es can provide up-to-date (albeit sometimes biased) information on drug treatments.

It is recognised that patient groups, insurance companies, medical managers and the Government, as purchasers of health care, wish for a high quality service. However, quality is difficult to define and assess. It is no longer acceptable for the profession to act without providing quality measurements, although at the moment it is recognised that these are not universally fair.

Currently the best methods of measuring quality is monitoring continuous professional development by CME points, monitoring performance by medical audit, monitoring departments by peer review and monitoring the whole process where possible by quality indicators and outcome measures. There are limitations to these crude tools. CME measures attendance at meetings and nothing more. Audit is time-consuming and often only measures easily measurable outcomes, it tends to be local and does not compare clinical activity from one hospital to another. The peer review system is very good for staffing, resources, education and networking, but has a tendency to be self-congratulatory. Quality indicators and outcome measures are currently at a rudimentary stage of development for medicine.

It is important that the medical profession ensures that it provides a quality and cost-effective service to its patients and society, before this role is undertaken by others (for example patient pressure groups, non-clinical managers and politicians). It is vital that adequate infrastructures are in place, eg staffing and funding. Nonetheless, the systems that are put into place should have the potential to detect team or individual problem areas at an early stage, to avoid sanctions or suspicions which undermine public confidence and threaten clinicians and their teams. Rectification of any problem rather than punishment should be the aim of clinical governance.

Training Issues for Pneumonologists in Europe

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The UEMS advises the European Commissioners via the permanent committee of EU Doctors on training aspects within Europe. The rnission statement of the UEMS 1994 is that the doctors in training should, at the end of his/her training, have gained broad theoretical and scientific knowledge of respiratory diseese and all conditions affecting the lung, as well as having wider clinical experience. After training the doctor should be able to make independent decisions within all areas concerning respiratory disease and take care of both acute and non-acute patients. At the end of training the doctor should be able to audit and advise upon research projects relative to the speciality and to participate as a tutor and teacher in the field.

The UEMS advocate harmonistation of training within the EU. Firstly, by virtue of European law, secondly because of the free movement of both patients and doctors within the EU, thirdly to promote shorter training, and finally to ensure quality training throughout Europe.

The mean length of training within Europe is 12.6

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years from the start of undergraduate training to completion of specialist training, ie gaining a CCST. The UEMS advocates an optimum training af 6 years at medical school (a mean of 6.5 years within Europe), one year of internship (mean 1.2 years), a period of general professional training in general internal medicine of 3 years (mean 1.9 years), and a minimum training in pneumonology of 3 years (mean 3.8 years). Eleven countries in Europe have an entry examination, with 12 countries having no entry examination. The UEMS recommends a training environment where there is wide experience, preferably with rotations. A training centre should have at least two specialist in pneumonology. There should be good facilities, wide contacts, research and teaching. Currently the trainees in 18 countries rotate and in 5 countries there is no rotation. Research is expected in only 6 countries. Assessment of training should be undertaken by a national authority, but it is hoped that there will be a European Diploma awarded to training centres, supervised by the UEMS, perhaps adminstrated by the European School of Respiratory Medicine.

The UEMS recommends visits to training centres by outside assessors to assess the quality of training (UEMS 1997).

Trainees should be assessed against the national curriculum. Eleven countries have a national curriculum and 9 countries have no curriculum. The UEMS published a curriculum suitable for each country in 1994. Systems of assessment and appraisal should be put in place. These should be valid, reliable, practicable, fair to the trainees and useful to the trainers.

The best methods currently are as follows:
humanistic – supervisor reports in conjunction with a log book
factual knowledge – multiple choice questionnaires
problem solving – case vignettes or extended matching MCQs
communication – standardised patients
pratical skills – objective, structured clinical examinations (OSCE)

Appraisal of trainees is regarded as an important part of their training. Trainees who have undertaken structured appraisal with their log book are more motivated, clinically confident and have better empathy with their trainers than those who have not undertaken structured appraisal. The lowest ratings were obtained by trainees who had undertaken no appraisal at all. Most European countries have a log book, but assessment and appraisal accurs in 12 countries and not in 10. Some kind of exit examination is recommended in order to reassure the public that trainees have attained an aceeptable level. Exit examinations are present in 17 countries and not in 6 countries.

In conclusion, quality training is a high priority for the UEMS and the European School of Respiratory Medicine, and harmonisation and perhaps European accreditation may well become a reality.