

OCCASIONAL COMMUNICATIONS

MEDICAL POSTGRADUATE TRAINING AND PRACTICE IN THE EXPANDED EUROPEAN UNION*

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INTRODUCTION

The Colloquium was held, under the auspices of the Federation of the Royal Colleges of Physicians of the United Kingdom, on 10 November 2003 at the Royal College of Physicians of Edinburgh. There were attendees from the Czech Republic, Hungary, Poland and Slovenia and from the three Royal Colleges, the General Medical Council, the Scottish Executive, the British Medical Association and the National Patient Safety Agency. A video link was established, for part of the programme, with Romania and Aberdeen to demonstrate the potential for distance learning and to provide an opportunity for information to be presented on postgraduate education from Romania.

The purpose of the Colloquium was to obtain an insight into postgraduate training in Eastern Europe and to explore the potential for cooperation between the medical Royal Colleges and colleagues in those countries which are to join the European Union (EU) in the near future.

SESSION 1

HEALTH CARE SYSTEMS AND POSTGRADUATE EDUCATION IN CENTRAL AND EASTERN EUROPE

The first session started with an endowed College lecture (The Sir Stanley Davidson Lecture) presented by Professor Martin McKee, Professor of European Health at the London School of Hygiene and Tropical Medicine. The lecture, entitled 'Health Systems in Transition in Central and Eastern Europe', provided an excellent background to the further deliberation of the day.

Professor McKee outlined the variable nature of the transition from the former Soviet systems to the current quest for freedom and change. There was an almost universal rejection of the methods of the previous system, even those aspects which were good. The 1993 Copenhagen Council decision to expand the EU, to bring democracy, the rule of law, human rights and economic stability, presented the countries of Central and Eastern Europe with significant challenges. The countries that join the EU must accept all the legislation that has already been enacted in the EU and this has been a major preoccupation with Governments since 1993. Furthermore, all countries will have to face the changing nature of healthcare due to a variety of factors.

The common challenges facing the countries joining the EU are:

1. Changing demography, from a declining birth rate and ageing population, together with an increase in non-communicable diseases caused by smoking, alcohol and obesity. There is also the emergence of certain infectious diseases such as tuberculosis and sexually transmitted diseases and high levels of avoidable mortality such as Type 2 diabetes mellitus.
2. Fiscal pressure to provide an acceptable level of affordable healthcare.
3. The reorganisation of healthcare with a move away from centralisation requires a change in planning strategy and discarding outdated management practices.
4. Overcoming potential accession difficulties in:
 - a. the free movement of patients and doctors;
 - b. the free movement of goods and in particular pharmaceutical products; and
 - c. the free movement of services, all of which are part of current EU legislation.

The transition period will therefore raise many difficulties that will take time to address and overcome.

There then followed presentations from representatives of the four participating Central and Eastern European countries, outlining the current status of postgraduate training.

Professor K Trnavský, Professor of Internal Medicine and Rheumatology, Institute of Postgraduate Medical Education, Prague, Czech Republic

In the Czech Republic undergraduate training lasts six years and there are about 1,000 graduates each year. Postgraduate education is mandatory with basic speciality training lasting 30 months. There are seven medical faculties, 19 basic specialties and 60 subspecialties. There are 2,000 educational programmes running each year for about 24,000 doctors and some 2,000 physicians each year receive specialty diplomas. Continuing professional development (CPD) is a priority in life-long learning and credit points are awarded for attendance at meetings and publishing; diplomas are awarded and are necessary to continue to practice. The Czech Medical Association is a professional body and

* An International Colloquium exploring Postgraduate Education and Physician Assessment in the UK and Central and Eastern Europe

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the Czech Medical Chamber acts as a union. The problems are lack of financial support for educational activities and for the accreditation of educational facilities. There is a lack of coordination in training programmes, a variable quality in CPD, little regulation in the number of specialists and a lack of supervision of postgraduate training by senior clinicians.

Professor A Eros, Associate Professor and Deputy General Director, National Institute of Primary Health Care, Hungary

In Hungary there are four Medical Universities and, since 1956, a Postgraduate Medical University. There are 36,000 physicians and 700 medical graduates each year, in a country with a population of 10×10^6 . There are 26 basic specialties and more than 100 sub-specialties. Since the year 2000 a new system has been introduced with finance and planning being decentralised and therefore different in each region. There are seven common trunk training programmes that last for 28 months. This is followed by three to six years of specialty training, after which there is a State examination prepared by the National Specialty Board. Cardiology has the longest training requirement of six years. During training there are tutors responsible for the overall process and mentors responsible for parts of the course. There is a system of continuing medical education (CME) with a requirement to obtain 250 points in five years (one hour = one CPD point). Attendance at conferences, courses, self study and distance learning count towards CME. There are obligatory and optional courses available and the physician is responsible for any fees for such courses.

Professor A Wiecek, Vice-Rector and Head of the Department of Nephrology, Endocrinology and Metabolic Diseases, Medical University of Silesia, Katowice, Poland

In Poland there are 100,000 physicians for a population of 38×10^6 with 35 basic specialties and 33 higher specialisations. The number of training places is restricted and entry is by an MCQ examination. Basic training lasts five years, followed by an examination and then three years of higher specialist training, which also has an examination at the end. Training is supervised by tutors and the training is in line with European Union of Medical Specialists (UEMS) recommendations; Medical Societies arrange CME.

Professor M Horvat, Professor Emeritus of Internal Medicine, University of Ljubljana, Slovenia

There are 4,486 doctors in Slovenia of which 1,493 are general practitioners. Undergraduate training lasts six years and this is followed by two years of basic training (internship). The first six months is in emergency medicine, followed by eight months in internal medicine, four months in surgery and two months in paediatrics. After examination a licence is awarded and the doctor

can enter general practice. A Medical Chamber has been responsible for postgraduate medical education (PGME) since 1992. Specialist training lasts six years and a mentor is assigned from a national panel. Training is supported from central funds. Re-certification is mandatory, is regulated by the Professional Association and occurs every seven years. More than 20% of a physician's working time must be spent in the specialty for which the licence applies.

Professor I Bocsan and Professor A Radulescu, respectively Professor and Associate Professor of Epidemiology, Department of Community Health and Family Medicine, University of Medicine and Pharmacy, Cluj-Napoca (this occurred by videolink in Session 3)

In Romania, CME is mandatory and is achieved by gaining credit points. The main problems are a lack of coordination between CME providers, incomplete databases relating to CME activities and poor quality control. Postgraduate medical education is UEMS-based and a study of the present state is being undertaken currently.

In the discussion following the presentations questions were raised about academic medicine, postgraduate degrees and the potential movement of physicians to other countries. In response, it was indicated that in the Czech Republic and Hungary three years of study were required for a PhD. In Slovenia, a PhD was only obtained after specialisation and a separate two years of study. In Hungary, approximately 3,000 physicians held a PhD and a further 1,000 held a DSc. In Poland, a PhD was mandatory for a career in academic medicine. The movement of physicians was not considered to be a major problem. In the Czech Republic, around 7% of physicians move to Germany mainly, but there is an influx from the Ukraine. In Poland, some go to Germany, the US and Canada. From Hungary most go to Germany, the UK and Scandinavia. In Slovenia, there is mainly an influx from countries of the former Yugoslavia. It was mentioned that around 100–150 doctors each year come to the UK from Central and Eastern Europe.

The general impression gained from this session was that there were systems in place for postgraduate training and CME but that there were significant differences between the countries and between UK practice. A common problem seemed to be quality control and lack of financial support for training programmes.

SESSION 2

DEVELOPING PARTNERSHIPS IN POSTGRADUATE EDUCATION

This session was introduced by a brief outline from Dr Watson, Dean, Royal College of Physicians of Edinburgh, of the functions and activities of the Royal Colleges in

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the UK. Thereafter there were four workshops to consider the potential for the development of partnerships in postgraduate education. Each workshop had a facilitator and a rapporteur.

During the workshops there was much discussion and the development of ideas for cooperation. At the end of the workshops there was a brief resumé given by the rapporteur. The common themes to emerge were:

- the possibility of exchange of teachers and trainees;
- exchange of specialty curricula;
- development of a Cochrane base facility;
- exchange of multiple-choice question banks;
- developing distance learning;
- exchange of postgraduates to learn new technology;
- development of guidelines;
- linking in with UEMS;
- designing common exit examinations for specialties; and
- providing support to PGME courses.

There was not time to take this further but there was a feeling that the major benefit would come from the exchange of trainees and teachers, together with support of national societies and courses by providing lecturers. This might best be provided by specific links between centres (similar to twinning). Postgraduate training was not a real issue except in the fields of cutting edge technology where exchange for specific training would be useful.

SESSION 3

DEVELOPMENTS IN DISTANCE LEARNING

This session was introduced by Professor Iain Ledingham, Consultant, Middle East Affairs, Faculty of Health Informatics, Royal College of Surgeons of Edinburgh, outlining the principles of distance learning. He detailed the attributes of the trainer and the problems arising from the limited number of trainers. He emphasised that distance learning was not a substitute for on-the-job learning and there were difficulties in relating theory to practice. Mr Steve Nixon, Consultant General Surgeon, Royal Infirmary of Edinburgh and Ms Alice Breton, Director, Faculty of Health Informatics, Royal College of Surgeons of Edinburgh, presented examples of distance learning and provided information relating to Surgical Education Linking Effective Study, Clinical Practice and Training (SELECT) giving details of two websites – www.edu.rcsed.ac.uk and www.health-informatics.info.

Video links were made with Aberdeen and Romania. Mr James Ferguson, Consultant Surgeon, Aberdeen Royal Infirmary gave a practical demonstration of near and remote group learning and how support could be provided in emergency medicine for general practitioners, paramedics and nurses. The video link

with Romania provided them with the opportunity of giving the Colloquium information about postgraduate training.

The video link presentations were impressive and gave a clear indication of that which could be achieved. It was not obvious how such technology could be developed between the UK and Central and Eastern Europe but at least it provided food for thought.

SESSION 4

DEVELOPING GUIDELINES IN MEDICAL CARE

Dr Sara Twaddle, Director of the Scottish Intercollegiate Guidelines Network (SIGN) was, unfortunately, indisposed. However, Mr Robin Harbour, Quality and Information Director of SIGN, delivered her presentation. This provided information on guideline development and implementation. Two practical presentations followed; the first related to diabetes mellitus and was given by Dr John McKnight, Consultant Physician, Western General Hospital, Edinburgh and Lead Clinician, Diabetes Mellitus for Lothian. The second, on breast cancer, was given by Dr Douglas Adamson, Consultant Clinical Oncologist, Tayside Institute of Cancer Care, Dundee. In addition, the problem of guideline revision was discussed, whether parts be revised as required and whether publication be undertaken electronically.

There was clear interest in guidelines and the impression was that this was a useful session which had the potential for considerable collaboration. Further details about SIGN are on its website: www.sign.ac.uk.

SESSION 5

PHYSICIAN PERFORMANCE AND PATIENT SAFETY

In the last session of the day there were presentations relating to monitoring medical error, establishing standards of medical care and maintaining the confidence of the public in physicians. Dr John Scarpello, Clinical Specialist Adviser for Medicine to the National Patient Safety Agency, detailed the need to monitor medical error to improve patient care and to enhance medical practice by learning from mistakes. Sir Graeme Catto, President of the General Medical Council (GMC), outlined the role of the GMC and drew attention to some draft EU directives, particularly that relating to the possibility that a doctor may come to the UK and practise for 16 weeks in a year without being registered. Dr Mac Armstrong, Chief Medical Officer, Scottish Executive Health Department, described current healthcare dilemmas, the problems posed by consumerism and the dangers of medical information on the Internet. He also drew attention to adverse events, such as healthcare associated infections. In particular, he indicated that we must move from a blame culture to a learning culture when considering adverse effects.

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This was a very full session engendering considerable interest. It seems that the issues discussed were relatively new to Central and Eastern Europe. The post-presentation discussion centred around the issues of EU regulation and the Working Hours Directive which seemed to be unknown by the attendees from Central and Eastern Europe

SUMMARY

The Colloquium provided for a useful exchange of information regarding postgraduate training. It established potential contacts for active cooperation and future joint ventures. It should be viewed as a beginning on which to build by further contact, particularly along the lines suggested in Session 2.
