



VU Research Portal

Harmonising postgraduate medical education in Europe

van der Aa, J.E.

2019

document version

Publisher's PDF, also known as Version of record

[Link to publication in VU Research Portal](#)

citation for published version (APA)

van der Aa, J. E. (2019). *Harmonising postgraduate medical education in Europe: the case of Obstetrics & Gynaecology*.

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal ?

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

E-mail address:

vuresearchportal.ub@vu.nl

English summary

Jessica E. van der Aa

The topic of this thesis is introduced in **Chapter 1**, in which we discuss that the increasing mobility of medical doctors in Europe, requires better alignment of medical doctors' education across Europe. This need for alignment accounts specifically for the phase of postgraduate medical education (PGME), which prepares medical doctors to work as a medical specialist, or as a general practitioner. In Europe, PGME varies greatly between different countries, as well as between different medical specialties. Alignment of PGME across Europe could diminish the differences in PGME and therefore facilitate medical doctors to practice in different countries, which can eventually lead to better quality of care. One approach of educational alignment is standardisation, which refers to a strive for uniformity of training. Another approach of educational alignment is harmonisation, which refers to the establishment of common standards in training, while maintaining institutional autonomy rather than creating uniformity in training practices. This approach is more applicable for alignment of PGME in Europe, considering the diversity of training contexts. However, harmonisation processes are challenging. For instance, challenges lie in the development of training standards that are shared by the entire Europe, while they take into account the wide variation of contexts in training. In this thesis, we aim to explore the challenges that may be encountered in a process of European harmonisation of PGME, and additionally we aim to provide recommendations for dealing with these challenges. For our research, we take the case of the development of a European harmonised curriculum in Obstetrics and Gynaecology (OBGYN) as a learning case.

In **Chapter 2**, we argue more specifically why there is a need for a harmonised European curriculum in the field of OBGYN. Harmonisation of European OBGYN training, could enhance harmonisation of both quality standards of women's healthcare, and therefore lead to assurance of equal quality of training of gynaecologists. This may enhance mobility throughout Europe. Also, harmonisation of OBGYN training could enhance cooperation and exchange of best practices between medical specialists and hospitals within Europe. For these reasons, the European Board and College of Obstetrics & Gynaecology (EBCOG), aimed to develop a European OBGYN curriculum, which was initiated through a project called 'PACT' (Project for Achieving Consensus in Training). As elements of the curriculum, the project delivers (1) a description of the required medical expertise outcomes in a core and in electives (2) a societally responsive competency framework based on input from societal stakeholders and (3) strategies for education and assessment based on the current medical education literature. In addition, the project delivers (4) a SWOT-analysis for the implementation based on insights into transcultural differences, (5) recommendations for implementation, change management and sustainability based on the SWOT analysis, and (6) a handbook for other medical specialties who want to develop a European harmonised curriculum. This project offers an interesting learning case, through which European harmonisation of PGME can be researched.

To further explore the possibilities for European harmonisation of OBGYN training, we aimed to explore training variation in the field of OBGYN across Europe, as described in **Chapter 3**. The European context consists of many different clinical settings, which offer variation in training, determined by underlying norms, values and rules of a specific clinical setting. It is necessary to gain insight into the extent to which this training variation should be respected when pursuing

harmonisation of training, as the variation determines the boundaries of harmonisation. We explored variation in OBGYN training for the caesarean section (CS) procedure specifically, because this is a common procedure that all OBGYN trainees are required to learn. We interviewed trainees in Obstetrics and Gynaecology who had been trained in, altogether, fifteen different European countries. The trainees shared experiences with being trained to perform caesarean sections and with what had been important in their training. Analysis of data showed that there were many similarities in the experiences of the trainees, as their training relied on observation of others performing CS, performing CS themselves, and having interactions with their supervisors, for instance by receiving direct feedback on their performance. However, trainees seem to conceive of the concept of 'independence' in their caesarean section training differently. Hence, trainees' ambitions in performing caesarean section varied, their experiences regarding the contributions of supervisors to their training varied, and the development of the trainees' role in the procedure varied between the European trainees. These are relevant findings, because in general, European trainees are prepared for unsupervised practice as OBGYN specialists throughout training through progressive independence. However, diverging conceptions of 'independence' across Europe may affect harmonisation of PGME. Potentially, these diverging conceptions are affected by cultural norms and values. Currently, we lack understanding of how much educational concepts are affected by cultural factors. We need more knowledge on how medical educational concepts are affected by cultural values, to gain better insight in the possibilities of harmonisation.

In **Chapter 4**, we describe how a shared perspective on training was determined, in a process of European harmonisation of PGME. For the development of the European OBGYN curriculum, the medical expertise outcomes of training were determined. A Delphi (consensus) procedure was performed amongst European OBGYN specialists and OBGYN trainees, who were affiliated to EBCOG or ENTOG. The consensus procedure consisted of two questionnaire rounds, followed by a consensus meeting. To ensure reasonability and feasibility for implementation of the training standards in Europe, implications of the outcomes were considered in a working group. Sixty people participated in round 1 and 2 of the consensus procedure, 38 (63.3%) of whom were OBGYN specialists and 22 (36.7%) were OBGYN trainees. Twenty-eight European countries were represented in this response. Round 3 of the consensus procedure was performed in a consensus meeting with six experts. The entire consensus procedure resulted in the description the core content of the curriculum, which describes 188 medical expertise outcomes, categorised in ten topics. The subjects 'general gynaecology' and 'obstetrics' were considered most important for medical expertise outcomes of the European OBGYN curriculum. The process and the outcomes of the consensus procedure taught us that local incidence of specific procedures and local standards of practice affect training more strongly than was expected at first. Also, we learned that local training affects contemporary debates in the field of OBGYN, such as the debate on decreasing exposure of OBGYN specialists and trainees to specific procedures in relation to the quality and accessibility of health care delivery. Due to local habits and needs, not all elements of training can be harmonised easily, and this may even change over time. The implications of the study were on one hand, the establishment of the medical expertise outcomes for the core and electives of the European OBGYN curriculum. In addition, the study has provided insights in opportunities and threats of European harmonisation of PGME.

In harmonisation processes, it is essential to align standards of training with contexts of training. However, the aims of both standardisation and contextualisation may cause tensions. Standardisation of training refers to the use of common learning outcomes, strategies for training, and systems of

assessment. Contextualisation of training implies making optimal use of the workplace while aligning standards of training with workplace-based contexts. A better understanding of potential tensions in the process of harmonisation and how they are negotiated is necessary to understand and address potential challenges in the process. In **Chapter 5**, we describe how we explored if and how tensions between standardisation and contextualisation surfaced during the development of the European OBGYN curriculum. We held focus groups with curriculum developers of the European OBGYN curriculum, to discuss challenges that resulted from tensions between standardisation and contextualisation in the phase of curriculum development. From the results we concluded that tensions surfaced in two domains: 1) Varying ideas about what the harmonised curriculum means for the current curriculum and 2) Inconsistencies between educational principles and the reality of training. Additionally, we identified ways of dealing with these tensions, which were characterised as 'negotiating flexibility'. These tensions surfaced, partly because it was anticipated that there could be problems when implementing the curriculum. In harmonisation, translating a curriculum to a unique practice will cause tensions. Understanding how to deal with these tensions allows for better understanding of how harmonisation can be achieved.

In **Chapter 6** we elaborate on the importance of generic competency frameworks in PGME curricula and we report on how a generic competency framework for the harmonised European OBGYN curriculum was developed. We explored whether alternative strategies in design and development of a competency framework may enhance implementation of such frameworks in PGME. Integration of relevant change management literature encouraged us to suggest that there is a need for competency framework design that allows for re-invention and creative adaptation by medical professionals. Subsequently, we developed a generic competency framework through action research. Data were collected by four European stakeholder groups (patients, nurses, midwives and hospital boards), using a variety of methods. The data were analysed further in consensus discussions with European OBGYN specialists and OBGYN trainees. These discussions ensured that the framework provides guidance, is specialty-specific, and that implementation in all European countries could be feasible. The presented generic competency framework identifies four domains: 'Patient-centred care', 'Teamwork', 'System-based practice' and 'Personal and professional development'. For each of these four domains, guiding competencies were defined. European OBGYN specialists and trainees, as well as their European stakeholders supported the generic competency framework that was developed. As practical implications, we suggest that local re-invention and creative adaptation of the framework will stimulate the development of local frameworks by local medical professionals. We call for PGME design that is based on guiding principles, rather than on prescribing standards, to allow for re-invention and creative adaptation of PGME.

In **Chapter 7**, we summarise the purposes and the achievements of 'EBCOG-PACT' in the development of the European OBGYN curriculum. The curriculum is societally responsive, and based on the latest medical educational methodology. It consists of the description of medical expertise outcomes of training for the content of the core and electives, the general competencies and soft skills to be trained, as well as strategies for training of obstetrical, gynaecological, ultrasound, bio-psychosocial, and communicative skills. Also, the curriculum provides strategies for assessment through entrustment, a model for portfolio as well as strategies for faculty development and quality management of training. The implementation of the European curriculum in OBGYN provides opportunities for national scientific and professional societies and ministries of health or education to consider modernisation of national or local OBGYN training programs.

Finally, in **Chapter 8** we synthesise the findings of our research, into a novel perspective on educational alignment. We use the lens of the 'universal European gynaecologist' and the 'culturally versed European gynaecologist' to illustrate our new perspective. We argue that 'educational alignment' is the overarching term to be used, which entails a spectrum of levels of alignment, ranging from 'standardisation' as one extreme, to 'harmonisation' at the centre of the spectrum, to 'professional freedom' at the other extreme. Standardisation means striving for uniformity in a curriculum and in the enactment of training. Harmonisation means striving for commonly shared principles of training, combined with contextual autonomy in enactment of training. We explain how our research has helped us to interpret both concepts more distinctively. We conclude that standardisation aligns more with the lens of the universal European gynaecologist and harmonisation aligns more with the lens of the culturally versed European gynaecologist. In addition we recommended that, in processes of educational alignment local translation of an aligned curriculum should be encouraged. In educational alignment it is essential to carefully consider the needs of local contexts, to explore unintended effects of alignment, to explore ethical dilemmas in alignment and to ensure local implementation. This can be achieved by reaching out to different contexts, to understand what flexibility they need, and to negotiate this flexibility and integrate it in the process of alignment. Local contexts should be allowed room for re-invention and creative adaptation of a curriculum, to enhance implementation and enactment. Therefore, in educational alignment, local contexts should be encouraged to develop a local translation of an aligned curriculum, that meets the needs of the local context's daily practice. We argue that the spectrum and its levels of educational alignment should be understood, and their purposes and implicated strategies should be explored and considered. Parties who are involved in educational alignment should together determine for which elements of education, which level of alignment is required. We conclude that educational alignment should not be seen as a task that can be accomplished, rather it should be seen as an evolving and ongoing process that requires continuous reflection on which levels of educational alignment are required.