Summary

This book concerns the reform of medical residency training. In short, the reform takes in the shift from apprenticeship-based training models of “learning-by-doing” and role modeling to structured training programs based on educational insights as competency-based training and standardized performance assessment. Up to now, many sociological accounts of medical education have narrowly focused on the world of doctors and how they are educated. This book aims to contribute to a more comprehensive understanding of current transitions in medical education. The overall research aim is to reveal how medical residency has changed due to the interplay of policy development, transitions in the medical profession, traditional values and training practices, and new ideologies.

The book discusses and relates two closely related, yet usually distinct topics. First, we explore the changing objectives and processes of medical training itself, and examine how current reforms affect the learning process of medical residents. Second, medical education is generally seen as a core institution of medical professional self-regulation. Through exploring medical training reform we seek to gauge the dynamics of present trends in medical governance.

We explore these research aims through a multiple-sited ethnographic study of medical training reform in the Netherlands. For five years, we traveled around and participated in various sites that enacted the reform of medical training: the Ministry of Health, medical associations, the clinic, local meetings of clinical teachers, medical residents and educationalists, conferences pertaining to the reform and scientific conferences on medical education. We ‘acted with’, observed and interviewed local and national actors. Drawing on theoretical insights of medical sociology, the sociology of professions, science and technology studies and political sciences the book reveals the multiple ontologies of medical training reform, and provides in-depth insight in the processes and mechanisms of changes in medical governance more in general.

Chapter Two sketches the various perspectives on medical training reform. How do the actors involved in residency training give meaning to the reform and what are their expectations? We conducted a Q-methodological study. Q methodology
Summary

is a mixed quantitative-qualitative research method to studying subjectivity, such as people’s viewpoints, beliefs, attitudes and opinions. The study revealed four different perspectives on medical training reform: the accountability perspective, the educational perspective, the work-life balance perspective, and the trust-based perspective. The different perspectives reflect current debates in medical training on, on the one hand, the importance of transparency about and the quantification of residents’ capabilities and accountability in taking care of patients, and protecting ‘old school’ models of professional training which basically rely on relationships of trust on the other. The work-life balance is a slightly different perspective, as this is more about the importance of the learning climate and possibility to combine residency training with a private life. The work-life balance perspective reflects current normalization - and, with that, demystification- of medical training and medical work more broadly.

Chapter Three turns to the topic of medical professional governance. Here we conduct a comparative historical institutional analysis of medical training reform in the United Kingdom and The Netherlands. Drawing on theories of institutional change we explore current transformations in the medical training regime and the consequences for the capacity of the medical profession to govern medical residency training. The chapter shows that in both countries the medical training regimes have shifted from a predominantly professionally controlled system into regimes of coregulation, though in quite different ways and pace. In the United Kingdom, the transformation process had already started in the 1960s and 1970s. The more gradual process was interrupted in the late 1990s, when growing distrust in the medical profession provided the British government with the authority to claim partial control over the medical training system. However, by attempting to wield medical education to improve the NHS, and by rushing past the objections of the medical profession it provoked a revolt of practicing clinicians against the government as well as their own professional bodies. The debacle led to a renegotiation of authority in the medical training regime, putting in place new governance arrangements of coregulation.

Compared to the British case, the Dutch reforms underwent a far more deliberate process, though not less contested. Here the reforms can be characterized by a process of institutional layering through which new governance arrangements have been introduced along existing ones. It is along these alternative trajectories that, from the 1960s onwards, changes in regulatory bodies gradually enforced state
authority in the medical training regime. These changes induced state-profession coalitions in which hospital organizations increasingly took part. The introduction of regulated competition in the overarching health care system in the 2000s - more particularly the introduction of the Education Fund - seemingly unintentionally enhanced the process of governance change. The fund opened up the traditional closed practices of training post allocation, providing other stakeholders (that is, the government and hospital boards) with new incentives and means to intervene in the process, enforcing mutual dependency in the medical training regime.

Overall, the analysis contributes to the current debate on institutional transformation by demonstrating the necessity of detailed (historical) empirical analysis for our understanding of on- and off-path change. We stress the need to study the interactions among political context, the properties of institutions, and negotiating authority processes as they are crucially important to understanding institutional transformation.

In Chapter Four we turn to the clinical work place to explore the governance of residency training in daily practice. The chapter examines current trend of increasing visibility among medical residents. Following the new training requirements, residents have to act under close supervision of clinical supervisors and are only allowed to perform clinical procedures on “real patients” when they have proven their capabilities. Drawing on the medical sociological body of literature on medical education, we explore how the visibility of medical residents is enacted in everyday clinical work, what aims these visibilities serve and how they are coordinated.

The chapter shows that in everyday clinical work multiple practices of residents’ visibility coexist. We list four of these visibilities: staging residents, negotiating supervision, playing the invisibility game and filming surgical procedures. The chapter demonstrates how the different visibilities are flexibly brought together to serve the two central and in principal conflicting goals of good patient care and good education. Whereas patient care asks for experience, expertise and close supervision, medical training requires practice and ‘invisibility’ of medical residents. We show how both attending physicians and residents persistently tinker with visibility to serve both of these aims and how they are coordinated in everyday work.

Moreover, the chapter adds to traditional sociological accounts of medical education by shifting the focus from medical education as a social institution to the
Summary

practices of residency training itself. A practice-oriented approach not only focuses on the social implications of medicine but highlights the practices and contingencies of everyday clinical work, the (sometimes conflicting) values and purposes that emerge as well as the way in which medical practitioners deal with these. Such a focus on practice helps to gain an understanding of how the current reform challenges clinicians’ educational activities.

In Chapter Five we take the analysis of daily training of medical residents further by examining how contemporary reforms in medical training intervene in the social interactional order of clinical practice and in the position of medical residents, and how this influences the learning opportunities for medical residents. We use Erving Goffman’s concept of social interactional order and Trevor Pinch’ recent social technical explanation of Goffman’s work to examine how the social interactional order of medical training practice is reconfigured through contemporary reforms in medical training and how participants seek to (re)negotiate these changes. We argue that physician-resident interactions can be conceived as a social interactional order of clinical care delivery in which residents must negotiate a more central position by performing well in order to conduct clinical procedures. During training, residents move from the periphery to the center of medical work in a process that is embedded in, and mediated by, the socio-technical environment of clinical practice. Personal relationships, based on numerous resident-attending interactions underpin this transition. Residents must become familiar with and act along with (tacit) local rules and habits, they must to get to know the nurses and the geography of the building, as well as the (personal) expectations and preferences of the attending physicians to be able to present themselves as reliable and skilled practitioners and obtain a central place in the social interactional order.

However, current reforms in medical training such as the limitation of resident duty hours and the standardization of resident assessment, tend to underplay this process as they create social distance between attending physicians and residents. As a consequence, residents are relegated to more peripheral stages of learning. Yet the paper also shows how these unexpected and unwanted consequences of current reforms are repaired by relinking changes with clinical work.

The chapter adds to current policy debate on medical training reform by pointing out that personal relationships of trust and hands-on practices of training are crucial for good medical education.
In chapter Six we conduct a multiple-level analysis of medical training governance change. We deal with the question how medical training reform is enacted at different sites (in policy making, the clinical workplace, the medical associations, educationalists and all kinds of meetings pertaining to the reform of residency training) and how the interplay between these reform activities leads to new governance arrangements. The chapter seeks to provide broader lessons about medical governance evolvement by examining how policies and policy ideas are developed and negotiated, how they ‘travel’ between sites and how these are ‘fleshed out’ in everyday practice. As such, we aim to overcome the classic sociological conflict model that sets the (medical) profession on the one site and ‘external actors’ (the state, managers) on the other.

The chapter shows how the convergence of both ‘internal’ and ‘external’ reforms have led to an increasingly diffused constellation of interests and authority in medical residency training. This shift has been driven by three related and interacting processes. First, a group of entrepreneurial physicians aimed to enhance the quality and timeliness of medical residency training by introducing educational tools and methods. To this purpose they entered into new coalitions with educationalists and government representatives. Second, educational tools turned out to be important carriers and mediators of institutional change as they, as managing epistemic objects, reconfigured traditional training practice and framed the notion of ‘good residency training’. Third was the shift of interest of other stakeholders. In the chapter we show that following substantial changes in the policy context (particular the introduction of regulated competition in Dutch health care) formerly marginalized stakeholders in postgraduate medical education developed a renewed interest in residency training. These three broad processes led to an increasingly diffused constellation of interests and authority in medical residency training. Stakeholders’ interests increasingly have become entangled, despite their basic differences and conflicting aims. We argue that the concept of entanglement provides an interesting concept to the understanding of contemporary medical governance change.

Chapter Seven are the Conclusions. Here we turn to the main questions of the book, reflect on our methodological and theoretical approach, and sketch the societal implications of the research. We argue that the ‘modern doctor’ will be not so much different from the doctors treating us today. Old values, traditional practices, new ideologies and expectations have intertwined in everyday clinical
Summary

practice. This entwinement of ‘old’ and ‘new’ is also visible in the governance of medical education; although medical doctors are still responsible for training new recruits, they have become increasingly dependent on other actors setting and fulfilling their training duties.

Drawing on the work of Steven Shaping and Charles Bosk we point at two important findings of our study. First is the shift from attending-residents relationships based on trust as ‘familiarity’ to trust based on ‘laity’ (measurable performance). We argue that the loss of personal relationships is at the expense of residents’ learning space. Yet learning space is crucial when learning to doctor. Second, we observe a shift from patient safety as a collective practice to an emphasis on patient safety in single doctor-patient interactions. Although we underscore the importance of patient safety, we also point at the danger if residents are not longer able to learn to deal with uncertain clinical situations.

Finally, the chapter emphasizes the importance of multidisciplinary and multiple-sited research to come to an in-depth understanding of (the consequences of) medical (educational) reform.