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In training or at work?

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Specialty registrars are responsible for their own learning in an unpredictable specialist training programme in which the day-to-day work may take precedence over learning activities. The lack of clear regulations on specialisation can result in a delicate balancing act.

Photo: Sturlason

New regulations on specialty training for doctors implemented in 2019 state that hospital doctors without a speciality must be employed as specialty registrars (1). One of the goals is for doctors to complete specialist training. It would be easier to accomplish this through regulations that more clearly define the balance between rights and duties in a position where the doctor is both in training and at work.

The new regulations assigned responsibility for the 43 hospital specialties to the hospital trusts (1, 2). Apart from a minimum training period of five years (following the completion of stage 1 of specialist training (LIS 1)), the regulations give no recommendation or other indication as to how many years it can or should take to become a fully qualified specialist. Nor do the regulations or circulars state how doctors' responsibility for their own learning should be balanced against independent authorised professional practice, as laid down in the Health Personnel Act (1, 3). Being both a candidate in training and an employee can be challenging in terms of progression in the training pathway, as well as for managers with both employment and training responsibilities. Unless the specialty registrar's work tasks, such as being on call, in the laboratory or on the ward, involve necessary learning activities, their

specialist training will be delayed or will stagnate. Consequently, despite being a specialty registrar per definition, qualifying as a specialist is a distant prospect.

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Irrespective of the training programme, experience and position – the work of a doctor entails learning for life and life-long learning. Working in a hospital provides good learning opportunities, and the previous specialist education programmes were mainly based on the integration of theory and practice and a traditional master-apprentice training. The new regulations involve up to several hundred required learning outcomes, which must be achieved and documented via specified learning activities in given learning arenas (1). The regulations have therefore resulted in a bureaucratic and detail-oriented specialisation system that has proved challenging to put in place (4).

Both the quality of specialist training and working conditions are important in relation to completion of the training (5, 6). A high workload will make a well-structured training pathway difficult to follow. Conversely, better working conditions will not compensate for poor speciality training. We do not know to what extent these factors contribute to recruitment problems and the attrition rate for doctors working in hospitals in Norway. Younger doctors despair when 'the day-to-day work trump education', pointing out that their employer can arrange for the day-to-day work to take priority over learning activities (4). No one benefits from such an approach in light of specialist needs in the future.

In Denmark, specialist education for doctors has been organised as an established training pathway in which the where, what and when are specified from the start of employment until the end of the training (7). The Norwegian scheme allows for more flexibility. In addition, specialty registrars are entitled to a permanent post, giving young doctors in Norway stronger employment protection. However, the Norwegian scheme also entails more unpredictability, causing disadvantages for both employer and employees. In particular, training pathways that involve temporary rotating assignments at other hospitals need to be far more predictable and better planned.

The specialty registrar regulations have been in force for four years, so no one has completed their training under the new scheme as yet. It is therefore uncertain how long it will actually take to become a fully qualified specialist, and whether the average length of time will differ from that of the former system, i.e. no less than eight years (8).

In the coming years, we will gain more experience and acquire data allowing us to estimate the average length of training. This information should be collected systematically and made available so that it can guide doctors in their choice of specialty, and hospital trusts to plan their activities. This knowledge base should also be used by the national authorities when considering specialty-related changes in the regulations.

So how can specialist registrars in training be confident that they are receiving the appropriate education? Four years after a far-reaching reform, the time has now come for a systematic review – and preferably a national evaluation – of the specialist training in hospitals. Pending the acquisition of a knowledge base and an evaluation, specialty registrars are dependent on training and employer responsibilities being managed wisely and balanced well against the doctors' responsibility for their own learning.

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