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Becoming a medical specialist in the Netherlands

Structure, organisation and supervision
of training and (re)registering
medical specialists

Dear colleagues, good morning and welcome to Deventer. It is a honour and pleasure to have you here.

Dr. Smeets has given you an excellent outline of Mental Health Care in the Netherlands. It is my privilege to tell you something about the Dutch system for training *medical specialists in general*, especially how its rules and regulations are made and enforced. Experiences with the training of *psychiatrists* will be presented by one of our trainees, Dr Vleugels.

Characteristics of Dutch postgraduate medical education

- Specialist training is *characterised* by
 - presence of elaborately regulated and closely monitored training system
 - absence of a specialist exam.
- Regulations for specialism training concern *requirements* for
 - specialists in charge of the training
 - teaching hospitals/institutions
 - duration, content and conditions of trainingproposed by the organisations of the various *specialisms*, to ensure content-validity and public support
- Focus on *practical* training

Undergraduate medical training takes 6 years in the Netherlands and ends with the final licensing examination. Having passed that examination the student obtains the university degree of Medical Doctor, the formal qualification to practise medicine. Registration as a medical doctor in accordance with the Individual Health Care Professions Act is a prerequisite for a specialist training post.

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These regulations are proposed by the organisations of the various medical specialisms, to ensure content-validity and public support.

The focus is on practical training.

Teachers and training facilities

Specialist training is provided
by *recognised* specialists in *approved* training hospitals

- Only doctors working in a hospital/institution, recognised as training hospital, are eligible for recognition as head of specialist training
- To be recognised as head of training, trainers must:
 - have been registered in their specialism for at least five years
 - have adequate practical experience in their specialism
 - be able to teach
 - provide evidence of organisational skills
 - provide evidence of research
 - meet current standards of medical ethics

The basic assumption of the system is that specialist training only can be provided by *recognised* specialists in *approved* training hospitals.

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To be recognised as head of training, the specialist concerned must:

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be able to teach

provide evidence of organisational skills

provide evidence of research

meet current standards of medical ethics

From trainee to specialist

- Application for a specialist-training post and inclusion in the training register of the MSRC
- Working under supervision of a trainer/specialist-coach for a specified period (4.5 years in psychiatry)
- At least annual evaluation of progress
- After the completion of training and on receipt of the trainer's final statement, the MSRC may enter the resident in the Dutch register of specialists
- Once registered, he/she must practise for at least 16 hours pro week and attend 40 hours of formal CME a year, in order to be re-registered every five years.

A doctor who plans to *enter training* in a specialism programme has to apply for a training place to a specialist training department. If accepted by the trainer, he or she is required to notify the Committee for the Registration of Medical Specialists (MSRC) and to submit a training schedule for approval. This schedule must be in accordance with regulations for the specialism concerned.

The *trainee* works as a resident under the supervision of a trainer. In the course of the training, the resident should assume gradually greater responsibility. Training consists of a theoretical and a practical part. The relative importance of practice and theory varies from specialism to specialism and is laid down in the teaching rules for each specialism.

At the end of each year of training, the trainer sends an *evaluation* of the resident to the MSRC. In the case of problems concerning the resident's progress, the MSRC is empowered to decide that the resident must prolong, or even terminate, the training.

Having completed the training, the MSRC may, on receipt of the trainer's final statement, enter the resident in the Dutch register of specialists. The resident must provide the MSRC with detailed information on the training in the form of a logbook. As one of the requirements for registration, he or she must publish a paper in a peer-reviewed journal or present a lecture at a peer-reviewed scientific meeting.

Once registered, he or she has to practise on a regular basis for 16 hours a week and attend 40 hours of formal continuing medical education a year, to be reregistered after and for another 5 years.

National differences in standard setting for postgraduate training

Different patterns of responsibility for standard setting:

- National medical associations (e.g. Netherlands)
- Designated professional bodies, distinct from the national medical associations (e.g. U.K.)
- Ministry of Health, together with regional medical administration (e.g. Sweden)
- Universities (e.g. Finland, Southern Europe)
- Postgraduate institutions (e.g. Central and Eastern Europe)

So far we have seen some aspects of the Dutch training system for medical specialists. The question is, *who decides* on these specific regulations. Before we go more deeply into this question, let us have a look at the different systems European countries have adopted for the establishment of standards.

In broad terms, five different patterns of responsibility for standard setting can be identified:

1) National *medical associations*, as in the Netherlands, Norway, Germany, certain Central European countries and Portugal, have the main responsibility. The medical profession itself, in other words, provides and dispenses postgraduate training in these countries.

2) *Designated professional bodies*, distinct from the national medical associations, may have major responsibilities, as in the U.K., where the Royal Colleges approve training posts and assess the competence of doctors in training.

3) The *government* (Ministry of Health), together with the regional medical administration may play the main role (e.g. Sweden).

4) *Universities* may be the chief responsible bodies, as in Finland and Southern Europe.

5) *Postgraduate institutions* are the chief postgraduate authority as in Central and Eastern Europe.

History of the Dutch system

- Second half 19th century: emergence of specialist doctors (54 in 1890)
- 1900-1930: discussion about regulation of specialization
- 1930: decision by Dutch Medical Association to set up a register
- 1932: establishment Registration Committee
- 1950: establishment Review Committees for different specialisms
- 1961: establishment Central Board for the regulation of training and Board of Appeal (trias politica – separation of powers)
- 1997: Individual Health Care Professions Act (Wet BIG) comes into effect for doctors
- 1998: establishment of the Regulation for specialist training and registration, in accordance with the Individual Health Care Professions Act and the General Administrative Law (Awb) ⇒ Central Board and Registration Committee become Autonomous Administrative Bodies

As in other European countries, the first specialised doctors in Dutch Health Care emerged in the second half of the 19th century. The statistics of the Dutch Medical Association show that there were 32 in 1880, 54 in 1890 and 462 in 1910. Many of these doctors tried to gain experience in their specialism by working for some time in a university clinic, but there were no statutory requirements. There was, in other words, no guarantee that the specialist concerned was actually competent to practice. With the rise in the number of specialists, there was an increasing demand for regulation of the specialization process. Finally, in 1930, the Dutch Medical Association decided to set up a register and in 1932 established to that end the Registration Committee for (Medical) Specialists (SRC). It was agreed with the sickness insurance funds that, henceforth, only the services of registered specialists would be reimbursed. In this way, the practise of non-registered specialists was made more or less impossible by means of private law. In addition to registers for certified *specialists*, the SRC drew up lists of recognised *specialisms* and of certified *teaching hospitals*. The SRC was not able by itself to audit the certification of the fast growing number of would-be teaching hospitals and so in 1950 established Review Committees for different specialisms. Initially, the SRC performed tasks with respect to the regulation and implementation of specialist training and handled appeals to its decisions as well. To do justice to the trias politica, a new organisational structure was introduced in 1961 with separate legislative, executive and judicial bodies to cover the administration of the whole postgraduate training system. There are three branches: one for *general practitioners and nursing-home physicians*, one for *medical specialists* and one for *public health physicians*. Each branch has a board for the *regulation* of the training (e.g. the Central Board for the approving and registration of medical specialists –CCMS), a committee for the *implementation* of the regulations and for the registration (e.g. MSRC) and a board of *appeal*. Regulations on training are laid down in resolutions which have to be approved by the Royal Dutch Medical Association and the Minister for Health. The Individual Health Care Professions Act (Wet BIG - replacing 12 existing statutory regulations, aimed at fostering and monitoring high standards of professional practice and at protecting patients against professional negligence and incompetence), that came into effect for doctors in 1997, ties in closely with current practice. Regarding procedures and terms, the Regulation for specialist training and registration follows the General Administrative Law (Awb): the Central Board and Registration Committee have become Autonomous Administrative Bodies.

Structure of Training Authority

Royal Dutch Medical Association: Training and Registration

- Central Board (CCMS)
 - Recognition of medical specialisms (now 27)
 - Decree on regulations for specialism training, concerning requirements
 - for specialists in charge of training
 - for the teaching hospitals/institutions
 - for duration, content and conditions of training
- Committee for the Registration of Medical Specialists (MSRC)
 - Registration of medical specialists
 - Approval of specialists in charge of training and of teaching hospitals/institutions
 - Implementation of regulations and monitoring training process
- Board of Appeal
 - Hearing of objections to MSRC decisions

The Royal Dutch Medical Association has a Training and Registration Unit, that functions as a general and technical service for the two Autonomous Administrative Bodies, CCMS and MSRC, that fall under the General Administrative Law. The activities of the Medical Association are thus covered by *private* law, those of CCMS and MSRC by *public* law.

The *Central Board (CCMS)* is responsible for the recognition of medical specialisms (now 27) and for decrees on regulations for specialism training. This concerns requirements for specialists in charge of training, training hospitals/institutions and for the duration, content and conditions of the training.

The *Committee for the Registration of Medical Specialists (MSRC)* is responsible for the registration and reregistration of medical specialists, for the approval of specialists in charge of training and of training hospitals/institutions, and for the implementation of the regulations and monitoring the training process.

The *Board of Appeal* is a kind of court for the hearing of objections to MSRC decisions.

Characteristic elements in regulations for specialist training

- Duration of training
 - varies from 4 to 6 years, with possible exemptions
 - in accordance with European regulations and UEMS recommendations
- Training environment
 - training only by an MSRC recognised specialist trainer, in a MSRC recognised teaching hospital/institution
- Training schedule and duties of trainee
 - uninterrupted training period in accordance with approved training schedule
 - explicit duties with respect to office and clinical work and training activity
- Training and clinical research
 - trainee is obliged to attend scientific meetings and to publish research
- Training abroad
 - part of the training may be followed abroad in well-established foreign institutions

Typical elements in the training regulations concern:

the *duration of training*, which varies from 4 to 6 years, and is in accordance with European regulations and UEMS recommendations; exemptions are possible, if somebody has gained relevant experience outside the specific training situation

the *training environment*, meaning that specialist training can be given *only* by an MSRC recognised specialist trainer, in an MSRC recognised training hospital/institution

the *training schedule*, which provides for an uninterrupted training period in accordance with the approved training schedule and which stipulates explicit *duties* with respect to office and clinical work, and training activity

clinical research, requiring the trainee to attend scientific meetings and to publish research

training abroad: part of the training may be followed abroad in well-established foreign institutions

Recognition process for trainers and training institutions

MSRC

- **checks** fulfilment by trainers and training institutes applying for recognition of *requirements and obligations*, laid down by CCMS
 - supported by
 - *27 Plenary Review Committees (PVC)*, made up of expert-trainers for each recognised medical specialism, as advisory boards
 - *ad hoc Review Committees*, made up of 2-5 members of the PVC, including at least one trainee, for on site visits
- ⇒ Review report and opinion on applications are submitted to the *plenary assembly* of the MSRC (27 representatives of the recognised specialisms, 3 representatives of the universities, 3 representatives of the general hospitals, 1 representative of the trainees, 2 legal advisors, 2 permanent secretaries/medical specialists/ex-trainers, chair)
- ⇒ **provisional decision**, debatable by those concerned
- ⇒ **final decision**, which may be brought before the Board of Appeal and the courts.

The core business of the MSRC is to check if would-be and previously approved trainers and training institutes fulfill the requirements and obligations laid down by the CCMS.

To that end the MSRC has at its disposal:

27 Plenary Review Committees (PVC), made up of expert-trainers for each recognised medical specialism, as advisory boards

ad hoc Review Committees, made up of 2-5 members of the PVC, including at least one trainee, for on site visits

Review report and opinion on applications are submitted to the *plenary assembly* of the MSRC (composed of 27 representatives of the recognised specialisms, 3 representatives of the universities, 3 representatives of the general hospitals, 1 representative of the trainees, 2 legal advisors, 2 permanent secretaries/medical specialists/ex-trainers, chair)

The plenary assembly takes a **provisional decision**, which can be debated by those concerned.

After a specified period and having weighed the pros and cons put forward by those concerned, a **final decision** is taken, which may be brought before the Committee of Appeal and, where necessary, the courts.

Characteristic elements of the recognition process

- Linking trainer and training institution
- Requirement of a deputy trainer
- Training climate
- Central Training Committee

To achieve the desired reciprocity between the trainer and the board of the training institution, *a trainer cannot be recognised unless the training institution is recognised and vice-versa.*

To avoid the trainees, having their training interrupted, when the trainer is absent, *a deputy trainer is required*, who has to meet the same stringent requirements as the trainer, to warrant both the continuity and the quality of the training process.

The totality of requirements and obligations for the trainer, for the deputy-trainer, for other medical specialists working together with the trainers in the training process, for the training institution and for the trainees, is intended to ensure a favourable *training climate*. The medical specialists, involved in the training process serve as role models in their attitude and uniform approach towards patient care and research. Furthermore, they have to establish an open atmosphere, in which all relevant topics can be discussed and the trainees feel safe to express their uncertainties and learn from their mistakes. Because it is nearly impossible to judge from paper the existence of an adequate training climate, a review committee made up of several experienced trainers is brought in for on-site visits.

In a teaching hospital recognised for the training of several specialisms, a *Central Training Committee* is required as a consultative body for maintaining and promoting an optimal training climate. Trainers, trainees, board-members and medical specialists not involved in training are represented on this body.

Forms of recognition & training capacity

- Basic assumption: *training is only possible in a formally recognised training environment*, regularly checked by the MSRC
 - Traditionally, recognition bound to *one* location, to guarantee availability of sufficient trainers/medical specialists and a consistent training climate
 - Organisational developments in Health Care \Rightarrow different forms of recognition
 - recognition for the *whole* of the training
 - at *one* location
 - at *multiple* locations,
 - recognition for a *part* of the training
 - recognition for a *specific* work placement
- on condition of formal collaboration agreement with other training institutes

As a *basic assumption* the Dutch training system holds that the trainee can be *trained only in a formally recognised training environment*, regularly monitored by the MSRC in respect of its adherence to the regulations laid down by the CCMS. Traditionally, recognition of the training was bound to one location of a training institution, to guarantee the availability of sufficient medical specialists, to be involved in the training process and so to create a consistent training climate. As a result of the increasing number of mergers between hospitals and the need to have sufficient training capacity, the CCMS had to establish different forms of recognition: recognition for the whole of the training at *one* location or at *multiple* locations, recognition for a *part* of the training and recognition for a *specific* work placement. Recognition for part of the training and for a specific work placement can only be obtained if the training institution is able to show a formal collaboration agreement with other training institutions, to make sure that the trainee can follow a complete training schedule without interruption.

Developments

- Widening of training structure:
from individual trainer to team of trainers
- Combination of university and non-university
(regional) training circuits
- Change of trainee profile
- Juridification of the training system
- Renewal in the medical professions

The rapid socio-economic and socio-cultural developments of the last decades have had their repercussions on the delivery of specialist health care. As a consequence, the regulation, execution and testing of medical specialist training needed adjustment.

Most prominent in that respect is the widening of the training structure, I spoke of earlier. The emphasis shifted from the *individual* trainer to a *team* of trainers responsible for an optimal training climate.

Over time, the contribution of general teaching hospitals to the training of medical specialists has grown considerably. They now outnumber the university training facilities. For an optimal integration of practical and scientific skills, leading to the true evidencebased practice of specialist medicine, a combination of university and non-university training circuits seems to be a good solution. The regulations should be adapted to that end.

The trainee of today and the medical specialist of tomorrow has as a profile which is different from that of the traditional Dutch specialist. That trainee is a woman, has a working partner, makes more use of maternity- and parental leave, is more often exempted from night and weekend duty, works more often parttime and retires earlier.

Then there is the general trend towards juridification (or increased regulation) in society, which is reflected in the implementation of MSRC decisions with respect to the training system. I will discuss the consequences of that trend on the basis of the next slide.

The minister of Health has announced a drastic reorganisation of the professions and training systems in Health Care. I will discuss that topic later as well.

Juridification of the training system

- **CCMS** and **MSRC** become *Autonomous Administrative Bodies*, move from *private* law to *public* law domains
- Project '*Optimizing Regulations of the Boards*' ⇒ *Framework Decision*: one *general* regulation system for all medical specialisms, with 27 sets of *specific* regulations, each for a recognised specialism
- *Reorganisation Administrative System MSRC*

When the Individual Health Care Professions Act (Wet BIG) came into force, the Central Board (CCMS) and the Registration Committee (MSRC) were given the formal status of *Autonomous Administrative Bodies*, and moved from the domain of *private* law to that of *public* law. As a consequence, it became necessary that the form and content of the regulations laid down by the CCMS and of the decisions adopted by the MSRC met high standards.

They therefore undertook the project *Optimizing Regulations of the Boards*, which resulted in a coherent, up-to-date and legally correct system of regulations for the training, recognition and (re)-registration of medical specialists, trainers and training institutions: the *Framework Decision*. This Framework Decision consists of regulations governing all medical specialisms. In addition there are 27 specific regulations, one for each recognised specialism. In this way the MSRC has acquired an up-to-date instrument to help it carry out its remit.

At the same time, the MSRC *reorganised its administrative system*, to meet the legally required deadlines, to ensure its decisions are in accordance with the regulations, and to clarify its responsibility as a referee between different players in the field of training.

Modernizing the training of medical specialists

- Aims concerning *form and content of training*:
 - description of trainee *competences* at end of training, *modules* of training process, content of modules
 - structured *teaching course*, at least one day a month
 - *quality enhancement* of trainers
 - Links between specialist training and final year of medical school
- Aims concerning *testing and assessment*:
 - annual *knowledge test* in first years of training
 - short *clinical assessments* during entire training period
 - *portfolio*
 - regular *evaluation discussion* between trainer and trainee
 - assessment and exam *code*

In the wake of the announcement by the Minister of Health, that he is planning a drastic reorganisation of the professions and training systems in Health Care, the CCMS has started a project to modernize the training of medical specialists. I mentioned earlier the general starting points for this modernization. In addition, the CCMS has formulated several aims concerning the *form and content* of training and concerning the *testing and assessment* of trainees. These aims should be achieved before 2007.

The aims concerning *form and content of training* are:

description for each specialism of
trainee *competences* at end of training
modules that make up the training process
content of the modules
introduction of a structured *teaching course*, at least one day a month
formulation of a system for *quality enhancement* of trainers
establishment of a link between specialist training and the final year of medical school

The aims concerning *testing and assessment* are:

introduction of an annual *knowledge test* in the first years of training
introduction of short *clinical assessments* during the entire training period
introduction of a *portfolio*
introduction of regular *evaluation discussions* between trainer and trainee
drawing up an assessment and exam *code*

Essential condition for enduring quality in medical specialist training

Optimal *cooperation* between

- scientific associations of *medical specialists*
- *CCMS* for regulation of training
- *MSRC* for implementation of regulations