Tidsskriftet Tidsskrift for Den norske legeforening

What would Winnie the Pooh have said?

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When new study places are established, the interests of society, students and patients need to be taken into account. But what is the most important concern?

Photo: Øystein Horgmo

To cover the need for doctors in Norway, many medical students have to do their training abroad. Meanwhile, international treaties obligate Norway to take a greater responsibility for training its own healthcare personnel (1). The Grimstad Commission recommends that 440 new study places be established in Norway over the next eight years, permitting 80 % of all the country's doctors to be trained here (2). Studying abroad is also to be made less attractive.

The number of Norwegian medical students abroad has grown from 2 380 in 2009 to 3 166 in 2018. Over the same period there was a slight increase in the number of study places in Norway, from 580 to 636 (2). In other words, nearly half of all Norwegian doctors are trained abroad, most of whom (> 75 %) in Poland, Hungary, Slovakia and the Czech Republic (3). In addition, nearly one-fifth of all working doctors are foreign nationals, very few of whom were trained in Norway (4). The medical help provided to patients in Norway therefore draws on a diverse professional and cultural base.

Medical studies in Norwegian seats of learning seek to promote an understanding of the needs of the Norwegian health services and patients resident in Norway. Abroad, other approaches to both medical training and the medical profession prevail. When compared to most Norwegian educational institutions, Eastern European institutions are known for placing a greater focus on basic medical science. The saying there is that the anatomist will

decide whether you will become a doctor, and the pharmacologist will decide when. Most students are permitted to meet patients only after completing three long years of pre-clinical study. The study programmes are characterised by continuous testing of knowledge (or lack thereof). The clinical teaching suffers from the same challenges as the health services in general: few resources, overworked healthcare personnel and a system which few people really understand, still dating back to the Communist era. The situation is further exacerbated by the fact that very few patients can speak English (Russian was the mandatory second language until 1989).

> ***«We have a responsibility to identify, and replace if necessary, what we stand to lose if the training capacity in Norway is expanded at the cost of study places abroad»***

In Norway, knowledge testing is sometimes conducted at random (a lottery system), and it is my impression that the teachers wish to find out what the students know, rather than what they do not know. The clinicians who teach have been liberated from their other functions while they are teaching. Concepts such as well-being, co-determination, career guidance and research opportunities are crucial for students in Norway, while they may be non-existent among Norwegian medical students in Eastern Europe.

I have myself been a medical student, doctor, researcher, teacher, citizen and patient, first in Hungary and later in Norway. I am often asked which study programme was best. The answer is simple: a combination of the both – the Eastern European 'tyranny of theory' and the Scandinavian clinical teaching and its democratic humanitarian principles.

Medical studies in Norway are adapted not only to the development of medical science, but also to society's norms. The workload should be optimal, teaching should be facilitated (yet not mandatory), the teacher should be popular, examinations objective and evaluations fair. Teaching of basic theoretical knowledge (such as anatomy, physiology and pharmacology) must therefore often yield to other subjects (5). Arguments about objectivity and fairness have undermined the role of oral examinations in the training programme, and the opportunities for making an overall assessment of the students' personal suitability are constantly decreasing.

Globalisation and rapid scientific development have meant that multi-faceted cultural competence, multidisciplinary cooperation and international collaboration have become cornerstones of our profession (6). In parallel with the growing proportion of doctors who are trained in Norway, we need to continue discussing the content of medical training. We know relatively little about the characteristics of those who currently study abroad, but a study from 2001 showed that they spent far more hours on study-related activities and were perceived as more robust than medical students in Norway. Moreover, fewer of them wanted to specialise in general practice or psychiatry, the fields in which Norway is facing the greatest shortages (7).

We have a responsibility to identify, and replace if necessary, what we stand to lose if the training capacity in Norway is expanded at the cost of study places abroad. A broad competence in both basic and clinical medicine provides robust doctors with better adaptability and creativity (7, 8). In our health services, this competence relies on a rich and diverse base. Do we really dare to tone down this diversity, instead of taking it with us into the future?

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Publisert: 4 November 2019. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.19.0679

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