The same, but different

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Introduction

The Dutch healthcare sector has seen many major changes lately: the introduction of a new health insurance scheme, a shift from supply-based healthcare to a demand-based system and a trend towards increasingly assertive patients. This requires a new approach to the education and training of future doctors. How is this approach implemented in practice and how do the changes affect medical students? This article discusses medical students' experiences with the revised Framework for medical training, the bachelor-master structure and the clerkships.

The 2009 Framework for undergraduate medical education

Undergraduate medical education in the Netherlands is based on principles set out in the national Blueprint of 2001, which was recently superseded by the 2009 Framework. The principles are re-assessed every five to ten years and offer universities guidelines for the development of their curricula. The training requirements set out in the Framework must be met by all students graduating from Dutch medical education programmes. This helps to improve the monitoring and assessment of medical education [1]. All eight Dutch medical faculties must ensure that their curricula meet the requirements laid down in the revised 2009 Framework and therefore have to implement changes in their medical curricula.

After critical re-assessment, Blueprint 2001 was adjusted to reflect developments in the medical sector and society at large and to create a better fit with the bachelor-master structure of medical education. The resulting 20009 Framework contains adjustments to the medical training profile for doctors based on the CanMEDS model [2], [3]. Each university has to incorporate these general competencies into its training programme in a structured and transparent manner. "A major step forward, that nevertheless evokes key issues in terms of curricular implementation. A source of concern is translating the general competencies into clinical teaching" [4].

Most faculties try to implement the competencies in a practical, patient centred way.

One of the general competencies of the CanMEDS model is communication. According to fifth-year student Maurits Buiten the curriculum devotes a great deal of attention to communication skills, with students learning to communicate with patients using role play, actors and even real patients.

Patient centred education is translated further in the training programme in order to make training closely related to the working environment in the hospital. Education at the University of Groningen is based around weekly case studies and students have the opportunity to question patients and learn from real life disease. According to Maurits Buiten, lessons are "often inspiring due to the impressive, extensive and severe nature of the medical conditions we get to see. It is a clear-cut teaching method, and it is well suited to the first three years of training."

In order to further increase practical learning an increasing number of universities are now offering education in

small groups, consisting of twelve students and a "mentor," usually a medical specialist or a general practitioner. This format offers medical students contacts with medical specialists in a relatively informal setting at an early stage of their education. Also, smaller groups make it possible to tailor education to students' needs.

The bachelor-master structure

The new Framework is the first revision of the Blueprint published in 2001 after the introduction of the bachelor-master structure. The Netherlands is among the first European countries to have implemented this system. In theory, the bachelor-master structure enables students to transfer from one university (national or foreign) to another without losing any ECTS. After obtaining their bachelor's degree, students can earn a master's degree in medicine at another university of their choice. This broadens their options and promotes mobility. Medical students are generally satisfied with the bachelor-master system and the options it offers in terms of determining an individual learning pathway [3].

Fourth-year student Tom Brouwer at the University of Amsterdam welcomes the introduction of the bachelor-master structure. It offers future students more opportunities in terms of mobility and freedom of choice. Unfortunately, medical students have not been able to take full advantage of the bachelor-master structure yet. Universities do not seem to be making the most of its potential at the moment and it is impossible for students to do a minor, let alone a full master's degree, at another university. We will have to find a way to take measures to make this possible in the short term." A more diverse range of master programmes could offer major benefits to medical faculties and students. A good case in point are the so-called research masters, which enable students to combine a master's degree in medicine with a PhD programme. In the Netherlands, this option is currently exclusively available at the medical faculties of Maastricht and Groningen. As mentioned before, the bachelor-master structure can offer medical students a host of benefits. However, there is still a long way to go before the new structure will have changed the face of medical training in the Netherlands and students will actually be able to reap the benefits.

Clerkships

The Framework allows medical faculties a certain degree of freedom in designing their own curriculum. This is reflected in aspects like the timing and content of clinical clerkships.

Different universities schedule clerkships in different phases of the study programme. Students at Utrecht for example can start clerkships from the third year onwards, while other universities offer this part of the curriculum from the fourth year. In Groningen and Maastricht, there is no fixed order for clerkship rotations. These two universities are unique in offering their students the option to undertake all or part of their clinical rotations in a single hospital.

In Nijmegen, the introduction of the bachelor-master structure has led to several changes in the curriculum. One change affects the structure of the clerkship period. Ilse Kleine Schaars, a seventh-year student at Radboud University Nijmegen, explains: "We do our clerkships in a fixed order. The duration varies from two to eight weeks, depending on the specialty. Prior to the clerkship, you get three weeks of preparation in which you learn the required skills for the upcoming period. This allows you to familiarize yourself with common clinical pictures in your area of specialization. After the rotation, you have a week to reflect on what you have learned. Next, you do an in-depth assignment based on case studies and literature study. It is an effective way of preparing students for clerkships and of ensuring that they round off this phase in a suitable way."

...but different

The Framework offers clear guidelines for medical education programmes at the Dutch faculties of medicine. Despite some local differences in the order of compulsory components, it is clear what is expected from each student when they have completed the programme. With universities at liberty to determine the details of their own curricula, medical education programmes are the same, but different.

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Both teachers and students play important but different roles in medical education. Despite their different roles, it is important for teachers and students to cooperate and share experiences, because in that way they can help to improve the design and implementation of medical education programmes. In the next five contributions students from the Netherlands, Flanders, Germany, Switzerland and Austria describe their experiences with medical education programmes in their respective countries. As students are the 'consumers' of medical educa-

tion, their opinions should be valued and careful attention should be paid to them.

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