Specialty training in health professional education: time for a paradigm-shift?

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1. Background

2. Analysis

3. Five challenging reflections

4. The Flemish experience (Belgium)

5. Conclusion
1. Background.

- Huge variation in organisation of post-graduate specialty training in health professional education worldwide.
- Dominant model: “UK-model” with “(Royal) College of…”.
- Strong mono-disciplinary bodies, influential in policy debates.
- Sometimes: hybrid system: universities do the residency-training to College specifications.
- European model: universities organise a “Master-after-Master”-program.
FRAGMENTATION
“Is there a need for a paradigm-shift for specialty training in health professional education in order to respond better to the changing health (care) needs?”
2. Analysis.

- Demographic and epidemiological transition, shift towards more chronic care and multi-morbidity.
Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie

Figure 1: Number of chronic disorders by age-group
Figure 2: Prevalence of multimorbidity by age and socioeconomic status
On socioeconomic status scale, 1=most affluent and 10=most deprived.
2. Analysis.

- Demographic and epidemiological transition, shift towards more chronic care and multi-morbidity.
- Scientific and technological evolutions.
- Socio-economic developments with an increasing social gradient in health.
- Cultural developments: changing position of the patient.
- Globalization.

→ How can the post-graduate educational system be responsive to the new challenges?
3. Five challenging reflections (1).

- Is generalism limited to the discipline of “family medicine”?
- The concept of EPAs: Entrustable Professional Activities: interdisciplinary supervision of post-graduate training.
- The Internet changes the role of doctors as memorized content experts towards synthesizers and interpreters of the evidence that is easily and democratically available.
- Integrative models of medical practitioners are more possible now than ever before.
3. Five challenging reflections (2).

• Distinction between the “core-content” of a discipline and the development of procedural skills?

• Role of “Physician assistant”, “technicians”, …

• The end of income models of sub-specialists who rely on procedural monopoly?
3. Five challenging reflections (3).

- “Who pays?” the trainees and the supervisors?
- Move of the training out of hospitals into ambulatory care and private practice settings
- Debate on the length of training until unsupervised practice.
3. Five challenging reflections (4).

- Difference between certification and “license to practice” (“credentialing”).
Recognition professional qualification

Language test

Licence to practice (credentialing)
- lifelong
- maintenance of licence according to criteria

Request for additional information (+ national provisions)
3. **Five challenging reflections (4).**

- Difference between certification and “license to practice” (“credentialing”).
- In the interest of patient safety, but often sullied with protectionism and prejudice.
- Need to construct an evidence base around maintenance of expertise, that is not developed by those who have the most to protect.
3. Five challenging reflections (5).

- Medicine, nursing,… are “professions” which includes that the profession has control over certification, standards, credentialing,…
Profession of Medicine

A Study of the Sociology of Applied Knowledge

Eliot Freidson
3. **Five challenging reflections (5).**

- Medicine, nursing are “professions” which includes that the profession has control over certification, standards, credentialing,…

- Status as a profession should be seen as a gift from society, not as a claim by a group.

- Social accountability of professions.

- Tension between “professional” versus “government” control is very evident in the post-graduate training space.
4. The Flemish experience (Belgium).

- Until 2010: Federal Ministry of Health designed a framework mainly focused on “learning by doing”.
- Within the European “Bologna-agreement”, it was decided that universities and the Ministry of Education could take the responsibility for post-graduate specialty training.
- Specific tracks for the different specialties, with established learning outcomes.
- Final certification by the Ministry of Health by “Certification-Committees”: 50% university, 50% representation of professional bodies.
- Advantages: joint interprofessional curricular modules, integration with innovative views from basic medical sciences and inputs from other faculties: economy, anthropology, management,…
- Facilitate the creation of “protected time” to harmonize “workplace learning” with other learning processes.
MODEL 1

Undergraduate curriculum

University
College 1
College 2
Society 3
...

FRAGMENTATION
MODEL 2

Undergraduate curriculum

Other faculties

- Family Med.
- Internal Med.
- Gynecology
4. Conclusion.

The changing societal needs require appropriate training for specialties in the context of health professional education.

The five reflections that we formulated, bring us to the hypothesis that traditional "Colleges" are probably not the best solution for post-graduate training, due to the demonstrated conflicts of interest and lack of integrative capability of the College system.

We hypothesize that Universities, especially if they are public universities, are better placed to serve society in post-graduate training. This hypothesis needs immediate investigation, exploring the ability of universities to experiment with different models, shifting the paradigm from "focus on sub-specialization" towards "comprehensive integrative approaches".
Thank you…
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