



Geir Wenberg Jacobsen (born 1945) professor emeritus at the Norwegian University of Science and Technology and editor of the Journal of the Norwegian Medical Association.

Photo: The Journal of the Norwegian Medical Association

A PhD degree must continue to be fully credited as part of the specialist training for members of the medical profession. We also need to accept that research topics and methodologies stem from different medical disciplines.

That blasted research

There is a popular legend associated with the establishment of the medical degree programme at the then Trondheim University and Regional Hospital (1). Allegedly, a representative of the hospital owners, Sør-Trøndelag County Council, expressed himself in no uncertain terms, stating that there would certainly not be any of «that blasted research»! Things clearly did not pan out that way, but it did take almost ten years for the first ten PhD degrees to be awarded.

Medicine is an academic discipline. All patient diagnosis and treatment should be based on research and evaluated in accordance with scholarly methodology. This is what distinguishes evidence-based practice from superstition and unfounded tradition; this forms the very foundation for providing the population with ever-improving health services. We have witnessed this for a long time in that a Nordic PhD or similar degree is credited on par with a full year's specialist training. Notably, the PhD degree counts towards this credit irrespective of the specialty. It is the generic knowledge – insight into the formulation of a research question, retrieval and processing of information, combined with critical reflection on the outcome – which is rewarded.

The traditional compulsory practice period arrangements for medical doctors in specialty training is currently being wound up, to be replaced by a new educational model. This process is in full swing and involves partnership working among the four regional education centres, headed by the South-Eastern Norway Regional Health Authority (2). The scheme involves a three-part programme which will take at least six and a half years to complete. The first eighteen months will replace the current compulsory internship period. Part 2 is a joint platform for groups of specialists, referred to as internal medicine and surgical disciplines, while the third part is unique to each specialty. Learning objectives are introduced, as well as joint competence modules and ICT solutions for the planning and documentation of competence. There will be strong emphasis on guidance and practice supervision (2, 3).

We are familiar with the application of learning objectives as part of undergraduate curricula. What is new is that the individual assessment of doctors in specialty training will be on-going at pace with their attainment of each learning objective. Every education institution is responsible for coming up with good systems for assessing the attainment of objectives (4). The Norwegian Directorate of Health is involved with the work to draw up a special template («recipe book») that will provide guidelines for what is required to achieve each learning objective (Karin Straume, Head of Division, personal communication). Until this template has been drawn up, it will be impossible to consider exactly how wrong or right it will be

to remove all the requirements for a summary assessment of time spent and the number of procedures, as is current practice.

Based on the discussion surrounding the centralisation of high-tech medical services at the expense of small-scale A&E departments, it gives cause for thought that the specialist training programme will no longer stress the importance of volume. A recent example is the organisation of the vascular surgery activities in Norway (5). Unlike the training for doctor in specialty training, this assessment is singularly concerned with the volume of operations carried out on each ward and by individual surgeons. This is a paradox. The regulations on specialty training make no mention of the current general practice of crediting a PhD degree (4). It is hard to understand how doctors in specialty training will receive fair treatment when this is replaced by a scheme which singularly focuses on the achievement of learning objectives. With no knowledge of how the objectives have been designed and how they will be assessed, this becomes even more difficult. How is it envisaged that 3–4 years of in-depth academic study will be exchanged for learning objectives when it comes to programme approval? Furthermore, it is not certain that these efforts will be rewarded if the dissertation topic or methodology is considered not to «fit in with the profile» of the specialty (4). Many doctors training to become a specialist may well be very unpleasantly surprised.

One particular group of doctors in training gives cause for concern: these are the many doctors who have chosen to work in a part time clinical position while also working part time as a PhD student. They may find it hard to achieve all the learning objectives set for their training programme. Like everyone else, these people also run the risk of having all or parts of their PhD work disallowed because it does not «fit in» with the specialty of their choice.

The strategy document produced by St. Olav's Hospital stresses their ambition to undertake «considerable research activity» (6). If so, it is a prerequisite that the people conducting this research are in command of the methodology. In this context, no learning objective can possibly trump a PhD degree. Up-and-coming doctors in training are encouraged to apply for work in hospitals and wards where there is active clinical research (2). The matter of who will be passing on these skills is a pressing question, as is whether research is indeed feasible in a climate where «production» is in the process of gaining a stranglehold.

A ongoing pilot project compares peer review assessments made by experienced colleagues to those made by younger doctors. The latter have a medical research background and all have completed

their PhD degree, yet have limited clinical experience. Our impression of this work so far confirms that academic training provides a competence which should not be disregarded. If today's practice of earning credits for research undertaken while in specialty training falls by the wayside, as intimated by current proposals, there is reason to fear that the interest in and the enthusiasm for academic medicine is thrown out with the bathwater. If so, it may well be that «that blasted research» is curtailed after all.

References

1. Jacobsen GW, Hansen AS. Medisinstudiet i Trondheim 1975–2015. Tidsskr Nor Legeforen 2015; 135: 2090–1.
2. Ny ordning for spesialistutdanning for leger – tverregionalt prosjekt. <http://lis-utdanning.info/beskrivelse-av-prosjektet/> (22.5.2017).
3. Etablering av ny modell for nasjonal spesialistutdanning for leger: Notat til Styretsgruppe. Regionalt utdanningscenter (RegUt). Oslo: Helse Sør-Øst, 2016. <https://www.helse-sorost.no/Documents/Styret/Styrem%C3%B8ter/2016/20161117/091-2016%20Orienteringssak%20-%20Etablering%20av%20ny%20modell%20for%20spesialistutdanning.pdf> (29.5.2017).
4. Regjeringen. Rundskriv I-2/2017 om spesialistutdanning og spesialistgodkjenning for leger og tannleger (spesialistforskriften). <https://www.regjeringen.no/dokumenter/rundskriv-i-2-2017-om-spesialistutdanning-og-spesialistgodkjenning-for-leger-og-tannleger-spesialistforskriften/id2539295/> (29.5.2017).
5. Haug ES. Hva er mange og når er det nok? Tidsskr Nor Legeforen 2017; 137: 505.
6. Fremragende behandling. Strategi 2015–2018, St Olavs Hospital/ Universitetssykehuset i Trondheim. <https://stolav.no/Documents/Strategi%20for%20St.%20Olavs%20Hospital%202015-2018.pdf> (28.5.2017).