Provincia Autonoma
di Trento
Assessorato
alle Politiche per la salute

Ordine dei
Medici Chirurghi
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della Provincia di Trento

Scuola di Formazione
Specifica in Medicina
Generale
Trento

Azienda Provinciale per i
Servizi Sanitari

PROCEEDINGS

Conference

EDUCATIONAL TRAINING IN FAMILY MEDICINE (FM) IN THE DEVELOPING EUROPEAN CONTEST

The Trento's and Maastricht's school experience

Friday, October 10, 2008
Sala Conferenze
Agenzia delle Entrate
Via Brennero 133 - Trento

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Description

1. Introduction

The Motivation

This initiative focuses on the cultural and scientific exchange between two different, European teaching experiences, which however, have many things in common.

On the one hand the Trento School in General Practice, which after an initial period where it adopted the curricula, the methods and the teaching approaches typical of Northern European countries, has been recently developing its own training methodology and is now in a position to offer young GPs an "Italian way" to the development and promotion of their profession.

On the other, the Maastricht General Practice School, which is part of the University, and is universally recognized as the place of innovation in medical education and has the potential for focussing on the quality of its own teaching methods and for opening up to other experiences.

Organizing this event was useful in its own right, because it made it possible to assess the work so far carried out by the School faculty. Having such an extraordinary audience, like the Maastricht academics, was a reason for pride for the Trento School tutors and has contributed to their qualification as a skilful and united working team.

The Evolution

This initiative was organised in two complementary events: the first day, open to local and national professionals, managers, and tutors, was devoted to illustrating the evolution of the Trento School and knowing from the Dutch colleagues, but also to underlining the essence of GP training by means of an open debate moderated by authoritative discussants. The first day was very useful also to the initiators of this exchange as a first opportunity for a general reciprocal introduction.

The second day was devoted to the discussion of specific topics and was open to a limited number of participants, so as to promote an open discussion in the form of a true and proper group interview. This workshop resulted in the launch of joint initiatives in the areas of research, teaching and research into teaching and education.

The Results

The main short-term result was a greater visibility of the specific training courses in GP for all those who work in the area of primary care. Exchanges and comparisons are always useful to better understand the processes and changes underway.

The final tangible result has been this publication which includes all the reports presented and all the aspects discussed and tells about the specific features of the progress so far achieved.

The expected outcome is a closer and even more solid collaboration between our two institutions, useful for scientific production and training research, which is almost negligible in our country.
It will also be possible to set up a European network for tutors and trainees, including study periods abroad, with the aim of training a GP with European-wide competences.

2. The conference

Post-degree specific training in General Practice in Italy has been provided for more than ten years. However, curricula and teaching standards differ from region to region, as the courses are organized and managed by the relevant regional authorities. The forthcoming challenge for General Practice is to favour innovation and develop consistent and uniform curricula, able to take full account of the complexity of this training system.

The challenge ahead is to promote GP professionalism, using knowledge and competences which are well established in the theoretical corpus of General Practice, but also using innovative and informal forms of knowledge, which are implicitly present in the attitudes and decisions of Italian GPs.

At the beginning of this process, the Italian specific training system looked at Europe to learn and draw inspiration from the experiences of those countries, where specific training in General Practice has a long and traditional history. More recently Italian GP tutors have developed their own programmes, finding an "Italian way" to specific training in family medicine.

This conference was a great opportunity, offered to all those who are interested in developing and organizing primary care, to know and discuss interesting experiences from the Netherland, Florence and Trento. This event was also the first tangible demonstration of active collaboration between Italian and European institutes with a view to improving GP education and training a full-fledged professional with international competences.

EDUCATIONAL TRAINING IN FAMILY MEDICINE (FM) IN THE DEVELOPING EUROPEAN CONTEST

THE TRENTO'S AND MAASTRICHT'S SCHOOL EXPERIENCE

Program of the conference:

08:30 : participants registration

09:10 : First session

Chairman: dr. Romano Paduano

- Building up an European network for quality care in Family Medicine (dr. Giorgio Visentin)
- The Maastricht experience: facts, results and considerations (dr. Bas Maiburg, dr. Paul Ram)

Discussion

11:00 :second session :chairman (dr. Luciano Vettore):

- The evolution of FM (Family Medicine) educational training at Trento's School: from consultation to the "Family of Caregivers". (Giuseppe Parisi)
- The evolution of Gp/FM's educational training at Trento's school: From practice to theory. (dr. Fabrizio Valcanover)

Discussion

13:00 lunch

14:00 third session :chairman (dr. Maria Pia Perlot):

- The Tuscanian GP/ FM's educational training experience (dr. Emanuele Messina, Alessandro Bussotti, Stefano Giovannoni)
- The Italian reality of "Signorie" : fragmentations and shared projects in FM (dr. Paolo Colorio).
- The future European GP/FM .networks and pathways (dr. Ingrid V. der Heijden, dr. David Fasoletti)

Discussion

16:00 fourth session: chairman: (dr. Amelia Marzano):

- The patient in the training setting: the "relational laboratory", "simulated patient" and "cultural laboratory" (dr. Norma Sartori)
- The Dutch GP/FM tutors' trainingship (dr. Gerard Benthem)

Discussion

Closing session and filling of evaluation questionnaires

Scientific Committee

Rino Fasol	Dipartimento di Sociologia e Ricerca Sociale. Università di Trento
Silvia Gherardi	Dipartimento di Sociologia e Ricerca Sociale. Università di Trento
Pasquale Laurino	*Coordinatore attività d'aula scuola di medicina generale di Trento*
Gianni Martini	Esperto in politiche sanitarie
Ugo Morelli	Università di Venezia
Claudia Pancino	Dipartimento di Storia. Università di Bologna
Massimo Tombesi	Medicina Generale Macerata

Speakers and discussants

Gerard Benthem	*Coordinator trainers curriculum GP vocational training Institute University Maastricht*
Alessandro Bussotti	Coordinatore attività teoriche Formazione Specifica in Medicina Generale Regione Toscana
Paolo Colorio	*Vice Direttore scuola di medicina generale di Trento*
David Fasoletti	*Coordinatore Gruppo Giotto Italia e Vasco de Gama Group*
Stefano Giovannoni	Coordinatore attività teoriche Formazione Specifica in Medicina Generale Regione Toscana
Bas Maiburg	Education coordinator GP vocational training Institute University Maastricht, coordinator trainees' curriculum
Amelia. Marzano	Responsabile Ufficio Aggiornamento Azienda Sanitaria Trento
Emanuele Messina	Direttore Formazione Specifica in Medicina Generale Regione Toscana
Romano Paduano	Professore a contratto di medicina generale Università di Udine
Giuseppe Parisi	*Responsabile qualità formativa scuola di medicina generale di Trento*
Maria Pia Perlot	Coordinatore tutor scuola di medicina generale di Trento
Paul Ram	Director GP vocational training Institute University Maastricht
Norma Sartori	*Coordinatore laboratorio relazione e comunicazione Scuola di medicina generale di Trento*
Fabrizio Valcanover	*Direttore scuola di medicina generale di Trento*
Ingrid van der Heijden	*Staff member International Competences GP vocational training Institute University Maastricht*
Luciano Vettore	Past president and Consigliere emerito della Società italiana di Pedagogia medica (SIPeM)
Giorgio Visentin	Copresidente Wonca Italia

3. Saturday

Workshop open to 20 selected persons. Consecutive translation.

PROGRAMME

9.00 to 13.00 presentation of Trento School and discussion

Issues

Integration of art and humanities in the curriculum of Trento's School
The comedy (setting up, past, present and future)
To act a comedy was a learning experience and an opportunity to the learners group
The didactic purpose of film projections (methods: for clinical method or for stimulating the sensibility, affectivity and the perception of the others as human being) - the Venetian experience -
Artistic pathways: the "Mart" experience
Leonardo Spina "Clown in Kabul"
The "creative writing" laboratory

Focusing on complex and interrelated educational aspects
Simulated patient as an example for holistic approach and as a resource for relational models.
Seminar on: "Theory and Methods of general practice"

Lights and shadows
Critical points on introducing humanities: experiences and considerations
Elements in medical sociology
Elements in medical antropology

Lunch and visit of the school

Promotional Committee: Provincia Autonoma di Trento Department of Health Policy Quality in Healthcare Service Office of Education and Human Resources Tel 0461 494105 Formazionesanita@provincia.tn.it	**Organizational Committee** Scuola di Formazione Specifica in Medicina Generale Tel 0461 492431 segreteria@scuolamgtn.it

Organizing committee
Fabrizio Valcanover, Giuseppe Parisi, Paolo Colorio, Andrea Moser, David Fasoletti, Mauro Bertoluzza, Norma Sartori, Monica Bonenti, Pasquale Laurino
School of general practice- Trento

Proceedings

1. A European Network for Health Care Quality in General Practice

Giorgio Visentin

In my presentation I am not going to report literature data, but rather I will speak about General Practice Organizations. I will present some facts, but also my personal impressions on the positive and negative aspects of these organizations, with a view to demonstrating how work and know-how networks can be built.
This event is an example of good networking practices: the Trento School started its networking activity first by establishing contacts with the Veneto schools. At a later point in time this collaboration was extended to Tuscany and Lazio, while now an international network with the Maastricht University is being proposed. The real objective of this effort is to have a continuous exchange of experiences and opinions to promote and spread knowledge and culture in the area of general practice. This is a remarkable effort, because sometimes in Italy, but also in other countries in Europe, local egotism prevents this fruitful exchange.
I would like to describe existing general practice networks, starting from the most well-known and most extended:

WONCA
WONCA was set up in 1972 and it currently includes 120 states, covering up to 80% of the world population. It was set up as a scientific society and is well represented in each country. National colleges and academies are assessed based on their quality and not on their representativeness. For example, also the representatives of Trinidad and Tobago (where the number of colleges is small) have had the opportunity to illustrate their successful experience in the fight against smoking, where famous athletes were recruited for the campaign, with a strong impact on the public. Results have been substantial and the initiative implemented in Trinidad and Tobago is now an example for the whole world.
There are some negative aspects regarding WONCA. First, representation is not complete: some Asian countries and most African countries are not included, while small countries like the Netherlands are very much represented. Other states, like Italy, are included in the network, although its representatives do not have a clear mandate from the relevant national institutions.
Second, WONCA, being very large, organizes huge conferences with even 4000 participants, which look like big fairs and which are not very interesting from the scientific viewpoint.

Third, its philosophy is not clear. Within WONCA you can hear different and even opposing opinions and in some areas a certain degree of independence has been eroded.

WONCA EUROPE

WONCA Europe is one of the most successful branches of WONCA. It is a network that produces knowledge and which, thanks not only to EURACT, coined the "Definition of General Practice", a precondition for defining family medicine as an autonomous discipline.

Its lobbying capacity is not always well expressed within WONCA and this turns into little influence and little communication both within WONCA itself and politically with the European Union.

EURACT

EURACT is one of the three satellite networks of WONCA Europe. It is a well-functioning network of trainers who contributed to the development of General Practice. It is the working group which has produced more results in terms of education and training, although it is running the risk of declining as it focuses too much on the internal problems of schools.

A greater attention to the profession would be advisable, as general practitioners work mainly with patients and not only with students.

EGPRN

This is a well-balanced organization made by General Practice academics. The objective is the enhancement end evaluation of research in general practice. This is perhaps the liveliest network within WONCA, although it tends to be too self-focussed and seems not to be able to develop high-level multi-centre trials. A closer co-operation with training networks would be advisable.

EQUIP

This organization has carried out valuable works on quality assessment methods in General Practice, but some of its instruments have gone into commercial channels that cannot guarantee a general access to culture.

HEELSUM COLLABORATION

This is a working group supported by dairy farms, aimed at producing works and publications on diets. It drafted important guidelines, but it was seen that sources cannot always be transferred into General Practice, and in the end the main focus was on communication and the question of social impacts. New lines of research were thus opened and it was demonstrated that also small informal networks can produce major results.

WONCAITALIA

As far as Italy is concerned, it is worth recalling that the first time that the whole WONCA community was brought to Italy was on the occasion of the Florence Conference in 2006. This was a historical event for two reasons: it was the starting point of other networks in our country and of the students' working group on General Practice. The scientific committee of the conference decided to set up WONCAITALIA, which includes scientific societies like ASSIMEFAC AIMEF and CSeRMEG, paediatricians and "Gruppo Giotto".

The aim of this organization is to build networks of specific training and develop new methodological proposals, like for example "position papers" to separate General Practice both from the influence of the market and from influences deriving from other professional specialities.

In March 2009 a conference on information and management continuity from paediatric patients to adult patients will be held.

EUROPEAN FORUM

This is a group formed not only by general practitioners, but also by nurses and other primary care professionals. It carries out lobbying activities at the level of the European Commission for the independence and strengthening of primary care. This group launched an initiative called "15 by 2015" to support horizontal, instead of vertical programmes in primary care.

VASCO DE GAMA

This is a group of young doctors set up on the occasion of the European Conference in Amsterdam in 2004. Its aim is to organize exchange forums and come up with new ideas. It was included in the key notes session at the Paris conference.

GIOTTO

This is a cultural movement formed by and targeted to general practitioners at the beginning of their training and professional career, that is from the first day they register with the Specific Training Course on General Practice up to the fifth year, after obtaining the licence for General Practice (Primary Care).

General Practitioners are invited as senior trainers to hold courses. They also ensure continuous contacts with the schools of General Practice. GIOTTO's mission is to facilitate discussion and exchanges between young Italian physicians, so as to create a sort of "common awareness" of the cultural and scientific contents which are specific to General Practice.

Common topics of discussion are the following: the specific competences of General Practice, the organization of community-based work, the training needs of general practitioners, research in the field of General Practice.

A further objective of this organization is to facilitate exchanges and comparisons with other GP experiences in Europe. In this case the main partner is the Vasco da

Gama Movement. The GIOTTO movement has no political, economic or trade union objectives.

Now, after introducing all the official organizations in the area of General Practice, I would like to mention a working group of WONCAITALIA, whose objective is to propose a multi-centre research protocol. If General Practice wants to produce new knowledge, it needs to draft its own research protocols and use the call-for-funding method (both public and private).

In conclusion:

- General Practice has managed to define itself and build its speciality.
- There are still many grey or black areas of knowledge, where we depend on the knowledge provided by Disease Oriented Evidence.
- It is time to build new networks, with the aim of producing more knowledge.
- Italian training schools and European specialization schools are the ideal starting point for the production of new knowledge (shared theses between different schools, multi-centre research works, etc.)

2. The Maastricht experience: facts, results and considerations

Bas Maiburg, Paul Ram

Thank you for your introduction and for your kind invitation. We are happy to be here and we are enthusiastic about exchanging ideas and experiences on GP-training with you.
Bas Maiburg and I would like to share the Dutch reality with you. I will start with some general information on the Dutch situation then Bas will take over. He will outline the GP-trainees' competency profile, working towards the GP-trainees' curriculum.
After our presentation there is plenty of time scheduled to discuss the content of our presentation and to share ideas on these subjects. Please feel free to interrupt and clarify any questions you have during our presentation.
We come from Maastricht, capital of the most southern Province of the Netherlands.
The Netherlands is a monarchy. It has a population of 16 million and the country has one of the most urbanised populations in Europe. The most striking demographic feature in the Netherlands- similar to the demographic changes in Italy-, is the increasing proportion of elderly people in the population.
The share of people aged 65 years and over is expected to grow to an estimated 23% in the next two decades.
The life-expectancy in the Netherlands is nearly 80 years. This is at the European average for men and slightly under the average for women.
Italy has a better score and has one additional year of life expectancy.
People in Italy as well as the Netherlands can expect to be healthy for about 90% of their lives.
The self-reported health of Italians however is second lowest in Europe with only 56% of Italians perceiving their health status as good or very good, compared to over 77% of Dutch.
The top 3 of disabling conditions in the Netherlands is similar to that of Italy. Neuropsychiatric conditions account for approximately 25%, Cardiovascular diseases and Malignant neoplasms each account for nearly 18%.
One striking difference in the mortality ranking of both countries is the 7 times higher proportion of deaths due to unintentional injury in Italy, mainly caused by motor vehicle accidents and falls.
The Netherlands has comparable to Italy a total of nearly 400 physicians per 100.000 inhabitants. The number of family doctors per 100.000 inhabitants in the Nether-

lands is however nearly half that of Italy: only 51 per 100.000 compared to 93 per 100.000 inhabitants in Italy.
It is interesting that in contrast to that the Netherlands have a ratio of nurses to doctors that is doubled compared to Italy (4 nurses to every doctor compared to 2 nurses to every doctor in Italy)
The Netherlands has a dual-level healthcare system. All primary and curative care is financed from private compulsory insurance.
Long term care for the elderly, the dying, the long term mentally ill etc. is covered by social insurance funded from taxes.
The health care system in the Netherlands was 60% government funded and 40% privately funded.
Every adult in the Netherlands is obliged to choose a private insurance scheme.
Also everyone is supposed to enroll with one family doctor (FD) who acts as a gate-keeper for specialist and inpatient care. FDs have an average of 2350 patients on their list. Patients are free to change to the list of another family doctor, but in reality the majority of patients remain with the same family doctor for life, thus building up a long term relationship of trust.
Family doctors receive a capitation fee for each patient on their list as well as a fee for service.
Looking at the organisation of healthcare and family medicine in the Netherlands it is fair to state that Family Medicine has a strong position within the primary care setting as well as within the health care system as a whole. It provides continuous care 24 hours a day 7 days a week, with direct access to family doctors.
Family medicine in the Netherlands is shaped according to the WONCA Europe Definition of Family Medicine.
Family doctors treat most medical problems, the referral rate is low: approximately 4%.
The total expenditure on healthcare in the Netherlands is roughly 9 % of GDP (gross domestic product), which is similar to the spending in Italy.
If we focus on the workforce of family doctors in the Netherlands we see a changing trend: there is an increasing percentage of family doctors that are working part-time and in group practices.
Currently the percentage of licensed female family doctors is 34%, but the percentage of females in training to become family doctor is approaching 70%. This also brings along new challenges in logistic organisation of the FD vocational training as most female trainees are in the childbearing ages and will take maternity leave during the vocational training program.
Before a trainee can apply for a position at the vocational training institute he has to have his Medical Degree.
The basic medical education generally starts after secondary school at the age of 18 at the university medical department. A four year period of acquisition of knowledge and skills is followed by 2 years of clerkships, where medical students gain

their basic medical experience in teaching hospitals and (for 8 weeks) in general practice.
When they graduate after 6 years of successful training they are ready for specialisation. At that moment they are not yet allowed to fulfil tasks autonomously in specialised areas. Graduation hallmarks the start of their postgraduate training. They can choose between 23 specialties. Postgraduate training for general practice is provided by the 8 FD vocational training departments and takes 3 years.
To be able to understand the organization of FD vocational training in the Netherlands I will explain the role and position of the parties involved.
The Ministry of Health spends 100 million euro to ensure FD vocational training. The money is forwarded to a foundation called SBOH. The SBOH employs approximately 1.500 FD trainees and has signed agreements with 1.800 FD trainers.
A FD trainee costs 5.500,- euro a month, approximately 3.400,- euro salary en 2.100,- euro towards education.
There is a separate body that ensures conformation to national regulations and legislation.
FD vocational training is provided through 8 academic departments united in a national association called "Huisartsopleiding Nederland".
The Dutch College of General Practitioners-the national scientific organization- and the national association of FDs both contribute significantly to the professionalization of general practice.
Since 1989, the Dutch College has been developing *Practice Guidelines*. Each Practice Guideline - for a specific complaint or diagnosis - reflects the 'state of the art' in medical science. Over eighty Practice Guidelines have now been issued and these are continuously updated. The Dutch College and National Association are both guiding in setting up the future perspective of family medicine in the Netherlands.
The trainees' union and the FD trainers' union guard the specific interests of their members.
IN 2003 was settled the Curriculum Reform project, in which the 8 department for F.D. training worked closely together towards several common goals.
The catchphrase at that moment was: '**one** training on **8** places'.
As you could say, or see, there appeared to be a rather favourable 'stellar conjunction' at that time:
Together with the Dutch Scientific College, the National Association of family doctors published an important report called the 'Future perspective of the family doctor': a comprehensive and practical description of the characteristics of family practice.
But there was more: from didactical space the CanMeds classification just had emerged, a society based and detailed document pertaining to the roles of physicians during their work; and next, teachers start to incorporate the CanMeds rolls into competency-based curricula, the new belief in education.

And last but not least: educational legislators were willing to endorse those developments for the sake of uniformity!
As you can imagine, these events produced a kind of 'Big Bang' in the cosmos of Dutch vocational training. Right from the epicentre something like the 'two tables' raised: the competency profile (CP) for the family doctor and the core curriculum (CC) for vocational training.
Two important frameworks for education and assessment of trainees, both in practice and at the training institute. The frameworks were not only developed, but also firmly implemented into Dutch curricula.

I will now present these Dutch concepts to you in an Italian style, using as suggestion Piazza del Campo (Siena).
First: the CP. It depicts the work of the family doctor in terms of goals to be mastered, these goals being formulated as competencies.
I will show that the Piazza del Campo is not only very suitable to take pictures or to parade along the terraces, but also - I suppose rather unexpectedly – extremely fit to explain the composition of the CP. As you will see this is due to its great construction.
Piazza as well as profile are composed of several corresponding elements.
Zooming in you see the basic elements, the building blocks of the Piazza. In the CP small parts of knowledge, separate skills or attitudes constitute the building blocks.
We formulated and compiled these 'building blocks' into a booklet called 'final requirements for family doctor training': it has become a comprehensive list of knowledge-items and skills, merely to be used as a tick off list.
[Mind you, the knowledge-items, skills and attitudes in this booklet are drawn up at the level of facts (like book knowledge)].
We now gradually zoom out, to see the relationship or connection between this separate parts.
First, you will discover certain patterns or designs; building blocks that are put in rows (or other formats).
This corresponds with the expectation we have from trainees regarding knowledge, skills and attitudes: that is, to apply these elements in an integrated way during their work in daily practice. So, we now evolved to the practice level. In case, this is the level we refer to when we use the term 'competency'.
That means that the list of competencies in the CP profile has not the character of a tick off list, but that it refers to the ability to cope with all kinds of complaints in a continuous, sustained and up-to-date manner.
The next step we decided to, was to put the competencies in a greater framework in order to survey the entity of family practice.
Competencies were arranged into domains, these domains being diverted from the CanMeds roles. Each domain encompasses at about 3 competencies, 22 competencies in total. As you will understand, the medical expertise domain has a central position with the doctor-patient communication domain closely related to it.

Again, like a parade along the piazza, the trainee uses competencies from different domains during each patient visit. Rather evidently, when you look at the first two domains.
The piazza also clearly depicts, that all domains point to the centre or, as you wish, to one "outcome": that is the family doctor.
Furthermore, they all meet in the centre; in other words: all domains (and competencies) are in a way interrelated.
An example of a competency from the medical expertise domain: "considers physical, psychological, social, cultural and ideological backgrounds of the patient, the stage of life and medical history in interpreting symptom".
In the CP a specification is added to the competency and a reference to the matching knowledge and skills items (and that makes the circle round).
The second concept I'll like to present to you is the core curriculum (CC). It represents the national global curriculum, and is conceived by the 8 heads of the vocational training departments.
Where the CP describes and prescribes **what** to learn and teach during family doctor vocational training, the CC indicates **how** the profession is learned and taught.
Like Da Vinci's sketches, it is a sketch or blueprint for the local curricula which had to be reformed.
In the meantime, the CC has been spread over the country and nation wide implemented. It outlines 3 years of vocational training and has become known as the sandwich, or in good Italian, "the tramezzini model". I will come back on this name at the end.
The 3 years of education are projected on the Vitruvian man, and may be considered as different, though coherent parts of the curriculum.
Before entering the first year, the trainee has to pass an interview of about one hour with a committee, consisting of faculty, trainees and trainers of our department. Especially, the committee takes into account elements regarding to the motivation for and prior familiarisation with family medicine.
So, we don't use knowledge or in practice tests for selection of applicants.
After being selected, trainees participate in meeting-rounds, a so-called 'carosello', with a group of trainees and available family doctor trainers. Based on mutual preferences we try to provide a match between trainees and trainers as good as possible.
Trainees then spend the first year of training in a family practice. One-to-one refers to the trainer-trainee situation: one trainee and one family doctor trainer per practice.
As you can see, there is an average of a weekly training day at our school.
Besides working in small groups, trainees also receive individual guidance by a mentor.
The curriculum starts with an introductory period of one month, in which trainees spend half of the week at our institute. During the first year, the content of learning

(in the medical expertise domain) ranges from 'sore throat' to 'unexplained fatigue'. In addition, the courses on management and EBM begin during the first year (the management and science domains from the CP!)
In this phase of education the trainee readily seeks for advice of his or her trainer.
The second year of vocational training builds on the first year base: during this year in the clinical setting, trainees now are able to look at their clinical apprenticeship from a more or less family doctor point of view. The curriculum this year balances between supporting the work at the clinical departments and developing further family doctor knowledge and skills.
The minimal clinical period during vocational training amounts to 6 months, according to European legislation. In the Netherlands, trainees have to spend this time at the emergency department.
In order to be well equipped as a trainee for this apprenticeship, a two weeks introductory class is organized on a national scale.
Thereafter, training days at the institute are scheduled in a lowered frequency.
The trainee becomes part of the ER team, works in a roster and gradually becomes acquainted with all kinds of acute events at the ER department. Main goal: becoming well prepared for emergencies in family practice which happen to present rather occasionally.
Next, a 3 months apprenticeship pertaining to mental and psychological disorders takes places. Trainees are placed at psychiatric departments as well as at first line centres for psychological care, depending on their pre-existing experience and individual learning objectives.
In a minority of cases the whole apprenticeship can replaced by an elective, designed again according to trainee's experience and objectives.
The second year is concluded by a 3 months 'care apprenticeship'. The trainee works at a clinic or nursing home where care is the central concept, not cure.
A favourite elective is a 6-weeks elective in palliative care, taking place at a hospice in the United Kingdom. However, trainees only may replace either one of the two 3 months apprenticeships.
The third year is meant to make the training for family doctor complete, to become a professional. This can be illustrated by the head of the Vitruvian man, the seat of mind and reflection.
The third year is again a year in family practice as a workplace. And this explains the use of the name 'Tramezzini' model for the total education programme: clinical training is, like a sandwich filling, put between two slices of family practice training (year 1 and 3).
On first sight, the third year resembles the first year. A closer look reveals some important differences:

- no **patient** is seen in the consultation room as the trainee increases pace and efficiency
- The trainee also works more independently from the family doctor trainer

- And, the weekly training days focus on programmes with a higher level of difficulty.

However, the balance between practice and institute remains while making the link between both work- and learning places more solid: trainees receive more assignments to carry out in practice, and bring more practice related cases and questions to the training days.
Medical content of the curriculum reflects the increasing number of patients with chronic diseases and multimorbidity. During this course diabetes mellitus and palliative care in family practice are used as examples and are totally worked out.
Beside this, we notice that professional development requires individual and group reflection (on daily practice).
And, in practice, the trainee now fully acts within a team with family doctors, nurses, secretaries, dieticians, physiotherapists etc.
When trainees have a well-founded plan, a second elective is possible during this year of education: plans vary from ICT-training to training in psychological consultation.
We can summarize the four basic elements of our vocational training programme, that offers:

- An integration of working and learning during the whole course: the trainee works in practice and attends vocational training days throughout the 3 year education
- A level of difficulty that increases with the years of education: from children with 'sore throat' to the elderly with multimorbidity
- Worked out courses that extend over the 3 years (for instance we have got courses in: doctor-patient communication, management and EBM)
- Topics that recur in the curriculum in a varying, though sustained way: a so-called spiral curriculum

And what makes Maastricht even more special?
Without doubt, our drive to tailor individual trainee programmes. Not two trainees are alike, in prior experience, knowledge or attitude.
So, whenever possible or wanted, we not only try to model the training programme per trainee, but also to introduce assessments on a personal scale.
Dr. Paul Ram will now guide you through the assessment protocol.
I will show you **our assessment program** over the three years. Let's start with the first year, fully spent in general practice.
After 3 months both the family doctor and the member of staff, i.e the tutor, discuss the progress with the FD trainee, purely focussed on educational aims.
After 6 months the FD trainee will be advised by his or her trainer and tutor how to continue, taking into account specific learning goals, resulting in a high stake decision three month later. The head of the department takes this decision, based on the advices of the trainer and the tutor / member of staff: is FD trainee allowed to continue the training program in the second year and, if so, under specific conditions or not..?

The Combel, we called it the “competency based assessment list”, is used to support the decision.
How does the overall assessment protocol look like?
Four times a year, so once within the three month’s, both the trainer and the tutor discuss the progress of the trainee with the trainee. Is everything going all-right, is he or she on schedule? If not, why and how to improve this?
The last session in each year however is summative. The decision has to be made about the permission to continue the vocational training program.
That decision will be based first of all on the advices of the trainer and the tutor, described in the Combel, secondly on the results of the knowledge-tests. The results of the video-observation will be taken into account as well.
Skills tests in a skills LAB and in daily practice can be used in addition.
So, what kind of decisions should be made by the head of the department?
“GO”: that means stay with us after year one you’re welcome in the next year, Go at the end of year two = stay with us in year three and at the end of year three: yes, you have finished the whole program successfully, GO and go ahead, be a good Family Doctor and stay a good FD by continuing professional development (CPD)!
“Go under conditions”, that might be an extra knowledge-test, an oral focussed on clinical reasoning, a search or a small quality improvement project on practice level, resulting in a “GO” or “NO GO” decision.
“NO GO” that means: “Stop, you better look for an other job, it’s insufficient over the whole line...”
So, to conclude: we try to change a culture from “painful to assess” to “proud to be assessed”: it’s great to show the people that you’re a good or even very good FD.
Thank you very much for your attention.

3. The Evolution of the Trento School Curriculum: From Consultation to the "care network"

Giuseppe Parisi

In this presentation I will describe three different approaches to training that have been developed during almost two decades of activity by the Trento School.
I would like to show that organizing the training course and the actual teaching activity have been for all of us a continuous stimulus and not a sterile crystallization of pre-determined stances.
We have always seen the curriculum as a continuous and evolving process and not as a pre-established and untouchable marble mausoleum. This flexibility and this openness to dialogue are demonstrated by the very fact that we are here to meet our Dutch colleagues, who are moved by our same wish to learn and compare new ideas with an open mind.
The first step in the philosophical approach to training started from the need and determination to look for specific theoretical models. Such models needed to be useful to trainees when learning *"how to act effectively"* in the specific setting of primary care. We then gradually moved to paying particular attention to a teaching method which could be useful to trainees to learn *"how to give sense to action"* . We will now look at the evolution of the Trento School curriculum.
At the beginning Dr Valcanover and I used a simple model to identify the "set of beliefs" which are at the basis of the "actions" of the general practitioner. We assumed that this "set of beliefs" do not include only clinical knowledge that is scarcely correlated to psycho-social, anthropological and organizational knowledge, but rather it is made of three areas, which are interrelated, equally present and important (clinical, anthropological and organizational areas).
While the importance of the anthropological area in the GP's action was already described in the '50s by Balint and later by the current of social psychology, the importance of the organizational area was less recognized.
It was therefore an innovation at the theoretical level to state that GPs actions, i.e. their human and psychological skills, their scientific competencies, their ability to treat and cure people, that all these are abilities are closely connected with the network organization that GPs have been able to set up, interacting with the culture of their patients, with the individual needs of each patient and at the same time influenced by the culture of the national health service.
While the three areas are equally present, non clinical subjects should be taught with the same intensity and to the same extent as clinical subjects.

The program of relational and methodological skills at the Trento School was increased from the 70 hours offered during the course before 2000 to the current 90 hours of communication workshop, together with 60 hours of simulation sessions, 72 hours of theory and General Practice methods, for a total schedule of 220 hours. A seminar of 54 hours on medical sociology was also introduced.

At a later stage, the need was felt to establish the rules and the geography of the general practitioner activity: General Practice has been compared to a picture by Arcimboldo, a human face in its entirety, but with a different texture in each different part. We can teach every single part of the subject, but this does not necessarily mean that we are thus able to teach the harmonious whole, which makes the subject what it actually is. The real challenge is to be able to teach trainees to become general practitioners. What turns a health professional into a general practitioner is not the mere knowledge in a clinical area, though connected with psycho-social and organizational skills, but the actual *habit in practice*, the *style* adopted in a difficult professional setting, the harmonious combination of different knowledge in different subjects. To quote Bateson, what interests us is "the connection structure".
We focussed on how to teach these special skills by establishing some specific goals. For example, our interest was not so much in training a professional able to treat pneumonia, but rather in training a general practitioner able to treat at home an elderly patient with an airway infection, with the help of the family and other community health professionals. Greater attention was attached to learning contributive goals, rather than learning the main goals.
Also the denomination of seminars has changed over time: for example the title "seminar on oncology or internal medicine" was replaced by the title: seminar on patients with headache, dysuria, haematuria, etc.

We then made other steps forwards and decided to face a basic issue of health-care today: currently, the heath activity rests on an incredible combination of two opposing factors: on the one hand the complexity of the approach to patients, and on the other, an increasing specialization. We are therefore faced with the need to give sense to the treatment of a specific patient. This means to address different and complex issues, for which there is no technical solution, and which are resolved when the natural history of the disease can be modified.
On the other hand, what is needed is the detailed knowledge of the specialist, which however does not reach the necessary depth in order to be helpful when making a decision for the single patient. To learn how to give sense to consultation, or simply to think while acting or making a critical assessment of one's own actions: these are methodological skills that become as crucial as biomedical knowledge itself.
What is the most appropriate training for a professional that wants to combine specific technical skills and an open approach to primary questions, those relating to the life and death of people? What is the most appropriate training for a profes-

sional who is to combine the manual dexterity of a craftsman with the wisdom of a philosopher, a mentor and at the same time a technical expert. What is the most appropriate training for a professional able *to give sense to action*?
To answer these questions we have laid the emphasis on methods of cultural change, and set up seminars and ad-hoc workshops: the cultural workshop, simulated patient sessions, the seminar on theory and practice and complementary seminars for trainers.

The second line of evolution in training and education starts from the awareness that the specificity of General Practice in the community includes a set of general skills expected from professionals who work in this context with a view to creating *community-based professionalism*.
At the beginning, we focussed on the specificities of our profession, and we then gradually recognized professionals who are closer to the community, those who actually work in the community.
The phrase "outpatient care" has been used since the '80s in the jargon of health-care professionals, health experts and law-makers to define the outpatient, front-line care provided to people, based on a clear distinction (which has become clearer and clearer over the years) between hospital-care and primary care.
In the past few years new outpatient facilities have been set up, which are more in line with primary care principles rather than with acute medicine principles, as for example nursing homes, hospices, country hospitals, long-term care facilities, and all those intermediate institutes which obviously can not provide diagnostic and treatment services comparable with those in a hospital. They too can be included in the phrase "outpatient care". This does not identify only a type of ambulatory care or community care, or home visits. Outpatient care can also mean a practice in a situation which somehow questions or shows the limitations of hospital care and its organization.
It is believed that a health-care professional (a community-care nurse, a care provider, a general practitioner, a physician in a nursing home working out of a hospital) should have both core skills and general skills: they should be able to take decisions in uncertain situations; they should be able to plan and develop an action, identify constraints and opportunities; they should be able to carry out appropriate consultations and finally have an ecological approach to problems, based on the ability to make a thorough analysis of the context. What is also necessary is intuition, the so-called clinical eye. These are skills which make medicine a bit like an artistic activity.
Community-care professionals should be clear about the distinction between contingency and determinism. The consequences of their actions are not only determined by chance; community-care professionals can have an impact by modulating and sometimes even drastically changing the natural history of a disease, but they should be aware that the final outcome and the contingent obstacles can not be foreseen

on paper. This unpredictability should help community-care professionals regain a sense of their own limitations, that has often been lost over the past few years.
While in-patients are sort of *captive*, patients at home have completely different characteristics: the vast medical literature, plenty of articles on demanding patients and consumers should be considered by community-care professionals as a basis to effectively manage relations with patients.

The third line of evolution is related to the increasingly urgent need to manage the patient together with other professional in an integrated way, implementing synergistic actions in the framework of a *network of carers.*
The problem has therefore been raised as to how to include in the curriculum new didactical targets, in order to teach team-work skills and the ability to provide shared care together with other health professionals.

In conclusion, the outcome of the work made in the past few years and of the cultural commitment of the Trento School is based on a very precise idea of the medical doctor that we want to train: a professional who is aware of his/her specificities and able to give sense to action; a professional who is aware of belonging to the local professional community, able to use the general competencies of the community and to work as a team to provide integrated care.

4. The Trento School: from practice to theory

Fabrizio Valcanover

Good morning and welcome. My presentation follows the reports by our colleagues from Maastricht, from whom we have a lot to learn. Their collaboration will be useful in many aspects, starting from what was mentioned by Prof. Vettore, i.e. assessment. This is a difficult and delicate aspect. Italian general practitioners find it very hard to assess a colleague; it is not in their culture, in their tradition.
For some years now, we have been working on this aspect here in Trento, trying not to limit ourselves to an "objective" test-based assessment.
Currently, the two main assessment criteria used are the final thesis, which is an original product developed by the colleague, and the assessment carried out by the Trainer GP.
I would like to clarify that even though the Trento School is a small entity as compared to others in Italy, a class of 15-20 trainees in Trento is the same as those in Rome, Milan, Palermo, etc.. From this viewpoint teaching is reproducible and comparable.

The title of my presentation "From theory to practice" can seem provocative; in fact it occurred to me looking back at the progress the Trento School has made over the past eight years, taking advantage of the theoretical contributions to training, not only in the medical area. This is in line with the current debate on functionalism, as opposed to constructivism. Other contributions were taken from neurosciences, with the recent findings on the importance of emotions, affections and perception in the learning process.
As Giuseppe O. Longo of the Department of http://www.units.it/Electro-Technique and IT Electronics of the University of Trieste said, the assumed superiority of theory over practice is, in our culture, a "Platonic prejudice": a five-year-old child speaks in a way that it is very clear that he/she more or less knows how to use grammar and syntax, but then they go to primary school and – I tell you – they start to forget grammar and syntax.
In my presentation I will make reference to known experiences and authors. I will speak about our practice, showing that in our work we put together various teaching experiences made by colleagues who worked with us in this project. We saw that these were based on theoretical contributions to training and education coming not only from learning and teaching methodologies peculiar to medicine, but also from organization, corporate and classical fields.

What I would like to point out is that our work has always been focussed on the final user, that is the person, not only as the object of our work, but also because without persons, without patients, our profession would not exist.
I think that today's meeting can or should be of interest also for the public at large, who should be interested to know how prospective family doctors are educated and trained.
At a time when advanced technologies (CT and MRI) and eternal life are continuously proposed in the media and are present in the promises of science, perhaps it would be useful to go back to those issues patients often complain about, that is the ability to be close to them when they suffer.

In Italy the General Practice Course was set up in 1994, after the hundredth EU ultimatum, stating that the same curriculum throughout Europe was necessary for the free circulation of GPs. This "Community obligation" certainly influenced the quality of funds and the practice of Vocational Training in Italy, as a rule poorly carried out, with a complete lack of interest by local authorities, regions, universities and partly also by family doctors themselves, with only a few exceptions.
Starting from 1994 the course lasted two years. It was then extended to three years starting from 2003. A two-year application bid was introduced in 2006. In Italy it was not even known that in Europe there was a qualification in General Practice. Therefore Italy was not prepared to and not even interested in it. In brief, the process of harmonization with Europe has been slow and is still under way.

<u>Italian slow approach to Europe</u>
- Vocational training in General Practice was just recently introduced in Italy (1994).
- In 1994 the first two-year course was introduced; in 2004 (Law 277/03) the three-year course was started.
- Just in 2006 a yearly nation-wide application bid was introduced.

<u>Current general characteristics; very similar to Europe, but not that much</u>
- It is managed by the Regions based on principles and programmes that should be indicated by the Ministry of Health.
- The actual organization is responsibility of the Physicians' Societies, the General Practitioners' Societies and private training schools.
- Only recently have universities started to introduce General Practice in the General Medicine degree course and to cooperate with regional training schools.
- Application bid for admission.
- Final exam to obtain the qualification.
- (Almost) programmed number of 1500 places, while entry exams were previously irregular. Positions are subdivided between Regions based on an entry exam (15 places for Trento).

- Trainees have a grant that is lower as compared to other residents.
- Doomed to remain an eternal student.

Therefore, from the organizational viewpoint the situation is very similar to the rest of Europe. However, in my opinion, it is so only from this viewpoint, because the working student attending a General Practice training course is still underpaid and discriminated against, as compared to other specializations (800 Euros per month vs. about 1600 Euros). The 5,000 Euros given to Dutch trainees seem therefore very very far away.
Moreover, the practical training (also at GPs' offices) do not enable trainees to "work while learning and learn while working", as is the case in many countries in Europe.

The new training course from 2000 onwards (decree law 369/1999 mod. 2003; 2006)

Practical attendance (NON working) : 3,200 hours out of 4,800

- **General practitioner** **(12 months;** 6 months until 2004**)**
- General medicine (6 months)
- General surgery (3 months)
- Paediatrics (4 months)
- Community clinics (6 months)
- Obstetrics and gynaecology (2 months)
- Casualties (3 months)

Theoretical seminars: 1,600 hours out of 4,800

- Following the law of 1999, the definitive framework program has been entrusted to a national commission, which however has not yet developed it.
- In many regions the two-year course has been kept, subdivided in methodological seminars (IT, ethics, doctor-patients relations, legislation, research, quality assurance) and technical seminars (internal medicine, surgery, etc).
- In some regions (also in the Province of Trento) starting from 2000 on autonomous training courses have been launched, in some cases in line with the 2002 WONCA definitions.

The Trento School

In Trento from 1994 to 2000 the course was managed by the Autonomous Province of Trento, which was keen to promote innovations, also in the light of a general interest for training and education expressed by the local health department.
The main innovation by comparison with other regions has been the determination to train general practitioners who could themselves become trainers of general

medicine doctors, not only as a support to specialists, but also in the development and implementation of training courses. That was a real revolution and contributed to training doctors to become themselves trainers.

At the origin the first 3 two-year courses (1994- 2000)

- 1994 : first innovations introduced in the first two-year course.
- Literature, philosophy, role playing, organization, service management and final simulation sessions.
- Innovations introduced in some methodological and clinical seminars upon spontaneous initiative by a group of general practitioners.

From 2000 onwards, following decree law 369/99 and successive reviews, something has changed both in Italy and in the Trento region. The course has been extended to three years, with 4,800 hours, of which 3,200 of practical attendance and 1,600 of theoretical seminars. The practical part includes 12 months in the office of a general practitioner, longer than the six months which were previously established. Eventually no implementation regulations were passed and, as is often the case, almost all the regions (with the only exceptions of Tuscany and partly of Veneto) continued to follow the old curricula.
But, what happened in Trento? The management was entrusted by the Provincial Authority to the Physicians Society, which gave full freedom to the training school. This drew inspiration from other European schools and training and education experiences in other fields and finally developed its own program.

The Trento School and the first three-year courses(2000 – 2008)

- From 2000 onwards there has been an official agreement between the Physicians Society and the Autonomous Province of Trento, granting teaching freedom and in part also economic freedom: the model of Specific Training in General Practice was thus set up.
- In the year 2000, first course for trainers directly managed by the newly-born Trento School. From 2003 on three-year course and revision of the regional agreement: creation of the Specific Training School in General Practice.
- The Trento School soon started to develop its own teaching model, based on skills and not on subjects and drawing on several cultural and methodological sources and on different experiences.
- Speaking of "skills" for us means to have a strong connection with practice, which becomes the basis for theory.

<u>Who inspired our curricula in 2001, 2003 and 2007</u>

- Europe's contribution: Olesen definition of General Practice of 2000 has been universally accepted as the cultural basis of the Trento School.

- The training experience made by general practitioners in the framework of life-long learning and training courses provided by the Society of General Practice (Simg)
- The training experience offered by public entities, which in the Trento region, has enabled some general practitioners to attend courses on planning, teaching and management of working groups.
- Training experiences based on the practice of research in family medicine at the Training and Research School of the Fondazione Mario Negri and pioneer experiences of the Centro Studi e Ricerca in Medicina Generale
- Other colleagues have contributed their experience with different approaches, including:
  - o neurosciences (first of all Edelman)
  - o pedagogy and use of narration (J. Brunner)
  - o sociology (in particular the works on learning in the "Practice Communities" with subsequent developments and revisions – S. Gherardi)
  - o anthropology in its cultural and symbolic dimension (A. Kleimann e B. Good)
  - o study on conflict and negotiation in a non medical context (Shelling, Lax Sibelius, U. Morelli)
  - o epidemiological studies on inequalities and health determinants (De Vogli, Marmot)
- Contributions in this direction also in the field of General Practice (C. Helman, T. Greenhalgh).

Not only did we draw on different authors and different methods, but we also wanted to take advantage of other significant experiences, both Italian and European. We have learnt from everybody.

Some of our guests/mentors

- M. Giambalvo - Philosopher
- J. Middleton – GP Leichester
- Igor Svaab – Dep. GP University Lubiana
- Evelyn Baumgarten Van Weel - Univ. Nijmegen
- S. Gherardi – Sociology
- Leonardo Spina – Clown-doctor
- Massimo Tombesi – Italian Family Doctor

Instruments and methods for the development of our curriculum

While the 2002 WONCA definition of General Practice, the Euract Educational Agenda and the Danish, British and obviously Dutch curricula have been a constant source of reference together with our experience and that of our staff, many other

authors have contributed to strengthening the conceptual basis and the application methodologies of our training curriculum.
We decided to begin from what had been done starting from 1994 onwards and compare it with these authors, with the European and international experiences in a series of classical and scientific subjects.
I would like to point out that for us theory has almost always been a precious instrument to redefine and correct what was being done: curiosity has often encouraged us to see what theory was embodied in our practice and how we could trigger off improvement mechanisms.

Practice-based studies and learning as practical know-how

- Ideas travel globally and are applied locally. This means that their true meaning has to be searched in the local context and in the community of people that give shape to a given idea.
- Learning as an opportunity to participate, with the necessary competence, in the complex network of relations and activities one is involved into, when implementing an idea.

S. Gherardi

Narration

However, neither the knowledge verified by the empiricist, nor the axiomatic truths of the rationalist can describe the reasons why ordinary people see and understand the meaning of their experiences, for example, what the slightly cold greeting of a friend could mean and what IRA meant when avoiding to use the word "permanent" in the cease-fire declaration of 1994.
All these issues require a historical basis.

J. Brunner

Rules for conflicts

In the aspects of our life which count more […] those which are more important and deeper, those which mostly differentiate us as human beings; in all those cases we never apply rules, but continuously create them. Conflict situations that offer us the possibility and the need for redefining relations are among these.

U. Morelli

The holistic approach "in practice"

When we observe a person perform a given action, in our brain the same cells are activated that would normally fire when we ourselves perform that action.

Mirror neurons by V. Gallese e G. Rizzolati

Intuition

Features of Intuition

- Rapid, unconscious process.
- Context-sensitive.
- It comes with practice.
- It involves selective attention to small details.
- It cannot be reduced to cause-and-effect logic (i.e. B happened because of A).
- It addresses, integrates, and makes sense of, multiple complex pieces of data

Intuition and evidence - uneasy bedfellow? T. Greenhalgh, BJGP 2002,52,395-400

Some scientific items can not be explored by means of scientific methods

Not every phenomenon can be measured, or reduced to numbers - especially those intangible elements of a successful doctor-patient relationship: trust, affection, compassion, understanding, humour, and a shared history.

The culture of general practice

British Journal of General Practice, August 2002 - Editorial : 619

Cecil Helman

Department of Primary Care and Population Sciences, Royal Free and University College Medical School London

The qualitative phenomenological contribution

- As compared with the training objectives set at the beginning, have there been changes based on the needs, as they emerged?
- Have the activities met with the interests of the participants?
- Have they been an interesting experience?
- Has the approach of participants changed with respect to the training problems emerged in the teaching context?

Theoretical references

- Neurosciences, evolution selectionism: we learn through selection and not from instructions (G.M. Edelman et al.).
- Activity theory (A.N. Leontev).
- Meaning as a unitary moment of thought and language (Vigotskij).
- Conflict and its generative and creative potential (T. Shelling, U. Morelli).
- Learning, passion and meaning (J. Brunner).
- Learning, narration.
- Learning and complexity (problem setting).
- Learning in the communities of practices (or from the community practices) (S. Gherardi, et al.).

A rapid look at our curriculum

The practical part focuses on the tutorial activity of the general practitioner; we do

not neglect hospital and community work, which are managed and organized together with the colleagues involved.
We regard the theoretical part as a methodological school. Active, experiential methods are preferred. Much attention is attached to the simulated patient session, where we developed our own program, though drawing on similar European experiences. Attention is given also to the cognitive aspect, though learning and knowledge updating are above all concentrated in the practical part and in sessions combining practice and theory.
The theses are seen as an opportunity to stimulate one's professional and personal self; therefore not only as a time when knowledge is assessed, but also as an evidence that one has become a full professional.

The curriculum in practice

- The curriculum is organized in five theoretical areas over a period of three years, combined with the practical sessions.
- The tutorial activity of the general practitioner is privileged.
- The theoretical part is seen as a methodological school and/or a practice metaphor.
- By means of simulation the theoretical part needs to demonstrate that it is real.
- The thesis as a moment that stimulates the overall growth of the professional self.

The five theoretical areas

Without going into great detail, I would like to recall that the first two areas are eminently clinical; the third relates to the critical issue of end-of-life problems. The fourth area relates to questions which have a marked social and cultural connotation.

- ***Area 1*** (Between 11% and 13% of total hours – credits for the theoretical activity)
  - Diagnosing and treating clinical problems, often acute in nature and commonly found in clinical practice, as they have an immediate impact on the patient. These mainly require differential diagnosis skills (examples of seminars: the patient with acute osteo-articular problems. The patient with dysuria and/or haematuria. The patient with thyroid disorders, etc.)
- ***Area 2*** (Between 13% and 15 % of total hours - credits for the theoretical activity)
  - Managing complex chronic problems that presuppose that the GP is able to personalize the diagnostic and therapeutic processes in collaboration with specialists, and that the doctor is able to manage a long-term relationship (examples: The patient with asthma and/or COPD. The patient at risk of cardio-vascular disorders - hypertensive, diabetic, dismetabolic) Part 1 and 2.
- ***Area 3*** (Between 3% and 5% of total hours - credits for the theoretical activity)
  - Treating the patient with a severe pathology and bad prognosis in his/her context: terminally-ill patients and end-of-life issues.

- ***Area 4*** (Between 10% and 12% of total hours – credits for the theoretical activity)
  - Managing complex problems that are not exclusively clinical. Examples of seminars: the elderly patient. Patients with sexual problems. Family and children health. Woman health issues. Disadvantaged patients (marginalised and/poor and/or poor immigrants, etc.).

The fifth area is distributed in the second and third year. I would like to underline the importance of the seminar "Theory and methods of General Practice", which will be the topic of Dr. Parisi talk. We believe that a discipline should teach its fundamentals. That is why we have given ample room to this seminar.
In the last area, which is certainly methodological, cultural and supportive in nature, we have included also organization, the quality workshop, relations and communication, psychiatry seminars, simulated patient sessions and cognitive neuropsychology. We give ample room to research and research training in General Practice. Though not without difficulty, many thesis works are actual research projects, both qualitative and quantitative.
Finally, we have also introduced a cultural workshop, which lasts two years and includes many activities. This workshop will be described later on.
Social sciences have not been neglected: there is a course on medical sociology and seminars on medical anthropology. There is also a part devoted to medical technological instruments, to highlight that technology is a means and not an end of our profession.

- ***Area 5*** (Between 54% and 64% of total hours – credits for the theoretical activity)
  - Theories and methods in General Practice.
  - Organization, IT tools.
  - Research and Quality Workshop.
  - Communication and relations workshop (it includes separate seminars on psychiatry and psychic disorders, simulated patient sessions, and cognitive neuropsychology).
  - Code of conduct, legal, ethical and administrative issues.
  - Cultural workshop.
  - Social Sciences.
  - Introduction to the use of technological instruments.

Finally, I would like to recall that the Trento School currently involves about 80 GPs (out of 400), who work in teaching, planning and organization activities. We cover all the hospitals and community clinics in the region, involving more than 250 hospital MDs and community MDs.
We have an agreement with the Faculty of Social Sciences and have relations with various Italian and European Universities.
Before concluding I would like to point out that, in my opinion, our task is not only to train competent and skilled professionals, but also to train reflective doctors, able

to take responsibility and take care of patients. Obviously we cannot do everything. Many responsibilities are in the hands of citizens and decision-makers. We are responsible for a small part, which we want to perform in a competent and qualified way.
I would like to conclude with a "Memorandum" of 1999 by Richard Smith who was for a long period editor of the British Medical Journal and then with a poem by Auden, not by chance the son of a doctor and a nurse.

Thank you for your attention.

Memorandum for medical doctors, residents, medical students, patients and decision-makers

- Death is unavoidable.
- Most severe illnesses can not be cured.
- Antibiotics are not for treating flue.
- Artificial prostheses do break from time to time.
- Hospitals are dangerous places.
- Each drug has also side-effects.
- Most medical treatments give only marginal benefits and many others do not work at all.
- Screening schemes produce also false-negatives and false-positives. There are better ways to spend money than to buy medical technologies.

Richard Smith BMJ 1999

Give me a doctor

Give me a doctor partridge plump,
short in the leg and broad in the rump,
an endomorph with gentle hands,
who'll never make absurd demands
that I abandon all my vices,
or pull a long face in a crisis,
but with a twinkle in his eye,
will tell me that I have to die

Wystan Hugh Auden (1907-1973)

5. Specific Training in General Practice in Tuscany

Emanuele Messina, Alessandro Bussotti, Stefano Giovannoni

Organization of the Course

The Specific Training Course in General Practice in Tuscany is provided in three different sites (Florence, Pisa and Siena) and 9 classes. The three-year course currently includes 200 participants.

The theoretical activities in each classroom are planned by a GP, who acts as a Co-ordinator, assisted by other colleagues (44 GPs for the whole of Tuscany) organized in Class Committees. These include GPs working in the Course as Trainers and Teachers, young GPs who have already obtained their qualification, though not yet active as GPs, and finally some representatives of the trainees.

The actual teaching staff of this Course is made up of 102 Trainers (GPs), 88 GPs qualified as teachers and 68 hospital wards. These hospital wards and the community clinics have been identified by the Regional Health Authority upon proposal of the Course Technical and Scientific Committee. The Trainers are selected based on their professional qualifications. They are then officially appointed by the regional council after attending an ad-hoc training course. The Teachers are selected by the teaching staff of the Course.

The theoretical subjects are taught at the three universities in the Region (Florence, Pisa and Siena), but are completely independent of the universities, both in terms of curricula and management, as they depend directly on the Regional Health Authority.

The relations between General Practice and Universities are complicated by the lack of a University Department of General Practice, even though since 2005 the School of Medicine of the University of Florence has hosted a Faculty Centre for the Study and Research in General Practice. This Centre organizes General Practice training and education in the framework of the university course in medicine and surgery and is responsible for the organization of a residency period for 5th year students at Tutors' offices.

Curriculum

Theoretical subjects are organised in one-day seminars, carried out once a week and aimed to acquire knowledge and information, compare practical experiences, discuss working methods and organize simulations based on the format developed by the Trento School.

The curriculum is revised every year, taking as a reference the national curriculum. It aims at the acquisition of skills and competences and considers theoretical and practical lessons as different parts of the same teaching plan.

The selection of the skills to be taught is based on Wonca Europe 2002, on the National Health Workers Agreement and on the Tuscany Regional Health Plan 2008-2010.
For each single competence taught, the clinical, relational, organizational and context-related aspects are studied in depth.

The curriculum is divided into Teaching Areas:

Teaching Area 1 – Management of acute cases in GP (Watchful Waiting)
A - Situations defined as emergencies:
- Patient with acute abdomen.
- Patient with acute dyspnea.
- Patient with chest pain.
- Patient at risk of committing suicide.
- Patient with acute functional failure of a body area.

Teaching venues: Surgical Departments and Emergency Departments

B - Situations defined as non emergencies:
- Patient with acute back pain.
- Patient with acute shoulder pain.
- Patient with acute symptoms of the airways.
- Patient with acute symptoms of the urinary tract.
- Patient with panic attacks.

Teaching venues: Office of the Trainer GP
Community Medical Practices
Medicine and Paediatrics Hospital Departments

C - "Undefined" situations with or without emergency characteristics:
- Patient with dizziness.
- Patient with cough.
- Patient with pruritus.
- Patient with fever.
- Patient with cardiopalmus.

Teaching venues: Office of the Trainer GP

Teaching Area 2 – Management of chronic cases (Initiative Medicine)
A - Chronic Diseases without functional deficit:
- Patient with diabetes.
- Patient with COPD.
- Patient with arterial hypertension.
- Patient with chronic heart failure.
- Patient with thyroid disfunction.

B- Chronic Diseases with functional deficit:
- Patient with respiratory insufficiency.
- Patient with motor deficit due to cerebral vasculopathy.
- Patient with motor deficit following bone/joint lesion.
- Patient with a cerebral degenerative disease.

Teaching venues: Office of the Trainer GP
Hospital Departments
Community-care practices
Hospital wards
Community clinics

The lessons taught within this area will soon include the description of new organizational models, such as UMG and the Chronic Care Model, the role of GPs within a multidisciplinary team, and the exchange of roles, above all with nurses.

Teaching Area 3 – Management of paraphysiological problems
- Management of pregnant patients.
- Management of adolescents.
- Management of menopausal patients.
- Management of elderly patients.

Teaching venues: Office of the Trainer GP
Specialized hospital departments
Community clinics

During the lessons, special attention is given to the risk of health consumerism and disease mongering.

Teaching Area 4 – Prevention and health education
- To assess and manage risks in General Practice.
- To manage patients at increased cardiovascular risk.
- To organize periodic and opportunity screening tests.
- To manage patients with drug addiction problems.
- To manage patients with smoking habits.
- To manage patients who are at risk of fractures.

Teaching venues: Office of the Trainer GP/MMG tutor
SERT (Drug addiction Consultancy Offices)
Prevention offices
Health education facilities

The lessons taught in the framework of this area also focus on the risk of health consumerism and disease mongering and the introduction of an interdisciplinary and multi-professional model.

Teaching Area 5 – Instruments for developing the specific method of General Practice

- Ability to implement GP based on the model proposed at WONCA Europe 2002.
- Ability to manage patients, understand their clinical and non clinical problems.
- Reconstruction of the medical history and examination based on the problem.
- Ability to resolve problems: use of a decision-making process based on a compromise between EBM, personal experience and knowledge of the patient.

Teaching venue: Office of the Trainer GP

As is the case also with the previous program, each group of skills has its natural teaching site: the office of the Trainer GP is the most appropriate site, as it includes all the aspects related to health-care and it makes it possible to observe the evolution of real clinical cases. Teaching is certainly favoured by the personal one-to-one relation between tutor and trainee.
Training in hospital wards and community clinics is certainly useful for some clinical aspects, in particular for those problems which are rarely seen by GPs.

Future perspectives

In the future small groups of trainers will be formed, where the discussion will focus on increasingly sharing competences and procedures, on office organization and management of single cases, thereby aiming at standardizing behaviours and delivering consistent and coordinated teaching methods both for theory and practice.
We expect to further promote simulation sessions, also played by Trainer GPs, which will be video-recorded. These videos will be presented to other groups of trainees, with the aim of analysing clinical behaviours, but above all the doctor-patient relationship and organizational models.
Trainers are expected to continuously increase their participation in the training process and in the assessment process.

6. The Italy of Signoria: fragmentation and common projects

Paolo Colorio

During most of the past thousand years, Italy was divided into communes or even small states. This division has been the most serious weakness of the State, but at the same time has generated a lively and continuous competition between these entities, finally leading to the production of a large number of works of art and contributing to the splendid socio-cultural process called Renaissance.
With the due differences, this trend towards division and competition is still present in many fields, including General Practice.
Specific training in General Practice was introduced in Italy in 1994, as a consequence of the application of an EU regulation on free circulation of goods and people. It was not the result of a specific requirement advanced by Italy's General Medicine, but rather a measure introduced to fill an "administrative gap".
It was first set up as a two-year course and was entrusted to regional authorities (or to autonomous provinces) and not to universities. This was due to economic problems and to the fact that universities in general did not have local facilities – GM departments – dedicated to General Practice.
The teaching and methodological organization was proposed in the context of ministry's decrees that Regions and Autonomous Provinces had to apply based on their specific characteristics and needs. The main piece of legislation (the only one which actually goes into organizational and teaching details) was decree 368/99 later revised into 277/03, regulating some major changes, including the extension of the two-year course to three years. Another important rule was the result of the Constitutional revision of 2001 (devolution of powers), whereby single regions were given responsibility for the actual organization of GP courses. Regional and provincial authorities were thus given full autonomy in the area of specific training in General Practice. This rule makes it difficult to have a national standardization of specific training in General Practice.
In Europe a similar model applies, and each State has full organizational and teaching autonomy in the framework of a common legislation that regulates the free circulation of general practitioners within the Community. There is no one single model of MMG/GP/MdF or GP standards which apply to individual countries.
In Europe, while there are countries with a long-standing tradition in General Practice and its training and education (the Netherlands and Great Britain), there are others where this experience is shorter or even just at the beginning. Therefore,

also in Europe there are no standardized organization models, teaching criteria and methodologies.
About two thirds of European universities do have General Practice departments, though with wide variations. There are countries where all medicine schools have a GP department and others where there are none (for example Italy). At the same time in all Italian regions there is a Faculty of Medicine (with the only exceptions of Trentino Alto Adige and Valle d'Aosta). Generally speaking, trainees in Europe regularly work in clinics and offices, though with different time schedules and patterns. In Italy, however, trainees have a grant, which differs in the various regions, and generally do not have a work contract.
While these regional differences may appear as negative aspects due to the lack of coordination and standardization, different objectives, methodologies and curricula, they can also be viewed as opportunities, as a cultural laboratory, where, based on individual needs and characteristics, partially differentiated models are developed, thereby contributing to the general picture of General Practice Training.

Among the various regional and provincial experiences in Italy, I would like to mention only some, without going into detail, for lack of time:
Umbria: the methodological week. Presentation of GP in small groups working together and finally in plenary sessions chaired by GP trainers.
Piemonte: definition of training objectives for trainers of groups of trainees (until 2004) and later focussed on the trainees' curriculum.
Liguria: introduction of a training period in management of emergencies at Casualty Departments.
Friuli: it was the site of the first GP training centre dedicated to specific training, life-long learning and research in General Practice.
Lombardia: management entrusted to a non medical organization, which is in charge of the medical training and education.
Lazio: difficult management of training in five universities and in many hospital wards, with a consequent large number of trainers, all in the same territory (Roma, in particular). This led to "a Babel of teaching targets". To remedy this situation, in 2004 a process was started, aimed at defining the core curriculum of General Practice training, which has just recently been adopted by local universities. That has been a big success of General Practice and of specific Training, in particular.
As regards *Tuscany*, we have just listened to a specific presentation on it.
In *South Tyrol* there is a special organization (the Academy), which is particularly focussed on hospital and specialized training, and attaches great attention to the German-speaking world.
In *Emilia Romagna* there are different experiences. In particular, there are a couple of centres in Modena and Reggio dedicated to tutors' training, above all for university teaching.

Apart from particular and different aspects in the various regions, there are also elements which tend to be common to all GP training experiences. For example, GP Trainers are bound to undergo specific training before being allowed to teach, which is not the case for hospital or university tutors. In order to meet this provision, some specific training programmes have been organized by the regional authorities in collaboration with GP experts, scientific and medical societies, with the consequent development of rather homogeneous programmes throughout the national territory.
Another common element is the final exam and the discussion of a thesis, generally focussed on General Practice.
Another step towards a closer aggregation of Italian General Practice was the revised system of medical licensing (since 2004), with the introduction of a trial period for the newly graduated physicians under the supervision of a senior GP. This provision has further strengthened the tutorial role of GPs, in the light of the WONCA Europe 2002 definition of General Practice.
A fundamental problem, which has been felt since the beginning, is the need to collect and coordinate all these experiences to give a single, authoritative voice to specific training itself. I am particularly glad to note that the Trento School was the first to promote a series of meetings on the subject, in particular:
The *Veneto Coordination Committee* (Bassano 2003, Treviso 2004), with the definition of objectives, teaching methods and specific contents. Moreover, the proposal was made to extend this Committee to all other Italian regions, in view of the application of the new regulations (extension from two years to three-year courses starting from 2004).
This *national coordination committee* was launched in 2004 in Bologna. It drafted various national documents, organised the meeting in Rome in 2004 and introduced a mailing list exclusively dedicated to GP training.

Various national meetings (a yearly conference in Modena starting from 2003 on organisation, role of trainers and assessment; Milan 2004 and 2005 with the development of a common project; Bari 2004; Rome 2004 and 2006 for the discussion of a shared definition of core competences and a core curriculum; a yearly conference in Treviso starting from 2005; Costermano within the frame work of the congress of the GP society).

At the beginning of 2006, with a view to WONCA Europe 2006 in Florence, the Trento School initiated the Giotto group, an association of trainees and young GPs in their first five years of work, affiliated to the European movement Vasco da Gama.
All these meetings and conferences led to the creation of an informal group of GPs, dedicated to specific GP training and who have by now made a significant teaching experience.
However, an official and formal organization able to play a role in the political and administrative decision-making process has not been established yet.

Some areas have been identified, where coordinated efforts are advocated: for example, minimum learning levels; a teaching model reflecting the need for a complete professional training; the parameters for the recruitment of trainees and prospective GPs; trainers' training; appropriate job placement, etc.

In conclusion, Italy shows a rather heterogeneous picture in many aspects of specific training. However, these differences are not to be seen only as weaknesses, but also as positive aspects. This variabilty can bee seen also as a laboratory of ideas and projects. It is now important to take stock of all these experiences and revise them.

7. The future European GP/FM .networks and pathaways

Ingrid V.der Heijden, David Fasoletti

David Fasoletti:

With regard to the Italian contest, our Health Care System is historically "hospital-centred". Italian FM has recently gone through troubled periods, marked by a lack of identity and the lack of structural and organizational conditions needed to develop its potentiality. Nevertheless, FM represents the strongest Care Structure offered to the Italian population. In the hospital setting however, the scientific and technological improvements seem to focus more on pathology. This is sometimes in contrast with the patient's needs. It is therefore necessary to improve the cultural approach to health care problems. For its nature, FM is called upon to give an answer to them, also by improving educational aspects and patient information.

This challenge is particularly demanding in view of the growing share of elderly people. In 1971 patients over 60 amounted to 17% of the Italian population. In 2000 this share was equal to 24%. It is estimated that by 2020 it will be equal to 30% and 40% by 2040. But the ageing of population not necessarily implies more health care measures, if the right information and prevention is provided to patients. To this end, it is necessary to move from a hi-tech to a hi-touch medical and social strategy, to provide the best health care services, prevent hospitalization and improve the quality of life.

According to colleagues' presentation on the European demographic changes, we need to analyze our national changes with a view to the European context. The ageing of the population and the issue of migration represent common challenges. This means that is necessary to start thinking globally and acting locally.

Since its beginning, the Trento Training School in General Practice has been willing to promote FM in a European context, facilitating international exchange programs and experiences involving both tutors and trainees. In the last few years, the Hyppocrates trainees exchange program allowed visiting trainees from Sweden and England to visit our School. Some trainees from Trento had the opportunity to join this program and go to Spain. Moreover, thanks to the Dutch yearly program of exchanges, our School was involved in several interesting experiences in the Netherlands. A constructive relationship was started with Tutor GPs from the GP School of Nijmegen (NL) and Leicester (UK)

Further important goals have been reached when Trento participated in the first official VdGm meeting in London 2005 with two representatives. The Vasco da Gama Movement is the European movement of young GPs under the aegis of Wonca Eu-

rope. This experience helped us to look over the Alps, resolve the first uncertainties and start a collaborative dialogue that is still going on. Based on this background, the Italian Giotto Movement was set up.
We took this European opportunity as the motor to start a national movement directly in touch with European FM developments. We also wanted to have the opportunity to promote General Practice in cultural and scientific terms. For this reason we decided to start a national network and various collaborations with scientific and medical societies. This is an example of how it is possible to build a concrete national young GP network, to be able to grasp the challenges that we are going to face in the near future.
That is to explain that it is possible to consider further perspectives on FM world by sharing experiences. It is possible to provide motivation and improve quality in our work. We have just started, but, like a snowball, we are growing and we are determined to make further steps in this direction.
Putting in practice new cultural strategies would require deep changes in our primary Care Setting. It would mean to move from a sort of professional isolation to a collaborative way of acting between GPs (for example sharing the same computer programs to build up databases), but also having a real dialogue with other care givers. The lack of a tangible basis, such as publications and FM literature stimulated us to set up a proper database and work on the creation of FM departments. Italy's historical and cultural fragmentation represents an important opportunity in terms of variety and cultural liveliness. This energy can be channeled to create a proper national FM college that can work as a reference for other international FM colleges. Moreover, moving from a local perspective to a European one, sharing projects and experiences (for ex. on migration) can stimulate and improve the quality of our work.

Ingrid V.der Heijden:
The daily reality in Europe is influenced by the expanding world through internet. Patients can find all sorts of relevant medical information on the web and this influences the way they seek care or the expectations they may have from a consultation with their family doctor.
For doctors the world wide web has brought about a huge change. As was discussed in the editorial of BMJ of september 2008: What we know about diseases, diagnosis, and effective treatments is growing rapidly. Today family doctors cannot solely rely on what they were first taught if they want to do the best for their patients. The speed of the increase in EBM represents a challenge—more than 2000 new research papers are added to Medline each day.
Evidence based guidelines may help family doctors in selected areas, but they cannot cover the range of questions of individual patients or have the timeliness that clinical practice needs. Family practitioners need to be able to find and use evidence themselves. The family doctor of the future should have sufficient research appraisal

skills and a commitment to lifelong learning and keep in mind that it is not only the skill in practising EBM that is important, but the integrated results in terms of quality of care for the individual patient.
Europe faces an ageing population. The life expectancy for Europeans in 2050 (Eurostat): 79,7 years for men 85,1 for females. The burden of chronic diseases increases accordingly.
Another relevant factor is the development of new farmaceutical drugs and new technologies that make it possible for patients to remain at home whereas before they had to rely on in-patient care. For example administration of ambulatory chemotherapy and the use of subcutaneous infusions in palliative care settings. These developments add new dimensions to the content of care of the family doctor.
Another demographic feature is the ageing population in the European Union. The life expectancy for Europeans in 2050 is nearly 80 years for men and 85 for females. The percentage of elderly people in the population is expected to increase to nearly a quarter of the population. The burden of chronic diseases increases accordingly.
If we take a look at the demographic developments in Europe we expect another striking feature: the increasing cultural diversity in the consultation room. This is only partly due to demographic changes within the workforce of family doctors: in the Netherlands for instance the current ratio male vs female family doctors is 70/30, but in the training situation this ratio is already reversed. This major shift in gender will influence the doctor patient communication.
Then there is increasing mobility of family doctors: European legislation makes it possible for a doctor to work in another EU country. But even if a family doctor will remain in his own country he (or better I should say “she”) will be challenged by an increase in cultural diversity due to immigration and refugees.
Not only language skill will play an important role, there are for instance also different cultural frames of reference that will need specific communication skills. Also will the family doctor need to gain more insight in specific diseases and complaints that are culturally or ethnically bound.
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will the family doctor need to gain more insight in specific diseases and complaints that are culturally or ethnically bound.
In Maastricht we have developed a programme for trainees on intercultural communication skills. Guiding in this programme is Hofstede's *Cultures and Organizations, Software of the Mind*. Trainees are made aware of their own frames of reference and given tools to explore other cultural dimensions (Power Distance, Individualism, Masculinity, Uncertainty Avoidance and Long-Term Orientation).
We have also developed a programme that makes trainees aware of the cultural bias in EBM and our database holds a variety of programmes on medical expertise like tropical medicine and for instance prescribing medication during Ramadan.
Maastricht University has always been internationally oriented. This is reflected in the position of Maastricht's staff members of the vocational training department in international organisations for family doctors like EURACT (the European Academy for Teachers) and involvement in setting up Vasco da Gama Movement, the WONCA Europe Working Group for junior doctors.
It was actually a coincidence of timing: the WONCA Europe conference was organised in Amsterdam in 2004 in the same year that SBOH, the employer of the Dutch trainees celebrated its anniversary and decided to sponsor trainees to participate in this international conference. Fons Sips, a Maastricht teacher with a personal interest in the European context and many years of experience in WONCA Europe set up the first junior doctor preconference meeting in Amsterdam. This exchange of experiences and best practices between European trainees was very inspiring and on a national level -in the Netherlands- revived the national network of trainees. It was evident to many that this experience needed to be continued. Vasco da Gama Movement was set up, serving a need for a European forum for junior doctors in family medicine.
Maastricht vocational training department facilitated the emergence of VdGM and hosted 2 international exchange meetings of junior doctors in the past 5 years.
Maastricht also has a format to host a yearly exchange meeting with a small group of a few Belgian and possibly German trainees.
On a national level the necessity of continuing this experience of trainees participating in international conferences was recognised by the employer and a structural yearly budget was approved for 50 trainees to attend the WONCA Europe conferences. They will have to share their experience for instance by writing an article for a national magazine about the conference or by giving an oral presentation at their vocational training department for other trainees. This year was the fifth consecutive time that 50 trainees were sponsored to participate and it was the first year that the employer also sponsored 20 staff members from the 8 departments to attend the WONCA Europe conference.
Trainees from Maastricht have the opportunity to do an 8-week clinical elective in palliative care in the United Kingdom. The elective is highly valued by trainees, not only because it gives the opportunity to experience the state of the art in

palliative care, it also enriches the trainees by experiencing a different health care organisational setting. Prerequisite for participating in this elective is being fluent in English.
Italy and the Netherlands for instance differ mainly on the masculinity scale. The masculinity index is the dimension that ranges a society according to the level of polarization between men and women. A high score on this index is regarded as masculine and implicates strong gender differentiation: the male population is competitive and assertive relative to the female population. Typical values of a feminine society are modesty and caring. The most feminine countries in Europe are the Scandinavian countries for instance also the Netherlands score relatively low on this dimension. The most masculine country in Europe is Austria, followed by Switzerland and Italy.
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In 2004 the WONCA Europe conference was organised in Amsterdam. It was great timing as in the same year the employer of the Dutch trainees celebrated its anniversary and decided to sponsor trainees to participate in this European conference.
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8.The patient in the training setting: the workshop on relations, the simulated patient and the cultural workshop

Norma Sartori

One of the main educational challenges faced by the Trento School has always been to help trainees establish a closer contact with patients in a practical and concrete way, to let these two actors meet in a teaching setting, to help young GPs pay special attention to relations in their profession.

I started to attend the Trento School of General Practice in 1994 as a trainee. The first day of attendance I was confronted with a patient and I had to "play" the doctor's role for ten minutes. It was a role-playing session and the patient was not a true one. I could afford to make mistakes, but above all I had the opportunity to think of the scene, to analyze it and rethink of what had taken place during those ten minutes. The fear I felt when facing a patient, the emotions, the light euphoria that I experienced when a distinguished person looked for my help, the difficulty, which became so suddenly evident, in taking a decision (I just had ten minutes available), the difficulty in choosing the right words not to frighten the patient and convince him that my diagnosis and the therapy I proposed were correct, and realizing that that distinguished person was frightened, perhaps more frightened than myself or frightened in a different way. These and many other emotions were there during those ten minutes. It was immediately very clear to me that the road to become a good professional was still long, that the things to learn were many, new and different by comparison with those I had learnt at university and in the ward.

The story of this personal experience is a way to underlie that the Trento School puts relations at the core of its training activities and on top of its objectives. Over the years the Trento School has therefore adopted teaching tools and instruments specifically suited for that objective. Today in my short presentation I will describe the relations and communication workshop, the cultural workshop and the simulated patient sessions.

The short experience I described at the beginning is a role-playing session, used as a preparatory tool before the Simulated Patient session.

Role playing is used as a preliminary tool before trainees meet simulated patients. During the first six months of attendance, during the lessons on "Theories and methods of General Practice" and during the first lessons of the "Relations workshop" some short role-playing sessions are introduced, where trainees play

and exchange the roles of physician and patient, based on simple situations relating to the topics treated during the lessons. For time reasons I will limit myself to describing the Simulated Patient session, which differs from role-playing, where the patient is played by a colleague, while in the first situation the patient is played by someone who is not a doctor. What both techniques have in common is a strong emotional tension. Emotional stress can be really considerable, above all in the first experiences with this technique. Emotions are less marked when the trainee plays a role together with a colleague. That is why role-playing comes first and only after breaking the ice do trainees start to work with simulated patients.

The Trento School has developed an original Simulated Patient method, after having the opportunity to know and observe the techniques used in England (Leister), the Netherlands (Nimeghen) and Belgium. In 2003 the first Simulated Patient was recruited and the first experiences were carried out. In 2007 six more simulators were selected (3 men and 3 women). This selection is based on some important elements: simulators do not have to be physicians or anyway work in health-related jobs; they should not have dramatic experiences of illnesses either directly or in their family; they should not be actors; they need to have medium-level education, enabling them to have a dialogue with the trainee.

How is the simulation carried out? The patient plays his/her role based on a script. The character of the patient must be very clear. The medical history. The problem, or the problems discussed that day in the doctor's practice. The scene takes place in the schoolroom where the GP practice is reproduced. The trainee has pen and paper available, telephone and sometimes also other tools (drug samples, the drug handbook, phonendoscope, peak-flow meter, etc.), which are commonly present in a GP office. The simulated consultation lasts 10 minutes and takes place following a set of very strict behavioural rules, which apply to those who play, but also to those who watch the scene. These rules are always recalled before any role-playing session and before any simulation session, until trainees fully absorb them. For example, it is forbidden to interrupt, speak, criticize, help, judge or give one's opinion. However, it should be clear that this technique involves the whole classroom. It is not something passive, but rather participation is required. All those present are indeed involved first in the observation and later in a discussion, where they are invited to help the role-playing trainee. At the end of this unit (3 hours) the senior trainer carries out an overview of the consultancy session. Finally, each person in the room (trainers, trainees, simulators and external observers) is invited to write down some notes to answer the question "what I have learnt today". The first difficulties met are related to a certain degree of competition between trainees, but this attitude usually changes after a few sessions and a sense of collaboration prevails. How trainers run the session is critical for the success of this activity and for the whole learning process of the group.

Workshop on relations and communication

Why the need for this workshop?

The topic of our discussion is relations, an element which is always implicitly present whenever people meet, independently of their willingness or intentions. Relations are founding elements of the individual conscience. The latest neuroscience studies suggest that relations come first, and only after comes the individual. Relations are something which cannot be avoided in a caring profession like General Practice, but which can be modulated and one can learn to use for diagnostic and therapeutic objectives. However, it is necessary to be aware of the existence of relations, of their characteristics, of how we experience them, if we then want to be able to modulate them and make them therapeutic. It is also necessary to become aware of emotional and affective relations which are more or less unconscious and which can be provoked by relations. We cannot though study all this only theoretically, but we need to create specific teaching situations where we can try and experience all this in practice. That is why a workshop was conceived, where together with role-playing sessions and simulations there is also the possibility of reflecting, of thinking of new sensitive and difficult notions, which are rarely covered by university courses. The general aim of this workshop is to "promote the development of patient management skills aimed at an effective, shared and relation-focussed treatment plan. The aim is to favour the awareness of the existence of emotional relations and interactions in the relationships with patients, which cannot always be modified, but which need to be guided, as they are possible therapeutic instruments, but also possible critical elements in the treatment process."

The skills that trainees need to acquire during this process are the following:

- To stimulate awareness of the current theories on patient-doctor relationships and be able to modify their approach, shifting the focus from the patient to the relationship.
- To recognize and be able to use the specificities of the long-term relationship with the patient, which is typical of General Practice, by means of an in-depth study of consultation skills and related theories.
- To learn the concepts of conflict and negotiation in General Practice and develop management skills in the relationship with the patient.
- To acquire management skills in the case of difficult relations.
- To become aware of one's own emotions and feelings which come into play in the doctor-patient relationship, and develop the ability to listen to, to pay attention to affective situations, to learn how to use the setting and other instruments that may modulate the relation.
- To develop, in sinergy with other seminars, skills for managing relations in complex situations, with multiple actors or in contexts associated with general medicine.
- To acquire knowledge and awareness instruments on the narrative approach in general practice.

Seven sessions of three hours each in a period of three years are planned, although in fact there are continuous connections and correlations with other teaching units which partially overlap with each other in terms of topics treated and skills learnt. These are:

- Theories and methods in General Practice.
- Cognitive neuropsychology.
- Organization in General Practice.
- Psychiatry and psychic disorders.

The cultural workshop

To facilitate the reflection on the complexity of the situation, in order to integrate biological disease and subjective disease, to promote the ability to listen to patients, to learn how to be far and close at the same time, to refine one's management skills and promote a holistic approach to the patient, thanks to the focus on the relationship.

The instruments used range from films to literature, creative writing, theatre playing, guided visits to exhibitions and art shows.

This workshop is currently working on the preparation of a play taken from "Un caso clinico" (A clinical case) by Dino Buzzati, which involves all third-year trainees. Each of them read the script and expressed their ideas and opinions. Another item in this unit is the show of the movie "Un fischio al naso" (The nose whistle). At last, after the assignment of roles, rehearsal started.

During the previous course Doctor Knock was staged. Apart from the personal satisfaction and fun of the participants, this had a positive impact on learning: trainees saw a change in their mutual relations, as a group, in the relations with their patients and with the tutors. The atmosphere at school changed and people got much more interested in the lessons. This method also helped to develop co-operation between trainees. However this is a very demanding and costly instrument in terms of time and energy both for participants and for the trainer in charge of the workshop (Dr. Bertoluzza). This workshop has been the result of years of trials, when activities were mainly focussed on the watching of movies. "the cinema, because of its extraordinary narrative efficacy and its representation power, can be used together with more traditional teaching tools and, by means of introspective analysis, can help viewers better understand other people's experiences and difficulties related to a disease".

9. The dutch gp/fm tutor trainingship

Gerard Benthem

Thank you for your invitation for this lecture and my special thanks to all the members of the "comitato organizzatore". I really feel very welcome here
I would like to tell you about our teaching the teachers programme or training the trainers program in this lecture and I'll tell you about the competency profile of the trainer of the FD trainee first. The competency profile prescribes what to teach the trainers. It is the content of their curriculum.
The second part of the lecture is more practical and I will tell you when and how we teach the trainers these competencies.
First I would like to make this statement. 80% of time the trainees are in practice. The practice is the workplace and is the central place of learning. In the practice they develop themselves to independent FD specialist by working like a FD specialist with training and education in practice by the trainer. This means that the role of the trainers in practice with regards to the education of the FD trainee is a central one.
The institutes have a strong role by supplying of complementary and supporting education and also on other processes like assessment, logistics and so on.
The integration of the education in practice and in the institutes is very important. Therefore Bas Maiburg and I have structured consultations about the content of the training of trainers and trainees. Also the trainers are most of the time in practice as a FD but also as a trainer. The trainers determine in practice most of their goals to improve their functioning as a trainer. Also the practice-based experiences are the source for their learning process.
I would like now to introduce you the following term: "Learning on the run" from Ruth Bankey from Canada. She is one of the authors of the Canmeds.
This process helps to enhance and develop skills that are used on the every day basis. It is a practical process about the development of skills for practice and the daily experiences are the sources for the learning process by identifying learning goals. These learning goals are the start of the learning process and everybody has his own ways to learn
It focuses on the multiple aspects of practice that trainers and trainees expierence. About trainee: in the second presentation Maiburg has explained to you the 7 competencies: medical expert and the others like collaborator, manager and so on. For the trainers: these learning goals come from the experiences which are connected to their competency profile . This competency profile I will explain now to you, in the light of three very famous men in world history. I am sorry I didn't find an Italian man. There are a lot of famous Italian, but it was hard for me to understand their

lifestyle good enough for making the comparison. I will tell you something about these men and then I will explain why they failed on the competency profile.
They are Newton an Englishman, van Leeuwenhoek a Dutchman and Salvador Dali a Spanish painter. These are their famous products: the second Law of Newton (action is reaction), the microscope of van Leeuwenhoek and the paintings of Salvador Dali. These three men had two things in common:

1. They were very good craftsmen; all three they have changed the view on the world. Being a good craftsman is the first domain of being a good trainer. This is the central domain.
   but
2. None of them had trainees and I will explain to you why they didn't. For being a good trainer for FD trainees you must be a good craftsman and also have other competencies.

Isaac Newton lived in the 17th century and changed the view on the world by discovering 4 famous laws for the physical science. Before these laws there where religious and spiritual laws which dominated the thinking of people. He discovered there are more laws and explained why the sun arises and the planets go around the sky. He wrote a book named Principia and was in his time already very famous. But he made his lectures and his books so very difficult to understand that no one could read his book and no one was present at his lectures. He had always spoken for empty rooms. This man didn't have any didactical skills whatsoever. The didactical skills are essential for being a good trainer, we call this domain 2 of the competency profile. A very bad teacher has no trainees.
The second man I will introduce to you is A. van Leeuwenhoek. Until his time it was possible to make lenses with enlargements of about 30 times. He made lenses with enlargement of almost 500 times and discovered the new microscopic world; with red blood cells, sperms, bacteria and so on.
He made his lenses always on his own. Nobody did ever see him making his lenses and when he died nobody could make lenses of the same quality. This lasted more than 150 years and the microscopic discoveries stood still. Van Leeuwenhoek was a very good craftsman but he was a very bad facilitator. He didn't facilitate the transferral of his skills to trainees by failing to admit them to his atelier or workplace. Facilitating is the third domain of the competency profile and means the accessibility of your workplace, instruments and time for the learning process of a trainee.
Salvador Dali was a Spanish painter who painted the world of surrealism and he became very famous last century.But he didn't have any trainees either becouse he was very vain and could not share the attention with another. He was the centre of his world. All the attention was fixed on him. He didn't have the attitude to share attention and to invest in others. This is the fourth domain of the competency profile: the professionalism of the trainer.
One of the most famous Dutch artists was Rembrandt. He has made this painting called: the anatomic lesson, it was painted in 1632. In it doctor Nicolaas Tulp was

teaching his trainees. Rembrandt had about 40 trainees and a lot of his trainees became very good painters. There is still a lot of discussions whether some paintings were painted by Rembrandt or by a trainee. Some of them became as good as the Master. He was in his time already a famous painter and a famous trainer. And Rembrandt had all of the necessary competencies.

We started in Maastricht 3 years ago with the new curriculum based on the competency profile and at this moments all the 8 institutes are implementing a new program. With the 8 coordinators we have frequent meetings about the content of the curriculum for trainers and especially about assessments we make agreements. We are cooperating very well and are important for the national programme for training and teaching the 1800 FD trainers in the Netherlands.
I want to give you an overview of the complete programme for our trainers, but I give you first the description of the competency profile and in that way the content of the curriculum: it is in fact the description of "what to learn" and to clarify I will give a few examples of each domain.
Domain 1 is to be a good FD, to have the 7 competencies of a good FD that was already explained by Bas Maiburg in the second lecture.
Domain 2 is to have didactical skills. These are a few examples of the necessary didactical skills of the trainer:

1. It is important not only to let the trainee do the work by providing the opportunity to work, but also take the lessons from the work, the every day basis work is the source of the learning process and the trainer must stimulate this process
2. The trainer needs communication techniques like giving feedback and giving instruction, but he must also concretise the faults and deficits of the trainee and help to transform these in concrete learning goals
3. Assessing is a great stimulus for learning if it is well done and in the curriculum of the trainees there are 4 times a year important moments for the assessment of the trainee and also there is the every day work with a lot of assessments moments

The domain of the facilitative performance means that the FD trainer provides a good atelier or workplace for the trainee. The trainer has to organize his work accordingly to leave opportunity to the training. It means in practice that the trainers reserves time for teaching and discussing with the trainee everyday, no interruptions by patients or telephone. Therefore the trainer has to monitor that the trainee is supplied with differential patients. This means that the trainee sees all kind of patients in the practice, in the beginning the minor ailments and later the chronic diseases. The trainer is responsible for managing this patient flow.
The last domain is connected with profession. The trainer has to maintain and improve professional performances as trainer. The most important item for the trainees is not a competency but a quality: being enthusiastic for teaching. This is what the trainees mostly appreciate in their trainers. The trainer is the role model for the

trainee and he is well aware that he serves as a model. To maintain his professional performance the trainer has signed a contract with our institute for 8 days of training for himself every year.

Now we can do an overview of the total programme for trainers from the applying till the end of trainership.
They start with a selection by telephone by my secretary questioning about the practice, how long registered as FD, assistance and educational performance with students in basic medical education. Previous educational performance experience with students is obligatory. If a FD wants to become a FD trainer and he/she has no experience with students we introduce him to the coordinator for the students. After two years of experience with students he is welcome. Then the candidates receive a lot of information by my secretary and they have to write a short application.
The second step is selection and enrolment: the selection procedure is based on an assessment on knowledge and communication. The knowledge test is the same as the trainees make twice a year.
But first I go to the coordinator of students in the basic medical education and inquire about his previous educational performance and about his practice and the personal qualities of the doctor
We don't recruit FD's with a negative advice for trainership. Paul Ram has told you about the official organisation which control the rules the HVRC, and they make an official visitation and control the "hardware" of the practice: building, rooms, patient registration system, computer with internet access, assistance, certification of the FD and the assistants
The start course lasts two days and contains the first training in basic educational skills and video assessments. They write a personal vocational training plan and discuss it together. Next year all the 8 institutes introduce a new digital training plan with a profile of the practice and the FD.
The new trainers again receive a lot of information during these two days.
After the start course the trainer starts with his first trainee and he also starts with period 1 of his personal education. This period lasts 3 years with 8 days of training : all together 24 training days.
We use a lot of educational methods, but it is all in small groups.
The choice we made for the professional education is that every trainers participates 6 years in an intervision group., 3 years in period 1 and 3 years in the second period with other participants and another intervisor. These groups consist of 5-7 participants.
We have started already with one to one talks with every trainer once in 3 years
With the start of 2009 after 1 year and after 3 years there is the evaluation of progress with a staff member.
The following is the second period: this period is in big lines the same as the first. The difference is the special emphasis on the process of learning. In the first period

the emphasis is on the different educational skills like giving feedback en assessment of the trainee. There are a lot of training programs for the learning process, but coaching is a very important one.
After 3 years is the evaluation of progress with a member of the staff.
Period 3 is the time after 6 years of training trainees and 6 years of training their personal trainership. They are our experienced trainers and they compose half of the programme according to their own needs. The choices they can made for example supervision, coaching of a new FD trainer, didactical lessons or create educational programs for the institute. New are lessons about accreditation of their practice. We will start next year with every 3 years an evaluation of progress.
I think our group of trainers all agree with the statement of lifelong learning and they use the presence of the trainee also for realising this goal. All the time they are connected to the institute.
The trainers' record is the instrument we need to monitor the learning process of the trainer and to evaluate his functioning.
It contains the following items:

- Knowledge test (every 2 years)
- Video-assessment (once at start)
- Evaluation by trainee (every year)
- Evaluation by staff (every year)
- Critical incidents (occasional)
- Evaluation of progress

10. The Cultural Workshop

Mauro Bertoluzza

The cultural workshop is divided into several modules, at times independent, and often connected with other seminars. It is an instrument used throughout the whole training process. It works as a support to and a completion of other teaching units. The tools used range from films to literature, from creative writing to acting, guided visits to exhibitions and other forms of arts.
The cultural workshop is intended as a path for the professional and personal growth of the trainee. It is intended to help trainees be able to understand the difficult and complex aspects of human relations, where actions do always have a meaning, although they do not always appear to be reasonable.
In other words, what the cultural workshop wants to achieve is to facilitate a discussion on the difficult task of combining the notion of biological disease with that of subjective illness, with a view to stimulating the capacity to listen to patients, learning how to keep an appropriate relational distance, to improve management skills and promote a holistic approach to patients.

The film-based narrative path
This unit consists in the introduction into some teaching modules of one or more film-watching sessions, preceded or followed by a discussion, so as to experience in a narrative fiction some of the issues analyzed during the theoretical modules and face questions relating to experiencing and managing complex relational situations.
Movies can play a major role in the training of physicians at a time when technical and scientific education alone is no longer sufficient to manage a type of care which should be focussed on patients and their needs and requirements. The need is increasingly felt for a multidimensional approach, where new languages, like movies, are used.
Physicians' action is increasingly regarded as an integral act, a starting point and a platform for the application not only of strictly medical knowledge, but also psychological, philosophical and ethical in nature. Thinking and encouraging physicians to think about the fact that each patient has a personal history is indispensable to understand the disease, although it is not that easy at a time when evidence-based medicine seems to impose its statistical paradigms, linking physicians' choices to precise guidelines.
The cinema, thanks to its extraordinary narrative and didactic efficacy and thanks to its representation strength, its introspective, interpretative and clinical analy-

sis, can help better understand the experiences and the sufferings linked to a disease.
Narration, including movies, is at the heart of the experience of the disease and of the care relationship, as suffering needs to be included in a narration in order to acquire sense and be shared.
The cinema has the merit of condensing in a limited period of time long human stories, of describing sketches, episodes, characters and actions which can hardly be covered during a traditional training process and which, thanks to the suggestion created by film-making, become a tangible object for discussion, reflection and critical evaluation.
One could object that this teaching method focussed on watching and discussing a movie can be equated to those teaching activities that are aimed at the cultural and personal enrichment of trainees, which therefore do not have an immediate practical impact. In fact, we are more and more convinced that impacting on the sensitivity and affectivity of trainees will have an equally significant weight in the long term.
The South African novelist Andrè Brink wrote:

"….in a world which is increasingly threatened by famine and illness, violence and war, refuges, dictators and crowds of oppressed people, the word ***culture*** *may risk becoming obscene. This is true only if we insist on considering culture as a reserve of a few privileged people, instead of considering it as the generator of meaning in a society. Hunger exists and can be appeased only by bread and not by a piece of music. The recognition of the full human nature of a woman does not depend on a painting. But this does not mean that humankind does not need music, literature, theatre or painting. (non official translation)*

Some examples of the modules offered:
Representation of psychic disorders and mental illnesses
- ***Don Juan de Marco*** (by the physician-director Jeremy Leven) on the relationship between a delirious patient and the physician.
- ***Un'ora sola ti vorrei*** by Alina Marazzi on the relationship between a depressed patient and the doctor.

Third age:
- ***Wild strawberries (Smultronstallet)*** by Ingmar Bergman.
- ***Straight story*** by David Lynch.
- ***Iris*** by Richard Eyre, a real story of an Alzheimer patient.

End-of-life issues:
- ***Cries and Whispers (Viskningar och rop)*** by Ingmar Bergman, on pain and compassion.

- ***Wit*** by Mike Nichols on the relation between physician and a patient with cancer subjected to heavy chemotherapy.
- ***The Sunchaser*** by Michael Cimino on the relationship between physician and a cancer patient refusing chemotherapy.

Clinical Ethics:
- ***Life as a fatal sexually transmitted disease*** by Krzysztof Zanussi on assisted suicide.
- ***Les invasion barbares*** by the Canadian film director Denys Arcand on euthanasia.
- ***Mar adentro*** by Alejandro Amenabar, a real case of euthanasia.
- ***Vera Drake*** by Mike Leight on abortion.

Humour (smile therapy)
- ***Patch Adams*** by Tom Shadyac, with the protagonist in the cinema.
- ***Clown in Kabul*** by Enzo Balestrieri and Stefano Moser on the humanitarian mission of some clown-doctors in Kabul. A meeting was organized with the protagonist, Leonardo Spina, and another twenty clown-doctors from the movie "Clown in Kabul". Leonardo Spina is head of the Associazione Ridere per Vivere, and expert in clown-therapy.

Social commitment:
- ***Insider*** by Michael Mann on the trial against tobacco multinationals.
- ***Jung – Nella terra dei mujaheddin*** by Vendemmiati and Lazzaretti. A documentary film on the human and professional adventure of Gino Strada (Emergency) in Afghanistan.
- ***A fond kiss*** by Ken Loach on the question of immigrants.

Relationship between disease, genius and art production
- ***An angel at my table*** by Jane Champion, autobiography of the New Zealand novelist Janet Frame, who was mistakenly treated for schizophrenia.
- ***Shine*** by Scott Hicks, a biography of piano-player David Helfgoot suffering from schizophrenia.
- ***Pollock*** by Ed Harris on the main representative of action painting, destroyed by alcohol.
- ***Basquiat*** by the painter and film director Julian Schnabel, on the short life of one of the main representatives of American abstract neo-expressionism who died of overdose.
- ***A Beautiful Mind*** by Ron Howard on the career and disease (schizophrenia) of John Nash, Nobel Prize in Economics.
- ***Frida*** by Julie Taymor on the short and unfortunate life of the Mexican painter Frida Kahlo.

Theatre module

Performance of the theatre play ***"Knock or the triumph of medicine"*** by the trainees and the teachers of the 1° three-year course in General Practice, Trento.

This play by Jules Romains, shown for the first time in Paris in December 1923, describes issues which are now very topical, including the excessive medicalization of normal aspects of human life, cleverly highlighting how the society tends to emphasize or invent new pathologies in order to turn healthy people into ill patients.

"Getting ill…….an old concept that does no longer hold when confronted with current scientific data. Health is nothing but a word that could be easily deleted from our vocabulary. I do not know healthy people…those who believe to be healthy are in fact ill without realizing it" (Knock). (non official translation)

All the three-year course trainees had a role in the play and this teaching experience helped create a particular work climate, favouring group relations and learning, with consequent lesser hesitation and greater self-control and control of one's own emotions in these role-playing and simulation sessions.

The theatre experience, where trainees were the real protagonists, has been an important teaching tool to improve personal relational and communication skills in the framework of the training course in General Practice of the Trento School.

Currently the play *Un caso clinico"* (A clinical case) by Dino Buzzati is offered, taken from his short story "Sette Piani" (Seven floors), which was first shown in 1953 at Piccolo Teatro di Milano and directed by Giorgio Strehler.

It is the grotesque story of Giovanni Corte, a well-off manager, who is hospitalized for a general check-up at the highest floor of a hospital organized on seven floors depending on the severity of the symptoms. Once brought to a lower floor it is no longer possible to be taken to a higher level. Going down floor after floor, Corte inevitably approaches the end of his days, deprived of his health and surrounded by a veil of lies.

Apart from the contents of the play (doctor-patient communication, the risk of "preventive medicine", the patient's loss of identity, the separation of patients from the healthy, the distance and lack of interest by the family…) also in this case the involvement of trainees has a specific teaching purpose in helping trainees shape their own professional self.

Art module

Guided visit to Mart in Rovereto (Museum of Modern and Contemporary Art) on the occasion of the inaugural exhibition "Le stanze dell'arte – Viaggio nel Novecento" and showing of the movie ***Arte e medicina***, a documentary film by Sergio Davi and ***Il dolore nelle arti figurative***, by Sergio Davi

Literature module

The following texts have been proposed on medicine, physicians, diseases described by novelists and poets:

- *"The man who mistook his wife for a hat"* by Oliver Sacks
- *"Ancien malade des hopitaux de Paris"* by Daniel Pennac
- *"Il male oscuro"* di Giuseppe Berto)
- *"La Mort heureuse"* by Alber Camus
- *"La cura"* di Herman Hesse
- *"Mémoires d'Hadrien"* by Margherite Yourcener
- *"La morte di Ivan Il'ic"* di Tolstoj
- *"Il medico della mutua"* di Giuseppe d'Agata
- *"La Vie et l'œuvre de Philippe Ignace Semmelweis"* by L.F. Celine
- *"Doctor Faustus"* by Thomas Mann
- *"Ricordi di un giovane medico"* di M. Bulgakov

11. Creative writing

Laura Zambanini

"If you want to learn how to write well, you need to do three things: to read a lot, lo listen well and intensively and write a lot. Dogen, who was a great Zen teacher, said: "If you walk in the mist, you get wet". Therefore you should not do anything else but to listen, read and write" (Non official translation of Natalie Goldberg's "Scrivere Zen")

In the school year 2002-03 the Trento School started, within the framework of its cultural activities, a "Workshop on writing: techniques and models for written production", with the following objectives:

- To offer useful tools to help trainees become more familiar with the practice of writing;
- To stimulate creativity and hence the taste for writing;
- To activate, by means of corrections and re-writing, the idea that a text can be improved and that it is possible to consider the habit of writing as a process and as a skill which can be learnt, rather than as an in-born ability;
- To improve the understanding of a text by means of appropriate techniques of reading and rephrasing;
- To develop, by means of group activities, a sense of collaboration;
- By means of a process of individual corrections, to focus on personal idiosyncrasies and develop an effective writing style with the help of the tools of rhetoric.

In brief, energy and personal commitment were required for a type of work which was regarded as useful, or appealing, for the cultural or existential growth of a person, but not as a traditional subject in the curriculum of a General Practitioner.
Each of the 4 lessons, focussed on different text typologies - descriptive, narrative, expositive and argumentative - was divided into two stages:

- A stimulus-writing unit, followed by group or individual exercises;
- Group corrections of the texts (spelling and syntactic skills, paragraphation, spatial organization of the text, punctuation, expositive order, agreements, use of connective elements, identification of the main sentence, connection between the text and the communication situation/the target/the viewpoint).

We gave a positive assessment of this experience: the trainees' reactions were attention and lively participation in the lessons. We noted actual improvements in their writing practices. However, during a conclusive meeting of self-assessment, a certain difficulty was noted in fully "linking" this experience, which was satisfactory in aesthetic and cognitive terms, with their professional practice. As a result, we de-

cided to introduce some slight changes in the next proposal for the period 2008-09, also in the wake of the experience I had meanwhile made in a writing seminar at the School of Political Sciences of the University of Bologna.
This year course ("The path of the word: reading, studying, writing") is in a way a more ambitious proposal, but also more well defined, as it sets two specific objectives: narration and argumentation (rhetorical structure of the text).
At the basis of the course there is a double perspective:

- A specific attention to the types of texts that the trainee is required to produce during his/her specialist training, for example drafting and summarizing study texts or projects and drafting of expositive or argumentative texts (special emphasis will be laid on the ability to recognize the information referred to in the text, by identifying its internal organization, that is the hierarchical layout of the thematic elements).
- The development of skills which go well beyond the drafting of texts and involve the professional and personal life, in relation to skills such as text comprehension, creativity, the pleasure of writing and narrating as specific ways of forming relations with other human beings (and specifically with a view to the diagnostic and treatment process, in search of a "shared truth" between doctor and patient).

Each of the four lessons will be based on 4 parts:

- Group correction of material and solution of specific problems (mistakes seen as a tool to recognize strategies and identify a process of self-correction, in particular by focussing on "mistakes" as the inappropriateness of a choice in relation to the context and the communication objective).
- A theoretical-illustrative part: writing techniques, in particular the argumentative and narrative techniques.
- Text-analysis, both argumentative and narrative.
- A session on creative writing starting from a narrative stimulus.

The theoretical reference point is the "sense of the text": the ability to analyse the architecture of the text, its cohesion and coherence, to be recognized – when you read – and organized – when you write.
The trainees will write in order to shed light on their past experiences, both professional and non professional (as Giuseppe Pontiggia wrote, "rhetoric is not only an instrument to express oneself, but also to invent, in the etymological sense of the word, that comes from *invenio*: finding what one did not know was there"), and unleash precious internal resources; trainees will learn how to transcribe verbality (which is a language of words and of the body, a *natural* language), being aware that writing is an *artificial* operation; trainees will learn how to build possible worlds and thus focus their attention on all the worlds and all the stories that they will meet in their profession; they will use this skill to analyse, interpret and reprocess knowledge and situations by means of instruments that perhaps were not so much focussed on during their school years.

"How well would I write if I were not! If between the white piece of paper and the words and stories taking shape and dissolving without anybody writing them, was not that clumsy barrier which is my person. If I were just a hand, a cropped hand that holds a pen and writes…….(non official translation of Italo Calvino' "If on a winter's night a traveller").

12. Learning from cultural workshop and simulated patient

Fabrizio Valcanover and Norma Sartori

Playing theatre comedies has a positive effect on trainees as for what concerns learning and group dynamics, as Dr. Bertoluzza pointed out before. The evaluation of those effects needs to be done by means of non quantitative tools, since it is troublesome to reduce the complexity of subjective emotions, perceptions and assignment of meaning to observable standardized behaviours. This process is possible, although it is not an adequate tool to fully understand the complexity of all the elements put at stake.

We observed that the atmosphere of the group has changed: from a competitive climate to a collaborative one. In the primary care team and in the general practices (as well as in many working contexts in services and industries) expertise is required, characterized by the ability to work together. Generally, the training course goes along just reverse: straighten individualism and competitiveness among individuals. This is a formative feature also for the personal development.

Interpersonal relationship among trainees and between trainees and trainers were strengthen, without a decrease in respect. Most of the learning theories underline the importance of emotional relationship in the transition process and in the acquisition of competence.

The way to relate with the patient has changed. This has been observed not only by the trainers that perceived it during simulation sessions and during role playing, but also by the tutors of the practitioners who understood it during the practical session at their practice.

The way to use the simulated patient as a tool for learning has changed as well: it turned to be a tool for professional "counselling", instead of a service due to the teacher, where one feels judged by him.

Simulated patient is a tool for thinking about a holistic approach, and a rich mine full of theories on doctor patient relationship in general practice.

Key-points of simulated patient: In Italy this technique is used in many different branches of Medicine, especially in the very normative-executive ones, where there is a protocol – very standardized, easy to evaluate by quantity - to be strictly followed, as for instance in CPR (cardiopulmonary resuscitation). In those cases the main target is to learn and to evaluate a series of skills from which emotions are excluded, or rather the presence of emotions invalidates the learning and evaluating process.

We use this technique with the opposite aim: to express also emotions, feelings and affections in order to become subject for discussion and for learning. In the doctor/patient relationship in general practice the clinical aspects are not to be separated from the relational, socio-anthropological ones. In particular, we deal with emotions and perceptions/ideas expressed both by patient and doctor, and they must not be interpreted in a psychological or socio-anthropological way, but used as a means to know the other and as a way to be aware of one's own emotional and perceptive inner world.

This attitude is required for participants joining the session. When one deals with clinical matters or with the consultation map, this approach becomes analytic and makes reference to knowledge, skills and theories, even if the reference theory is that of general practice.

The aim here is to provide learning based on a genuine holistic approach. For this reason, our scenarios are always inspired by real case histories. Even when the case histories show mainly clinical targets – as for instance the correct diagnosis and therapy for a patient with asthma, or a patient with diabetes, or even a patient with high cardio-vascular risk – there is always a special attention to the overall managing expertise, that cannot abstract from the relationship.

The relationship. By means of the simulated patient we go to the heart of the matter and force the trainee to become aware of the emotions stemming out from the relationship. We require him to understand that they might be positive and negative, but they always have an effect on the patient and on the diagnosis and care process. The trainees must understand also that they need to modulate the relationship, since it can be a tool for diagnosis and care by itself. Through this technique, the trainees can make exercise.

This method represents also the only chance to receive a feedback from the patient, and to discuss together with them all the questions emerged during the consultation – why and how things went well or not wrong. Finally, although it is a very REAL situation, with a very REAL patient, one can still "rewind" and try again the same consultation in order to correct mistakes.

Trainees usually meet with simulators several time during three years, so that they get acquainted with them. They are always the same persons and can establish a long term relationship, that is typical for general practice. In this way the exercise is not merely theoretical, but very pragmatic.

The difference between the classical bio-psycho-social approach and this approach is that the three components are not analyzed separately, but together as soon as they emerge. This means that sometimes some clinical aspects loose significance, or influence trainer's didactics. For example, the non compliance with a guideline for a complicated diabetes patient depends on the trainee knowledge, or on the didactical method used to teach them, or on the feasibility (that has to do with its truth) of the guideline itself. Reality must adapt to the model, or the model must adjust to reality?

In conclusion, breaking down the analysis in the above-mentioned three parts may hinder the understanding of the global complexity of both diagnosis and therapy, and may also not be a positive learning process.

13. Towards a theory of General Practice
The experience of a ten years seminar

Giuseppe Parisi

The General Practice School has been offering theoretical courses on General Practice for more than 10 years. Some years ago they were presented in a specific seminar called "Theories and Methods of General Practice". This seminar aims to offer a well structured approach to all the situations that GPs have to face during their daily work, in order to manage them better. The idea behind this seminar is that giving a name to things help GPs deal with them and discuss them with colleagues.

This seminar however, has a much more ambitious objective: the intention is to make the first steps in the development of a consistent theory of General Practice, seen as a discipline. It is well known that the principles underlying the work of GPs are different from those of hospital professionals, though it is difficult to present them in a scientifically correct and convincing way.

The educational objective of trainees is to identify the link between theoretical models and actions. To develop a theory of clinical action in General Practice it is important for trainees to be able to grasp the underlying theoretical models and the forces at play.

The seminar, as it is today, is the result of a long theoretical work carried out by Fabrizio Valcanover and myself in the last twenty years. The question that we raised at that time was: What is the theory, the vision, the research plan that can help GPs in their work? Which theory can be at the basis of the "theory in practice" that GPs display in their activity?

We immediately understood that it would be a mistake to take only one theory as a reference and that General Practice could well be represented by one of Arcimboldo paintings, that is a puzzle, a patchwork of theories, models and research projects belonging to different disciplines. If that was the case how could we develop a framework including all these elements and how could we teach them?

After twenty years of work and study Valcanover and I were able to draw up the program of the seminar which is broadly described below. It is important to add that the program is still a work in progress. It is a lively picture of all these years of research and discussions on our practice, while it tries to give a coherent form to all these elements.

The seminar currently consists of 16 teaching units. Each unit, lasting three hours, generally starts with a theoretical lesson, followed by group work, role-playing or by a simulated patient session. This pattern is of course flexible. The model discussed during the theoretical lesson is not necessarily the topic of the simulated

patient session. This scenario is actually used to explore new possibilities, to teach trainees that the theoretical model is simply a useful tool among many others to describe a complex context.

The title of the first teaching unit is: "The specificity of General Practice: what is General Practice – competences, objectives activities - in the Italian and European context". Trainees are invited to express their ideas of GP, share them with their colleagues, compare and supplement them with the core competencies defined by WONCA. The final result is the development of a shared idea of General Practice and the competencies to be learnt.

The second unit focuses on the history of Italian General Practice. Trainees are encouraged to think about the figure and role of healthcare professionals since the eighteenth century in Italy, in order to better understand the role and functions of today's general practitioners.
The third teaching unit presents the two major settings where general practice takes place, that is consultation and the long-term relationship with the patient.
The general practitioner has three wide-ranging objectives when treating patients: the first one is to take care, that is helping patients keep healthy, advise them in the case of health problems. The second one is to build and maintain a long-term relationship with patients and have a good capital of trust and collaboration with them. The third one is to maintain one's own professionalism, i.e. to keep professional boundaries, to provide well-organized care and protect one's own private life. All these objectives are to be developed during the long-term relationship with patients.
There is however also the narrower framework of the single consultation, where GPs set their short-term tactical objectives. In military jargon "tactical" means everything you do to reach your strategic objective, though not directly connected with it. For example, to carry cannons on top of the mountain a bit far from the border, in order to easily hit the target beyond the border. During the consultation, a classical tactical objective is to be able to understand the reason why the patient is there. This is not directly connected with the patient's health, but it is the first step for a good consultation.
For all these reasons, the first part of the seminar is subdivided into two major topics: consultation and the relationship with the patient.
The consultation part includes six units, from the third to the eighth unit of the seminar. The first one broadly describes consultation models, based on the literature. The second one illustrates the start of the consultation procedure, where trainees are invited to analyze the very first minutes in a consultation. The successive units describe various models of consultation in detail.
Fifteen years ago only the Pendleton model was taught. Simulated consultations and role-play sessions were based on this method. However it was then seen that,

though being a powerful tool for analysing many consultations, the model could not cover them all: in fact, most of them did not fit into Pendleton's rigid pattern. We reached the conclusion that Pendleton's was just one of the many possible ways to describe and analyse the speaking dance, the dancing dialogue, the complex interaction called consultation. The risk was there to misrecognise major phenomena if they did not fit into the model, based on the rule that if you have only the hammer every problem is a nail. We therefore gave up teaching only one model, which was used to analyse and describe every consultation.

The fifth and the sixth units (the third and fourth on consultation) relate to so-called "cyclopic models" or "one-agenda models", that are useful in simple and straightforward consultations. The units illustrate the models of social psychology on health and illness behaviours. The patient is historically described as a social actor, that has changed in these last years from being a sum of signs and symptoms useful for diagnosis to being a so-called "full patient", i.e. a person with expectations, fears and concerns on his/her health and even a health expert.

The seventh teaching unit focuses on negotiation models, in particular Middleton's "face-model", that can be applied in the case of complex consultations. This unit also discusses the notion of patient-orientation and disease-orientation, starting from Byrne's and Long's formulation in 1974 until the current use.

The last unit on consultation focuses on difficult cases and suggests the possibility of creating metaphors to manage them and to give sense to one's work. The underlying message is: even the worst and most frustrating consultations have a sense, have a structure and contain elements that can be described both by means of traditional models, and above all by means of well grounded metaphors.

The ninth teaching unit is about the long-term relationship with the patient and offers theoretical instruments to face contingencies, time problems, turbulent and complex situations by means of stories that are read, commented on and narrated by trainees themselves. This unit concludes the general theoretical part and opens the way to the clinical methodological part.

The tenth unit focuses on the epidemiology of General Practice as an introduction to the next four units on new clinical methods, where workshops on sensitivity, specificity and predictive value of tests are followed by discussions on clinical cases, and where diagnostic tools typical of primary care medicine are used (for example, the use of time as a diagnostic instrument).

Lessons are devoted to trainees' prescriptive habits and specialist referrals in the case of common pathologies. Results are discussed together and attention is given also to the use of medical technologies. Also the placebo effect is presented as a powerful treatment tool.

The two final units deal with the other side of a strategic approach, i.e. the thrust of values.

The work of a general practitioner, who every day is confronted with the complexity and difficulty of a community, is like the activity of a manager, who, as Morgan

stated, works in turbulent settings and cannot set objective to be achieved, but rather needs to be moved by values, and should not pay attention to results but rather to constraints. In the end a GP should be a designer and not a simple actor. That is why values are so important for GPs' work.
Trainees work on identifying the specific values of general practitioners and General Practice as a whole, and on defining a series of professional objectives to be pursued in the future.

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