

Postgraduate Training Around the World

Go North young woman—a look at Finnish specialist training

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Introduction

Finland is the European Reporting Country for the World Health Organisation Programme of Health for All by the year 2000. When one considers that this nation of just under 5 million inhabitants achieved full independence only in 1917, its steady push towards a comprehensive health care system is remarkable by any standards. Its origins go back to the District Doctor system of its Swedish neighbour, but in the 1950s and 1960s an extensive hospital building programme took place (19,000 general hospital beds, and 11,000 psychiatric beds in 25 years). Virtually all Finnish nationals are covered by health insurance—a universal scheme was introduced in 1964.

In 1972 the Primary Health Care Act swung the emphasis, and the funding, towards community care, embodied in the Health Centre – of which there are now about 200 in Finland, each providing a comprehensive range of services – not only doctors, but nurses, physiotherapists, dentists, laboratory technicians, nutritionists, social workers, and in some areas, hospital beds. The most important administrative unit of the Finnish system is the local (elected) municipality – there are about 460 in Finland – some of which share in the cost of hospitals and health centres. About 50% of the money comes from central government, however, and together with the municipalities five year health care plans are devised, updated each year so that they are constantly in force. The eventual split in costs between central and local government to some extent depends on the wealth of the local municipality, and its level of agreement with overall national plans.

Despite the increased expenditure on primary care, only about a quarter of Finland's 12,000 doctors work in health centres. Over 40% still work

in hospitals exclusively. Furthermore there is a thriving private sector, which accounts for nearly a fifth of national health care expenditure overall. In one study in the early 1980s it was found that about 25% of patients seeking medical help in the community attended a private health clinic – 10% of them going to a private clinic only. This trend may be reversed by the now growing emphasis on vocational training in general practice – a curiously late development in Finland. Furthermore an increasing proportion of women are entering medicine (nearly 70%), and many opt for general practice.

Medical education

There are about 20 universities in Finland, but only 5 have medical faculties. The first was established by the Swedes in Turku (then the capital city) in 1641. Sadly, Turku was largely destroyed by fire, and the University was transferred to Helsinki in 1828. A new University in Turku did not materialize until 1940.

In the 1960s and 1970s three new medical schools were established to meet the growing demands of health care, particularly in hospitals. These were at Oulu (1960), and Kuopio and Tampere (1972). Nowadays around 500 medical students graduate each year. Entry to medical school is by competitive examination, in biology, chemistry, physics, and psychology. A considerable element of book learning by rote is required to pass this exam, and many more girls than boys qualify. Consequently the intake of many medical schools is two-thirds female at least. My suggestion that the UK system of allocating 50% of places to boys and girls equally is sexually fairer, was met with indignation by at least one Finnish Dean, on the grounds of 'discrimination against women' – food for thought!

Some medical schools are showing interest in Swedish trends towards allocating, say, 10% of medical school places to a discreet cohort of school

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leavers selected for their 'scientific' promise, and presumably destined for research. The entry requirements for such students would be more exacting and scientifically orientated.

Basic medical education follows fairly well established processes, through pre-clinical to clinical studies, then an Internship. The Internship lasts 6 months, and is regarded as a practical part of the training – levels of responsibility are less than for fully licenced physicians. A modest salary is paid during the Internship.

In some medical schools, notably Helsinki, medical students might share periods of training with students from other disciplines related to health care, such as Health Care Services studies; and there is close collaboration with faculties of political science and education.

Finnish medical students are given the opportunity to comment on their experiences at the end of the course, and some are increasingly critical. In particular, there is concern about too little exposure to common clinical disorders – the teaching hospitals provide perhaps a too specialized spectrum of disease, and appear to be under increasing pressure of work. The problems are compounded by a shortage of nurses (low pay, hard work), and up to 10% unfilled medical posts. The latter is due to several factors – the increasing numbers of female doctors on maternity leave, the growth of private practice, foreign travel (possibly up to a quarter of all Finnish doctors spend some time in the United States), and increasing demand.

Furthermore, national policy, and the linguistic barrier, does not allow for much importation of foreign doctors – only around 100 work in Finland.

All this militates against adequate time for teaching. Increasingly this may be found in the non-teaching hospitals, who welcome a higher exposure to medical students because it is thought they will return later to fill their 'service' posts. However, not all students view this with delight, because many still see their destiny in the teaching centres. Overall, however, this should have a positive effect on the impetus towards primary medical care. There is apparently little career counselling in medical schools.

After qualifying, doctors in Finland are obliged to undertake an 'orienting' year which consists of 6 months in a hospital and 6 months in general practice. This orienting year is universal throughout Scandinavia. It is not always popular with doctors, who sometimes complain of little training during these posts. The posts are controlled by the National Board of Health (NBH), not the Universities, and only on completion of this year is a doctor fully licensed for independent or private practice by the National Board.

There is a further year of post-basic training between the orienting year and specialist training.

However, although compulsory, this year can be taken during, or even after, specialist training. However, the content and timing of this year will be determined by the university which accepts a doctor for specialist training, and it cannot be avoided.

Specialist training

Specialist training otherwise involves a 4-year program, following acceptance by one of the 5 Universities. Two further years are required for a subspecialty. Competition for places on training programs is fairly stiff, but once enrolled, the trainee's path is fairly clear. Originally the whole process of accreditation and licensing was in the hands of the NBH – the top administrative health body in Finland – but now accreditation is largely in the hands of the University faculties (and hence the Ministry of Education). NBH now have a more limited 'authorization' role, although it contains a body which concerns itself with the principles of postgraduate specialist training. Licences are granted in 32 specialties, and 57 subspecialties.

At least 2 of the 4 years have to be spent in a teaching hospital – in practice it is often 3 years. The remaining time is spent in a 'generalist' hospital. One fifth of Finnish doctors also submit a scientific dissertation, a requirement for the title of Doctor of Medicine. Years spent away from Finland – in the USA for example – are usually regarded as 'extra' years, to enhance a doctor's experience, but occasionally they count towards the 4-year training program. In addition, the trainee has to attend a prescribed number of hours, or 'credits' of formal teaching – 400 over the training period would be the norm. These 'in house' teaching sessions would be provided by the University and are needed by them to obtain recognition as teaching hospitals. A further 80 credits of teaching are needed, from outside activities, provided by specialist societies, the Finnish Medical Association, and other learned bodies such as Finnish Medical Society Duodecim. These sessions are accredited separately by the medical faculties.

The trainee may also have his or her training program mapped out on paper, particularly in surgical specialties, where a clear, written graded or step-wise path is provided, indicating an expected increasing surgical expertise throughout the 4 years. At the end of the 4-year training program, there is an exit examination – a large proportion of which is based on specialist publications from recent editions of selected relevant journals.

There is no formal career counselling system for hospital doctors, as suggested recently for the UK, although trainees no doubt discuss matters with their seniors or peers. Each hospital has an

'ombudsman', who is mainly concerned with trouble shooting on conditions of employment. This area is also covered by membership of the Finnish Medical Association – taken out by almost all Finnish doctors. The state system of maternity leave is extremely generous – one year can be taken on about 80% pay, which can be utilized by the husband if that is the wish of the couple. Further years are also available. In addition Finland has a well developed system of child day care, and even night and evening care, and an Act of 1984 guarantees by 1990 either day care, or a child allowance, for parents of all children under three. The train that took me from Helsinki to Turku had one entire carriage given over to providing a large nursery/playroom for mothers with small children. I wondered who needed career counselling, given such a well organized and generous system.

General practice

What of general practice? Here, a similar training program is materializing, but is still in its infancy compared to that in hospitals. As already mentioned, until recently a majority of Finnish medical graduates opted for a hospital specialist career. The old system of medical officers of health was poorly regarded by the medical profession as a whole, although they were often well-enough liked by their patients.

Even now, in the absence of organized or legally binding vocational training programs, doctors can still go straight into primary care – public or private – immediately they are fully licensed. Equally, there appeared to be problems in the newer health centres, in terms of whether nurses or doctors had the 'leadership' role.

The first chair of general practice was established in Helsinki in 1981, and the first department was set up the following year in that University. Up until 1981, teaching of general practice had been given by the university departments of Public Health Science.

Initially the program covered undergraduate training, and continuing education for GPs. But at the same time, a degree course in Health Services Studies was started, and designed to be closely integrated with training for general practice. This ensured the goal of training medical students, and subsequently GPs, in all aspects of health care delivery, and practice management. Similar courses already existed at the new Universities of Koupio and Tampere, but entrants had to have a nursing degree. In Helsinki, entrants to the health services degree course are from a mixed background, including doctors, and can choose modules for nursing, management, and teacher training. Doctors can also take a 2-year post-

graduate course in management.

The department in Helsinki finally became responsible for vocational training in general practice in 1988. The program is similar to that for hospital specialists, with 2 years in general practice, and 2 years in hospital, and an exit exam. The hospital modules are more out-patient orientated. By 1991 there will be 110 training posts in health centres and hospitals. Much of this was made possible by the signing of an agreement between the University and City of Helsinki in 1986. The University teaching staff have part-time positions in the health centres.

The University department of general practice has an extensive research program, some of which is conducted in collaboration with the city health department. Particular emphasis is placed on evaluative research, such as efficient organization of appointment systems, physiotherapy departments, home care, etc.

A vigorous continuing education program is also underway, providing, for example, 15–17 one week courses annually, many in collaboration with other hospital departments. Some of these take place in a beautifully equipped education centre in Lahti, just north of Helsinki. Needless to say, the department also trains its own trainers – both for undergraduate and vocational training. (Trainers are separate for these two programs.) GP trainees are obliged to attend 120 outside 'credits' of education (20 of them in administration). Once trained though, a GP only has to attend one course per 5 years – but many attend more.

With similar developments taking place in the other 4 universities, albeit with local variations, there must surely be a boost in recruitment of medical graduates into primary health care. Time will tell, but the strategy towards the year 2000 is based on an increase of 28% of resources in primary health care, but 13% in specialist health care. The emphasis is on promotion of healthy life habits, reduction of preventable health risks, and development of health services. Finland has some well known problems to tackle – such as unhealthy eating, smoking, psychological problems and suicide, particularly in lone socially disadvantaged males.

Conclusions

Does the Finnish system of medical education have any lessons for the UK? It is clearly difficult to compare two such diverse nation states, but certain elements of the Finnish system are attractive.

One is struck by the coordinating role of the Universities in all aspects of medical training, from entry-point to medical school, right the way through to continuing education for fully trained

specialists and GPs.

There appears to be a more democratic public contribution to local priorities for provision of health care, embodied in the system of elected municipalities. (We have to ask ourselves whether the new Purchaser District Health Authorities in the UK will be so accountable.) This is placed into yet sharper focus by the degree of collaboration between these basically political and public bodies, and the universities they partially fund. Combine that with the State and Communal 5-year plans, and one perceives a wholeness that must be rare among nations.

Within this environment, women – both doctors and their clients – are clearly at some advantage compared to their UK counterparts, especially considering the generous availability of maternity and child care benefits.

If there is a negative side, the UK system of training for general practice is notably ahead of its Finnish counterpart, a factor largely responsible for the quite opposite career aspirations of British doctors. But like so many aspects of this remarkable country, it will catch up, and perhaps overtake us, if one considers how their system is combining, from the outset, elements such as management, quality, audit, prevention, health education, and overall efficiency and effectiveness of health care delivery. De-centralization of decision making processes – down to the level of individual physicians – is also occurring in Finland.

Some of these supposedly ‘Thatcherite’ impositions are probably of more inherent importance to a nation whose health care system carries a uniquely emphasized tradition of community service. This is not to suggest that Finnish doctors have less

clinical freedom, but one wonders if the controlling ‘municipal’ hand is felt, particularly in primary care. If this control is exercised by the Voting Finn, is this such a bad thing? It is interesting to note some similarities in the new contract for British GPs. One other big difference, however, is that the dissatisfied Finnish customer can (and does) just go round the corner to the private clinic!

Every year, about one third of all Finnish doctors gather for an enormous educational jamboree, with hundreds of lectures, seminars, and workshops. It would be nice to be there, but before the girls reach for their suitcases and passports, a word of warning: a complete grasp of the Finnish language is mandatory. There are 15 cases, and many words are unique among European languages – although because of similarities of origin, a working knowledge of Hungarian would come in handy. However, perhaps significantly, there is no grammatical gender, no distinction between ‘he’ and ‘she’. If asked which European country first gave women the vote, finding the answer should not be difficult.

One final question I forgot to ask my Finnish hosts, bearing in mind the trend in education to home based learning, was whether one could earn a ‘credit’ for an hour in the sauna with a textbook.

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