Harmonisation of specialist training in Europe: is it a mirage?

Stephen Brearley

For the past 18 years there has been a proliferation of European committees, boards, associations, colleges, and working groups set up to promote the harmonisation of specialist training in Europe. It has been taken as read that this objective is desirable. The fact that these bodies have achieved remarkably little is telling, and it is time to question their activity. There are good practical reasons behind the evolution of Europe's disparate training schemes, and the arguments for retaining diversity rather than continuing to strive for homogeneity are persuasive.

Harmonisation of specialist training is a concept that has pervaded—even dominated—European medical bodies for at least a quarter of a century. The adoption of the medical directives (75/362/EEC and 75/363/EEC) in 1976, and the resulting legal equivalence between basic and specialist qualifications awarded in all member states of the European Community, reinforced the notion of harmonisation in the minds of many and led to an assumption that national systems of training leading to those qualifications would inevitably converge.

Since 1976, obsession with harmonisation has spawned numerous new craft related or specialty based organisations, each of which has worked to further develop the concept. Innumerable person hours of committee work and countless air miles have been devoted to its promotion. Nowhere can a voice be heard to question it. Yet, 18 years after the directives were signed, remarkably little has been achieved in concrete terms and a cogent argument in favour of harmonisation has yet to be put forward.

Why the drive to harmonise?

The most cynical explanation of the harmonisation bandwagon is the opportunity which it affords to representatives to travel to attractive places and to meet interesting foreigners. Cynical, but not entirely without foundation. Foreign travel is undoubtedly attractive and the opportunity to do it at someone else's expense is even more so. The durability of some representatives on the European circuit testifies either to extreme commitment to the cause or to extreme contentment with the lifestyle which it offers. Many European bodies would have difficulty in justifying their continued existence on the basis of their achievements; none has thus far voted itself out of existence.

Those who participate in European bodies do, none the less, seem to believe in the goal of harmonisation. Often this is for quite idealistic reasons, having to do with a sense of brotherhood, a desire to exchange ideas and to facilitate migration, particularly for educational purposes. Sometimes there is a belief that harmonisation is necessary to ensure acceptable standards and achieve higher ones. Occasionally there is an element of outright cultural imperialism.

The ideal of brotherhood between Europe's doctors is a worthy one, but its fulfilment in no way demands that all should have undergone the same training. Similarly, free exchange of information and experience between colleagues in different countries is desirable but does not demand harmonisation of training. Medical migration for educational purposes has not become widespread despite many attempts to encourage it, but this has little to do with disparity between training systems. The real barriers are the lack of employment opportunities in countries that have substantial medical unemployment; language difficulties; and the extraordinary reluctance of the very bodies which advocate harmonisation to recognise periods of training spent in another country. Those who have managed to migrate do not seem to have had difficulty in adapting to a different training system.

Chasing chimeras

The maintenance of standards, in view of the right of specialists to migrate between any two member states of the European Union, is often put forward as another reason to promote harmonisation of training. But migration at this level of seniority is rare and likely to remain so because of the inherent difficulties of establishing a practice or finding a permanent appointment in another country. For the few doctors who attempt it, host countries have many means of assessing experience and expertise irrespective of the qualification which the doctor holds or the training system from which he or she has come.

Attempts at harmonisation have sought to define standards which all training systems should meet; to arrange external inspection of training centres; and to set examinations for the trainees. But the content of training cannot be prescribed without consideration of the role that those who have been trained are to fulfil in a particular health care system. Inspections and examinations similarly require a context if they are to have validity. Even basic educational principles may not translate easily across cultural boundaries, and some countries may not have the resources to follow them. The extent to which international standard setting is valid is thus limited. The scope for enforcing such standards is negligible.

The final argument in favour of harmonisation is that participants may learn from it and be able to import into their own training systems the best features of others. This is true in principle but seems rarely to occur in practice. The structure and approach of international medical bodies militate against it. Effort is directed towards achieving consensus rather than exchanging experience. Understanding among delegates of the health care and training systems of other countries is often poor. Even when insights are gained, the difficulties of explaining them at home and achieving change are enormous. Improvements in national training systems continue to occur but they are internally generated, not externally driven.

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*Homogeneity—like beauty—is
a vain pursuit*

The arguments for diversity

"Homogeneity or diversity?" is a central question for the European Union as a whole. The argument for homogeneity is an economic one—a large, single market is conducive to economic success—and has nothing to do with freedom, democracy, or accountability. The economic imperative may lead to a single currency, a single central bank, a single economic policy; but elsewhere—in language, in culture, and, for the foreseeable future, in health care—diversity is likely to remain. This is desirable. Quite apart from the enormity of the task of unifying Europe's health services, and the unmanageability of the organisation that would result, diversity in health care is as vital as genetic diversity in avoiding the dangers of inbreeding and in generating innovation by means of cross fertilisation.

The European Commission has no interest in harmonising health services, not least because health care largely falls outside the scope of the European treaties. European doctors will continue to serve a variety of health care systems in which staff mix, roles, and responsibilities are enormously variable. The United Kingdom is at one end of a spectrum, with relatively few doctors, specialists in the minority, and a high proportion of care carried out by allied professions. Elsewhere, specialists predominate but provide many services which in Britain would be undertaken in primary care; and doctors, because they are so numerous, carry out tasks which in Britain are the domain of nurses, physiotherapists, technical staff, and managers.

Since the roles of doctors, and of specialists, vary so greatly from country to country, the training which prepares them for those roles must also vary—as indeed it does. Variation exists not only in respect of clinical capacity but also with regard to other skills, such as prevention, administration, working in a team, teaching, and research. In every country, training has evolved to meet, however well or badly, the needs of the national system of health care. It would be as nonsensical as it is impossible to devise a training system that could meet the needs of all.

Doomed to failure

The leading organisation concerned with the harmonisation of specialist training is the European specialists organisation (UEMS). Recently it published

both a charter and a compendium of training.^{1,2} The charter reiterates principles of good practice which have previously been enunciated by the European Commission's Advisory Committee on Medical Training³ and the Permanent Working Group of European Junior Hospital Doctors,⁴ and it adds nothing of substance to them. In particular, the charter proposes no method of enforcement of the specified good practice. The compendium purports to list the regulations governing duration, content, and assessment of training which currently apply in each specialty in each country. Apart from being patently inaccurate, the compendium constitutes a hopelessly simplistic approach to describing what is a very complex matter.

The charter and the compendium are intended as a starting point for the work of newly established specialty boards, set up under the auspices of the existing specialist sections of the UEMS. The boards aim to raise standards by making recommendations about the content and duration of training in each specialty and how this should be monitored. Such procedures will be costly and time consuming, and previous experience suggests that the exercise is doomed to failure. Furthermore, with notable exceptions, there has been a lack of enthusiasm among training centres in Europe to accept inspection, and indeed validation, of their posts by the European boards. This lack of cooperation has tempted many of the boards to consider assessing the trainees by examination. Quite apart from the recognised inadequacy of examinations alone as a means of assessing clinical competence, variation in the skills and knowledge expected of specialists in different countries makes the setting of a single examination for all an exercise of dubious validity.

Recently the UEMS has also published a charter on continuing medical education.⁵ These recommendations are likely to be well received in Britain and bear a striking resemblance to some already published here, notably those of the Royal College of Obstetricians and Gynaecologists. This is perhaps not surprising as the president of UEMS is a British gynaecologist. The central proposal is for the establishment of a professional body in each country to oversee continuing medical education. Although all of the principles set out in the charter are laudable, the lack of any means of enforcement and, in some countries, of the necessary educational infrastructure means that member states are likely to go their own way, and at their own pace, in this as in every other educational issue.

A real advance, at least with respect to general practice, seemed to have been made when the directive on specific training for general practice (86/457/EEC) was adopted in 1986. Stemming from an initiative of the European general practitioners' organisation, UEMO, it requires that, with effect from January this year, all doctors entering general practice should have completed specific training lasting a minimum of two years, one year being hospital based and the other under the supervision of a recognised general practitioner trainer. Although implementation would be a major step forward in countries that have not previously offered or required such training, these are precisely the countries in which money has not been forthcoming to establish traineeships in general practices and where hospital posts are hugely oversubscribed. Full implementation seems unlikely in the foreseeable future.

Perhaps the most telling indicator of the limited future of harmonisation is the present predicament of the Advisory Committee on Medical Training. Set up by directive in 1976 to advise the European Commission, it is the only statutory body dealing with medical education at European level. Early in its life it

produced sound recommendations on all stages of medical training, which were largely ignored by the commission. More recently it has been progressively starved of resources, so that meetings have become infrequent and work has been seriously hampered. The commission is now proposing to give to the Committee of Senior Officials in Public Health, which is composed of officials from health ministries most of whom are not doctors, the task of updating the medical directives. The commission's lack of interest in the Advisory Committee on Medical Training, combined with the weakness of the non-statutory alternatives, suggests that harmonisation of medical training is as unlikely as it is misconceived.

Conclusion

It is ironic that the only instance of change in post-graduate training programmes which can be attributed directly to European intervention has been brought about in Britain, a country whose training standards have always been among the highest. *Hospital Doctors: Training for the Future* (the Calman report)⁶ was the response to an allegation by the European Commission that, by awarding two different specialist certificates at two different levels of experience, the United Kingdom was in breach of the medical directives. It is an attempt to force into a continental mould a system of training which had evolved to serve the United Kingdom's rather unusual health care system.

If the Calman report succeeds in reducing the duration of specialist training it will have achieved a goal that long antedated it. Like previous initiatives, it is likely to be frustrated by the well proved inability of

government, health authorities, and the medical profession to generate the 30% increase in consultant numbers that implementation demands.⁷ The report will, however, make it much more difficult for British trainees to obtain part of their training abroad; virtually impossible for trainees from Europe to obtain training leading to specialist status in Britain; and very likely that trainees will spend considerable periods marking time in posts that are not recognised for training at all, if they are not unemployed.

It is time for some reappraisal of harmonisation—what it is, what its objectives are, and its desirability, feasibility, and cost. The meddlesome and self-perpetuating enthusiasm of a plethora of committees, boards, associations, colleges, and working groups needs to be tempered by a realisation that diversity is not only inevitable but desirable.

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- 1 Union Européenne des Médecins Spécialistes. *Charter on training of specialists in the European Community*. Brussels: UEMS, 1992. (Doc D9367.)
- 2 Union Européenne des Médecins Spécialistes. *Compendium medical specialist training in the EC*. Brussels: UEMS, 1992.
- 3 Advisory Committee on Medical Training. *Second report and recommendations on the training of specialists*. Brussels: Commission of the European Communities, 1983.
- 4 Brearley S, Beuzart S, Gredal J, Suntinger A, Gentleman D. Permanent Working Group of European Junior Hospital Doctors. Policy statement on postgraduate medical training. *Med Educ* 1989;23:339-47.
- 5 Union Européenne des Médecins Spécialistes. *Charter on continuing medical education of specialists in the European Union*. Brussels: UEMS, 1994. (Doc D9426.)
- 6 Working Group on Specialist Medical Training. *Hospital doctors: training for the future*. London: Department of Health, 1993. (Chairman K Calman.)
- 7 Brearley S. The failure of consultant expansion. *BMJ* 1994;309:1245-6.

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Qualitative Research

Introducing focus groups

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This is the fifth in a series of seven articles describing non-quantitative techniques and showing their value in health research

This paper introduces focus group methodology, gives advice on group composition, running the groups, and analysing the results. Focus groups have advantages for researchers in the field of health and medicine: they do not discriminate against people who cannot read or write and they can encourage participation from people reluctant to be interviewed on their own or who feel they have nothing to say.

Rationale and uses of focus groups

Focus groups are a form of group interview that capitalises on communication between research participants in order to generate data. Although group interviews are often used simply as a quick and convenient way to collect data from several people simultaneously, focus groups explicitly use group interaction as part of the method. This means that instead of the researcher asking each person to respond to a question in turn, people are encouraged to talk to one another: asking questions, exchanging anecdotes and commenting on each others' experiences and points of view.¹ The method is particularly useful for exploring people's knowledge and experiences and can be used to examine not only what people think but how they think and why they think that way.

Focus groups were originally used within communication studies to explore the effects of films and television programmes,² and are a popular method for

assessing health education messages and examining public understandings of illness and of health behaviours.³⁻⁷ They are widely used to examine people's experiences of disease and of health services.^{8,9} and are an effective technique for exploring the attitudes and needs of staff.^{10,11}

The idea behind the focus group method is that group processes can help people to explore and clarify their views in ways that would be less easily accessible in a one to one interview. Group discussion is particularly appropriate when the interviewer has a series of open ended questions and wishes to encourage research participants to explore the issues of importance to them, in their own vocabulary, generating their own questions and pursuing their own priorities. When group dynamics work well the participants work alongside the researcher, taking the research in new and often unexpected directions.

Group work also helps researchers tap into the many different forms of communication that people use in day to day interaction, including jokes, anecdotes, teasing, and arguing. Gaining access to such variety of communication is useful because people's knowledge and attitudes are not entirely encapsulated in reasoned responses to direct questions. Everyday forms of communication may tell us as much, if not more, about what people know or experience. In this sense focus groups reach the parts that other methods cannot reach, revealing dimensions of understanding that

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