

CURRICULUM DEVELOPMENT PRODUCT III.H.

**STRENGTHENING
FAMILY MEDICINE EDUCATION
IN L'VIV OBLAST, UKRAINE**

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SUMMARY

Family medicine education in the L'viv Oblast was developed by Professor Eugenia Zaremba and Rector Michael Pavlovsky at L'viv Medical University, and currently consists of three general components:

- * There is a 'short' (four-month) course to retrain as family physicians, practicing primary care doctors such as pediatricians, internists and district doctors. Currently 98 physicians have completed this course.
- * A 'long' (2-3-year) course is designed to more fully train family physicians. It is primarily intended to serve as a residency program for recent graduates of L'viv Medical University. Currently, six physicians have completed this course.
- * Continuing education of the family physician after graduation from either of the above two training courses exists and also has several components. These include the new journal "Practical Medicine," the translation of a practical text of family medicine, the formation of an oblast-wide Association of Family Physicians, and conferences among family physicians and between family physicians and specialists.

These programs have been successful, as they have provided competent graduates who have initiated the practice of family medicine in both urban and rural settings. These practices have been found to improve health care while simultaneously reducing costs. The educational programs, even as they currently exist, can serve as models for other oblasts. Because the concept of family medicine and the education required for its practice are relatively new to Ukraine, policy makers and health professionals may be interested in the following recommendations for further strengthening education within the constraints of current resource limitations:

- The most urgent need is the recognition of, and the support for, family physicians as a specialty, so that physicians will be encouraged to enter the field, and positions for graduates will be available. Use of the Coordinating Committee for Family Medicine and other means to encourage prompt Ministry action is essential.
- Planning for family medical education should be broadened to develop strategies nation-wide for undergraduate medical education in the field, and to extend post-graduate education to other medical universities. The need for specialists is decreasing rapidly in Ukraine and resources should be diverted from specialty training to the needs of primary care education. An initial step might be to convene conferences and workshops for other university educators to consider the educational needs and how they might be met.
- Curricular adjustments will 'fine tune' the current program. Suggested is emphasis on interviewing techniques, approach to patients, family planning, psychology, obstetrics,

and trauma. Further curricular adjustments will be needed as changes occur in available educational resources, the frequencies of the various illnesses within the population, and the availability of new technologies.

- The formal training programs for both the ‘short’ and the ‘long’ courses should increase the use of ‘preceptorships’ and clinical training in emergency medicine. These options will not increase the cost of the programs, but they will expose trainees to the clinical problems they are likely to see in practice.
- Continuing education strategies already begun (“Practical Medicine,” the translation and printing of a practical family medicine text, the Association of Family Physicians, increased use of specialists and computers) should be encouraged and strengthened.

STRENGTHENING FAMILY MEDICAL EDUCATION IN THE L'VIV OBLAST OF UKRAINE

1.0 INTRODUCTION

1.1. History of Family Medicine Education in the L'viv Oblast

In the L'viv Oblast, and probably for all of Ukraine, the education of family physicians began in 1988, i.e., before the breakup of the former Soviet Union. It began when Dr. Eugenia Zaremba of the L'viv Medical University identified family medicine as a better system for health than that available at the time. The reasons for, and history of, the educational development is described (in Ukrainian) in a recent article in Practical Medicine. Review of the article indicates that an important part of the rationale for initiating family medicine was its focus on the family as an essential biological unit for society.¹ The authors noted that a family physician would be an ideal person to look after the physical and emotional health of the entire family. Further, they indicated the substantial experience in England, Canada, and the United States which showed that family medicine provided effective primary care.

In 1988 there was the nearly simultaneous introduction of an experimental family medicine practice at L'viv City Polyclinic No. 2, and a training course for family physicians at the L'viv Medical University. The latter was with the enthusiastic support of the University Rector, Professor Michael Pavlovsky. Professor Pavlovsky visited family medicine units in the United States, and Dr. Zaremba visited units in England. In 1990 internists and pediatricians at the Polyclinic received training in family medicine. Over two years, internists were gradually introduced to pediatrics, learning in steps to care for children down to the age of 7 years, then to 3 years, 1 year, and finally as newborns. The training then expanded to include district physicians. Clearly the development of education proceeded in lock step with the development of practice, which was important so that education would be practical and not theoretical only. These early steps were prescient because in the rigid Soviet system at the time, there was no family medicine, which meant that family physicians had no recognition, no guidelines for practice, and no monetary compensation for their additional training.

It wasn't until 1992, one year after Ukrainian independence, that official recognition began, in the form of approval by the Supreme Council for family medicine as an experiment. In 1994 the Ministry of Health established provisions for general practice and family medicine licensure and accreditation. But by that time in L'viv, many pediatricians, internists and district physicians had been retrained as family physicians, a three-year residency program had already begun, and a family practice office had been established in L'viv City Polyclinic No. 2. Thus the education and practice of family medicine in L'viv led the way and the government followed in small steps.

¹ Zaremba, E.X., I.O. Marmuniuk and G.D. Snyak. "The Development of Family Medicine in L'viv". *Practical Medicine* 1:118-120, 1996.

In 1995 a Department of Family Medicine was established at L'viv Medical University, with Professor Zaremba as the head. In the same year she established the Association of Family Medicine with more than 100 members. In 1996 she established a journal, Practical Medicine, of which she is the Editor-in-Chief. The journal appears quarterly, and two issues have so far been published. The successful practice of family medicine has spread to City Hospital No. 1.² At the Medical University, 98 physicians have been retrained as family physicians, and six residents have graduated from the three-year course. Dr. Zaremba is the driving force of these accomplishments, which occurred in the setting of continued, progressive deterioration of the Ukrainian economy.

Looking back with the advantage of hindsight, one sees that the strategies employed at the outset were largely correct. The choice to retrain practicing physicians had the advantage of requiring a shorter time than to educate medical students or even recent graduates. Focusing on pediatricians, internists and rural district doctors expanded the skills of physicians who, to some extent, were already doing primary care. For example, in the United States, more than two decades ago, it was the pediatrician who led the introduction of family medicine. In Ukraine, the use of a short retraining course developed with minimal time delay a cadre of family physicians who have subsequently made an impact in the L'viv Oblast.

1.2. The Need for Family Medicine Education

Education to help reform the health care system in Ukraine comes none too soon. With the deterioration of the economy has come an appalling decline in the indicators of national health. The increase in overall mortality, combined with the decrease in birth rate has led to an actual decrease in the population.³

Indicator	1991	1992	1993	1994	1995
Mortality/1000 persons	12.9	13.4	14.2	14.7	15.4
Births/1000 persons	12.1	11.4	10.7	10.0	9.6
Population (millions)	52.1	52.2	52.1	51.7	51.3

The high and deteriorating mortality probably relates to deteriorating life styles. Leading causes of death are cardiovascular disease, cancer, and pulmonary disease. These leading causes of death have important behavioral and environmental components which include smoking, alcohol abuse, high fat diet, inadequate exercise, air pollution, and radiation. Experience in the United States has shown that public education will greatly

² See ZRP Technical Report #Ukr-14 and Narrative Product #II.G., by John Reeves and Annemarie Wouters, "Strengthening Clinical and Economic Aspects of Family Medicine in the L'viv Oblast."

³ Pirozhkov, Serhiy. "Current Demographic Problems of Ukraine". *Medical Newspaper of Ukraine* #26-28 (120), July 1996.

help offset these negative factors. Educating patients is an essential function of family physicians, and physician education must reflect this role.

An important contributor to the low birth rate is the extraordinarily high incidence of abortions. The official record, which probably underestimates the actual number, records 772,000 abortions in 1993.⁴ This is about 50 percent more than the recorded number of live births for the country. Of the abortions, 90 percent are in adult women and 10 percent are in women aged 18 years or less. The numbers suggest that married women are using abortion as a means of birth control to avoid increasing the size of their families in these hard times. A recent report suggests that a contributor to the low birth rate also could be male infertility.⁵ Therefore, family planning is important for Ukraine, and the family physician is strategically positioned to facilitate it. Education of the physician to advise the family on issues of infertility and to be effective in preventing unwanted pregnancies becomes important.

Education for primary care is essential, because it is the most effective way to deal with these global issues. As defined by the Institute of Medicine in the United States, *primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.*⁶ Thus, the central feature of primary care is the patient. Family medicine is one system which aims at providing primary care by developing a sustained partnership with the patient. By focusing on the individual, primary care aims at improving the health of the population.

1.3. The 'Soviet' System Contrasted with Family Medicine

Education for this philosophy runs squarely against 70 years of Soviet influence. The Soviet philosophy was that the health of the population depended on a centrally controlled system. It was a system on a grand scale. There was a physician for every 300 persons, some three to four times the number in Western countries. Hospitals were for 1,000 to 2,000 patients, polyclinics were nine stories high and were designed to serve 125,000 people. Staffing was by specialists; medical practice was compartmentalized. There were 140 different medical specialties established in Ukraine⁷ and there were numerous other special services, as for example, for immunization, and special teams for alcohol education. District physicians existed but their function was primarily that of writing medical excuses for patients not able to go to work. They were also responsible for administering immunizations at the discretion of the Sanitation and Immunization Service. The health of the population was by decree from the central government, based

⁴ United Nations Development Programme, Ukraine Human Development Report, 1996.

⁵ Swanson, R.J. and T. Sereborvska. Second Ukrainian Congress of Pathophysiology, Bogomolets Institute of Physiology, October 9-11, 1996.

⁶ "The Future of Primary Care." Institute of Medicine. United States of America. 1996.

⁷ Dr. Morosov, Ministry of Health of Ukraine. From speech to the Coordinating Committee for Family Practice, Kiev, 17 October, 1996.

on a punitive system. Physicians, usually district doctors, were responsible for the health of their district. If immunizations were not carried out in sufficient numbers or if there was even a slight increase in mortality, it was the fault of the physician, who was reprimanded or even fined. It was thus the physician, not the patient, who was responsible for the patient's health.

Despite this charge to the physicians and their relatively large numbers, patients could easily get lost in the system. If district doctors, charged with mundane duties such as immunizations and work absence slips, were not respected medical practitioners, then patients would not go to them when they got sick. Rather, they would go to specialists, who were considered to be better trained. A problem was that the patient had to self-diagnose in order to know which specialist to go to. Frequent patient error led to frequent referrals to yet another new doctor. Further, follow-up care was not a priority, so that it was not clear where a patient should go for continuing problems. Not only did patients get lost in the system, but there was no health professional to provide health advice and education on a continuing basis. Even so, with massive funding, this inefficient system did function. But in the current economic crisis it is collapsing under its own weight.

Medical education is also centrally controlled and on a grand scale. Medical schools, organized on a six-year program, are large: the Kiev State Medical University has 6,000 students. Students decide on a specialty by their second year and are trained to that end before graduation, after which they are assigned by the government to further specialty training or to a post. There is no choice. Clinical training of the student is by lecture and by observation, where students may graduate without ever having seen the retina of the eye or performed a pelvic examination. Except for home visits performed by the student, the student has no patient responsibility during medical school. And because the home visits are supervised poorly by faculty or not at all, they are a service to the system rather than education for the student.

After graduation, specialty training is often in very large institutes, of which the largest and most prestigious is the Kiev Institute for the Advanced Training of Physicians. Ukraine has two other such institutes, but 17 medical universities also have faculty departments for post-graduate training. In all these facilities post-graduate training is often rather perfunctory. After four to six months of training, the physician is designated an ophthalmologist or a neuropathologist. An internist who becomes a sub-specialist requires, for example, three months of training to become a gastroenterologist. Thus the specialist in Ukraine does not carry the same credentials as in England, Canada, or the United States, where several years go into specialty training and more years into sub-specialty training. With the recent limitation of resources in Ukraine, consideration is being given to closure of the post-graduate institutes and even the university faculties, a move which would further centralize an already over-centralized system.

From the above it follows that Ukrainian undergraduate and post-graduate medical education as well as medical practice has long been focused on the specialist, which implies emphasis on the science and mechanics of medicine. Largely ignored has

been the 'art' of medicine, i.e., understanding, relating to, and treating the whole patient, in the context of emotions, family, and community. Professional competence and the art of medicine are the essences of family medicine. Introducing the concepts of family medicine and family medical education into a system which has largely ignored the art aspect of family medicine for two generations is certain to cause tension. The fact that these concepts have been understood and accepted in L'viv, and have been introduced with some success, is truly remarkable.

2.0 OBSERVATIONS ON THE EDUCATIONAL MODELS AT L'VIV STATE MEDICAL UNIVERSITY

2.1 Objections and Problems

Given that family medicine has not existed in Ukraine for many decades, family medical education is new, and some of the concepts are foreign, it is no surprise that objections arise, as recently summarized in a speech at the Ministry of Health of Ukraine.⁸

These objections include the following:

- Everything new costs money, including family medical education, and Ukraine is in no position to bear new expenditures.
- Family medicine is not an officially recognized specialty, complete with description, salary structure, and supporting personnel, so there is no incentive for physicians to enter the discipline.
- There is already a surfeit of trained and practicing physicians in Ukraine, and the introduction of family medical doctors will put thousands of doctors out of a job.

Each of these objections has merit which needs careful consideration. With regard to cost, it is true that Ukraine has decreasing resources available for education and, indeed, the resources available for family medical education have been or will be reduced. However, the retraining of existing physicians requires less in resources than it does in commitment, as demonstrated in L'viv, where retraining has gone forward in a progressively restrained economy. Further, because there are already too many specialists, the resources previously used to train them can be redirected to train family physicians. Indeed, reductions in educational support by the Ministry of Health have been much less for family medical education than for the specialties. Finally, strategies can be developed that will minimize training and retraining costs for family physicians.

The problem of lack of description and support for family medicine is both real and urgent for those training the physicians. Recently reported to the Ministry of Health in Kiev⁹ was the fact that family physicians trained in the L'viv program had difficulty finding jobs because their training was not recognized and because they had no salary designation from the Ministry. This problem is recognized by the Ministry, which has 'floated' a decree for discussion to provide a description of the family doctor. Assignments were made by Dr. Morosov at the October 17, 1996 Coordinating Committee meeting for the delegates to prepare descriptions of the duties, requirements, work scope, etc. for family physicians and to report on these for meetings to be called in November and December of 1996. Thus the Ministry realizes the urgency of the problem and is taking steps to rectify it. Oddly enough, even with this problem there is growing interest in family medicine among specialists, and particularly among students.

⁸ Koretsky, V. Speech before the Coordinating Committee of Family Medicine, Ministry of Health, Kiev, 17 October, 1996.

⁹ Zaremba, E. Speech to the Coordinating Committee for Family Medicine, Kiev, 17 October, 1996.

Perhaps the most difficult problem is that physicians currently employed will become unemployed with the advent of family practice. This will likely happen even if the new work force is made up totally from the retraining of existing primary care physicians such as pediatricians, internists, and district doctors. First, there are already at least twice as many physicians as needed in Ukraine. Second, one competent family physician whose retraining provides an expanded scope of practice can easily replace two currently practicing physicians. In addition, new physicians continue to be graduated from medical schools. The question is what to do with all these physicians. At the present time the answer is not clear, and the Ministry should be urged to actively address this problem. Even without the advent of family practice, strategies need to be developed to reduce the number of newly educated physicians, and to effectively utilize those who will soon become redundant.

2.2. Retraining of Primary Care Physicians. (the ‘Short’ Course)

Dr. Eugenia Zaremba conducts a “short course” to retrain pediatricians, internists and district doctors for family medicine. The course has 624 hours of instruction based on a six-day week for four months. The course structure has 45 percent of time for didactic lecture, 37 percent for case presentations and seminars, 10 percent for clinic participation with specialists, and 8 percent for examination on the material presented. Specialists from 20 disciplines from the University faculty teach the course. The time allotted to each varies from 30 percent each for internal medicine and pediatrics, to 1 percent each for proctology, dentistry, and clinical laboratory. Thus an attempt has been made to allocate time for specialties according to the importance of illness in the population. By intent, the course is intense and comprehensive.

To date the course has graduated 98 persons, several of whom were interviewed. For solo doctors from remote districts the training made them more confident, but did not change what they did because of lack of equipment and uncertainty as to how they might legally expand their practice. For sub-specialists and urban physicians, the course substantially expanded the scope of their practice by increasing their ability to diagnose and manage patients of various ages and complaints.

A list of nearly 100 practical skills to be mastered by the graduates was drawn up by Dr. Zaremba. Ten graduates picked at random from urban practicing graduates scored each skill as to its usefulness. Seventy percent of the skills taught were found to be used frequently and were judged to be very important; 30 percent were used less frequently or were only for information to be used for referral. The course was judged to be both well received and useful. The result of the course has been that improved utilization of medical talent already available in the oblast has allowed family medicine to develop expeditiously and with little cost. The course serves as a model for other oblasts, particularly in the urban setting.

2.3. A Residency in Family Medicine (the ‘Long’ Course)

The ‘long course’ residency for recent medical graduates of L’viv Medical University is designed to be 11 months per year for three years for a total of 33 months. The division between classroom and clinic/hospital shows a progressive decrease in class time with a complementary increase in practical work.

	Year 1	Year 2	Year 3
Months in University Department	5	3	2
Months in Hospital/Clinic	6	8	9

The 20 specialties taught in the University Department are those also taught in the short course, with a similar distribution of emphasis, and a similar division between lecture, seminar, workshop, and testing. The course is highly structured, and well organized. There have been six graduates to date. This long course serves as a model, and the graduates should be considered to ultimately serve as trainers and educators for future trainees. There is also offered, for highly trained family physicians, a two-month course as a pre-accreditation refresher.

2.4. Association of Family Physicians

Dr. Zaremba has established the Association for the program graduates and trainees. There are monthly meetings for dissemination of information, discussion of common issues, and continuing medical education. The Association serves as a model for other oblasts, in order that a country-wide organization can occur. Also, Dr. Zaremba has established a journal, “Practical Medicine”, for which she is the Editor-in-Chief. The journal appears quarterly and the first two issues have been published on time.

2.5. Further Strengthening of Family Medical Education

2.5.1. The Coordinating Committee for Family Medicine

Clearly the most urgent need is for the Ministry of Health to recognize, describe, and support family medicine. Without a ‘job slot’ for graduates, there is no future of an educational program. The *ZdravReform* Program encouraged the Ministry to set up a Coordinating Committee for Family Medicine. The Ministry is essentially bankrupt, but ZRP funded attendance of the delegates at the initial meeting in October 1996, and will fund the meetings in November and December. A half-day meeting entails relatively little expense, but initiates the democratic process of having informed citizens give input to the decision-making process. For its part, the Ministry seems to be urgently receptive to this input, with a target date as of the end of 1996 to initiate changes. Family medicine is not a specialty that the Ministry understands well, so the deputy ministers are looking for assistance. There is therefore, a window of opportunity.

2.5.2. Broaden Family Medicine Education

Assuming that the Ministry of Health will approve, describe, and develop support for family medicine, then planning needs to go forward among universities for the training of family physicians at the undergraduate and post-graduate levels. The national need for specialists is decreasing, and basic decisions must be made as to manpower requirements, what kind of training is needed, and how much. These decisions must not be left to the Ministry without input from informed and concerned educators and oblast officials. Strategies need to be developed for workshops, seminars, and conferences to deal with these issues in advance, in order to inform the Ministry.

2.5.3. Educational Sessions on Patient Interviewing, Dignity

Curricula traditionally require continual modification, and this is particularly true in Ukraine, where economic pressures are reducing educational resources. Also, the introduction of new tools, activities, and diagnostic possibilities will change the curriculum. Thus the observations in the following sections will likely apply for a limited time only.

The observation in the clinics was that patients should be treated with greater dignity, by ensuring that the patient-doctor relationship is more confidential and private. Practice of this principle was much better in the ambulatories than in the specialists' offices, but there is always room for improvement. To facilitate this goal, sessions on interviewing techniques could be an initial part of both the short and long courses. The interviewing sessions would emphasize the need to focus on, and be sensitive to, patient concerns, and to minimize extraneous interruptions. Accessories such as curtained cubicles and patient gowns will be helpful, but better education is key. The importance of a session(s) on patient dignity, courtesy, and interviewing techniques is that as the doctor-patient relationship improves, patient self esteem increases, health awareness improves, and receptivity to health education is enhanced.

In 1996 life expectancy for men in Ukraine was age 55, which implies that life style issues such as use of tobacco and alcohol, poor diet and lack of proper exercise are adversely impacting health. Monitoring of clinic visits indicated that education of the patient on these topics was rare. The relation of these to individual and population health should be stressed in the curriculum, along with techniques by which the physician can use clinic visits to educate the patients.

2.5.4. More Emphasis on Trauma, Obstetrics, Family Planning, Psychology

Questioning of graduated family physicians indicated, from their actual experience, that further training would have been useful in certain disciplines. Rural physicians specified that more training would have helped them handle trauma cases,

particularly where fractures were possibly involved. Both rural and urban physicians said they wanted more training in obstetrics. Urban physicians stressed the need for more psychology in the training period. If, as has been suggested, family planning is to be included in the job of the family physician, then it should be added to the curriculum. The teaching of family planning to family physicians is a logical extension of their activity and it combines obstetrics and psychology.

2.5.5. Increased Use of Preceptors

There are two different but not mutually exclusive philosophies for educating family physicians. The first is that they should be trained in all specialties, and the second is that they should be trained to handle the common health problems in the population. The training at the L'viv Medical University emphasizes the first in that teaching is done by a cadre of specialists. However, the training includes the second philosophy in that the various specialties are weighted according to their clinical importance. Complicating these issues is the continuing reduction in resources available for all training.

One resolution to these problems is to emphasize more clinical training at the successful ambulatories, both in L'viv and in rural areas. Thus, if time for faculty input to training is reduced, training at the ambulatories can make up the difference. Further, the trainee will gain practical experience in the illnesses to be faced after training has been completed. There is such experience in the three-year, but not in the four-month, course. Another strategy to be considered is the use of emergency rooms at hospitals for clinical training sites. The patient mix at emergency rooms resembles that at family medical practices, with the addition of critically ill patients.

At issue is how to maximize the effectiveness of such clinical training. One key is that each patient visit is to be a teaching experience. Successful features of the teaching experience are that the trainee be given responsibility for the patient and not be only an observer, that the preceptor reviews the patient with the trainee, and that the trainee is required to document how appropriate was patient handling as judged from the literature. Discussions with other preceptors and other trainees broaden the educational experience. This model of teaching, which is widespread in other countries, can be more broadly applied in family medicine. The advantages of this training model are that it is effective, it reinforces classroom teaching, it maintains clinical skills of the preceptors, and the costs are minimal. The disadvantages are that the preceptor needs to invest time in the trainee, and that clinic space will need to be provided for the trainee.

2.5.6. The Journal "Practical Medicine"

The publication of this journal is a signal step forward. The goal should be that all members of the Association receive the issues as they are published. Dues will likely be necessary to defray the costs of publication and mailing. Members are to be encouraged to submit articles to the journal and to participate in its operation.

2.5.7. A Text of Family Medicine

Dr. Zaremba has identified a text published by the British Royal Society of Family Medicine. The initial translation into Ukrainian has been completed and a review is under way. This plan is to be encouraged and resources sought for its implementation.

2.5.8. Strengthen the Association of Family Physicians

The Association is young and its existence and continuity depend on Dr. Zaremba. Its future strength will require more organizational structure with officers, by-laws, membership lists, and dues. Decisions will have to be made as to inclusion of family medicine nurses, economists and other professionals. The Association will need to develop and maintain among its members effective communication, as through a newsletter. A planned introduction of computers will allow convenient e-mail communication. As the membership grows, a public policy arm should be considered to encourage health reform and Association interests.

2.5.9. Strengthen Post-Graduate Medical Education

Formal and informal conferences involving family physicians and specialists should be strengthened. For rural ambulatories this may take the form of clinics for a visiting specialist to see problem patients. For urban settings, the specialist may be invited in for 30 minutes or an hour updating of a field, or for review of difficult problems. With the planned introduction of computers and modems, there will be the capacity for literature searches and e-mail consultation inside and outside Ukraine. Selected sites could be targeted for use of educational compact disks which are now available through Scientific American Medicine.

3.0 SUMMARY OF RECOMMENDATIONS

3.1. Coordinating Committee for Family Medicine

This committee should be used as an effective tool to inform the Ministry of Health and to encourage rapid and appropriate action for the strengthening of family medicine. A necessary step for a strong educational program are job opportunities for the graduates.

3.2. Nation-wide Plan for Family Medical Education

The educational model at L'viv Medical University is apparently well ahead of that at other universities, and is sufficiently well developed that it can serve as a basis for discussion in other oblasts.

3.3. Introduce Teaching Sessions on Patient-Doctor Relationships, Interviewing, and Patient Education

The surveys, comments from program graduates, and numerous direct observations indicate that more emphasis should be given in the training program to the "whole patient" approach. The Soviet emphasis on specialties and the mechanics of medicine ignored the art of medicine. Family physicians have already made a start at restitution, but the curriculum needs to be revised to include this aspect.

3.4. Alter Course Emphases to Meet Practice Needs

A physician skills survey indicated some areas of the curriculum which should be de-emphasized. Rural physicians wanted more training in trauma and fractures, while urban physicians wanted more training in psychology. Both wanted more emphasis on obstetrics. Family planning should be introduced into the curriculum.

3.5. Increase Utilization of Preceptorships

The decreasing resources for training family physicians dictate new strategies, which should include the broader use of successful ambulatories as preceptorships for the trainees. Preceptorships are the heart of training in many Western countries, where they have been utilized with great success, and an expanded role for these should be sought in Ukraine.

3.6. Enhance the Use of "Practical Medicine"

The Editor-in-Chief of this journal is Dr. Zaremba, and the journal is an ideal mechanism to disseminate news and ideas about family medical practices. Strategies need to be developed to see that each practicing family physician has a subscription to the journal, and that contributions are encouraged.

3.7. A Text on Practical Family Medicine

A text from the Royal Society in London, translated into Ukrainian, is currently under translation review. Strategies need to be developed to see that the text comes to publication, and that copies be made available.

3.8. Strengthen the Association of Family Physicians

The Association can serve many functions including continuing education, dissemination of ideas and news, and helping to form local and national opinion. The Association is newly formed and thus needs strengthening to provide for continuity. Suggestions are to develop by-laws, a broad base of membership, collections of dues from members, institution of newsletters, utilization of electronic mail when the planned computers are introduced, and ultimately to develop a public policy arm to advance family medicine in the political arena. Associations need to be developed in other oblasts to establish a nation-wide association.

3.9. Strengthen Post-Graduate Education

Once family physicians have been trained, it is important that their skills stay current. Strategies to maintain physician clinical skills include enhanced communication with specialists when patients are referred and by conferences, and with the advent of the planned computers, by literature searches, by e-mail contact inside and outside Ukraine, and by the use of educational compact disks.