Opening, Introduction by the president of the UEMS Dr H. Halilila.
The President, Dr H Halila, welcomed new delegates from anaesthesics, medical
bio-pathology, cardiology, surgery, cardio thoracic surgery, vascular surgery,
dermato-venereology, obstetrics/gynaecology, rehabilitation medicine, ophthalmo-
logy and neurology.

D 0230: Report of the meeting on 11 May 2002
D 0301: UEMS Annual report 2002
D 0324 April 2003 reports sections.
D 0305: Meeting of the Advisory Committee on CME on 23 November 2002.
Chapter 6 of Document on Postgraduate Training.
WFME: Global standards for Quality Improvement.

1. Approval of the report of the meeting on 11 May 2002 (D230), UEMS 2002
annual report (D 0301) and April 2003 reports Sections:
The Minutes of the previous meeting were approved and the UEMS annual report
accepted.

2. Representation of the Sections in the UEMS Management Council
meetings:
Two representatives from each of three groups of specialities have sat on two
Management Council meetings. Although the UEMS Secretariat has received their
reports, not all Sections and Boards have done so. None of the representatives have
received any feedback from those they represent. The representatives met with
their constituencies. The conclusion from Section 1 (Medical Specialties) was that
there was a lack of understanding of the function of the Management Council, (A
meeting of representatives of the National Medical Societies in the EU to meet,
discuss and where appropriate lobby the EU as the official means of
communication.), and why representatives were required? (Designed to improve
communication and demonstrate transparency in the process.) Specialty specific
problems should be communicated directly to the Management Council but generic
problems, or certain issues such as quality assurance could be shared with the
representatives as well, who could then act as an advocate. It was felt that a
reminder should be sent to each Section and Board by the UEMS secretariat two
months before every Management Council meeting so that, in turn, they could
contact their representative if there were particular issues they wish to be
addressed. At the end of each report, the representatives could give a short
comment on issues or feedback received from other Sections, in case they were
more widely applicable. It is to be hoped that this two-way communication process will be easier in future. This process is in an embryonic stage and needs some fine tuning.

The question of the voting right was raised but following our rules only national members have voting rights at the Management Council level. It is not a fundamental problem: it is much more important to be present at the MC meeting than having voting rights. It seems for some specialties difficult to have there problems presented but of course the direct contact to UEMS remains possible. More information on the activities of the MC should be transmitted to the members of the Sections so that they can be discussed in the Sections. A proposal was made to schedule a meeting of the representatives of the Sections at the MC on 9:30 before the meeting of the MC. It was also proposed to have next year first a meeting of the three groups represented at the MC and afterwards a General Meeting.

3. European Union;
The UEMS is represented at the European Health Policy Forum where was proposed to move all the items related to doctors from DG Internal Market to DG Sanco.

The President briefly summarised of the situation regarding the EC directorates involved in health care. Health and Consumer Protection was mainly concerned with the European Health Forum and the Internal Market with the proposed changes to the Doctors Directive. There was much opposition to the latter and it might be that the process would run into 2004 when EU expansion occurs, when it could be dropped but for the moment, UEMS was still doing everything it could because of the potential risks to patients. The new draft directive effectively prohibited the specialty of General Practice/Family Medicine. There were those in the European Parliament and in the working group of the Council of Ministers, as well as medical and other professional bodies, who were critical of the proposal.

Looking at the enlargement 7 of the new countries are already Associated Members. For the harmonization of the Quality it is important to study the Medical Education in each new country. Some transition period has to be proposed based on the guidelines published in Chapter 6.

4. UEMS working groups:
Postgraduate Training and Updating of Chapter 6 of the Charter
Some specialties need to complete/update their section before publication. There was a discussion about the European Board Certificate and exams in assessment. It appeared that some specialties, mainly surgical, were using exams whereas medical specialties tended not to do so. Debate followed about the cost of exams, in which language they should be held and if they perform a useful function as a European Board Certificate did not confer any advantage to holders practicing in their own EU country. Some sections perform a visitation of the different departments or both a visitation and an exam.

CME/CPD Quality Assurance in Clinical Practice
Dr Edwin Borman presented a paper on this. It dealt with the role of the UEMS and identified the various stakeholders in the process. He emphasised the need for accountability within health care in general with the doctor being a member of the team and also for the individual specialist. The quality agenda includes quality improvement, quality assurance and quality control. Quality improvement was covered in the previous policy paper – ‘The Basel Declaration on CPD’. Quality assurance was defined as regular review against defined standards of clinical practice. He emphasised the need for added resources to enable this. The objective was to reassure the various stakeholders. (Patients society, doctors, fund holders, employers and regulators.) Each should recognise their responsibility in the support of quality assurance and in turn each stakeholder should have a clear understanding
of why quality assurance matters. The quality assurance cycle should include setting standards, monitoring performance and practice, reviewing results and outcomes and then, if appropriate, introducing improvements. No system will work without adequate resources. The whole process must be supportive and not destructive. There must be a good correlation between performance (what a doctor can) and competence (what he knows). A good proportion of Knowledge, Skills and Attitudes. We have to look at the well being of doctors, working conditions and workload.

5. **UEMS website:**
Dr Theuvenet gave a presentation on the new website which can be found at [www.uems.net](http://www.uems.net). A large European ISP, Tiscali will be the provider and will assist on technical problems. Some parts of the website will be protected and every user will have an id and a password. A very big part of the work will remain the protection against viruses.

6. **EACCME:**
Minutes of the annual UEMS Advisory Committee on CME, a report on development and structure of CME/CPD, and the EACCME Annual Report for 2002 were received. Countries have different approaches to CME, some voluntary, some semi mandatory and others mandatory. The UEMS collaborates with national bodies when they exist and supports them when none exist. Sections and Boards, not other European bodies were responsible for this. A Working Group on distance learning has been set up. A sliding scale of fees for recognition of meetings exists. The lack of power of the UEMS in enforcing changes caused anxiety but UEMS makes good progress by negotiation, encouragement and harmonization.

7. **Specialist issues:**
There was discussion about possible new Sections in Clinical Pharmacology, Forensic Medicine and Audiology and if existing Sections were involved in ethical issues. In a number of countries in Europe there was a trend towards generalists who could deal with acute medical takes. The number of sub specialties was being reduced. In Sweden, Public Health was going to disappear. It was important for EU patients to have equal access to a specialist in every country.

8. **Compendium 2004:**
Following problems with Kensington Publications, UEMS is exploring other publishers with the aim of producing an edition for 2004 themed on CME/CPD.

9. **World Federation for Medical Education (WFME) :** conference on WFME global Standards for Quality Improvement:
This NGO based in Denmark has produced three papers on CPD, basic and postgraduate medical education aiming to identify global standards for quality improvement. These were thought to be consistent with UEMS recommendations. (see [http://www.sund.ku.dk/wfme](http://www.sund.ku.dk/wfme)).

10. **Miscellaneous:**
The President highlighted the non-payment of fees by France 2002 & 2003 and explained that if the problem were not resolved by 2004, France would have to be expelled. All of the French representatives on each Section and Board would be excluded. He requested they liaise with French colleagues to encourage them to press for a remedy of this. France had already been expelled from the UEMO because of this. The Treasurer had been to France recently to try and negotiate a solution. He was mildly optimistic about the outcome.
Next meeting:
The next meeting will be on **Saturday 15 May 2004**, also in Brussels.

Bernard Maillet
Secretary-General UEMS
With thanks to Dr Rodney Burnham