Federaal Kenniscentrum voor de Gezondheidszorg
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KCE

Quality criteria for training settings for candidate medical specialists and candidates general practitioners

KCE reports 130C

Belgian Health Care Knowledge Centre
Federaal Kenniscentrum voor de Gezondheidszorg
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Executive summary

BACKGROUND AND OBJECTIVE OF THE REPORT

The postgraduate training (PGT) of candidates medical specialists and candidates general practitioners (GPs) encompasses a theoretical part and a practical part (professional training) with internship in training settings, under the supervision of senior physicians ("trainers").

The initial objective of the report was to propose quality criteria for trainers and training settings. Yet, during the course of the research, the situation appeared to be more complex. However, the scope of the study remains limited to the issue of the quality of training settings and trainers during PGT (i.e. the exclusion of quality of training in general and its outcomes' measurement).

METHODOLOGY

The description of the situation in other countries was based on two sources. A systematic literature review has been performed from 1995 onwards in Medline, EMBASE, ERIC and RDRB databases. A search in the grey literature analysed the situation in 5 selected countries. The objective was to collect information on the use of quality criteria for the training settings and the trainers in other countries.

The analysis of the Belgian recognition process for training settings and trainers was divided into four chapters, each based on a different source of information. The first one is mainly a description of the federal legislation. This description has been completed, in a next chapter, by a search in the grey literature to analyse the situation according to specialties and according to the Communities and universities, when such variations existed. The third chapter is based on an internet survey among the presidents of the recognition commissions (RCs) about their initiatives for the quality of the professional training of the candidates medical specialists and candidates GPs. Forty-seven (n=47) presidents completed the questionnaire out of an official list of 35 RCs for each community. Finally, in the fourth chapter that relates to Belgium, the results of a series of interviews give more information on the gap between the legal framework and its application, and concerning initiatives or experimentation to improve quality of PGT in Belgium. Twenty-one key informants have been selected based on a theoretical sampling targeted to the different stakeholders involved in the recognition process: trainers, trainees, hospital medical directors, deans, representatives from physicians" unions, from federal recognition bodies and from Community/university initiatives for quality in professional training of candidates GPs and candidates medical specialists.

RECOGNITION PROCESS IN BELGIUM FOR TRAINERS AND TRAINING SETTINGS

EUROPEAN FRAMEWORK

European legislation defines the regulatory framework of the training process and the working conditions. Within this framework member states can elaborate national legislation. Admission to specialist and GP PGT requires the completion and validation of at least six years of basic medical training. For GP training, EU legislation requires a minimum duration of at least 3 more years. For the other medical specialties, the duration of PGT training varies according to the specialty.

REGULATORY FRAMEWORK IN BELGIUM

According to the federal authorities the access to the medical profession depends upon a recognition whose conditions are define by the law. The completion of professional training and theoretical academic teaching is required by the authorities to get a recognition as a GP or as a medical specialist.

For the candidates medical specialists the theoretical courses take place during the two first years of PGT. The candidate has also to prove that he/she followed at least 30 hours in relation to communication with the patient and at least 20 hours of evidence-based medicine. The professional training consists of an internship in one or several recognised training settings.

The candidate GP needs to have successfully completed academic theoretical courses in GP. This teaching has to reach the objectives defined by the law and includes at least 8 ECTS (European Credit Transfer System). The practical professional training lasts for 3 years : 6 to 12 months in one or several hospital services (that have a recognition for GP training) and the rest in one or several GP practices (also with a recognition for GP training). During the practical training, the candidate GP also attends theoretical courses (40 hours per year) with a GP trainer.

Two bodies are responsible for the quality of the professional training of the candidates medical specialists and candidates GPs. First, the Superior Council (SC) mainly acts as a "recognition body" for trainers and training settings. The SC has 101 members who represent the universities, the medical profession, the Royal Academies of Medicine and the Medical Order.

Working groups within the SC are committed for specific tasks i.e. the SC working group of GPs, the SC working group of medical specialists, the SC working group for the recognition of specific professional qualifications.

Second, there are specific Recognition Commissions (RCs) for each specialty. They have an equal representation of university and profession and give advice on the candidates' training plan, its follow-up and the requests for recognition as a general practitioner or a medical specialist.

The table below gives an overview of the regulations and parallel initiatives regarding the training of the candidates GPs and candidates medical specialists.

	GPs	Other medical specialists
Training period	• At least 3 years	• From 2 to 6 years for basic specializations and 1-2,5 years for particular professional qualifications
Working conditions trainees	• 1 coordinating centre in each Community manages trainees' contracts and remunerations • Working conditions (e.g. working hours) defined by the law	• Remuneration by the hospital or by the trainee • Bill aiming at implementation EU working hours Directive
Organisation of training	• Flemish Community: • Interuniversity platform (ISHO/ICHOvzw) defines the GP training content and assessment • French Community: • Universities have their own organisation of training and assessment of trainees	• Medical faculties give a certificate for having successfully attended university courses during the first 2 years of training; • Assessment: variable per specialty • Different specialties have consultative bodies (e.g. Collegium Chirurgicum). • Internship organized at hospital level
Training Outcomes	• Defined in the federal law; universities guarantee the quality by a final evaluation	• Defined in general terms in the federal law + specific requirements by specialty
Recognition process of trainees	• Competent chamber of RC advises the Minister on application for recognition • Appeal at competent Chamber of SC	
Recognition process of trainers and training settings	• Criteria defined by federal law; in Flanders ISHO/ICHO and some French speaking universities added additional criteria to rank trainers after federal recognition • In principle the SC advises the Minister on the request for recognition; in actual practice delegation of this task to a working group • Renewable recognition term of 2 years	• Generic + specialty-specific recognition criteria defined by the federal legislation • Recognition criteria mainly structure- or process-based and often out-of-date • In principle SC advises the minister on the request for recognition; in actual practice delegation of this task to a working group • Renewable recognition term of 5 years

SITUATION ON THE FIELD

A survey among the presidents of the RCs and interviews of stakeholders provided useful complementary information on the situation on the field.

Survey among recognition commissions

Trainers: training, dedicated time for candidates GPs and candidates medical specialists, evaluation procedures

The training of trainers is provided in about one fifth of all specialties and is usually linked to a university. The frequency and content vary between specialties. The training of GP trainers has the most formal organisation. In Flanders it is organised by the interuniversity platform (ICHOvzw), while in the French Community it is organised by each university individually.

Six RCs mentioned a specific time that a trainer would dedicate for the training of candidates medical specialists in hospital but no specialty did quantify the hours to devote each week to this task. Some RC presidents referred to the concept of 'continuous availability'.

As stated in the legislation most RCs did not report any active role in the evaluation of the trainers. Some of them referred to the legal power of the SC. Yet site visits take place sometimes in case of problems but they are exceptional.

Evaluation of training settings

Some specialties have set up a procedure to assess the training sites, although the legislation states that this recognition falls within the competences of the SC. These evaluations are triggered by problems and never organised on a systematic basis. Some specialties use their own informal feedback loops. Most RCs (70%) mentioned that the candidates GPs and candidates medical specialists evaluate the training site and that their logbook might be used for the assessment of training sites. However this tool has been developed for the assessment of the quality of the training of the candidate and not for the assessment of the training site. The legislation foresees a specific assessment procedure of the training by the candidate but this procedure is not used in practice.

Interviews of key informants

Most key informants mentioned the gap between the legislation and the factual situation. This observation raises the question of quality control. As an illustration, some interviewees mention a selection procedure of the training sites set up by some universities. They use additional criteria over and above the minimum criteria set up at federal level but this additional selection overlooks the legal framework relating to the recognition of the trainers and training settings. Moreover, in case of problems, solutions are implemented by the universities using informal processes. The interviewees raised questions about the consistency between federal and community levels and about the additional selection by the universities. They acknowledged that the limited federal control is linked to inadequate financial resources.

The complexity of the recognition system is an issue often mentioned. Due to the lack of control, all levels of the recognition process simply seem to rely on agreements based on trust. Reputation plays an important role within this agreement process. The stakeholders expressed their concern about the independence of federal recognition bodies, the poor management of conflicting interests and the lack of interaction between the SC and the RC whilst this possibility exists by law.

The answers of the key informants highlight the strengths and weaknesses of the current system:

Some strengths of the system according to the interviews:

- Experienced members in the recognition bodies;
- Strong legal framework;

Weaknesses of the system according to the interviews:

- Lack of transparency;
- Community and university initiatives violating the federal laws;
- Quality control procedures of poor quality;
- Obsolete quality criteria;
- Inadequate financial resources;
- Lack of interaction between the bodies for the recognition of trainers/training settings and for the recognition of candidates;
- Poor management of conflicts of interest.

RECOGNITION PROCESS FOR TRAINERS AND TRAINING SETTINGS IN OTHER COUNTRIES

SITUATION IN FIVE SELECTED COUNTRIES

The recognition processes in The Netherlands, United Kingdom, France, Switzerland and Canada have been analysed by means of three main questions: who are the actors endorsed for the recognition of training settings and trainers? What are the generic standards used? What evidence is used to determine whether the standards are met? The results show interesting examples for Belgium but the situation is still evolving in all countries.

First, the stakeholders endorsed for the recognition are part of a global recognition process regulated by the government (France), the medical profession (Canada, The Netherlands and Switzerland) or an independent regulatory body (United Kingdom). Specific recognition bodies have been created with the following characteristics: work performed by professionalized organisations committed to this task, simplified administration, transparency and conflicts of interest management. In Canada, Switzerland and the United Kingdom, the governance model of these organizations includes the coordination of several actors within a legal or a quality framework.

Second, the recognition of training settings and trainers is embedded in a broader process of recognition of the whole PGT pathway that aims to develop the physicians' competencies. There is a shift towards less structure-based and more process-oriented criteria. The final decision on the recognition is the responsibility of the regional authority in France ("Préfet de région"). In the four other countries "accreditation commissions" set up by the medical profession take the final decision in relation to the recognition. These commissions that vote have a variable size according to the country and if votes are even the president takes the final decision.

Finally, in all five countries, internal surveys, external site visits and regular reviews are used as tools to collect evidence on the quality of professional training. The collection of information from the candidates, the confidentiality of the data and the composition of the visiting team are of paramount importance. The remuneration of those visit teams comes either from the recognition bodies (UK and the Netherlands) or from the professional organisation to which the visitors belong (Canada) or from the visited settings themselves (Switzerland).

The transferability of those findings needs to take account of particularities of the respective education and health systems and of the cultural differences with Belgium.

SYSTEMATIC LITERATURE REVIEW

The systematic review of the literature did not identify criteria for the assessment of the quality of the training settings or trainers.

No comprehensive systematic review on quality in PGT was identified. Thirty-two literature reviews were selected and most primary studies published afterwards partly summarised the conclusions of these reviews. The current evidence on quality in professional training mostly relies on descriptive studies (mainly from the US) of questionable quality.

Some findings are interesting for the quality of PGT in general. The results confirm the importance to work with patients during professional training and the importance of the quality of the supervision. Some conditions to facilitate learning are the quality of the relationship with the supervisor and formative feedbacks to the trainee. These feedbacks are effective when provided systematically over multiple years by an authoritative source.

Favourable working conditions are a prerequisite for the optimal quality of the professional training. There is no consensus on the potential impact of reducing working hours on the quality of care and on the outcomes of the training.

CONCLUSIONS

The initial research question to the KCE was the definition of quality criteria for PGT training practices and trainers. The results have shown that this question cannot be disentangled from the broader issue of PGT. Moreover, the definition of the quality criteria implies their implementation within a broader system of quality assurance with measurement, evaluation and proposals for improvement.

MAJOR ISSUES IN BELGIUM

Gap between law and situation on the field

Most key informants mentioned the gap between the legislation and the factual situation. The existence of obsolete criteria, some initiatives from universities violating the federal legislation and the lack of close follow-up on the field are a breeding ground for local interpretations of the rules. It also creates a legal uncertainty for the candidates GPs and candidates medical specialists as well as for the trainers.

Weaknesses in the organizational structure

The SC is the "recognition body" for trainers and training settings: its members represent the main stakeholders but many weaknesses have been identified :

- The functioning mostly relies on the (voluntary) participation of representatives appointed by their organisation;
- Many stakeholders/structures involved in the decisions wear several hats and play multiple roles with potential conflicts of interest;
- There is a lack of interaction between the RCs and the SC regarding the recognition criteria for trainees, trainers and training settings;
- Finally, there is no external independent team to perform the evaluation work e.g. site visits, surveys among candidates GPs and candidates medical specialists.

Quality criteria at national and local level

Generic criteria

Generic quality criteria for the recognition of trainers and training settings have been defined at the federal level. However, shortcomings exist in the knowledge and implementation of the legislation and the scope of these criteria is limited (mainly structure-oriented instead of process criteria about the quality of teaching). This results in different interpretations according to the training settings and a heterogeneity of the quality of professional training between specialties and even between training settings for the same specialty. This heterogeneity is reinforced by the absence of external evaluation.

Criteria specific to the specialties

In addition to the generic criteria, criteria specific to each specialty have been defined. However, they are often out of date and sometimes exclude training settings on the basis of norms independent of the teaching aspects. One illustration is the minimum number of beds requirement, whilst the current policy strategy precisely is aimed at decreasing their number in hospitals.

For GPs in Flanders (and at UCL) the universities produced an additional list of transparent criteria for trainers and training settings: these criteria are additional to the recognition criteria defined by the federal legislation.

For the other specialties some universities use their own additional quality criteria to accept training settings and trainers who already have a recognition from the federal level. They make a ranking of the settings and trainers for the limited number of candidates allowed by the legal quotas.

However the federal recognition remains the only necessary and sufficient condition for being a trainer or training setting.

Lack of evaluation in the recognition procedure

At the federal level, the recognition procedure only relies on a self-report of the trainers in relation to the fulfilment of legal criteria. The system can react in case of problems, with an official pathway described in the law. The withdrawal of recognition for quality of training reasons scarcely ever occurs. Moreover, the lack of resources and the conflicts of interest are major concerns.

POSSIBLE AVENUES FOR THE FUTURE

Some interesting initiatives already running in Belgium can inspire a future system. The initiatives set up by GPs demonstrate the feasibility of a clear definition of and adherence to quality criteria for trainers and training settings, including quality procedures and site visits. The high costs of well conducted site visits deserve attention.

Foreign systems can also inspire the implementation of a new quality system. E.g. the systems in Canada, the United Kingdom and Switzerland, each found specific solutions to the problems that were identified in Belgium:

- A global recognition process encompassing the whole PGT is regulated by recognition bodies at national level. These bodies are professionalized, with simplified administration, transparency (via websites) and conflicts of interest management;
- The coordination of the main stakeholders within a legal or a quality framework;
- Explicit standards (more process than structure-oriented) are the basis of the recognition system in these countries.

However these systems are evolving and have not yet been evaluated. The systematic review of the literature did not provide any evidence of a link between quality criteria for training settings or trainers and favourable outcomes in terms of learning outcomes and physicians' competences. Moreover, the relation with quality of care is never analysed although it should be the ultimate goal of a high quality PGT.

RECOMMENDATIONS

- **Clarification of the current legislation and control of its correct implementation**

On the one hand the current legislation should be spread among the stakeholders in a comprehensible way, in particular for the candidates GPs, candidates medical specialists and trainers. On the other hand the current legislation should be systematically applied and there is a need for a proactive control to ensure its correct implementation. It should be useful to set up the necessary framework to make this control operational. Human and financial resources are needed for that purpose.

- **External, independent professionalized evaluation**

An external independent professionalized evaluation should complement the current organisation to guarantee the evaluation of training settings (and trainers) including the definition of quality criteria and of evaluation methods to measure their implementation. The results of this independent evaluation would be transmitted to the SC with an advice on the (conditional) renewal (or not) of the recognition.

- **Reshaping of the Superior Council into a smaller efficient structure**

The SC would supervise this evaluation and would use its results for the official recognition of trainers and training settings. The composition of the SC should involve all main stakeholders with a balance between representatives of the universities and those of the medical profession but within a much smaller structure to enhance its efficiency.

- **Revision and extension of the quality criteria for the training settings**

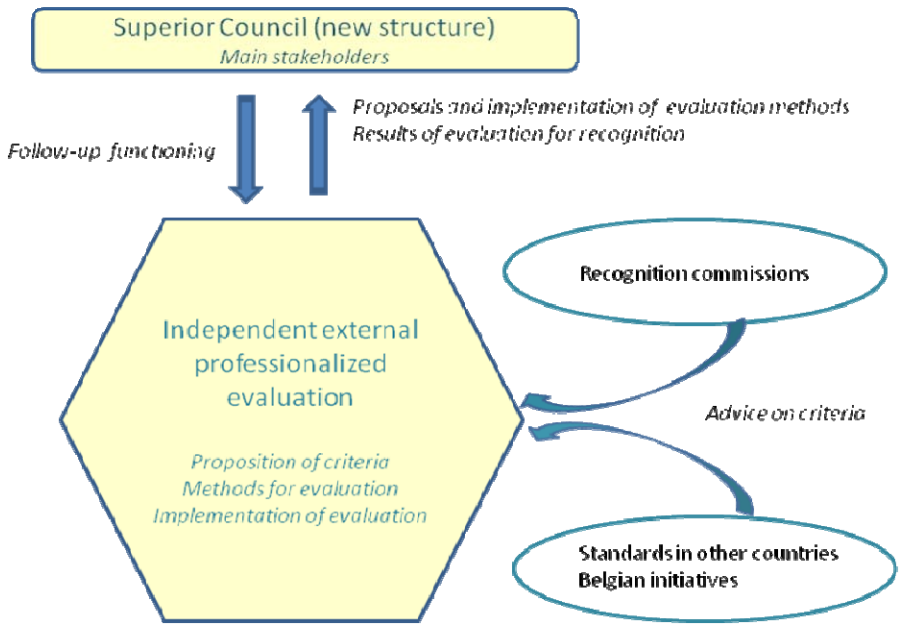
Sources of inspiration for comprehensive, up-to-date sets of standards can be those in use in Canada, United Kingdom and Switzerland. Another source of inspiration could be the list of criteria locally developed for general practice (ICHO in Flanders and EQUALISP at UCL – "Evaluation de la Qualité des Lieux de Stages par les Pairs"): those lists could be used as a basis to develop criteria for all specialties within a federal legal context.

The definition of additional specific criteria for each specialty by the evaluation team would benefit from the advice of the respective RCs.

- **Development and implementation of formal evaluation methods**

  - **Periodic standardised surveys among candidates GPs and candidates medical specialists (the current logbook is nor intended nor used for this purpose);**
  - **Self-evaluation at individual (trainers) level and training setting level;**
  - **Site visits;**
  - **Recognition (or not) linked to the results of the evaluation.**

The schema below could gives an overview of the new organisation recommended for the recognition of training settings:



- **Appropriate financing for the evaluation process**

The proposals outlined in the previous paragraphs imply an investment for the implementation of a quality assurance system in PG training settings. This study did not analyse the optimal way for organising this financing but examples abroad suggest different solutions (with or without the contribution of the interested parties).

Scientific summary

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1 INTRODUCTION

1.1 BACKGROUND AND OBJECTIVE OF THIS STUDY

The focus of this report is the quality of training settings and trainers during postgraduate medical training. This report analyses the current situation in Belgium and in other countries to propose avenues for improving the quality of training settings for all specialties.

Professional training refers in this report to the practical training of medical graduates entering a specialty to meet the requirements established by accrediting authorities. Professional training is offered in training settings under the supervision of senior physicians ("trainers") to candidates general practitioners (GPs)and candidate specialists.

Professional training is a part of Postgraduate Training (PGT), also called Postgraduate Medical Education (PME) in the international literature. The MESH thesaurus defines it as "Educational programs for medical graduates entering a specialty. They include formal specialty training as well as academic work in the clinical and basic medical sciences, and may lead to board certification or an advanced medical degree."

At the time of writing, the Belgian government declared to reduce the term of undergraduate medical training to 6 years. The PGT for all specialties would begin after the medical degree[1].

The federal government defined recognition criteria for the trainers and training practices for candidate medical specialists, including the specialty of general practice. A further question from the "Superior Council of Medical Specialists and General Practitioners" was to define further quantitative and qualitative criteria for the quality of training practices and trainers who supervise young doctors during their specialization. The federal Health care knowledge centre was commissioned to propose quality criteria for training practices and trainers.

1.2 QUALITY IN POSTGRADUATE MEDICAL EDUCATION

Professional training can not be disentangled from the whole process of PME in the international literature. Therefore the scope of this report is larger than professional training in some chapters.

The World federation of Medical Education (WFME) launched in 1998 a paper on international standards in medical education. Specific standards for PME followed in 2003[2]. The 9 WFME domains were used as a backbone of this report[3] given their comprehensiveness, adaptation to the European situation and worldwide adoption:

1. Mission and outcomes: objectives of the programme;
2. Training process: to what extent the training process is detailed and systematic. This part deals with supervision, regular appraisal and feedback;
3. Assessment of candidates medical specialists: both formative assessment within the scope of learning and summative procedures should allow to steer the learning processes;
4. Candidates medical specialists: transparency of selection and admission procedures for candidates are cornerstones here, together with optimal working conditions, work and case load;
5. Staffing: what is the required expertise for training staff and what is the summing up of all their duties?
6. Training settings and educational resources: clinical settings, physical facilities, team, equipment;
7. Evaluation of training process: includes e.g. use of feedback from candidate specialists, monitoring of training setting;

8. Governance and administration: authorities that acknowledge educational efforts and offer certification to candidates medical specialists for formal recognition and accreditation of the training;
9. Continuous renewal: procedures for regular review and updating of the structure, function and quality of the training programmes.

However, given the objective of this report, the results will focus on the fifth and sixth domains.

1.3 OUTLINE OF THIS REPORT

The first part is an overview of the systems running abroad. This will be covered by a systematic literature review (chapter 2) and by an analysis of five other countries i.e. United Kingdom, Canada, the Netherlands, France and Switzerland (chapter 3).

The second part is an assessment of the current situation in Belgium. The fourth chapter details the European and Belgian legislation. Chapter 5 complements the former one with further information on the situation on the field and in both communities. The sixth chapter synthesises the results of a survey among the presidents of the "Commissions d'Agrément - Erkenningscommissies" (Recognition Commissions - RCs). The seventh chapter describes the results of interviews with stakeholders involved in PGT in Belgium. The last chapter summarizes the main findings and proposes avenues to enhance the quality of training settings.

1.4 ABBREVIATIONS AND GLOSSARY

Academic part of training: The master after master part of the post graduate training

ACGME: Accreditation Council for Graduate Medical Education: responsible for the accreditation of PME training programs in the US.

AMEE: International Association for Medical Education

Assessments:

1. Formative assessment. during the process, with educational objectives;
2. Summative assessment: pass or fail assessment, i.e. examinations

CANMEDS: Canadian Medical Education Directives for Specialists

CCT: Certificate of Completion Training

CFPC: the College of Family Physicians of Canada

CRAMS: Canadian Resident Matching Service

DES: diplômes d'études spécialisées

DESC: diplômes d'études spécialisées complémentaires

ECTS: European credits transfer and accumulation system

EQUALISP: Evaluation de la QUAlité des LIeux de Stages par les Pairs

FAIMER: Foundation for Advancement of International Medical Education and Research

FDHA: Federal Department of Home Affairs

FITER: Final In-Training Evaluation Report

GMC: General Medical Council

HAIO: Huisarts in opleiding (formerly referred to as HIBO)

ICHO: Interuniversitair Centrum voor HuisartsenOpleiding. Interuniversity network of universities in Flanders

ISFM: L'Institut suisse pour la formation médicale postgraduée et continue (Swiss Postgraduate and Continuing Medical Education Institute)

KNMG: Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst

LPMED: The Federal Medical Profession Law

MANAMA: Masters after masters programme.

Min. D: Ministerial Decree

MEDINE: medical education in Europe

NIHDI: National Institute of Health and Disability Insurance (INAMI – RIZIV)

NOK- ORL: ear-Nose-Throat specialty

NVAO: Nederlands Vlaamse accreditering Organisatie (Accreditation Organisation of the Netherlands and Flanders). The organisation was established by international treaty and it ensures the quality of higher education in the Netherlands and Flanders.

OAQ: Quality Assurance of the Swiss Universities

OECD: Organisation for Economic Co-operation and Development

OSCE: Objective-Structured Clinical Examination

Professional training: practical training of medical graduates entering a specialty to meet the requirements established by accrediting authorities. Professional training is the practical part of PGT

PME: (Post)Graduate Medical Education. MESH definition: Educational programs for medical graduates entering a specialty. They include formal specialty training as well as academic work in the clinical and basic medical sciences, and may lead to board certification or an advanced medical degree.

PMETB: Postgraduate Medical Education and Training Board

PGT (PostGraduate Training): cf. definition of PME

RC : Recognition Commission

RD: Royal Decree

RCPSC: the Royal College of Physicians and Surgeons of Canada

SC: Superior Council

SFOPH: Swiss Federal Office of Public Health

SMA: Swiss Medical Association

STA: Specialist Training Authority

UEMS : European Union of medical Specialist http://www.uems.net/

UFR: Unité de Formation et de Recherche (Training and Research units in medicine)

WHO: World Health Organization

WFME: World Federation for Medical Education

2 SYSTEMATIC LITERATURE REVIEW

2.1 RESEARCH QUESTIONS

The objective of this chapter is to review the current evidence regarding aspects of quality of Professional training in the indexed literature and identify key areas for Belgium. As mentioned above the search strategy and results could not disentangle the quality of Professional training from the quality of PGT in general.

The results of the literature review have been structured according to the 9 areas of the WFME global standards for quality[2]. However, only the relevant areas for the research questions are reported in this text. The comprehensive results are in appendix 1.4.

The term "trainee" is used in this chapter as it is constantly mentioned in the international literature to refer to the candidates GPs and candidates medical specialists during their training. The term "resident" is more specific in the indexed literature and used when this trainee works in a clinical setting.

2.2 METHODS

A first search for meta-analyses and systematic reviews was completed by the search for good quality primary studies. The appendix on literature review details the search strategy (appendix 1.1), the tools used for critical appraisal (appendix 1.2) and the tables of evidence (appendix 1.3).

2.2.1 Databases

The systematic literature search was performed from 1995 onwards, using language limits (English, French and Dutch). The following databases have been consulted: Medline Ovid (April 23, 2009), EMBASE (June 9, 2009), ERIC database (July 30, 2009) and RDRB database (August 1, 2009).

At the end of the project the authors performed a hand search in five core Journals (The Lancet, JAMA, New England Journal of Medicine, British Medical Journal, Annals of Internal Medicine) and other medical education journals (Academic Medicine, Medical Education, BMC Medical Education, Medical Teacher, Teaching and Learning in Medicine, Education for Health). Nineteen additional references were included for the period between April and October 2009.

2.2.2 Selection criteria

The selection of papers was performed on the basis of title and abstract by two independent readers (in combinations AD, RR, JW) using the following *exclusion* criteria:

- out of scope, not related to postgraduate clinical training;
- not part of the WMFE areas;
- programmes to enhance technical specific competencies within a specialty;
- description of personal views, comments, strategies to be implemented;

not related to western world.

The selection of papers used the following *inclusion* criteria:

- scope: quality of training programs/training practices / trainers;
- description of national, regional or official postgraduate programmes;

study design: systematic reviews

2.2.3 Quality appraisal

The researchers used the grids of Scottish Intercollegiate Network Group (SIGN) (see link in appendix 1.2.1). They gave a score of 3 for well covered criteria, a score of 2 for adequately addressed criteria, a score of 1 for poorly addressed criteria and a score 0 for not addressed criteria, not reported criteria or not applicable criteria.

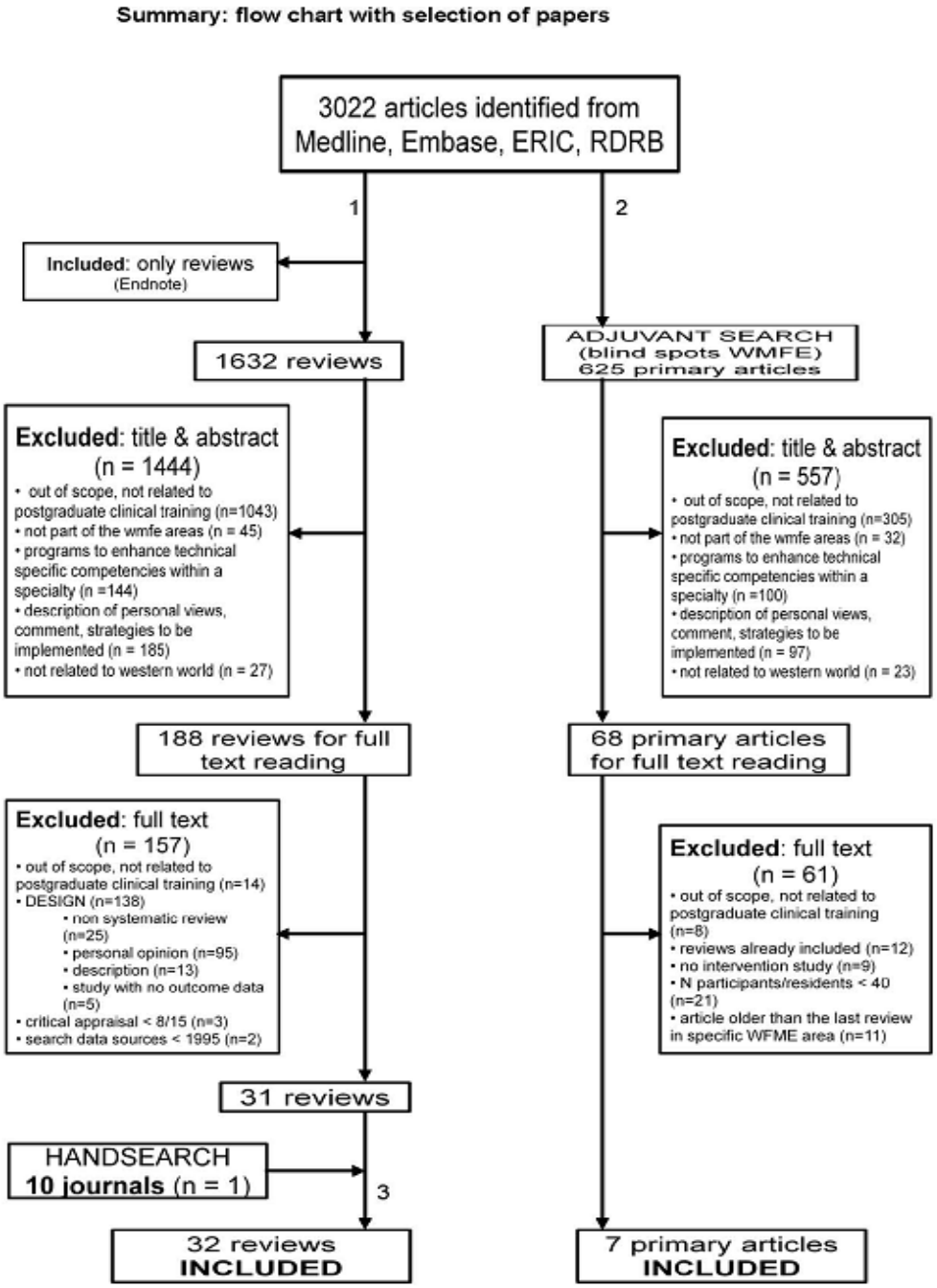
The researchers excluded studies with scores equal to 0 or 1 on three or more items out of a total of 5 items. This strategy resulted in 3 excluded reviews.

Evidence was subsequently graded using the criteria of the ´Modified evidence based rating scale´(see appendix 1.2.2). This tool has been used in a former KCE report [4]. This grid has been deemed more appropriate than the grade system designed for evidence on clinical topics for which many RCTs have been published.

2.2.4 Final data set

32 reviews and 7 primary articles were finally selected as summarized in the flow chart below:

Figure 1: Flow chart with the selection of papers



2.3 GENERAL FINDINGS

The evidence table in appendix 1.3 provides the summary of the results and quality appraisal scores. Overall the quality of reviews (using the SIGN criteria with a semi quantitative approach) was as follows:

- high (> 12/15) in 24 reviews;
- moderate (8/15-12/15) in 8 reviews;
- low: 3 reviews of low quality have been excluded.

The 32 included reviews evaluated 1570 primary studies carried out in the context of postgraduate medical education. The publication of reviews ranges from 2000 to 2009. Most primary studies covered the areas already studied by reviews.

2.3.1 Populations and settings

Many reviews did not solely focus on trainees. They also analyzed primary studies of undergraduate training, continuing medical education and professional development [5]. Other studies focused on training of nurses, paramedics and medical students [6].

Most papers were from hospital setting (n=14). Other study settings were: GP setting (n=1), outpatient setting (n=2), not specified (n=13). Nine papers studied a mixed setting (= hospital setting and/or GP setting and/or outpatient setting and/or not specified). The large majority of papers came from the US (n=25) and UK (n=7).

2.3.2 WFME areas under study

Few reviews focused on areas 5 ("staffing") and 6 ("training settings") that are in fact the scope of this report. The majority of the reviews gave detailed information on 'training process', 'assessment of trainees' and 'trainees'. Only one review covered 'governance and administration' .

The results presented below focus on the areas linked with the research questions. The comprehensive results for all WFME areas are in appendix 1.4.

2.3.3 WMFE area 4: Trainees – sub area "working conditions"

The fourth area of the WFME ("trainees") is the best covered area, with ten reviews and five primary articles. Only the sub-area "working conditions" is described here in relation with the quality of the training settings. The other sub areas ("admission policy and selection", "support and counselling of trainers") are in appendix 1.4. No review covered the sub area "number of trainees" and "trainee representation".

2.3.3.1 Reviews

Six reviews covered sub area 'working conditions'. They mostly covered the problems of burnout and working hours.

Young physicians who readily embraced hard work in premedical and undergraduate medical education experience high levels of professional burnout in residency training years. Aside from working long hours, something about residency seems to leave many residents feeling emotionally exhausted and cynical and leaves some depressed and critical of their own patient care performance as well[7].

Another problem is the increased risk of pregnancy complications, especially adverse late-pregnancy events. Pregnant residents found the physical demands of residency and lack of support from fellow residents and their departments most stressful[8].

A review on burnout in medical residents mentioned burnout rates between 18 and 82%. Four of the 16 occupational risk factors (i.e. quantitative work overload, increased perception of work as stressful, an increase in anticipation of debt at the end of training and increased conflict between work and home) appeared to be strongly related to burnout [9]. McCray et al. conclude that prospective, controlled studies are needed to examine the effects of interventions to manage burnout among resident physicians. Only 2 studies were RCT's and many studies used volunteers.

The use of support groups and meditation-type practices was very flexible and hard to replicate, although showing some promising results [10].

Interventions to reduce work hours (night and day float teams, extra cross coverage and physician extenders) resulted in mixed effects on both operative experience and on a perceived educational quality. Interventions intended to decrease work hours might have a varying impact at different levels of training. Potential unintended consequences of reducing resident work hours included inadequate development of professionalism, worse patient – physician communication and a decrease in experience. However, reducing work hours generally improved the residents' quality of life [11]. The interpretations of the outcomes of these studies is hampered by suboptimal study design, the use of non validated instruments and the absence of knowledge on the long-term impact on educational quality and patient outcomes. So, it is unclear if the improved quality of life of residents ultimately results in better patient care [11].

It is valuable to consider the number of hours worked by residents but the educational content needs further consideration. Boex estimated that approximately 15% was directed to programs teaching activities, 36% of time was devoted to patient care with specialty-specific learning objectives and 35% to patient care with marginal or no educational value [12].

2.3.3.2 Primary studies

The first study showed that nurses had a negative perception of the nightshifts of residents: they felt communication aspects and knowledge of patients was unsatisfactory[13].

One study showed that otolaryngology programs successfully restricted resident duty hours through significant infrastructural changes. The majority of residents surveyed were in favour of restrictions, whereas most program directors and faculty were opposed[14].

Residents in surgery reported decreased burnout scores after work hours changes. Apparently, this did not lead to diminished learning experiences. This study highlights many concerns with regards to the professional development of future surgeons, including a change towards a shift-workers mentality that is not patient-focused, less continuity of care with loss of critical information with each handoff, and a decrease in the patient/doctor relationship [15]. However it seems that time spent to direct patient care diminishes whilst the volume of clinical experiences remains stable [16].

In a nationwide survey of USA nation's internal medicine residency training programmes to determine the intensity of evaluating night float systems, it appeared that evaluation of these residents is most common by morning report and attending evaluation [17].

2.3.4 WMFE area 5: Staffing

Staffing is a major focus of this report. Unfortunately no systematic review covered strictly the two sub areas i.e., 'appointment policy' and 'obligations and development of trainers'.

Two reviews analysed the value of teaching of undergraduates by residents. They concluded that resident-as-teachers curricula might significantly improve the residents' teaching skills[18, 19].

2.3.5 WMFE area 6: Training settings and educational resources

This area is the second focus of this report. However, few data were found for the quality of training settings in PME.

No review covered the sub areas 'physical facilities and equipment', 'clinical teams', 'information technology' and 'research'.

2.3.5.1 *Sub area: clinical settings and patients*

The effectiveness of working with patients was measured by evaluation studies and reported improvement in clinical skills and knowledge about the disease or condition or about social aspects of the disease. There is evidence of the short-term positive impact of working with patients in medical education but the evidence of longer-term impact is still lacking. Issues of ethics, psychological impact and influence on educational policy were poorly explored [20].

2.3.5.2 *Sub area: educational expertise*

Kilminster reviewed the literature on effective supervision in practice settings. He concluded that there is no good quality research on this topic. Available data show some evidence of the effectiveness of the quality of the relationship with the supervisor, probably the most important factor, even more important than the supervisory methods. As stated above, feedback is essential. Finding sufficient time for supervision can be a problem [21].

2.3.5.3 *Sub area: training in other settings and abroad*

One review did not find any study that assessed the overall effectiveness of ambulatory training in internal medicine. Several studies consistently showed that residents lack confidence and competence for many common health issues [22].

Keypoints: – systematic literature review

- **The evidence on quality in PME mostly relies on descriptive studies;**
- **The most frequent WFME quality areas described in the literature are the training process and the assessment of trainees;**
- **Working conditions are a prerequisite for the optimal quality of the PGT. There is no consensus on the potential impact of reducing working hours i.e. if working less would have negative consequences on the quality of care and on the outcomes of the training;**
- **This systematic review did not identify criteria to assess the quality of the staffing neither criteria for the training settings;**
- **The results confirm the importance of the quality of the supervision.**

2.4 DISCUSSION

The discussion of all results of the systematic literature review is in appendix 1.5. The paragraphs below focus on the research questions of this project i.e. quality of training settings and trainers.

2.4.1 Limits of the studies: design and population

Many reviews indicated that the quality of the primary articles was questionable. Most primary studies relate to single institutions and the designs are often of poor quality. The current best evidence on quality in PME mainly relies on descriptive studies, on cohorts and before-and-after measurements. Moreover, many reviews included other groups than residents and it was sometimes hard to distinguish the results specific for trainees.

2.4.2 WFME areas: gaps in the literature

The quality of staffing and training settings has been hardly studied in the literature. The most frequent addressed quality areas were the training process, the assessment of trainees and the trainees.

The researchers faced challenges to put the selected papers in the appropriate area and sub areas of the WMFE grid. Some papers would fit in more than one sub area and were classified in the most relevant area.

2.4.3 Lessons to learn

The lessons to learn are multiple within the wide scope of quality in PME (see appendix 1.5). However for the scope of this project they are limited to some points in relation with training settings and working conditions.

2.4.3.1 Training settings and educational resources

First, the literature underlines the importance of an effective supervision in the training settings. Effective supervision includes the quality of the relationship with the trainee and positive feedbacks. Secondly, the training settings have to reflect the most common health issues to increase the competences of the trainees for those problems.

2.4.3.2 Working conditions

Work hours restrictions may improve the resident's quality of life but its influence on the learning outcomes and quality of care is a matter of debate [11, 14, 15]. It must be noted that American (80 hour work week recommendation cfr ACGME[23]) and European directives (a maximum of 48 hours per week since August 2009 [24] greatly differ. The problem is also a lack of human resources with more work for senior doctors or reallocating [25] tasks to other health personnel.

2.4.4 Strengths and limitations of this systematic review

This literature search has some strengths:

- The topic is original;
- The search strategy has been exhaustive and used strict selection procedures;
- The results have been structured according to international concepts in PME (see appendix 1.4);
- The outcome of the literature search highlights gaps in the knowledge on quality issues of PME and professional training in particular.

This literature search has also some limitations. The first one is the limitation of search strings by the selection of key words. The topic covers a broad area and the researchers had to make selections of (key)words to keep a feasible search strategy. Secondly, the authors performed strict limitations in the quality appraisal to focus on literature of good quality. In the large number of hits initially selected they observed a large number of papers of low quality, ranging from personal opinions, to very subjective and narrative reviews of the literature, often aiming to demonstrate a particular statement.

3 DESCRIPTION OF RECOGNITION PROCESS IN FIVE COUNTRIES

3.1 INTRODUCTION

PGT is an evolving sector whose developments are linked to major international conferences (e.g. AMEE), to international research networks (e.g. MEDINE), to the development of European legislation (e.g. Directive 2005/36 / EC), to publications in educational journals (e.g. Medical Education, Medical Teacher) as well as to national events (e.g. cases in medical education were followed by parliamentary inquiries in the UK). These are opportunities to transfer ideas and concepts that cross national borders with diverse implementations in national systems. The need for international recognition of diplomas issued by national authorities compels the recognition bodies to pay attention to the development of PGT worldwide.

3.2 AIM

An international comparison was designed to analyse national answers to 3 questions:

1. who are the actors endorsed for the recognition of training settings and trainers?
2. what are the generic standards used?
3. what evidence is used to determine whether the standards are met?

3.3 METHODS

3.3.1 Country selection

Three border countries were selected. France has a health system that can be compared to the Belgian one. The Netherlands and the UK had recent developments in their recognition procedures. Switzerland has been purposely chosen for the same two reasons. Canada was added because of its pioneering development in such matter.

3.3.2 Information gathering

Scientific and grey literature about recognition procedures in these five countries was found by systematically browsing official websites from Worldwide organizations to European and national organizations (see appendix). These websites and their external connections were fully scrutinized using crawling and netmapping softwares (Navicrawler and Gephi). This systematic exploration gave access to fifty national reports concerning quality standards and/or recognition procedures in postgraduate medical education.

3.4 FINDINGS

3.4.1 Who are the actors endorsed for the recognition of training settings and trainers?

3.4.1.1 Type of regulation

Three types of regulatory bodies were found in these five countries: a governmental regulatory body (France), a professional regulatory body (Canada, Switzerland and The Netherlands) and an independent regulatory body (United Kingdom). However, situation is evolving in UK as PMETB is merging with the General Medical Council (GMC) on 1st April 2010.

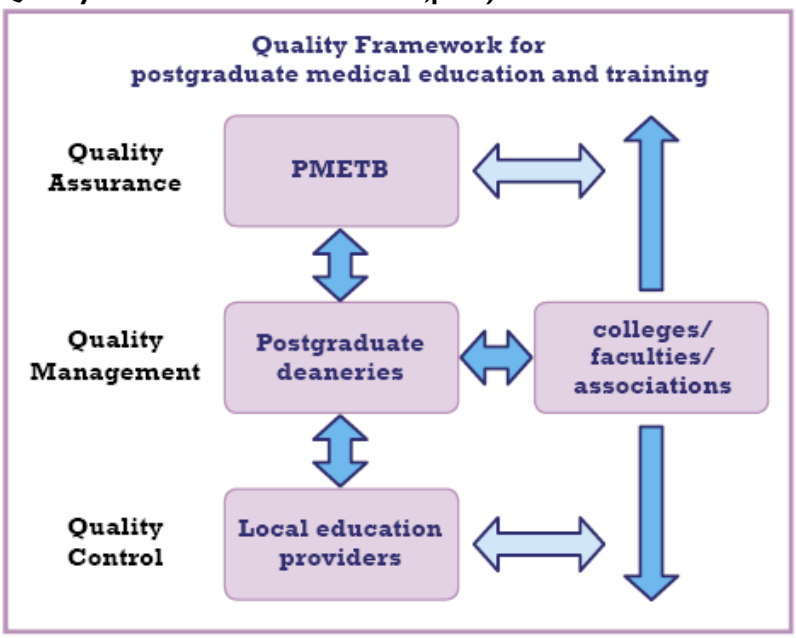
3.4.1.2 *Specific recognition organization*

Specific recognition organizations are under regulation of bodies which encompass multiple tasks in PGT: evaluation of candidates specialists, approval of curricula, approval of assessment systems, standards setting, control of entry to specialty training, policy development for quality assurance and certification at the completion of training. These regulatory bodies dedicate specific organizations to training settings and/or residency programs recognition but rarely to trainers recognition (they remain under academic control).

3.4.1.3 *Specific recognition organization: level of competencies*

Specific recognition commission are usually set up to work at national level (except in France) and to give advice to competent authority with help from specialty commission in each discipline. In United Kingdom where a quality framework involves many educational actors, responsibilities are vertically distributed in a global recognition process. In Switzerland, the federal government –via the center of recognition and quality assurance of the swiss universities (OAQ)- gives recognition to global training program for each specialty ("filières de formation postgrade"). This global federal recognition expects that recognition of training settings is dealt by ISFM.

Figure 2: Quality framework for PGT and training (source: The PMETB Quality Framework Autumn 2007,p.9[26])



3.4.1.4 *Specific recognition organization : mission*

Trainers, training settings and residency programs recognition are not dissociated activities in The Netherlands. In general, no specific recognition organization exists for trainers. In Canada and in the United Kingdom, appropriateness of training settings and trainers is evaluated by university internal review process (in UK, data is collected by deaneries as part of their quality management processes). In France, trainers are listed by universities according to governmental standards. In Switzerland, the recognition of candidates specialists is added to the function of training settings.

3.4.1.5 *Composition*

France has a wide diversity of voting members in its recognition committees. Universities and professional regulatory bodies are often voting members of these specific recognition organizations; sometimes employers (hospitals); trainers and local authorities only in France. Switzerland has no intersectoral representatives in its recognition commission. Candidates specialists are considered as voting representatives only in France and Canada.

Table 1: Actors endorsed for the recognition of training settings and trainers

	FR	CA	UK	SW	NL
Type of regulation	Governmental	Professional	Independent	Professional (under governmental control)	Professional
Specific recognition organization	*Commission de subdivision de l'internat et du résidanat-Commission d'agrément*	*RCPSC, CFPC, CMQ-Recognition Committee*	*PMETB*	*ISFM-Commission des établissements de formation postgraduée*	*KNMG-Registratie Commissies*
Level of competencies	presided by educational actor at regional level, advised by interregional coordinator teacher	assisted by Specialty Committee at national level	multiple actors coordinated at national level (quality framework)	under federal control at national level (legal framework)	coupled with Specialty Colleges at national level
Mission	to accredit training settings	to accredit residency programs	to approve training and providers such as hospitals, institutions such as deaneries and persons (trainers) for provision of education and training	to recognize training settings	to accredit trainers and training settings
Composition	n=20 ; Voting representative : university, hospital, trainers, candidates specialists, local authorities. Advisory members : coordinator-teacher	n=min 16 ; Voting representative : university, professional regulatory bodies, candidates specialists. Observers : university, candidates specialists, professional regulatory bodies, international recognition bodies.	n=29 ; Voting representative: medical (17) and lay members (8). Observers: departments of health representatives (4)	n=60 ; Voting representative: 1 delegate from Medical Society concerned and 1 from ISFM (not from the discipline).	n=min 10 ; Voting representative : professional Regulatory Bodies, hospital, university, medical. Advisory members : medical, professional Regulatory Bodies

3.4.2 What are the generic standards used?

3.4.2.1 Generic domains

Hard is to disentangle trainers or training setting standards from residency programs standards. Even in France or Switzerland where recognition committees are especially dedicated to training settings recognition, recognition process requires information about residency programs developed in these sites ("le projet pédagogique" in France and "le concept de formation postgraduée" in Switzerland).

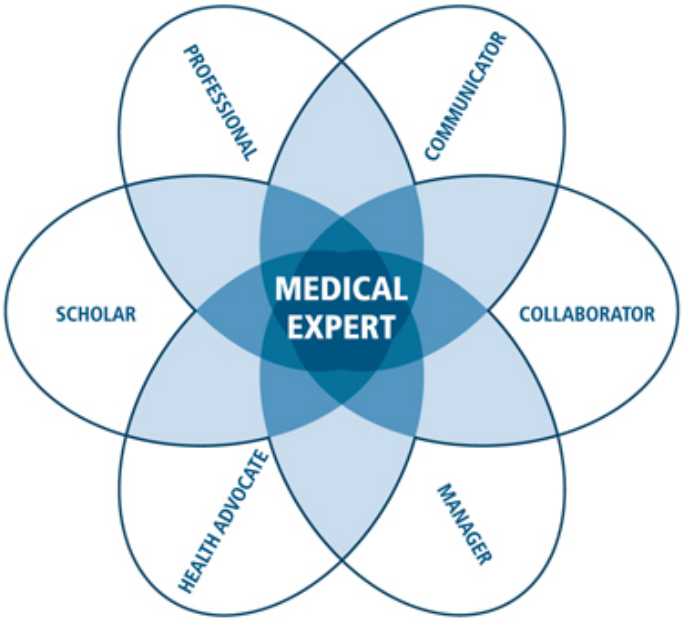
3.4.2.2 Type of standards

Standards are clearly stated as such in Canada and in United Kingdom. Elsewhere, recognition criteria have to be found in legal rule or recognition questionnaire. General standards are usually completed by specific standards in each of the specialties and subspecialties. The level of requirement is sometimes indicated, distinguishing "should" and "must" (Canada), "requirement" and "obligation" (The Netherlands).

3.4.2.3 Standards for generic domains

Canada and United Kingdom have pioneered the development of standards more focused on educational process than on setting activities and structures. This kind of standards was too adopted by The Netherlands (CanMEDS standards[27]) and Switzerland (WFME standards) respectively for residency programs and for education program recognition ("les fillières de formation postgraduées" in Switzerland). The RCPSC (Canada) has also pinpointed the need of inter-professional collaboration on training site.

Figure 3: CanMEDS standards[27]



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3.4.2.4 Standards for trainers

Little is said about standards for trainers. But these are of paramount importance as we consider growing importance of training for trainers, education teams, outcome measurement and trainers' high responsibility in teaching competencies (United Kingdom, Canada and The Netherlands).

Table 2: Generic standards

	FR	CA	UK	SW	NL
Generic domains	Training settings (including standards for residency programs and trainers)	Residency programs (including standards for trainers and training settings)	Training (including standards for trainers and training settings)	Training settings (including standards for residency programs and trainers)	Trainers and training settings
Type of standards	Governmental standards	General and specific RCPSC, CFPC or CMQ standards (including CANMEDS standards[27])	PMETB Standards for training	ISFM standards (satisfying to WFME standards)	KNMG-Colleges standards
Standards for generic domains	Setting activities and structure; Educational resources; Commitment to education and research activities; Autonomy of junior doctors; Assessment of candidates specialists; Educational project	Administrative structure; Opportunities and Resources; Commitment to education and quality of patient care; Goals and objectives clearly worded to reflect the CanMEDS competencies; Clinical, academic and scholarly content to prepare residents to fulfill CanMEDS roles; Assessment of candidates specialists; inter-professional collaboration on training sites	Patient safety; Quality Management, review and evaluation; Equality, diversity and opportunity; Recruitment, selection and appointment; Delivery of approved curriculum including assessment; Support and development of candidates specialists, trainers and local faculty; Management of education and training; Educational resources and capacity; Outcomes	Setting activities and structure; Opportunities and Resources; Quality Management, review and evaluation; Commitment to education; Support and development of candidates specialists and trainers; Delivery of approved curriculum including assessment	Opportunities and Resources; Educational resources; Support and development of of candidates specialists and trainers; Quality Management, review and evaluation; Management of education and training
Standards for trainers	minimum length of practice	educational aptitudes (training for trainers); CanMEDS competencies teaching	educational aptitudes (training for trainers); supported by postgraduate medical education team	minimum length of practice; educational aptitudes (training for trainers); continuing professional development	minimum length of practice; educational aptitudes; involved in research activities; supported by postgraduate medical education team; CanMEDS competencies teaching

3.4.3 What evidence is used to determine whether the standards are met?

3.4.3.1 Evaluation Process

The evaluation process is internationally shared. It combines internal evaluation (required to fulfil recognition files), external evaluation (required to control recognition files information) and additional surveys conducted with assistants (required to monitor training quality).

3.4.3.2 Visiting committes

The composition of the visiting committees has important role to play to objectify training situations. Managing conflicts of interests specifically works at this level. One of them is remuneration of surveyors. In Switzerland, training settings pay up to 3600 euros to the professional regulatory body to be visited. In Canada, members of the survey team are appointed by their respective associations (the Association of Canadian Academic Healthcare Organizations (ACAHO),the Federation of Medical Regulatory Authorities of Canada (FMRAC), the Canadian Association of Internes and Residents or the Fédération des médecins résidents du Québec, the Collège des médecins du Québec in Québec and with the College of Family Physicians of Canada). In United Kingdom and in The Netherlands, the visit team will consist of partners who have been specifically recruited and trained for this activity and have been contracted for this work by the professional regulatory body.

3.4.3.3 Training settings recognition validity

The validity of the recognition of a training setting is relatively homogeneous. The recognition is prematurely reassessed when settings' responsible persons are changing or when problems occur.

3.4.3.4 Logbook / portfolio

The candidate's logbook -in that it evolves now to a portfolio- provides new sources of information for the recognition of settings and trainers. As defined in the literature review, a portfolio is a set of materials collected to represent a person's work. The use of a portfolio allows to incorporate a variety of tools in order to foster reflective learning, which is the key to professional development. It can deliver information on how the development of skills (e.g. CanMEDS) is actually implemented. But strict confidentiality criteria have to be set up to get useful information for recognition.

Table 3: Evidence used to determine whether the standards are met

	FR	CA	UK	SW	NL
Evaluation process	internal survey; residency program; (triggered) visitation report; independent external recognition	internal survey; educational program; (triggered) visitation report; report from the residents	internal survey (of candidates specialists and trainers); (triggered) visitation report; regular review (questionnaires to trainees)	internal survey; residency program; regular review (questionnaires to trainees)	internal survey; (triggered) visitation report
Visitation members	university, lay member, trainee	university, professional regulatory bodies, candidate medical specialist	Trained PMETB partners (medical specialists and lay members)	Trained ISFM partners (medical specialists)	Medical specialists, candidate medical specialist (optional)
Training settings recognition validity	5 years	6 years	5 years	7 years	5 years
Logbook/portfolio	"Carnet de stage" : planning; candidate medical specialist performance assessment (clinical and research activities); training setting assessment by candidate medical specialist ;	"CanMEDS portfolio" : logbooks, multi-source feedback instruments, continuous quality improvement projects, learning diaries, encounter cards, essays, rating scales, etc.	"Learning portfolio" : planning; assessment of of candidates specialists (Mini-CEX;DOPs;CbD;MSF (360 degree);Patient survey;Other)	"Logbook": planning; assessment of candidates specialists (Mini-CEX; DOPS); certifications; curricula content	"Portfolio": planning; assessment of candidates specialists ; may be used during visitations

3.5 DISCUSSION

The recognition of training settings and trainers is a process under development in most countries analysed. Switzerland recently improved the transparency of its procedures (2009). The Netherlands made a complete revision of its legal framework. In France, the organizational and legal landscape is evolving too with creation of new regional health agencies, a new internship commission and a new law concerning hospitals, patients, health and territories. In the UK the recent merge of PMETB with the GMC will offer a single point of responsibility from admission to medical school, through PGT, to continued practice until retirement.

The recognition process little varies on the form (evaluation processes are commonly shared) but greatly differs in its foundations. Self-regulation by professional societies or medical schools, regulation by governmental authorities or independent bodies are deeply grounded in historical contexts. Thus the United Kingdom developed a system of independent recognition following a series of cases where self-regulation by the medical profession has been incriminated. The Swiss Medical Association developed a specific organization dedicated to the recognition of training settings as part of a broader federal recognition campaign: this decision was triggered by a problem of recognition at European level. Only France has a system quite similar to the Belgian one as it proceeds from governmental regulation : omissions are specifically dedicated to recognition of training settings (although they work at regional level with a mission to advise the Prefect of the region).

This report only focused on the organization of national official regulatory bodies. But interesting European initiatives on quality requirements in training have been developed for more than 50 years. By example, the UEMS created European Boards to involve academic and scientific institutions to improve medical specialist training in Europe (1990). In this framework, European charters on training of candidates medical specialists in the European Community (1993) and on visitation of training centres (1997) were elaborated.

3.6 CONCLUSION

The results show interesting examples for Belgium but the situation is still evolving in all countries under study.

3.6.1 Who are the actors endorsed for the recognition of training settings and trainers?

These actors are part of a global recognition process regulated by government (France), medical profession (Canada, The Netherlands and Switzerland (under federal control)) or until recently by independent regulatory body (United Kingdom). Specific recognition organizations are set up and characterized by professional functions, simplified administration, transparency (via websites) and conflicts of interest management. The governance model that characterizes many of these organizations includes the coordination of several actors within a legal or a quality framework. That governance model aims to coordinate the three areas of regulation i.e. professional, academic and governmental. The Swiss governance model is the only one to give important role of coordination to federal authorities.

3.6.2 What are the generic standards?

An important point is the significant influence of Canada on the Swiss, British and Dutch recognition processes. In these three countries the renewal of quality standards shifted from less structure oriented to more process oriented criteria. By doing so, the recognition of training settings and trainers is included in a broad process of recognition encompassing the whole PME.

3.6.3 What evidence is used to determine whether the standards are met?

Internal surveys, external on-site visits and regular reviews are used to collect evidences. Feedback from candidates specialists via portfolio, confidentiality of information, composition of visiting team and remuneration of visitors are of paramount importance. Three forms of payment for site visits have been observed: training settings have to pay for visitation (Switzerland); visitors are appointed by there respective associations (Canada); the professional regulatory body recruit, train and remunerate visitors (United Kingdom and The Netherlands).

The transferability of the findings needs to take account of the respective education and health systems and of the cultural differences with Belgium for those domains.

4 LEGAL FRAMEWORK

4.1 INTRODUCTION

This chapter describes the legal framework for specialist PGT.

4.1.1 Structure of the chapter

In the first part the European legal context is described since Belgian legislation and national legislation of other member states is based on it. First general principles are described. Then we zoom in to the European regulations on the working hours.

With regard to the Belgian situation, first the generic regulations for the training of GPs and other medical specialists are described. Then, peculiarities of the training and recognition process for GPs and other medical specialties are studied. The detailed specific regulations linked to the WFME domain for each specialty have been analysed. This extensive description is available upon request.

The entire legal chapter is linked to the domains identified in the WFME global standards for quality improvement scheme, serving as the backbone of this report.

4.1.2 Methodology

The legal databases Juridat and Jura, as well as the official sites of the courts and legal bodies were consulted to search for legislation, jurisprudence and doctrine. Moreover websites of the respective federal and community governments, the universities and institutes organising training for medical specialist served as source of information.

4.2 EUROPEAN LEGAL CONTEXT[a]

4.2.1 Directive on the recognition of professional qualification: minimum standards for PGT in medical specialties

The Directive on the recognition of professional qualifications consolidates and modernises the rules regulating the recognition of professional qualifications[b] and lays down a framework to ensure minimum standards for the specialist PGT in medical specialties.

4.2.1.1 Postgraduate training in general practice

Admission policy and selection

Admission to postgraduate training in general medical practice can be started after the completion and validation of at least six years of study (undergraduate/basic medical training programme).

Member States may however issue evidence of formal qualification as a GP to a medical doctor who has not completed the undergraduate medical training programme but who has completed a different, supplementary training, as attested by evidence of formal qualifications issued by the competent authorities in a Member State. They may not, however, award evidence of formal qualifications unless it attests knowledge of a level qualitatively equivalent to the knowledge acquired from the undergraduate medical training programme. Member States determine, inter alia, the extent to which the complementary training and professional experience already acquired by the applicant may replace the undergraduate medical training programme. The Member States may only issue the evidence of formal qualification as a GP if the applicant has acquired at least six months' experience of GP in a GP setting or a centre where doctors provide primary health care.

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a For a general overview of EU law and (future) Health professionals see M. Peeters, M. McKee and S. Merkur, EU Law and Health professionals[28]

b Directive 2005/36/EC of the European Parliament and of the council of 7 September 2005 on the recognition professional qualifications[29], incorporating amongst others the Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications[30]

Training structure, composition and duration

The postgraduate training in general practice leading to the award of evidence of formal qualifications issued before 1 January 2006 is of a duration of at least two years on a full-time basis. In the case of evidence of formal qualifications issued after that date, the training is of a duration of at least three years on a full-time basis. Where the undergraduate medical training programme comprises practical training given by an approved hospital possessing appropriate general medical equipment and services or as part of an approved general medical practice or an approved centre in which doctors provide primary medical care. The duration of that practical training may, up to a maximum of one year, be included in the three years of training provided for certificates of training issued on or after 1 January 2006. This option is available only for Member States in which the specific training in general medical practice lasted two years as from 1 January 2001.

The professional training is given, on the one hand, for at least six months in an approved hospital with appropriate equipment and services and on the other hand, for at least six months, as part of an approved general medical practice or an approved centre at which doctors provide primary health care. The professional training takes place in conjunction with other health establishments or structures concerned with general practice. The professional training may be given during a period of not more than six months in other approved establishments or health structures concerned with general practice.

Training content

Training is more practical than theoretical. The training includes the personal participation of the candidate GP in the professional activity and responsibilities of the persons with whom he is working.

Governance

The PGT in general practice is carried out on a full-time basis, under the supervision of the competent authorities or bodies.

4.2.1.2 Other medical specialist training

Admission policy and selection

Admission to specialist PGT also requires the completion and validation of at least six years of study as a basic medical training programme.

Training content

Specialist PGT comprises theoretical and practical training. It includes personal participation of the candidate medical specialist in the activity and responsibilities entailed by the services.

Training structure, composition and duration

The directive also provides a minimum duration of specialist medical training courses per specialist specialty (Annex V, point 5.1.3 Directive on the recognition of professional qualifications). The minimum periods of training can be adapted to scientific and technical progress.

Training should be given on a full-time basis at specific training settings recognised by the competent authorities.

Training setting

Training is given at a university or medical teaching hospital or, where appropriate, a medical care service approved for that purpose by the competent authorities or bodies.

Governance

Training is provided under the supervision of the competent authorities or bodies.

4.2.2 European Directive concerning aspects of the organisation of working time

Professional training entails participation in the full range of medical activities of the department where the training is given, including on-call duty, in such a way that the candidate-specialist/GP devotes all his professional activity to his practical and theoretical training throughout the entire working week and throughout the year. Accordingly, these posts are the subject of appropriate remuneration.

With regard to the working hours the European Directive concerning certain aspects of the organisation of working time[31] (Hereafter Working Time Directive) specifies the minimum requirements (art. 3 – 7):

- the average working week for a candidate specialist/GP should be no more than 48 hours (calculated on an average reference period of max. 4 months);
- a minimum of 11 hours continuous rest in each 24 hour period;
- a rest break after every six hours worked;
- a minimum period of 24 hours continuous rest in every seven days period
- a minimum of 4 weeks paid annual leave.

Derogations to the rest requirements, the 8 hour/night work schedule and the reference periods are explicitly allowed where health services must ensure continuity.

Member states can decide to allow individual workers to opt-out of the 48 hours limit. The conditions for the opt-out are (art. 18 , 1° b):

- The worker must agree to work more than 48 hours a week;
- No worker should be disadvantaged by deciding not to opt-out;
- The employer must keep up to date records of all workers who carry out such work;
- These records must be made available to the competent authorities, who can restrict working hours above the maximum for health and safety reasons.

For candidate specialists/GPs there is a transitional period before full implementation of the 48 hours week. Although intended to enter into force by August 2009, a member state can ask for a delay of 3 years, if this can be justified. In no case a candidate specialists/GP should work more than 58 hours since August 2007 and no more than 52 hours from September 2009.

The legislation was clarified and interpreted by several court rulings of the European Court of Justice. A major point of discussion was the status of on-call duty of doctors. The Directive defines working time as the period a worker is working, at his/her disposal and carrying out his/her activity or duties (art. 2, 1st section). In the The Simap case[32], the European Court of Justice ruled that on-call duty by doctors counts as working time when they are present at the facility but when they are on-call from home, it only counts when they are actually working. Other judgements[33-35], confirmed that a candidate specialist on-call in a hospital, but resting in bed, is still considered to be working.

Mainly based on these judgments a proposal for amendment of the Working Time Directive was launched. Parliament and Council however could not find a compromise on the crucial points of the opt-out possibility and on-call time. The main stumbling block was the opt-out clause, which Parliament had wanted to become exceptional and temporary. However, the Council had been unwilling to put an end to the opt-out. Parliament had also sought to defend the position upheld in rulings by the European Court of Justice, whereby on-call time should be regarded as working time. As no compromise could be found in conciliation, the proposal lapsed and the current directive remains in force.

Key points European legal context

- **European legislation defines the legislative framework of the specialist PGT. Within this framework member states can elaborate national legislation.**
- **Undergraduate medical training takes at least 6 years.**
- **PGT for GPs lasts 3 years. The duration of PGT for other medical specialties varies according to the specialty.**
- **Specialist PGT comprises theoretical and practical training**
- **An average working week for candidate medical specialists should not exceed 48 hours (calculated on an average of max. 4 months).**
- **According to the jurisprudence of the European Court of Justice, on-call duty by doctors counts as working time when they are present at the facility (even resting in bed) but when they are on-call from home, it only counts when they are actually working.**

4.3 BELGIAN LEGAL CONTEXT OF SPECIALIST POSTGRADUATE TRAINING

4.3.1 Federal legal framework for recognition[c]

The federal government is competent for the definition of the necessary qualification with regard to the access to the profession, definition of minimum capabilities necessary to practice the profession and the protection of professional titles[42-44]. The federal government makes the access to the medical profession subject to a recognition and has defined the conditions for the recognition. In order to get recognition as a medical specialist, the federal government requires that professional training and academic teaching have been completed by the candidate specialist and the candidate GP. The universities are responsible for the academic teaching.

4.3.2 Financing of universities for academic teaching for medical specialists

4.3.2.1 Flemish Community

Recently a new financing model came into force for the universities providing a.o. academic teaching for candidate GPs and other candidate medical specialists in the Flemish community.[66] The aim of the new financing regulations is that universities are no longer solely financed based on the input (number of enrolled students) but also on their efforts for education and research. The investment in education by the university is not only measured by the number of credit points used by the students but also by the number of credit points acquired and thus based on the output. In that scope the universities are triggered to organize education as good as possible and to pay special attention to the structure of the study program. The study workload and results of a student are translated into credits.[67] Solely students with a positive credit level are eligible for financingd.

The Flemish government divides a fixed budget of € 100mio over the universities for the educational activities based on the average assumed study credits calculated over 5 years (=enrolments). Moreover there is a variable part of €313,5 mio for the universities, to be divided based on the average of the financing points calculated over 5 years (system of student specific weighing). Except for GP PGT, master after master programs, are not taken into account for the calculation of the budgets. The rationale behind the exception for GP PGT is that GP PGT has to be considered as a continuation of the undergraduate medical training instead of optional additional training.[68]

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c For an extensive overview see[36-40]

d For details on the "leerkrediet" see http://www.ond.vlaanderen.be/hogeronderwijs/studeren/leerkrediet/allesoverhetleerkrediet.htm

It has to be noted that this reasoning no longer can be defended since undergraduate medical training has been reduced to 6 years and GP PGT starts after the medical degree has been obtained instead of in the 7th year of the undergraduate medical training program. Accomplished GP PGT generates 120 study credits if the following criteria are taken into account (Art. 16 Decreet van 14 maart 2008 betreffende de financiering en de werking van Hogescholen en universiteiten in Vlaanderen)[66]:

- PGT complies with the regulations of the European Directive 2005/35/EC;
- a formal assessment of the study results;
- an external assessment of quality if the academic teaching relates to the entire PGT, coordinated by VLIR according to the protocol.

From 2011, The Flemish government can put aside a sum of at the most 1% of the total amount that is paid to the universities and the colleges for higher education for an additional financing of the master after master or bachelor after bachelor programs. This amount will be divided over the eligible programs based on the acquired study points and the number of granted diplomas. The recognition commission (=institute of experts advising on educational matters) compares the requests of the universities/colleges for higher education based on the following criteria:

- 1° The societal added value, e.g. the needs at the job market;
- 2° the scientific relevance;
- 3° the quality of the programs, determined by the visitation reports.

Depending on the comparative judgment, the recognition commission will set a list with bachelor after bachelor programs and master after master programs that are eligible for extra financing.

It can be argued that the master-after-master programs in medicine comply to a large extent to these conditions. GP PGT in Flanders was accredited in 2007 by the "Nederlands- Vlaamse Accreditatie Organisatie (NVAO)".[69] Other specialist teaching in Flanders was accredited by NVAO in 2009.[70]

4.3.2.2 *French speaking Community*

The financing of academic teaching organized by the universities by the French Community is also twofold: there's a fixed part of 102 million euro for the years 2006 till 2015 (23 % ULG; 30 % UCL; 25 % ULB; 4% U.Mons-Hainaut; 2 % Fac. Univ. des Sciences agronomiques de Gembloux; 7 % Facultés universitaires Notre-Dame de la Paix Namur) (Art. 117, §1 Décret du 31 mars 2004 définissant l'enseignement supérieur, favorisant son intégration à l'espace européen de l'enseignement supérieur et refinançant les universités)[64] and a variable part of €308 mio. based on the relation of the weighted average of enrollments over 4 years per university and the weighted average of enrollments of all universities in the French speaking community (Art. 117, §2 and 3 Décret du 31 mars 2004 définissant l'enseignement supérieur, favorisant son intégration à l'espace européen de l'enseignement supérieur et refinançant les universités)[64]. Master after master programs for which legislation has set a contingent, such as the medical specialties (including GP training) are taken into account for the calculation of the allocated amount (Art. 126, 3rd section Décret du 31 mars 2004 définissant l'enseignement supérieur, favorisant son intégration à l'espace européen de l'enseignement supérieur et refinançant les universités).[64]

4.3.3 Governing bodies

4.3.3.1 The Superior Council of medical specialists and GP's (hereafter Superior Council): recognition of trainers and training settings

Structure

The Superior Council (SC) is composed of a Dutch speaking and a French-speaking chamber and is presided by a medical doctor-official or an emeritus medical doctor-official of the department of health designated by the minister of Health. The secretary is an official, designated by the minister of Health and Social Affairs. At least 50% of the members of each group (except for the individual representing the minister of Health) of each chamber has to be present in order to deliberate in a valid way. If the required number of members is not present the president organises a second meeting with the same agenda where the minimum quorum does not apply. The advices of the SC are taken by majority of the present members. If an advice affects GPs or other medical specialists, the majority of the members representing respectively the GPs or the other medical specialists have to be present. The deliberations are undisclosed and have to be motivated.

Each chamber is presided by a medical doctor selected out of two nominees presented by the Koninklijke Academie voor geneeskunde van België for the Dutch Chamber and by the Académie royale de médecine de Belgique for the French Chamber (art. 5 and 6 Koninklijk besluit van 21 april 1983 tot vaststelling van de nadere regelen voor erkenning van geneesheren-specialisten en van huisartsen/arrêté royal du 21 avril 1983 fixant les modalités de l'agréation des médecins spécialistes et des médecins généralistes).[71] The vice president is a medical doctor selected out of two nominees presented by the National council of the Orde der geneesheren/Ordre des médecins. The other members are

- 12 recognised specialists-academics or emeritus specialist - academics, each selected from two nominees presented by the faculties of medicine
- 10 recognised specialists, each selected from two nominees presented by the professional organisations
- 2 recognised specialists or 2 candidate medical specialists, representing the candidate medical specialists, each selected from two nominees presented by the professional organisations
- 12 recognised GPs, each selected from two nominees presented by the faculties of medicine;
- 10 recognised GPs, each selected from two nominees presented by the professional organisations
- 2 recognised GPs or 2 candidate GPs, representing the candidate GPs, each selected from two nominees presented by the professional organisations;
- a medical doctor representing the Minister of Public Health.

At least 75% of these members need to practice their own specialty. The member's activity is evaluated at the moment of appointment by means of criteria that are set by the Minister. Until today, these criteria have not been defined. Once a member is considered to be active, he/she keeps that quality till the end of his/her mandate lasting for 6 years. The Minister can cancel the mandate, based on the advice of the superior council if the respective member lacked regular presence at the meetings of the SC or has no sufficient interest in the tasks confided.

The secretaries are officials, designated by the minister of Health and Social Affairs. At least one of the secretaries per linguistic register is a lawyer.

Tasks

The plenary SC is charged with the following tasks (art. 5 § 4 RD 21 April 1983)[71]:

- Formulation of proposals to the minister with regard to the criteria for the recognition of candidate medical specialists, candidate GPs, trainers and training settings,
- Giving a motivated advice to the Minister with regard to the demands for recognition as trainer or training setting,
- Advising the Minister, on his request or on its own initiative with regard to recommendations and guidelines for the recognition commissions, the trainers and the candidate specialists or with regard to conceptual matters.

In order to handle with a specific task, the SC has working groups composed of members of the SC and eventually external experts (art. 5 § 5 RD 21 April 1983).[71]Working groups have the following tasks (source: Ministry of Public Health):

- Working Group GPs (i.e. trainers for candidates GPs): recognition of trainers and training settings for candidates GPs;
- Working Group medical specialists (i.e. trainers for candidates medical specialists): recognition of trainers and training settings for candidates medical specialists;
- Working Group for the creation of particular professional titles: give advice on topics proposed by the Working Group medical specialists or SC.

The Chambers of the SC have the following tasks (art. 6 § 5 RD 21 April 1983)[71]:

- advising, after a motivated consultation, on the appeal lodged against the advices of the recognition commissions,
- advising, after a motivated consultation, at the request of the Minister of Health and Social Affairs, on the advice of the recognition commissions with regard to the training plan, the training and the recognition of the candidate medical specialist.

4.3.3.2 The recognition commissions for candidates GPs and candidates medical specialists

Structure

There is a recognition commission per medical specialty specified in the Royal Decree of 25 November 1991 listing the specific occupational titles of medical practitioners.[72]

Each recognition commission is composed of a Dutch and a French speaking Chamber. Each Chamber is composed of (art. 7 RD 21 April 1983[71]):

- At least 3 and at the most 8 medical doctors – academics recognised in the respective medical specialty and nominated by the faculties of medicine,
- At least 3 and at the most 8 medical doctors recognised in the respective medical specialty and nominated by the professional associations.

The president and the vice president are elected among the members of each chamber. The secretary is an official person, designated by the minister of Health and Social Affairs. The secretary gives administrative and legal support for the files that are submitted for advice to the chambers of the recognition commission and consults legal experts of the Federale Overheidsdienst Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu/ Service Public Fédéral Santé Publique, Sécurité de la Chaîne Alimentaire et Environnement (hereafter FOD Volksgezondheid/SPF Santé Publique) to examine the files.

At least 50% of the members has to be present in order to deliberate in a valid way. If the required number of members is not present the president organises a second meeting with the same agenda where the minimum quorum does not apply. The decisions are taken by majority of the present members. The deliberations are undisclosed and the decisions have to be motivated.

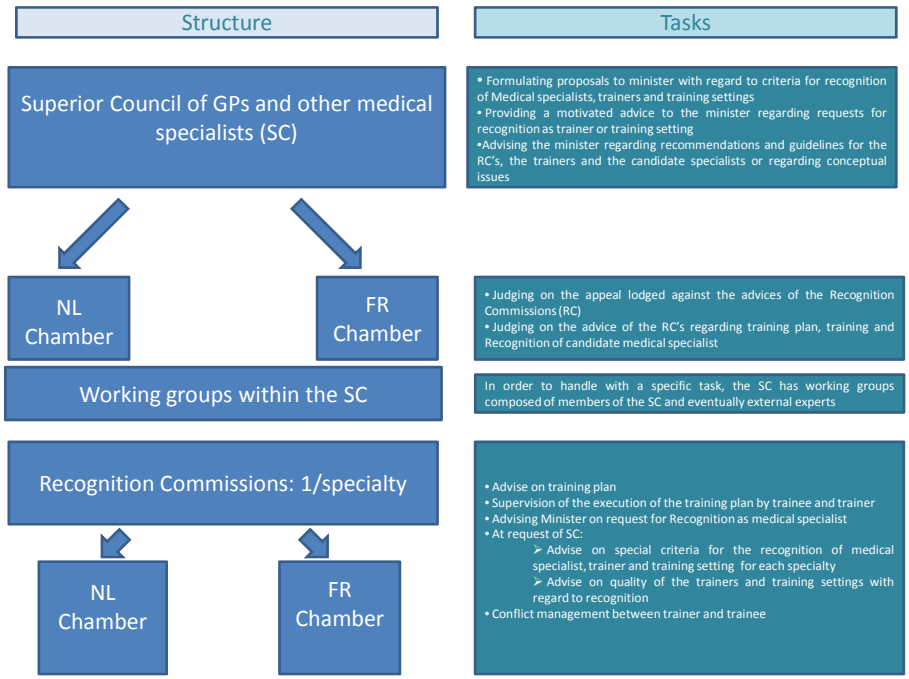
Tasks

The chambers of the recognition commissions of GPs and other medical specialists have the following tasks (art. 8 RD 21 April 1983[71]):

- Advising on the training plan that was submitted by the candidate and proposing changes to the criteria within the limits of the recommendations and guidelines formulated by the Superior Council,
- Supervising the execution of the training plan, by the trainer as well as by the candidate,
- Giving a motivated advice to the Minister of Health and Social Affairs on the requests for recognition as a medical specialist,
- At request of the Superior Council, giving advice on the special criteria, proper to each specialty, for the recognition of GPs, trainers and training settings,
- At request of the SC, giving advice on the value of the trainers and the training settings with regard to their recognition.

At any time, each RC or any Chamber of the SC can send a note to the Superior Council with advice or remarks on issues related to their respective specialty.

Figure 4: Structure and tasks of the governing bodies



Key points Belgian situation: structures, competencies and financing

- **In order to get recognition as a medical specialist, the federal government requires the completion of professional training and academic teaching by the candidate.**
- **Financing of universities: In the French speaking Community the financing of universities is twofold, a fixed part and a variable part based on the number of enrolments. Master after master programs in medical specialties are taken into account for the calculation of the variable part. In the Flemish Community there's also a fixed and a variable part. For the calculation of the variable part master after master programs, except for GP PGT, are not taken into account. From 2011, master after master programs in medical specialties other the GP PGT will be possibly additionally financed.**
- **The governing bodies for specialist PGT are the Superior Council of GPs/other medical specialists and its working groups and the recognition commissions. There is one recognition commission per specialty.**

4.3.4 Procedures to start specialist PGT

4.3.4.1 Admission policy and selection

Legal quota, entrance exam and numerus clausus

After having obtained the medical doctor's degree, a medical doctor needs a licence granted by the Federal Ministry of Public Health to be able to practise. Further PGT is needed to obtain this licence.

The number of medical specialists that may practise under the national health insurance system is limited by legal quota [73, 74] There are fixed numbers of positions for candidate medical specialists per year, for instance in 2008, at the most 757 candidate medical specialists (454 for the Fl community and 303 for the FR community), of which at least 300 per year (180 for the FL community and 120 for the FR community) for the GP specialisation. Since 2008, the specification of numbers for each speciality other than general practice is omitted.[75] The certificates allowing students to specialise are granted by the universities. The division of the number of certificates per university is regulated by law. (Art. 79ter Décret du 31 mars 2004 définissant l'enseignement supérieur, favorisant son intégration à l'espace européen de l'enseignement supérieur et refinançant les universités[64]). One way to manage the respect of these legal quota is the limitation of the intake of students. In that scope, the Flemish community has implemented an entrance exam (Art. 68 §2 Decreet van 4 april 2003 betreffende de herstructurering van het hoger onderwijs in Vlaanderen).[57] [76]In the French Community the numerus clauses that was applied after the first year of undergraduate training in medicine, has been suspended.[77] Certificates to start the second year of undergraduate training were handed to students within the limits of the available number of certificates. These certificates were awarded according to a decreasing ranking based on the acquired results during the first year. The minimum condition to obtain a certificate is a result of at least 60 credits and at least 10/20 for each course (Art. 10 Décret du 1er juillet 2005 relatif aux études de médecine et de dentisterie).[78] This situation possibly creates an inequality between different groups of students having complied with the minimum conditions for succeeding in an academic year specified in the "Bologna decree".[64] Indeed, depending on the ranking, students having obtained 60 credits and 10/20 for each course or students not complying with these requirement but being deliberated by the jury are (possibly) not selected to start the second year. Based on the inequality argumentation, jurisprudence has obliged the respective universities to allow the students in the cases at stake to start provisionally the second year of undergraduate training.[79, 80] The Raad van State/Conseil d'Etat has asked a prejudicial question to the Grondwettelijk Hof/Cour Constitionelle.

In the mean time the numerus clausus has been suspended and a transitory situation has been inserted in legislation: students enrolled for the first year of undergraduate training during the academic years 2005-2006, 2006-2007, 2007-2008 and 2008-2009 can have access to the second year of GP training as far as they have obtained 60 credits in the first year of GP training (seventh year)(Art. 1 Décret du 24 octobre 2008 relatif à la situation des étudiants en médecine et dentisterie)[76]. The minister responsible for higher education in the French Community has expressed the intention to prolong the suspension for the academic year 2010-2011. [e]

In practice the legal quota and the actual fulfilled positions are not equal. The total number of the certificates delivered by French and Flemish universities should not exceed the maximum number of certificates fixed for each Community and discipline by the Royal Decrees. However, although the overall quotas are respected nationwide, discrepancies can be observed between requirements as defined by legal quotas and actual fulfilled positions. In 2006, the quotum of GPs was not fulfilled, with a difference of -25.5% in comparison to scheduled numbers. With regard to other specialists, there was an excess of 19.5%.[81]

Free movement of students

At the time of writing the undergraduate training program in Belgium takes 7 years, but the government officially declared that the term will be reduced to 6 years from 2011 on. In the former system Belgian students could have an interest in having basic medical training abroad since basic training takes 6 years in some European member states. When returning to Belgium after undergraduate training however extra training can be required. For general practice for instance, students having finished undergraduate training abroad in 6 years have to complete the fourth year of the master in medicine with major general practice before they can start the master program in general practice.

When returning to Belgium for specialisation the student has another advantage since only (undergraduate training) diploma's from Belgian universities are taken into account for the application of the quota (Art. 1, 1° Koninklijk Besluit van 12 juni 2008 betreffende de planning van het medisch aanbod/ Arrêté royal relatif à la planification de l'offre médicale)[75]. Students having performed the entire curriculum abroad and returning to Belgium can increase the number of practicing doctors beyond the quotas.

Foreign students often come to Belgium to benefit from a different selection system[f,g]. . In the French community there is a quotum of 70% for students residing in Belgium.[82] Infringement cases were introduced to this practice. The European Commission however has decided to suspend the case for an additional five years to give the Belgian authorities the opportunity to provide supplementary data supporting their argument that the restrictive measures they have imposed are necessary and proportionate[h].

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e http://marcourt.wallonie.be/actualites/~numerus-clausus-marcourt-veut-prolonger-d-un-an-le-moratoire.htm?lng=fr

f In 2006, 78 or 10.4 % of all training plans were introduced by foreign holders of medical diploma i.e. 4.4% of all training plans submitted.

g In 2007, 25.6% of all candidates for the selection exams in the Flemish Community came from the Netherlands.

h http://europa.eu/rapid/pressReleasesAction.do?reference=IP/07/1788&format=HTML&aged=0&language=EN&guiLanguage=en

Selection in the seventh year of undergraduate training

As mentioned above, at the time of writing the undergraduate training program in Belgium takes 7 years, but the government officially declared that the term will be reduced to 6 years. Since this was not yet confirmed by law however, the selection procedure applicable at the time of writing will be explained in this report.

A second selection takes place in the seventh year of undergraduate training. In order to start specialist PGT the candidate needs to prove that he was taken up in the contingent of the respective year. The procedures for this selection differ in the French and in the Flemish community. In the Flemish community different procedures exist per university (see chapter Belgian situation). In the French community the procedure is set by decree and is uniform for candidate GPs and candidate other medical specialists. An admission certificate is granted by the university institution where the candidate will subscribe for specialisation. A list, ranking the candidates, is set by each university commission ("commission institutionnelle"). This ranking is based for 50 % on the academic results of the candidate medical specialist of every academic year of the second cycle of the undergraduate training, for 25% from the courses in the field of general practice/other medical specialisation during the undergraduate program and 25% from the evaluation of the capacities and the specific motivation of the student (interview) (Art. 3 Décret du 27 Février 2003 modifiant les dispositions relatives aux études du secteur des sciences de la santé dans le décret du 5 septembre 1994 relatif au régime des études universitaires et des grades académiques et dans la loi du 27 juillet 1971 sur le financement et le contrôle des institutions universitaires[83] inserted art. 14 §2 bis in Decrèt du 5 septembre 1994 relatif au régime des études universitaires et des grades académiques).[84].

It should be noted that although formal selection criteria exist, in practice the selection remains within the universities' autonomy. Moreover criteria such as the capacities and the specific motivation, tested in an interview, can possibly hamper objectivity.

The operation guidelines of each commission precise the modalities of the ranking.[85] For each specialisation there's an interuniversity section composed of 2 members (in practice the president and the secretary) of each university organising the respective specialisation. The tasks of these commissions are the following:

- Checking the concordance with the number of candidates proposed by each university and the interuniversity agreements;
- Negotiating the interuniversity exchange of candidates in case there are not sufficient candidates for a specialty;
- Verifying 'in fine' the number of candidates that were proposed for the respective specialty and compares with the federal quota;
- Verifying if the selection procedure was respected;
- Examining the eventual complaints that student would like to address to the university.

During the first week of July of each academic year, each interuniversity commission per specialty transfers the report to an interuniversity admission commission composed of the deans and vice deans (or the mandated persons) of the faculties of medicine of the universities that are organising the specialty. This commission selects the candidates, the ranking and the legal quota taken into account (Art. 14 Decret du 5 septembre 1994 relatif au régime des études universitaires et des grades académiques[84]). All attestations are handed in to the federal authorities (FOD Volksgezondheid/SPF Santé public).

Key points: Procedures to start specialist training

- **The number of medical specialists that may practise under the national compulsory health insurance system is limited by legal quota.**
- **The selection of candidates in the seventh year of undergraduate medical training differs in the Flemish and in the French community. The decision on the selection however is in both communities left to the universities; there's no centralised and independent "selection body".**

4.3.4.2 *Authorisation of the training plan (art. 10 and following RD 21 April 1983[71])*

Next to the admission certificate, candidates have to submit a training plan to start PGT. At the latest three months after the start of the training the candidate has to send a training plan and a certificate of the faculty of Medicine where the candidate is accepted to follow the PGT of the respective specialty.

The training plan contains the following information:

- The specialty concerned;
- The start and ending date of the training, because the training plan concerns the entire duration of the training;
- The training service(s) where they want to work;
- The name and the authorization of the trainer(s) and/or the trainer-coordinator. If a candidate has more than one trainer, one of them has to be designated as a coordinator. The task of the trainer-coordinator is to coach the candidate at the drawing up of the training plan and to coordinate the training process. The trainer-coordinator has to be recognised for the same specialty as the candidate;
- For periods abroad (cfr. supra) the domicile address in Belgium has to be mentioned.

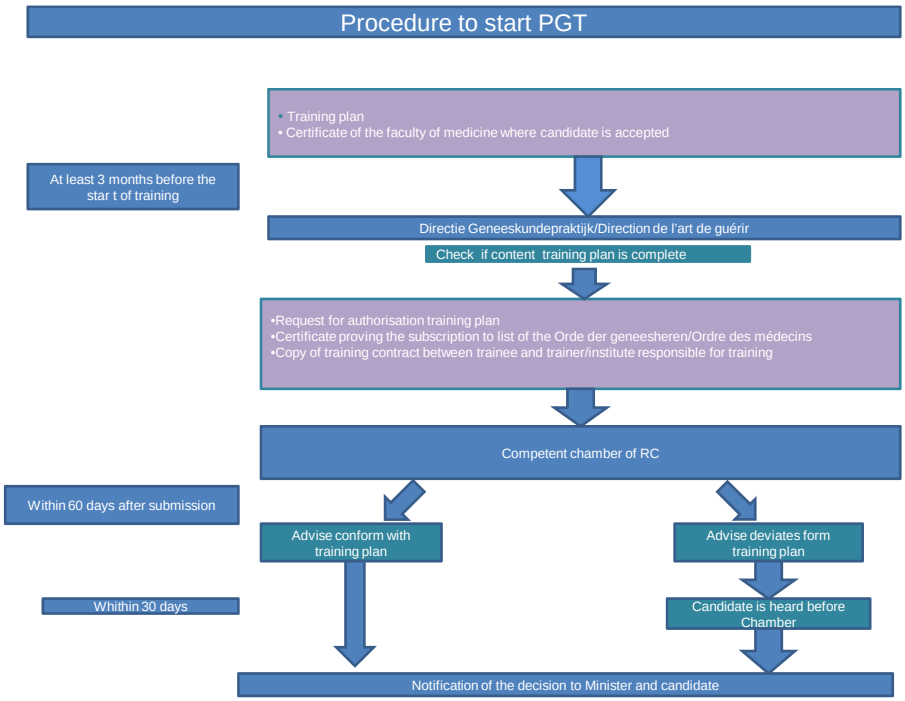
The "Directoraat Basisgezondheidszorg en Crisisbeheer/Direction des Soins de Santé et Gestion de Crise" checks if the above mentioned criteria are met. If this is the case, the request for authorization of the training plan, a certificate proving that the candidate candidate subscribed to the list of the Orde der Geneesheren/Ordre des Médecins, a proof that he was taken up in the contingent of the respective year and a copy of the training contract between the candidate and the trainer if the institute responsible for training has to be submitted to the competent Chamber of the Recognition Commission.

For candidate GPs, the training contract should include all modalities of the professional training, e.g. the work schedules of the candidate the amount of on-call hours, the planned specific medical activities and the duration of the contract. For other medical specialists the contract should explicit the remuneration of the candidate and the duration of the contract (see further). The contract is also sent to the Orde der Geneesheren/Ordre des Médecins for certification. As soon as the chamber received all documents, all the data are automatically transferred to the National Institute for Health and Disability Insurance (NIHDI). A NIHDI number is sent to the candidate. The competent chamber of the recognition commission judges on the documents within 60 days after submission. If the advice deviates from the training plan introduced by the candidate, the decision is taken into consideration and the candidate will be asked to appear before the Chamber. If the candidate does not appear the Chamber can base its judgment solely on the documents, except in case of justified absence.

The advice of the Chamber is notified to the Minister of Health and Social Affairs and is notified to the candidate within 30 days.

At the start of training, the candidate medical specialist is provided with a training logbook, in which professional training activities have to be noted. The candidate medical specialist has to return the logbook to the competent Chamber of the recognition commission. Additionally and also yearly the candidate medical specialist has to report annually on the progress of the training to the competent Chamber of the recognition commission.

Figure 5: Procedure to start PGT



4.3.5 Follow-up of the training (plan) during training

4.3.5.1 Changes to the training plan (art.16 RD 21 April 1983[71])

Any changes to the training plan have to be submitted to the Minister for approval. The Minister previously asks for an advice to the competent Chamber of the recognition Commission. Neither the candidate nor the trainer can change the training plan unilaterally or terminate the training contract before the term has expired.

4.3.5.2 Interruption of training (art.17 RD 21 April 1983[71])

A break in the training period can not shorten the total duration of the training period. If the candidate takes a break of at least 3 months, he immediately has to notify the break and the reason for the break to the competent chamber of the recognition Commission and propose a way to practice additional training. The Chamber advices on the proposal within 30 days and notifies its advice to the candidate, the trainers and sends the proposal with the advice to the Minister for approval.

4.3.5.3 Conflict management during training (art. 18 – 19 RD 21 April 1983[71])

In case of disagreement between the candidate and the trainer, each of them can bring the case before the competent chamber of the recognition commission. The Chamber will hear both parties. If the dispute cannot be solved, the Chamber will charge a commission of one or more of her members and a medical doctor– official of the Ministry of Health with a local investigation. The chamber will notify its advice to the trainer and to the candidate within 30 days after having consulted the report of the Commission and will send it to the Minister of Health and Social affairs.

Although an internal procedure for conflict management exists, jurisprudence confirms that the judge for summary proceedings (kort geding) is competent to judge a violation or the imminent violation of the rights of a candidate [86]. In case a candidate in internal medicine complained that the insufficient level of training (the lack of supervision) provided by the trainer would hamper her recognition by the recognition commission. Instead of following the procedure before the recognition commission, the candidate went to court. In the case at stake the judge decided that given the level of training, supervision of the trainer is needed in the interest of the patients. This judgment is an important step in the direction of jurisdictional supervision to the realization of the right to qualitative PGT.

If the trainer judges that the candidate is not apt for the respective specialty or is undesired at the training setting, he has to notify this and the reason to the competent chamber of the recognition commission. The chamber will hear both parties. If the trainer sticks to his opinion, the chamber will charge a Commission of one or more of its members and a medical doctor– official of the Ministry of Health with a local investigation. After having consulted the report of the Commission, the chamber will advise either to stop the training or part of the training, or designate another trainer. In the latter case, the Chamber decides to what extent the training period with the former trainer will be taken into account for the calculation of the total duration of the training. If the second trainer also gives a negative advice the Chamber can not allow the candidate to continue his or her training. In that case the candidate has the right to be heard and to be assisted by one or more lawyers.

The Chamber will notify its advice to the trainer and the candidate within 30 days and send it to the Minister of Health and Social affairs for approval.

If no appeal was lodged against the advices of the recognition commission with regard to the training plan and the training, the Minister decides. If the recognition commission has omitted to give an advice within the provided delay the Minister can decide by himself. The minister has to notify the decision. If this decision deviates from the plan introduced by the candidate medical specialist , notification is sent by certified mail.

Candidate medical specialists are not represented in the recognition commission. All the members are peers of the trainer which could hamper the guarantees for objectivity. The non-representation of the candidate medical specialist is rational for the advising task of the recognition commission on the recognition of the candidate medical specialist. Indeed, there would be a conflict of interest for representatives of candidate medical specialists advising on the recognition of a candidate medical specialist. For conflict management however, representation of the candidate medical specialist is justifiable. Moreover, the fact that the same institution that advices at the end of the training on the recognition of the candidate medical specialist also judges conflicts during professional training increases the barrier for candidate medical specialist to start proceedings.

Keypoints: Follow-up of the training plan during the training

- **The training plan has to be authorized at the start of the professional training : the candidate gets a logbook where he notes his/her training activities.**
- **Any changes to the training plan in the current of professional training have to be submitted to the Minister for approval.**
- **Each year, the candidate has to report on the progress of professional training to the competent chamber of the recognition commission.**
- **Conflict management is handled by the competent chamber of the recognition commission. Due to the composition of the chamber, the candidate is not represented in the procedure hampering guarantees for objectivity.**

4.3.6 The training process

4.3.6.1 GP training

Training duration

The duration of the training program for GPs has been a matter of discussion for a long time. The Flemish Decree of 5 April 1995 inserted a GP training program with a duration of 3 years, starting in the fourth year of the second cycle of undergraduate training (Art. 4 §2 Decreet van 5 april 1995 tot wijziging van het decreet van 12 juni 1991 betreffende de universiteiten in de Vlaamse Gemeenschap om de organisatie van een specifieke opleiding in de huisartsgeneeskunde te organiseren, en andere bepalingen betreffende de universiteiten).[55]

On the federal level a Ministerial Decree of 2006 introduced the possibility to start GP training during the last year of basic medical training (art. 3 Ministerieel Besluit van 21 februari 2006 tot vaststelling van de criteria voor de erkenning van huisartsen/ Arrêté ministériel fixant les critères d'agrément des médecins généralistes).[87] The Raad van Staat/Conseil d'Etat stated with regard to this regulation that this might create an inequality between candidate GPs and candidate medical specialists who have to complete seven years of undergraduate training before starting specialist PGT.[89] The Raad van State/Conseil d'Etat canceled the respective Ministerial decree based on procedural grounds.[90] At the time of writing, the government declared to reduce the term of undergraduate training to 6 years for all specialties. The specialist PGT for all specialties, including GP, will start after the medical degree has been obtained.

Training composition and structure

The GP training contains academic and professional training. The professional training is a program of recognised internships that are relevant for training of GP's in one or more hospital services and in one or more practices of GP trainers.

The candidate GP has to perform the professional training on a full time or part time basis (after approval of the RC). Until today no specific conditions for part-time professional training were specified (art. 3 and 9 Min D. 1 March 2010[1]).

Professional training can be started once the authorisation to practice medicine has been granted. The professional training consists of at least 6 months and at the most 12 months in a hospital service recognised for GP professional training. Professional training in the same hospital service can take at the most 6 months. The professional training focuses at the clinical work relevant for general practice (art. 6 Min D. 1 March 2010[1]). Additionally one or more training periods in a recognised GP practice must be performed.

The GP professional training duration can be reduced and training content can be adapted for GP candidates that already possess a diploma of medical specialists in another specialty. The candidate has a well equipped office at his disposal, treats patients and keeps patient files and participates for at least 120 hours per year to officially organised on-call rota's of the region during the weekend (art. 7 and 8 Min D. 1 March 2010[1] and art. 4 § 1 Ministerieel Besluit van 17 juli 2009 tot vaststelling van de medische activiteiten van de kandidaat huisarts, tijdens de stageperiodes bij een erkende stagemeester, in het kader van de specifieke opleiding in de huisartsgeneeskunde/Arrêté ministériel fixant les activités médicales du candidat médecin généraliste, durant les périodes de stage auprès d'un maître de stage agréé, dans le cadre de la formation spécifique en médecine générale) [91](see also working hours infra).

In order to start the professional training the candidate GP has to prove that he/she succeeded in a specific academic teaching program in GP medicine of at least 8 ECTS intended to achieve the final attainment level defined in law. Solely teaching organized by a university in the scope of the specific training for GP medicine can be taken into account (art. 4 Min D. 1 March 2010[1]).

During the professional training periods the candidate GP has to participate yearly to at least 40 hours of seminars conducted by a recognised GP trainer. In these seminars medical problems are discussed in group. Solely seminars organized by universities can be taken into account (art. 5 Min D. 1 March 2010[1]).

Training abroad

Candidate GPs can go to have training abroad for a limited period. European legislation does not limit the maximum period or other conditions for partial training in another state. As regards academic recognition of a title or a period of study abroad in order to continue studying in the country of origin, each Member State is responsible under the Amsterdam Treaty for its own educational content and organization. However, the European Commission has encouraged mutual recognition (for academic purposes) between the various education systems in Europe through such Community programmes as Erasmus (for training during undergraduate medical education). Although participation in Erasmus is entirely voluntary, it has greatly contributed to an understanding and recognition of education systems that are often very different.

For GP PGT a guideline of the Ministry of Health sets the conditions for partial training abroad.[92] The training in a EU member state has to comply with the conditions set in the Direction on the recognition of professional qualifications. PGT in a non-EU member state for a limited period can only be recognised if there's a bilateral agreement between Belgium and the respective country regulating the mutual and equal regulation of PGT and the mutual recognition of trainers and training settings.

Statute of the candidate GP

Candidate GPs who have started the master in GP before the 1st of July 2009 can choose between the (old) self employment or employee statute and the (new) particular so called "sui generis" statute, similar to the statute of candidate medical specialists. For candidate GPs having started the master in GP after that date, the sui generis statute automatically applies.

In the sui generis statute, the candidate GP can benefit from several social benefits proper to the statute of employees such as allowance of 65% in case of illness, a disability benefit of 45%, child benefit, maternity benefit, maternity leave, maternity help or cheques, circumstantial leave and does not have to subscribe with a "self employment fund" (Art. 15bis, 1e lid, 2°, Koninklijk besluit tot uitvoering van de wet van 27 juni 1969 tot herziening van de besluitwet van 28 december 1944 betreffende de maatschappelijke zekerheid der arbeiders/ Arrêté royal pris en exécution de la loi du 27 juin 1969 revisant l'arrêté-loi du 28 décembre 1944 concernant la sécurité sociale des travailleurs).[93]

Coordination Centres

Two centres have corporate personality for the coordination of GP professional training i.e. one for Flanders (SUIvzw) and one for Wallonia and Brussels (Centre de Coordination Francophone pour la formation en Médecine Générale – CCFFMG) (Art. 3 Koninklijk besluit van 17 juli 2009 tot wijziging van het Koninklijk besluit van 21 april 1983 tot vaststelling van de nadere regelen voor erkenning van geneesheren-specialisten en van huisartsen/Arrêté royal modifiant l'arrêté royal du 21 avril 1983 fixant les modalités de l'agréation des médecins spécialistes et des médecins généralistes).[94] In the steering committees of these coordination centres 2/3 of the voting members have to be academic (recognised) medical specialists, 1/3 of the voting members have to be recognised GP trainers and at least 6 representatives with an advising vote, voted by the candidate GPs. A consultative committee will be responsible for the management of the payment of the remuneration of the candidate GPs and will have equal representation of representatives of the faculties of medicine and the professional organisations. The centre will be responsible for drafting different models of contracts such as for instance a model of the contract between the GP trainer and the coordination centre, a training contract between the candidate GP and the trainer. The model contracts are submitted for advice to the Superior Council. The centre will supervise the respect and the execution of the contracts, except for the aspects regarding the GP training. In case of violation of the contracts, the centre reports this to the Minister.

The coordination centre having a contract with a candidate GP is remunerated by the NIHDI (€27 200/Year of training/candidate GP) for the professional training and the social security contribution, the insurance professional liability, the insurance accidents during training, the travel costs of the candidate GP and an amount for the on-call services performed by the candidate GPs.[95]

The overhead costs of the SUIvzw is remunerated as a percentage of the total remuneration cost of the candidate GP that is financed by the NIHDI and the trainers.

Remuneration

CANDIDATE GPS

GP trainers pay the amount of about €1400,00 per month to the coordination centre and the NIHDI pays about €1200,00. The candidate GP receives a gross wage of approximately €2600,00 per month.

TRAINER - COORDINATOR

In the 'old' system, the trainer-coordinator is remunerated by the NIHDI according to the number of hours of seminars, the number of candidate GPs he/she is coaching and the number of candidate GPs present at the seminar sessions (Art. 2 Koninklijk besluit van 4 september 1985 tot vaststelling van de voorwaarden en de regels volgens dewelke een vergoeding aan de stagemeesters in de huisartsgeneeskunde wordt toegekend/ Arrêté royal fixant les conditions et les règles selon lesquelles une indemnité est accordée aux maîtres de stage en médecine générale). [96] The maximum amount is allocated to coordinators coaching yearly at least 50 hours and at least 10 and the most 15 candidate GPs. For every academic year the trainer-coordinator has to transfer a list to the NIHDI with the data and the duration of the seminars. Additionally, for each seminar the trainer – coordinator has to explicit the list of the present candidate GPs, if the candidate GPs accepted the convention medical doctors -NIHDI and if the candidate GPs obtained the recognition for an additional qualification. A declaration confirming the accuracy of the data of the Centre for General Medicine organizing the seminars has to be added to those lists.

In the new sui generis system, in Flanders the coordinator gets a wage of €1400/ candidate GP/academic year of the SUIvzw irrespective of the activities or the presence of candidate GPs (Abolished by Art. 7 Koninklijk besluit van 17 juli 2009 tot vaststelling van het bedrag en de betalingsmodaliteiten van de vergoeding voor de kandidaat-huisartsen/ Arrêté royal fixant le montant et les modalités de paiement de l'indemnité pour les candidats-médecins généralistes).[95] This allows more flexibility for the trainer - coordinator in teaching methods.

GP TRAINERS

The practical training given by the trainers in the 7th year is not remunerated. Mostly there's only a small compensation by the universities.

For training provided in the 8th and in the 9th year on the other hand a distinction has to be made between the "old" system and the sui generis statute. In the "old" system, the trainer is remunerated by the NIHDI for 50% of the wages paid to his candidate GPs (max. €16.850 for the part of the training posterior to 01/09/2008).[97]

In the new system, the trainer is no longer remunerated since most of the wage charges are now paid by the coordination centre. Nowadays, the infrastructure for training is not remunerated. The Ministry of health considers however the creation of a Fund providing a remuneration for GP trainers committing themselves to provide GP training for a longer period and for GP trainers investing in an infrastructure for training.

GP trainers are not directly remunerated for the training they offer but they earn the benefits generated by the candidate GP i.e. all honoraria of medical acts performed by the candidate GP. If candidate GPs work in the presence of the trainer, the trainer attests the medical act via his/her own NIHDI number. If the candidate GP performs medical acts under the supervision of the trainer who is available by phone, the candidate GP can use the medical certificates of the trainer, signing with his own name and mentioning that he acts "under orders of". If the conditions of supervision by the trainer are not met or if the candidate GP performs medical acts that were not confided by the trainer, the candidate GP can cash 75% of the remuneration tariffs set for recognised GPs. In that case the candidate GP uses his own medical certificates (candidate GPs have a nomenclature number ending at 005-006)

(Art. 1 §4 ter, 2° Bijlage bij het Koninklijk Besluit van 14 september 1984 tot vaststelling van de nomenclatuur van de geneeskundige verstrekkingen inzake verplichte verzekering voor geneeskundige verzorging en uitkeringen/ annex à l'arrêté royal du 14 septembre 1984 établissant la nomenclature des prestations de santé en matière d'assurance obligatoire soins de santé et indemnités[95], inserted by the Royal Decrees of 13 November 1989[98], 29 April 1999[99] and 1 juni 2001[100]). The part of the candidate GP's remuneration paid by the trainer to the SUIvzw can be taken into account as professional costs for taxation.

Working conditions

The Ministerial Decree of 17 July 2009 specifies working conditions of candidate GPs.[91] A full time week consists of at least 38 hours and at the most 48 hours/week, exclusively the legally obliged minimum of on-call hours and inclusive the on-call duty during the day, the seminars, the obligatory training periods and specific medical activities.

VOLUME OF ACTIVITIES

The candidate GP has to see 10 to 15 patients/day. Moreover candidate GPs are legally obliged to participate to on-call duty (art. 9 Koninklijk besluit nr. 78 van 10 november 1967/ Arrêté Royal n° 78 du 10 novembre 1967[74]) for at least 120 hours per year of training (Art. 8 Min; D. 4 March 2010[1]) in organised on-call rota's in the region (next to the on the eventual on-call duty related to the practice of the trainer). A subscription receipt of the local on-call service has to be sent to the RC as well as an attestation mentioning the amount of hours of all on-call duties performed by the candidate GP. For every period of 24 hours of on-call duty that is part of the obligatory minimal 120 hours per year of training, the candidate GP has right to a rest period of 4 hours the day after the on-call duty.

This rest period has to be taken into account for the calculation of the maximum of 48hours/week (Art. 4§2 Ministerieel besluit van 17 juli 2009 tot vaststelling van de medische activiteiten van de kandidaat-huisarts, tijdens de stageperiode bij een erkende stagemeester, in het kader van de specifieke opleiding in de huisartsgeneeskunde/ Arrêté ministériel fixant les activités médicales du candidat médecin généraliste, durant les périodes de stage auprès d'un maître de stage agréé, dans le cadre de la formation spécifique en médecine générale). [91] According to a guideline of the RC a candidate GP can perform at the most 240 hours per year of training (during the weekend or on holidays) of on-call duty.

The GP trainer has to consent to the on-call hours superior to 120 hours since he/she is obliged to supervise (stand-by, at least by phone or supervision by another GP trainer) the candidate GP.[101] Since the trainer has to be stand-by, the trainer and the candidate GP should not be separately on the on-call list.

The new legislation regarding the medical activities of the candidate GP does not specify a limited amount of on-call hours. It has to be stressed however that on-call hours supplementary to the minimum of 120 hours per year of training are included in the maximum of 48 hours a week (see next section). Until today the ceiling of 240 hours is strictly respected in Flanders. Indeed, the candidate GPs' remuneration is determined by a variable package of on-call hours with a maximum of 240 hours, paid by a lump sum. Possibly in the future these regulations will be changed into a system of variable payment/hour with a ceiling up to +/- more than 240 hours[i]. In Flanders additional recommendations with regard to the modalities of the on-call duty are formulated by the ICHO.[102] In Wallonia, the 240 hours ceiling is not respected. Type contracts of the CCFFMG specify that candidate GPs can perform at the most 500 hours of on-call hours additional to the legal minimum.

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i Personal communication Guy Gielis, ICHO

SPECIFIC MEDICAL ACTIVITIES

Specific medical activities can only be carried out if the trainer consents and if the Minister of Health agrees following the advice of the competent chamber of the recognition commission on the training plan. The specific medical activities are enumerated by law in a limitative way: the on-call hours superior to the legal minimum of 120 hours on-call rota's in the region, activities in blood transfusion centres, in the local centres of 'Kind en Gezin', centres for preventive healthcare, centres for family planning, collaboration to scientific research regarding general practice or in the scope of a project of a scientific GP organisation.[91]

These specific activities can be exercised under the supervision of the trainer, be it at least stand-by by telephone or delegating the supervision to another trainer or to a recognised GP, responsible within the institution where the specific activity is practiced.

No other activities than those mentioned above may be practiced by the candidate GP during professional training. In that way the former discriminatory situation between candidate GPs who were able to earn extra money from several medical sideline activities apart from GP professional training tasks and candidates other medical specialties who were forced to limit their medical activities to the professional training tasks is abolished.

Although the working conditions are stipulated in law, control on the compliance lacks and specific sanctions to possible violations are not available (cf. part on working conditions).

Training outcomes in GP

The federal government defines the final competences that have to be achieved to be eligible for a position in healthcare. The universities organise a national final examination. This final examination assesses knowledge, skills, ethics and judgment competencies (see also chapter Belgian situation, "assessment of candidate GPs").

The following specific competencies have to be acquired after completion of training (annex of the Min. D. 1 March 2010[1]):

COMPETENCIES WITH REGARD TO HEALTH CARE

The GP has to have knowledge of:

- The normal course of life of an individual;
- The normal biological, psychological and social development;
- The epidemiological and the natural course of diseases, occurring in GP practice;
- The way patients deal with illness and health;
- Cultural, religious and ethnical influences on the perception of illness and health;
- The impact of societal developments and the working conditions on illness and health.

He has to be able to integrate the principles of evidence based medicine when solving problems in the patient-GP relation.

He has to have the following basic competencies in the patient – GP relation:

- reacting systematically and properly to patients' requests for help;
- understanding the relational aspects of the patient-GP relation and acting psychosocially adequately;
- acting somatically adequately;
- playing a coordinating and navigating role in health care.

He has to be able to use adequately registration methods.

COMPETENCIES WITH REGARD TO PARTICULAR CATEGORIES OF PATIENTS, SYMPTOMS AND DISORDERS

The GP has to have sufficient knowledge of acute and chronic problems that are important because of the prevalence or the gravity of the situation, for all age classes of the entire population. The GP will pay special attention to the following groups: pregnant women, newborns, infants, children, the active adult population included the socially vulnerable groups, elderly people, people with a chronic illness, persons in the terminal phase of life.

COMPETENCIES WITH REGARD TO THE WORKING METHOD

The GP has to have acquired sufficient knowledge, skills and critical attitude to judge the medical literature and permanent medical training and to maintain his professional competencies.

- He has to be able to develop an evidence based practice;
- He has to be able to collaborate with other specialties and function within care networks such as home care, palliative care, care for elderly people and in care structures aiming at prevention;
- He has to be able the act in accordance to medical ethics.

COMPETENCIES WITH REGARD TO THE PERSONAL FUNCTIONING

The GP has to be aware of his/her personal methods of working and the standards of value so that he/she can define his/her position within a medical therapeutical scope and at the same tome respect the autonomy and values of the patient.

Keypoints: Training process in general practice

- **At the time of writing the government officially stated that undergraduate training will be reduced from 7 to 6 years. GP PGT takes 3 years and can start after the medical degree has been obtained.**
- **Candidate GPs having started the master program before the 1st of July 2009 can choose between the self employment or the employee statute and the new sui generis statute. After that date the sui generis statute automatically applies**
- **A coordination centre (SUIvzw in the FL community and CCFFMG for the FR community) manages the remuneration of the candidate GPs (gross wage approx. €2600/month). The wage consists of contributions by the NIHDI and the GP trainer.**
- **In the former system the GP trainers were remunerated by the NIHDI for 50% of the wages paid to his candidate GP with a ceiling. In the "Sui generis" system, there is no remuneration for the GP trainer but he earns indirect benefits generated by the candidate GPs' activities.**
- **In the former system, the trainer coordinators were paid according to the number of hours of seminars, the number of candidate GPs to coach and present at the seminar sessions. In the new system trainer – coordinators are remunerated a fixed amount by the coordination centre.**
- **A full time week consists of at least 38 hours and at the most 48 hours/week. This includes the on call during the day, the seminars, the obligatory training periods and specific medical activities. Moreover, there is a legally obliged minimum of 120 hours per year of training of on-call hours within call rota's in the region. Legally, there is no maximum amount of on-call hours.**
- **The candidate GP has to treat 10 to 15 patients/day.**
- **The legislation specifies a limited list of specific medical activities, other than the GP clinical practice during professional training, that can be performed with the consent of the trainer.**
- **The federal government defines the final competences required to be eligible for a position in healthcare. In general practice the universities organise a final examination.**

Staff

The trainer managing the seminars for the candidate GP's is the same as person as the trainer coordinating and supervising the entirety of the training (art. 2 Ministerieel besluit van 26 november 1997 tot vaststelling van de criteria voor erkenning van de stagemeesters in de huisartsgeneeskunde/Arrêté ministériel déterminant les critères de l'agrément des maîtres de stage en médecine générale). [88]

Two or three recognised trainers can coach one candidate GP in their practices if the competent Chamber consents. In that way the candidate GP has the advantage of a larger experience. The trainers divide the financial duties and there is a contract between the trainers and between the trainers and the candidate GP. The contract will be submitted to the competent Chamber of the recognition commission. One of the trainers will be officially responsible for the smooth proceeding of the training (art. 3[88]).

The staff to guide and maintain the quality of training and training settings is guaranteed by the universities and interuniversity groups (see chapter Belgian situation under the heading "staffing"). Next to the generic and the specific criteria for trainers involved in GP training specified by federal legislation, universities and interuniversity groups apply additional (quality) criteria to select trainers (see Belgian situation).

This illegal practice leads to the situation that a recognised trainer possibly will not be selected by a university or an interuniversity group because he/she does not meet the additional quality criteria. As mentioned solely the federal government can set the recognition criteria and recognise trainers.

GENERIC CRITERIA FOR GP TRAINERS (TRAINER-GP'S, TRAINER- GP'S LEADING THE SEMINARS, TRAINER-OTHER MEDICAL SPECIALISTS)

The trainer has to prove that the training and the coaching are based on an evidence-based practice. He/she pays special attention to his/her personal continuous training.

The trainer has to provide a certificate proving that he/she followed the training for GP trainers. The training consists of at least one day of training organized at the initiative of a university institute or in collaboration with a scientific organization for GP's. The trainer will have to participate yearly to at least one day of continuous training, specifically aimed at the scientific and didactical training and coaching of candidate GP's, organized at the initiative of a university institute or in collaboration with a scientific organization for GP's.

He/she has to spend sufficient time and attention to the training and the coaching of the candidate GP in his practice. The training will regularly have personal contact with the candidate GP for the reporting, discussion of progress and coaching, for the teaching of diagnostic and therapeutical skills, for case studies, evaluation and adjusting. The candidate GP can always consult the trainer to obtain information, guidelines or recommendations with regard to the exercise of general practice (art. 4[88]).

SPECIFIC CRITERIA FOR GP TRAINERS

The trainer GP has to be a recognised GP. He/she has to have a length of GP service of at least seven years and/or having held a position directly linked to research and/or teaching in GP PGT. He/she has to continue these activities during the entire period of recognised trainership. The trainer – GP can regularly assign jobs of general practice and/or study activities guaranteeing that scientific and practical work go together. The trainer also has to take care of the necessary contacts with the trainer-coordinator leading the seminars. The trainer GP has to notify to the competent Chamber of the recognition commission at the end of each training period and at any rate annually the course of the coached training by means of an evaluation report. The template of this report is determined by this Chamber and has to reach to competent Chamber at the latest 15 days after the end of the respective period (art. 5[88]).

SPECIFIC CRITERIA FOR TRAINER-GPS LEADING SEMINARS/OR GP TRAINING[88]

The trainer manages, sometimes in collaboration with other experts, the seminars for candidate GP's, organized by a university of a university centre for general practice. These centres take care of the organizational, scientific and didactical support of these seminars. There are at least 40 hours of seminar annually. The trainer GP manages and coordinates the training of candidate GP's administratively. He/she will regularly contact all candidate GPs consigned to him/her, as well as the trainer-GP and or the trainer – other medical specialist in the hospital where the candidate GP performs the training, with the competent Chamber of the recognition commission and with the university centre for general practice that is responsible for the organization and the scientific and didactical support of the seminars.

The trainer coordinates the training of minimum 6 and maximum 15 candidates a year and he/she is responsible for the seminars of this group.

For each candidate GP for whom the trainer coordinates en manages the seminars, he/she has to report to the competent Chamber of the recognition commission at the end of each training period and in every way after the first and the second year the course of the coached training by means of an evaluation report. The template of this report is determined by this Chamber after advice of the Superior Council of Medical specialists and GPs and has to reach to competent Chamber at the latest 15 days after the end of the respective period. The trainer has to visit at least once a year the practice of the candidate GPS that are under his/her supervision and work in their own practice. The trainer has to report to the competent Chamber of the recognition Commission.

SPECIFIC CRITERIA DURING GP TRAINING FOR THE TRAINER FROM OTHER MEDICAL SPECIALISTS[88]

A GP trainer from another medical specialty has to be recognised for at least 7 years as a medical specialist and exercise regular medical activities in a recognised hospital service during the entire course of the professional training. He/she has to prove that the candidate GP can perform the aspects of medical acting that are relevant for general practice. He/she has to take care of the necessary contacts with the trainer – coordinator who leads the seminars.

Training settings in general practice

At the federal level the recognition criteria for training settings are defined (see part on the recognition process). In current practice, the universities and interuniversity groups however have set additional selection criteria for the selection of training settings after they have been recognised (see also chapter Belgian situation under heading training settings and educational resources). Similar to the selection of staff, training settings complying with the federal recognition commission will possibly not be selected by the university or the interuniversity group when not meeting the additional quality criteria. Legally, solely the federal government can set the recognition criteria and recognise training settings.

GP PRACTICE[88]

The practice of the trainer – GP has to consist of consultations, visits at home and eventually collective prevention activities. These prevention activities cannot take more that on third of the totality of the trainer's activities. The trainer – GP has to prove that the candidate GP will come across varying pathologies and will treat independently a number of patients, suited to his progress. The trainer GP has to make sure that the structure and the organization of the practice are adapted for the evidence based exercise of general practice, that continuity is assured and that a specific patient record system exists. The training setting has to comply with the conditions specified regulations for the recognition of the practice. Training in the practice of relatives is limited by law.[103]

CENTRE FOR PRIMARY CARE[88]

A centre for primary care needs to be a centre where different GPs -in collaboration with other health care professionals- provide health care to non-priorly selected patients. The centre has to be coordinated by a trainer-GP exercising his main activity in this respective centre.

HOSPITAL SERVICES[88]

Hospital services proving the collaboration with at least one other recognised hospital service of the same campus can be recognised as training service for GPs. These hospital services need to have a relevant and varying pathology with regard to general practice and have to be put forward by the Superior Council of Medical Specialists and GPs. The hospital services recognised as training setting for the training of other candidate medical specialists can also serve as training setting for GPs. A hospital service can organize training for a period of maximum 6 months for the same candidate GP.

The following services can serve as training settings providing training for 6 months: internal medicine, surgery, emergency medicine, geriatrics, gynaecology-obstetrics, paediatric medicine, urology and orthopaedics.[104] Services for cardiology, pneumology, gastro-enterology, neurology, psychiatry, rheumatology, physical medicine and rehabilitation, otorhinolaryngology, ophthalmology, dermatology, nephrology, oncology, palliative care and endocrinology are eligible to serve as training setting for 3 months only. A combination of these services for at the most 6 months is possible. At the end of every training period the hospital trainer specialist reports to the competent Chamber of the recognition commission for GPs on the commitment, the knowledge and the diagnostic and therapeutic capacities of the candidate GP. He sends a copy of this report to the coordinating trainer-GP.

In Flanders hospital services serving as a training setting for GPs are appointed by ICHO.

MEDICO-SOCIAL CENTRES FOR THE TRAINING OF GPS

The medico-social services where medical doctors and one or more collaboration primarily are responsible for social work, can also be recognised as a training setting for the professional training of GPs. At least one of these medical doctors has to practice sufficiently in the centre and has to be recognised as trainer-GP. The same medico-social service can organize training for a period of maximum 3 months for the same candidate GP.

Keypoints: Recognition criteria for the specialty of general practice

- **Federal legislation defines generic and specific recognition criteria for GP trainers, trainers-coordinators and trainers from other medical specialties. In the current practice, the universities and interuniversity groups however have set additional selection criteria for the selection of trainers who already got a recognition from the federal government. Legally, the recognition is a necessary and sufficient condition to work as a GP trainer.**
- **Different settings can serve as a training setting for GP training once they are recognised. In current practice, the universities and interuniversity groups however have set additional selection criteria for the selection of training settings after they have been recognised. Legally, solely the federal government can set the recognition criteria and recognise training settings.**

4.3.6.2 *Other medical specialist training*

Next to the generic criteria there are specific criteria per specialty for the recognition of medical specialists, trainers and training settings, set in different Ministerial Decrees. The detailed specific regulations linked to the WFME domain for each specialty have been analysed by the researchers. This extensive description is available upon request.

Training structure and duration

At the start of specialist PGT the faculty of Medicine where the candidate is accepted to follow the training of the respective specialty provides a certificate (for the selection procedure see heading "selection in the seventh year of undergraduate training").

The candidate has to complete a training period set for each specialty, with one or more recognised trainers, in one ore more recognised training centres, complying to the conditions set for the respective specialty (art. 2 § 2 MB 30 April 1999; 29 Mei 1999 #171}.

There is a distinction between basic specializations and particular professional titles (see tables in the appendix on legislation).[72] Medical doctors already possessing a diploma for a basic specialization are eligible for training for a particular professional title. Candidates whose recognition request for a basic specialization was positively advised on can start training for the particular professional title.

The professional training duration of basic specializations lasts from 2 tot 6 years. If medical doctors already possessing a diploma of a basic specialization want to obtain an additional diploma in a basic specialization, a reduction of the training period is mostly provided.

The professional training duration of the particular professional titles is limited from 1 (data management) to 2,5 (surgery of mouth-jaw) years. For all of the training programs for particular professional titles 1 year of the training period can already be practiced during the training for the (advanced professional training of the) basic specialization. Particular professional titles are exclusive and thus can not be cumulated. The training for the basic specializations is divided in general basic training and advanced professional training . The general basic training has to be followed during at least (basic training for e.g. nuclear medicine takes 3 years) the first two years of training, comprises theoretical and practical training in the basic concepts and techniques of the respective discipline. If specific branches of the discipline are not or not sufficiently practiced at the training service, the candidate medical specialist may follow training in other specialized homologated services, if the trainer consents. This rotation system is limited in period.

In parallel with the professional training, the candidate has to complete an academic teaching program that corresponds with the first two years of PGT. At the end of this academic teaching, the university grants a certificate that the candidate medical specialist successfully accomplished university training. The academic character of the first two years of specialist PGT was introduced on the federal level by the Royal Decree of 16 March 1999.{, 24 juni 1999 #182} Moreover, in Flanders, the "structuurdecreet"[57] implemented the Bachelor – Master (BAMA) structure (implementation of the Bologna Declaration) and created a master after master (MANAMA) university program for the medical specialties. The master – after – master program in specialist medicine is recognized in the Flemish universities[58-61]. In the French Community, the BAMA structure was implemented by the decree of 31 March 2004[64]. The "Diplôme d'études spécialisées complémentaires" was replaced by the title of "Master complémentaire" with a list of medical specialist master titles explicitly inserted in the legislation.[65] It should be stressed however that despite of these community initiatives only 2 years of academic teaching (on top of the professional training) are necessary to obtain a recognition as a medical specialist.

Training content

Independent of the specialty, there are some generic criteria for the professional training of a candidate medical specialist. The most important criteria are:

- Full time basis presence at the training setting, except if a motivated exception was permitted by the competent recognition commission in consultation with the trainer and according to the guidelines of the Minister (art. 2 § 3[105]) . The total duration can not be shortened;
- Following the professional training in one or more of the recognised training settings, in accordance with the conditions set in the specific criteria for the respective specialty;
- Following professional training continuously (exceptions can be allowed by the recognition commission in accordance with the guidelines of the Minister) and limitation of the medical activities to the training tasks (art. 2 § 5 en 6[105]);
- Working under the supervision of his trainer, following the guidelines of the trainer and respecting the regulations of the hospital (art. 2 § 7, 1st section[105]);
- Progressively bearing larger personal responsibility, as his professional training proceeds (art. 2 § 7, 2nd section[105]).
- During the professional training, the candidate is a member of the medical team of the hospital; consequently he has to comply with the regulations of the hospital (art. 2 § 8[105]);
- The candidate medical specialist has to participate actively to all activities of the training setting that are necessary for professional training. He/she will participate to the relief and treatment of emergency cases in his own and in related specialties, under the supervision of the trainer and according to the progress of his/her professional training. He/she can only participate to guard duty under the supervision of his/her trainer according to the progress of his/her professional training and solely in the hospital where he/she follows the professional training. (art. 2 § 9[105]);
- Candidate medical specialists following professional training for one of the specialties that can lead to the special title of urgency medicine or intensive care, have to make themselves familiar with the relief of all emergency cases, even outside the specialty, so that they will acquire experience in the preservation of vital functions (art. 2 § 10[105]);
- The candidate medical specialist has to develop his/her scientific training under the supervision of his/her trainer and participate regularly to teaching organized by the faculties of medicine and other scientific institutes (art. 2 § 11[105]);
- The candidate medical specialist has to prove that he/she followed at least 30 hours of teaching regarding communication with patients and at least 20 hours in evidence – base medicine (art. 2 § 11[105]);
- For training abroad no guidelines are formulated. Universities however use the guideline for GPs (cfr. supra)). The university of Antwerp for instance adds the condition that the training abroad has to have a particular additional benefitj. It has to be noted however that solely the federal government and more particularly the recognition commissions are competent to authorize training abroad.

j http://webh01.ua.ac.be/gso/opleidin.htm#stage buitenland

Training outcomes

Most disciplines define the training outcomes in general terms. For instance one of the specified outcomes for the training in paediatric hematology and oncology is having general specific, clinical and technical basic knowledge regarding the treatment and the follow-up of hematological and oncological diseases. Discipline-specific outcomes are formulated for some specializations such as e.g. training in oncology and medical oncology: the candidate medical specialist has to have acquired knowledge on the registration and classification of tumors; experience in the execution of scientific evaluation of clinical trials in oncology. For the more "technical" specialisms, output volumes are set. For surgery for instance, the candidate medical specialist has have performed at least 750 surgeries. The notebook in which the character and the number of interventions are noted, can serve as a proof.

For most disciplines the candidate medical specialist has to present at least once during the training period on a topic related to his discipline in a scientific committee and/or has to publish an article in an authoritative journal on a topic related to the discipline.

Governance

There is no coordinating centre for the organisation of training for medical specialists.

Financing of (university) hospitals for training

Budgets for professional training are included in the global budgets for university hospitals, more specifically in the ´B7´ funds, coming from the federal government for the professional training of candidate medical specialists. The B7A budget is attributed to university hospitals (Art. 7, 2°, g., 1° Koninklijk besluit van 25 april 2002 betreffende de vaststelling en de vereffening van het budget van financiële middelen van de ziekenhuizen/Arrêté royal relatif à la fixation et à la liquidation du budget des moyens financiers des hôpitaux).[106] Part B of the B7 budget is allocated to general hospitals for the development, the evaluation and the application of new medical technologies and/or the professional training of candidate medical specialists (Art. 7,2, g, 2°[106]).

In practice non-university hospitals hardly get any financing for candidate medical specialists and for trainers. Candidate medical specialists are paid by the trainers. If trainers of non-university hospitals organize the payments of the candidate medical specialists via the social secretary of a university hospital, it is doubtful if the university hospital considers the candidate medical specialist as linked to the university hospital and thus if the hospital gets any budget or not.

The B7A budget is allocated to cover costs that are directly and indirectly to the university task of professional training (Art. 77 [106]). The budget for the costs that are directly related to the university task are allocated to the respective hospitals based on the criteria of scientific publications regarding clinical research and the development, evaluation and application of new technologies. The university hospitals have to prove at least 3 publications/10 beds during the 3 years preceding the year in which the budget is set. Additionally, at least 4 publications in the domain of at least 10 different medical specialties in that specific period are required. A small part of the B7A budget is directly allocated to cover the costs for professional training. The allocated amount per hospital equals €30.460,50 (value on the 1st of January 2003) per trainer and €4.822,92 (value on the 1st of January 2003) per candidate medical specialist.

The allocation of the budget to costs indirectly related to the university task are calculated on the share of the respective hospital in the B2 budget (costs for clinical services) of the year 2003.

Additionally budgets for equipment and a budget that is calculated based on the employer's charges/gross wages of the non self employed physicians is allocated.

In 2007, the B7A allocation for the UZ Brussels represented 5,4 % of the global income of the hospital. The total income for the academic task (university allocation for academic personnel, research income, sponsoring) was estimated at 9,3 % of the global income of the hospital, whereas the real additional cost for university hospitals was estimated in 2003 at 25 %.

Statute of the candidate medical specialist

Jurisprudence confirmed that the contract between the candidate medical specialist and the institute where the professional training takes place is a "training contract".[79] Although there is a relation of authority between the trainer and the candidate medical specialist; this kind of contract has to be distinguished from a labour contract since the primary objective is to acquire the specific competencies needed to obtain the professional qualification instead of the realisation of activities that are benefiting the employer.[107] The social statute of a candidate medical specialist is a particular one, 'sui generis' since he/she does not contribute for the pension and does not have employment benefit or double vacation allowance. On the other hand, he/she benefits from different sectors of social security such as health insurance, illness allowance.

Remuneration of the candidate medical specialist

The trainer assures that candidate medical specialists earn a reasonable wage. He notifies the arrangement to the competent recognition commission. The wage amounts at least the gross wage of an assistant advisor federal official with equal length of service. The hospital nor the trainer, nor any authority may reduce the candidate medical specialist's wage irrespective of the reason (art. 5, 25° Min. D. 30 April 1999[105]). Although the contract in which the amount of wage is specified is inserted in the file introduced to the competent Chamber of the recognition commission, there is no control on the amount[k]. It is questionable if a recognition chamber is competent to modify the candidate medical specialist's wage if the legally stipulated minimum was not respected since this is a contractual aspect which is regulated by civil law.

Billing of medical acts performed by the candidate medical specialist

The trainer can bill the medical act of the candidate medical specialist at 100% if the following conditions have been met[108, 109]:

During the regular working hours at the hospital the trainer or a medical specialist mandated by the trainer has to be present at the training service.

Beyond the regular working hours the trainer has to be standby 24/24 for the candidate medical specialist performing on call duty intra muros.

During the weekends and on holidays, the trainer (or the mandated medical specialist) has to visit patients aiming at the supervision of the candidate medical specialist. .

The list of medical doctors, medical specialists of the same discipline, that can daily be called up and of the medical doctors that are charged with the control visits during the weekends and on holidays, had to be handed over to the departmental head medical doctors and has to be kept for 2 years and has to be available for the controlling instances. The trainer can be replaced by a medical specialist of the same discipline.

If one of the above mentioned conditions was not met, the candidate medical specialist has to bill the medical acts himself to a rate of 75 %.

Working conditions

NO TRANSPOSITION OF THE EUROPEAN WORKING TIME DIRECTIVE INTO BELGIAN LEGISLATION

The European Working Time Directive (see section 4.2.2) had to be transposed into Belgian legislation by 23 November 1996. The former labour legislation stipulated that the regulations with regard to the working hours were not applicable to candidate medical specialists .[110] In 1998 new legislation stipulated that these regulations were still not applicable to candidate medical specialist but that they could be made applicable by a Royal Decree.[111] In April 2002 the European Commission declared Belgium in default for not transposing the Working Time Directive into Belgian legislation. In reply to this a Royal Decree of 16 June 2003 confirmed the applicability of the labour law regulations with regard to the working hours to doctors and candidate medical specialist and stated that the weekly maximum time (8 hours a day or 40 hours a week) could be crossed as far as the mean working time, calculated over 8 succeeding weeks, does not cross 48

k Personal communication X. Van Cauter, Ministry of Public Health

hours.[112] The Raad van State/Conseil d'Etat however has annulled this Royal Decree based on procedural faults.[79] Until today no other legislation has replaced the annulled Royal Decree of 2003.

MINISTERIAL DECREE OF 30 APRIL 1999 REGARDING THE RECOGNITION CRITERIA FOR MEDICAL SPECIALISTS (OTHER THAN GPS), TRAINERS AND TRAINING SETTINGS

The Ministerial Decree regarding the recognition criteria for medical specialists (other than GPs), trainers and training settings does not render the regulations of the labour law applicable but contains some dispositions formulated as a duty of the trainer with regard to the working time. (Art. 5, 17° Ministerieel Besluit van 30 april 1999 tot vaststelling van de algemene criteria voor de erkenning van geneesheren-specialisten, stagemeesters en stagediensten/Arrêté ministériel fixant les critères généraux d'agréation des médecins spécialistes, des maîtres de stage et des services de stage).[105] Candidate medical specialists work at the most 9 hours a day and 48 hours per week, exclusively the on-call duty. The exclusion of the on-call hours does not match with the case law of the European Court of Justice (cfr. 4.2.2).

The Ministerial Decree also stipulates that overtime work (on-call not included) can be allowed as far as the average working time calculated over 8 weeks does not cross the maxima. A candidate medical specialist can be scheduled for five succeeding on-call duties of 12 hours, on condition that he does not have to work during the day during this period. In that case an average working time of 48 hours a week, guard duty included, calculated over 8 succeeding weeks can not be crossed. A candidate medical specialist may not be scheduled for more than 1 guard duty per three weekends; this guard duty can be organised between Saturday noon and Monday morning. A continuous period of availability may account at the most 24 hours, included on-call duty, pauses and interruptions of service. Since the Belgian state did not apply the opting out possibility, derogations to the limits in working time were not allowed.

LACK OF CONTROL ON WORKING HOURS AND LACK OF SPECIFIC SANCTIONS IN CASE OF VIOLATION

Whereas the Ministerial Decree regarding the recognition criteria for medical specialists (other than GPs), trainers and training settings limits working hours, there are however no clear sanctions in case of infringement as in labour law where violations are eligible for sanctions as fines and/or imprisonment from 8 days to 1 month. Based on the Ministerial Decree regarding the recognition criteria for medical specialists (other than GPs), trainers and training settings, liability of the training setting for not respecting the working hours can be considered since the training service is responsible for the respect of amongst others the working hours specified (art. 10[105]) . Moreover, as the scheduling of the candidate medical specialist's work is formulated as the duty of the trainer, he could eventually be held liable for not respecting the working hours limits. Legislation specifies that if the trainer or the training setting does not comply any longer with the criteria, the recognition can be withdrawn. The control of the respect of the working hours (and consequently the proof of the violation in court) however is very difficult. The sole conceivable control is the visitation by the services of the FOD Volksgezondheid, veiligheid van de voedselketen en leefmilieu/SPF Santé, sécurité de la chaine alimentaire et environnement in the scope of conflict management (see further).

Unfortunately these services have no repressive competence in the scope of labour relations between the trainer/training service and the candidate medical specialist. Moreover budget is lacking to make this kind of visitations current practice[1].

If the respective regulations in labour law would be applicable to candidates medical specialists, this would enable the "service control of social laws" ("Dienst toezicht op de sociale wetten"/ "Contrôle des lois socials") to visit the working place, record possible infringement at the training setting and make a report of the offence which could lead to specific sanctions (Art. 53 e.v. Arbeidswet van 16 maart 1971/ Loi sur le travail du 16 mars 1971)[113]

1 Personal communication X. Van Cauter, Ministry of Public Health

CURRENT DEVELOPMENTS

The European Commissioner declared Belgium in default and requested the Belgian government to regularize the situation before 23 January 2010. This deadline has been postponed to 23 February 2010. At the time of writing a bill has been approved in the council of ministers implementing the European legislation regarding the working hours. The main idea is the limitation of the weekly working time to an average of 48 hours calculated over a reference period of 13 weeks. The absolute amount of weekly working hours is limited to 60 hours. After a working period of at least 12 hours a rest period of at least 12 hours within that week has to be respected. Anyhow activities can not exceed a period of 24 succeeding hours. Additionally, the possibility to opt–out, as set in the European Directive, will be implemented. A candidate medical specialist will be able to choose for an additional working time of 12 hours. Moreover the draft text also plans to make direct control by the "service control of social laws" ("Dienst toezicht op de sociale wetten"/ "Contrôle des lois socials") applicable and will set specific sanctions in case of violation of the working time limits.

The "voluntary" character of the opt – out possibility is questionable since there is a hierarchic relation between the trainer - judging at the end of training the candidate medical specialist's capacities- and the candidate medical specialist.

4.3.6.3 Assessment of candidate medical specialists

The universities are responsible for the academic teaching during the two first years of PGT (Art. 21, second section, 4° Koninklijk Besluit van 21 april 1983 tot vaststelling van de nadere regelen voor erkenning van geneesheren – specialisten en van huisartsen/ Arrêté royal fixant les modalités de l'agrément des médecins spécialistes et des médecins généralistes [71], inserted by art. 4 Koninklijk besluit van 16 maart 1999 tot wijziging van het koninklijk besluit van 21 april 1983 tot vaststelling van de nadere regelen voor erkenning van geneesheren-specialisten en van huisartsen/ Arrêté royal modifiant l'arrêté royal du 21 avril 1983 fixant les modalités de l'agréation des médecins spécialistes et des médecins généralistes [114]).These end up with a university or interuniversity examination

The candidate medical specialist yearly sends the training logbook to the competent Chamber of the recognition Commission and annually reports on the progress of training (art . 3 § 1 Ministerieel Besluit van 30 april 1999 tot vaststelling van de algemene criteria voor de erkenning van geneesheren-specialisten, stagemeesters en stagediensten/Arrêté ministériel fixant les critères généraux d'agréation des médecins spécialistes, des maîtres de stage et des services de stage [105]).

At the end of the professional training, the candidate medical specialist transfers all necessary data to the competent recognition commission as to this one can judge if the candidate medical specialist has met the requirements and is competent to exercise the respective specialty independently and on his own responsibility (art. 3 § 3[105]).

The trainer with his collaborators, have to evaluate regularly and in an objective way the progress of the candidate medical specialist. He notifies the results of the evaluation and the elements on which these results are based to the candidate medical specialist. At least once a year and globally at the end of the training the trainer has to notify to the competent recognition commission the progress of the professional training (art. 5, 10° and 12°[105]).

4.3.6.4 Staff

A number of requirements and duties of the trainer are formulated in the law (art. 5 Ministerieel Besluit van 30 april 1999 tot vaststelling van de algemene criteria voor de erkenning van geneesheren-specialisten, stagemeesters en stagediensten/Arrêté ministériel fixant les critères généraux d'agréation des médecins spécialistes, des maîtres de stage et des services de stage [105]). There are additional appointment policy and obligations for trainers per specialty (see appendix on legislation).

PEDAGOGICAL COMPETENCIES

- The training provided by the trainer has to be evidence based and he has to take care that scientific and practical activities go together;
- He has to have published at least one article in a five year period with regard to his specialty in an authoritative journal (art. 5, 1°[105]);
- A trainer trains a limited number of candidate medical specialists. The number is determined per specialty and per training year in the recognition decree of the trainer (art. 5, 5°[105]);
- The trainer commits himself to spend sufficient time for the professional training of the candidate medical specialist. He will teach the candidate medical specialist to make critical judgments by frequent personal contacts. He will teach the candidate medical specialist the way to treat patients, their family, peers, other collaborators, the nursing and administrative personnel, public services and the general public (art. 5, 6°[105]);
- The trainer encourages the candidate medical specialist to do scientific work; at least 4 hours a week have to be dedicated to this activity (art. 5, 8°[105]);
- The trainer merely consigns responsibility to the candidate medical specialist in accordance with the progress of professional training, including emergency cases and guard duty (art. 5, 15°[105]);
- The trainer offers the opportunity to the candidate medical specialist to follow the organized lessons, presentations and discussion groups (art. 5, 9°[105]).

CLINICAL COMPETENCIES

The trainer has to be recognised for at least 8 years in the respective specialty and having exercised the specialty during that period in a continuous and active way, except if a motivated exception was given by the Minister and except if there are other dispositions in the specific criteria of the respective specialty. (art.5, 2°[105])

The trainer has to exercise his clinical activity during the entire period of the recognition on a full-time basis and only in his training service. Full time implies 40 hours a week, during the normal working hours. He can not hospitalize patients in his name in another service than in his recognised training service. (art. 5, 3°[105]).

A trainer can be recognised for the entire or part of the duration of the professional training in a specialty. He is in charge of a hospital service or of a department of a hospital service, of a medical-technical or medical–social service complying with the recognition criteria determined for the respective specialty. The recognition of the trainer only counts for the activities he is performing in the recognised training service (art. 5, 4°[105]).

ORGANISATIONAL COMPETENCIES

The trainer organizes and presides at least once a week, group meetings (seminars, case studies, discussion groups on medical publications, etc.) including the socio-economic and ethical aspects in the exercise of the specialty, as well as social legislation. He will encourage the contact with other specialists by organizing interdisciplinary meetings (art. 5, 7°[105]).

The trainer schedules a training program that takes the training criteria and the already completed training into account. This program, signed by the trainer and the candidate medical specialist is sent to the recognition commission within the first three months of training as well as to the trainer coordinator (art. 5, 11°[105]).

The trainer supervises the activities of the candidate medical specialist, as well as the medical files and the correspondence drawn up by the candidate medical specialist (art. 5, 13°[105]).

During the medical activities the training at the training setting the trainer or one of his collaborators has to be present during working hours and available for backup during on-calls (art 5, 14°[105]).

Before the start of training the trainer has to make sure that an appropriate liability insurance contract was concluded for the candidate medical specialist by a university, a recognised trainer or a hospital (art. 5, 27°[105]).

If the training setting is located in different places of a merged hospital or in different hospitals of a hospital group or an association, the trainer has to practice a substantial medical activity in all of the places that are part of the training setting and has to dispose in all of these places of a full time collaborator that is recognised in the respective specialty for at least five years (art 5, 16°[105]).

The trainer organises the legal relationships between the candidate medical specialist and the hospital, with regard to the organization of guard duties and the working conditions including the financial conditions of guard duties, as well as the special compensations. This regulation is set after a mutual consultation between the candidate medical specialist and the hospital where the training setting is located. The regulation has to be notified to the Superior Council for approval (art. 5, 18°[105])

In practice however the contracts are not presented to the Superior Council. Solely the commitment that the trainer will conform to the Ministerial Decree regarding the recognition criteria for medical specialists (other than GPs), trainers and training settings is mentioned and signed by the candidate trainer.

The trainer has to allow at least 20 holidays, the legal holidays not included, of which at least 7 succeeding days. Moreover the trainer has to allow the necessary exemptions to the candidate medical specialist in order for him/her to fulfil his/her civil, social or family duties (art. 5, 24°[105]).

Training settings

Generic criteria for all specialties to obtain recognition are set at the federal level. Moreover the training setting has to comply with the specific conditions of the respective specialty. The detailed specific regulations linked to the WFME domain for each specialty have been analysed by the researchers. This extensive description is available upon request.

GENERIC CRITERIA

The recognition can be assigned for the entire period or partly (art. 6, 1°[105]).

The recognition concerns the entirety, a department or a group of departments of a hospital service, a medical–technical service or a medical-social Service. The training service has to be lead by the trainer (art. 6, 2°[105]).

If the training setting is located at different places of a merged hospital or in different hospitals of a group or an association a primary and one or more secondary training settings are distinguished. The primary training setting has to comply with the requirements of a training setting for the respective specialty, except for the required number of beds. The required number of beds has to be available within the entirety of the training settings (art. 6, 3°[105]).

The function of the medical head of service has to be a recognised medical specialist in all medical hospital services. There has to be an intensive care unit and the possibility to perform biopsies and autopsies. With regard to the other specialties, the service has to be able to consult recognised specialists (art. 6 , 4°[105]).

There has to be a recognised emergency unit in the hospital unit of the training service. If the training service is spread over different locations of a merged hospital or different hospitals of a group or an association, the permanence has to be ensured by at least one candidate medical specialist in surgery and by a candidate medical specialist in internal medicine or in anesthesiology-reanimation. Both have to have completed 1 year of training. The supervision of both candidate medical specialists has to be ensured at any time by medical specialists of the respective specialty. These have to be consultable at any time and if necessary they have to be able to be on-site within a reasonable delay (art. 6, 5°[105]).

The hospital has to have a laboratory that performs examinations in biochemistry, haematology and microbiology or it has to be able to make an appeal to laboratories contracted with the hospital. They have to ensure a permanent duty (art. 6, 6°[105]).

The volume of the activities of the training service has to be sufficient. Activities need to be differentiated, so that candidates medical specialist can gain experience, quantitatively as well as qualitatively. When evaluating the activities of the training service the number of beds, the number of hospitalizations, the number of annual consultations and the diversity of pathological cases, the activity in day hospital, the character and the number of diagnostic and therapeutic interventions will be taken into account. To this end the direction of the training service puts all necessary data, a.o. the minimal clinical data in an anonymous way to the disposal of the administrative service that is charged with the procedure for the recognition of trainers and training service (art. 6, 7°[105])

The training service has to dispose of a place for seminars or for meetings of the medical staff, a medical library located in adapted rooms, where candidate medical specialists can consult the standard medical books and journals (art. 6 ,8°[105]).

The training service has a proper lodging for the candidate medical specialists during the guard duty (art. 6, 9°[105]).

Evaluation of the trainer and the training process

The candidate medical specialists yearly notifies a confidential report to the medical doctors leading official of the "Directoraat Basisgezondheidszorg en Crisisbeheer/Direction des Soins de Santé et Gestion with regard to the qualitative and quantitative aspects of his training. These reports serve as one of the elements to re-evaluate the trainer and the training setting (art. 3 §2).

Keypoints: Criteria for other specialties than general practice

- **There is a distinction between basic specializations and particular professional titles additional to these basic specializations.**
- **The professional training period varies between specialties (from 2 to 6 years for basic specialization and from 1 to 2,5 years for particular professional titles). In parallel with the professional training, the candidate has to complete academic teaching that corresponds with the first two years of PGT.**
- **Generic criteria are formulated next to the specialty – specific criteria. Most of them are based on the presence or participation to an activity. Some criteria can be subject to interpretation.**
- **The specialty-specific criteria are often out-of-date and often lack detail.**
- **Candidates medical specialist yearly send the training logbook to the competent chamber of the recognition commission and annually report on the progress of training.**
- **Training outcomes are mostly defined in general terms. The more technical specialties use quantitative criteria such as for instance a minimum number of performed operations.**
- **Budgets for the professional training are included in the global budgets for university hospitals and ´B7´ funds, coming from the federal government for the training of junior doctors. In non-university hospitals candidate medical specialists are usually paid by the trainers.**
- **The candidate medical specialist has a "sui generis" statute and is paid at least the gross wage of an assistant advisor federal official with equal length of service.**
- **Working conditions are specified in the European legislation but Belgium omitted to transpose this legislation into its national legislation. Some minimum working conditions are specified in the law but there is no control on their respect and specific sanctions for possible violations are not provided. The Belgian authorities currently discuss the implementation of the European legislation.**
- **Recognition criteria for trainers and training settings are structure – or process based.**
- **Trainers are paid by billing the medical acts of the candidate medical specialist (100% if supervision)**

4.3.7 Evaluation of the training process: the recognition process

4.3.7.1 Recognition process for candidate medical specialists and candidate GPs

The process of recognition for candidate medical specialists and candidate GPS is detailed in the law (art. 21 -24 Koninklijk besluit van 21 april 1983 tot vaststellling van de nadere regelen voor erkenning van geneesheren-specialisten en van huisartsen/Arrêté royal fixant les modalités de l'[agrément] des médecins spécialistes et des médecins généralistes [71]). The request for recognition as a GP or another medical specialist is sent after having completed the training to the Minister of Health and Social Affairs by certified mail by means of a standardized form. The following documents have to be attached:

- The certificates of the trainers;
- The last training logbook as well as any other document that allows the Chamber to judge upon the value of the candidate medical specialist;
- A certificate not older than 3 months proving that the candidate medical specialist is registered at the Order of Medical Practitioners;
- A certificate proving that the candidate medical specialist has successfully attended academic teaching. For candidates medical specialist other than GPs this academic teaching attended during the first two years of the PGT.

The Minister can request additional documents needed for the judgment of the request. Candidate GPs in Flanders send the following documents to the recognition commission, according to the ICHO guidelines: the abstract of the master thesis, a certificate proving that the candidate medical specialist has completed the legal duty of the on-call duty, a copy of the ICHO certificate that the seminars have been followed is directly sent by the ICHO to the recognition commission. It has to be noted however that the ICHO has no legal competence to impose additional requirements for the recognition process.

The Minister sends the file for advice to the competent Chamber of the recognition commission. This Chamber compares the files with the documents that were provided during training. If the files do not match, the Chamber will postpone the advice and ask the candidate medical specialist for further explanation.

The Chamber can also decide that the training has to be continued during a certain period in order to satisfy the recognition criteria. The motivated advice of the Chamber is notified to the Minister and within 30 days to the candidate medical specialist. In case of a positive decision the FOD Volksgezondheid, veiligheid van de voedselketen en leefmilieu/SPF Santé public, sécurité de la chaine publique et environnement automatically transfers the data to the NIHDI that will inform the medical doctors on the use the new NIHDI number (003/004).

All of the members are peers of the trainer which could hamper the guarantees for objectivity in the assessment of the candidate medical specialist. Moreover there's a possible conflict of interest for the members academics, since universities also represented for one third in the Board of directors of the university hospitals. An overlap between professional training aspects and manpower issues at the respective university hospitals may hamper a neutral position of those members.

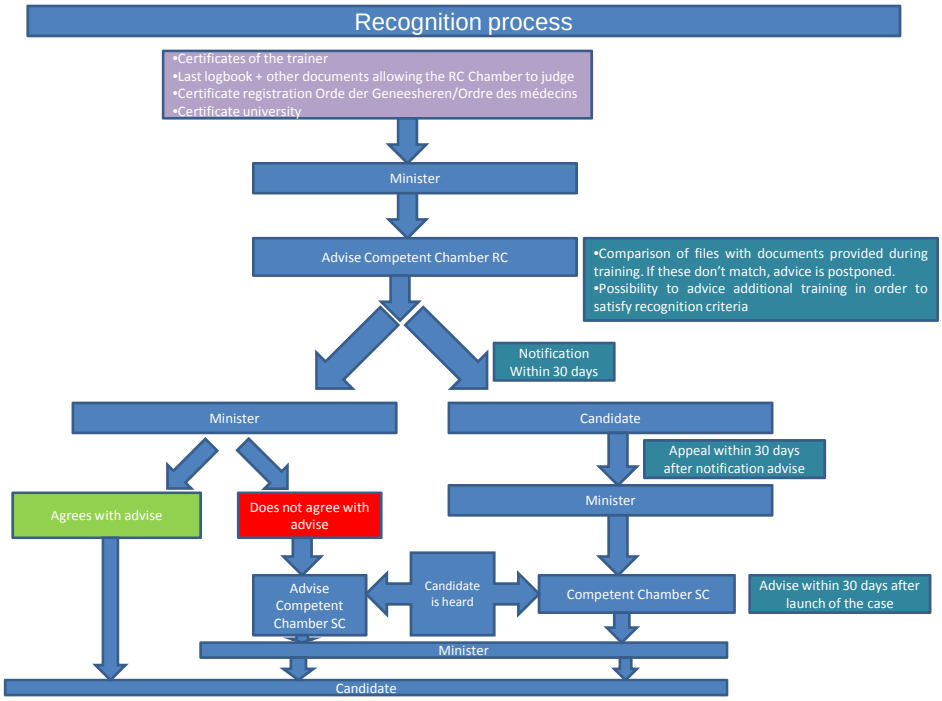
4.3.7.2 *The Appeal procedure (art. 29 – 33[71])*

If the Minister does not agree with an advice of the Chamber of a recognition commission, he notifies the candidate medical specialists or candidate GP. Prior to his decision he submits the file for advice to the competent Chamber of the Superior Council.

The candidate can lodge an appeal against any advice of the Chamber of the recognition commission. To be admissible, the appeal has to be motivated and be sent to the Minister within 30 days after the notification of the advice. The Minister will transfer the file to the competent Chamber of the Superior Council. In case of an appeal of a candidate or if the Minister does not agree with the advise of the competent Chamber, the candidate is heard by the competent Chamber of the Superior Council. The candidate at stake is informed by certified mail within at least 15 days before the deliberation takes place. He/she can be assisted by one or more lawyers. In case of unjustified absence of the candidate, the Chamber can base its decision on the available documents. If the chamber of the superior council has to decide on the training plan, the training or the recognition of a candidate medical specialist or a candidate GP, at least one recognised member of the respective specialty has to be present at the deliberation. If there is no recognised member of the respective specialty in the Chamber, the president designates a doctor recognised in this specialty to attend the deliberation. This doctor can give an advice on the respective issue. At the deliberation one member of the recognition commission that has given the advice against which an appeal was lodged will explain the dossier. This member can not attend the debates or the deliberation.

The Chamber judges within a delay of 60 days after the launching of the case. The advice has to be motivated and has to reply to the conclusions of the candidate that lodged the appeal as well as to the elements that were presented by the member of the commission. The Chamber judges on the procedural aspects and on the content. The motivated advice is then notified to the Minister. If the competent Chamber has not advised within the set delay, the Minister can decide without an advice. His decisions will be notified to the applicant by certified mail.

Figure 6: Recognition process for the recognition of a medical specialist or GP



Keypoints: Recognition process for candidate medical specialists or candidate GPs

- **The request for recognition as a GP or another medical specialist is sent after the training to the Minister of Health and Social Affairs along with documents attesting the content of the training.**
- **The competent chambers of the recognition commissions play a role in the decision. However its members are peers of the trainer: that could hamper the guarantee for objectivity in the assessment of the candidate medical specialist.**
- **There is a possible conflict of interest for the members academics, since universities are represented for one third in the Board of directors of the university hospitals. An overlap between aspects of academic teaching and manpower issues at the respective university hospitals may hamper a neutral position of those members.**

4.3.7.3 Recognition process for the trainer and training settings

The request for recognition as a trainer (art. 34[71]) is sent to the Minister by certified mail, by means of a template that is drawn up by the Minister and that is provided by the "Directoraat Basisgezondheidszorg en Crisisbeheer/Direction des Soins de Santé et Gestion de Crise". The request consists of all data that can inform the Superior Council and the Minister on the value of the candidate, such as his titles, functions, publications, lectures, activities in scientific associations and his active collaboration to congresses. The request also contains a commitment disposition of the candidate trainer that he/she will make sure that the candidate medical specialist will receive a reasonable remuneration for the training. The name of the faculty(ies) of medicine where training will be given has to be mentioned.

The request for recognition as a training service is similar (art. 35-38[71]). The request is cosigned by the manager of the service. It contains all elements that can inform the Superior Council and the Minister on the value of the service, such as statistical and bibliographical data and information on scientific activity and titles.

The Minister transfers the request for recognition of the trainer or of the training service with the file to the Superior Council for advice. The latter can charge one or more of its members with an investigation and to report on this. This investigation can take place at the workplace. If the advice of the Superior Council is negative, it can be kept under consideration. In that case the candidate – trainer or the responsible medical doctor of the respective training service will be acknowledged at least 15 days before the meeting of the day and the moment of the meeting of the Superior Council.

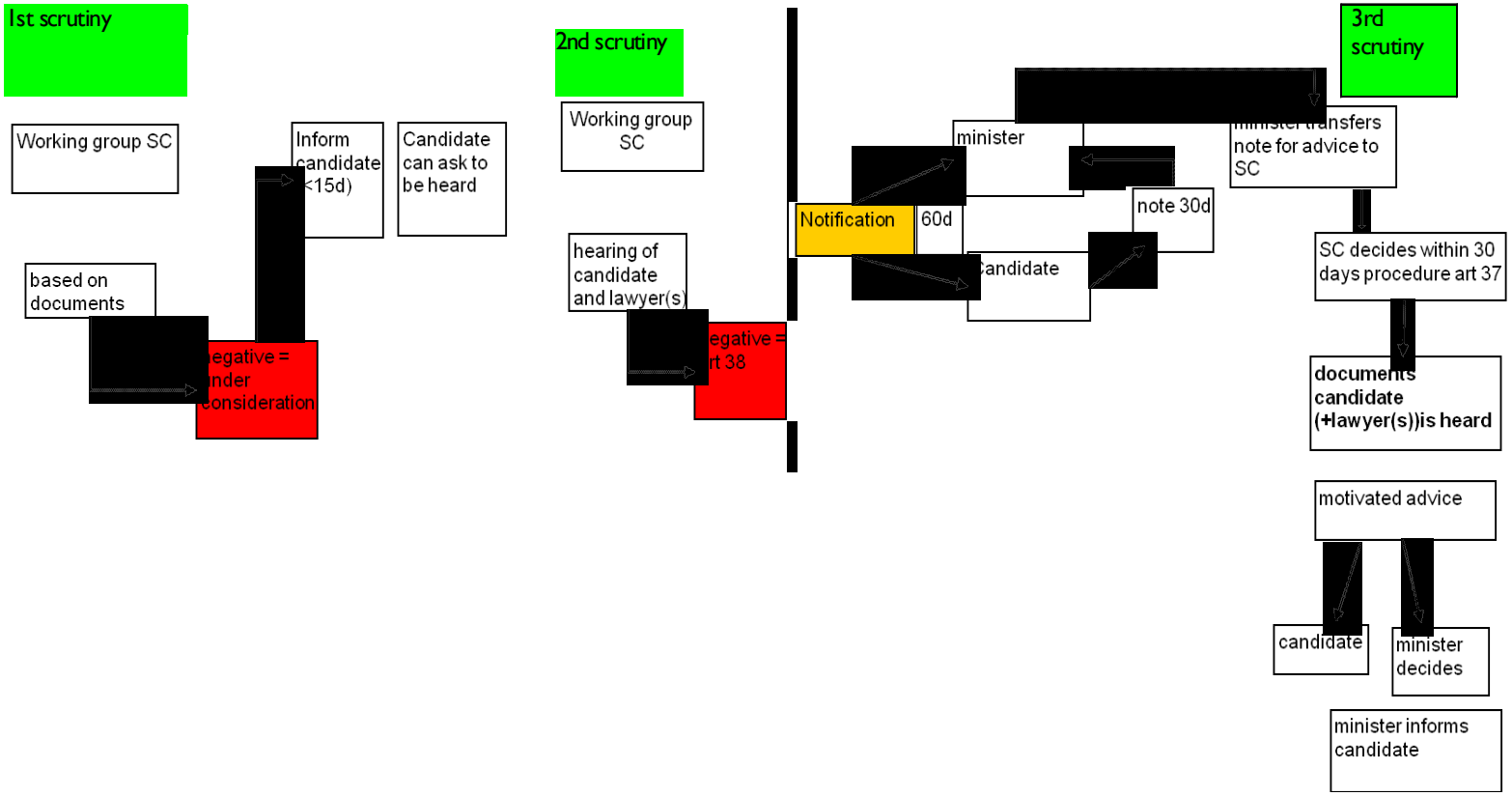
The person concerned can ask to be heard by the Superior Council in order to provide all necessary information. He is allowed to be assisted by one or more lawyers. Within 60 days after the reception of the file, the Superior Council sends the motivated advice to the Minister and the concerned party. The concerned party can, within a period of 30 days after reception of the advice send a note with his motivated remarks. The Minister then transfers the note to the Superior Council. The Superior Council judges within 30 days after the reception of this note. The motivated advice is then sent to the Minister and the concerned party. After reception of the advice the Minister decides. If the Superior Council neglected to give an advice within the delays, the Minister can decide without an advice.

The procedure described in law is different from the actual practice. The Superior Council has delegated its task in the recognition process of trainers and training setting to a working group. The members of this working group are also members of the Superior Council. The working group's advices to the Superior Council can be 4-fold:

- Positive advice: The general director is mandated by the minister to sign the recognitions following a positive advice.
- Additional information is asked to the candidate; depending on the provided information the advice can be positive or positive but deviating (e.g. trainer asks to supervise 6 candidates medical specialist, working group proposes 4).
- Deviating advice: the general director notifies the candidate that he/she can be heard.
- Negative advice: the general director notifies the candidate that he/she can be heard.

The working group will hear the candidate. Solely if the advice remains negative or deviating the candidate (and eventually his/her counsellor(s)) will be heard in the plenary session of the superior council. Since the members of the working group are also members of the Superior Council, the case will possibly be judged twice by the same persons.

Figure 7: Procedure for the recognition of a trainer



Recognition terms for trainers and training settings (art. 39[71])

The recognition of trainers and training services for GPs is assigned for 2 years and can be prolonged for a period of 5 years if the trainer has trained during the first two years at least 1 candidate GP and/or presided during 1 year seminars for GPs. Further prolongations of 5 years are possible if the trainer has trained in the preceding period of 5 years at least one candidate-GP for 6 months and/or presided seminars for GPs during 1 year

The recognition of trainers and training settings for other medical specialists than GPs is assigned for a renewable term of 5 years.

Keypoints: Recognition process for trainers and training settings

- **The procedure for the recognition of a trainer and a training setting is legally set. The tasks of the Superior Council in the recognition process are delegated to a working group.**
- **The members of the working group are also member of the Superior Council. Hence the case is (possibly) judged twice by the same persons.**
- **The recognition term for GP trainers and training settings is 2 years and can be prolonged. For other medical specialties, there is a renewable recognition term of 5 years for trainers and training settings.**

4.4 DISCUSSION

4.4.1 Governing bodies and procedures

The composition of the RCs hampers objectivity in the procedure of conflict management and in the recognition process since all members are peers of the trainer and the candidate is not represented. Moreover, the fact that the same institution judges conflicts during training and advices at the end of the training on the recognition of the candidate is also a barrier for the candidates to start proceedings.

There is a possible conflict of interest for the academic members specialists other than GP's in the recognition commissions, since universities are represented for one third in the Board of Directors of the university hospitals. An overlap between professional training issues and manpower issues at the respective university hospitals may hamper a neutral position of those members.

Procedures are formal and usually out-of-date. For example the requirement of a presence quorum of 50% in the chambers of the recognition commissions seem to be difficult to fulfil in practice.

In the current practice the procedures often differ from the legal procedures as will be confirmed in the interviews (chapter 7). This situation might lead to legal uncertainty for the candidate medical specialists or candidate GPs and candidate trainers and create a problematic relation between the governing bodies.

4.4.2 Training process

4.4.3 Selection of candidates

The selection of candidates in the seventh year of undergraduate medical training differs in the Flemish and in the French community. The decision on the selection however is in both communities left to the universities; there's no centralised and independent "selection body". There is a possible conflict of interest since universities are represented for one third in the Board of directors of the university hospitals. An overlap between aspects of academic teaching and manpower issues at the respective university hospitals may hamper a neutral position of the universities.

4.4.4 Working conditions

Working conditions for candidate GPs have recently been explicited in legislation. At the time of writing, legislation regarding the working conditions for candidates medical specialists implementing the European working time Directive is drafted at Belgian level.

4.4.5 Conflict Management

Conflict management between the trainer and the candidate is regulated but the objectivity and neutrality are hampered because the judging bodies are composed of the "stakeholders" participating in the selection and assessment of the candidates medical specialist.

4.4.6 Evaluation of candidate medical specialists

Although legislation defines generic and discipline-specific recognition criteria at federal level, recognition commissions of some specialties, apply additional extra-legal recognition criteria. This creates the problematic situation where candidates medical specialist are not recognized according to the criteria of the respective recognition commission but do comply with the legal criteria. This is illegal. Solely the recognition criteria defined by the federal legislation have to be complied with in order to get recognition. If the recognition commissions experiences problems with the applicability of the legal recognition criteria - for instance because they seem to be outdated – this should be ventilated to the Superior Council.

4.4.7 Evaluation of trainers and training settings

Recognition criteria for trainers and training settings are mainly structure – or process based. There are no criteria regarding the quality and results of the teaching during the professional training. Moreover the specific specialty-specific criteria are often out of date (for instance: sufficient number of beds to get recognised as a training setting, whereas the actual policy aims at reducing the number of beds).

For GP training, at community level, additional selection criteria have been set to select trainers and training settings. In Flanders, the interuniversity system elaborated by the ISHO/ICHO in general practice is described in the next chapter. Legally, however, solely the federal government is competent to recognize trainers and training settings.

4.5 CONCLUSION

Although legislation on the training process, working conditions and procedures regarding the recognition of trainers, training settings and candidates exist, there is no match with current practice. Federal legislation is often violated and not sanctioned. Several examples in the current chapter and in particular in the next chapters illustrate this statement.

This situation is partly due to the fact that assessment criteria and procedures date from years ago and were hardly updated. Yet many deviating practices, such as for instance rotation trainings in non recognised training settings are the result of shortcomings in underlying organizational aspects of healthcare and reveal more fundamental issues such as for instance the lack of personnel in hospitals. Whatever the underlying reason for deviation may be, however, rotation trainings in non-recognised training settings are illegal and should be sanctioned.

The effectiveness of a legislative framework not only depends on the match with reality but also on the (pro-active) control of the application and sanctioning in case of violation. Theoretically, training settings can be inspected every five years, but in practice visitations at the spot seem to be very rare. It is clear that the operating of a well functioning visitation system necessitates manpower and financial means.

The current situation where violations to the existing legislation are hardly controlled or sanctioned, might also result in (or maintain) the lack of knowledge by the parties concerned of the correct applicable legislation.

5 POSTGRADUATE TRAINING OF PHYSICIANS IN BELGIUM: PRESENT SITUATION

5.1 INTRODUCTION

As mentioned in the previous chapter the federal legislation defines recognition criteria for the recognition of candidate medical specialists, trainers and training settings. PGT comprises academic teaching and professional training. The universities are solely responsible for the academic teaching. In practice, the implementation of PGT differs between communities and even varies according to universities and specialties, in particular for general practice. Therefore the description of situation for the specialty of general practice and other medical specialties will be split accordingly.

This narrative study uses two sources of information:

- The consultation of documents and websites of universities and specialties;
- Contacts with key persons, as for instance directors of postgraduate GP training programmes, senior academics and presidents of the recognition commissions ('commissions d´agrément'-'erkenningscommissies').

The information is structured according to the areas of the WFME grid [2]. The content only related to the additional information to the chapter on legislation i.e. the implementation within the communities/specialties.

5.2 GP TRAINING IN BELGIUM

In Flanders, a interuniversity organisation and representatives of students and trainers play a role in the quality processes in GP training. In the French Community GP training has a university-based organisation. The appendix on the Belgian situation displays the internet links related to the interuniversity and university PGT.

5.2.1 GP training in the Flemish-speaking part of the country

5.2.1.1 Structures

ICHO - ISHO

The Interuniversity Centre for GP training ("Interuniversitair Centrum voor Huisartsopleiding" - ICHOvzw) was created in 1984 [115]. In 1995 the departments of general practice established together the Interuniversity Collaboration for GP Vocational Training (ISHO - Interuniversitair Samenwerkingsverband Huisartsen Opleiding[116]). These two organisations work in close cooperation and will therefore in this text referred to as ISHO/ICHOvzw if applicable. At present, the funds from the Flemish Ministry of Education for the master in GP are allocated approximately 40% to personnel for the universities (I.S.H.O.) and 60% to ICHOvzw. They also receive funding from the Belgian Ministry of Public Health. Operational and coordinating issues are organized by ICHO*vzw* for the I.S.H.O.
It should be noted that ISHO/ICHOvzw is an organisation pertaining to private law to which no legal competences were attributed with regard to the recognition of trainers or training settings.

Coordination centre "Sui Generis"

From the academic year 2009-2010, a Coordination Centre "Sui Generis vzw" started activities [117]. This organisation deals with the money fluxes from the Federal Government. Working conditions are described in the Ministerial Decree of 17 July 2009 mentioned in the chapter on legislation[91].

Candidate GPs' remuneration is determined by a variable package of on-call hours with a maximum of 240 hours, paid by a lump sum. It is possible that in the future this regulation will be changed into a system of variable payment/hour with a ceiling of approximately 240 hours per year. When candidate GPs are trained in a hospital setting, on-call duty is paid differently [117].

5.2.1.2 Development of the academic training for candidate GPs

The decree of 12 June 1991 regarding universities in the Flemish Community assigns to the universities of the Flemish Community the autonomy to elaborate the training programs for all academic training, with respect of the existing federal and European regulations (art. 11). From 1995 onwards, the Flemish government approved and financed the training of candidate GPs and the collaborating departments of general practice [55]. Since 2003, this academic degree follows the European legislation and the Bologna declaration.[57]

In Flanders, all university training programmes are required to undergo an external quality process every 8 years. This practice visit which is organised by the Vlaamse Interuniversitaire Raad (VLIR)[57, 118]. The institutions first perform a self assessment of quality. An external and independent committee subsequently reviews all training programmes using site visits, documents' analysis and stakeholders interviews (i.e. teachers, students). Different posts determine the total cost of a visitation. First, costs directly related to the work of the visitation commission relate to wages, travel costs and costs related to the editing of a report. On the other hand there are costs for personnel and overhead costs[120]. A site visit of 3 days represents a total time investment of 10,5 days, including the kick off meeting, the visit, the redaction of the report and the closing meeting. In principle a visitation commission counts 3 experts in the domain, 1 education expert and 1 student. The costs of one visit by a commission is estimated at least about €15 000,00. These include the costs of the visitors, the costs for the personnel and overheads costs. In 2005, all Flemish medical academic teaching programmes (including GP training) were assessed and the GP curriculum has been positively evaluated with some suggestions for improvement[116 119].

5.2.1.3 WFME Domains

Mission and Outcomes

The 2nd and 3rd year of GP PGT are organised by the ISHO and coordinated by the ICHO*vzw*. There is a representation of candidate GPs (HIBO forum) [121] and trainers (Overstag) [116, 122].

The mission and outcomes of the training are defined in detail [123]. Stakeholders i.e. candidate GPs (HIBO forum) and trainers (Overstag) are involved in this process through the permanent educational commission (Permanente OpleidingsCommissie - POC) and by regular forums relating to educational issues [123]. The HIBO forum is also represented in the coordination centre SUI Generis and in the Flemish chamber of the Recognition Commission. The trainers are represented in the coordination centre SUI Generis vzw [117]. This entire process is supervised by the Flemish Ministry of Education.

Selection of the candidate GPs

Candidate GPs are selected by the departments of general practice, after completing the seventh year. Students are invited to fill out a form to apply formally and to discuss their choice for general practice. They are subsequently interviewed by the heads of the departments. In the faculty of medicine of the KULeuven criteria like the curriculum (25%), communication- and consultation competencies (25%) and a portfolio presentation (50%) are taken into account[124]. It has to be noted that over the last 5 years the number of candidate GPs was not sufficient to cover all available training positions.

Training Process

FIRST YEAR OF GP TRAINING

The programme of the first year of GP training consists of:

- A practical training of 6 months in a hospital in departments/units that have an added value for general practice;
- An integrated programme of :
  - 6 months (at least 200 hours) of theoretical and clinical courses, seminars, practical exercises and training in general practice;
  - Professional training (2 to 3 months) in recognized GP practices or in a recognized centre where GPs provide primary care;
  - An exam on the programme of the 4th year master in medicine and specific tests to obtain the certificate ("geschiktheidsattest") for starting the Master in general practice.

SECOND- THIRD YEARS OF GP TRAINING

The programme of the second and third years of GP training consists of:

- Professional training supervised by a recognized trainer, appointed by ICHOvzw in the Dutch-speaking part of Belgium or in Brussels;
- 50 hours of seminars under the supervision of a coordinator;
- Organised thematic training modules;
- Self-driven learning:
- Master's evaluation consisting of a project and a portfolio;
- Additional short practical training (optional);

The RC only is competent to solve conflicts between the candidate GP and the trainer or the coordinator. In Flanders the ICHO*vzw* however has a parallel mediating role and a procedure to be followed in case of difficulties before referring to the RC.

Training abroad is possible during 6 to 12 months in specific countries only i.e., the Netherlands, Ireland, Denmark and the UK. The candidate GP has to satisfy all training conditions to work in the respective country. The GP trainer and the training setting (excluding hospital) have to fulfil specific conditions for being accepted.

Assessment of the candidate GPs

There is a formative assessment including a portfolio (intermediate assessment by supervisors). The final summative assessment is organised by ICHOvzw in the universities. It includes an objective structured examination, a knowledge test, case reports, a master's thesis. When there is doubt about the proficiency of candidate GPs, these are followed more closely in a flexible remediating programme. In the academic year 2008-2009, about 30 candidate GPs were more closely followed (i.e. about 10-15%)[115].

Staffing

The appointment policy of trainers relies on their legal recognition by the Ministry. The further selection of practices by ISHO/ICHO*vzw* is based on additional quality criteria[125]. If more candidate trainers are available than needed the ISHO/ICHOvzw sets a ranking. However, legally the recognition is a necessary and a sufficient requirement to work as a GP trainer.

The ICHOvzw criteria for the trainer are for example [125]:

- The trainer has to give the candidate GP the opportunity to perform consultations independently in order to get experienced;
- The trainer has to spend sufficient time in the training, consisting of e.g. teaching GP practices, cooperation in consulting, exchanging patient information on a daily basis, having an evaluation after training practice;
- The trainer has to participate to the training and support groups of ISHO/ICHOvzw; elaborating the practice and the methodology for a visitation by colleagues in the scope of the training;

GPs interested in becoming a training practice have to follow 2½ days introductory sessions and three half days training. They are interviewed by ICHO*vzw* staff and a psychologist and they receive an on-site visit at their practice. Starting training practices gets an appointment for two years;

The ICHO*vzw* staff includes one training coordinator for 8-12 candidates GP and their trainers. They are paid by the RIZIV/INAMI. Furthermore, regional staff members (GPs paid by ICHO*vzw*) coordinate these training coordinators in their region.

Evaluation of the trainer

Trainers are evaluated yearly by the Candidate GPs. Formally, when three candidate GPs have expressed a negative evaluation, a staff member of the ICHO*vzw* discusses the problems with the trainer.

All trainers are supervised by a regional staff member. This staff member works under the umbrella of ICHO*vzw*. They have their own portfolio, to attend regional meetings and should also execute their own learning plans. Several criteria are used for the renewal [125] with a major influence of the staff member.

- The supervision, attendance to training sessions and visitation from a regional ICHO*vzw* staff member with feedback;
- A task profile for each trainer encompasses fulfilling the contract, organisation of the training practice, organisation of learning and working, assisting the candidate GPs in their learning, working and development, cooperation with other trainers, personal development;
- The quality of their personal learning plans and portfolios.

Training Settings and Educational Resources

ICHO*vzw* also formulated some quality criteria for the training setting [125]:

- The training practice has to ensure a full-time continuity and is part of the GP on-call service;
- Varied GP pathology and a sufficiently large population so that the candidate GP can see at least 10 patients a day;
- The practice has to practice evidence-based medicine i.e., alternative medicine practices are excluded as training settings;
- Well-equipped and decent infrastructure.

Evaluation of the training process at interuniversity level

At trainers' level there is a feedback from the candidate GPs, a follow-up by the training coordinators and site visits at the renewal of the appointment[116].

Continuous Renewal

Goals are yearly set by the Direction Committee of ICHO*vzw* i.e. the directors of the 4 Centres for General Practice. Input of routine data and evaluation from VLIR are used for steering educational processes [115].

5.2.2 GP training in the French-speaking community, the Communauté Française de Wallonie-Bruxelles (CFWB)

5.2.2.1 Developments of the training for GP specialists

The CCFFMG-asbl (Centre de Coordination Francophone pour la Formation en Médecine Générale) has been created following the introduction of the new decree in 2009 [94]. This centre has a coordination convention with the candidate GP and a trainer's convention with the trainer, who in turn has a training convention with each candidate GP [126].

The salary is 2700€ gross per month and 100€ per month for traveling expenses. The trainers pay 1472€ per month with the added amount covering the extra on-call duty contract. Finally, the CCFFMG-asbl keeps 5% of the salary paid by the trainer in order to cover the costs linked to insurances and financial transactions necessary to pay their personnel.

In the contracts of the CCFFMG, the on-call duty hours in the GP training practice and the legal minimum of 120 hours on-call rota's of the region during the weekend are included in this amount. On-call hours superior to the legal minimum are remunerated via a lump sum agreed with the trainer, with respect of the wage scales and the modalities fixed by the Board of the CCFFMG and the "Comité de Concertation". Yearly indexation is provided and an additional lump sum for transport costs in the scope of home visits is foreseen.

The three universities have their own programme. The European Credit Transfer and accumulation System (ECTS) process is not yet implemented except at the UCL (academic year 2009-2010).

5.2.2.2 WFME domains

Mission and outcomes

The mission and outcomes of postgraduate training in GP are currently not defined. The candidate GPs are not involved in the process of organizing the professional training programme. However, the trainers have the opportunity of being involved in the process at the level of each university through informal contacts.

Selection of candidate GPs

At the beginning of their 7th year of medicine, students fill in a form expliciting the specialty of their choice. As for other specialties, they then have an interview with two academics-GPs.

The selection of candidate GPs is organised by each department and the criteria are the following: out of a total of 100 points, 50 come from the curriculum vitae, 25 from the interview and 25 from the undergraduate academic results in the field of general practice (Art. 3 Décret du 27 février 2003 modifiant les dispositions relatives aux études du secteur des sciences de la santé dans le décret du 5 septembre 1994 relatif au régime des études universitaires et des grades académiques et dans la loi du 27 juillet 1971 sur le financement et le contrôle des institutions universitaires[83] inserted art. 14 §2 bis in Décret du 5 septembre 1994 relatif au régime des études universitaires et des grades académiques[84]).

Training Process

As for the Dutch speaking community, the first year of training is the 7th year of the curriculum, followed by 2 years full-time professional training in a GP setting or a maximum of one year in a hospital structure. For the academic part 40 hrs seminars are mandatory and organised by each university. Each year, three days of interuniversity courses cover approximately six different topics i.e. Evidence-Based Medicine, literature search, prevention, end of life, ethics and laws, correct prescription of drugs, addiction[127], [128, 129]l.

With the new status, there is a mandatory time dedicated for the (self-)learning process [127]. This time also includes the compulsory personal thesis (TFE: Travail de Fin d'Etudes). In the context of the Bologna reform and the ECTS system, each year is awarded a number of 60 ECTS for the PGT training during clerkships.

Most trainings abroad are accepted as long as the training setting and the training plan have been reccognised by the Ministry of Public Health. In principle, the candidate has to benefit from a remunerated post.

Assessment of candidate GPs

At the end of the first year of specialty (year 7 of the core curriculum, 4th year of the 2nd cycle), there is an Objective Structured Clinical Examination (OSCE) assessment organised at UCL and at the University of Liège.

At the end of the three years, an assessment procedure is organized by an interuniversity jury. The candidate GP presents a thesis (Travail de Fin d'Etudes) and the overall evaluation takes into account the "parcours" i.e., the curriculum of the student during the three years of PGT, based on criteria defined by each university.

There is a mandatory process of feedback (formative assessment) during the training practice by the trainers but at present, there is no verification of this practice.

Staffing

A system of quality criteria comparable to the one of ICHOvzw exists at UCL. EQUALISP is a set of quality indicators useful for a peer-review process between trainers. The EQUALISP criteria are used for the recognition of the trainers by the faculty[127]. These quality criteria were written in collaboration with trainers during regional meetings. There are 4 sets of quality criteria: clinical (e.g. scientific aspects), educational, organisational and ethical. Trainers have to be nominated both academically by the University and by legally by the Ministry.

Approaches for the training of trainers differ between universities. For instance, at UCL some issues are described on the website available for all trainers. All trainers in GP need to follow a training one day per year in order to maintain their recognition.

Training settings and educational resources

There are many differences between practices and no standardized criteria for the training settings. One reason is to offer a diversity of settings to the future GP.

Evaluation of Training Process

To date there is no systematic approach for the evaluation of the training programme and no systematic feedback about the quality of the programme.

Governance and Administration

These topics will be addressed during the course of 2009-2010 in the CCFFMG[94]. The criteria for financing as well as for organising the administrative aspects of the PGT are in progress.

Continuous Renewal

To date there is no procedure for regular review and updating of the GP training programmes.

Keypoints: GP PGT in Belgium

- **The seventh year of undergraduate training of the GPs is part of their specialty training;**
- **The new Federal legislation triggered the creation of two centres for the contracts and payment of candidate GPs in 2009;**
- **Academic teaching for candidate GPs in Flanders is organised by an interuniversity approach (ISHO/ICHOvzw). In the French speaking part, universities adopted an individual approach;**
- **Flemish and some French speaking universities defined additional criteria to rank the potential trainers who have been accepted by the Superior Council.**

5.3 SPECIALISTS' TRAINING IN BELGIUM

5.3.1 Organisation of PGT

The federal legislation requires 2 years of academic teaching and the successful completion of professional training.

This professional training is organised in academic and non-academic hospitals: its outline and supervision depend on the respective RCs.

Medical faculties are responsible for the academic teaching of the candidate medical specialist during the first 2 years of their PGT[94]. Moreover, the legislation states that at least 30 hours of training in communication and at least 20 hours in evidence-based medicine are mandatory regardless of their speciality. In 2001, the VLIR launched in Flanders an initiative to formalize the academic teaching of the candidate medical specialists. An interuniversity council (KUL-UA-UG-VUB) developed the programme by including - beside the above mentioned academic teaching during the first 2 years of the professional training - all formal training sessions and scientific work performed by the candidates medical specialists. The programme proposes a training of 120 ECTS In concordance with the Bologna process[130]. The academic teaching was approved by the Dutch-Flemish Accreditation Organisation (Nederlands-Vlaamse Accreditatie Organisatie -NVAO)[131] and by the Flemish Government for each university[58-61].

There is no official coordination centre for the organisation of PGT as there is for GP training. In practice however, different specialties have national coordination bodies, aiming at the coordination of training within the respective speciality. The Collegium Orthopaedicum[m] for instance organises national examinations in the third, fourth, fifth and the sixth years of specialisation. The RCs are informed on the results of the exams but do not necessarily take them into account.

5.3.2 Recognition process of the trainers and training settings

The recognition process of the trainers and training settings has been extensively described in the chapter on legislation.

5.3.3 Candidate medical specialists

5.3.3.1 Selection of candidates medical specialists

Most candidate medical specialists are selected by a formal selection procedure, based on pre-defined objective criteria. However differences exist between and within the universities (depending on the speciality). The selection mostly relies on the grades and examination results in the undergraduate curriculum[83, 84]. The number of candidates medical specialists selected by each university is proportionate to the outflow of physicians by university. The selection commissions of each specialty are composed of senior doctors: in Flanders they are from academic and non academic hospitals whilst in the French-speaking part from academic settings only.

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[m] http://www.collegium.be/

5.3.3.2 *Assessment of candidate medical specialists*

For the professional training, different assessment procedures are applied by the RCs (see next chapter). One tool common to all RCs is the portfolio that has to be sent back to the respective RCs after each year of training (see chapter 4).

There is a tendency towards an interuniversity and sometimes national examination. Some specialties refer to European diplomas established years ago by the EUMS (e.g. European Diploma of Gastroenterology from the European Board of Gastroenterology, European diploma in Urology established in 1992)[132]. However, these European diplomas do not have any legal value.

In contrast to GP training, the writing of a thesis is not mandatory in most specialities, although writing scientific work is requested by legislation.

5.3.4 Governance and administration

For the professional training financing for the trainers, and part of the remuneration of the candidate medical specialists funds are allocated by the university hospitals. Funding for non-university hospitals is regarded as insufficient as was recently addressed by the Vlaamse Interuniversitaire Raad[133].

Keypoints: - PGT in other specialties in Belgium

- **Universities play a paramount role in the selection of training practices and academic teaching during the two first years of specialisation: there is no interuniversity structure;**
- **Although there is no official coordination centre, different specialties have national bodies aiming at the coordination of training within the specialty.**
- **Candidates medical specialists are selected by the universities and on the pay lists of hospitals**
- **The Dutch speaking Community set up the MANAMA (Master na Master) in order to harmonize the content of PGT. However in order to get recognition solely 2 years of academic teaching (and professional training) are legally required.**
- **The assessment of candidates medical specialists greatly differs between universities and between specialties: some of them seek inter university and European collaborations;**

5.4 CONCLUSION

This chapter further clarifies the processes of PGT in Belgium. Globally the concept of quality in PGT has not yet received the attention it would deserve.

Differences exist between universities and between the specialties under study while at the same time some specialties look at a standardisation according to the European standards. The assessment of the candidate medical specialists varies according to the specialties and to the universities. Initiatives of universities in PGT training are sometimes in discrepancy with the federal legislation;

Many specialties only have a small number of candidates medical specialists. An enlargement of scale would enable the implementation of initiatives concerning quality, including research activities in PGT.

6 SURVEY: RECOGNITION COMMISSIONS

6.1 INTRODUCTION

The Recognition Commissions (RCs) play an important role in the process of training medical specialists in Belgium. Their structure and tasks have been described in the chapter on legislation (see 4.3.4.2). The aim of this chapter is to complement chapters 4 (legislation) and 5 (description of the situation in Belgium) with the results of a survey among the presidents of RC to analyse how the RCs deal with the domains of their competence.

6.2 METHODS

A transversal study was performed to collect information from the presidents of all RCs. The content of the questionnaire was based on the chapters of the WFME document. The instrument has been developed by the core team of researchers (DP, DP, RR, JP, IV, CdB). The questionnaire was pilot-tested among four senior doctors at UCL and UA and a final check on content and wording was made afterwards. The French and Dutch questionnaires were entered in a web-based application software [134] and posted on the KCE website.

To identify the presidents of the RCs, listings were checked using information from the websites of the commissions when available. If no website was available, a personal telephone call was made to verify this information with the professional associations.

Invitation letters were sent mid-June 2009 to all presidents. The data collection was stopped by August 28, 2009. Non-responders were called by telephone on two occasions during July. Extra information sent by email to the research team was taken into account. Two researchers (CdB, RR) analysed the results per questionnaire item. A check has been performed by another member of the research team (JP).

6.3 RESULTS

The main findings are described below, with details in appendix.

6.3.1 General findings

Forty seven questionnaires were valid i.e., 25 Dutch-speaking and 22 French-speaking ones, out of an official list of 35 RCs (source: Ministry of Public Health). The phone calls to non-responders highlighted the interest of many RC presidents for the project. However, a couple of them feared that this project would favour the opinion of academics, one of them referred to colleagues of the professional association. Some could not seek advice from their RC in view of the timing. Several presidents also provided additional written information. Some answers reflect the current situation at a particular University or institution depending on the mention of individual initiatives.

Table 4: Overview of the answers from the RCs

	Question	Yes	No	I don't know	No Response	Total
1	Do trainers receive specific training in order to learn how to teach and train their trainees?	9	34	3	1	47
2	Does your recognition chamber specify a minimal amount of hours/week for trainers to train their trainees?	6	38	1	2	47
3	Does your recognition chamber assess the quality of the trainer?	19	7	1	0	47
4	Is there an external organization for the evaluation of trainers?	10	33	4	0	47
5	Does your RC assess the quality of the training sites?	0	24	23	0	47
6	Is there an external organization which assesses the training sites?	12	28	5	2	47
7	Do the trainees assess the quality of the training sites?	33	11	3	0	47
8	At the end of their training, is there an assessment of the trainees in your specialty?	42	4	1	0	47
9	Is support provided to the trainees in case of any difficulty during their training?	40	3	3	1	47

6.3.2 Trainers

6.3.2.1 Training of trainers

Question 1 was the following "Do trainers receive specific training in order to train their candidate GP/medical specialist? 1a: if so, in which subject area? 1b: how often? 1c: who organizes this training? 1d: who gives this training?"

About a fifth of the respondents reported some form of training of the trainers The content and frequency varied. The most commonly reported training frequency was once a year (to seven times per year for Occupational Health N).

The training of GP trainers in Flanders is organised by ICHOvzw(Interuniversitair Centrum voor Huisartsenopleiding). For all the other specialties, training courses for trainers are frequently linked to a university. In the case of Radiotherapy/Oncology (F-N), the training is connected to the Belgian professional association, based on the 5-year curriculum proposed by the specialty's European Society.

6.3.2.2 Minimum amount of time per week specified by the recognition commission for the training of candidate GP/medical specialists

Question 2 was as follows: "Does your RC specify a minimal amount of hours/week for trainers to train their candidate GP/medical specialist? 2a: if so, please specify."A handful of specialties answered positively (6 out of 47 RCs), while none of the respondents reported a specified amount of hours per week allocated for training junior doctors. Two presidents of RCs considered training as a full-time job. Some presidents referred to the concept of 'continuous availability'.

Key points. Training of trainers

- **Training of trainers is provided in about one fifth of all specialties, usually linked to a university;**
- **Its frequency and the subjects covered vary between specialties;**
- **Only 6 out of 47 responding RCs allocate time for training the candidate GP or candidate medical specialist but no RC reported a specific amount of hours per week allocated for training tasks.**

6.3.2.3 *Evaluation of the trainer by the RC*

Question 3: Does your RC assess the quality of the trainer? 3a: How and on the basis of which criteria? 3b. How and to whom are results communicated? 3c: What are the consequences of this evaluation?

Some specialties only refer to the legal requirements of the recognition process (cf. Chapter legislation). Less than half of the respondents identify this work within their RC. For GP (N) it is not the commission but the ICHO that may use the feedback of the candidate GP/medical specialist identify trainers who do not satisfy quality criteria. For all other specialties, the evaluation criteria and its consequences were variable.

One president reports discussions within the recognition commission over training continuity, for example after a change of the trainer's position. Some presidents report that the RC has no legal power but that all problems are referred to the Superior Council which is the only body that has any legal power to act.

Exceptionally a letter is sent or a visit is organized by the recognition commission itself, as for instance in Obstetrics/Gynaecology (N), Internal Medicine, Nuclear Medicine (F). An interesting initiative was reported by Radiology (N) that began an electronic logbook evaluation: however, the analysis is still ongoing.

The only reported consequence of a poor evaluation of the trainer has so far been the withdrawal of recognition as a trainer. This situation was only mentioned for general practitioners in both language communities.

Evaluation procedures of trainers by the RC

- **Some RCs report that only the Superior Council has legal power;**
- **Most RCs do not report any active role in the evaluation of trainers (as foreseen by the legislation) except in case of major problems with the trainee;**
- **For the Dutch speaking GPs, the evaluation of the trainer is delegated to the interuniversity umbrella ICHO.**

6.3.2.4 *Are there evaluations of the trainers by external stakeholders?*

Question 4: Is there an external organization for the evaluation of trainers? 4a: How and on the basis of which criteria? 4b. How and to whom are results communicated? 4c: What are the consequences of this evaluation?

One fourth of the responding RCs mention the universities as external bodies, whilst this evaluation task is not defined by law. The role of the Ministry was correctly mentioned by some RCs (renewal of statute) with one president pointing out that RCs do not receive the information concerning the outcome, as only the trainers get the results. This situation has potential difficult consequences for candidate GP/medical specialists whose training may not be validated.

Some external assessments were reported.

- Report by candidate GP/medical specialist: in gastroenterology (F), following each internship the candidate GP/medical specialist writes a report for the RC: comments are delivered by the President of the RC to the trainer as a feedback.
- Specialty College: Radiology (N) and Radiotherapy/Oncology (F,N) mention that the assessment is performed by the College of their specialty nominated by the Minister. All data are sent to the Ministry of Health anonymously as well as to all consultants /chief of staff. Any consequence is then further decided by this College.
- Interuniversity platform: For GP (N) there is an agreement that the proposed list of trainers of ICHO is accepted as a framework for appointing trainer by the federal government, implying that ICHO also acts as an external organisation.

- European platform: Neurology (N) mentions a project concerning the fact that the European board of neurology can send a visitor to training settings but only if the trainer asks for it.

Evaluation procedures of trainers by external organisations

- **Many actors are considered by the RCs as external evaluators for the quality of the trainers whilst this evaluation is legally foreseen within the competencies of the Superior Council;**
- **The nature of the evaluation differs between specialties.**

6.3.2.5 Does the Recognition Commission evaluate the quality of training sites?

Question 5: Does your RC assess the quality of the training sites? 5a: How and on the basis of which criteria? 5b. How and to whom are results communicated? 5c: What are the consequences of this evaluation?

Half of the respondents (24 out of 47) report that there is no role for the RC and that the only accessible quality assurance of training sites is the recognition status of the individual physician.

Evaluation of the quality of the training site only occurs once prior to the recognition of a trainer, but that it is then not re-evaluated. Some presidents mention the need to identify whether there is a link between the quality evaluation of a training site and the quality evaluation of the trainer.

The evaluation procedures mentioned by the RCs range from analogous to the way trainers are evaluated (see previous paragraph) to unstructured, unstandardized, 'artisanal' methods. Informal contacts seem important for the assessment of the training sites within the university networks..

A few presidents of RCs report that evaluation of training sites is only performed on request or following complaints, the results are subsequently communicated to the Superior Council.

Role of the Superior Council

One RC reports that in the 1990's it took the initiative of visiting training sites. However, the Superior Council advised them that this task was not their responsibility but the role of the Superior Council. Another RC similarly reports that training settings used to be evaluated by the junior doctors and reported to their commission, but that the Superior Council did not accept this evaluation and told them that an external organization had to perform this quality evaluation.

The suggestion of one RC president is that a duplicate of the trainer's request to be accredited should actually be sent to the recognition commissions in order for them to be able to give circumstantial advice.

In case of repeated difficulties the presidents of the RCs report to the Superior Council which can then decide whether or not to act.

GP (N) also mentions that there is currently no formal evaluation of the quality of training settings although they have repeatedly asked for quality evaluations, and that this is under the responsibility of the Superior Council. They also refer to the role of ICHO (cf chapter Belgian situation).

Role of the training logbook

The training logbook is often referred to as an evaluation tool. One specialty reported that it could be read by a member of the RC who could make a report to the RC. The training gaps are then brought to the attention of both the candidate GP/medical specialist and the trainer and the RC would ask to improve the following year.

Radiology (N) refers to the role of the new electronic training logbook for which there is still ongoing analysis.

6.3.2.6 Are there external organisations to evaluate the quality of training sites?

Question 6 was as follows: "Is there an external organization which assesses the quality of the training sites? 6a: How and on the basis of which criteria? 6b. How and to whom are results communicated? 6c: What are the consequences of this evaluation?"

Only 10 RCs reported positively, i.e. under a quarter of the respondents.

Respiratory Medicine RC (F) mentions the five yearly evaluation by the Ministry of Health according to official criteria. Nuclear Medicine (F) states that since there are only 6 French-speaking training settings, each is well known and difficulties are openly discussed during the commission meetings, which therefore act as informal external evaluation. Occupational Health (F) reports the obligation of quality politics and the ISO certification of a training setting. Both Radiotherapy (F, N) RCs refer to the federal agencies' role to control their nuclear infrastructure and to the role of the radiotherapy professional association.

Keypoints: - Evaluation of training settings

- **The RCs have different perceptions of the role of the SC**
- **Half of the respondents confirms that the RC does not evaluate the training sites, as stated by law. However the evaluation of training sites has been set up by some specialties**
- **Those evaluations are triggered by problems and not organised on a continuous basis**
- **Logbooks might play an important role in the evaluation of training practices as mentioned by some specialties**

6.3.3 Candidates GP and candidates medical specialists

6.3.3.1 Does the candidate GP/medical specialist evaluate the training site?

Question 7 was the following: "Do the candidates GP/medical specialists assess the quality of the training sites? 6a: How and on the basis of which criteria? 6b. How and to whom are results communicated? 6c: What are the consequences of this evaluation?"

A majority of RCs (33 out of 47, i.e. above 70% of respondents) reported positively. However, some presidents did not know whether candidates GP or candidates medical specialists evaluated training sites.

The evaluation is formal in some RCs. The candidate medical specialist in Gastroenterology sends a written report to the RC and the president writes to the trainer in case of problems. The coordinating trainer can decide whether or not to send junior doctors there again. For Paediatrics (F), there is an annual evaluation through the medical training logbook according to strict criteria: scientific and practical contributions, relationship to the professionals and the parents, evaluation of supervision, availability, scientific infrastructure (library). In case of problems, the RC reports to the trainer.

Some RCs use an informal or unstructured evaluation methodology. The logbook is mentioned by some RCs but without any precision on the methodology. Informal feedback of candidates medical specialists is reported for instance in stomatology (F) and respiratory medicine (N). Surgery (N) mentions that following the interview of the candidates medical specialist, there is usually either verbal or written communication to the trainer and if necessary, a visitation.

For GPs (F) an annual report is read by the RC and only if there is a problem either the junior doctor and/or the trainer are asked to come in person. GP (N) report that they receive the individual reports of candidates GPs but they acknowledge the role of ICHO which also takes up the tasks. However, in case of a negative report, the GP RCs refer to the Superior Council.

In Obstetrics and Gynaecology (N) meetings occur with the junior doctors so that problems can be openly discussed. The results are communicated to the president and members of the recognition commission. When there is a problem, a visitation has been suggested on some occasions.

The consequences of the evaluation of candidates GPs or candidates medical specialists vary from no impact at all to an annual evaluation for example via the logbook - but only if the logbook is returned within three months prior to the end of the training period. In other RCs, the written evaluation is read by one member of the commission and its contents are communicated verbally at the commission's meeting. There is occasionally an audition that sometimes leads to an adaptation of the training by the trainer.

Keypoints: – evaluation of training settings by the candidate GP or candidate medical specialist

- **Most RCs (70%) mention that the candidate GP or candidate medical specialist evaluates the training site**
- **The use of the logbook for the assessment of training sites differs between specialties, and is not clearly specified**
- **Some specialties use their own, largely indefinite and generally informal feedback loops**
- **Consequences, if any, are not reported: only the GP recognition commission (N) reports to the interuniversity collaboration (ICHO).**

6.3.3.2 Evaluation of the candidate GP or candidate medical specialist at the end of his/her training

Question 8 was the following: "At the end of their training, is there an assessment of the candidate GP or candidate medical specialist in your specialty? 6a: On the basis of which criteria? 6b. How are they evaluated in view of the criteria?"

The vast majority of presidents of RCs (42 out of 47) reported positively, stating there was an assessment of candidate GP or candidate medical specialists at the end of their training, sometimes with detailed annexes specifying the requirements of the final examination of the specialty concerned.

There appears to be no consensus of approaches between specialties. Some specialties mention the absence of final examination criteria. For some specialties the final examination criteria are tougher than the legal requirements. Several Dutch-speaking RC presidents mention the recent VLIR MANAMA documents and refer to the fact that the examination now has to be organised.

Cardiology RC (N) refers to an electronic portfolio with the results of formative examinations concerning knowledge acquisition, skills evaluation by DOPS (Direct Observation of Procedural Skills) as well as an evaluation of the professional attitude (360° test) by the trainer and his colleagues in cardiology.

RCs mention different possibilities, either isolated or in combination:

- Validation of training periods on each training site
- Logbook evaluation
- Publication in a peer-review journal or presentation at congress of the specialty
- A thesis with oral defence
- Examinations at Community, national or European level

Interuniversity examination

GP (N) mentions that this final examination is the responsibility of ICHO. The RC only validates the procedure. The reader is referred to the chapter entitled "Belgian situation" for more details on this procedure.

National examination

Interestingly, Radiotherapy (F) mentions a curriculum established by the European Society (ESTRO), accepted/endorsed by the Belgian associations ABRO-BVRO and by the RCs. There is therefore one national examination, both theoretical (multiple choice questionnaire) and practical (oral examination). The exam covers the whole training.

For Oncology (F), the candidate medical specialist has to answer at least half of the questions of the national Multiple Choice Questionnaire (prepared by all 7 universities) in combination with a final examination in each university.

Respiratory Medicine (F) mentions that training candidates medical specialists is organized by the Belgian Society of Respiratory Medicine (for all) and separately by each language community, but that a final federal examination is organized jointly by both chambers of the RC.

European examination

Several RC presidents refer to European examinations and standards, mentioning that the European examinations are not compulsory, but that their RC tries to follow European criteria specified for the curriculum of their specialty, for instance according to the UEMS recommendations.

6.3.3.3 Support offered to candidates GP or candidates medical specialists in case of difficulties

The answers were mostly positive (40/47). A small minority were unaware of any support offered to candidates medical specialists and supposed that each university had their own system.

Discussion with the coordinating trainer

Most positive answers referred to either sessions or interviews with the coordinating trainer or at the Recognition Commission itself, with one (the President usually) or several people. If necessary the coordinating trainer can ask for the help of other universities or refer to the ministerial commission.

One RC president remarks that any support is today purely reactive and not proactive.

Follow-up by a member of the RC or by an ad hoc commission

One RC mentions that in case of problems, a member of the RC is designated to follow-up and report on that specific issue.

In another RC the president reports that in case of difficulties, an ad hoc commission is created. This commission reports to the RC so that the latter can advise the medical candidate specialist and the trainer appropriately.

Keypoints: – Evaluation and support of candidate GP or candidate medical specialist

- **Most RCs mention an assessment at the end of the training. When the assessment exists, the criteria used for the final examination greatly vary between specialties e.g. validation of training periods, logbooks, examinations;**
- **Some specialties offer well-structured final examination procedures: interesting initiatives refer to national or European criteria;**
- **Some Dutch-speaking RCs address the compulsory need for assessment procedures imposed by the recent developments of the master after master system;**
- **Most RCs report some support for candidates GP or candidates medical specialists who need it: the methods vary and the procedures are usually unclear**

6.3.4 Suggestions from the Presidents of the Recognition Commissions

Question 10 was the following "What would your RC recommend to improve the quality of training?"

Some presidents of RCs formulated suggestions to improve the current situation:

- Standardize the curriculum across all training sites;
- Electronic logbook as an initiative for improving the quality of the training;A portfolio for each specialty with a European vision: trainership as part of job description - train the trainer - establish useful evaluation methods (360° evaluation, interim evaluation) - visitation of training settings - definition of competencies, technical skills and attitudes;
- Compulsory examination at the end of the 2nd year as well as at the completion of the training;
- Acceleration of the implementation of the European initiatives at the level of training;
- Assessment and quality assurance of training practices;
- Specific training of trainers;
- On-site visits;
- Financing a system of evaluations of trainers, candidates and training settings is paramount for improvement;
- Improve clear communications between the various organisations 5 yearly visitation of all training places by members of the recognition commission;
- Anonymous evaluation of the training site by candidate GP or candidate medical specialist;
- Recognition commissions working together with better communication with the Superior Council.

6.4 DISCUSSION

The overall response rate to this survey was high: 47 presidents of the various recognition commissions (i.e. just over 2/3 specialties) filled in the online questionnaire. There are, however, several limitations to this type of survey, as these answers mostly only reflect the views of presidents of RCs, and it should be noted that many of them did not have the opportunity to discuss the questionnaire within their commission due to a lack of time.

Interestingly, one president requested later to receive back the specific questions and answers he had provided in order to present and discuss them with his own RC and also with colleagues of the other language community.

The paragraphs here below discuss main points identified from the answers of the RC presidents about quality criteria in the field of specialist PGT in Belgium.

6.4.1 Large variations between recognition commissions

The RCs reported large variations in the tasks they perform. Most often, subjectivity prevails and only a few initiatives or activities are planned to ensure and improve the quality of specialist medical trainers and training practices.

6.4.2 Situation on the field

For all specialties, the universities play a paramount role with a few exceptions. For Radiotherapy/Oncology a national organisation is mentioned. Some specialties refer to a European association and/or UEMS specifications. For general practice in the Dutch speaking community the quality process is delegated to the ICHO.

The respondents mentioned many positive suggestions to join efforts by harmonising (parts) of training. This could well be achieved for many of the generic competencies of training. Enlarging scale could lead to better use of money for training, as it was accomplished for general practice in Flanders.

6.4.3 Trainers and training settings

Training of trainers, if any, is limited in time, frequency and intensity and also greatly vary between specialties (frequency and content). Training does not seem to be systematically part of the job of trainer.

Interestingly, according to the various responses, there are major difficulties with regard to who is, or is not, allowed to perform visitations of the training settings: some take it upon themselves to organize visitations, some have clearly been communicated that this is not of their competence, yet many refer at some point in the questionnaire to the need for 'on-site' evaluations.

For specialties with small numbers of candidate medical specialists, a suggestion for on-site visits can be valuable. This might lead to cross fertilisation of training settings.

6.4.4 Candidates GPs or candidates medical specialists

There is no specific time per week allocated to the task of training. This finding is of paramount importance as it is one of the cornerstones for quality in the WFME statements. One cannot infer that training is not offered, as training while doing the daily work can be offered on many occasions. However, transparency can be important, for instance for the job description at the senior physician level: this could include teaching as part of the job. Furthermore, when problems arise during the training process because of competing duties it is worthwhile having transparency in these tasks.

In case of difficulty, the RCs usually have a procedure to support the candidate GP or candidate medical specialist. The RC plays a role of mediator between the candidate and the trainer in case of disagreement. However support is not proactive but rather in answer to tricky situations.

6.4.5 Final assessment

Most remarkably, the (final) assessment of candidates GPs or candidates medical specialists varies between specialties and does not exist in some of them, whereas it is a complex intra- or interuniversity and occasionally international procedure for other specialties.

6.4.6 Superior Council

The role of the superior council is legally defined. However, the RCs report that the communication channels from the RCs towards this council are not well known. Letters can be sent but respondents are unaware of procedures that they may follow. Here again, a large amount of subjectivity can be observed.

6.4.7 Logbooks

Obviously, there is a role for the logbooks as mentioned by most commissions. RCs state that logbooks could provide valuable information on candidates, trainers and training practices.

However, this survey underlines the absence of any formal and longitudinal use of data to look into the quality of a particular training practice, except for a detailed description in one RC. Indeed, the Ministry collects the data, and data per training practice could be used for the recognition process.

6.4.8 Evaluation following European criteria

The criteria used for evaluation of trainers and training settings were rarely reproducible between the RCs. However, some referred to European criteria either based on the UEMS or on the European Society of their Medical Specialty.

6.4.9 Suggestions from open questions

The RCs sometimes expressed frustrations in the open questions about uncertain roles, lack of legal means, lack of communication with the Superior Council and the lack of coordination with regard to the renewal of the trainers' statute.

Some presidents proposed that the RCs should only focus on more general tasks of looking at formal regulations of training processes and leave the other tasks (training of trainers, quality assessment of trainers and training settings, assessment of candidates medical specialists) to an independent body or independent organisations. This could enhance the processes of reaching uniform sets of criteria across the specialties.

7 INTERVIEWS OF KEY INFORMANTS

7.1 INTRODUCTION

Experts consulted during expert meetings have given descriptions based on facts which were rather different from legal or organizational descriptions depicted in this report's legislation and present situation chapters. The survey performed to collect information from the presidents of all Recognition Commissions has confirmed a growing assumption of a gap between theory and practice, frameworks and implementation of these.

7.2 AIM

It was decided to collect more information concerning legal framework and its application, and initiatives or experimentation designed to improve quality in PGT in Belgium.

7.3 METHODS

7.3.1 Selection of interviewees

Twenty-two key informants have been selected based on theoretical sampling to include all types of actors regularly involved in recognition process: trainers, candidates GPs and candidates medical specialists, hospital medical directors, deans, representatives from unions, from federal recognition bodies and from community/university initiatives for quality in professional training. Nine of these 22 persons are members of the Superior Council.

Based on experts' advice to pay attention to differences between communities or specialties in the field of these initiatives for quality, the sample was structured to well represent parity between Dutch and French speaking. A special focus was put too on general practitioners who were overrepresented to explain in detail recent development in their specialty.

Two lawyers working in trainers' or training settings' recognition domain and two representatives of a university network for quality initiative were added to these key informants' list.

7.3.2 Information gathering

Twenty one-hour semi-directed interviews have been guided during December 2009 and January 2010. Trainers' and training settings' recognition were under scrutiny. Based on five questions communicated in advance (see below), interviews have been recorded with the signed agreement of the interviewee. Interviewees were informed that interviews would be anonymised and their name and function written in the list of key informants (see appendix). French-speaking interviews have been conducted by a KCE expert (a sociologist who performed the international comparison) who assisted dutch-speaking interviews conducted by a member from UA team (a GP who performed the systematic literature review). Analysis remained to KCE's remit.

Five domains have been identified in the legislation chapter as tricky areas and the corresponding open questions have been the following:

1. Stages de rotation/rotatie stage (i.e. periods of training in non recognized settings): Did you ever hear about that ? Is that a frequent phenomenon ? Do you think that the working or learning conditions are different from the other trainings ? Are you aware of official rules that regulates such training periods ?
2. Criteria to evaluate the candidate GP or candidate medical specialist: do you know the official criteria to assess the candidate GP or candidate medical specialist ? (if yes, mention) Do you think the assessment usually relies on those criteria ? Who has the highest influence in the decision ?

3. Conflict management: are you aware of conflicts between the candidates GPs or candidates medical specialists and the trainers ? When they occur, what is the procedure set up to solve the problem ? Do you think this procedure is used ? If yes, is it effective ? What are the pitfalls and possible solutions ?
4. Weekly work hours: The European Directive set up the maximum at an average of 48H/week (+ mention a few other points). Are there major discrepancies with the Belgian situation ?
5. Remuneration. Are there problems linked with candidate GP's or candidate medical specialist's remuneration?
6. Positive aspects of the current system of Professional training ?
7. Negative points and possible suggestions to improve the system ?

7.3.3 Data analysis

Analysis was based on the structured notes of the researchers. The "WFME guidelines for recognition" grid was used to synthesize the data collected. Anonymity has conditioned a not too detailed data presentation; consensual views are especially presented.

7.4 FINDINGS

7.4.1 Fundamental requirements of a recognition system

7.4.1.1 Lack of transparency

Transparency is never cited by key informants to describe the existing recognition process or structures in Belgium. Opacity is far and away the most often used word to evoke a one way information process, deliberations behind closed doors and little feedback about decisions. A little more visibility on administration procedures occurs when problems occur.

7.4.1.2 Necessary trust

However, no suspicion nor mistrust has been explicitly mentioned but a shared trust in recognition principles. Describing recognition process weaknesses like poor internal or external reviews, some interviewees referred to the necessity to trust. Indeed, without few means of control, recognition bodies' members have to judge recognition files on declaration supposed to be honest. And, in the absence of assessment, deans have to be confident of trainers' teaching competencies. When these feelings of poor –if not lack of- control at all level of the recognition process were strong, such reactions as "we need to trust" or "it's like as you travel by airplane, you need to be confident" have been heard.

In these cases of necessary trust, reputation is of importance. Judgments on trainer's or setting's quality are greatly based on reputation. When drawing up training plan or when counseling training settings or trainers to candidates GPs or candidates medical specialists, official recognitions are not considered as sufficient quality proof. Reputation makes the difference. Reputation is also taken into account in recognition bodies to condone deviations (see below).

7.4.2 The legal framework

In the present legal framework, some criteria are real issues (e.g. the impossibility to get the number of beds required for one specialty in one training setting). Some deviations are condoned by recognition bodies. Although these tolerated deviations were never precisely quantified they were often mentioned as widespread.

7.4.2.1 *Reputational networks*

Autonomy as such is never cited about Superior Council. On the contrary, links and connections of the recognition commission members, their insertion in multiple networks are pinpointed. Indeed, in recognition commissions, the experience of members, reciprocal familiarity and individual connections to professional/reputational networks are resources sometimes mobilized to influence the decision. These connections are helpful to gather more information on recognition files judged to be not honest.

7.4.2.2 *Conflicting interests*

At recognition bodies level, these connections hide potential conflicts of interests which are not under stated control procedures and remain mostly black-boxed. These connections are considered as important issues in such a competitive context between training settings. At ground level, denunciations from competing trainers to recognition bodies have been reported. In these cases, administration was depicted to react as a safety valve by giving time to defendant person or setting to be in accordance with legal framework.

7.4.2.3 *Lack of information*

A gap is reported between SC for training settings and trainers on the one hand and RCs on the other hand. Although exchange of complementary information could be useful to decisions, the communication between these recognition bodies is poor. Recognition files are also filled in various ways with information not always as detailed as it should be, missing or sometimes false. Usually, the attention which is paid to filling recognition files depends on settings concerned.

7.4.2.4 *Counterproductive handling of complaints*

Decision about trainers and training settings recognition may be followed by a final appeal with the Raad van State/Conseil d'état. Disadvantages are that it's time-consuming and that quality is no more under evaluation but procedural aspects are only taken into account.

7.4.2.5 *Limited power*

At the end of an appeal procedure, judgment on quality is replaced by judgment on administrative process so that the Raad van State/Conseil d'état 's final decision may be counter-productive. This problem was cited in relation to bad trainers or candidates who are under way and whose name is not easily removable from the list.

7.4.3 Organizational structure

7.4.3.1 *Huge number of members*

Recognition activities at Superior Council level, described as repetitive and administrative, are based on badly-paid jobs of experts whose personal involvement is required. There is no real professionalization of these activities. If workload is increased by urgency, some members could see it as the last straw and give up.

7.4.3.2 *Three thirds*

The interviewees state that professional associations/university parity is of importance in the functioning of RCs. Few people are aware of this functioning which remains opaque for a large majority. The respondents suppose that from one point of view, seating in these assemblies offers opportunities to medical societies to regulate the access to profession by defining some standards. From the other point of view, seating in these assemblies gives opportunity to universities to act in their own interests.

7.4.3.3 Site visits: potential danger

Little is known or said about site visits. They have sometimes been reported as the "Flying Dutchman" due to lack of transparency, the rumours that surround them and the potential danger that they bring with them. This refers to a widespread impression that this kind of external control is rare, if it ever existed.

7.4.4 Standards or criteria

Legal criteria are mentioned when their obsolescence is criticized or when deviations are justified. Though, specific attention is paid to some criteria as weekly work hours, remuneration, workload and education. The way these criteria are assessed by interviewees depends on the way they are placed in specific context.

7.4.4.1 Context

Globally, womanization of medicine and lack of candidates GPs and medical specialists are pinpointed. Womanization to express a growing wish to better articulation of work and family life. Lack of candidates to say how the situation today is different from the past. Yesterday, "trainees were on their knees" (sic) in front of employers and trainers. Today, it's exactly the inverse situation. The present situation is mostly described as comfortable for candidates but also potentially problematic for the future.

7.4.4.2 Workload

Some key informants insist to say that the present situation is better than before and that a sort of equilibrium between trainers' offer and candidates' demand exists: "there are few issues", "there are few complaints", "the system functions well".

Some other key informants insist on fears they get about future and so question this equilibrium. These fears concern all that work that have to be done without any more candidates to do it; a "second division medicine" will be done by badly-paid foreign physicians. This argument divides those ones who judge necessary to practise a lot to learn more (even rest is to postpone), and those ones who, on the contrary, judge important to rest enough to learn more (but without adding supplementary years to training).

What is a tolerable workload is a question that divides candidates GPs or candidates medical specialists too. This division is not so much linked to gender factors but to the parents' profession. To be son or daughter of physician appears to have more influence on the candidate's answer about tolerable workload. An important factor is also real possibilities to negotiate his/her workload with the trainer; even the new status for candidates GPs is not a guarantee to fair agreement.

7.4.4.3 Variable quality of training

The relationship between the trainer and the candidate specialist is often mentioned as a quality standard. When this relationship is seen as a positive apprenticeship (like "compagnonnage"), training is described as fundamental in a career. But this situation of high quality relationship is considered as exceptional. More often, trainers are reported to need training to be efficient as teachers. Isolated reluctant trainers have been compared to "old mandarins".

7.4.4.4 Between dependency and excessive autonomy

The growing autonomy of the candidate GP or candidate medical specialist partly depends on the quality of the trainer's follow-up. Many cases have been mentioned of problematic situations linked to badly managed autonomy. On one hand, the candidate does not get enough opportunities to practice (even under supervision) because of forensic reasons, potential competition (trainers who keep jealously secret some techniques or patients) or insufficient self-confidence of trainers. On the other hand, the candidate might be left in the dark because of trainer's heavy workload or bad coordination between multiple trainers.

7.4.4.5 Remuneration

Remuneration is sometimes mentioned as an important criterion to attract or retain candidates GPs or candidates medical specialists in disadvantaged settings. Though salary scales are followed in many cases, extra pay is less often mentioned than badly-paid extra hours. The new status of candidate GP is already an open door to new frustrations as regards to money transfer from salaried candidates to independent trainers.

7.4.5 Process of recognition

7.4.5.1 Internal evaluation

The importance of internal evaluation is growing in academic sector. Survey techniques and peer groups are employed to assess and improve quality of training setting and trainers. By example, the candidate GP or candidate medical specialist is invited to give appreciation on the training; trainers are invited to meet other trainers during meetings about training. Trainers' evaluation is more formative than summative although it may partly explain specific inclusion in or exclusion from academic networks of accredited trainers.

7.4.5.2 External evaluation

Site visits are more often mentioned in this academic recognition process than in federal recognition process cited above ("the Flying Dutchman"). But identical questions are raised about their composition and freedom of speech they give to consulted people.

7.4.6 Main elements in the process of recognition

7.4.6.1 Self-evaluation

The quality assessment of trainers and training settings has been left free to academic and community initiatives for years. These initiatives are gradually moving in the same direction:

1) toward formative evaluation of trainers;

2) toward surveys of candidates GPs or candidates medical specialists and trainers;

3) toward internal investigation and mediation within university or network.

Under university control, problems are solved through diplomacy. If diplomacy fails, legal or media means are not used by universities but well by candidates GPs or candidates medical specialists associations. Internal self-regulation is preferred: e.g. an embargo is put on reluctant trainer or training setting until these are in conformity with local standards.

7.4.6.2 Site-visits

About federal site-visits, too little information has been delivered on this subject for the reasons mentioned in §7.4.3.3. Site visits undertaken by local initiatives have been reported.

7.4.6.3 Explanations to condone deviations

Three kind of justifications might explain the tolerance of "deviations" in Belgium:

1. the obsolescence of many quality criteria;
2. the low supply of training posts in small academic networks entangled in small communities part of a small country;
3. a bad management of conflicts of interest pushing federal administration to refrain from any hasty decision unfavourable to one or to another competing setting.

7.4.7 Decisions on recognition

A majority of key informants state that decisions on recognition are rarely based solely on the fulfillment or lack of fulfillment of standards. In a context of low supply of training posts, to follow the letter of the law was often reported to be risky business. Consequences could be to temporally close entire specialties for training. Conditional recognition or delays to be in conformity are therefore allowed to trainers or settings.

7.4.8 Public announcement of decisions on recognition

As already mentioned above, decisions on recognition are perceived as taken in full opacity. No other information was gathered on this subject.

7.4.9 Benefits of recognition

Strengths and weaknesses of the present system that have been most often cited during interviews are summarized below.

Strengths of the system

- Flexible administration
- Experienced members
- Strong legal framework

Weaknesses of the system:

- Lack of transparency
- Community and academic quality initiatives (in competing environment)
- Poor quality control procedures
- Obsolete quality criteria
- Inadequate financial resources
- No interactions between recognition bodies for trainers/settings and for candidates GP or candidates medical specialists.
- Poor management of conflicts of interests

7.5 DISCUSSION

The gap between the legal framework and the factual situation raises the question of quality control. The key informants often underline this lack of quality control that might be explained by weaknesses of federal recognition bodies. Community and/or academic initiatives have been developed to fulfill this gap.

While in other countries (Canada, Switzerland and UK), a model of good governance aims to bring together different actors involved in quality control, in Belgium the distance between them is obvious. Employers, medical schools, unions, candidates GPs or candidates medical specialists associations, federal administration work too little in good intelligence. Even at federal level, a lack of communication between recognition bodies is pinpointed.

Two main explanations are constantly proposed. First, a blackboxed management of conflicting interests at federal level would have a bad influence on the relations between these PGT actors. Now each actor defines quality in relation to its own interests. Second, the rationale for the federal criteria is never clearly stated unlike standard definitions available in other countries (UK, Canada). Federal recognition criteria are subject to multiple interpretations. Deviations are tolerated or not without anyone really knowing why. Is it to improve the quality of PGT? To save the functioning of a training system that too stringent application of the law threatens to paralysis? To protect the interests of some stakeholders in the system?

7.6 CONCLUSION

1. Key informants gave additional information about their perception of the legal framework, its implementation and about initiatives locally designed to improve quality in professional training. Only information concerning trainers' and training settings' recognition has been reported in this chapter.
2. Concerning fundamental requirements of the recognition system, opacity is far and away the most often used word. Due to lack of control, a trust agreement ("contrat de confiance") is in use at all levels of the recognition process. In such agreement, reputational networks play an important role.
3. The legal framework, despite its strong architecture, suffers from weaknesses given to the number of tolerated deviations. Concerns are raised about the independence of federal recognition bodies and poor management of conflicting interests in a competitive environment. Lack of resources at federal level is underlined.
4. The interviewees suggest to set up new standards reviewed in accordance with evolving socio-demographic context and medical innovation. Teaching relationship, autonomy, workload and remuneration are standards that carry potential conflicts. These conflicts are presently not managed at federal level.
5. The quality control set up by academic/community initiatives is more extensive than the criteria set by federal legislation. It encompasses the quality assessment of training evaluation, trainers and training settings. A sort of recognition process (internal survey, visitation reports and regular review) is also reproduced at this local level. Self-regulation by diplomatic means characterizes this local process of quality control. Questions are raised about the continuity between federal and local levels and about the external control of this local recognition process.
6. Decisions on recognition are not based solely on the fulfillment or lack of fulfillment of the criteria or standards (as proposed in the WFME guidelines). To follow the letter to the law was reported to be an issue. Up to now, tolerance to deviations and flexible administration have been considered as a necessary security valve.

8 SUMMARY AND PROPOSALS FOR BELGIUM

The conclusions developed in the following paragraphs focus on the research objective of the document i.e. the quality criteria for the recognition of training settings and trainers. The first part highlights major issues in the Belgian situation. The second part outlines possible avenues for the future. The final part addresses some caveats that might hamper the implementation and/or success of these proposals.

8.1 MAJOR ISSUES IN BELGIUM

8.1.1 Belgian situation within the perspective of the WFME guidelines for medical education

This report allows putting the current Belgian situation into perspective with regard to the requirements proposed by the WFME for a recognition procedure, in particular for the quality of PME: basic requirements, legal framework, organizational structure, standards or criteria and formal process of recognition are the topics covered by those guidelines.

8.1.1.1 Basic requirement: trustworthy quality and recognition system

The report and the interviews in particular reveal that the main stakeholders have a limited but necessary trust in the current system e.g. government, medical schools, students and profession.

8.1.1.2 Organizational structure

In Belgium the Superior Council principally serves as a "recognition body" for trainers and training settings, including the main stakeholders (medical schools and profession). The final decision remains with the Minister. These groups mostly rely on the (voluntary) participation of representatives appointed by their organisation. The size of the Superior Council is huge (about a hundred members) compared to what is recommended by the WFME guidelines (9-15 members). The tasks of the Superior Council however have been confided to working groups to enhance its efficiency.

Per specialty there is a Recognition Commission that advises the Minister on the recognition of the candidate GP or candidate medical specialist. The possibility of consultation between the Superior Council and the Recognition Commissions regarding the recognition criteria for trainees, trainers and training settings and the quality of trainers and training settings in the scope of a recognition is set by the law. Yet, the interviewed stakeholders reported a lack of interaction between SC and RCs.

Finally, there is no independent team to perform the concrete evaluation work e.g. site visits, surveys among candidates medical specialists. Some Recognition Commissions therefore decided to set up a quality system to warrant the quality of the training in the settings.

8.1.1.3 Legal framework

The Belgian recognition and quality system has a legal framework, a major requirement according to the WFME.. The federal government makes the access to the medical profession subject to a recognition and has defined the criteria for the recognition of medical specialists. The universities are responsible for the academic teaching.

In relation to the recognition of training settings, the federal government also has set recognition criteria. However, criteria additional to those foreseen in legislation are used in practice. The universities select the future candidates medical specialist in accordance with the defined quota and on the other hand set quality rules for the corresponding limited amount of training settings recognised by the Federal authorities. For the specialty training programs, deans and heads of departments make a selection per university, based on their own criteria.

For general practice in Flanders this implementation is performed by an interuniversity consortium: the selection of training settings among those recognised by the Federal authorities is based on a ranking procedure and explicit criteria as explained further (see 8.1.1.4).

The use of other criteria than those that were legally set may lead to legal uncertainty for all parties concerned. Legally, solely the federal government has the legal competence to set recognition criteria.

The implicit renewal of the recognition by the SC is common practice except in case of problems. Its withdrawal for quality of training reasons scarcely ever occurs.

8.1.1.4 Criteria for training settings and staffing:

Quality criteria at national level

The WFME document advises the definition of predetermined criteria, agreed upon by stakeholders and made public. These should be used for the recognition process i.e. self-evaluation, external evaluation and final decision on recognition. Generic quality criteria for the recognition of trainers and training settings have been defined at the level of the Belgian federal government. However, their scope is limited (mainly structure criteria instead of process criteria focused on the quality of training), they are subject to many interpretations by trainers (as shown in the interviews) and not used for the purposes proposed by the WFME. As stated above (see 8.1.1.3) some universities use additional quality criteria to accept GP training settings in their curricula. They make rankings of the best settings for the limited amount of candidates according to the defined quota. For the selection of training settings providing professional training for candidate medical specialists other than candidate GPs commercial and competition elements may play a role.

Next to the generic criteria, criteria specific for each specialty have been defined. However they are often out of date and sometimes exclude training settings on the basis of norms independent of the pedagogical aspects. One illustration is the number of beds whilst the current policy strategy aims at decreasing their number in hospitals.

Specific criteria for the specialty of general practice

For the GP specialty more specific criteria have been recently defined by the legislation. They do include quality criteria for training settings and for the trainers. They also state rules about working conditions (e.g. out-of-hours). Some universities added intrinsic quality criteria and produced a transparent criteria list for training settings. The inclusion of judgments on the quality by the candidates GPs completes the ranking of the training setting on a ranking list. This ranking only includes training settings that are already accepted by the federal level. In principle, however, the recognition is a necessary and sufficient condition to serve as a training setting or to work as a trainer.

Lack of homogeneity in the quality of training between settings

The result of this situation is the heterogeneity of the quality of professional training between specialties (and general practice in particular) and even between settings for the same specialty according to the local implementation of the legislation within the training setting. This heterogeneity is reinforced by the absence of external evaluation except within the scope of a conflict management. Theoretically site visits are also possible every five years. In practice however, this hardly seems to be practiced. The problem is that in case of conflicting values, candidates and trainers have no firm grounds to act on for particular situations. For example, what is the meaning of "supervision" or autonomy in the absence of standards?

A local interpretation of the legislation by the training settings might have negative consequences as for example candidates medical specialists who give up their training as currently observed in Belgium.

Process of quality evaluation and recognition

The process of quality evaluation and recognition of training settings and trainers must include the following stages according to the WFME:

- Self-evaluation;
- External evaluation based on the report and a site visit;
- Final report of the evaluation team;
- Final decision: full recognition, conditional recognition, denial/withdrawal of the recognition.

In Belgium, at the Federal level, the recognition procedure only relies on a self-report of the trainers in relation to the fulfilment of legal criteria. The criteria are mostly quantitative and structure based. They do not refer to the pedagogical quality and in particular they do not take into account the feedback of the candidates. The interviews confirmed that these feedbacks are sometimes taken into account at the university level.

The current system can react in case of problems, with an official pathway described in the legislation part. However, the survey among RCs showed some complementary initiatives to improve this system. These parallel initiatives, coupled with the fact that the quality itself does not receive any attention until its obvious absence, call for a new quality assurance system: this would guarantee a continuous training of quality for all candidates GPs and candidates specialists.

8.1.2 Additional issues: gap between legislation and reality

Some additional major issues have been described for the Belgian legislation and situation.

8.1.2.1 Recognition bodies: plurality of functions

The organisation of professional training in Belgium involves highly specialised issues, in particular when talking about specific specialties. The result is that many stakeholders/structures involved in decisions wear several hats and play multiple roles with potential conflicts of interest. One illustration is the composition and role of the recognition commissions: they arbitrate potential conflicts during the training but also advise on the final recognition of the candidate GP or candidate medical specialist as a specialist. However all members are peers of the trainer and the candidate is not represented in the RC. In that way, the same persons act as employers, as trainers, as judges for the candidate's evaluation and are also future colleagues.

8.1.2.2 Non-application of the federal legislation

This report highlighted the non-application of the federal legislation in different stages of the recognition process. Although the Federal government set up a sound legal framework for the recognition of candidates, trainers and training settings, in practice many deviations exist. Universities also added further conditions as for example the quality criteria set by the ICHO or by UCL for the recognition of GP trainers. The positive consequences might be a better definition of a high quality content of the training that should lead to better training outcomes. Potential unintended consequences were however identified e.g. heterogeneous quality of the training between Communities/universities, training settings accepted by the federal authorities are not all used in the university programmes, difficult mobility between Belgian Communities. Candidates GPs or candidates medical specialists might have conflict to comply with the federal legislation and with the universities rules. The arbitrage of those disputes raises important difficulties.

8.1.3 Gap between regulations and reality according to the interviews of stakeholders

An issue reported by the key informants is to follow the letter to the law. In the current legal framework, some criteria are obsolete. For this reason and other ones which remain black-boxed in recognition commissions, deviations are condoned. These tolerated deviations are never precisely quantified but often mentioned as being common.

8.2 POSSIBLE AVENUES FOR THE FUTURE

Some findings of this report highlighted possible avenues for the future.

First, some interesting initiatives already running in Belgium can inspire a future system to ensure the quality of professional training. The initiatives set up by (inter)university GP departments demonstrate the feasibility to define and to adhere to quality criteria for trainers and training settings, including quality procedures and site visits. The visits from the VLIR (VLaamse Interuniversitaire Raad) illustrate the feasibility of conducting an external evaluation to assess the quality of teaching in university faculties using explicit criteria. A similar procedure could be created to assess the quality of training in settings with the involvement of the stakeholders.

Secondly, foreign systems can also inspire the implementation of a new quality system such as the systems in Canada, in the United Kingdom and in Switzerland. Each of these three countries found specific solutions to the problems that were identified in Belgium:

- A global recognition process encompassing the whole PGT is regulated by recognition bodies at national level. These are characterized by professional functions, simplified administration, transparency (via websites), self-assessment and conflicts of interest management;
- A governance model characterizes these organizations with the coordination of several actors within a legal or a quality framework.
- Recognition bodies in Canada, UK and Switzerland base the recognition system on well-defined sets of explicit standards. These standards are less structure-oriented than process-oriented.

8.3 TOWARDS QUALITY ASSURANCE IN TRAINING SETTINGS

The initial research question was the definition of quality criteria for training settings and trainers. This work showed that this definition is a part only of a broader quality system to be set up to guarantee the quality of professional training. The answers are therefore not limited to the quality criteria but also to their implementation and follow-up. The analysis of the Belgian situation and the examples from other countries brought out a set of unavoidable conditions to be filled for implementing a system for quality of training settings. Variations in scenarios might be discussed according to the existing Belgian structures.

The consecutive steps involve:

- The existence of an independent evaluation team;
- The revision and extension of the national generic quality criteria;
- The definition of tools to measure the quality of training;
- A clear definition of the potential consequences of the non-fulfilment of the defined standards (e.g. conditional renewal).

8.3.1 Independent evaluation team

The paragraphs above underlined the need for an evaluation of the quality conducted on a regular basis. The current recognition body i.e. the Superior Council, does not have the sufficient manpower, time and budget to conduct those evaluation. For this reason, the qualified recognition bodies that have been set up in Canada (RCPSC, CFPC, CMQ), United Kingdom (PMETB) or Switzerland (ISFM) could be inspiring models. All these bodies implement quality assurance in a good governance framework including multiple actors as medical schools (in Canada and United Kingdom) or professional societies (in Switzerland). An illustration is the quality framework of the PMETB displayed in chapter 3.4.1.3.

A possible scenario is the replacement of the current Superior Council by a smaller structure, possibly with appointed persons with a dedicated time. This new Superior Council would be complemented by an independent team fully devoted to the evaluation of training settings including the trainers i.e. the definition of quality criteria, of evaluation methods and their implementation. It should be noted that the UK body mentioned above is also in charge of the trainees' evaluation.

This evaluation team would work under supervision of the Superior Council and work with the advice of RCs for the definition and validation of criteria for specific specialties. The recognition (full or conditional) as well as its possible withdrawal would strictly depend on the results of the evaluation. The universities (responsible for the quality of teaching) should play their role in order to prepare the official recognition procedure.

8.3.2 National generic quality criteria: a basis for the follow-up of quality

8.3.2.1 Scope

Clearly stated comprehensive, up-to-date sets of standards are needed in Belgium. These are already in use in the three countries mentioned above i.e. standards inspired by WFME in Switzerland, PMETB standards in UK and standards partly anchored in CanMEDS role model in Canada. In addition, the quality criteria of ICHO and EQUALISP show sets of quality criteria that could also be used for a broad evaluation:

- Criteria generic for all specialties:
  - Teaching skills and methods (including e.g. trainers' training, formal feedbacks to the candidate medical specialist);
  - Development of professional competences: the CANMEDS role model could be an example of a pre-existing framework that covers most physicians' competences;
  - working environment and conditions (including e.g., team work, working conditions);
- Additional specific criteria defined for each specialty (e.g. core competencies, specific decision rules, techniques).

In this configuration there is a comprehensive view of the recognition of trainers and training settings: those last ones should fulfil structure and process quality criteria, including the presence of at least one trainer with specific training skills.

8.3.3 Evaluation methods

The evaluation should be a constant and implicit feature of quality of PGT. Instruments, methods and procedures used for it should be optimized to the maximum in order to gain a judgment on the quality of the training in the training settings. They should fit in a quality evaluation system. The WFME suggested the concrete following methods, as implemented by the VLIR for universities and by other systems abroad:

- Periodic standardised surveys among candidates GPs or candidates medical specialists (the current logbook is nor intended nor used for this purpose);
- Self-evaluation at individual (trainers) level and training setting level;
- Site visits;

- Formal recognition subject to renewal.

A coordination between actors is necessary to implement these evaluation methods. This coordination should be written in a legal framework as in the Swiss governance model or in the UK quality framework.

8.3.4 Caveats

8.3.4.1 Lack of evidence

The proposals outlined above come from the analysis of the Belgian situation and experiences in other countries. However the reader should be aware that the systematic review of literature did not provide any evidence of a link between quality criteria for training settings – trainers and favourable outcomes in terms of learning outcomes and physicians' competences. Moreover, the relation with quality of care is never analysed whilst it should be the ultimate goal of a high quality training.

8.3.4.2 A broader issue than a simple definition of quality criteria

The initial research question to the KCE was the definition of quality criteria for training practices and trainers. The results have shown that the question can not be disentangled from the broader issue of PGT. Moreover, the definition of the quality criteria implies their implementation within a broader system of quality assurance with measurement, evaluation and proposals for improvement.

As many criteria are common to the different specialties, there is a need for a multidimensional generic evaluation of training settings. Additionally, the evaluation should take into account the differences between specialties as for instance general practice and more technical disciplines such as surgical specialties. Here interuniversity programs have a global advantage on often more competitive university programs to standardize the quality of training in a given specialty.

8.3.4.3 Financing

The proposals outlined in the previous paragraphs imply an investment for the implementation of a quality assurance system. In particular, it should encompass an investment in the independent evaluation team responsible for the selection of quality criteria, the methodology to gather the information on quality and the follow-up to control their implementation using the predetermined criteria and methodology. In particular site visits have a cost. As an illustration, a VLIR site visit of three days with three experts represents an investment of 10.5 days, including the kick-off meeting, the visit on site, the report and closing meeting.

8.3.4.4 Legislation and implementation

The current situation where federal legislation is often not applied pleads for a clear communication to all parties concerned of the existing federal legislation, a pro-active control to the application of the legislation and sanctioning of violations. The precondition for the operability of the legal framework however is that sufficient financing and manpower are provided.

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