NFYOG Nordic Seminar

Concerning

Obstetrical & Gynaecological Education

Malmø 16-17 jan 2004

Program

Friday 16 of January

10.00-10.30 Registration and coffee

10.30-12.00
"Presentation of national problems" - Exchange of experiences.
One from each country present focusing on the solution of the problems! (20 minutes per country). Followed by discussion and condensation of the major problems on "flip-overs"/large papers which can be used in the seminar.

12.00-13.00 Lunch

13.00 -15.00
Aims and objectives, learning strategies and assessment including discussion about portfolio and logbook in obs. gyn. specialist training"
Jette Led Sørensen (DK)

15.00-15.30 Coffee

15.30-17.30
How do grown-up people learn? and How to train the trainees? Trouble-shooting – how can we handle suboptimal specialist training ? *Jette Seidelin, (DK)*

How to evaluate the competences of the trainees - both the personal and the medical skills?
Magnus Lindahl (S)

Specialist examination ?
Seppo Heinonen (F)

17.30-18.30
Discussion and suggestion of how to improve the education in Obstetrics & Gynecology in the future
based on topics discussed in previous 3 sessions/workshops.
Subjects to present at the NFOG congress in Helsinki June 2004

Saturday 17 of Januar

9.00-10.30
How can the organization support and facilitate specialist training ?
Magnus Lindahl,(S) and Jette Seidelin (DK)

10.30-10.45 Coffee

10.45-11.30
Subspecialization – when and how?
CME – documentation of continued medical education
Seppo Heinonen,(F)

11.30-12.30
Recruitment and how to keep people in our specialty? (in e.g. Sweden a lack of approximately 600 gynecologists will be the fact in 5 to 10 years) – What can we do?
Discussion between all the participants in the seminar.

12.30 – 13.00 Evaluation of the course

Participants in the seminar

Name	Country
Jeanne Mette Goderstad goderstad68@hotmail.com	**N**
Kevin Sunde titch@online.no	**N**
Riikka Aaltonen, riikka.aaltonen@pp.inet.fi	**F**
Sari Silventoinen, sari.silventoinen@fimnet.fi	**F**
Kaisa Raatikainen, kaisa.e.raatikainen@kuh.fi	**F**
Johanna Haikonen, johanna.haikonen@pshp.fi	**F**
Virva Nyyssönen, virva.nyyssonen@ppshp.fi	**F**
Helena Blom: helena-blom@swipnet.se	**S**
Åsa Rosén: asa.rosen@vgregion.se	**S**
Karin Stålberg: karin.stalberg@kbh.uu.se	**S**
Johanna Wagenius: johanna.wagenius@telia.com	**S**
Sara Törnblom: sara.tornblom@spray.se	**S**
Jan Wall: jan.wall@telia.com	**S**
Åsa Wahlberg: asaulrika73@hotmail.com	**S**
Thea Lousen: lousen@dadlnet.dk	**DK**
Kirsten Jochumsen: kirsten.jochumsen@dadlnet.dk	**DK**
Gitte Eriksen: eriksen_gv@hotmail.com	**DK**
Marie Søgård: mariesoegaard@dadlnet.dk	**DK**
NFOG board	
Peter Hornnes; peter.hornnes@dadlnet.dk Per Ole Jansen (S)	
Total	**18**
Speakers Jette Seidelin (DK) Seppo Heinonen (F) Magnus Lindahl (S) Jette Led Sørensen (DK)	
I alt	**22**

The seminar was financial supported by NFOG and Novo Nordic A/S covering all expenses. All participants had fully financial support covering transportation and accommodation from either the department or the organization.

Aim of the seminar

The aim of the seminar was to discuss the Ob Gyn specialist training in the Nordic countries and update the knowledge of the participants upon the education in general. In addition a closer contact between younger OB/GYNs in the Nordic countries should facilitate exchange of knowledge on education in the future.

Resume and highlights from the lectures

Aims and objectives, learning strategies and assessment including discussion about portfolio and logbook in obs. gyn. specialist training

Jette Led Sørensen, Specialized Obstetrician Gynaecologist / Educational coordinator
The Juliane Marie Centre for Children, Women and Reproduction, H:S Rigshospitalet, DK

In the year 2000 the Danish national health departments demanded all specialties to create a new curriculum. Evaluation of competences should be based on 7 roles (the model imported from Canada); the medical expert – health advocator – leader/administrator – professional – academic – coordinator – communicator.

It has been important to create a feeling of ownership to the end product. A group of 22 counting professors, consultants and trainees representing different parts of the country, University departments and county hospitals – all interested in education. The work has been focused on the process and the insecurity of end point has been stressful for many of the participants in the work.

The Danish curriculum describes aims and objectives for the different parts of the specialist training. The objectives can be about knowledge (describe the care of…) or about skills (can diagnose and treat….). It is important that the assessments/ evaluations are matched to the objectives – Millards pyramid was presented to illustrate that.

For each objective the curriculum define;
competence to achieve, ***learning strategies*** (e.g. clinical work – skilled periods – use of delivery mannequin – courses – presentation) and ***assessment strategies*** (e.g. checklist to account activity – observation of clinical work – structural clinical observation – audit of records – selection of critical incidences – list of pictures (UL) – 360 degree evaluation (competences like communicator (structured coffee-room talk) .

The portfolio – defined as a collection of papers and other material that document that learning has taken place – is introduced in DK from Jan 2004. The principle is that the trainee through continuous work and reflection increase the level of competence.
Assessment has in general two functions;
summativ; to distinguish between passed vs. failed (done by the consultant responsible for education) and
formative based on feedback on strength and weakness, ensure development (done by the supervisor/tutor during the education).
Each competence has to be signed and approved to become a specialist.
Right now everyone in DK is waiting to see how the specialist training program based on the new curriculum will work in real life – in practise. Work concerning “how to secure a similar

evaluation at the different departments" is in progress. The trainers/supervisors need further education and so on. It is an ongoing project !
The Danish curriculum can be downloaded in Danish from www.dsog.dk – education (uddannelse) – "Målbeskrivelse"

How to evaluate the competences of the trainees – both the personal and medical skills

Magnus Lindahl, St-studierektor, Akademiska Sjukhuset, Kvinnokliniken, Uppsala, Sweden

Magnus Lindahl, specialist in Gynaecology and Obstetrics from Sweden and responsible for specialist training in Uppsala has a broad theoretical education on training doctors. His lecture was focused on "outcome-based education" which specifies the outcomes, students should be able to demonstrate upon leaving the system, ensuring that students master the outcomes and that all students succeed. The system was invented in the USA by ACGME (Accreditation Council for Graduate Medical Education) and is commonly used by the American Board of Medical Specialties. It is a well studied and evidence based system of education which specifies six different competencies in which the trainee should be assessed; patient care, medical knowledge, practise-based learning, interpersonal and communication skills, professionalism and system-based practice.
Dr Lindahl stressed that the primary purpose of the evaluation of the performance of trainees is to improve their performance.

ACGME has developed a "toolbox of assessment methods" to which dr Lindahl introduced us. It includes thirteen different methods of assessing medical training. One of the methods was the 360-Degree Evaluation Instrument, which means that the trainee is evaluated by the surrounding staff, such as nurses, colleagues, midwives, superiors, patient etc through a questionnaire to gather information on topics such as teamwork, communication, management skills and decision-making.

Another method is the OSCE (Objective Structured Clinical Examination) where the trainees are evaluated at 12 to 20 separate standardized patient encounter stations, each lasting 10-15 minutes.

We were also told about the portfolio-system, where the trainee collects evidence of learning and achievement related to a learning plan. It can contain written documents, video- or audio-recordings, photographs etc.

In groups we discussed the different assessment methods, which competence each method best evaluates and the methods' advantages and disadvantages. It was a fruitful and interesting discussion.

Specialist Examination

Seppo Heinonen, Professor, Department of Obstetrics and Gynaecology, Kuopio University Hospital, Finland

As a contrast to the lecture on "outcome-based education" stood the lecture about Specialist Examination in Finland by professor Seppo Heinonen from Kuopio. The Finnish National Written Examination is compulsory, very theoretical and the questions are very detailed. The trainee get four weeks of unpaid time off to read the compulsory literature of 6000 pages, plus the two latest years editions of twelve medical journals. The lecturers from Sweden and

Denmark earlier that day had stressed that when reading huge amounts of text in a short time, and then testing it through a traditional written examination, only 5-10% of the knowledge will last a few weeks later. Consequently the participants from Denmark, Sweden and Norway were rather critical towards the Finnish system, and an interesting debate was held were the Finnish Written Exam was defended by both the Finnish professor and the trainees.

Professor Heinonen also informed us about the work of the Union Européenne des Médecins Spécialistes (UEMS) whose main purpose is the harmonization and improvement of the quality of medical specialist practice in the European Union (EU). One of the ways to improve the quality of medical specialists is through the CME (Continuing Medical Education) Accreditation System. The speed of development of medical science in the 20th and 21st century is fast. This morally obliges all doctors to spend more of their time and energy on Continuing Education. The patient rightfully expects that the doctor is able to administer "state of the art" medical care. Therefore knowledge and skills have to be updated on a continuous basis.

For the moment there are no plans to make CME mandatory, although there is a mounting pressure from sources outside the profession that the doctor gives proof of his or her Continuous Professional Development (CPD). CME is a national responsibility under national authority. In some European countries re-certification of doctors is already practised. The EU do not require re-certification but the European Union considers CME as the primary means to evaluate the professional capabilities of migrating doctors to the standards of host countries.

The UEMS has developed the European Accreditation Council for CME (EACCME), to make the awarding of CME credits transparent as well as transferable between the EU countries.

In Finland the Finnish Medical Association has recommended that every doctor should have the right for at least two weeks CME/CPD outside the working place at the expense of the employer every year and should have at least 5 hours weekly dedicated for internal CME/CPD such as meetings, personal studies etc.

The lecture was interesting and hopefully CME could be a way for doctors to put pressure on their employer to get more time for education.

How can the organization support and facilitate specialist training?

Magnus Lindahl, and
Jette Seidelin
Specialized Obstetrician Gynaecologist, Department of Gynaecology and Obstetrics, H:S Hvidovre Hospital, Denmark

The session was divided into a theoretical part given by Dr Lindahl and a small practical exercise illustrating how important back-up and direct supervision both are for effective learning. The latter part held by Jette Seidelin, who has been in charge of the work concerning the new Danish curriculum.

The question “What *is needed to make an induction program work?”* was used to illustrate and discuss organization in a broader context.

1. A good mentor.

We discussed the mentor/mentee concept. For mentoring to contribute to educational reform, it must be connected to a vision of good teaching. The mentor must have an opinion about what makes a good doctor. Mentoring is more than a social role; it is also a professional practice.

Mentors need time to mentor, opportunities to learn to mentor and time to meet other mentors.

2. A head of department with the right attitude.

   The head of department must be interested in good training and promote it to the different people he is working with. The head of department influences the department's working environment.

3. Instructors.

   Everybody in a department is a potential instructor. He or she must be interested in teaching.

4. Coordinator.

   Someone needs to coordinate the activity in a department to make sure there is time for training, the right trainee at the right place, a rotation plan etc.

   A well functioning department promotes efficiency and prevents conflicts.

5. Other trainees.

   Trainees can create a network. They can support each other and influence training in a positive way. When you have other trainees in your department you can teach each other. Teaching is an effective method to learn something

6. Intra-departmental relations.

   A good working relation with one's colleagues is encouraged in an atmosphere without a hierarchy. The departmental leader sets the standard for the department. As doctors, we also need a social program with an opportunity to interact outside working hours. Ideally, this would be an environment where the doctors can talk about negative and positive events in everyday life at the clinic. All aspects of work would be open to discussion. It is important that these sessions are held at regular intervals.

7. Establish a portfolio system of documentation.
8. Establish self and/or peer evaluation programs.

Structured self-analysis should be encouraged.

CME and sub specialization

Seppo Heinonen

Basic principles of the EU are free movement of services, funds, products and manpower. Currently there are 15 countries in the EU and 10 new member countries will join in May 2004. The organisation and delivery of health care is the responsibility of each member country. EU´s Doctor´s directive 93/16/EC was first drawn up in 1975. It gave common requirements for undergraduate and postgraduate medical training and also directions to update on medical specialities in order to make free movement possible CME, Continuous Medical Education, a continuum from undergraduate to postgraduate and onwards throughout one's medical professional life. UEMS, European Union of Medical Specialist, defines CME as the educative means of updating, developing and enhancing how doctors apply the knowledge, skills and attitudes required in their working lives. The goal of CME is to improve all aspects of the medical work. Should it be voluntary of mandatory? Right now all European medical organisations are saying that there is no need for mandatory re-certification. CME should be part of the ethical responsibility of every doctor. In national levels CME is still very minimal, but discussion and plans are emerging in several member

countries. The practical instrument to improve the quality of CME in Europe will be the facilitation of transfer of credits obtained by individual specialist in CME activity that meet common quality requirement between European countries, between different specialist and case of migration of a specialist within Europe. The structures responsible for the delivery of funding of CME will vary depending on national arrangements and the balance between the private, insurance-based and employed sectors. Funding from the third partiers, such as the pharmaceutical industry, must comply with openness and transparency and should only be permitted in accordance with national and international guidelines.

In Europe there is sub specialist training programs in Materno-foetal and Perinatal medicine, in Gynaecological oncology, in Reproductive medicine and maybe in the future also program in urogynaecology. The number of training posts should be strictly regulated by the relevant national body in order to provide sufficient expertise. For each country, the estimated number of training posts should reflect the national need for subspecialists as well as the facilities and finance available for training. Training programmes should be in multidisciplinary centre of Obstetrics and Gynaecology and should be organised by subspecialist or an accredited subspecialist. Centers should use the guidelines and protocols which are finalised by national professional bodies and are reviewed at regular intervals. Trainees should participate in all relevant activities of the training unit such as care of out-patients and in-patients, on call duties, different operations, also the teaching of other health professionals, participate on audit and clinical or basic research in essential. The duration of subspecialist training should include a minimum of two years in an approved programme and should cover the clinical and research aspects of area of subspecialization. Training should be structured, an educational plan made individually and progress is to be monitored. A trainee may spend some training time in another centre recognised by EBCOG. Training as a subspecialist does not imply that she/he cannot practise in the generalist field of Obstetrics and Gynaecology.

Presentation of national problems concerning training in obstetrics and gynaecology

Sweden

Facts about Sweden

- Population: 8,9 million
- Physicians: approx 36583, 42 % women
- 1193 gynecologists in working age (<63 years)
- Approx 300 in specialist training

Facts about the Swedish specialist training

- Specialist training takes min 5 years
- In average 1 year in other specialties (surgery, anesthesiology, urology, neonatology, oncology)
- In average 4 years in ob/gyn.
- Approx 240 hours theoretical courses
- Logbook – competence based
- Voluntary written specialist examination (10-15 per year)
- Trainee average salary 3530 €/month (daytime job, does not include on call work)

Problems and their possible *solutions* in Swedish specialist training

- **Shortage of free cources**

The courses were earlier arranged by the National Board of Health and Welfare, but since a couple of years by an organisation called IPULS. Since long there has been a shortage of courses. The trainee is admitted to a course on basis of how long he/she have been training, and in general the trainee need around two years of training before admittance. There are also courses arranged by SFOG, but those courses cost between 300-1400 € and some employers will not pay those fees.

Suggested solutions;

Increased funding to increase the number of free courses.

A suggestion of different levels of the courses has already been made with courses available for trainees in their first two years of training, more advanced courses for those in year 2-4 and finally in the end the training even more advanced courses.

Another possibility is to increase the available courses without increasing the costs increasing the number of trainees attending each course. It may be possible to have 50 or even 100 in each course (today 20-30 trainees) as the courses mainly is based on lectures. That could of course not be done in practical courses such as laparoscopy or ultrasound.

Pressure should be put at the hospitals that offer specialist training. The trainees should not just be used as cheap staff to fill in the empty spaces in the schedule. If a hospital offer specialist training they should also invest some money in the training of the trainee and at least let the trainee attend one course every semester.

- **Surgical training**

In some hospitals the trainees do not get enough gynaecological surgical training and have difficulties in full filling the aims defined by the logbook. The problem seems to

be more common in larger hospitals. Maybe due to too many trainees at the same department per time?

Suggested solutions;
To increase the cooperation between the University hospitals and the smaller clinics including arrangements of exchange programs. Today the trainees in smaller hospitals need to go to a larger hospital for at least one year. Maybe the trainees in the University hospitals should be forced to go to smaller clinics as well to get more practical training and see more of "common gynaecological cases".

- **Lack of specialist in the future**

It has been estimated that Sweden would have a lack of approximately 600 gynaecologists in 5-10 years, when many senior doctors retire. These figures are always difficult to estimate as doctors are not stationary. The last couple of years we have actually had an influx of doctors from abroad and also many foreign doctors (e.g. refugee) living in Sweden have had their licences approved recently. Additionally the economy of many Swedish hospitals is very poor and for the moment it may due to that actually be hard to get a training position in some parts of Sweden. Another recruitment problem is the fact that only 10-20% of the trainees are men.

Suggested solutions
Improved working conditions such as better salary, reduced time on call etc. will make it easier to recruit new trainees for the speciality and keep specialists staying in Sweden and also to attract foreign doctors to come to Sweden.

A positive attitude towards medical students in general and especially towards male students is essential to make them consider the speciality. It is essential that they get to see and examine patients, and not just wait in the corridor! In that respect collaboration with and information of midwifes and nurses are of importance.

It is important that OGU and SFOG are present at occasions as AT-stämman, where all those doing their internship meet, to present the speciality.

Many doctors make their choice of speciality during the internship. In general gynaecology is not a part of the internship in most Swedish hospitals. Some hospitals offer a couple of weeks of gynaecology during the period of general medicine, which is a good way of creating interest for the speciality.

Finland

Facts about Finland

- Population: 5,2 million
- Physicians: 19 764, 48 % women
- 769 gynecologists, 600 in working age (<63 years)
- 170 in specialist training

Facts about Finnish specialist training in ob/gyn

- Training takes 6 years after medical school
- 9 months in primary health care, 6 months in surgery
- 6 months in another specialty or research (optional)
- 4,75 years in ob/gyn, max. half in university hospital
- 80 hours theoretical courses (20 hours administration)

- logbook (based on EBCOG guidelines)
- Mandatory written specialist examination (10 % fails per year)
- Trainee average salary 2744 €/month (daytime job, does not include on call work)

Problems and their possible *solutions* in Finnish specialist training

- **Lack of time, people and money**
  Lack of time to study and to train. Most of the work time goes in a routine patient work. Some hospitals have problems in recruiting specialists. Little or no time is reserved for education besides the normal meeting times.
  Suggested solutions; *Finnish health care system needs more funding. Good education should be something the hospital earns money with. Education should have separate budgets.*

- **Lack of coordination**
  The trainee is responsible for her/his rotation between hospitals. Also inside hospitals the rotations are not well enough planned. There are few individual long time plans for training.
  Suggested solutions; *Each University hospital should have a senior coordinator who should be responsible for rotations and individual study plans.*

- **Problems in organization and attitudes**
  The tradition for or culture of evaluation and assessment is quite new in Finland and it is not yet properly adopted and implemented. The organization does not encourage and require it at all levels. On the other hand the situation has improved a lot during last couple of years.
  Suggested solutions; *The organization should value and require feedback and evaluation. Attitudes need to be changed.*

- **Long working hours, heavy on call duty**
  Working time is 38,25 hrs/wk, which does not include on call duty. Average total working hour is 50 – 60 hrs/wk. On call duty is placed after a normal workday making it in to 24-hour shift. On call duty alone (senior doctor at home on call) in large hospitals with a high work-load is normal often resulting in young trainees working with a high stress-load.
  Suggested solutions;
  Shorter shifts. More people including senior doctors on "on call" duty.

- **Certain areas of the specialty are less well covered**
  Problem areas are endocrinology and infertility, fetal diagnostics, administration and leadership and in some hospitals operative training.
  Suggested solutions; *planned and organized rotations including individual study plans.*

Denmark.

Facts about Denmark

- Population: 5.4 millions
- Physicians: 17300 (37 % female)
- Gynaecologists/ obstetrics: approx 530 specialists

- In specialist training: approx 120 in training positions plus minimum 150 under qualification or waiting

Facts about Danish specialist training in Ob.Gyn.

- 6 years in University to have a Doctor degree
- 1½ year of internship
  - ½ year of general surgery
  - ½ year of intern medicine
  - ½ year in general practice
- 1 year of introduction position – **limited number of positions (50)**
- 4 years of specialist training **– limited number of positions (26 per year)**
  - ½ year of abdominal surgery incl. Urology
  - 3½ years of gynaecology/ obstetrics, 2 different departments, min 1½ year at a University clinic
- 200 hours theoretical courses
- NO examination
- Trainee average salary 4570 €/month (including on call work)

Problems and their *possible solutions* in Denmark

- **Lack of doctors - especially specialists!**

  Everybody is busy resulting in less time for education and training. The problem gets even worse due to an unequal age distribution among the consultants resulting in a 25% reduction of the number of specialists in 2025 in Ob/Gyn in Denmark

  Suggested solutions;

  Working hours have to be used in an effective way

  The trainer and the trainees at the same position

  The patients have to be seen by a trainee with access to supervision/counselling

  The operations possible to perform by the trainees have to be done by the trainees

  The function as a supervisor has to be valued (maybe also financially?)

  Everybody has to share the"on call duty"

  Focused, motivated and demanding trainees

  Everybody should take part in training others

  Training has to be look at as a part of the production in line with number of operations performed. The individual department should have "education of trainees" on the budget to make education both visible and valued.

- **Gyn/Ob VERY (if not the most) popular speciality in Denmark**.

  The last 20 years there have been at least 3 applicants for every "4-year-specialist-training" position. A lot of well-qualified people are waiting to get a training position getting older and older. When acquiring the training position the:

  - mean candidate age: 10 years
  - mean age: 38 years
  - mean candidate age as a specialist 14 year
  - mean age as a specialist: 42 years
  - mean age "out of work": 63 years

Looking forward to a massive lack of specialists in a future it is not a problem to educate more gynaecologists, however the National Health care department wants to educate more in to general medicine

Suggested solutions;

The number of positions has to be raised now!!!

Creating a more effective training system reducing the "waist-time"

Norway

Facts about Norway

- Population: 4,5 million
- Physicians: 17561, 35% women
- Gynaecologists/ obstetrics: 480 specialists and 217 trainees
- In specialist training: approx 160 in training positions (15-25 specialists per year)
- Surplus in specialists in the future

Facts about Norwegian specialist training in Ob.Gyn.

- 6 years in University to have a Doctor degree
- 1½ year of internship
  - ½ year of general surgery
  - ½ year of intern medicine
  - ½ year in general practice
- 5 ½ years of specialist training
  - 1 year of surgery
  - 4 ½ years of gynaecology/ obstetrics, minimum 1½ year at a University clinic. You can replace ½ year with research.
- mean time to become a specialist is 8 years
- 200 hours theoretical courses – 130 hours compulsive
- log book including operation list
  No examination
- Trainee average salary 5720 €/month (including on call work)

Problems and their *possible solutions* in Norway

- **Lack of organization.**

The main problem in many hospitals is the lack in organisation of the training. The training plans, which many hospitals possess looks good on paper, but is not working in every day practice.

Changes in the week plan are common, and then the trainee gets other assignments at the clinic so that the day can be completed. Few departments have a coordinator who plans the training at a daily basis.

- **Lack of mentor.**

Many have a mentor, but few get good mentoring. We get supervision, but no evaluation of our work, how we are behaving as doctors etc.

- **Lack of time to Self-study.**

The trainees have 2-4 hours of self-study each week. This time is often used to clinical activities instead because of changes in the week plan.

- **Balance in Out-patient clinic**

In the small hospitals the trainees often get too much out patient clinic whilst in the large hospitals they might not have out patient clinic at all.

Possible solutions
Overall
Creating a better organization of the training program

Making doctors interested in the training, both the trainees, trainers and the heads of departments

Changing the attitude in the departments so that training becomes more important and therefore given a higher priority in the daily work.

Final discussions points

During the seminar it came clear that every country has a lot of good things in their training program, but also unfortunately a lot of things need to be improved as presented above. It also seemed that we all are very proud of our own system, even though we were critical to areas which have to be improved and developed further in the nearby future.

We all agreed that education need planning and organization; scheduled rotation, individual educational plans, structured training instead of ad hoc self-learning. Stressed by the question; "How can you know you are doing the right if you newer are told/showed a given procedure?"
It is therefore mandatory that the leaders of Ob&Gyn departments all over Scandinavia through their position and influence create environments focused on training in all levels of the organisation. This in addition means that we as trainees take responsibility in our own education.

We were pleased with the fact that all 4 countries used some kind of a "Log book", and that training overall was "competence based".

Some problems were common (except in Denmark), like the problems to recruit new trainees into our speciality. We all agreed that the lack of specialist in the future will affect our future training and we have to find a way to "speed up" and be more effective in the training of specialist in the coming years. Norway seems to be the only country with enough specialists in the future.

We all agreed and concluded that the working conditions in general need to be improved. Our speciality demands a full-skilled specialist to be around throughout all 24 hours. NFYOG agree that we have to divide the "on call" hours between all members of the staff ensuring that both the trainer and the trainee can be present during daytime to be a part of outpatient clinic, planned operations, UL-scanning and so on. We have to create as many "cross-point" as possible between the inexperienced and the experienced doctor making education impossible to avoid. Cross-point is also possible to create during night time and the presence of a consultant on call will create better working condition for the trainee being more secure, and more keen to challenge his/hers skills as help is nearby and not 30 min away. In addition, the

safety of the patients would be improved. It will of course be a challenge to create a balance between on call and day time hours.

And finally what is good in every country, what things we are proud of?

- In Norway you can start your training immediately after medical school. Also salary is good enough.
- In Sweden you can also start your training right after medical school. About 80-90% of trainees complete their training plan.
- In Denmark working hours are good, and now there has been made Log book and education plans to every trainee.
- In Finland you need to do independence work a lot, and two years ago EGO started own program for theoretical courses to all trainees. Those courses are held twice a year and 2/3 of all trainees have been attended.

What have we learned from seminar, what can we take home?

- Norway; will focus on evaluation and structural supervision
- Sweden; will try to create better working hours, portfolio, evaluation/assessment
- Finland; improve our leaderships attitude towards training, and try to get our organisation ready for future changes
- Denmark; to start your specialization earlier – needs more training positions. Continued evaluation of the newly introduced curriculum.

Perspectives

NFYOG will based on the conclusions and the evaluations obtained from the seminar strongly recommend NFOG to arrange a similar seminar including both trainees and trainers.
All though our educational system/organizations are different in our Nordic countries the exchange of information and the discussions with others looking upon your own glorious system with critical eyes asking; “Why?”, “How?” Explain me?”, “Show me?” is of high value towards improving specialist training.

NFYOG hope that NFOG find the idea presented above interesting and we will of course be willing to help with the planning and organizing of the seminar if wanted.

At the NFOG congress in Helsinki each country will present a poster focused on the educational problems/challenges in each country. In addition, part of the subjects will be discussed at the precongress symposium entitled “Improving Education”.

NFYOG Board
April 2004