes (2180 ph)
HUNGARY	Yes	Yes?	Yes	Yes	Yes (<1%)
LATVIA	Yes	No	Yes	Yes	No
LITHUANIA	Yes	No	Yes	Yes	No
POLAND	Yes	No	Yes	Yes	Yes (?)
ROMANIA	Yes	Yes	Yes	No	Yes (?)
SLOVAKIA	Yes	Yes	Yes	No	Yes (136 ph)
SLOVENIA	Yes	Yes	Yes	No	No

Access to medical practice (2).

There are no precise data on medical practice facilities by residential area and health care structures (level and state/private), nevertheless, several countries provided some estimations indicating that physicians:

- Up to 85% work in urban areas.
- Up to 60% are employed in hospitals, 30-35% - in out-patient and 5-10% in other structures, including research.
- Only around 1% work in private hospital care while involvement in private out-patient care varies considerably between countries (from 10 to 80%).

How can role of medical school in access to medical practice be optimized?

Is it necessary???

In case the answer is "yes" this function might be accomplished through:

Improvement of medical education at all levels (graduate, residency, cme).

Improvement of collaboration with MOH in:

Accreditation process.

Licensing process.

Improvement of collaboration with professional medical societies by:

Organizing joint research.

Introducing new training programmes.

Involvement of medical care structures into residency training programmes and research projects.

In any case this role will be limited to advisory, consultative and partnership type of activities and arrangements.

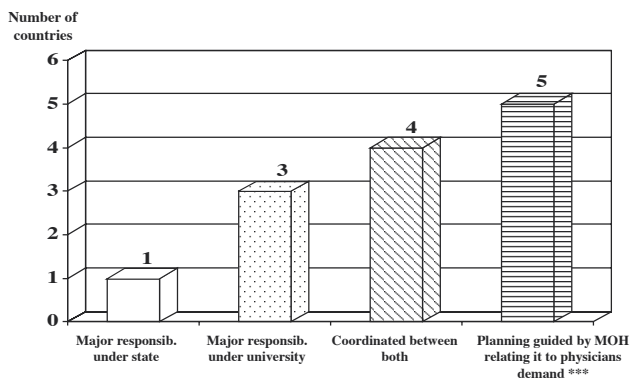
Conclusions.

The role of medical schools in access to medical practice is rather marginal except functioning of University teaching hospitals.

In broader terms this role is accomplished through quality of educational programmes at all levels (graduate, residency, cme).

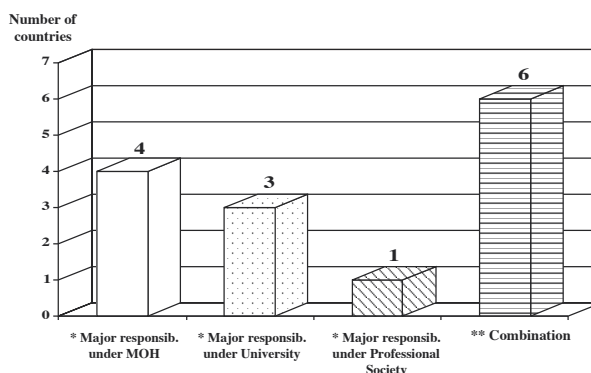
In case effective collaborative/partnership relations with MOH, professional medical societies, health care structures exist this role might be strengthened through participation of medical school in certification, accreditation, licensing processes.

Responsibility for admission of new students to medical schools.



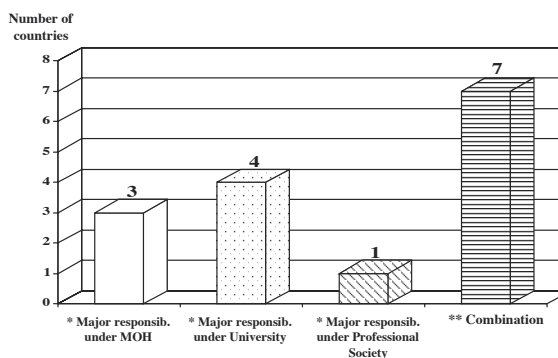
*** NO REGULATORY MECHANISM FROM MOH IN ROMANIA, SLOVAKIA AND SLOVENIA

Responsibility for obtaining medical qualifications: Residency training programmes.



* "Major responsibility" refers to those structures which are responsible for certification.
 ** However, in 6 countries practical implementation of residency training programmes involves varying degree of participation of all structures certified by Universities in Hungary, Lithuania and Slovenia, by MOH in Romania, and by professional society in Latvia and Poland.

Responsibility for obtaining medical qualifications: Continuing medical education (cme).



* - Major responsibility refers to those structures which are responsible for certification.
 ** - "Combination" means that several structures are involved in CME (professional societies-in all Universities in 7 countries, and only in Slovenia professional societies alone are responsible for CME)

Some information on process of medical education.

COUNTRY	NUMBER OF MEDICAL SCHOOLS	FIRST YEAR ADMISSION/m/m	YEARS OF BASIC MEDICAL EDUCATION	PHYSICIANS/ 10 000 POPUL.	PREREGISTRATION (YEARS)	RESIDENCY TRAINING PROGRAMMES		CME
						SPECIALITY	SPECIALIZATION	
BULGARIA	5	50	6	34,5	-	3-5	3-6	YES
HUNGARY	4	73	6	36,1	2	2	3-4	YES
LATVIA	2	180	6	30,0	-	3-5	2-3	YES
LITHUANIA	2	86	6	37,0	1	3-4	3-4	YES
POLAND	11	84	6	23,0	1	-	4-6	YES
ROMANIA	10	138	6	19,0	1	3-4	3-4	YES
SLOVAKIA	3	120	6	32,2	1	3	3	YES
SLOVENIA	1	83	6	20,0	2	3-6	3-6	YES

Role of the medical school in access to medical practice in Europe. Spanish overview.

Juan Viñas Salas (Lleida, Spain)

History.

In Spain from 1978 to 1995 Schools of Medicine are responsible of the physicians general learning and practice, as well as Specialist's training and the Minister of Education certifies University title. Since 1978 the Health Care System and the Minister of Health are responsible of Specialist's admission and training, but the Minister of Education still certifies specialist's title.

Since 1995 the European title of Generalist is homologate in Spain as Specialist in Familiar and Communitary Medicine in by a Government law in 1989, adapting to the European legislation. (RD 931/1995 Guidelines for the Specialist in Familiar and Communitary Medicine training for the doctors graduates posteriorly to the 1st January 1995.

Communication 90/C 26B/02 to the European Commission that the Spanish title of Specialist in Familiar and Communitary Medicine is the European equivalent to general practitioner (D.O. 24 October 1990).

(Real Decreto 326/2000 BOE 4 marzo 2000).

Schools of Medicine are responsible of the training of the Generalist Doctor. Health care system is responsible of the admission and training of the Specialist in Familiar and Communitary Medicine. General Physician cannot work in Health Care Public System nor have free European circulation.

After the six-year undergraduate curricula, with more than 50% of practice training, Spanish graduates must pass a theoretical test examination to be able to start their postgraduate specialisation, including Familiar and Communitary Medicine.

Table 1 shows the evolution of Graduates, Postgraduate applications and positions in the last years. The number of graduates that applies to a postgraduate specialisation position triplicate its positions in 2001

TABLE 1
Evolution of Graduates, Postgraduate (MIR) Applications and Positions 1985/97

Year	Graduates	Applications (a)	MIR(b)	a/b
1985/86	7.856	19.935	1.336	14,9
1986/87	7.013	20.654	1.903	10,8
1987/88	6.703	19.968	2.288	8'7
1988/89	5.623	18.056	3.062	5,9
1992/93	5.138	18.561	4.081	4,5
1994/95	4.451	17.427	4.282	4,1
1995/96	4.000	16.463	4.819	3,4

(Propuesta de Criterios Generales para Informe del Consejo de Universidades sobre la Creación de Nuevas Facultades de Medicina. Madrid. 12 de noviembre de 1997)



In Spain we have a Public Health Care System that covers 100% of the population and is the employer of 90% of Physicians. Nowadays Familiar and Communitary Medicine Physicians visits double number of patients that in other European countries with Public Health Care Systems, as Finland, Portugal or Sweden, and they have a higher number of inhabitants per physicians (WHO A.M.S. 5012667 Target

19, 2000). Today with the actual policies the number of postgraduate specialisation positions cannot be increased continuously because there exists specialists unemployment.

The mean age of Spanish Physicians is about 48 years old. We have a large patient's waiting list for surgery and complementary explorations. All this means that actually we does not know the real number of physicians we needs and that this number will be high in 12 to 15 years.

Actual Spanish laws adversely affects our Physicians as more then 1/3 (about 7.000) of them cannot access to work in Public Health Care System and get free European circulation.

There is a divorce between University and Health Care System. University decide number of medical students and Health Care System the number of Specialists including Generalists.

From the University point of view there are possible solutions, proposed to our Administrations:

- **The Conference of the Deans Schools of Medicine** in the year 2000 accorded that: 1) All post-1995 Physicians must have option to Specialist training, 2) There must be conversations to co-ordinate the number of positions of undergraduate and specialists students. 3) It is necessary to elaborate a study of the Spanish needs of General Practitioners and Specialists and 4) Postgraduate access test examination must be changed.

- **The Students of Medicine Association** propositions are that: 1) Health Care System must offer 100% of Specialisation positions (20% more), 2) Increment of the number of specialisations. 3) Adapt Physicians working time to European legislation. 4) Postgraduate training offered to all graduates from Medical Schools, 5)

Increment of Public Health Care Physicians to avoid diminution of quality assistance.

All University or Health Care System policies must be directed to solve Health care social needs. It is necessary a change of Spanish legislation; that is a political problem. A dialogue with the Association of Familiar and Communitary Medicine centred on social needs is necessary for their major implication in undergraduate training and arrive to the solution of the graduate medical students problem.

Global challenges in medical science education initiatives in Turkey

Curriculum change & innovative medical teaching: Growing demand, emerging awareness & pioneering implementations in Turkey

Gönül Ö. Peker (Izmir, Turkey)

Turkey is a developing country with a high and considerably young population and a very high population increase rate. Beginning from the nineteenth century and later then, following the foundation of the modern Turkish Republic, there have been at least five different generations of medical schools and respective curricula reflecting different visions and pursuing different objectives and concerns. All together, there are 40+ medical schools in Turkey today. Turkish medical education and its end products do neither comply with the health service policies nor meet the health promotion and service demands of the growing diverse population.

In the early sixties, Hacettepe University Faculty of Medicine in Ankara introduced a breakthrough by integrating medical science and clinical disciplines within organ system blocks, practising a methodology which could presently be named interactive teaching or active learning, and including extensive community-based clerkship and internship training. This model proved itself and worked very well in the heydays of the University and was adapted by several other medical schools in Turkey and even in Europe. In parallel with the politico-socio-economic turmoil and decline, this curriculum has eroded and become inefficient in time.

Presently, the problems and challenges can be summarized as follows: Too many incompetent medical schools were opened and too many unqualified medical teachers have been promoted. The classes are usually too crowded and the teaching facilities, hi- and lo-tec teaching aids and learning resources are very short. The curricula are saturated with extreme theoretical knowledge and are weak in hands-on lab practicals, bedside and community / primary care / general practitioner training, and problem solving. Also, medical graduates have to compete very harshly for a 1/10 probability on the National Placement Exams for Residency Training. There is shortage of medical practitioners in the less developed regions of Turkey, whereas; there is unemployment of physicians in larger cities.

In the mid nineties, a novel national awareness was initiated at a symposium in Istanbul under leadership of a few medical scholars and teachers from various Istanbul universities. Meantime, the Turkish Parliament sponsored an extensive survey on the existing status, weaknesses and urgent needs of medical education nation-wide. The Turkish Medical Association (TMA) became very actively involved and sometimes took leadership in similar procedures for data collecting and project development for improvement of programs and methodology.

Towards the end of the nineties, a relatively recently established medical school, Dokuz Eylül University Faculty of

Medicine (DEUFM) in Izmir has adapted a student-centered PBL curriculum from New Mexico, Dundee, and Maastricht Medical Schools. Several Turkish basic and clinical science faculty visited role-modeling medical schools in the U.S. on ECFMG-FFFP and IFME grants to gain know-how and experience in curriculum change. The First National, (with international participation), Congress on Medical Education was held by the Ankara University Faculty of Medicine in Ankara in 1998. Many of the medical schools have initiated faculty development programs and launched / charged various structures / bodies for development and research in medical curriculum. The curricula, in general, have begun evolving by inclusion of systematic clinical, communication and computer skills modules / courses, PBL sessions, reliable assessment and evaluation systems, and very seriously prepared syllabi. TMA conducted two other very extensive surveys in the last three years.

Numerous symposia and workshops on various aspects of medical education were held in the last seven years. The Marmara University Faculty of Medicine in Istanbul, the Ege University Faculty of Medicine (EUFM) in Izmir, and few other schools organized very extensive Workshops on Basic and Clinical Medical Assessment for their respective faculty by inviting an expert from the Maastricht Medical Faculty. The Symposia, titled, "Novel Technologies in Medical Education" and "Learning How to Learn" held by the Akdeniz University Faculty of Medicine in Antalya and Istanbul University Faculty of Medicine in Istanbul, respectively, made great publicity and inspired relative initiations.

Since the beginning, EUFM has preferred an evolutionary approach and began the innovation procedure by macro-analysis and revision of her 10+ year old organ system based, horizontally (basic science) integrated curriculum. Accordingly, 1) computer skills, CPR - basic clinical skills and psychodrama modules; 2) clinical orientation courses comprising of clinical introductions, multidisciplinary bio-psycho-social focus scenarios, clinical cases, and primary care modules; and 3) integrated learning modules built around a clinical presentation or an organ system were inserted into the first; second; and third year curricula, respectively. Comprehensive Student Guides followed by exclusive Study Guides and Syllabi, which later became models for many other medical schools, were created / developed for each year and each clerkship program. Systematic post-mortem evaluation of the End-Block, End-Clerkship, Final and Remedial MCQ, OSPE and OSCE Exams has initiated the "Question Bank Project" whereas; pioneering attempts for student and faculty satisfaction / feedback / criticism have inspired structured standardization and quality assurance interventions in the institute. Inspired by JHPHEP, EUFM developed a Faculty Training Workshop which has been educating the majority of her own faculty, other health sciences faculty and practitioner preceptors at the other regional and remote university and state primary care and educational institutions for free.

In addition to TMA, Higher Education Department (HED) of Turkey, Turkish Ministry of Health, the national Platform for

Physician and Medical Faculty Rectors and the national Platform for Medical School Deans, the Turkish Health Council, and the Scientific and Technical Research Council of Turkey have become deeply involved. Meanwhile, TMA led the establishment of the Institute for Education of General Practitioners. Individual Professional Medical and Clinical Science Associations have allocated new committees, task forces, and Boards for development of golden standards, and for conduct of research and innovative improvement in undergraduate and graduate medical education.

The legislation promoting Medical Education as an academic discipline and a field of graduate study and calling for establishment of Medical Education Departments (MED) in Medical Schools was an important milestone in 1999. Following the emergence of the first MED at EUFM, similar units, offices, departments and centers have been established in other universities. Meanwhile, the foundation of the NGO, titled, "Association for Development of Medical Education in Turkey" (AMET) in Izmir marked the end of the 20th Century in Turkey.

The DEUFM received a significant grant to support her curricular research and development from the State Planning Department of Turkey (SPDT) in 2000. Recently, EUFM has also been granted by SPDT for an "extensive regional survey on priority health problems and primary health requirements in an optimally representative population at the environs of the Institute to provide demographic data for the State Health Department Primary Care Service and EU Hospital Outpatient Care Unit". The outcomes will serve as guidelines to state the very relevant learning objectives and enable EUFM to very specifically revise and restate her Vision, Mission Statement, and Core Curriculum to meet the immediate demands of the Community and to display a model for the other medical schools in Turkey.

General awareness in curricular innovation has boomed lately. A minority of the medical schools has adapted / modified versions of DEUFM's PBL curriculum, whereas an important majority has preferred the "evolutionary rather than revolutionary" attempts for curricular innovation. The

recently held Izmir Second National (with international participation) Congress on Medical Education presenting superb quality state of the art program and attracting very high attendance highlighted the year 2001. ECFMG support for invaluable international scholarly participation and tutoring enriched the event. The congress ended with a declaration stating the short and long term obligations to be followed up by the Medical Schools, TMA and AMET until the 2003 National Congress to be held at Harran University Faculty of Medicine which is located at neglected / lesser developed Southeastern Anatolia region.

Several working groups have focused on revision of the National Exams for Residency Training so that it complies with the learning objectives reflecting specific priority community needs and that it is compatible with international standards. Others are trying to make publicity for and exert driving forces on governmental and civil bodies to prevent establishment of new medical schools and to decrease enrollment in medical education. There is growing interest in inclusion of medical ethics, social medicine, history and philosophy of science, and other humanitarian courses, either mandatory or as elective, in the medical curricula in general.

The MEDs and the HED are in process of developing world-class programs for graduate academic degrees in Medical Education. There are extensive attempts for pilot studies on Self, National and International Evaluation Procedures and Quality Concepts for development of Institutional, Regional, National and Global Standards. Several Medical Schools have begun meriting medical teaching performance by monetary compensations and other promotions comparable to clinical service and research activities. Nowadays, students and younger faculty are being more highly regarded and are entitled to effective "say" in planning, development and operation of "change" in medical schools. Nation-wide, the MED Network, similar electronic groups and other efficient platforms have been formed for conducting brave, innovative, state of the art discussions on medical education in Turkey.

CONFERENCE REPORT - FREE COMMUNICATIONS

Elective course "Health promotion, communication and primary care"

Maria Antonia Modolo (Perugia, Italy)

The innovative course is already in its third year, offering classes to I through IV year Medical students on themes regarding "health promotion, communication and primary care". The aim of the course is to offer students "capacities to adopt a holistic approach to health problems", "capacities to communicate" and "capacities to recognize community health problems", training objectives which are central to the new curriculum of the undergraduate program.

The course also responds to the student's desire to experience practical and working aspects of the profession from the first year of studies on, through contact with a wide range of medical activities, giving particular attention to primary care which is often excluded from medical school experience.

Considering the various situations, in the first year of medical school attention is centred on the "person" in the experience of "illness"; in the second year on the "family" for its contribution to the management of health/illness. In the third

year (experimented in a three year ERASMUS project), the course concentrates on Health Systems and trans-cultural impact; in the fourth year on the identification of problems and the importance of health promotion actions for population groups in the community. In the V and VI year the objectives are verified in internship sessions in the practices of general practitioners.

Methodology

Organisation and use of manuals for tutors and students and a contract.

Use of adult education methods. Learning through experience, visits, interviews. Group work theme exercises, learning games, analysis and case discussions. Contact with primary care workers, general practitioners, health centres. Research of links with other primary disciplines. Common activities with students from other courses. Use of the Internet and web pages. Readings and study of documents.

Evaluation

Elective courses do not have exams, the student's progress is evaluated by: mandatory attendance, the filling out of forms on activities carried out and a rational: "a diary", web pages. Student evaluation by: evaluation of the course, teachers and tutors.

The sickness of health and its treatment

Ioannis Dimoliatis (Ioannina, Greece)

The appearance of the symptoms of a disease divides one's life in "before symptoms" (BS, healthy) and "after symptoms" (AS, patient). The vast majority of a population is at the state of BS, the professionals who meet their flexible needs for disease prevention and health maintenance & promotion we the social doctors (doctors of public health), and the institutions which provide these services are (in theory) the Health Centres (HC), which should have their own budget and should belong to an independent ministry. The professionals, who meet the inflexible demands of a small number of people in a population which are at the state of AS, are the doctors (physicians), the institutions where they provide their services are hospitals (including surgeries) and they consume almost the entire budget of the ministry and lead to medicalization of our lives. The above analysis leads to the following proposals:

1. Graduate Schools of Public Health, lasting at least 4 years, must be founded; graduates will work with healthy people, their health and its promotion, and will not be physicians; furthermore they might be in constant opposition with them.
2. Ministry's splitting in two independent departments (directions) or even better in two independent ministries, the Ministry of Health (MoH) and the Ministry of Disease (MoD)
3. Patients, hospitals and medical & other academic schools dealing with disease must go under the MoD, academic schools especially, as exclusively professional institutions, should not belong to the Ministry of Education but to the competent professional ministry (MoD). The responsibility of healthy people, health schools and HCs must go under the MoH.
4. The directors of the HCs must be professionals of Health (Public Health, Social medicine) and not professionals of disease (physicians), even if they were to be General Practitioners.
5. It is necessary for Public Health to expand its area of interest, including what happens in all other sectors of life, such as Agriculture, Environment, Education, Defence etc.

Holistic medicine - A reality to be considered by the academic medical institutions

Augustin Cupsa (Craiova, Romania)

Holistic medicine or complementary/alternative medicine (CAM) has gradually developed into a constant presence in medical practice and raises genuine concerns and various attitudes among physicians and patients worldwide, from denial to complete endorsement.

Our Institution engaged several Departments (i.e. the Center for Medical Education, the Department for Promoting and Organizing the Scientific Research the Committee for Curriculum Development) in a joint program with the Professional Association of Physicians, the Nurses College, and registered CAM societies (homeopathy, acupuncture).

The program acknowledges the realities of CAM (i.e. minimal specific knowledge among practitioners with inadequate feedback to patient inquires, minimal curriculum information, constant ascending trend to address CAM procedures

and techniques among patients with chronic and/or incurable diseases, the growing number of CAM network and practitioners - licensed or not, some of them charlatans).

Although the program faces problems, such as lack of neutral qualified evaluators for a critical appraisal, the paucity of autochthon scientific literature and of evidence based trials and the difficulty to obtain grants for such studies, our institution has developed a framework and a time set.

The main goals are to develop studies on the epidemiology and description of the CAM phenomenon, to identify the strengths and the weakness of CAM, cost effectiveness, and to establish the patient motivation in addressing CAM. The results will generate adequate under- and postgraduate curriculum remodelling by including optional courses.

The program consists of five phases (i.e. collecting data, critical analysis of the literature and of the European legislation, cooperation with European centers with experience in the field, the elaboration of the courses and the remodelling of the curriculum according with the feedback from medical practice).

The Poznan program of undergraduate training in family medicine

W. Horst-Sikorska (Poznan, Poland)

The current, specialist-orientated pattern of clinical teaching for medical students results in inappropriate theoretical and practical preparation for their future work in basic health care. This lack of a holistic approach to patient care was the main reason behind the introduction into the undergraduate curriculum of a course in family medicine.

The staff of the Department Family Medicine prepared a program for our medical students, based on British models but adapted to comply with the structures existing in Poland.

The main idea of the training is to carry out the teaching process in family doctors' practices with assistance provided by specialists involved in family care and members of staff from the Department Family Medicine.

During the teaching process new methods of learning, such as case-studies, are implemented.

The program consists of two main parts: an introductory part designed to acquaint the student with the organization of all aspects of health care. During this period special attention is paid to the implementation of health promotion programmes in basic care in accordance with the National Polish and WHO programs of health care. In addition, strategies to transform health care in Poland involving both contracts with Kasa Chorych (a governmental institution which has contractual arrangements with private health care providers) and the introduction of private health insurance are planned.

The second part of the students' programme is focused on patient care and consists of elements of psychology and sociology in the context of patient care, clinical treatment and its connection with family medicine. Also, a number of difficult family care problems such as abuse, alcoholism and drugs are dealt with. The final stage in the training involves the student's active participation in family care, during which he is supervised by a teacher who has specialised in family medicine.

Towards reform of university hospitals in Romania

Ioan Romosan (Timisoara, Romania)

Although the quality of medical care in university hospitals in Romania is of high standards, low financing dependent on the national budget is still creating malfunctions. Improper management of the budget has led to financial privileges for the administration, ignoring real problems. Chaos in complementarities with regional health structures has created a kind of in-hospital "centralized" bureaucracy, impeding progress. Defections in interdepartmental cooperation and lack of computerized databases are still present in many hospitals.

University hospitals should be mobile and open systems integrated regionally and financed by public and private insurance companies. Associations between university hospitals according to European and WHO standards and collaboration with other hospitals, diagnostic centers and general

practitioners offices should enhance cooperation at national, regional and international levels. The role of university hospitals in medical education is of utmost importance. Today's high-tech functional organ-oriented approach in medical education has to be changed by integration of public health issues (behaviour, environment, prevention) and development of bedside skills. Formation of future doctors is done in 4 cycles: 1. Discovery (basic sciences), 2. Building of foundation (clinical training), 3. Residency and 4. Continuous up-to-date information. A higher attention should be given to formation and continuous information of family doctors by case presentations, periodical evaluations, seminars and courses. Discussion of specific problems of family doctors as well as flexibility of guidelines for general practice to meet the ever-changing criteria of modern evidence based medicine should also be on the agenda of university hospitals.

Another important function of the university hospital is clinical research, which should gain momentum due to a more flexible attitude of the government towards scientific research and international cooperation.

Feminization within medical profession in Poland a comparative analysis conducted on macroscale and in the medical faculty of the Jagiellonian university

Beata Tobiasz-Adamczyk (Cracow, Poland)

The analysis carried out on the level of social macrostructure (based on general statistics data on the local level) and in the oldest Medical Faculty in Poland has shown that despite continued discriminatory practices towards women's entry into medical schools until the 90s, there were 52-54% women physicians and about 81% women stomatologists, who entered into the profession in the last decade. The proportion of women in the medical profession in Poland ranged from 54-56% in the last 10 years and has stabilised, compared with 38% in 1960, and only 18.2% in 1937. Currently, women constitute about 55% of all students of the Medical

Faculty, and this figure has not been changed for the last 10 years. In Poland there are 23.6 physicians per 10 thousand population. Rapidly increasing proportions of women physicians observed in Poland over the last 50 years has social and economic explanations (for example, mean salary in health care sector in the last 10 years ranged from 87.9% in 1992 to 80.5% of the average salary in 1999). Furthermore, social esteem of medical profession has changed.

The presentation will analyse gendered structure of the medical specialities and gender specific tasks in health care sector (hospitals vs. outpatient departments) in the macroregion of the South Poland on the example of the graduates of the Medical Faculty, Jagiellonian University. They will also trace academic careers -of women physicians at the University (currently 32.8% professors and associate professors in the staff of the Medical Faculty; 30.8% professors and associate professors, in preclinical sciences and 21.7% in clinical disciplines).

Medical students in Greece indicate tendency towards specialization

Ioannis Dimoliatis (Ioannina, Greece)

PURPOSE: To investigate the career choices, the specialty preferences and criteria among medical students in Greece. **METHODS:** This is a questionnaire-based analysis using a sample of 488 students of 3 (out of 7) Greek medical schools. The sample includes students of all the academic years. **RESULTS:** The vast majority of the students wishes to specialize (97.8%), preferring Surgical (29.2%), than Medical specialties (27.4%). Laboratory medicine gathers a very low percentage (3.1%), while General Practice an even lower one

(1.8%). 55.3% of the students believe that General Practice is non prestigious. The most popular specialties are Pediatrics, (8%), Vascular Surgery (5.3%) and General Surgery (4.4%). Males' first choice is Vascular Surgery (9.3%), while females prefer Pediatrics. Scientific reasons seem to be the major criterion for most of the students' (62.4%) specialty choices. 74.8% of those asked, considers the possibility of specializing abroad due to the higher education level and the long waiting period for specializing in Greece.

CONCLUSION: The low concern of the Greek medical students for General Practice reveals and explains today's inefficiency in the Primary Health Care in Greece. Further more the lower education level urges students to specialize abroad.

Chronic pain therapy: An evolution from interventions to a holistic interdisciplinary patient approach

Jacques Devulder (Ghent, Belgium)

Introduction.

Since many decades anaesthesiologists treat chronic pain patients. Their skills in locoregional anaesthesia may be helpful performing injections into the epidural space, the nerve root sleeve, trigger points and joints. Most of them also perform radiofrequency lesions into the dorsal root ganglion, the sympathetic chain or at the medial branch of the facet joints to obtain a more sustained pain relief. By these interventions many patients can be treated but the question remains if treatment in the chronic pain patient is only a monotherapeutic approach by an anaesthesiologist?

Historical evolution.

Obviously, the answer to the above mentioned question is negative! John Bonica was an anaesthesiologist performing locoregional anaesthesia to alleviate pain. Very soon he noticed the importance of multidisciplinary discussions and he was the first to create a multidisciplinary pain clinic in the US. He also founded the International Association for the Study of Pain (IASP) in 1973. Nowadays, IASP represents thousands of members as basic scientists searching for the molecular mechanisms of pain, but also many clinical practitioners as neurologists, physicians in rehabilitation medicine, psychiatrists, anaesthesiologists, neurosurgeons. Also nurses and psychologists are member of this society. So, together this world association tries to get a more profound insight into pain mechanisms and pain treatment.

John Bonica was an important physician who stressed the biopsychosocial aspect of pain. His circle diagrams certainly explain the differences between the noxious input which can be small and the final clinical pain behaviour being much larger.

The Ghent University Hospital Pain Clinic Centre.

Considering the evolution in the treatment approach of chronic pain patients we changed our attitude of treating patients by a single interventional approach to a more holistic view.

At the first visit into the pain clinic, patients have the opportunity to explain their complaints. After intake, we perform a clinical examination and paraclinical examinations are looked at or requested. At the same visit we ask the patient to fill in our questionnaire that is the synthesis of different validated questionnaires. We also explain the patient the multicomponent theory of chronic pain. Indeed, whenever pain becomes chronic the sensory component becomes less important as wounds are healed and only fibrosis or scars are left. On the contrary, muscular contractions and autonomic nervous system reflexes become more and more pronounced. Chronic pain is very disabling even making patients depressed by the pain. Moreover, it is very interesting to understand patients personality, cognitions and emotions about pain. So, from the beginning it is must be clear

for the patient that all those components take part in the chronic pain syndrome. We explain them that a small reduction of the four components can give a much greater benefit than a single approach.

In the difficult chronic pain patients it is interesting to evaluate them by an anaesthesiologist, a psychologist and a physician in rehabilitation medicine.

Every week we have a half-day discussion meeting where anaesthesiologists, nurses, psychologist, psychiatrist and physician in rehabilitation medicine meets each other to discuss those difficult chronic pain patients. Together we try to put forward a more precise diagnosis and a clear cut treatment flow chart. In this session we also discuss the follow up of the patients we are treating. Indeed, new treatment can be multifactorial. Drugs, infiltrations, rehabilitation and cognitive behavioural psychotherapy can all start at the same time if needed. If necessary, we can still ask advice at the surgeon if more invasive therapy is necessary or could be helpful.

So, the patient has the best chance to get the most complete pain treatment and there is even some guarantee to prevent unnecessary surgery provoking even more disability afterwards.

It must be stressed that this multidisciplinary approach is only possible after good patient instructions about intake and referral to our colleagues. Indeed there is still great fear and misunderstanding about chronic pain and the psychological approach. Very often patients have the impression that the physician doesn't believe their complaints by sending them to the psychologist or the psychiatrist. Therefore good information at the beginning is mandatory.

Conclusions:

This patient approach is expensive but the method is well accepted by the patients. Obviously, better pain relief can be obtained although not all the patients can be helped. In some patients, somatic damage is such important that pain killing treatments will always remain insufficient. In those patients we can help by offering them insights in the mechanisms of their pain so that cognitive behavioural therapy as main therapy might be helpful. Unfortunately, patients with very important personality dysfunction and poor treatment outcome will persist.

In our setting, we are working much more in an interdisciplinary frame than in a multidisciplinary approach because by discussing and accepting every member's input we have a very solid idea about patient's pain. The general practitioner is the only physician we are lacking. Although we invite the GP's to come to our patient discussion sessions, they don't find time or lack a financial rewarding. In most cases the contacts remain limited to a telephone call and correspondence letter.

Members of the interdisciplinary team:

Jacques Devulder, anaesthesiologist. David Logé, anaesthesiologist. Carine Poppe, psychologist. Ann Mariman, psychiatrist. Luc Vandenbossche, physician in rehabilitation medicine. Lydie Ghys, nurse.

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
1. Impact of Feminization on the Medical Profession
 2. Holistic Medicine in a Tertiary Care Hospital-Impact on Undergraduate Education
 3. Role of the Medical School in Access to the Medical Practice in Europe
 4. The Continuum of Undergraduate and Postgraduate Medical Education - A European View on Access to Medical Practice
- 2002 Lille
1. Research and evaluation in a medical faculty
 2. How to encourage student's mobility?
 3. Teaching of basic sciences in integrated medical curricula
- 2003 Izmir

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AMSE Board meeting. Prague 13th of April 2002





2002 Annual Conference of the Association of Medical Schools in Europe

Lille, France - September 5-6, 2002

Under the patronage of:

*Mr. Daniel Percheron,
President of the Regional Council of the North- Pas-de-Calais*

*Mrs. Martine Aubry,
Mayor of Lille*

The meeting is hosted by:

*Prof. Dr. Albert Dutoit,
Dean of the Faculté Libre de Médecine, Institut Catholique de Lille*

*Prof. Dr. Jean-Paul Francke,
Dean of the Faculté de Médecine, Université Droit et Santé - Lille 2*

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AMSE Website

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

WELCOME MESSAGE

The Faculté Libre de Médecine – Institut Catholique de Lille & the Faculté de Médecine – Université Droit et Santé – Lille 2 are honoured to host the AMSE 2002 Conference in Lille, France, September 5-7, 2002.

We cordially invite you to attend this meeting which will cover 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 Application Form for membership to join the Association of Medical Schools in Europe (AMSE), in case your faculty is not yet a member of this association.

Lille is a friendly city selected as “European Culture Capital” in 2004 which offers a great number of cultural and tourist opportunities.

We hope to welcome as many colleagues and students as possible from Medical Faculties all over Europe.

Looking forward to meeting you in Lille.

Prof. Dr. A. Dutoit
Dean
Institut Libre de Médecine

Prof. Dr. J-P. Francke
Dean
Université Droit et Santé – Lille 2

TOPICS OF THE CONFERENCE

- **Research and evaluation in a medical faculty.**
- **How to encourage student’s mobility?**
- **Teaching of basic sciences in integrated medical curricula.**

Official language: English

The AMSE Conference will be preceded on Thursday September 5 by:

- **The plenary conference of Deans of French Faculties of Medicine.**
- **The plenary conference of Deans of Spanish Faculties of Medicine.**
- **The Executive Committee of the Council of Heads of Medical Schools of the UK.**

SCIENTIFIC AND SOCIAL PROGRAMME

THURSDAY, SEPTEMBER 5, 2002

Faculté Libre de Médecine
Institut Catholique de Lille

18:00: Registration (56 rue du Port)

19:00: Opening Ceremony (60 boulevard Vauban)

20:30: Welcome Reception (60 boulevard Vauban)

Friday, September 6, 2002

Faculté de Médecine
Université Droit et Santé – Lille 2

Session I:

Research and evaluation in a medical faculty

Chairperson: Antonio Campos (Madrid - Spain)
Co-Chairperson: Salem Kacet (Lille - France)

9:00-9:15: **Indicators of research performance in a medical faculty and methods of evaluation.**

Bahram Bekhradnia
(London - United Kingdom)

9:15-9:25: *Discussion*

9:25-9:40: **How to optimise teaching, research and patients' care?**

Christophe Bauters (Lille - France)

9:40-9:50: *Discussion*

9:50-10:05: **Basic vs applied clinical research.**

Åke Wasteson (Linköping - Sweden)

10:05-10:15: *Discussion*

10:15-10:40: Coffee break

Free communications

11:30-11:45: **Communication by the Executive Committee of the Council of Heads of Medical Schools and Deans of United Kingdom Faculties of Medicine (CHMS).**

Developing the influence of UK Medical Schools

Robert Boyd (London - United Kingdom)

11:45-11:55: *Discussion*

11:55-12:10: **Communication by the Conference of Deans of French Faculties of Medicine.**

Jacques Roland (Nancy - France)

12:10-12:20: *Discussion*

12:30-14:00: Lunch

Session II: How to encourage student mobility?

Chairperson: Tim Jones (Bristol - United Kingdom)
Co-Chairperson: Mireille Bellet (Brest - France)

- 14:00-14:15: **How do we develop ECTS (European Credit Transfer System) in medical faculties with integrated curricula?**
Manuel Vijande (Oviedo - Spain)
- 14:15-14:25: *Discussion*
- 14:25-14:40: **Student exchanges**
Ladislav Mirossay (Kosice - Slovakia)
- 14:40-14:50: *Discussion*
- 14:50-15:10: **Students' points of view**
10': **EMSA (European Medical Students Association)**
Hrvoje Vrazic (Zagreb - Croatia)
10': **Students**
- 15:10-15:20: *Discussion*
- 15:20-15:45: Coffee break and student mobility coordinators' meeting point.

Free communications

- 15:45-16:00: **Communication by the Conference of Deans of Spanish Faculties of Medicine From undergraduate to postgraduate in the Spanish education and health systems : advantages, drawbacks and a proposal for European integration**
Justo Medrano Heredia (Alicante – Spain)
- 16:00-16:10: *Discussion*
- 16:10-16:20: **Presentation of the pilot project “Tuning Educational Structures in Europe”**
Martine Froissart (Lille - France)
- 16:20-16:25: *Discussion*
- 16:25-17:25: **AMSE General Assembly**
- 19:00: Visit of the Hospice Comtesse Museum
Welcome reception by
Mrs. Martine Aubry (Mayor of Lille)
- 20:30: Dinner

Saturday, September 7, 2002 Faculté Libre de Médecine Institut Catholique de Lille

Session III: Teaching of basic sciences in integrated medical curricula

Chairperson: Pierre Formstecher (Lille - France)
Co-Chairperson: Jean-Louis Dhondt (Lille - France)

- 9:00-9:15: **The role of basic sciences.**
Jorge Pales (Barcelona - Spain)
- 9:15-9:25: *Discussion*
- 9:25-9:40: **Who will teach basic sciences?**
Dan Larhammar (Uppsala - Sweden)
- 9:40-9:50: *Discussion*
- 9:50-10:05: **How to teach basic sciences?**
Ton de Goeij (Maastricht - The Netherlands)
- 10:05-10:15: *Discussion*
- 10:15-10:45: Coffee break

Free communications

- 10:45-10:55: **Presentation of AMEE (Association for Medical Education in Europe)**
Margarita Baron-Maldonado (Alcalà - Spain)
- 10:55-11:00: *Discussion*
- 11:00-11:10: **Presentation of MEDNET II (Medical Education and Didactics NETWORK)**
Enzo Molina (Parma - Italy)
- 11:10-11:15: *Discussion*
- 11:15-11:25: **Presentation of EMA (European Medical Education)**
Vincenzo Costigliola (Brussels - Belgium)
- 11:25-11:30: *Discussion*
- 12:00-14:00: Lunch
- 14:00: Departure / Tour through Lille

My payment is made by:

Cheque included made out payable to the Institut Catholique de Lille.

Bank Transfer in Euro to the account number:

CHEQUES POSTAUX LILLE

3 et 5 rue Paul Duez

FR 43 20041 01005 0226899Z026 82

A copy of the bank transfer request must be sent by regular mail, in order to identify your payment.

Credit card Visa American Express

number _____ expiry date ____

Date:

Signature:

Cancellation: 30% refund before July 31, 2002; no refund after July 31, 2002

Registration Form to be sent to the Conference Secretariat.
Please make sure to keep a copy of this Registration Form.

CALL FOR ABSTRACTS

Free communications

Poster session

Abstracts will cover the topics of the conference.

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:

MAY 31, 2002

Abstracts may be faxed, but should always be followed by a hard copy submitted by regular mail.
Additional abstract forms are available at the local secretariat.

Speakers will be notified by June 20, 2002 at the latest.

Invited speakers are also requested to provide an abstract of their presentation in the same form and by the same deadline. It is hoped that invited speakers will also, after the meeting, be willing to provide a text of their presentation in a form suitable for publication in the AMSE Newsletter.

Mailing address for abstracts:

Conference Secretariat

Prof. Dr. Colette Creusy
Olivier Bodart
Faculté Libre de Médecine
56 rue du Port
59046 LILLE CEDEX
FRANCE

Tel: 33-3-20-13-41-81

Fax: 33-3-20-13-41-31

e-mail: olivier.bodart@flm.fupl.asso.fr



ABSTRACT FORM

20 to 30 lines in "Times New Roman" point 10

Name of author(s):

Name of the presenting author:

Institution:

Address:

Zip code: City:

Country:

Phone: Fax:

E-mail:

DEADLINE: MAY 31st 2002



ANNUAL CONFERENCE OF THE AMSE
5-7 September 2002

To be returned before
5 August 2002 to:

OFFICE DU TOURISME DE LILLE
Palais Rihour – Place Rihour – BP 205
59002 LILLE CEDEX - FRANCE

HOTEL RESERVATION FORM - One form per room reserved
(Please fill in this form in capital letters)

Name: First Name:

Full Mailing Address:

Town: Post code:

Country: E-Mail:

Phone: Fax:

Arrival on:/..... 2002 - Departure on: /... .. 2002 Nbr of nights:

Please reserve in my name one:

Single room Double room with 1 bed Double room with 2 beds

PRICES PER NIGHT, PER ROOM (ON SINGLE BASIS) DO NOT INCLUDE BREAKFAST, NOR EXTRAS, NOR TOURIST TAX (INDICATIVE PRICES)
CATEGORY CHOSEN AND NIGHTS REQUESTED (Please tick the boxes corresponding):

	from Wednesday 4 to Thursday 5 September	from Thursday 5 to Friday 6 September	from Friday 6 to Saturday 7 September	from Saturday 7 to Sunday 8 September
4 STARS	<input type="checkbox"/> 185 €	<input type="checkbox"/> 185 €	<input type="checkbox"/> 185 €	<input type="checkbox"/> 185 €
3 STARS	<input type="checkbox"/> from 124 to 136 €	<input type="checkbox"/> from 124 to 136 €	<input type="checkbox"/> from 124 to 136 €	<input type="checkbox"/> from 124 to 136 €
2 STARS	<input type="checkbox"/> 75 €	<input type="checkbox"/> 75 €	<input type="checkbox"/> 75 €	<input type="checkbox"/> 75 €

*The requests will be satisfied in order of their receipt and within the reservation possibilities.
The Lille Tourist Office takes the right to accommodate you outside Lille if the hotels located in the town center are full, or to book a room in a lower category (or higher category for 2 stars requests) if the category chosen is full.
After 5 August, we cannot guarantee accommodation requests. However, we will do the maximum if there are vacancies.*

TO BE EFFECTIVE, THE TOTAL RESERVATION MUST BE ACCOMPANIED BY THE FOLLOWING DEPOSIT, ACCORDING TO THE HOTEL CATEGORY SELECTED :

	<u>4 STARS</u>	<u>3 STARS</u>	<u>2 STARS</u>
DEPOSIT TO PAY :	<input type="checkbox"/> 1 Night: 185 Euros	<input type="checkbox"/> 1 Night: 130 Euros	<input type="checkbox"/> 1 Night: 75 Euros
	<input type="checkbox"/> 2 Nights: 222 Euros	<input type="checkbox"/> 2 Nights: 156 Euros	<input type="checkbox"/> 2 Nights: 90 Euros
	<input type="checkbox"/> 3 Nights & +: 266 Euros	<input type="checkbox"/> 3 Nights & +: 187 Euros	<input type="checkbox"/> 3 Nights & +: 108 Euros

THE HOTEL RESERVATION REQUESTS WITHOUT PAYMENT OF THE DEPOSIT WILL NOT BE PROCESSED.

The deposit will be deducted from the bill to be paid directly to the hotel at the end of your stay.

By cheque in Euros made payable to: Office du Tourisme de Lille By credit card (Visa or Mastercard only) **AMOUNT:** €

Expiration date:/...../.....
N°

Faxed hotel reservation forms will not be processed, except for payment by Visa or Mastercard.

In case of cancellation, the deposit will be refunded as following:

- Totally before 15 August 2002
- Up to 50 % between 16 and 25 August 2002
- No refund on and after 26 August 2002

DATE : **SIGNATURE :**

For information :
OFFICE DU TOURISME DE LILLE - Service Congrès
Phone : + 33.3.20.21.94.31 / Fax : + 33.3.20.21.94.20
E-mail : congres@lilletourism.com



APPLICATION FORM

First: () Renewal: ()

The Medical School / Medical Faculty / Medical Academy of the

University:

Address:

.....

.....

ZIP code: Town:

Country:

E-mail:

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

.....

applies for membership of AMSE for the year 2002.

The Membership Fee of US Dollars 200
(excluding bank charges)
will be paid to the Account of AMSE:

Account nr. 0521-05335-00 (AMSE)
Creditanstalt Bankverein Wien
Swift Code: CABVATWW
Bank Code: 11000

Address:
Schottengasse 6-8
A – 1010 WIEN
AUSTRIA

Signature: Date: