POLIITIKAUURINGUTE KESKUS

PRAXIS

# Arstide residentuuriõppe vastavus WFME rahvusvahelistele standarditele: Eesti, Läti ja Leedu võrdlev analüüs

NORDPLUS Horizontal

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## Toetajad:

Vootele Veldre tegi osa Eestit puudutavast uurimistööst, mis avaldati poliitikaanalüüsina, ning korraldas uurimistööd Lätis ja Leedus. Praxise analüütik Laura Aaben tegi lõpparuande põhiosa kvaliteedikontrolli. Praxise analüütik Sandra Haugas aitas kaasa kvalitatiivsete andmete kogumisele Eestis.

*Analüüsi tellis Eesti Nooremarstide Ühendus projekti „Arstiks kasvamine Läänemere regioonis – Balti riikide nooremarstide võimestamine“ raames (mida rahastas osaliselt programm Nordplus Horizontal ning osaliselt Eesti Nooremarstide Ühendus, Eesti Sotsiaalministeerium, Tartu Ülikooli Kliinikum ja Ida-Tallinna Keskhaigla).*

*Poliitikauuringute Keskus Praxis on Eesti sõltumatu mittetulunduslik mõttekoda, mis toetab kaasamisele ja analüüsile rajatud poliitikakujundamist. Praxis on poliitikauuringuid teinud üle kümne aasta. Praxise eesmärk on sõltumatute uuringute tegemise ja avaliku arutelu ärgitamise kaudu parendada ja toetada poliitikakujundamist.*



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# Lühikokkuvõte

Arstide residentuur on väljaõppe osa, kus juhendajate järelevalve all omandatakse eriarsti tööks vajalik pädevus. Residentuur järgneb arstiteaduse ja hambaarstiteaduse põhiõppele. Residentuuriõpe on Balti riikides pälvinud palju kriitikat, kuid seni pole tehtud ühtki uuringut, milles oleks residentuuriõpet teaduslike meetodite abil analüüsitud. Uuringu eesmärk oli analüüsida, kuidas on residentuuriõpe Balti riikides (Eestis, Lätis ja Leedus) korraldatud, et teha kindlaks selle tugevused, nõrkused ja võimalused ning aidata kaasa residentuuriõppe arendamisele. Sel eesmärgil hinnati, mil määral vastab residentuuriõpe Balti riikides rahvusvahelistele standarditele. Uuringut võib pidada Balti riikide residentuuriõppe esmakordseks süstemaatiliseks analüüsiks.

Balti riikide residentuuriõppe praeguse olukorra analüüsimisel lähtuti Maailma Meditsiinihariduse Föderatsiooni (World Federation for Medical Education, WFME) ülemaailmsetest kvaliteedistandarditest. Balti riikide konteksti silmas pidades koostati WFME 254 algse standardi alusel lühem versioon, mis koosneb 56 standardist.

Uuring korraldati aastatel 2016–2018. Mitmekülgsuse nimel kombineeriti uuringus kvantitatiivseid ja kvalitatiivseid meetodeid. Kolmes valitud riigis (Eestis, Lätis ja Leedus) tehtud uuring koosnes neljast põhietapist: 1) dokumendianalüüs, 2) andmete kogumine ja analüüs, 3) standardite hindamine, 4) poliitikaanalüüside ja soovituste koostamine.

Analüüsist selgub, et residentuuriõppe korraldus on riikides, baasasutustes, osakondades ja erialadel erinev. Vaadeldud riikides vastab residentuuriõpe täielikult vaid mõnele rahvusvahelisele standardile. Kokkuvõtvalt iseloomustab Balti riikide residentuuri vastavust WFME standarditele andmete vastuolulisus. Peamised leitud probleemid on: residentuuriõppe raamdokumentide ebaõige rakendamine baasasutustes, juhendamise ebaühtlane kvaliteet, residendi pädevuste hindamise puudumine, pehmete oskuste ning teadusliku argumenteerimisoskuse ja metoodikaga seotud oskuste õpetamisele järjepideva lähenemisviisi puudumine, piisava ja regulaarse tagasiside, sh arengut toetava hindamise puudumine. Uuringule toetudes koostas Praxis nimekirja olulisematest poliitikasoovitustest, mis Eestis, Lätis ja Leedus residentuuriõppe olukorda parandaksid.

# Sisukord

# 1. Sissejuhatus

**Arstide residentuuriõpe** on meditsiinihariduse etapp, mis järgneb põhiõppele ja mille jooksul arstid omandavad juhendajate järelevalve all erialase pädevuse (Garofalo ja Aggarwal, 2017, lk 540). Siinses uuringus kasutatakse mõistet „**resident**" ja sellega viidatakse arst-residendile ehk teisisõnu arsti/hambaarsti põhiõppe läbinud arstile, kes õpib edasi residentuuris arsti või hambaarsti erialal.

Laiemalt on residentuuriõppe praegune sõlmküsimus Euroopa residentuuriprogrammide ühtlustamine, et tagada Euroopa Liidu liikuval tööturul väljaõppe ja kutseoskuste hea kvaliteet (Kuzman, Norstrom, Colin, Oakley ja Stoklosa, 2012; Pihlak, 2015, lk 401–402; Sivera jt, 2016). Balti riikide residentuuriõpet on kritiseeritud meedias,[1] erialaallikates[2] ning mõnel kohalikul ja piirkondlikul kutseala üritusel (näiteks Balti nooremarstide foorumil, mis toimus 2015. aasta aprillis Leedus Kaunases).

Seni pole tehtud ühtki uuringut, mille käigus oleks kogu residentuuriõpet teaduslike meetodite abil analüüsitud. See uuring korraldati seoses rahvusvahelise projektiga „Arstiks kasvamine Läänemere regioonis – Balti riikide nooremarstide võimestamine", mis viidi ellu aastatel 2016–2018. Projekti eesmärk oli kolme Põhjamaade partneri – Soome (Soome Nooremarstide Ühendus), Norra (Norra Nooremarstide Ühendus) ja Rootsi (Karolinska Instituut) – toel soodustada Balti riikide (Eesti, Läti, Leedu) nooremarstide ühenduste püsiva võrgustiku kujunemist, mis annab neile paremad võimalused poliitikadialoogis osalemiseks. Selle üldine siht oli kiirendada residentuuriõppe arengut Balti riikides.

## 1.1. Uuringu ulatus

Uuringu eesmärk oli analüüsida, kuidas on residentuuriõpe Balti riikides (Eestis, Lätis ja Leedus) korraldatud, et teha kindlaks selle tugevused, nõrkused ja võimalused ning aidata kaasa residentuuriõppe arendamisele. Sel eesmärgil hinnati, mil määral vastab residentuuriõpe Balti riikides rahvusvahelistele standarditele. Uuringu tulemusi saab kasutada residentuuriõppe kvaliteedi parandamiseks Balti riikides. **Seda uuringut võib pidada Balti riikide residentuuriõppe esmakordseks süstemaatiliseks analüüsiks.**

## 1.2. Uuringu metoodika

### 1.2.1. WFME standardid uuringu raamistikuna

Kuna analüüsi eesmärk oli hinnata eelkõige Balti riikide residentuuriõppe kvaliteeti, kasutati uuringu raamistikuna Maailma Meditsiinihariduse Föderatsiooni (World Federation for Medical Education, WFME) ülemaailmseid kvaliteedistandardeid (edaspidi **WFME standardid**, 2015. aasta versioon).

[1] Näiteks: http://epl.delfi.ee/news/eesti/kolmandik-residente-valvab-haiglas-uksi-ehkki-reeglid-seda-ei-luba?id=72033407, http://www.la.lv/jaruna-ar-pacientiem-un-politikiem, https://www.youtube.com/watch?v=C_xZH7yWjaI, https://www.delfi.lt/news/daily/lithuania/medikai-isejo-i-gatves-geriausi-zmones-palieka-sali.d?id=76807563

[2] Näiteks: https://www.jauniejigydytojai.lt/single-post/2017/12/28/Apie-k%C4%85-Jaun%C5%B3j%C5%B3-gydytoj%C5%B3-asociacija-kalb%C4%97s-Lietuvos-medik%C5%B3-mitinge-sausio-4-d; https://www.jauniejigydytojai.lt/single-post/2017/02/21/Jaun%C5%B3j%C5%B3-gydytoj%C5%B3-etapin%C4%97s-kompetencijos-nuo-prad%C5%BEi%C5%B3; Rācenis jt (2017). Jaunie ārsti Latvijas medicīnas notikumos. Latvijas Ārsts, detsember 2017.

WFME on mittetulunduslik valitsusväline organisatsioon, mille asutasid 1972. aastal Maailma Arstide Liit (World Medical Association, WMA) ja Maailma Terviseorganisatsioon (World Health Organization, WHO). Föderatsiooni eesmärk on parandada meditsiinihariduse kvaliteeti kogu maailmas (WFME veebisait, jaotis „About"). WFME meditsiinihariduse rahvusvaheliste standardite programmi elluviimist alustati 1998. aastal ja selle käigus töötati välja dokumendid, milles on määratletud WFME ülemaailmsed standardid (Lilley ja Harden, 2003). Eesmärk oli luua meditsiiniõppeasutuste ja -programmide riigisisese ja rahvusvahelise hindamise, akrediteerimise ja tunnustamise süsteem, et tagada meditsiinihariduse minimaalsete kvaliteedistandardite järgimine (Kokotailo, Baltag ja Sawyer, 2018). WFME standardid avaldati esimest korda 2003. aastal ja neid uuendati 2015. aastal (Garofalo ja Aggarwal, 2017; WFME, 2015). Residentuuriõppe kvaliteedi parandamise ülemaailmsed standardid hõlmavad üheksat valdkonda ja 36 alamvaldkonda ning 2015. aastal uuendatud standardid sisaldavad kokku 161 põhi- ehk miinimumstandardit, 94 kvaliteedistandardit ja 123 annotatsiooni (WFME, 2015).

WFME standardite aluseks on ülemaailmne ekspertide konsensus selle kohta, milliseid standardeid arstiteaduskonnad ja teised meditsiinihariduse pakkujad peaksid järgima kogu meditsiinihariduse ja -koolituse vältel, mis hõlmab arstide põhiõpet, residentuuri ja elukestvat õpet. WFME standardid jagunevad põhistandarditeks (miinimumnõuded) ja kvaliteedi parandamise standarditeks (WFME veebsait, jaotis „WFME Standards").

Riiklikud ja piirkondlikud kvaliteedi tagamise asutused võivad lähtuda WFME standarditest õppeprogrammide akrediteerimisel, samuti võivad arstiteaduskonnad ja muud haridusasutused kasutada neid enesehindamiseks ja -reformimiseks (Christensen, Karle ja Nystrup, 2007). Standardeid on sagedasti kasutatud nii arstiteaduskondade enesehindamisel (MacCarrick, Kelly ja Conroy, 2010) kui ka õppeprogrammide hindamisel (Al-Subait ja Elzubeir, 2012). Kuna huvi rahvusvahelise akrediteerimise vastu kasvab, rakendavad paljude riikide kvaliteedi tagamise asutused WFME standardeid arstiõppe akrediteerimiseks, et parandada meditsiinihariduse kvaliteeti arstide põhiõppe, residentuuriõppe ja täienduskoolituse tasemel (Fenoll-Brunet, 2016). Selle tulemusena on WFME standardeid kasutatud mitmesugustes uurimustes, näiteks on võrreldud kõrgkoolide arstiteaduskondade õppekavu residentuuriõppe ülemaailmse standardiga rahvusvahelise võrdluse vaatenurgast (Garofalo ja Aggarwal, 2017).

WFME standardite kasutamist meditsiinihariduse kvaliteedi hindamiseks on ka kritiseeritud. Väidetakse, et selle rõhuasetus on peamiselt protsessidel, mitte meditsiinihariduse programmide sisenditel, tulemustel ja mõjul (Boelen, 2016). Sellegipoolest on WFME standardeid rahvusvaheliselt laialdaselt rakendatud ja neid võib kasutada mallina, et määratleda standardeid, mis ulatuvad asutuse tasandilt riikliku tasandini (Kokotailo, Baltag ja Sawyer, 2018). WFME standarditele viidates väidavad Lilley ja Harden (2003), et meditsiinihariduse standardite tähtsus väljendub selles, et „need annavad meile tervikliku pildi õppekavast, olemasolevatest õppimisvõimalustest või eeldatavatest õpitulemustest ja hindamisest" (lk 351). Muu hulgas annavad WFME standardid võimaluse ühtlustada arstide valmisolekut iseseisvaks tööks rahvusvahelisel tööturul (DeMarco, Flotte, Kneeland, Seymour-Route ja Collins, 2015).

Kui kasutada WFME standardeid andmete kogumise ja analüüsi raamistikuna, tuleb uuringu teostatavust silmas pidades võtta arvesse mitmesuguste ressursside kättesaadavust ja muid piiranguid (Bickman ja Rock, 2008). **Seetõttu koostati selles uuringus algsete WFME standardite (N = 254) põhjal standardite lühem versioon (N = 56)**. Mõnd standardit kasutati sellisena, nagu see on sõnastatud algses WFME raamistikus, ja mõnd kohandati, ühendades kaks või enam standardit (vt lisa 1).

Standardite valik ja kohandamine põhinesid projektimeeskonna liikmete ja uurimistöö tellijaga peetud konsultatsioonidel. Kõiki standardeid hinnati, kusjuures lähtuti sellest, kui asjakohane on iga standard

Balti riikide kontekstis. Lisaks võeti arvesse iga standardi hinnatavust ja konkreetsust. WFME standardite üheksa valdkonna põhjal moodustati **neli valdkondade rühma**:

1. residentuuriõppe õiguslikud ja korralduslikud tahud,
2. residentuuriõppe kvaliteet,
3. hindamine ja tagasiside residentuuriõppes,
4. teadustöö roll residentuuriõppes.

Selle uuringu eesmärk oli **hinnata residentuuriõppe kvaliteeti, kasutades raamistikuna WFME standardeid.**

## 1.2.2. Uurimismeetodid ja andmete kogumine

Uuring viidi läbi kolme aasta jooksul (2016–2018). Et saada uuritavast teemast igakülgsem ja põhjalikum arusaam, kombineeriti kvantitatiivseid ja kvalitatiivseid meetodeid. Kolmes valitud riigis (Eestis, Lätis ja Leedus) tehtud uuring koosnes **neljast põhietapist**: **1) dokumendianalüüs, 2) andmete kogumine ja analüüs, 3) standardite hindamine, 4) poliitikaanalüüside ja soovituste koostamine.** Tulemused avaldati kahes etapis: kõigepealt kolm poliitikanalüüsi asjaomastes riikides ja seejärel lõpparuanne 2018. aasta detsembris.

### DOKUMENDIANALÜÜS

Selles etapis keskenduti standardite analüüsimisele ning valiti välja sobivaimad allikad hinnangute ja põhjenduste sõnastamiseks. Dokumendianalüüs hõlmas kirjanduse ülevaadet ja dokumentide analüüsi (keskenduti teemakohaste uurimistööde ja aruannete, õigusaktide ja muude kehtivate kirjalike eeskirjade, sealhulgas seletuskirjade analüüsimisele).

### ANDMETE KOGUMINE JA ANALÜÜS

Hinnangute sõnastamiseks vajalike andmete kogumisel kasutati triangulatsiooni. Kasutati järgmisi andmeallikaid ja analüüsimeetodeid: 1) dokumentide analüüs ja kirjanduse ülevaade, 2) veebiküsitlus, 3) seminarid kohalike sidusrühmadega, 4) individuaalintervjuud ja fookusgrupi intervjuud kohalike sidusrühmadega ning 5) e-posti teel saadetud ametlikud päringud asutustele.

*1. Dokumentide analüüs ja kirjanduse ülevaade*

**Dokumentide analüüs** hõlmas õigusaktide, poliitikadokumentide, poliitika ja uurimistööga seotud aruannete ning asjaomaste asutuste veebisaitidel esitatud teabe otsimist ja analüüsi.

Laiaulatuslik **kirjanduse ülevaade** koostati uurimisteemadest ja vastavatest otsingusõnadest lähtudes. Kirjanduse ülevaade piirdus eelretsenseeritud allikatega – asjakohaste teadusartiklite ja raamatupeatükkidega.

Valiku piiramine eelretsenseeritud teaduslike allikatega tagas selle, et kasutati ainult kvaliteetseid uurimistöid, milles käsitletakse põhjalikult ja tundlikult residentuuriõppega seotud teemasid. Eelretsenseeritud artikleid otsiti mitmesugustest teadusandmebaasidest, nagu ScienceDirect, Scopus, Taylor and Francis Online ja Web of Science. Teemakohase kirjanduse leidmiseks kasutati ka veebiotsingumootorit Google Scholar.

Dokumentide analüüsi ja kirjanduse ülevaate tulemusi kasutati selleks, et:

- analüüsida igas valitud riigis pakutava residentuuriõppe praegust olukorda;

- uurida välisriikide residentuuriõppe tavasid;
- analüüsida kõigis neljas uuringuraamistiku valdkonnas valitsevat olukorda;
- koostada veebiküsitluse küsimused;
- tõlgendada veebiküsitluse tulemusi;
- hinnata, mil määral vastab residentuuriõpe Balti riikides rahvusvahelistele standarditele, ja põhjendada hinnangut.

### 2. *Veebiküsitlus*

**Veebiküsitluse eesmärk oli hinnata residentide ja nende juhendajate residentuurikogemuse vastavust WFME standarditele. Veebiküsitluse jaoks sõnastati WFME standardid väidetena, mille paikapidavusele andsid vastajad hinnanguid 5-punktilisel Likerti skaalal. Iga küsimuse jaoks lisati märkuste lahter.** Veebiküsitlus korraldati igas riigis: Eestis 2017. aasta jaanuarist märtsini, Lätis 2018. aasta märtsist maini ja Leedus 2018. aasta märtsist aprillini. Küsitluses kutsuti osalema järgmisi rühmi:

- arst-residendid, kes olid küsitluse tegemise ajal residentuuris (sh need, kelle residentuur oli rasedus- ja sünnitus- või lapsehoolduspuhkuse või doktoriõppe tõttu peatunud);
- eriarstid, kes olid residentuuri viimase kahe aasta jooksul lõpetanud (või katkestanud): Eestis 2015. või 2016. aastal, Lätis ja Leedus aastatel 2016–2018;
- residentide juhendajad.

Ülikoolid saatsid küsitluses osalemise kutsed residentidele ja nende juhendajatele postiloendite kaudu[3]. Andmeid koguti SurveyMonkey[4] tarkvara abil. Eestis oli küsimustik eesti keeles, Lätis ja Leedus oli see inglise keeles (küsimustikud on esitatud lisas 2).

Valimi suurust kirjeldatakse alljärgnevas tabelis (tabel 1). Küsimustikud, mis sisaldasid ainult demograafilisi andmeid (sugu, vanus, eriala), kuid ei sisaldanud vastuseid sisulistele küsimustele, jäeti andmeanalüüsist välja. Samuti jäeti välja küsimustikud, mis tõenäoliselt esitati kaks või enam korda (see tehti kindlaks profiilide, st soo, vanuse, eriala ja IP-aadressi või vabas vormis esitatud märkuste sõnastuse kattuvuse kaudu)[5]. Peale kvantitatiivse teabe saadi kõigis Balti riikides üksikasjalikku kvalitatiivset teavet avatud küsimuste vastustes ja märkustes.

[3] Eestis saatsid kutseid ka õppebaasid.

Lätis palus ülikooli vastutav isik, kellel ei olnud kõigi juhendajate e-posti aadresse, erialade residentuuriprogrammide üldjuhendajatel edastada e-kirjad oma eriala juhendajatele. Juhendajate vähese aktiivsuse tõttu pöördus kohalik uurija ka enamiku Läti haiglate poole, saates e-kirjad haiglate juhtkonnale ja paludes saata küsimustiku edasi residente juhendavatele arstidele. Läti Nooremarstide Ühendus avaldas küsitluse lingi oma Facebooki-lehel.

Leedus võeti Leedu Tervishoiuülikooli residentide ja nende juhendajatega ühendust iga eriala residentide esindajate ja ülikooli töötaja kaudu. Vilniuse Ülikooli residentide ja nende juhendajatega võeti otse ühendust. Kuna Vilniuse Ülikool ei kogu residentide juhendajate e-posti aadresse, leiti need internetiotsingu abil ja seetõttu ei pruukinud küsitluse link jõuda kõigi juhendajateni.

[4] https://www.surveymonkey.com/

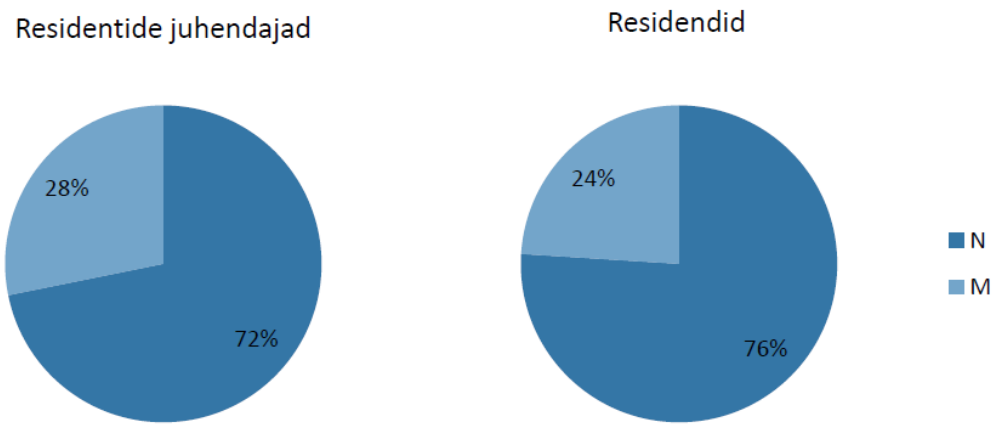
[5] Sellistel juhtudel valiti välja inforikkamad küsimustikud, mis olid esitatud üldjuhul hiljem.

**TABEL 1.** UURINGU VALIM

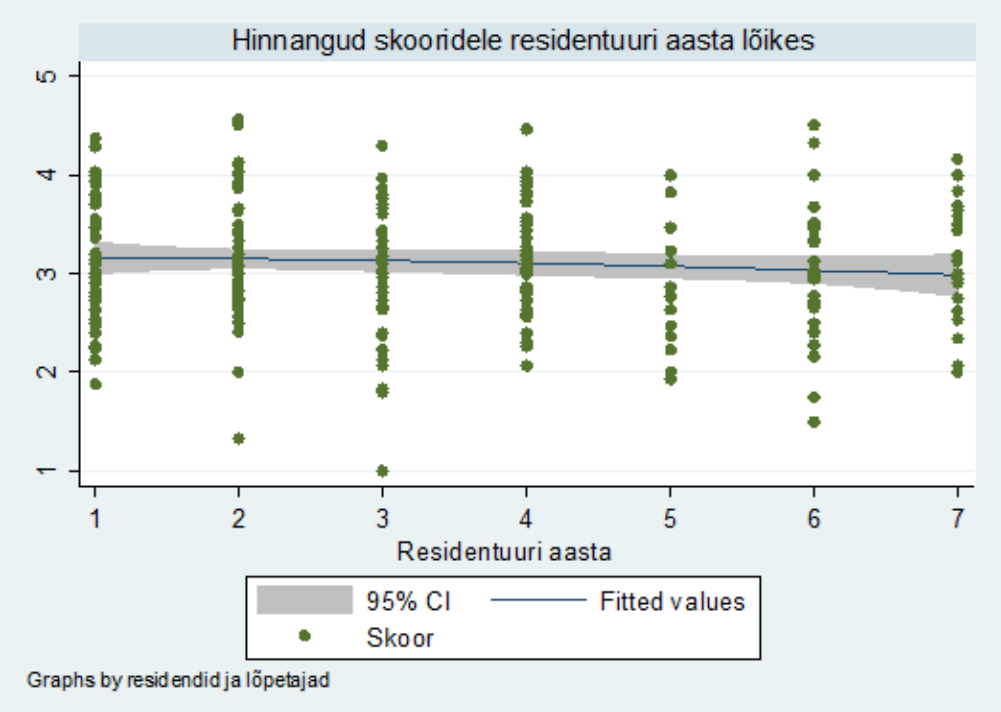
| | Saadud vastused (arv) | Analüüsi kaasatud vastajad (vastajate arv, %) | | Residendid (analüüsi kaasatud vastajate arv, %) | | Lõpetajad ja katkestajad (analüüsi kaasatud vastajate arv, %) | | Juhendajad (analüüsi kaasatud vastajate arv, %) | |
|---|---|---|---|---|---|---|---|---|---|
| **EESTI** | 600 | 454 | 75,7% | 218 | 48,0% | 55 | 12,1% | 181 | 39,9% |
| **LÄTI** | 337 | 221 | 65,6% | 138 | 62,4% | 27 | 12,2% | 46 | 20,8% |
| **LEEDU** | 471 | 261 | 55,4% | 178 | 68,2% | 42 | 16,1% | 41 | 15,7% |

Vastajate vanus registreeriti uuringu küsitluse osas (joonis 1), kuid vanuse erinevus ei tinginud erinevusi vastustes. Samuti ei sõltunud residentide hinnangud residentuurile nende soost (joonis 2) ega residentuuri läbimise aastast (joonis 3). Seetõttu ei ole analüüsi tulemustes eraldi esitatud seoseid vanuse ega ka residentuuri aastaga.


**Joonis 1.** Vastanute vanuseline jaotus Eestis (Residentuur, 2017)




**Joonis 2.** Vastanute sooline jaotus Eestis (Residentuur, 2017)




**Joonis 3.** Numbrilised hnnangud (skaalal 1 kuni 5) küsitlusankeedi vastustele residentuuri aasta lõikes Eestis

### 3. *Kohalikud seminarid*

Residentuuriõppega seotud peamiste probleemide väljaselgitamiseks korraldati kõigis Balti riikides **kohalikke seminare** peamiste sidusrühmadega: residentuuriõppe eest vastutavate partnerite (ministeeriumide ja ülikoolide), haiglajuhtide, tervishoiuvaldkonna kutseühenduste juhtide, patsiendiorganisatsioonide, residentide ja juhendajatega. Eestis korraldati kaks seminari 2016. ja 2017. aastal, Lätis üks seminar 2018. aastal ja Leedus üks seminar 2018. aastal. Neil üritustel (v.a Eestis 2016. aastal peetud seminaril) tutvustati iga riigi veebiküsitluse tulemusi ja korraldati ajurünnak, et leida teostatavaid lahendusi olukorra parandamiseks riigis. Arutelu tulemused kaasati igas riigis valminud analüüsi ja kokkuvõtvasse võrdlusanalüüsi. Seminare kasutati ka esialgsete järelduste ja hüpoteeside kontrollimise vahendina.

### 4. *Individuaalintervjuud, intervjuud fookusgruppidega ja kirjalikud päringud*

Eestis tehti sidusrühmadega neli poolstruktureeritud **individuaalintervjuud** ja kolm **fookusgrupi intervjuud** (uurimistöös kasutati ka mõnd osa residentuuriõppele pühendatud intervjuudest, mis tehti OSKA[6] tervishoiuvaldkonna uuringus). Lätis tehti sidusrühmadega kümme individuaalintervjuud ning Leedus saadeti kaks kirjalikku päringut ja tehti neli individuaalintervjuud. Nende intervjuudega oli eesmärk koguda uuringu jaoks lisateavet ja kinnitada uurimistöö tulemusi pärast analüüsi lõpuleviimist. Kõik intervjuud salvestati. Sõltuvalt uurijate vajadustest transkribeeriti mõned intervjuud.

Kui ilmnes lisateabe vajadus, siis koguti lisaandmeid, näiteks paluti saata ühe intervjuu käigus mainitud residentuuriõppe programmide eksperthindamise aruanded.

[6] OSKA analüüsib Eesti majanduse arenguks vajalike oskuste ja tööjõu vajadust lähema 10 aasta jooksul. http://oska.kutsekoda.ee/ (viimati vaadatud 27. septembril 2018)

## STANDARDITELE VASTAVUSE HINDAMINE

Võrdlusuuringu eesmärk oli võrrelda residentuuriõppe olukorda valitud riigis WFME standardite põhjal. Igas Balti riigis hinnati eeltoodud meetodite abil saadud andmete alusel standarditele vastavust numbriliselt ja põhjendati saadud hinnanguid.

Kokku analüüsiti 56 WFME standardit, mis olid kohandatud kohalikele oludele. Iga standardi täitmisele määrati numbriline väärtus, kasutades järgmist hindamisskaalat:

0 – residentuuriõppe praegune olukord ei vasta kuidagi standardile;

1 – vähesed või piiratud tõendid selle kohta, et residentuuriõpe vastab standardile;

2 – vastuolulised tõendid selle kohta, et residentuuriõpe vastab standardile;

3 – tugevad tõendid selle kohta, et residentuuriõpe vastab standardile, aga esineb mõningaid (väiksemaid) kõrvalekaldeid;

4 – vaieldamatud tõendid selle kohta, et residentuuriõppe praegune olukord vastab standardile.

Numbriliste väärtuste kasutamine muudab analüüsi tõlgendamise ja residentuuriõppe kvaliteedi võrdlemise riikide vahel lihtsamaks.

Kohaliku uurimisrühma liikmed lisasid numbrilistele väärtustele põhjendused, mis toetavad hinnangut. Hinnangud saadi ülalmainitud meetodite abil kogutud andmete triangulatsiooni põhjal. Hinnangute asjakohaseks aluseks peetakse ainult praegust olukorda (kehtivad õigusaktid) ja näiteid, mis kajastavad olukorda viimase 365 päeva jooksul (st 2016/17. aastal) ja 2018. aastal.

Balti riikide hindamistulemusi kasutati võrdlevas analüüsis eesmärgiga teha kindlaks kolme valitud riigi olulisemad sarnasused ja erinevused.

Et vähendada hindajate vahelist varieeruvust ja seeläbi suurendada riikide võrreldavust, standardiseeriti kõik hinnangud, arvutades need ümber *z*-skoorideks. See protseduur annab suurema kindluse väitmaks, et *z*-skoori väärtus 1 on sama tähendusega kõigis kolmes riigis, sest eri riikide hindajate hindamisskaala tõlgendused mõjutavad seda vähem.

Ümberarvutamiseks lahutati riigi igast hindamisskoorist ($x$) riigi kõigi 56 hinnangu keskmine skoor ($\bar{x}$) ja seejärel jagati tulemus riigi skooride standardhälbega ($s$):

$$z = \frac{x - \bar{x}}{s}$$

Riikide keskmised skoorid ja standardhälbed on esitatud tabelis 2.

**TABEL 2.** KÕIGI 56 STANDARDI ESIALGSETE NUMBRILISTE HINNANGUTE KESKVÄÄRTUS ($\bar{x}$) JA STANDARDHÄLVE ($s$) IGA RIIGI PUHUL

| | Eesti | Läti | Leedu |
|---|---|---|---|
| $\bar{x}$ | 1,86 | 2,13 | 2,02 |
| $s$ | 0,86 | 0,95 | 0,75 |

Näiteks kui Lätis anti standardile hinnang 2, arvutati selle standardi *z*-skoor järgmiselt:

$$z = \frac{2 - 2{,}1250}{0{,}9547} = -0{,}1309 \approx -0{,}13.$$

Iga riigi puhul on z-skooride keskväärtus 0 ja standardhälbe väärtus 1, sealjuures vastavad z-skoorid normaaljaotusele. See on üldiselt aktsepteeritav ja laialdaselt kasutatav skooride standardimise viis, mida kirjeldatakse enamikus statistikaõpikutes (nt Field, 2013). Esialgsete numbriliste hinnangute ja z-skooride võrdlus on esitatud lisas 4. Z-skoori keskväärtus 0 vastab aruande kontekstis hinnangule „vastuolulised tõendid selle kohta, et residentuuriõpe vastab WFME standarditele". Negatiivne skoor tähendab seega, et see on allpool keskmist ja iga positiivne skoor on ülalpool keskmist. Et standardhälve on 1, on skoor –1 keskväärtusest märkimisväärselt madalam ja skoor 1 on keskväärtusest märkimisväärselt kõrgem hinnang. Skoorid –2 ja 2 näitavad suurt erinevust keskväärtusest. Lihtsuse huvides kaardistasime z-skoorid eespool kirjeldatud skaalal järgmiselt:

–2 – residentuuriõppe praegune olukord ei vasta kuidagi standardile;

–1 – vähesed või piiratud tõendid selle kohta, et residentuuriõpe vastab standardile;

0 – vastuolulised tõendid selle kohta, et residentuuriõpe vastab standardile;

+1 – tugevad tõendid selle kohta, et residentuuriõpe vastab standardile, aga esineb mõningaid (väiksemaid) kõrvalekaldeid;

+2 – vaieldamatud tõendid selle kohta, et residentuuriõppe praegune olukord vastab standardile.

Analüüsides esitatakse mõlemad hinnangud, st esialgne numbriline hinnang ja standarditud hinnang (vt lisad 4 ja 5).

### POLIITIKAANALÜÜSIDE JA SOOVITUSTE KOOSTAMINE

Uuringu eesmärk oli esitada asjakohaseid poliitikasoovitusi, mille aluseks olid eespool kirjeldatud uurimismeetodite rakendamise tulemusena saadud teadmised. Poliitikasoovitustes pakuti välja realistlikud ja teostatavad viisid residentuuriõppe praeguste puuduste kõrvaldamiseks kõigis kolmes Balti riigis.

Kõigepealt töötati igas riigis välja esialgsed poliitikasoovitused, lähtudes dokumendianalüüsi ja veebiküsitluste tulemustest. Neid arutati kohalike seminaride, individuaalintervjuude ja fookusgruppidega tehtud intervjuude käigus ning pärast kogutud uurimistulemuste analüüsimist arendati neid edasi. Poliitikasoovitused avaldati kõigepealt riigipõhistes poliitikaanalüüsides, mis koostati ja avaldati siinsest aruandest eraldi ning milles keskenduti esmajoones küsitlustulemustele. Eesti puhul avaldati esmane riigipõhine poliitikaanalüüs juba 2017. aastal enne individuaalseid ja fookusgruppidega tehtud intervjuusid, mistõttu põhinesid selles sisalduvad hinnangud ja poliitikasoovitused suuresti dokumendianalüüsi ja veebiküsitluse tulemustel. Kolm riigipõhist poliitikaanalüüsi on järgmised:

- Veldre, V. (2017). *Residentuur Eestis – Kuidas edasi?* Tallinn: Poliitikauuringute Keskus Praxis. http://www.praxis.ee/wp-content/uploads/2017/02/Residentuur_Eestis_analyys.pdf (eesti keeles);
- Plakane, B. (2018). Rezidentūra Latvijā – izaicinājumi un izaugsmes iespējas. Tallinn: Poliitikauuringute Keskus Praxis. http://www.praxis.ee/wp-content/uploads/2017/02/Postgraduate-Medical-Education-in-Latvia_Policy-Brief.pdf (läti keeles);

- Grigaliūnaitė, K. & Pečkauskas, A. (2018). Rezidentūra Lietuvoje: bręstantis iššūkis. Tallinn: Poliitikauuringute Keskus Praxis. http://www.praxis.ee/wp-content/uploads/2017/02/Postgraduate-Medical-Education-in-Lithuania_Policy-Brief.pdf (leedu keeles).

Riigipõhiseid poliitikaanalüüse kasutati nii standardipõhiste analüüside tegemiseks (vt ingliskeelset lisa 5), kus kõrvutati residentuuriõppe olukorda iga standardiga eraldi, kui ka 2. peatükis esitatud võrdleva analüüsi tegemiseks. Siinses aruandes on iga riigi jaoks esitatud poliitikasoovitused ühendatud.

# 2. Vastavus rahvusvahelistele WFME standarditele: Eesti, Läti ja Leedu võrdlev analüüs

Selles peatükis võrreldakse residentuuriõpet Eestis, Lätis ja Leedus, kui analüüsitakse residentuuriõppe vastavust WFME standarditele. Peatükis käsitletakse tähtsamaid sarnasusi, erinevusi ja ühiseid probleeme iga valitud standardite rühma korral. Iga standardi järgimisele antud arvväärtused, st hinnangud selle kohta, mil määral riigis valitsev olukord vastab standardile, on esitatud lisas 4 olevas tabelis, kus on ära toodud andmed kõigi kolme riigi kohta.

Standarditele vastavusele antud arvväärtusi põhjendatakse ingliskeelses lisas 5. Need põhjendused koos peatükis 1.2 mainitud poliitikanalüüsidega on aluseks siinsele võrdlusanalüüsile, milles kasutatakse kogu uuringuperioodi jooksul kogutud andmeid (sh veebiküsitluste, individuaalintervjuude ja fookusgrupi intervjuude tulemusena saadud andmed) ja rakendatakse dokumendianalüüsi ning andmekogumise ja -analüüsi meetodeid.

Mitmes uuringus (nt Cranston jt, 2013; Pettoello-Mantovani jt, 2014; van der Aa, Goverde, Teunissen ja Scheele, 2016) on väidetud, et residentuuriõppe programmidest nähtuvalt on Euroopa riikide residentuuriõppe korralduses, sisus ja juhtimises suured erinevused. Balti riigid ei ole erand. Muu hulgas puudub ELis meditsiiniharidusega tegelev asutus. Seepärast jagunevad selle valdkonnaga seotud kohustused Euroopa Komisjoni talituste ja ametite vahel ning on leitud, et meditsiinihariduse haldamine Euroopa Liidu 28 liikmesriigis nõuaks asjakohast kooskõlastamist, mida toetavad piisavad kultuuriteadmised, tasakaalustatud strateegiline eesmärgipüstitus ja pidev järelevalve (Pettoello-Mantovani jt, 2014). Seetõttu on Euroopas tehtud katseid välja töötada ja rakendada nüüdisaegseid üleeuroopalisi õppekavasid, et ühtlustada praktika kvaliteedistandardeid ja residentuuri standardeid, tagada väljaõppe võrdne kvaliteet, edendada tööjõu liikuvust kogu Euroopas ning tõhustada koostööd ja parimate tavade jagamist (van der Aa, Goverde, Teunissen, Scheele, 2016). Euroopa Eriarstide Ühendus (European Union of Medical Specialists[7]) püüab kaasa aidata meditsiinihariduse parandamisele Euroopa tasandil, töötades välja meditsiinierialade Euroopa standardeid[8].

Et illustreerida residentuuriõppe korralduslikke erinevusi, kirjeldame lühidalt, kuidas residentuuriõpe on korraldatud kahes Põhjamaade riigis ja veel kolmes Euroopa riigis – Ühendkuningriigis, Madalmaades ja Saksamaal (vt lisa 3). Euroopa riikide hulgast valiti just need, sest lähtuti riigi lähedusest Eestile, usaldusväärsete teiseste ingliskeelsete allikate kättesaadavusest ning väiksemal määral ka võimalusest kirjeldada residentuuriõppe eri süsteemide eeliseid ja puudusi.

### EESTI, LÄTI JA LEEDU RESIDENTUURIÕPPE ÜLDKIRJELDUS

Balti riikides reguleerib residentuuriõpet seadus ja residentuuriõpe hõlmab mitut sidusrühma: residente, nende juhendajaid, praktilise väljaõppe baasasutusi ja teisi. Residentuuriõpe on teise taseme kõrgharidus, mis omandatakse töökeskkonnas ja mille eesmärk on varustada tervishoiusüsteemi kvalifitseeritud spetsialistidega. Kui Eestis ja Leedus piisab eriarsti kvalifikatsiooni saamiseks residentuuri läbimisest, siis Lätis peab resident sooritama lisaks ülikooli lõpueksamile erialaühenduste

[7] European Union of Medical Specialists. https://www.uems.eu/

[8] European Union of Medical Specialists. Postgraduate Training. https://www.uems.eu/areas-of-expertise/postgraduate-training

koostatud eksami. Eksamid toimuvad väljaspool residentuuriõpet ning neid korraldavad ülikool ja erialaühendused, kes vastutavad kvalifikatsiooni tõendamise eest oma erialal. Siiski on ülikoolid ja mõned erialaühendused Lätis kokku leppinud ülikooli- ja kvalifikatsioonieksami ühendamises üheks eksamiks.

Eestis kujundavad residentuuriõpet peamiselt kaks asutust. Tartu Ülikool korraldab residentuuriõpet ja pakub teoreetilisi kursusi. Sotsiaalministeerium vastutab residentuuriõppe rahastamise, tööjõu planeerimise ja õigusraamistiku arendamise eest mitmepoolsete läbirääkimiste teel ning määrab kindlaks riigi rahastatavate residentuurikohtade arvu. Erialaorganisatsioonid vastutavad eriarstide (re-)akrediteerimise eest ja osalevad ekspertidena aruteludes, mille tulemusena määratakse kindlaks residentide arv konkreetsel erialal. Eriarstide (re-)akrediteerimine toimub tavaliselt iga viie aasta tagant, aga see on vabatahtlik ja sõltub erialaorganisatsioonide välja töötatud eeskirjadest (Praxis, 2013). Residentuuriõpe hõlmab teoreetilist koolitust ülikoolis ja praktilist väljaõpet tervishoiuasutustes. Residendid on kogu residentuuri ajal oma õppebaasiga lepingulises suhtes ja osalevad tervishoiuteenuste osutamises. **Eestis on residentidel teatud tingimustel võimalus valida oma õppebaas erialaprogrammis esitatud nimekirjast.** Valikuvõimalus sõltub kohtade olemasolust, kokkuleppest programmi üldjuhendajaga ja muudest teguritest.

Lätis määrab tervishoiuministeerium kindlaks riigieelarvest rahastatavate residentuurikohtade arvu, jaotab raha ning töötab välja residentuuri ja tervishoidu reguleerivaid dokumente. Praktiline väljaõpe toimub tervishoiuasutustes. Läti Ülikool ja Riia Stradiņši Ülikool korraldavad residentuuriõpet, sh vastuvõttu ja väljaõpet, sõlmides selleks tervishoiuteenuste osutajatega lepinguid. Tervishoiuteenuste osutajad annavad olulise osa teoreetilisest koolitusest, ülikoolide pakutav koolitus moodustab vaid osa sellest. Lätis on residentidel kaks rolli: 1) nad on tervishoiuteenuste osutajad ja 2) üliõpilastena on neil ülikooliga õppeleping. Läti Arstide Liit vastutab eriarstide kvalifikatsiooni tõendamise eest. **Lätis on residentidel võimalus valida haigla ja osakond, kus konkreetne residentuuritsükkel läbitakse** (kui on olemas mitu haiglat või osakonda, mille vahel valida).

Leedus korraldavad residentuuriõpet tervishoiuministeerium, haridusministeerium ning kaks ülikooli – Leedu Tervishoiuülikool ja Vilniuse Ülikool. Tervishoiuministeerium prognoosib tulevast nõudlust erinevate erialade arstide järele ja esitab igal aastal haridusministeeriumile oma ettepanekud. **Leedus otsustavad ülikoolid residentuuri vastuvõtmise nõuete ja residentuuriprogrammide sisu üle.** Ülikoolid vastutavad ka residentuuriõppe teoreetilise osa eest. Ülikoolihaiglad teevad enamiku koolitusprotsessist, tegutsedes peamiste residentuuribaasidena. Tervishoiuministeeriumi haldusalas tegutsev riiklik tervishoiutöötajate akrediteerimise amet annab arstidele pärast residentuuriõppe lõpetamist ülikoolide esitatud dokumentide alusel välja tegevusload. Leedu residentuuriõppes minnakse peagi üle pädevuspõhisele õppele (nn usaldatavate professionaalsete oskuste süsteem, ingl *entrustable professional activities*), mis võib muuta kogu tervishoiusüsteemi tulevikku. Ilma kõigi sidusrühmade märkimisväärsete jõupingutuste ja koostööta on see siiski võimatu.

Järgmisena esitatakse neljas alapeatükis Balti riikide residentuuriõppe võrdlev analüüs. Iga alapeatükk vastab ühele neljast WFME standardite temaatilisest valdkonnast (vt lisa 1):

1. residentuuriõppe õiguslikud ja korralduslikud tahud,
2. residentuuriõppe kvaliteet,
3. hindamine ja tagasiside residentuuriõppes,
4. teadustöö roll residentuuriõppes.

Analüüsi kohta üksikasjalikuma teabe saamiseks soovitame tutvuda riigipõhiste poliitikaanalüüsidega ja standarditele vastavuse hindamisega, mis on esitatud lisas 5.

## 2.1. Residentuuriõppe õiguslikud ja korralduslikud tahud

Balti riikides on küll kehtestatud residentuuriõpet käsitlevad **eeskirjad**, kuid peamised probleemid on seotud nende rakendamisega. Kuigi residentuuriõpe on Eesti õigusaktides selgelt reguleeritud, esineb praktikas mitmeid puudusi. Näiteks ei ole kehtestatud koolitusbaaside miinimumstandardeid ega määratletud juhendamise sisu ning praegusel tagasisidesüsteemil puudub residentide hinnangul praktiline mõte ja sisu. Lätis on erialade residentuuriprogrammide sisu parandamiseks vaja eelkõige täiendada hindamisvorme ja ajakohastada vähemalt ühte eeskirja. Leedus sõltub dokumentide rakendamine residentide sõnul konkreetsetest komisjonidest ja koordinaatoritest, kes sageli tõlgendavad eeskirjades esitatud soovitusi erinevalt (vt lisa 5, 1. peatükk, standard 1.1).

Peamiste sidusrühmade rahulolu residentuuriprogrammide **kavandatud õpitulemustega** on riigiti erinev. Programmid on avalikult kättesaadavad (välja arvatud Lätis), aga need ei kajasta residentuuriõppe tegelikku olemust (Leedus). Eestis on põhiline probleem see, et residentuuritsüklite eeldatavaid tulemusi ei ole kindlaks määratud ja kõiki sidusrühmi ei kaasata residentuuriõppe programmide kohandamisse. Lätis mõjutavad kavandatud õpitulemuste saavutamist ülikoolide ja haiglate vahelised pinged, mis on seotud residentuuri korraldamise ja läbiviimise kohustuste jagamisega. Läti sidusrühmad märkisid, et residentuuriõppe programmide kavandatud õpitulemuste aluseks olevates riiklikes eeskirjades sätestatud erialaprogrammide kavandatud õpiväljundite kvaliteedi parandamiseks on vaja kooskõlastatud tegevust. Leedu residentide arvates ei ole residentuuriõppe korraldus nende erialal kooskõlas nende arusaamaga selle kohta, kuidas residentuuriõpet tuleks korraldada. Residentide ja nende juhendajate arvamuste lahknevus näitab, et kuigi kõigil huvitatud osalistel on ideid selle kohta, kuidas residentuuriprogramme tuleks ellu viia, ei ole praegused mehhanismid piisavalt tõhusad nende ideede arutamiseks ja vastuvõetud lahenduste rakendamiseks (vt lisa 5, 1. peatükk, standard 1.2).

Lisaks tõsteti esile mõnd probleemi, mis on seotud **residentuuriõppe kestusega** teatud erialadel Eestis ja Leedus ning kliinilise praktika vähesusega Leedus.

**Residentuuriprogrammide uuendamine** ei ole Balti riikides regulaarne, sõltub suuresti koordinaatorist või programmi üldjuhendajast ega hõlma kõiki sidusrühmi. Näiteks Eestis ja Lätis on residentuuriprogrammide läbivaatamine programmide üldjuhendajate ülesanne (teisi sidusrühmi ei kaasata) ja Leedus sisemise kvaliteedikontrolli käigus residentuurikomisjonide ülesanne.

Balti riikides on selgelt sõnastatud tegevuspõhimõtted, millega on kindlaks määratud **residentide valiku** kriteeriumid ja protsess. Leedus esineb siiski mõni praktiline puudus seoses asjaoluga, et kriteeriumide rakendamise suuniseid, mis on ülikooliti mõnevõrra erinevad, uuendatakse peaaegu igal aastal, et jõuda kõigi sidusrühmade vahel kokkuleppele, ja mõnes osakonnas neist ei lähtuta. Kuigi on välja töötatud kandidaatide valimise konkreetsed põhimõtted, **ei tajuta** valikuprotsessi, eriti eksami suulist osa, kõigis kolmes riigis **täielikult läbipaistvana**. Eesti puhul esineb vastuolulisi tõendeid selle kohta, et residentide valimist ja programmide rakendamist peetakse õiglaseks, Lätis ja Leedus tunnetatakse õigluse probleemi teravamalt. Näiteks Leedus võivad mõnel juhul osutuda vastuvõtutulemuste puhul otsustavaks motivatsioonipunktid. Eesti residentide vastustest ilmnes, et residentuuriõppesse vastuvõtmise eksam on subjektiivne ja et eelistatakse meessoost kandidaate või „tuttavaid nägusid“.

Residendid on kogenud **ebavõrdsust** ka kohtlemises, näiteks selgus Eestis intervjuude käigus ja Leedus küsimustikule lisatud märkustest, et on esinenud seksuaalse ahistamise juhtumeid.

**Residentide vastuvõtmise ja hariduse andmise suutlikkuse** planeerimine ei ole Balti riikides tasakaalus. Eestis puuduvad õppekohtade planeerimiseks interdistsiplinaarsed miinimumnõuded ja tööjõupuuduse tõttu võetakse vastu palju residente. Lätis on ülikoolide huvid (võtta vastu lisaresidente ja saada õppemaksu) vastuolus haiglate huvidega (haiglatel puudub lisasuutlikkus juhendada ja residentidele adekvaatne õpikeskkond tagada). Eestis ja Lätis väljendasid residendid muret vähese juhendamise pärast, juhendamissuutlikkust peeti teguriks, mis peaks mõjutama residentuurikohtade arvu määramise otsust. Residentide suure arvu ning haiglate ja residentuuriõppe korraliku haldamise puudumise tõttu ei jaotu residendid Leedus haiglate osakondade vahel tasakaalustatult. Kõigi kolme riigi residendid kaebasid töökeskkonna puuduste üle (näiteks napib mõne osakonna residentide jaoks töölaudu) (vt lisa 5, 1. peatükk, standard 1.6).

Balti riikide peamine ühine probleem seoses residentuuriõppega seisneb **juhendajate** värbamise ja valimise selgelt sõnastatud ja rakendatavate tegevuspõhimõtete puudumises. Kehtestatud on vaid põhilised nõuded, mis üldjuhul hõlmavad eriarstina töötamise aega. Eestis tehtud intervjuude käigus toodi esile, et eriarstide arv on mõnel konkreetsel meditsiinierialal väike ja võib juhtuda, et juhendajana saab tegutseda ainult üks eriarst (vt lisa 5, 1. peatükk, standard 1.7). Ka residentide poolt juhendajatele tagasiside andmine on riigiti erinevalt korraldatud. Leedus küsitakse residentidelt tagasisidet ainult ametlike kaebuste korral, Eestis antakse tagasisidet vabatahtlikkuse alusel. Ainult Lätis on residendid kohustatud täitma juhendaja hindamise vormi.

**Vabadus valida residentuuri läbimiseks asutus/osakond oma soovi järgi** sõltub Leedus intervjueeritud residentide arvates sageli residentuuri koordinaatori otsusest. Eesti residendid väidavad, et teatud erialade puhul ei ole residentuuritsükli läbimise koha valikul piisavalt paindlikkust ja residentuuritsükli läbimise koha määramisel ei arvestata perekondlikke asjaolusid (sealhulgas lapse olemasolu). Samuti **ei ole Eesti residentuuriõppe korraldus paindlik**. Praegu peavad kõik residendid osalema õppes täiskoormusega, kusjuures ei võeta arvesse terviseprobleeme, pere ja laste olemasolu ega muid isiklikke asjaolusid. Erandeid ei tehta ka residentidele, kes sooviksid samal ajal osaleda teadustegevuses või läbida doktorantuuri (vt lisa 5, 1. peatükk, standard 1.8). Eesti on üks viiest Euroopa riigist, kus residentidel ei ole lubatud residentuuri läbida osakoormusega. Euroopas nende riikide suhtarv, kus residendid võivad residentuuri läbida osakoormusega, on 73% (Euroopa Nooremarstide Ühendus, 2018).

Residentuuriõppe paindlikkus võib olla eriti kasulik naissoost residentidele. Ziegleri, Zimmermani, Krause-Solbergi, Schereri ja van den Bussche (2017) sõnul on mees- ja naisarstide eelistused töökoha (haigla, ambulatoorne arstiabi, muu), ametikoha ja tööaja suhtes erinevad. Ka võivad naisarstid, eriti need, kellel on lapsed, vajada residentuuri läbimiseks rohkem aega (Ziegler jt, 2017). Lastega naisarstid on sagedamini koormatud ja ebasoodsamas olukorras kui nende lasteta naissoost kolleegid ja meesarstid (näiteks algab nende residentuur hiljem, nad jõuavad harvem doktorikraadini, nende seas on rohkem osalise tööaja või lühiajalise töölepinguga arste ning nad jätavad residentuuri sagedamini pooleli) (Ziegler jt, 2017). Näiteks van den Bussche jt (2018) leidsid, et Saksamaal venib naissoost residentide residentuur pikemale perioodile ja enamasti on see nii just lastega residentidel, samal ajal kui pooled meessoost residentide esitatud põhjustest puudutavad residentuuriõppe korralduslikke ja õppekavaga seotud probleeme. Kokkuvõttes peaks residentide vajadustele vastamiseks olema residentuuriõpe paindlik.

## 2.2. Residentuuriõppe kvaliteet

Standardite hindamisskooride põhjal võib öelda, et **Balti riikides pakutavat residentuuriõpet iseloomustavad kaks hästi korraldatud tahku**: põhiõpe annab residentuuri eel head prekliinilised teadmised ja residentidel on juurdepääs ajakohasele erialakirjandusele.

Siiski on mitu põhimõttelist probleemi, mis vajab lahendamist. Peamine märksõna, mis iseloomustab residentuuriõpet Eestis, Lätis ja Leedus, on **ebaühtlus**. Juhendamise kvaliteet, teooria ja praktika vaheline tasakaal, residentuurikogemus ja pädevuste hindamine võivad erialadel, residentuuritsüklites, tervishoiuasutustes ja nende osakondades märkimisväärselt erineda. Järelikult võivad uute eriarstide erialased teadmised olla erinevad ja regulatiivdokumentides kirjeldatud koolitus ei kajasta tegelikkust.

Kõik residentuuriõppe programmid vastavad Euroopa miinimumstandarditele, mis on sätestatud Euroopa Komisjoni direktiivis 2013/55/EL[9] ning Euroopa Parlamendi ja nõukogu direktiivis 2005/36/EÜ[10]. Küsitlustulemused ja intervjuude analüüs näitasid siiski, et õppe **minimaalne kestus ei ole piisav eriarstilt nõutava täieliku pädevuse saavutamiseks**. Programmide sisu on sama, mis on esitatud üleeuroopaliste erialaorganisatsioonide koostatud soovituslikes õppekavades, aga õppeaeg on Euroopa keskmisest lühem (Eestis ja Leedus) või tuleb residentuuritsüklite sisu ja pikkust kohandada (Lätis) (vt lisa 5, 2. peatükk, standardid 2.1 ja 2.2).

Residentuuriõpe peaks valmistama residendi ette kõikideks eriarstilt oodatavateks rollideks. Lisaks kliiniliste teadmiste omandamisele peab õpe hõlmama ka teiste pädevuste, näiteks suhtlus- ja meeskonnatöö oskuse süstemaatilist arendamist ning elukestva õppe tähtsust. Praegu ei peeta **pehmeid oskusi** Balti riikides meditsiinihariduse võrdselt oluliseks osaks.

Kõigis kolmes riigis on kritiseeritud kutsealapõhistes ja kutsealadevahelistes meeskondades töötamiseks vajalike oskuste õpetamist. Residentuuriõppe programmides (Eestis ja Leedus) ja õigusaktides (Lätis) on **suhtlus- ja meeskonnatöö oskus** õpitulemustena määratletud, kuid nende rakendamist ja õpet alati ei pakuta. Eestis on suhtlusoskust ja tundlike olukordade lahendamise oskust põhiõppes õpetatud alates 2016. aastast, aga need kursused toimuvad õppe prekliinilises osas, kui arstitudengitel ei ole veel asjakohaseid kogemusi. Lätis ja Leedus eeldatakse, et suhtlusoskus ja tundlike olukordade lahendamise oskus omandatakse kliinilise töö käigus (vt lisa 5, 2. peatükk, standard 2.13). Meditsiinieetika, tervishoidu puudutavad õigusaktid ja muud pehmed oskused sisalduvad vaid mõnes residentuuriprogrammis (Eestis ja Leedus) või siis õpetatakse neid põhiõppe käigus (valik)ainena (Eestis). Lätis pakutakse residentidele meditsiinieetika ja patsiendi ohutuse alaseid seminare, aga need ei ole kohustuslikud (vt lisa 5, 2. peatükk, standardid 2.17 ja 2.18).

Ka **teadustöö kogemuse** võimaldamine residentidele vajab erialade kaupa ühtsemat lähenemist. Võimalus teadustööga tegeleda peaks olema nii doktorantidel kui ka neil, kes doktorikraadi omandada ei soovi. Praegu peetakse meditsiinialast teadustööd ja kliinilist epidemioloogiat kogemusteks, mis omandatakse eraldi doktoriõppe osana enne või pärast residentuuri (Eestis) või millele juhendajate huvi- ja kogemusepuuduse tõttu ei pöörata kuigivõrd tähelepanu (Lätis ja Leedus) (vt lisa 5, 2. peatükk, standard 2.14).

[9] Euroopa Parlamendi ja nõukogu 2013. aasta 20. novembri direktiiv 2013/55/EL, millega muudetakse direktiivi 2005/36/EÜ kutsekvalifikatsioonide tunnustamise kohta ning määrust (EL) nr 1024/2012 siseturu infosüsteemi kaudu tehtava halduskoostöö kohta (IMI määrus). Internetis aadressil https://eur-lex.europa.eu/eli/dir/2013/55/oj

[10] Euroopa Parlamendi ja nõukogu 2005. aasta 7. septembri direktiiv 2005/36/EÜ kutsekvalifikatsioonide tunnustamise kohta. Internetis aadressil https://eur-lex.europa.eu/eli/dir/2005/36/oj

Samuti **ei ole tervishoiuteenuste osutamine, koolitus ja teadustegevus residentuuri ajal omavahel piisavalt tasakaalustatud**. Sellele puudusele lisanduvad juhendajate õpetamisoskuse (pedagoogiliste oskuste) süstemaatilise arendamise ning tagasisidemehhanismide puudumine. Puudub ka juurdepääs kvaliteetsetele teadustöövõimalustele (vt lisa 5, 2. peatükk, standardid 2.10–2.12). **Sobivaid õpetamismeetodeid ei kasutata** peamiselt seetõttu, et juhendajatel puudub pedagoogiline haridus ja piisav aeg (vt lisa 5, 2. peatükk, standard 2.25). Residentuuriõppe hariduslik väärtus oleneb suuresti konkreetsest juhendajast. Mõnel juhul puudub juhendajatel õpetamiseks huvi, motivatsioon või oskus, nad ei soovi õppida sobivaid õpetamismeetodeid või siis ei ole neil võimalik sobitada vastavaid kursuseid oma töögraafikuga. Ametlikult kujutab residentuuriõpe endast kutsealasele arengule suunatud praktikat, aga residentuuriõppes on selgelt esiplaanil tervishoiuteenuse osutamine ja residente kasutatakse tööjõupuuduse katmiseks (Lätis ja Leedus, vähemal määral ka Eestis). Kliiniline praktika ja autonoomia on Eesti, Läti ja Leedu residentuuriprogrammide hindamise tulemuste kohaselt vastuoluline teema. Residendid on olenevalt erialast sageli ainult vaatlejad või siis vastupidi – peavad algusest peale töötama iseseisvalt ega saa juhendamist. Kliinilise praktika nappus tõsteti residentuuriõppe üldise probleemina esile standarditele vastavuse hindamisel Lätis ja Leedus.

Üheski residentuuriõppe programmis (Eestis, Lätis ja Leedus) **ei mainita arstide heaolu (enese eest hoolitsemist)**. Residentide madala palga ja majanduslikust olukorrast tingitud lisastressi tõttu tekitavad töötingimused ja residentide tervise hoidmine rohkem muret Lätis ja Leedus. Residentide füüsilist ja emotsionaalset tervist kahjustavad ka **ebasoodsad töötingimused**, töölaudade nappus (Eestis, Lätis ja Leedus), ametlikult kehtestatust pikem tööaeg (Lätis) ja residentide vajadus töötada mitmel töökohal, et majanduslikult toime tulla (Lätis ja Leedus) (vt lisa 5, 2. peatükk, standard 2.5).

Madala palga tõttu peavad residendid Lätis ja Leedus töötama mitmel töökohal, mille tulemuseks on pikad töönädalad ja kõrge stressitase. Eesti residendid saavad residentuuriõppes olles palka, mis on võrdne tõendatud kvalifikatsiooniga arsti miinimumpalgaga,[11] samal ajal mõjutavad Lätis ja Leedus residentide ja juhendajate madal palk, suur töökoormus ja ebapiisav infrastruktuur koolituse kvaliteeti. Lätis on residentide töötasu miinimummäär kehtestatud valitsuse määrusega nr 595[12]. Samas määruses on sätestatud ka miinimumtasu, mida makstakse tõendatud kvalifikatsiooniga arstidele, õdedele ning teistele riigi- ja munitsipaalasutustes töötavatele spetsialistidele. Leedus koosneb residentide kogusissetulek kahest osast: tervishoiuministeeriumi poolt haiglate kaudu makstavast palgast ja haridusministeeriumi poolt ülikoolide kaudu makstavast stipendiumist. Alates 2019. aastast makstakse kogu summa palgana (stipendium lisatakse palgale), et kindlustada residentidele sotsiaaltoetused, tasustatav rasedus- ja sünnituspuhkus jne. Residentide madal palk on vastavuses töötajate madala palgaga kogu tervishoiusektoris.

## 2.3. Hindamine ja tagasiside residentuuriõppes

Programmide kavandatud õpitulemuste – teadmiste, oskuste ja hoiakute ning tervishoiusektoris edaspidi täidetavate rollide – (vt lisa 5, 2. peatükk, standard 2.21) määratlemise tavad on erinevad ega vasta üheski Balti riigis täielikult rahvusvahelistele standarditele. Näiteks Eestis on teadmised, oskused ja hoiakud, mille resident peaks iga õppeaasta lõpuks omandama, kaardistatud vaid mõnes erialaprogrammis.

[11] Internetis aadressil https://haiglateliit.ee/wp-content/uploads/2017/05/Tervishoiuvaldkonna_kollektiivleping_25_1.pdf

[12] Internetis aadressil https://likumi.lv/doc.php?id=212565

Residentide iseseisva töö maht peaks oskuste, teadmiste ja kogemuste kasvades suurenema. Siiski on Eestis iseseisva töö maht väga erinev ning oleneb residentide kogemuste asemel pigem eriala tööjõuvajadusest ja sellest, mida juhendaja lubab. Sellele vaatamata kannab juhendaja oma juhendatavate residentide töö eest täielikku õiguslikku vastutust kuni residentuuritsükli lõpuni.

Lätis on residentide lubatava iseseisva töö maht erialadel ja tervishoiuasutustes väga erinev. Eeskirjade järgi tuleks residentide iseseisvat vastutust residentuuri kolmandal aastal suurendada. Seda, mida residendid peaksid olema võimelised iseseisvalt tegema, ei ole tegelikkuses siiski määratletud ja residentide oskusi ei hinnata pärast residentuuri teist aastat (vt lisa 5, 3. peatükk, standard 3.5).

Leedus on kasutusel noorem- ja vanemresidentide süsteem, aga vastutuse aste sõltub siiski juhendajast, sest puudub õiguslik alus, mis annaks juhiseid residentide pädevuse suurendamiseks.

Balti riikides pakutava residentuuriõppe üks peamisi puudusi seisneb selles, et **residentide hindamine ja neile antav tagasiside on vähene ja ebakorrapärane või mitteõigeaegne**. Hindamine ja tagasiside andmine on osakonniti ja programmiti erinev ning oleneb suuresti konkreetsest juhendajast. Residentide hindamise korraldus ei ole süstemaatiline. Eestis ei ole hindamise põhimõtteid, eesmärke, meetodeid ega korraldust üksikasjalikult kirjeldatud. Erandiks on vaid lõpueksam, mida erialade programmides põhjalikult selgitatakse, ning residentuuripäevikud (esitamise kohustus iga kuue kuu tagant) ja juhendaja tagasiside vormid, mis moodustavad osa kokkuvõtlikust hindamisest, aga need ei täida oma ülesannet (vt lisa 5, 2. peatükk, standard 2.28; 3. peatükk, standard 3.4). Tagasiside ei ole kõikehõlmav ega arendav ja kuna tagasisidet ei analüüsita, siis ei astuta selle põhjal edasisi samme. Juhendajad kasutavad tagasisidevormide täitmisel sageli ainult märkeruute, samuti võidakse residentidel paluda vorm ise täita. Vaheeksamid toimuvad vaid mõnel erialal. Seega näib, et enne lõpueksamit ei toimu hindamist või on hindamise osakaal marginaalne. Lätis toimub kokkuvõtlik hindamine, mis hõlmab teadmisi ja oskusi, aga mitte hoiakuid. Leedus ei ole lõplik hindamine ega tsüklitevaheline hindamine (elektroonilised päevikud) süstemaatiline ning osakondade vahel on suured erinevused: residentide eksamineerimise süsteem on sageli subjektiivne ja tasakaalustamata, selle rakendamine oleneb suuresti konkreetsest residentuuriprogrammist. Seega on kujundav hindamine ja tagasiside andmine residentuuriõppes kõigis Balti riikides üsna puudulik.

Üheski Balti riigis **ei hinnata ega dokumenteerita hindamismeetodite usaldusväärsust, asjakohasust ja õiglust** ning määratletud hindamismeetodeid ja -vorme kasutatakse harva ja ebajärjekindlalt. Seetõttu tajuvad residendid, et nad **ei saa konstruktiivset ja konkreetset tagasisidet**[13].

## 2.4. Teadustöö roll residentuuriõppes

WFME standardid rõhutavad teaduslike meetodite mõistmise tähtsust tõendusmaterjali kriitilise hindamise ja tõenduspõhise ravi seisukohast. Täheldati, et kõigi kolme Balti riigi õppeprogrammid pakuvad teatud määral teadusliku põhjendamise oskuste ja empiirilise metoodika õpet. Teisest küljest ei ole nende teadmiste andmist riikides (v.a Läti) ametlikult paika pandud. Tõenäoliselt eeldatakse, et

[13] Sisuline hindamine ja tagasiside andmine väärivad Balti riikides eraldi põhjalikku uurimistööd. Näiteks on ühes Kanada uuringus välja selgitatud arstiõppes osalejate sisulise hindamise ja neile tagasiside andmise takistused ning toodud esile juhendajate soovimatus halbadest tulemustest teatada ja halbade tulemustega praktikante läbi kukutada (McQueen jt, 2016). Sellel soovimatusel on mitu põhjust, sh ebapiisav dokumentatsioon, programmi juhtkonna toetuse puudumine, ebapiisav võimalus tulemuslikkust jälgida, ajapuudus, hirm kaebuste ja kohtuasjade ees ning hirm omakorda halva hinnangu osaliseks saada (McQueen jt, 2016).

residendid omandavad need oskused iseseisvalt, minimaalse toe ja tagasiside abil. Ometi on tagasiside kõrgkooliõppe oluline komponent, nagu väidavad Quinton ja Smallbone (2010).

Läti on Balti riikidest ainus riik, kus teadustöö on residentuuriõppe täieõiguslik osa: uurimistöö kirjutamine on kõigil erialadel residentuuriõppe lõpetamise eeldus. Eestis ja Leedus, kus teadustöö metoodika on põhiõppe õppekava osa, on teadustöö osakaal eri residentuuriõppe programmides erinev (vt lisa 5, 4. peatükk). Kuigi Lätis on kehtestatud ametlik teadustööga tegelemise nõue, on residentide valmisolek kasutada ja rakendada teaduslikke meetodeid ning põhjendusi väiksem kui Eestis ja Leedus. Lätis tehtud küsitluse tulemused osutavad sellele, et teadustöö võib olla pigem sümboolse väärtusega (vt ka allpool toodud lõiku): märkimisväärne osa residentidest ja juhendajatest ei ole kindel, et residentuuriõpe annab usaldusväärsed teadustöö oskused. Eestis ja Leedus ei pea kõik residendid teadustööd tegema, nad võivad teha seda vabatahtlikult või siis on teadusprojekti tulemuste hindamise kriteeriumid leebed. Mõlemas riigis pidas enamik residentidest ja juhendajatest teaduslikku mõtteviisi oma töövaldkonnas väga oluliseks. Seda konkreetselt küll ei uuritud, aga kuna teadustööga tegelemine ei ole kõigi kursuste kohustuslik osa, võib juhtuda, et residendid otsustavad siiski empiirilise uurimise kasuks. Seetõttu võivad nad olla sisemiselt rohkem motiveeritud ning suudavad protsessi käigus rohkem õppida ja tulemustele suuremat väärtust anda (vt Bomia jt, 1997, kus seda mõtet üksikasjalikumalt käsitletakse).

Hüpoteesi, et Läti tulevaste arstide teadusprojektid kipuvad olema pealiskaudsed, toetavad ka tõendid WFME standardi kohta, mis kõlab järgmiselt: „Residente julgustatakse osalema meditsiinialases teadustöös ning tervishoiu ja tervishoiusüsteemi kvaliteedi arendamises“. Läti puhul oli hinnang sellele standardi vastavusele teiste riikidega võrreldes tagasihoidlikum. Lätis puudub residentidel vabadus valida isiklikult huvipakkuv teadustöö teema. Selle asemel on residendid jäigalt seotud oma juhendajate teadustööga või peavad tegelema teemaga, mis on püsinud aastaid muutumatu. Eestis takistab residentide osalemist teadustöös asjaolu, et residentidele ei võimaldata teadustööga tegelemiseks lisaaega. Seevastu teatas Leedus enamik residente, et neid julgustatakse uurima enda valitud teemat.

Mis puudutab residentide suutlikkust hinnata teadusuuringute ja teaduslike andmete kvaliteeti, siis tõendid standardile vastavuse kohta on kõigis kolmes riigis vastuolulised ning osutavad sellele, et usk tulevaste arstide oskusesse hinnata olemasolevate tõendite usaldusväärsust on väike. See hinnang peegeldab kogu maailmas valitsevat olukorda, mis on püsinud viimased 40 aastat (Manrai, Bhatia, Strymish, Kohane ja Jain, 2014; Martyn, 2014). Seega õpetavad tänapäeval residente tõenäoliselt inimesed, kelle teadmised teadustulemuste tõlgendamisest on piiratud (eriti statistika ja tõenäosuse vallas). See on murettekitav, sest arstidel on sageli vaja tõendeid hinnata, näiteks siis, kui nad lähtuvad kliinilistest juhistest, hindavad riskitaset, tõlgendavad analüüsitulemusi või uurivad mittestandardsete raviviiside kasutamise kaalumisel teadusväljaandeid (Swift, Miles, Price, Shepstone ja Leinster, 2009). Kõigi kolme riigi residendid on sellest teadlikud ja väljendavad vajadust põhjalikuma koolituse järele selles valdkonnas (ühtemoodi Inglismaa idaosa arstidega, nagu on teatanud Swift jt, 2009).

## 2.5. Kokkuvõte

Riigipõhiste poliitikaanalüüside kõrval näitavad selles peatükis ja lisas 5 esitatud tulemused, et residentuuriõppe korraldus on Balti riikides ja asutuste osakondades erinev. Vaid üksikute standardite puhul vastab residentuuriõppe olukord riigis täielikult rahvusvahelisele standardile. Keskmiselt võiks Balti riikide olukorda iseloomustada sõnadega „vastuolulised tõendid selle kohta, et residentuuriõpe vastab standardile“, sest keskmine esialgne numbriline hinnang oli ligikaudu 2 (vt tabel 2 peatükis 1.2). Uuringu käigus tehti kindlaks järgmised põhiprobleemid.

- Õpiväljundite kirjeldamine ja tähendus on kohati puudulik.
- Puuduvad juhendajate värbamise ja valimise selgelt sõnastatud põhimõtted. Ei arendata süstemaatiliselt juhendajate õpetamisoskust (pedagoogilisi oskusi).
- Residentuuriprogrammide uuendamine ei ole regulaarne, sõltub suuresti koordinaatorist või programmi üldjuhendajast ega hõlma kõiki sidusrühmi.
- Residentuuriõpe ei ole paindlik, ei võeta arvesse residentide individuaalseid vajadusi (näiteks puudub osaajaga residentuuri võimalus).
- Residendid ja juhendajad peavad residentuuri vastuvõtmise süsteemi üldiselt läbipaistvaks ja õiglaseks. Sellegipoolest näitas analüüs, et kõigis kolmes riigis tajutakse ka läbipaistmatust ja teatud kandidaatide soosimist.
- Naissoost residendid kogevad seksuaalset ahistamist ja on märke ka naiste soolisest diskrimineerimisest residentuuriõppe ajal või residentuuri vastuvõtmisel.
- Koolituse kvaliteet on ebaühtlane:
    - juhendamise kvaliteet võib erialadel, residentuuritsüklites, tervishoiuasutustes ja nende osakondades märkimisväärselt erineda, st puudu on ajast, teooria ja praktika tasakaalust, residentuurikogemusest ja pädevuse hindamisest;
    - residentuuri rõhuasetus kipub vajalike oskuste õpetamise asemel nihkuma tervishoiuteenuste osutamisele;
    - pehmeid oskusi ei peeta meditsiinihariduse võrdselt oluliseks osaks.
- Residentide hindamine ja neile antav tagasiside on vähene ning ebakorrapärane või mitteõigeaegne. Hindamine on suures osas kokkuvõtlik. Praktika on osakonniti ja programmiti siiski erinev ning sõltub suurel määral ka konkreetsest juhendajast. Residentide hindamise korraldus ei ole süstemaatiline.
- Teadusliku põhjendamise ja empiirilise metoodika oskuste õpetamist ei ole Balti riikides (peale Läti) ametlikult paika pandud ja tõenäoliselt eeldatakse, et residendid omandavad need oskused enamasti iseseisvalt, minimaalse toe ja tagasiside abil.
- Tehti kindlaks mitmesugused puudused residentide töötingimustes, näiteks pikk tööaeg ja aja puudumine tööpäeva jooksul teoreetiliste materjalide või juhistega tutvumiseks, samuti probleemid vabade arvutite ja füüsiliste töötingimustega.

Neid probleeme käsitletakse järgmises peatükis, kus esitatakse poliitikasoovitused.

# 3. Poliitikasoovitused

Eelmises peatükis esitatud analüüsi, riigipõhiste poliitikaanalüüside ja lisas 5 esitatud standardipõhise analüüsi põhjal on välja töötatud poliitikasoovitused praeguse residentuuriõppe süsteemi parandamiseks Eestis, Lätis ja Leedus.

## 1. Kehtestada ja rakendada residentuuriõppe miinimumstandardid, sh juhendamise standardid

Eestis on residentuuriõppe praeguses süsteemis määratletud üksnes programmide üldised tulemused, ent ei ole täpsustatud individuaalsete tsüklite konkreetseid õpitulemusi. Lätis ei ole õppeprogrammid avalikult kättesaadavad ja õpiväljundid on erialadel erinevad, kusjuures mõned neist on väga laiaulatuslikud. Leedus ei kajasta residentuuriprogrammides loetletud õpitulemused sageli residentuuriõppe tegelikkust. Seetõttu sisaldab residentuuritsükkel mitmel erialal vaid vaatlust, mistõttu pole sellel peaaegu mingit koolitusväärtust. Lisaks sellele ei pruugi õppekava mõned aspektid vastata eriala vajadustele või kitsamale meditsiinivaldkonnale spetsialiseeruva residendi vajadustele.

Selle probleemi lahendamiseks tuleks kõigis Balti riikides kehtestada residentuuriõppe miinimumstandardid koolitusbaasidele. Miinimumstandardid peaksid Eestis ja Lätis hõlmama põhilisi nõudeid residentide töötingimustele ning Leedus õpitulemuste saavutamise paremat tagamist. Peale selle tuleks Eestis määratleda ja kehtestada iga tsükli õpitulemused.

Muu hulgas tuleks täpsustada juhendamise miinimumstandardeid, põhimõtteid ja kontseptsiooni – juhendamise sisu peaks olema õigusaktides või kirjalikes kokkulepetes selgelt määratletud, sest juhendamine kipub liiga sageli olema juhuslik, napp või ebapiisav ning juhendamise kvaliteet on juhendajate lõikes väga erinev.

Residentuuriõppe miinimumstandardid võivad aidata tagada ühtsema arusaama sellest, millist õpiväärtust iga resident peab igas residentuuribaasis ja igas residentuuritsüklis saama. Samuti aitaks see vähendada erapoolikust olukordades, kus koolitus ei vasta residentide ootustele või standardnõuetele, või kus residendi tulemusi ei peeta piisavateks. Miinimumstandardid võimaldaksid residentuuri korraldajal märgata baasasutusi või üksusi, kus igapäevane teenuseosutamine jätab residentide teadmiste ja oskuste järjepideva arendamise tagaplaanile. Samuti oleks võimalik kindlaks teha asutused, kus juhendaja omast erinevale valdkonnale spetsialiseerumise, juhtumite keerukuse või oskuste ja teadmiste vähesuse tõttu ei pakuta residendile tegevust.

## 2. Kehtestada residentuuriõppe programmide ajakohastamise riiklik süsteem

Eestis peaks programmide muutmise algatus ja sisend tulema programmi üldjuhendajalt, kes esitab vastava ettepaneku ülikooli residentuurikomisjonile. Seega sõltub erialade õppeprogrammide ajakohastamine programmide üldjuhendajate töökoormusest ja motivatsioonist ning residentuuriprogrammide seire ja hindamine ei ole reguleeritud. Seetõttu on programmide kvaliteedis ja ajakohasuses suuri põhjendamatuid erinevusi. Arstiteaduskonna veebilehe andmete

põhjal ajakohastati üle poolte kättesaadavatest residentuuriõppe erialade programmidest viimati 2011. aastal[14].

Lätis uuendatakse enamikku programme iga kuue aasta tagant enne akrediteerimist, õppeprogrammide üldjuhendajad jälgivad programmide koostamist ja uuendamist ning neil ei ole kohustust kaasata teisi sidusrühmi. Järelikult sõltub programmide uuendamine suuresti iga programmi üldjuhendaja ajaressursist ja seisukohtadest programmi kohta.

Leedus vastutavad programmide ajakohastamise eest residentuuriprogrammide komisjonid, kuhu peab kuuluma ka residentide esindaja. Tegelikkuses aga ei kohtu mõned komisjonid regulaarselt ja residendid kaasatakse üksnes paberil.

Seda arvesse võttes on soovitatav välja töötada süsteem, mis tagab, et kõik õppeprogrammid on alati ajakohased ja neid arutatakse kõigi asjaomaste sidusrühmadega. Selle süsteemi loomine suurendab esialgu halduskoormust, aga seda võib hajutada, kui võtta näiteks kasutusele kontrollküsimustikud, mis võimaldavad programmide üldjuhendajatel programmi hõlpsalt kontrollida, puudusi avastada ja programmis tehtud uuendusi lihtsamalt jälgida. Süsteem peab sisaldama kõikide sidusrühmade korrapärast tagasisidet, mis tagaks muudatuste tegemise suurema läbipaistvuse. Üheski kolmest riigist ei ole seni avalikustatud programmide sise- ega välishindamist.

## 3. Muuta residentuuriõpe residendikesksemaks ja luua osakoormusega residentuuriõppe võimalus

Kõigis Balti riikides ilmnes, et residentuuriõpe ei ole nii residendikeskne kui peaks. Kõigis kolmes riigis toodi esile, et residendid peavad sageli omapead hakkama saama, et neid kasutatakse lisatööjõuna, st teenuste osutamiseks, ja et nad saavad juhendajatelt vähe juhendamist (kui üldse).

Residendid ja hiljuti residentuuriõppe lõpetanud eriarstid ütlevad sageli, et residentuurisüsteem on jäik. Jäikust kinnitab objektiivselt õppekorralduse võrdlus WFME standarditega. Praegu ei ole võimalik residentuuri läbida osakoormusega, kuigi paljud residendid on väljendanud mitmesugustest põhjustest tulenevat tungivat vajadust sellise võimaluse järele. Teadaolevalt on Eestis siiski peagi kavas see võimalus luua. Plaanide järgi aga võetakse paindlikkuse võimaldamisel arvesse ainult mõne sihtrühma, näiteks väikelaste vanemate, doktorantide ja terviseprobleemidega inimeste vajadusi. Lisaks võib õppekoormus moodustada ei rohkem ega vähem kui pool täiskoormusest ja osakoormust saab kasutada maksimaalselt 11 kuu vältel. Kuigi see on suur samm edasi, jääks süsteem siiski üsna jäigaks. Soovitatav on kaaluda, kas on mõistlik piirduda osakoormusega residentuuriõppe võimaldamisel ainult enne kindlaksmääratud sihtrühmadega või jätta võimalus kasutada paindlikkust ka muudel juhtudel (näiteks kui resident osaleb doktorantuurivälises teadustöös, hooldab lähedast, töötab üldarstina (sh välismaal), täiendab ennast väljaspool meditsiinivaldkonda (näiteks juhtimiskoolitus, IKT-oskuste arendamine omal käel) või osaleb residentuuritsüklis elukohast kaugel asuvas praktikabaasis). Eeltoodut arvestades soovitame selleks, et muuta residentuuriõpe residendikesksemaks, lubada kasutada eriarstide puhul juba kehtivatele skeemidele lisaks osakoormuse skeeme (näiteks kolmandik või kaks kolmandikku nominaalsest õppekoormusest), kehtestamata rangeid ajapiiranguid.

Kuigi kirjeldatud muudatused suurendaksid nii residentuuri korraldava ülikooli kui ka tervishoiuteenuste osutajate halduskoormust, võivad need aidata paremini saavutada residentuuri

[14] https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid, vaadatud 6. augustil 2018.

põhieesmärki, st valmistada arstitööks ette piisaval arvul pädevaid eriarste ja parandada residentide võrdset kohtlemist.

## 4. Tagada residentuuri vastuvõtmisel läbipaistvus

Kõigis kolmes riigis peab suurem osa residente ja juhendajaid residentuuri vastuvõtmise süsteemi läbipaistvaks ja õiglaseks. Sellegipoolest näitas analüüs, et kõigis kolmes riigis tajutakse ka läbipaistmatust ja teatud kandidaatide soosimist.

Olemasoleva teabe kohaselt tuleb Eestis endiselt ette läbipaistmatust ja subjektiivsust – mõnel juhul määratakse konkreetsetele erialadele vastu võetud inimesed kindlaks enne vastuvõtueksameid ja nende jaoks luuakse spetsiaalselt residentuuri lisakohad. Praeguse vastuvõtusüsteemi kohaselt on vastuvõtukomisjonil kohustus teha tulemused teatavaks kolme tööpäeva jooksul. Kuigi kehtestatud on vastuvõtukriteeriumid, ilmnes individuaal- ja fookusgrupi intervjuudest, et mõne eriala puhul avaldab komisjon ainult vastu võetud kandidaatide nimed, aga mitte kõigi kandidaatide punktisummad[15].

Leedus osutavad analüüsi tulemused erinevustele residentuuriprogrammidesse vastuvõtmise korra läbipaistvuse tajumises. Ligikaudu kolmandik residentidest usub, et eelistatakse näiteks meessoost residente või neid, kelle sugulased töötavad selles valdkonnas, ja et Vilniuse Ülikoolist pärit kandidaadid saavad Leedu Tervishoiuülikoolis tõenäoliselt palju väiksema motivatsiooniintervjuu skoori.

Ka Lätis ei nõustunud umbes kolmandik residentidest, et residentide valimise protsess on läbipaistev ja õiglane. Ühtsed vastuvõtutingimused jõustuvad 2019/20. õppeaastal. Ühtsete vastuvõtukriteeriumide järgi saab enim punkte endiselt teaduspublikatsioonide ja -tegevuse eest. Soovitatud on vähendada vastuvõtmisel teadustegevuse osatähtsust ja suurendada eelneva praktilise kogemuse väärtust.

Seepärast on soovitatav teha kõigis kolmes riigis jõupingutusi tagamaks, et residentuuri vastuvõtmine on alati läbipaistev. Selleks tuleks kehtestada residentuuri vastuvõtmisel selged hindamiskriteeriumid, avaldada vastuvõtutulemused ning anda võimalus tulemused vaidlustada ja selgitusi või sõltumatu komisjoni tehtavat ümberhindamist nõuda.

## 5. Tagada sooline võrdõiguslikkus ning töötada välja vastavad suunised residentidele ja juhendajatele

Andmed näitasid, et naissoost residendid kogevad seksuaalset ahistamist ja on märke ka naiste soolisest diskrimineerimisest residentuuriõppe ajal või residentuuri vastuvõtmisel (Eestis ja Leedus). On olnud juhtumeid, kus naissoost residentuurikandidaadile teatati, et ta võeti vastu ainult seetõttu, et meessoost kandidaate ei olnud või kuna kohti jagus kõikidele kandidaatidele. Leedus toodi esile, et meessoost residendid saavad naissoost residentidega võrreldes rohkem opereerimisvõimalusi.

Praegu ei pakuta residentide ega juhendajate jaoks soolisele võrdõiguslikkusele ja võrdsele kohtlemisele pühendatud kursusi põhiõppe ega residentuuri ajal. Seetõttu peaksid ülikoolid välja

[15] Põhiõppe vastuvõtutulemused avaldatakse sisseastumise infosüsteemis (SAIS). Kandidaadid järjestatakse nende saadud punktide järgi, nende avalduse number ja nimi (kui nad on selle avalikustamisega nõustunud) on järjestuses avalikkusele nähtavad. Puuduvad tõendid selle kohta, et residentuuriõppe puhul oleks midagi sarnast kasutusel.

töötama meetmed, et võidelda soostereotüüpidega, suurendada teadlikkust soolisest võrdõiguslikkusest ja võrdsest kohtlemisest ning ennetada ja tõkestada seksuaalset ahistamist.

Soovitatav on koolitada residente ja juhendajaid soolise võrdõiguslikkuse ja võrdse kohtlemise teemal ning koostada neile suunised selle kohta, kuidas tegutseda ja kust saada toetust seksuaalse ahistamise korral.

## 6. Teha kogu teave residentuuri kohta – kursused, eeskirjad, uuendused jne – avalikult kättesaadavaks

Analüüsi kohaselt mainisid sidusrühmad kõigis kolmes riigis, et neil puudub teave residentuuri ja selle korralduse mitmesuguste tahkude kohta. Eestis tõid residendid ja juhendajad esile vajaduse saada teavet tasuta kursuste ja koolitusvõimaluste kohta. Kuigi ülikoolid on valmis residentide soovil korraldama eri teemadel (teoreetilist) koolitust, ei olnud residendid sellest võimalusest teadlikud.

Juhendajad juhtisid tähelepanu samale küsimusele: teave pedagoogiliste ehk õpetamise kursuste ja kursuse aja kohta peaks olema aegsasti ette teada ning asutused peaksid võimaldama ja soodustama juhendajate korrapärast osalemist sellistel koolituskursustel. Lisaks teabele kursuste kohta peaks ühes kohas avalikult kättesaadav olema teave residentuuriprogrammi uuenduste, sisemise ja välise kvaliteedikontrolli tulemuste ning muude asjakohaste dokumentide kohta (Lätis ka erialade programmide kohta). Selle eesmärk oleks tagada, et peale residentide, juhendajate ja ametnike oleks kõigil, kes kaaluvad residentuuri kandideerimist, olemas kogu vajalik teave otsuse tegemiseks. See toimiks ka järelevalvemehhanismina ja teeniks eesmärki tagada, et residentuur korraldatakse kõikide eeskirjade järgi.

## 7. Näha residentuuriõppe programmides ette pehmete oskuste arendamine

WFME standardite kohaselt peaks residentuuriõpe valmistama residendi ette kõikideks eriarstilt oodatavateks rollideks, hõlmates ka meeskonnatööd, suhtlusoskust, juhtimisoskust ja eetikat. Praegu ei õpetata neid oskusi residentuuriõppe käigus üheski Balti riigis ja sageli ignoreeritakse neid täielikult.

Lätis ei sisalda enamiku erialade programm (mõne erandiga, näiteks peremeditsiin) juhtimisoskuste õpetamist, aga seda olukorda on siiski kavas edaspidi muuta. Rohkem tähelepanu tuleks pöörata suhtlus- ja meeskonnatööoskuse arendamisele. Eestis ei õpetata nimetatud oskusi enamikus olemasolevates residentuuriprogrammides, kuigi üldjuhul on need oskused residentuuriõppe programmide õpitulemuste seas esitatud. Leedus näitas residentuuriprogrammide analüüs, et mõned pehmed oskused, näiteks suhtlusoskus, sisalduvad paljude residentuuriprogrammide kirjeldustes.

Sellegipoolest ei rakenda paljud Balti riikide kliinikud ja osakonnad süstemaatilisi meetodeid pehmete oskuste õpetamiseks ja residentuuriõppe programmides ei ole täpsustatud, kuidas residendid peaksid need oskused omandama. Seetõttu soovitame käsitleda pehmeid oskusi osana arstide põhipädevusest, mida tuleks residentuuriõppe käigus süstemaatiliselt arendada ja õpetada.

Nagu eelmainitud, napib kõigi kolme riigi juhendajatel õpetamisoskust, mistõttu teadmiste omandamine õpetamisoskuse kohta peaks sisalduma nii põhiõppes kui ka residentuuriõppes, sest tõenäoliselt saavad eriarstidest arstide tulevaste põlvkondade juhendajad. Kõigile juhendajatele tuleks pakkuda kohustuslikke pidevaid koolituskursusi õpetamise alal.

## 8. Hinnata kõiki olemasolevaid residentuuriõppe programme, arvestades kõiki WFME standardeid

Analüüsi põhjal ei vasta suurem osa olemasolevaid residentuuriprogramme WFME standardite kõikidele tingimustele, mispärast tuleks kõik programmid süstemaatiliselt läbi vaadata. Programm peab kliiniliste teadmiste kõrval pakkuma võimalusi ka muude pädevuste, näiteks meeskonnatöö- ja suhtlusoskuse ning juhtimisega seotud teadmiste süstemaatiliseks arendamiseks.

Seetõttu on soovitatav, et ülikoolid hakkaksid enesekontrolli vormis üksikasjalikult analüüsima residentuuriõppe vastavust kõikidele WFME standarditele ja looksid pideva kvaliteedikontrolli süsteemi.

Kõigis kolmes riigis tuleks teha seda koostöös kõigi asjakohaste sidusrühmadega, Eestis näiteks koostöös Tartu Ülikooli, sotsiaalministeeriumi ja erialaühendustega, kaasates ka residente (Eesti Nooremarstide Ühendus) ja üliõpilasorganisatsioone (Eesti Arstiteadusüliõpilaste Selts).

## 9. Tagada kõigile residentidele juurdepääs ülikoolide raamatukogudele ja andmebaasidele

Analüüsi kohaselt ei ole üheski kolmest riigist kõikidel residentidel piiramatut juurdepääsu vajalikele väljaannetele ja andmebaasidele. Eestis ei ole juurdepääs ülikooli raamatukogule ja muudele andmebaasidele automaatne ja sõltub baasasutusest. Kuigi residentidel on võimalik küsida luba parimate andmebaaside (näiteks PubMed, UpToDate) kasutamiseks, on see liiga bürokraatlik ja piirab seega mõne residendi juurdepääsu teadusväljaannetele.

Lätis tõsteti probleemina esile asjaolu, et mõne meditsiiniasutuse võrgust ei ole võimalik teatud andmebaasidele ligi pääseda isegi juhul, kui residendil on nendes andmebaasides isiklik konto.

Seetõttu soovitame tagada kõigile residentidele automaatse juurdepääsu ülikoolide raamatukogudele ja andmebaasidele.

## 10. Luua igakülgse tagasiside süsteem (sh tagasiside analüüs) ja muuta see avalikuks

Analüüsi järgi puudub kõigis kolmes riigis praegu terviklik tagasisidesüsteem, mis võimaldaks jälgida residentuuriõppe nõuetekohasust ning rahulolu baasasutuste, juhendajate ja residentidega. Seetõttu soovitame ülikoolidel luua tagasisidesüsteemi, mis annaks teavet selle kohta, mil määral baasasutus, residendid ja juhendamine vastavad residentuuriõppe standarditele, et tuvastada kitsaskohad ja puudused ning astuda samme olukorra parandamiseks.

Peale baasasutustele antava tagasiside süsteemi ei toimi ka praegune juhendajate poolt residentidele antava tagasiside süsteem: see tagasiside on formaalne ja sellel puudub praktiline sisu. Tagasiside on praegu üksnes kokkuvõtlik ja vaid väga harva kujundav. Residentide sõnul ei saa nad juhendajatelt korrapäraselt konstruktiivset tagasisidet ning seetõttu ei tunne residendid end piisavalt enesekindlate ja kvalifitseeritutena iseseisvaks arstitööks. Juhendajad on maininud, et isegi kui nad püüavad anda sisulist tagasisidet, ei pea programmide üldjuhendajad, ülikool ja mõnel juhul ka resident ise seda vajalikuks või oluliseks. Seetõttu on juhendajad loobunud sisulise tagasiside andmisest.

Tagasiside vähesus on seotud peamiselt huvipuudusega tagasiside kogumise vastu. Juhendajate napp õpetamisoskus on valdavalt tingitud suurest töökoormusest või sellisest töökorraldusest, mis vähendab nende võimalust osaleda vähestel juhendajatele mõeldud koolitustel. Järelikult on vaja luua nii juhendajatele kui ka praegustele residentidele pedagoogiliste oskuste õppimise võimalused ja tagada, et seda õpet peetaks eriarstiõppe tähtsaks osaks.

Leedu ja Eesti puhul soovitame, et teatud teemasid võiksid nooremresidentidele õpetada vanemresidendid ning et õpetamine ja õppimine kuuluksid residentuuriprogrammides põhipädevuse hulka. Seejuures on siiski oluline tagada, et juhendavatel residentidel endil oleks piisav õpetamisoskus.

Üle tuleb vaadata ka residentidelt juhendajatele antava tagasiside süsteem. Kuigi residentidel on võimalus (aga mitte kohustus) anda residentuuritsükli lõpus oma juhendajale tagasisidet, ei pruugi see alati jääda anonüümseks. See tähendab, et pragmaatilistel põhjustel võib olla mõistlik vältida ausat tagasisidet või kasutada enesetsensuuri. Tuleks luua juhendaja või osakonna töö hindamiseks anonüümse tagasiside andmise süsteem (seejuures tuleks siiski arvesse võtta residentuuriõppe programmi omadusi, tagamaks, et tagasiside jääb anonüümseks, näiteks juhtudel, kui erialal on ainult üks resident või paar residenti).

Samuti tuleks kaaluda, kas oleks võimalik välja töötada hulk küsimusi, mis võimaldavad saada sisulist, põhjendatud ja võrreldavat tagasisidet. See aitaks tagada, et tagasiside on asjakohane, selgemini väljendatud ja pigem konstruktiivne kui emotsionaalne. Selline tagasiside aitaks vähendada erapoolikust ning suurendada juhendajate rahulolu oma tööga ja motivatsiooni edasiste juhendamisülesannete täitmiseks, samuti selgitada välja arstid, kelle juhendamisoskus vajab parandamist.

Igakülgse tagasiside süsteemiga seoses tuleks selgelt määratleda igas olukorras antava tagasiside liik (summatiivne või formatiivne), kes annab tagasisidet ja kellele, kuidas tagasisidet antakse (sh kas ametlikult või mitteametlikult), tagasiside eesmärk ja kavandatud sisu, tagasiside andmise sagedus, kuidas andmeid analüüsitakse, kuidas esitatakse tulemused ja parandusettepanekud. Tagasisidesüsteemi põhimõtted peaksid olema avalikult kättesaadavad ja kergesti leitavad.

## 11. Töötada välja igakülgse hindamise meetodid ja neid rakendada

Residentide oskuste hindamine on praegu kõigis Balti riikides problemaatiline. Eestis on hindamine ainult summatiivne ja toimub üldjuhul lõpueksami vormis. Mõnel erialal toimuvad siiski ka vaheeksamid. Vaheeksamite põhimõtteid, eesmärke, meetodeid ega korraldust ei ole üksikasjalikult kirjeldatud. Erinevalt vaheeksamitest on lõpueksami olemus programmides põhjalikult selgitatud. Eestis on residentidel kohustus esitada iga kuue kuu järel residentuuripäevik, mis on summatiivse hindamise aluseks, kuid see ei täida oma eesmärke ja pole piisavalt põhjalik. Lätis toimub kokkuvõtlik hindamine, mis hõlmab teadmisi ja oskusi, kuid mitte arstilt eeldatavaid hoiakuid. Leedus ei ole lõpphindamine ja tsüklitevaheline hindamine (elektroonilised päevikud) süstemaatiliselt korraldatud ja osakondade vahel on suured erinevused. Residentide eksamineerimise süsteem on sageli subjektiivne ja tasakaalustamata ning selle rakendamine sõltub suuresti konkreetsest residentuuriprogrammist.

Vajalik on terviklik hindamissüsteem, milles tuleks määratleda ja avalikkusele kättesaadavaks teha meetodid ja põhimõtted. Hindamine peaks olema niihästi kujundav kui ka kokkuvõtlik ning hõlmama kõiki õpitulemusi, sealhulgas pehmeid oskusi nagu suhtlusoskus. Kujundav hindamine peaks olema korrapärane ning aitama residendil arendada programmis kirjeldatud kliinilisi ja muid kutseoskusi.

## 12. Vähendada juhendajate töökoormust, nähes tööplaanides ette juhendamisele mõeldud aja, võttes kasutusele tehnoloogilisi lahendusi ja palgates haldusassistente

Analüüsi kohaselt napib praegu eriarste, kes sobiksid täitma juhendaja ülesandeid. Selle olukorra tõttu on mõned arstid olnud sunnitud hakkama juhendajaks. Seega õpetatakse residente kohati vastumeelselt. Praktiseerivad juhendajad on sageli tööga ülekoormatud, mis vähendab nende suutlikkust residente juhendada.

Leedus nimetati ühe peamise lahendamist vajava probleemina bürokraatiast ja mittetoimivatest protsessidest tulenevat ülekoormust, mille vähendamine jätaks rohkem aega õpetamisele ja õppimisele. Seega on soovitatav leida viise juhendajate töökoormuse vähendamiseks.

Tehnoloogiliste lahenduste kasutuselevõtt (näiteks Eestis seniste paberkandjal residentuuripäevikute asendamine elektrooniliste päevikutega, mis hõlbustavad tagasiside andmist. Hetkel on võimalik esitada residentuuripäevik paberkandjal dekanaati või edastada täidetud tekstifail meili teel, mida kutsutakse ka elektrooniliseks päevikuks, kuid puudub kogu residentuuri kestel kasutatav elektrooniline keskkond.) ja haldusassistentide palkamine on kaks võimalust, mis võiksid juhendajate jaoks vähendada paberitööd ja bürokraatiat. Residendid leiavad mitme praeguse programmi puhul, et juhendajad või osakonnad ja haiglad ei väärtusta residentide õpetamist ning paljud peavad seda ajaraiskamiseks. Seetõttu on vaja muuta järgmise põlvkonna õpetamise kultuuri ja näha juhendajate tööplaanides ette aega juhendamiseks, vähendades nende muud töökoormust.

## 13. Võtta kasutusele residentide mentorluse süsteem

Residentide jaoks tuleks luua mentorlussüsteem, mille käigus igale residendile määratakse kogu residentuuriõppe ajaks oma eriala mentor, kes annab residendile korrapäraselt tagasisidet ja tagab, et resident omandab vajaliku pädevuse, ning vähendab mõnevõrra juhendajate töökoormust. Sellise süsteemiga tagatakse, et korrapärane kontakt mentoriga säilib ka koolitusbaasi muutumisel. Samuti võimaldaks see residendil kogu residentuuriperioodi vältel konsulteerida mentoriga peale erialaste küsimuste ka üldistes arstikutsega seotud küsimustes. Mentor saab pakkuda residendile tuge ka juhtudel, kus juhendamine koolitusbaasis ei ole piisaval tasemel. Lisaks võib mentor aidata residendil olla kursis eriala teadusarenguga.

Lätis tutvustab mõnes asutuses vanemresident esimese aasta residentidele mentorlusprogrammi käigus haiglatöö korraldust ja üldisi protsesse. Eestis on mentorlusprogramm mõnel residentuuri erialal juba rakendatud. Residendid, kes on sellise programmiga kokku puutunud, rõhutavad, et mentorluse süsteem peab olema vabatahtlik ja paindlik, võimaldades vajaduse korral mentorit vahetada (näiteks kui resident ja mentor ei saavuta head kontakti, resident otsustab muuta eriala vms).

Ühtlasi ei tohi unustada, et mentorlussüsteemi kasutuselevõtt ei lahendada süstemaatilist arstide ajapuuduse probleemi. Seda pigem vastupidi – mentorlus võib probleemi veelgi süvendada. Mentorlusprogramm eeldab kõigepealt mentorite ja nende hoolealuste koolitamist ning võimalikku prooviperioodi mõnel uuendusmeelsemal erialal, et hinnata mentorluse rakendamise lihtsust ja lahendada esialgsed probleemid. Alles seejärel võiks seda rakendada kõigil erialadel.

## 14. Tagada, et kõik residendid omandavad residentuuriõppe käigus teadustöö oskused

Teadustöö ei ole Eestis kõigi residentuuriprogrammide kohustuslik osa. Küsimuses, kas teadustööga tuleks tegeleda ainult doktoriõppes või ka residentuuris, lähevad seisukohad lahku. Lätis on mõlema ülikooli kõigi erialade puhul teadustöö kirjutamine ja avaldamine residentuuri läbimise eeltingimus. On välja pakutud, et Läti Ülikool võiks vähendada teadustöö formaalset jäikust, andes residentidele võimaluse valida, kas kirjutada ametlik lõputöö või avaldada oma teadustöö mõnes rahvusvahelises ajakirjas. Leedus näeb Leedu Tervishoiuülikooli residentuurieeskiri ette, et residentuuriõppe läbimiseks tuleb esitada lõputöö, samal ajal kui Vilniuse Ülikoolis sõltub see nõue konkreetsest residentuuriõppe programmist. Mõlemas ülikoolis saavad residendid juhendajatelt vähe tuge. Eestis ja Leedus on mõnel erialal loodud nn ajakirjaklubid (ingl *journal club*), kus esitletakse ja arutatakse mitmesuguseid artikleid.

Analüüsi kohaselt on nii residendid kui ka nende juhendajad osutanud vajadusele õpetada residentidele akadeemilise kirjanduse kriitilise hindamise oskust, statistikaga seotud oskusi ja tõenduspõhise meditsiini aluseid. Seega tuleks kõikide residentuuriprogrammide käigus õpetada teadustöö tulemuste, eelkõige aga statistika ja uuringu korralduse tõlgendamise oskust.

## 15. Tagada residentidele korralikud töötingimused, sealhulgas psühholoogiline tugi

Kõigis kolmes riigis tehti kindlaks puudusi residentide töötingimustes. Eri riikide residendid tõstsid esile järgmised probleemid: pikk tööaeg, tööpäeva jooksul ei ole aega lugeda meditsiinikirjandust või juhiseid, raskused töövõimetuslehe või palgata puhkuse võtmisel, probleemid residentide töölaudade ja vabade arvutitega, tööriideid napib ja puudub võimalus kasutada riietusruume, piiratud juurdepääs haigla IT-süsteemidele, väike palk (Lätis ja Leedus), märkimisväärne hulk ületunnitööd. Kõik see tekitab lisastressi ning võib põhjustada vaimseid ja füüsilisi terviseprobleeme.

Mainitakse ka vähest juhendamist ja psühholoogilise toe puudumist rasketes olukordades, nagu patsiendi surm. Seetõttu on soovitatav, et kõik asjaomased sidusrühmad (näiteks ülikoolid ja baasasutused) koostaksid plaani, kuidas tagada residentidele korralikud töötingimused. Lisaks tuleks kõigile meditsiinitöötajatele ette näha psühholoogiline tugi konfliktiolukordade ja keeruliste meditsiiniliste juhtumite korral.

## 16. Panna rohkem rõhku õppimisele tervishoiuteenuste osutamise käigus

WFME standardite järgi peaks residentuuriõppe kui tasemeharidusjärgse spetsialiseerumise vormi keskmes olema õppimine teenuseosutamise käigus. Kõigis kolmes riigis osutasid erinevate erialade residendid, et nende valdkonnas domineerib residentuuri ajal täiendava õpiväärtuseta kliiniline töö ja teoreetiline õppimine on tagaplaanil, kuna vaikimisi eeldatakse, et teoreetiliste teadmiste omandamine toimub igapäevatöö taustal.

Seega on soovitatav, et teenuseosutamise käigus pööratak rohkem tähelepanu residentide õpetamisele. See eeldab, et juhendajatel on juhendamiseks rohkem aega ning nende õpetamisoskust ja residentide tagasisidet juhendajatele on parandatud.

# 4. Järeldused

Uuringu eesmärk oli analüüsida, kuidas on residentuuriõpe Balti riikides (Eestis, Lätis ja Leedus) korraldatud, et teha kindlaks selle tugevused, nõrkused ja võimalused ning aidata kaasa residentuuriõppe arendamisele. Sel eesmärgil hinnati, mil määral vastab Balti riikide residentuuriõpe rahvusvahelistele standarditele.

Balti riikides läbiviidava residentuuriõppe praeguse olukorra analüüsimisel lähtuti WFME ülemaailmsetest kvaliteedistandarditest. Uuringus kombineeriti mitmekülgsuse nimel kvantitatiivseid ja kvalitatiivseid meetodeid. Analüüsi aluseks oli uurimismeetodite ja andmete triangulatsioon.

Tulemused näitasid, et **residentuuriõppe korraldus erineb nii riikide võrdluses kui ka riikide sees baasasutuste ja erialade lõikes**. Vaid üksikute standardite puhul vastab residentuuriõppe olukord riigis täielikult rahvusvahelisele standardile. Keskmiselt võiks Balti riikide olukorda iseloomustada sõnadega „vastuolulised tõendid selle kohta, et residentuuriõpe vastab standardile“.

Kuigi Balti riikides on kehtestatud residentuuriõpet käsitlevad raamdokumendid, on peamised probleemid seotud nende ebaõige rakendamisega. Residentuuriprogrammide uuendamine ei ole Balti riikides regulaarne, sõltub suuresti koordinaatorist või programmi üldjuhendajast ega hõlma kõiki asjassepuutuvaid osalisi. Kuigi üldiselt peavad residendid ja juhendajad kõigis Balti riikides residentuuri vastuvõtmise süsteemi enamjaolt läbipaistvaks ja õiglaseks, näitas analüüs, et kõigis kolmes riigis tajutakse ka läbipaistmatust ja konkreetsete kandidaatide soosimist. Samuti ei ole tasakaalus residentide vastuvõtmise ja hariduse andmise suutlikkuse planeerimine. Veel üks korralduslik probleem on juhendajate värbamist ja valimist käsitlevate selgelt sõnastatud põhimõtete puudumine. Leiti, et residentuuriõpe ei ole paindlik ega võeta arvesse residentide individuaalseid vajadusi (näiteks puudub osaajaga residentuuriõppe võimalus). Naissoost residendid on kogenud seksuaalset ahistamist ja on märke ka naiste soolisest diskrimineerimisest residentuuriõppe ajal või residentuuri vastuvõtmisel (Eestis ja Leedus).

Koolituse kvaliteedi seisukohast leiti, et põhiõpe annab residentuuri eel head prekliinilised teadmised ja residentidel on juurdepääs ajakohasele erialakirjandusele. Siiski **võib Balti riikides läbiviidavat residentuuriõpet pidada kvaliteedi poolest ebaühtlaseks**: juhendamise kvaliteet, teooria ja praktika tasakaal, residentuurikogemus ja pädevuste hindamine võivad erialadel, residentuuritsüklites, tervishoiuasutustes ja nende osakondades märkimisväärselt erineda. Peale selle ei peeta pehmeid oskusi meditsiinihariduse võrdselt oluliseks osaks, kuigi need kuuluvad kavandatud õpitulemuste hulka.

Balti riikide residentuuriõppe üks peamisi puudusi seisneb selles, et residentide hindamine ja neile antav tagasiside on vähene ja ebakorrapärane või mitteõigeaegne. Praktika on osakonniti ja programmiti siiski erinev ja sõltub suuresti ka konkreetsest juhendajast. Residentide hindamise korraldus ei ole süstemaatiline ja läbipaistev ega aita residendi arengule kaasa.

Kõigi kolme Balti riigi residentuuriõppe programmid pakuvad mõnevõrra teadusliku põhjendamise oskuste ja empiirilise metoodika õpet. Teisest küljest ei ole nende teadmiste andmist (Eestis ja Leedus) ametlikult kindlaks määratud ja tõenäoliselt eeldatakse, et residendid omandavad need oskused iseseisvalt, minimaalse toe ja tagasiside abil.

Lisaks tehti kindlaks mitmesugused puudused residentide töötingimustes, näiteks pikk tööaeg ja tööpäeva jooksul meditsiinikirjanduse või juhistega tutvumiseks ettenähtud aja puudumine. Samuti on probleem residendi tööks vajaliku arvuti ja töölaua puudumine.

Praeguse residentuuriõppe süsteemi parandamiseks töötati välja järgmised poliitikasoovitused:

1. kehtestada ja rakendada residentuuriõppe miinimumstandardid, sh juhendamise standardid;
2. kehtestada residentuuriõppe programmide ajakohastamise riiklik süsteem;
3. muuta residentuuriõpe residendikesksemaks ja luua osakoormusega residentuuriõppe võimalus;
4. tagada residentuuri vastuvõtmisel läbipaistvus;
5. tagada sooline võrdõiguslikkus ning töötada välja vastavad suunised residentidele ja juhendajatele;
6. teha kogu teave residentuuri kohta – kursused, eeskirjad, uuendused jne – avalikult kättesaadavaks;
7. näha residentuuriõppe programmides ette pehmete oskuste arendamine;
8. hinnata kõiki olemasolevaid residentuuriõppe programme, arvestades kõiki WFME standardeid;
9. tagada kõigile residentidele juurdepääs ülikoolide raamatukogudele ja andmebaasidele;
10. luua igakülgse tagasiside süsteem (sh tagasiside analüüs) ja muuta see avalikuks;
11. töötada välja igakülgse hindamise meetodid ja neid rakendada;
12. vähendada juhendajate töökoormust, nähes tööplaanides ette juhendamisele mõeldud aja, võttes kasutusele tehnoloogilisi lahendusi ja palgates haldusassistente;
13. võtta kasutusele residentide mentorluse süsteem;
14. tagada, et kõik residendid omandavad residentuuriõppe käigus teadustöö oskused;
15. tagada residentidele korralikud töötingimused, sealhulgas psühholoogiline tugi;
16. panna rohkem rõhku õppimisele tervishoiuteenuste osutamise käigus.

Tähtis on märkida, et ükski sidusrühm ei suuda keerulisi probleeme lahendada üksi. Kõige tulemuslikumad lahendused sünnivad süstemaatilisest ja hästi läbimõeldud koostööst kõigi asjaomaste osaliste vahel.

### UURINGU PIIRANGUD JA EDASPIDINE UURIMISTÖÖ

Uuringul on mõned arvestatavad piirangud. Esiteks puudutab analüüs vaid osa WFME standarditest, nagu on mainitud punktis 1.2.1. Seetõttu ei analüüsitud mitut alamvaldkonda, näiteks arstiteaduskonna missiooni, infotehnoloogia kasutamist ja koostoimet tervishoiusektoriga.

Lätis ei olnud uurijal luba analüüsida residentuuriõppe programme, mis võis hindamist mõjutada. Konkurentidena peavad kaks Läti ülikooli residentuuriõppe programmide sisu intellektuaalomandiks ega võimalda kolmandatel isikutel nendega tutvuda. Vajaliku teabe saamiseks kasutati alternatiivseid meetodeid, nagu intervjuud.

Tulevane uurimistöö võiks keskenduda residentuuriõppe protsessi, ülesehituse, sisu, tulemuste, pädevuste, hindamise ja õpikeskkonna mis tahes valdkonna probleemide analüüsimisele. Näiteks võiks edaspidise uurimistöö üks peateema olla sisulise hindamise ja tagasiside andmise takistuste üksikasjalik kaardistamine. Samuti võiks uurida tervishoiusektori institutsionaalseid võimusuhteid

residentuuriõppe kvaliteedi parandamise seisukohast või soolist ebavõrdsust, mis mõjutab õppimisvõimalusi ja seda eriti naiste puhul.

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# **Lisa 1.** Uuringu jaoks kohandatud WFME standardid

## 1. **Residentuuriõppe õiguslikud ja korralduslikud tahud** (B 1.1 – B 5.1)

1.1. Residentuuriõppe korraldus on riigis selgelt reguleeritud.
1.2. Residentuuriõppe korralduse aluspõhimõtete ja õppeprogrammide kavandatud õpitulemuste kinnitamisse kaasatakse kõik peamised sidusrühmad.
1.3. Residentuuriõppe vorm ja õppeprogrammide kavandatud õpitulemused moodustavad tervishoiusüsteemi vajadustega ühtse terviku.
1.4. Residentide valimisel ja õppeprogrammide elluviimisel lähtutakse võrdsuse põhimõtetest.
1.5. Residentide valiku kriteeriumide ja protsessi põhimõtted on määratletud ning neid rakendatakse.
1.6. Residentide vastuvõtmine ja hariduse andmise suutlikkus on tasakaalus ning õppekohtade arv vastab kliinilistele/praktilistele koolitusvõimalustele ja asjakohase juhendamise suutlikkusele.
1.7. Koolitajate, juhendajate ja õpetajate värbamiseks ning valimiseks on välja töötatud ja rakendatud selgelt sõnastatud põhimõtted.
1.8. Residendid saavad mõistlikul määral valida asutuste ja nende allüksuste vahel, kus nad oma koolituse läbivad.

## 2. **Residentuuriõppe kvaliteet** (B 1.1 – B 9.0)

2.1. Residentuuriõppe vorm tagab arstide väljaõppe sellisel määral, et arstid on pädevad oma meditsiinierialal asjakohast meditsiini praktiseerima ja võimelised professionaalselt töötama.
2.2. Residentuuriõppe vorm ja kestus tagavad arstide väljaõppe sellisel määral, et arstid on võimelised oma meditsiinierialal järelevalveta ja iseseisvalt töötama.
2.3. Residentuuriõppe vorm tagab arstide väljaõppe sellisel määral, et arstid on võimelised vajaduse korral töötama nii kutsealapõhistes kui ka kutsealadevahelistes meeskondades.
2.4. Residentuuriõppe vorm tagab arstide väljaõppe sellisel määral, et arstid on pühendunud elukestvale õppele ning osalemisele täienduskoolituses ja pidevas tööalases enesearendamises.
2.5. Residentidele on tagatud töötingimused, mis on vajalikud nende tervise hoidmiseks.
2.6. Programmid on ajakohased ja vastavad konkreetse meditsiinieriala viimastele arengutele.
2.7. Programmide uuendamine on süstemaatiline ja toimub koostöös kõigi sidusrühmadega.
2.8. Residentuuriõppe raamistiku aluseks on olemasoleva arstide põhiõppe tulemusena saavutatud õpitulemused.
2.9. Õpe põhineb programmi kavandatud õpitulemustel ja residentidelt nõutaval kvalifikatsioonil.
2.10. Residentuuri õpperaamistik on korraldatud süstemaatiliselt ja läbipaistvalt.
2.11. Rakendatakse sobivaid õpetamis- ja õppemeetodeid ning kogu õppe vältel on tagatud praktiliste ja teoreetiliste komponentide integreerimine.
2.12. Kasutatakse residendikeskset lähenemisviisi, mis motiveerib ja valmistab residente ette võtma vastutust oma õpiprotsessi eest ja kaaluma hoolikalt oma tegevust ning pakub residentidele selles tuge.
2.13. Residentuuriprogrammi korraldajad ja residendid mõistavad soolisi, kultuurilisi ja usulisi eripärasid ning residendid on valmis tegutsema neist lähtudes.
2.14. Programmi käigus tutvustatakse meditsiinilise teadustöö, sealhulgas kliiniliste uuringute ja kliinilise epidemioloogia aluseid ja metoodikat.
2.15. Õppeprogramm ja -protsess tagavad, et resident tutvub tõenduspõhise raviga asjakohaste kliiniliste/praktiliste kogemuste kaudu oma meditsiinieriala mitmesugustes tööolukordades.
2.16. Programmi sisu kohandatakse teaduse arenguga.

2.17. Programm hõlmab kliinilist tööd ja asjakohaseid teoreetilisi teadmisi või kogemusi põhiliste biomeditsiiniteaduste, kliinilise teaduse, käitumis- ja sotsiaalteaduste, ennetava meditsiini, rahvatervise, meditsiiniliste õigusaktide ja juhtimise alal.
2.18. Programm hõlmab kliinilist tööd ja asjakohaseid teoreetilisi teadmisi või kogemusi kliiniliste otsuste tegemise, meditsiinieetika ja patsiendi ohutuse alal.
2.19. Programm hõlmab kliinilist tööd ja asjakohaseid teoreetilisi teadmisi või kogemusi arstide suhtlusoskuste ja enese eest hoolitsemise alal ning tõenduspõhise meditsiini seoseid täiendmeditsiiniga (ingl *complementary medicine*).
2.20. Õpe on olemuselt kutsealasele arengule suunatud praktika, mis hõlmab nii koolitust kui ka teenuseosutamist.
2.21. Residentuuriõpe valmistab residendid ette kõikideks rollideks, mida arstilt tervishoiusektoris eeldatakse.
2.22. Resident saab mitmesuguseid kogemusi, sealhulgas õpet eri asutustes ja piisavalt kogemusi valitud meditsiinieriala tahkudes.
2.23. Põhiõpe annab residentuuri eel head prekliinilised teadmised.
2.24. Õppeprotsess on mitmekülgne ja residendid osalevad kõigis õppe seisukohast olulistes meditsiinitoimingutes, sealhulgas valves, aga teenuseosutamine ei domineeri.
2.25. Juhendajatel on võimalik saada pedagoogilist õpet ja juhendajakoolitust.
2.26. [*analüüsist välja jäetud*]
2.27. Koolitajate ja juhendajate kliinilise töökoormuse ja koolituskohustuste vahel on tasakaal, mis jätab piisavalt aega õpetamiseks, juhendamiseks ja õppimiseks.
2.28. Koolitajate perioodilisel hindamisel kasutatakse residentide tagasisidet juhendajale.
2.29. Residentidel on juurdepääs ajakohasele erialakirjandusele.
2.30. Programmide rakendamist jälgitakse ja hinnatakse korrapäraselt, kogutakse andmeid programmide põhiliste tahkude kohta, et tagada õppe plaanipärasus ja teha kindlaks võimalikud sekkumist vajavad valdkonnad.
2.31. Järelevalve käigus tuvastatud probleeme ja asjakohaseid hindamistulemusi käsitletakse süstemaatiliselt.
2.32. Residentidelt, juhendajatelt, tööandjatelt ja kvalifitseeritud arstidelt kogutakse programmide kohta tagasisidet, mida kasutatakse programmide arendamiseks.
2.33. Kursuse ja programmi hindamise tulemused tehakse peamistele sidusrühmadele kättesaadavaks.
2.34. Programmi protsessi, ülesehituse, sisu, tulemuste ja pädevuste, hindamise ning õpikeskkonna korrapärase läbivaatamise ja ajakohastamise kord on kindlaks määratud.

## 3. Hindamine ja tagasiside residentuuriõppes (B 1.3 – B 4.1)

3.1. Residentide valimise protsess on läbipaistev ja kooskõlas kehtestatud valikupõhimõtetega.
3.2. Programmide kavandatud õpitulemused on määratletud residentuuriõppe tulemusena omandatavate teadmiste, oskuste ja hoiakute ning tervishoiusektoris edaspidi täidetavate rollide kaudu.
3.3. Programmide kavandatud õpitulemused on määratletud üldiste ja valdkonna- või erialapõhiste komponentide suhtes.
3.4. Residente suunatakse residentuuriõppe käigus juhendamise ning korrapärase hindamise ja tagasiside abil.
3.5. Residendi iseseisev vastutus suureneb oskuste, teadmiste ja kogemuste kasvades.
3.6. Residentide hindamise põhimõtted, eesmärgid, meetodid ja korraldus on määratletud, kehtestatud ja avaldatud.

3.7. Kasutatakse üksteist täiendavaid hindamismeetodeid ja -vorme, sh võetakse arvesse kujundava ja kokkuvõtliku hindamise tasakaalu, eksamite ja muude testide arvu, eri liiki eksamite (kirjalike ja suuliste) tasakaalu, normatiivseid ja kriteeriumipõhiseid hinnanguid, isiklike mappide ja päevikute kasutamist ning eksamineerimise erivormide (näiteks objektiivsed struktureeritud kliinilised eksamid (OSCE) ja lühivormis kliinilise hindamise harjutused (MiniCEX) kasutamist.
3.8. Hindamised hõlmavad teadmisi, oskusi ja hoiakuid.
3.9. Hindamismeetodite usaldusväärsust, valiidsust ja õiglust hinnatakse ja dokumenteeritakse.
3.10. Hindamispõhimõtted ja -meetodid ning hindamise korraldus on selgelt kooskõlas kavandatud õpitulemuste ja õpetamismeetoditega ning tagavad õppe piisavuse ja asjakohasuse.
3.11. Hindamispõhimõtted ja -meetodid ning hindamise korraldus edendavad residentide õppimist ning tagavad, et residendid saavutavad kavandatud õpitulemused.
3.12. Hindamispõhimõtted ja -meetodid ning hindamise korraldus tagavad hindamistulemuste põhjal residentidele õigeaegse, konkreetse, konstruktiivse ja õiglase tagasiside andmise.

## 4. **Teadustöö roll residentuuriõppes** (B 2.2 – B 6.5)

4.1. Õppeprogrammid ja -protsess tagavad, et resident õpib kasutama teaduslikku põhjendamist ning rakendab valitud meditsiinieriala teaduslikke aluseid ja meetodeid.
4.2. Õpe hõlmab kirjanduse ja teaduslike andmete kriitilise hindamise õpetamist.
4.3. Residente julgustatakse osalema meditsiinilises teadustöös ning tervishoiu ja tervishoiusüsteemi kvaliteedi arendamises.

# **Lisa 2.** Veebiküsitlused Eestis, Lätis ja Leedus

## Eestis (eesti keeles)

Eesti residentuuri hindamise küsimustik

| a[16] | b[17] | c[18] | Staatus:<br>a) olen resident<br>b) värskelt residentuuri lõpetanu või katkestanu<br>c) juhendan residente |
|---|---|---|---|
| X | X | X | Sugu<br>M<br>N |
| X | X | X | Vanus |
| X | X | X | Staatus |
| **X** | | | **a) olen resident** |
| | **X** | | **b) värskelt residentuuri lõpetanu või katkestanu** |
| | | **X** | **c) juhendan residente** |
| X | | | Mitmenda aasta resident olete?<br>1 … 5 |
| | X | | Mis aastal lõpetasite? |
| | | X | Mis aastal lõpetasite arstiteaduskonna? |
| | | X | Kui olete lõpetanud residentuuri, siis mis aastal see toimus? |
| X | | | Mis eriala omandate? |
| | X | | Mis eriala omandasite? |
| | | X | Mis erialal praktiseerite? |
| X | | | Kas olete läbinud residentuuritsükli mõnes välisriigis?<br>jah<br>ei<br>Palun täpsustage: |
| | X | | Kas olete läbinud mõne residentuuritsükli välisriigis?<br>jah |

[16] Küsimused residentidele.

[17] Küsimused residentidele, kes lõpetasid või katkestasid residentuuri aastatel 2016–2018.

[18] Küsimused residentide juhendajatele.

| | | | |
|---|---|---|---|
| | | | ei<br><br>'Jah' korral täpsustage, millises riigis ja millise kestusega: |
| X | | | Nimetage ilma abivahendeid kasutamata vähemalt 5 teie eriala residentuuriprogrammi õpiväljundit. |
| X | X | X | Hinnake, kuidas nõustute järgmiste väidetega: |
| | X | X | Minu eriala residentuur on sisu ja kestuse poolest piisav, et valmistada ette pädevaid eriarste.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| | X | X | Residentuuriõpe on korraldatud süsteemselt, tsüklid on loogilises järgnevuses.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| | | X | Nimetage ilma abivahendeid kasutamata vähemalt 5 teie eriala residentuuriprogrammi õpiväljundit. |
| X | X | X | Arsti põhiõppes omandatavad oskused ja teadmised haakuvad minu eriala residentuuris jätkamiseks vajalike oskuste ja teadmistega.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Residentuur minu erialal on korraldatud kooskõlas minu arusaamisega sellest, kuidas põhiõppejärgne erialaõpe peaks toimuma.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Residentide valikuprotsess on läbipaistev ja õiglane.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Residentuuris pööratakse piisavalt tähelepanu teiste arstidega meeskonnas töötamise oskuste arendamisele.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| x | X | X | Residentuuris pööratakse piisavalt tähelepanu teiste kutsealade esindajatega (õed, ämmaemandad, tehnikud, psühholoogid) meeskonnas töötamise oskustele.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Residentuuri vältel kujundatakse süsteemselt residentide oskuseid-harjumusi, mis toetavad nende järjepidevat kutsealast enesearendamist residentuuri lõpetamise järel.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |

| | | | |
|---|---|---|---|
| X | X | X | Residentuuri vältel käsitletakse piisavalt arsti autonoomsusega seonduvaid aspekte, sh arsti õigust teha informeeritud raviotsuseid, mis on patsiendi ja ühiskonna seisukohalt parimad.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Residentuuri vältel käsitletakse arsti professionaalsusega seonduvaid aspekte: oskused elukestvaks õppeks ja kompetentsuse hoidmiseks, eetiline käitumine, altruism, empaatia, kaasinimeste teenimise oskus, eetikakoodeksite järgimine, patsiendiohutus.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Residentuuri praktiline koolitus minu erialal sisaldab erinevaid seminare ja haigusjuhtude analüüse.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Residendid saavad residentuuri vältel piisavat tagasisidet kujul, mis toetab nende arenemist professionaalseks arstiks.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Residendi vastutuse määra tervishoiuteenuste osutamisel tõstetakse järk-järgult kooskõlas tema oskuste ja teadmiste suurenemisega.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Residentuuriõpe on korraldatud viisil, mis hoiab residendi vaimset ja füüsilist tervist.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Residentuuri vältel pööratakse süsteemselt tähelepanu suhtlemisoskusele kolleegide, teiste tervishoiutöötajate, patsientide ja nende lähedastega.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Minu eriala residentuuris on kesksel kohal teaduslik lähenemine, käsitlemist on leidnud meditsiiniline uurimistöö, sh kliiniliste uuringute ja kliinilise epidemioloogia alused.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Mul on hea ligipääs erialasele teaduskirjandusele.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Minu eriala residentuuriprogrammis on praktiline ja teoreetiline õpe ootuspärases tasakaalus.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult |

| | | | |
|---|---|---|---|
| | | | Täpsustage hinnangut: |
| X | X | X | Arstkonnas suhtutakse residenti kui täisväärtuslikku arsti.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Mulle on/olid loodud eeldused, et tegeleda residentuuris erialase teadustööga mulle huvipakkuval teemal.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Olen residentuuri vältel saanud õpet/juhendamist erialase teaduskirjanduse ja erialaste andmestike kriitiliseks hindamiseks.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Olen residentuuri vältel saanud õpet/juhendamist kliiniliste otsuste tegemiseks.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Mind on residentuuri vältel juhendatud ennetama ja lahendama kommunikatsiooniprobleeme või (potentsiaalselt) konfliktseid olukordi, mis tulenevad soolistest, kultuurilistest või religioossetest eripäradest.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Residentuuris kasutatavad juhendamise meetodid vastavad täielikult minu ootustele.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Residentuuris kasutatavad teoreetilised ja praktilised õpimeetodid vastavad täielikult minu ootustele.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Residentuur on korraldatud viisil, mis arvestab minu individuaalsete soovide ja vajadustega.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Patsiendid on kogu residentuuri vältel suhtunud minusse kui täisväärtuslikku arsti.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Ma ei ole residentuuri vältel kokku puutunud olukorraga, kus mind või kaasresidente koheldakse tööandja või juhendajate poolt ebavõrdselt või rikutakse muul viisil minu või teiste õiguseid. |

| | | | |
|---|---|---|---|
| | | | ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Residentuuri baasasutused on juhendamise kvaliteedi taseme poolest ühtlased.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Minu ja kaasresidentide teadmiste, oskuste ja hoiakute hindamine on toimunud õiglaselt, läbipaistvalt ja kooskõlas kavandatud õpitulemuste ja rakendatud juhendamismeetoditega.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Mul on nii residentuuri eel kui ka ajal olnud ligipääs pädevale nõustamisele karjääri planeerimiseks või seotuna läbipõlemisega või juhendajate-kolleegidega tekkinud põhimõtteliste eriarvamustega.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | | Residentuurijuhendajatel on/oli minu jaoks alati piisavalt aega.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| | | X | Lähtun juhendamisel residentuuriprogrammis sõnastatud õpitulemeist ja oodatavatest oskustest.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| | | X | Minu töö on korraldatud viisil, mis võimaldab tegeleda piisaval määral nii residentide juhendamise, tervishoiuteenuste osutamisega ning ka uute teadmiste omandamisega.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| | | X | Olen saanud piisavas määras õpetamisalast täiendõpet, mis võimaldab mul olla juhendajana tasemel.<br><br>ei nõustu – pigem ei nõustu – raske öelda – pigem nõustun – nõustun täielikult<br><br>Täpsustage hinnangut: |
| X | X | X | Kas eespool toodud küsimused käsitlesid teie silmis piisaval määral residentuuriga seotud olulisemaid küsimusi?<br><br>ei<br><br>jah<br><br>Palun täpsustage: |
| X | X | X | Iseloomustage palun 3-5 lausega kokkuvõtvalt tänast Eesti residentuuri. |

## Lätis ja Leedus (inglise keeles)

Postgraduate Medical Education in Latvia – Assessment Survey / Postgraduate Medical Education in Lithuania – Assessment Survey

| a[19] | b[20] | c[21] | Status:<br>a) I am resident<br>b) I have completed or discontinued residency between 2016–2018<br>c) I am supervisor of residents |
|---|---|---|---|
| X | X | X | Gender<br>Male<br>Female |
| X | X | X | Age |
| X | X | X | Status |
| **X** | | | **a) I am resident** |
| | **X** | | **b) I have completed or discontinued residency between 2016–2018** |
| | | **X** | **c) I am supervisor of residents** |
| X | X | | University[22]<br>Latvian University<br>Riga Stradiņš<br>Other |
| | X | X | What year did you complete postgraduate medical education? (original free form text) |
| X | | | Which year resident you are?<br>1 … 5 |
| X | | | What is your specialty? (original free form text) |
| | X | X | What is your chosen field of medicine? |
| X | X | X | Have you passed a part of your training in a foreign country?<br>Yes<br>No |

[19] Küsimused residentidele.

[20] Küsimused residentidele, kes lõpetasid või katkestasid residentuuri aastatel 2016–2018.

[21] Küsimused residentide juhendajatele.

[22] Küsiti ainult Lätis.

| | | | |
|---|---|---|---|
| | | | If yes, please specify the country and duration: |
| X | X | X | Please indicate how strongly you agree or disagree with the following statements and specify the assessment for each statement **regarding your residency program**. |
| | X | X | The overall structure, composition and duration of the programme on my specialty is sufficient to prepare competent specialists.<br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br>Please specify your assessment: |
| | X | X | Residency is organized systematically; study cycles are in a logical sequence.<br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br>Please specify your assessment: |
| X | X | X | The skills and knowledge acquired during basic education of medical doctors are relevant to the skills and knowledge necessary to continue postgraduate medical training on my specialty.<br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br>Please specify your assessment: |
| X | X | X | The postgraduate medical training on my specialty is organized in line with my understanding how postgraduate medical training should be provided.<br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br>Please specify your assessment: |
| X | X | X | The process of selecting trainees is transparent and fair.<br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br>Please specify your assessment: |
| X | X | X | During postgraduate medical training sufficient attention is paid developing skills that support working in a team with colleagues.<br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br>Please specify your assessment: |
| X | X | X | During postgraduate medical training sufficient attention is paid developing skills that support working in a team with other health professions (nurses, midwives, technicians, psychologists).<br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br>Please specify your assessment: |
| X | X | X | During postgraduate medical training the trainees are prepared to life-long learning and participation in continuing medical education/ continuing professional development.<br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br>Please specify your assessment: |

| | | | |
|---|---|---|---|
| X | X | X | During postgraduate medical training professional autonomy of doctors is fostered necessary to enable the doctor to act in the best interests of the patient and the community.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | X | During postgraduate medical training, the aspects related to the professionalism of the doctor are addressed: skills of lifelong learning and maintenance of competencies, ethical behaviour, altruism, empathy, service to others, adherence to professional codes, consideration of patient safety.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | X | Practical training in my specialty includes various seminars and case-study analyses.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | X | The trainees are guided by means of supervision, regular appraisal and feedback that supports their development to a professional doctor.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | X | The degree of independent responsibility of the trainees is increased gradually as skills, knowledge and experience grow.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | X | The trainees have appropriate working conditions to maintain their own mental and physical health.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | X | During postgraduate medical training, systematic attention is paid to developing skills to communicate with colleagues, other healthcare professionals, patients and their relatives.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | X | Throughout postgraduate medical training, trainees achieve knowledge of and ability to apply the scientific basis and methods on chosen field of medicine; the foundation and methodology of medical research on chosen field of medicine, including clinical research and clinical epidemiology are introduced.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |

| | | | |
|---|---|---|---|
| X | X | X | Trainees have access to up-to-date professional literature.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | X | There is a fine balance between educational, research and service functions in postgraduate medical training on my chosen field of medicine.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | | The trainees are encouraged to engage in medical research on a topic of their choice.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | | The programme in my chosen field of medicine includes formal teaching on critical appraisal of the literature and scientific data.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | | The programme in my chosen field of medicine includes clinical work and relevant theory or experience of clinical decision-making.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | | The trainees are prepared to recognise gender, cultural and religious specifications and to interact appropriately.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | | Supervisors use instructional and learning methods that are appropriate and ensure integration of practical and theoretical components.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | | Residency is organized in a way that takes into account my individual preferences and needs.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly adree<br><br>Please specify your assessment: |
| X | X | | During residency me and co-residents are treated equally and our rights have not been violated.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |

| | | | |
|---|---|---|---|
| X | X | | The quality of supervision is homogeneous across the training centres.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | | The assessment covers knowledge, skills and attitudes and is conducted fairly, transparently and in accordance with the proposed learning outcomes and supervision methods.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | | The trainees have access to competent counselling and support on need for career guidance and planning, in case of a professional crisis or in solving problematic trainee situations.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | | My supervisors have/had time for teaching and supervision.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| | | X | The learning outcomes and expected skills outlined in the residency program serve as basis on supervising and training the residents.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| | | X | My clinical work load is organized in a way that ensures also time for teaching, supervision and learning.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| | | X | I have been trained to be a supervisor in my chosen field of medicine.<br><br>strongly disagree – disagree – neither agree nor disagree – agree – strongly agree<br><br>Please specify your assessment: |
| X | X | X | Did the questions above address the most important issues related to residency in Latvia / Lithuania?<br><br>No<br><br>Yes<br><br>Please specify: |
| X | X | X | Please give us general assessment (3–5 sentences) on current situation of postgraduate medical education in Latvia / Lithuania. |

# **Lisa 3.** Näited residentuuriõppest valitud Euroopa riikides

## SOOME

Põhiõpe kestab Soomes vähemalt kuus ja pool aastat. Selle lõpetaja saab arstidiplomi,[23] mis annab õiguse töötada täielikult kvalifitseeritud eriarsti juhendamise ja järelevalve all (Mikkola, Suutala ja Parviainen, 2018). Et saada üldarsti täielik kutsekvalifikatsioon, mille annab riiklik tervishoiu õiguskaitsekeskus, peab põhiõppe lõpetanu läbima esmatasandi tervishoiu lisakoolituse (Mikkola jt, 2018). Eriarstiks saada soovijad läbivad täiendava arstiõppe ja 5–6 aastat kestva residentuuri (Mikkola jt, 2018).

Arstidiplomi saab omandada Helsingi, Ida-Soome, Oulu, Tampere ja Turu Ülikooli arstiteaduskonnas. Residentuuris on võimalik õppida 50 erialal (Parviainen, Halava, Leinonen, Kosunen ja Rannisto, 2018). Eriarstiõppe eelduseks on Soomes arstina tegutsemise luba (Soome Arstide Liit, 2018). Eriarstiõpe kestab 5–6 aastat ja hõlmab peamiselt kliinilist praktikat valitud erialal[24]. Teoreetilist õpet pakuvad paljud asutused, sealhulgas ülikoolid ja haiglad (Euroopa Nooremarstide Ühendus, 2018). Soome residentuuriõppe aluseks on traditsiooniline ajapõhine mudel (Niemi-Murola, 2018), mida Hodges (2010) on kirjeldanud „tee tõmbamise“ mudelina, kus üliõpilast „immutatakse“ õppeprogrammis ajalooliselt kindlaksmääratud ajavahemiku jooksul, et temast kujuneks edukas praktik.

Soome residentuuriõppe peamised kitsaskohad on selle kestus ja pedagoogilised alused. Ehkki eriarstiõpe kestab 5–6 aastat, kulub kvalifikatsiooni omandamiseks tegelikult umbes 10 aastat. Selle põhjuseks on ülikoolide ja baasaustuste (haiglate) vahelise kooskõlastamise puudumine. Residentide suure hulga tõttu on neil raskusi residentuurikohtade leidmisega ja kui kohta leida ei õnnestu, võib residentuur edasi lükkuda. Juhendajate pedagoogilise pädevuse puudumine tekitab raskusi tagasiside andmisel residentidele ja ka residentidelt juhendajatele (Euroopa Nooremarstide Ühendus, 2018), mis vähendab residentuuriõppe hariduslikku väärtust.

Üks Soomes pakutava residentuuriõppe positiivseid külgi on see, et eriala saab vajaduse korral hõlpsalt vahetada. Lisaks jaguneb õiguslik vastutus residendi ja juhendaja vahel (Euroopa Nooremarstide Ühendus, 2018), mis soodustab residentide iseseisvust. Praegu on väljatöötamisel uus pädevuspõhine õppekava (Niemi-Murola, 2018).[25]

## ROOTSI

Rootsis antakse meditsiiniharidust ja -koolitust kolmes etapis: põhiõppes, arstina registreerimisele eelneva õppe (praktika) käigus ja eriarstiõppes. Põhiõpe kestab viis ja pool aastat, millele järgneb

[23] Finnish Medical Association (Soome Arstide Liit). Medical education. Internetis aadressil: https://www.laakariliitto.fi/en/medical-education/

[24] Sosiaali- ja terveysministeriön asetuserikoislääkäri- ja erikoishammaslääkärikoulutuksesta sekä yleislääketieteen erityiskoulutuksesta. Internetis aadressil: https://www.finlex.fi/fi/laki/alkup/2015/20150056

[25] Pädevuspõhine meditsiiniharidus on paljudes riikides muutunud peamiseks lähenemisviisiks residentuuriõppele. Pädevuspõhist meditsiiniharidust iseloomustab kaks tunnusjoont: keskendumine konkreetsetele pädevusvaldkondadele ja suhteline sõltumatus ajakasutuse määramisel. Seega on tegemist individuaalse lähenemisviisiga, mida rakendatakse eelkõige töökohal toimuva väljaõppe puhul. Isiku valmisolekut iseseisvalt praktiseerida ei määra mitte õppe pikkus, vaid saavutatud pädevus või pädevused (ten Cate, 2017).

kohustuslik praktika[26]. Seejärel hindavad põhiõppe lõpetaja teadmisi ja oskusi vanemad kolleegid ning tuleb teha ülikooli korraldatav kirjalik eksam. Pärast õppe edukat läbimist annab riiklik tervishoiu- ja hoolekandeamet välja arstina tegutsemise loa, mis annab äsja kvalifitseeritud arstile ka õiguse taotleda kohta eriarstiõppes[27].

Eriarstiõppe programmide kestus on vähemalt viis aastat ja õpe toimub palgatöö käigus, millega kaasneb ka vastutus enda kui arsti tegevuse eest[28]. Õpe hõlmab kliinilist tööd valitud erialal umbes nelja aasta ja kõrvalerialadel 6–18 kuu jooksul. Residentuuriõpe toimub Rootsi ülikoolide haiglate akadeemilise ja kliinilise juhendamise all[29] ning teoreetilist õpet antakse paljudes asutustes. Õiguslik vastutus jaguneb residendi ja juhendaja vahel (Euroopa Nooremarstide Ühendus, 2018).

Igal residendil on individuaalne õppeprogramm, milles on määratletud nõutav praktiline koolitus eri osakondades koos täiendava teoreetilise õppega[30]. Õppeprogramm töötatakse välja arsti individuaalsete vajaduste järgi, mis võivad erialadel erineda[31]. Samuti on residendil õigus isiklikule juhendajale (mentorile) – tunnustatud eriarstile, kes residenti eriarstiõppe käigus suunab (Frydén, Ponzer, Heikkilä, Kihlström ja Nordquist, 2015).

Rootsi residentuuriõpe on üles ehitatud pädevustele ja ajapõhisele mudelile, mis tähendab, et kliinilisi oskusi ja teoreetilisi teadmisi hinnatakse spetsialiseerumisperioodi jooksul järjepidevalt. Enne eriarsti kvalifikatsiooni andmist ei pea residendid sooritama ametlikku lõpueksamit. Mõni erialaühing on siiski kasutusele võtnud vabatahtlikud eksamid[32].

Riiklikke erialade õppekavasid haldab riiklik tervishoiu- ja hoolekandeamet, kes saab erialade ametlike kirjelduste ja sisu määratlemisel abi erialaühingutelt (Rootsi Arstide Ühendus ja Rootsi Meditsiiniühing). Rootsi Arstide Liit viib koostöös Rootsi Meditsiiniühinguga ellu eri osakondades antava õppe kvaliteedi kontrollimise ja hindamise programmi, aga selles osalemine on vabatahtlik (Bexelius jt, 2016).

### ÜHENDKUNINGRIIK[33]

Ühendkuningriigis peavad põhiõppe lõpetajad enne täielikku arstina registreerimist kõigepealt läbima 1–2 aastat kestva praktika nooremarstidena või esimese residentuuriõppe aasta. Vajaduse korral

[26] Uppsala Universitet. Läkarprogrammet 2019/2020. Internetis aadressil: http://www.uu.se/utbildning/utbildningar/selma/program/?pKod=MME2Y

[27] Socialstyrelsen. (2017). Vägen till legitimation. Internetis aadressil: https://legitimation.socialstyrelsen.se/sv/utbildad-i-sverige/lakare

[28] Socialstyrelsens föreskrifter och allmänna råd (SOSFS 2015:8) om läkarnas specialiseringstjänstgöring. Internetis aadressil: http://www.socialstyrelsen.se/sosfs/2015-8

[29] Swedish Healthcare. Medical residency and fellowship programmes. https://www.swedishhealthcare.se/medical-postgraduate-programs/

[30] Socialstyrelsens föreskrifter och allmänna råd (SOSFS 2015:8) om läkarnas specialiseringstjänstgöring. Internetis aadressil: http://www.socialstyrelsen.se/sosfs/2015-8

[31] Swedish Healthcare. Medical residency and fellowship programmes. Internetis aadressil: https://www.swedishhealthcare.se/medical-postgraduate-programs/

[32] Socialstyrelsens föreskrifter och allmänna råd (SOSFS 2015:8) om läkarnas specialiseringstjänstgöring. Internetis aadressil: http://www.socialstyrelsen.se/sosfs/2015-8

[33] Vastavalt artiklile, mille autorid on Weggemans, van Dijk, van Dooijeweert, Veenendaal ja ten Cate (2017), kui ei ole osundatud teisiti.

pakutakse ajutisi õppekohti, et täita ajutist lünka eriala õppeprogrammis. Nendele kohtadele võivad kandideerida kõik registreeritud arstid, kes on lõpetanud alusprogrammi[34].

Residentuuriõppesse vastuvõtmise aluseks on avatud ja konkurentsipõhine valikuprotsess, eriarstiõppesse võivad kandideerida kõik täielikult litsentseeritud arstina registreeritud õppurid. Programmid kestavad 3–8 aastat ja eriarstiõpet on kaks liiki: järjepidev õpe, kus resident liigub automaatselt järgmisele tasandile, kui kõik nõutavad pädevused on rahuldavalt saavutatud, ja liigendatud õpe, mis koosneb 2–3 aasta pikkusest põhiõppest, mille järel residendid peavad läbima teise avatud konkursivooru, et kandideerida kõrgemale kohale erialaõppes. Residentuuriõppe standardid kehtestab tervishoiuamet (GMC) ja neid kirjeldatakse hea ravitava suunistes.

Residentuuriõpe on pädevuspõhine, kõigi erialade õppeprogrammides on määratletud teadmiste, oskuste ja käitumise standardid. Pädevuse omandamist hinnatakse juhendatud õppeüritustel kujundava hindamise vormis, tulemuslikkuse kokkuvõtliku hindamise ja eksamite vormis ning juhendaja trianguleeritud hinnangu vormis. Eriala õppeprogrammi rahuldaval läbimisel antakse õppe läbimise tunnistus (CCT), mis võimaldab registreerimist eriarstide registris.

### MADALMAAD[35]

Madalmaades on residentuuriõpe muutunud üha individualiseeritumaks: näiteks võib residentuur alata ja lõppeda aasta ringi erineval ajal ning põhiõppe lõpetajad võivad kandideerida residentuurikohtadele niipea, kui need vabanevad (Hoff, Frenkel, Imhof ja ten Cate, 2018). Täielik arstina registreerimine toimub pärast arstiteaduskonna lõpetamist. Viimane aasta on enamikus ülikoolides üleminekuaasta. Selle aasta jooksul läbivad tudengid praktika, mille vältel nende ülesanded suurenevad ja mille tingimused on lähedased residentuuri tingimustele. Selle eesmärk on lihtsustada üleminekut põhiõppest residentuuriõppesse. Pärast lõpetamist on nooremarstidel võimalik töötada mitteõppiva residendina, et saada rohkem töökogemust.

Residentuuriõppesse vastuvõtmise aluseks on avatud ja konkurentsipõhine valikuprotsess. Kandideerida võivad kõik lõpetajad, eelneva kliinilise töökogemuse pikkus ei ole oluline. Kuna konkurents on tihe, on siiski eelis kandidaatidel, kellel on pikem kliinilise töö kogemus, teadustöö kogemus või doktorikraad.

Madalmaades vastutab residentuuriõppe ja eriarstide registreerimise eest arstide liitude föderatsioon (College Geneeskundige Specialismen). Enamik residentuuriõppe programme kestab 4–6 aastat, kusjuures kestab üldarstiõpe 3 aastat. Paljud programmid hõlmavad praktikat nii ülikoolide meditsiinikeskustes kui ka piirkondlikes haiglates. Paljudel erialadel tuleb enne erialaõppe alustamist läbida alusõpe.

Residentuuriõppes põhineb hindamine pädevustel. Igal residendil on koostöös programmi üldjuhendajaga välja töötatud individuaalne õppeplaan. Plaani koostamisel lähtutakse pädevustest, mis on omandatud enne erialaõppe algust. Residendil on mapp, milles dokumenteeritakse tema areng kõigis pädevusvaldkondades ja mis on edusammude hindamise aluseks.

[34] Alusprogramm on kaheaastane üldõppe programm, mille eesmärk on anda arstidele üld- ja kutseoskused, mis võimaldavad neil liikuda edasi erialaõppesse.

[35] Vastavalt artiklile, mille autorid on Weggemans jt (2017), kui ei ole osundatud teisiti.

### SAKSAMAA

Saksamaal registreeritakse arstiteaduskonna lõpetaja arstina, aga täielikuks registreerimiseks litsentseeritud arstina tuleb sooritada litsentseerimiseksamid (Weggemans jt, 2017). Residentuurikohti ei eraldata, mistõttu soovijad peavad kohad tööturul ise leidma ja neile kandideerima (van den Bussche, Krause-Solberg, Scherer, Ziegler, 2017). Erialaõppesse võetakse vastu seega avatud ja konkurentsipõhise valikuprotsessi alusel ning residentuuri võivad kandideerida kõik tudengid, kes on arstina täielikult registreeritud (Weggemans jt, 2017).

Residentuuriõpe on Saksamaal killustunud. Ajaloolistel põhjustel on igal Saksamaa liidumaal (15) oma ametkond, kes vastutab arstide väljaõppe järelevalve ja reguleerimise eest (Cranston jt, 2013). Residentuuriõpe kestab 5–6 aastat (Weggemans jt, 2017) ja see ei ole seotud akadeemiliste keskustega. Pigem pakuvad õpet peamiselt haiglad. Sageli peetakse juhendatud õppe asemel tähtsamaks seda, et töö saaks tehtud (Chenot jt, 2016). Seetõttu rajaneb kursuste ülesehitus peaaegu täielikult töökohal toimuval väljaõppel ja ametlikud teoreetilised kursused puuduvad.

Üldarstiõpe kestab Saksamaal viis aastat, neist kolm läbitakse sisehaiguste statsionaarses osakonnas ja kaks on pühendatud üldarstipraktikale (Weggemans jt, 2017). Sisemeditsiini erialal tuleb residentuuriõppes õppida kõigepealt kolm aastat üldist sisemeditsiini ja need, kes soovivad lisaks spetsialiseeruda, õpivad veel kolm aastat vastavat eriala (Cranston jt, 2013).

Hiljutise uuringu käigus tehti Saksamaa residentuuriõppes kindlaks järgmised puudused (van den Bussche jt, 2017).

- Nii praktika- kui ka teooriakomponent on residentuuriõppes ebapiisav.
- Ei ole kehtestatud õppekavasid, milles oleksid esitatud õpieesmärgid ja neile vastava väljaõppe andmise kirjeldused. Õppetöö on tegelikult võrdsustatud igapäevase kliinilise tööga.
- Tööprotsess ei ole õpet silmas pidades struktureeritud. Näiteks on soovitatud dokumenteerimist ja tagasiside arutelusid, aga enamasti neid ei kasutata.
- Tõenduspõhine ravi ja residentide edusammude hindamine ei moodusta õppe põhiosa.
- Kokkuvõtliku suulise lõpueksami puhul eeldatakse, et eriarstilt nõutavaid pädevusi on võimalik igakülgselt hinnata 30 minuti jooksul.
- Paljud tegurid näitavad, et naissoost arstidel, eriti lastega arstidel, on meestega võrreldes vähem õppimisvõimalusi.

On jõutud järeldusele, et Saksamaal pakutava residentuuriõppe kvaliteet on ebapiisav, eriti rahvusvahelises võrdluses (van den Bussche jt, 2017).

Kokkuvõtteks võib öelda, et residentuuriõpe on Euroopa riikides erinev. Praktika (mis tahes vormis) positsioon erineb riigiti: mõnes riigis on see põhiõppe osa, teistes aga eraldi etapp pärast põhiõpet. Ühendkuningriik ja Madalmaad rakendavad pädevuspõhist hindamist, samal ajal kui Saksamaal toimub residentuuriõppe käigus väga vähe ametlikke kursusi ja hindamisi ning õpe hõlmab peamiselt kliinilist tööd sõltumatutes haiglates.

# **Lisa 4.** Esialgsete numbriliste hinnangute ja z-skooride võrdlus

**TABEL.** NUMBRILISTE HINNANGUTE VÕRDLUS (ESIALGSED NUMBRILISED HINNANGUD JA Z-SKOORID)

| Standardid | Esialgsed numbrilised hinnangud | | | | z-skoorid | | |
|---|---|---|---|---|---|---|---|
| **1. Residentuuriõppe õiguslikud ja korralduslikud tahud** | EE | LV | LT | | EE | LV | LT |
| **1.1. Residentuuriõppe korraldus on riigis selgelt reguleeritud.** | 3 | 2 | 3 | | 1.33 | -0.13 | 1.31 |
| **1.2. Residentuuriõppe korralduse aluspõhimõtete ja õppeprogrammide kavandatud õpitulemuste kinnitamisse kaasatakse kõik peamised sidusrühmad.** | 2 | 2 | 2 | | 0.17 | -0.13 | -0.02 |
| **1.3. Residentuuriõppe vorm ja õppeprogrammide kavandatud õpitulemused moodustavad tervishoiusüsteemi vajadustega ühtse terviku.** | 2 | 2 | 2 | | 0.17 | -0.13 | -0.02 |
| **1.4. Residentide valimisel ja õppeprogrammide elluviimisel lähtutakse võrdsuse põhimõtetest.** | 1 | 2 | 3 | | -0.99 | -0.13 | 1.31 |
| **1.5. Residentide valiku kriteeriumide ja protsessi põhimõtted on määratletud ning neid rakendatakse.** | 3 | 4 | 3 | | 1.33 | 1.96 | 1.31 |
| **1.6. Residentide vastuvõtmine ja hariduse andmise suutlikkus on tasakaalus ning õppekohtade arv vastab kliinilistele/praktilistele koolitusvõimalustele ja asjakohase juhendamise suutlikkusele.** | 2 | 2 | 2 | | 0.17 | -0.13 | -0.02 |
| **1.7. Koolitajate, juhendajate ja õpetajate värbamiseks ning valimiseks on välja töötatud ja rakendatud selgelt sõnastatud põhimõtted.** | 1 | 0 | 2 | | -0.99 | -2.23 | -0.02 |
| **1.8. Residendid saavad mõistlikul määral valida asutuste ja nende allüksuste vahel, kus nad oma koolituse läbivad.** | 3 | 4 | 2 | | 1.33 | 1.96 | -0.02 |
| **2. Residentuuriõppe kvaliteet** | EE | LV | LT | | EE | LV | LT |
| **2.1. Residentuuriõppe vorm tagab arstide väljaõppe sellisel määral, et arstid on pädevad oma meditsiinierialal asjakohast meditsiini praktiseerima ja võimelised professionaalselt töötama.** | 2 | 3 | 2 | | 0.17 | 0.92 | -0.02 |
| **2.2. Residentuuriõppe vorm ja kestus tagavad arstide väljaõppe sellisel määral, et arstid on võimelised oma meditsiinierialal järelevalveta ja iseseisvalt töötama.** | 3 | 2 | 2 | | 1.33 | -0.13 | -0.02 |
| **2.3. Residentuuriõppe vorm tagab arstide väljaõppe sellisel määral, et arstid on võimelised vajaduse korral töötama nii kutsealapõhistes kui ka kutsealadevahelistes meeskondades.** | 2 | 2 | 2 | | 0.17 | -0.13 | -0.02 |
| **2.4. Residentuuriõppe vorm tagab arstide väljaõppe sellisel määral, et arstid on pühendunud elukestvale õppele ning osalemisele täienduskoolituses ja pidevas tööalases enesearendamises.** | 2 | 2 | 3 | | 0.17 | -0.13 | 1.31 |
| **2.5. Residentidele on tagatud töötingimused, mis on vajalikud nende tervise hoidmiseks.** | 2 | 1 | 2 | | 0.17 | -1.18 | -0.02 |
| **2.6. Programmid on ajakohased ja vastavad konkreetse meditsiinieriala viimastele arengutele.** | 2 | 3 | 2 | | 0.17 | 0.92 | -0.02 |
| **2.7. Programmide uuendamine on süstemaatiline ja toimub koostöös kõigi sidusrühmadega.** | 2 | 1 | 2 | | 0.17 | -1.18 | -0.02 |
| **2.8. Residentuuriõppe raamistiku aluseks on olemasoleva arstide põhiõppe tulemusena saavutatud õpitulemused.** | 3 | 3 | 3 | | 1.33 | 0.92 | 1.31 |
| **2.9. Õpe põhineb programmi kavandatud õpitulemustel ja residentidelt nõutaval kvalifikatsioonil.** | 2 | 2 | 1 | | 0.17 | -0.13 | -1.36 |
| **2.10. Residentuuri õpperaamistik on korraldatud süstemaatiliselt ja läbipaistvalt.** | 2 | 2 | 2 | | 0.17 | -0.13 | -0.02 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **2.11 Rakendatakse sobivaid õpetamis- ja õppemeetodeid ning kogu õppe vältel on tagatud praktiliste ja teoreetiliste komponentide integreerimine.** | 2 | 2 | 2 | | 0.17 | -0.13 | -0.02 |
| **2.12. Kasutatakse residendikeskset lähenemisviisi, mis motiveerib ja valmistab residente ette võtma vastutust oma õpiprotsessi eest ja kaaluma hoolikalt oma tegevust ning pakub residentidele selles tuge.** | 1 | 1 | 1 | | -0.99 | -1.18 | -1.36 |
| **2.13. Residentuuriprogrammi korraldajad ja residendid mõistavad soolisi, kultuurilisi ja usulisi eripärasid ning residendid on valmis tegutsema neist lähtudes.** | 2 | 2 | 1 | | 0.17 | -0.13 | -1.36 |
| **2.14. Programmi käigus tutvustatakse meditsiinilise teadustöö, sealhulgas kliiniliste uuringute ja kliinilise epidemioloogia aluseid ja metoodikat.** | 2 | 2 | 2 | | 0.17 | -0.13 | -0.02 |
| **2.15. Õppeprogramm ja -protsess tagavad, et resident tutvub tõenduspõhise raviga asjakohaste kliiniliste/praktiliste kogemuste kaudu oma meditsiinieriala mitmesugustes tööolukordades.** | 3 | 3 | 3 | | 1.33 | 0.92 | 1.31 |
| **2.16. Programmi sisu kohandatakse teaduse arenguga.** | 1 | 4 | 2 | | -0.99 | 1.96 | -0.02 |
| **2.17. Programm hõlmab kliinilist tööd ja asjakohaseid teoreetilisi teadmisi või kogemusi põhiliste biomeditsiiniteaduste, kliinilise teaduse, käitumis- ja sotsiaalteaduste, ennetava meditsiini, rahvatervise, meditsiiniliste õigusaktide ja juhtimise alal.** | 2 | 2 | 2 | | 0.17 | -0.13 | -0.02 |
| **2.18. Programm hõlmab kliinilist tööd ja asjakohaseid teoreetilisi teadmisi või kogemusi kliiniliste otsuste tegemise, meditsiinieetika ja patsiendi ohutuse alal.** | 2 | 3 | 2 | | 0.17 | 0.92 | -0.02 |
| **2.19. Programm hõlmab kliinilist tööd ja asjakohaseid teoreetilisi teadmisi või kogemusi arstide suhtlusoskuste ja enese eest hoolitsemise alal ning tõenduspõhise meditsiini seoseid täiendmeditsiiniga.** | 1 | 2 | 2 | | -0.99 | -0.13 | -0.02 |
| **2.20. Õpe on olemuselt kutsealasele arengule suunatud praktika, mis hõlmab nii koolitust kui ka teenuseosutamist.** | 2 | 2 | 2 | | 0.17 | -0.13 | -0.02 |
| **2.21. Residentuuriõpe valmistab residendid ette kõikideks rollideks, mida arstilt tervishoiusektoris eeldatakse.** | 2 | 3 | 2 | | 0.17 | 0.92 | -0.02 |
| **2.22. Resident saab mitmesuguseid kogemusi, sealhulgas õpet eri asutustes ja piisavalt kogemusi valitud meditsiinieriala tahkudes.** | 3 | 3 | 3 | | 1.33 | 0.92 | 1.31 |
| **2.23. Põhiõpe annab residentuuri eel head prekliinilised teadmised.** | 3 | 4 | 3 | | 1.33 | 1.96 | 1.31 |
| **2.24. Õppeprotsess on mitmekülgne ja residendid osalevad kõigis õppe seisukohast olulistes meditsiinitoimingutes, sealhulgas valves, aga teenuseosutamine ei domineeri.** | 3 | 1 | 2 | | 1.33 | -1.18 | -0.02 |
| **2.25. Juhendajatel on võimalik saada pedagoogilist õpet ja juhendajakoolitust.** | 1 | 1 | 1 | | -0.99 | -1.18 | -1.36 |
| **2.27. Koolitajate ja juhendajate kliinilise töökoormuse ja koolituskohustuste vahel on tasakaal, mis jätab piisavalt aega õpetamiseks, juhendamiseks ja õppimiseks.** | 2 | 1 | 1 | | 0.17 | -1.18 | -1.36 |
| **2.28. Koolitajate perioodilisel hindamisel kasutatakse residentide tagasisidet juhendajale.** | 1 | 1 | 1 | | -0.99 | -1.18 | -1.36 |
| **2.29. Residentidel on juurdepääs ajakohasele erialakirjandusele.** | 3 | 3 | 4 | | 1.33 | 0.92 | 2.64 |
| **2.30. Programmide rakendamist jälgitakse ja hinnatakse korrapäraselt, kogutakse andmeid programmide põhiliste tahkude kohta, et tagada õppe plaanipärasus ja teha kindlaks võimalikud sekkumist vajavad valdkonnad.** | 1 | 2 | 2 | | -0.99 | -0.13 | -0.02 |
| **2.31. Järelevalve käigus tuvastatud probleeme ja asjakohaseid hindamistulemusi käsitletakse süstemaatiliselt.** | 1 | 4 | 1 | | -0.99 | 1.96 | -1.36 |
| **2.32. Residentidelt, juhendajatelt, tööandjatelt ja kvalifitseeritud arstidelt kogutakse programmide kohta tagasisidet, mida kasutatakse programmide arendamiseks.** | 0 | 2 | 0 | | -2.15 | -0.13 | -2.69 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **2.33. Kursuse ja programmi hindamise tulemused tehakse peamistele sidusrühmadele kättesaadavaks.** | 1 | 2 | 1 | | -0.99 | -0.13 | -1.36 |
| **2.34. Programmi protsessi, ülesehituse, sisu, tulemuste ja pädevuste, hindamise ning õpikeskkonna korrapärase läbivaatamise ja ajakohastamise kord on kindlaks määratud.** | 1 | 2 | 2 | | -0.99 | -0.13 | -0.02 |
| **3. Hindamine ja tagasiside residentuuriõppes** | EE | LV | LT | | EE | LV | LT |
| **3.1. Residentide valimise protsess on läbipaistev ja kooskõlas kehtestatud valikupõhimõtetega.** | 3 | 3 | 2 | | 1.33 | 0.92 | -0.02 |
| **3.2. Programmide kavandatud õpitulemused on määratletud residentuuriõppe tulemusena omandatavate teadmiste, oskuste ja hoiakute ning tervishoiusektoris edaspidi täidetavate rollide kaudu.** | 2 | 3 | 2 | | 0.17 | 0.92 | -0.02 |
| **3.3. Programmide kavandatud õpitulemused on määratletud üldiste ja valdkonna- või erialapõhiste komponentide suhtes.** | 4 | 3 | 3 | | 2.49 | 0.92 | 1.31 |
| **3.4. Residente suunatakse residentuuriõppe käigus juhendamise ning korrapärase hindamise ja tagasiside abil.** | 1 | 2 | 2 | | -0.99 | -0.13 | -0.02 |
| **3.5. Residendi iseseisev vastutus suureneb oskuste, teadmiste ja kogemuste kasvades.** | 2 | 2 | 2 | | 0.17 | -0.13 | -0.02 |
| **3.6. Residentide hindamise põhimõtted, eesmärgid, meetodid ja korraldus on määratletud, kehtestatud ja avaldatud.** | 1 | 1 | 2 | | -0.99 | -1.18 | -0.02 |
| **3.7. Kasutatakse üksteist täiendavaid hindamismeetodeid ja -vorme, sh võetakse arvesse kujundava ja kokkuvõtliku hindamise tasakaalu, eksamite ja muude testide arvu, eri liiki eksamite (kirjalike ja suuliste) tasakaalu, normatiivseid ja kriteeriumipõhiseid hinnanguid, isiklike mappide ja päevikute kasutamist ning eksamineerimise erivormide (näiteks objektiivsed struktureeritud kliinilised eksamid (OSCE) ja lühivormis kliinilise hindamise harjutused (MiniCEX) kasutamist.** | 1 | 1 | 2 | | -0.99 | -1.18 | -0.02 |
| **3.8. Hindamised hõlmavad teadmisi, oskusi ja hoiakuid.** | 1 | 2 | 2 | | -0.99 | -0.13 | -0.02 |
| **3.9. Hindamismeetodite usaldusväärsust, valiidsust ja õiglust hinnatakse ja dokumenteeritakse.** | 0 | 0 | 0 | | -2.15 | -2.23 | -2.69 |
| **3.10. Hindamispõhimõtted ja -meetodid ning hindamise korraldus on selgelt kooskõlas kavandatud õpitulemuste ja õpetamismeetoditega ning tagavad õppe piisavuse ja asjakohasuse.** | 1 | 2 | 2 | | -0.99 | -0.13 | -0.02 |
| **3.11. Hindamispõhimõtted ja -meetodid ning hindamise korraldus edendavad residentide õppimist ning tagavad, et residendid saavutavad kavandatud õpitulemused.** | 1 | 1 | 2 | | -0.99 | -1.18 | -0.02 |
| **3.12. Hindamispõhimõtted ja -meetodid ning hindamise korraldus tagavad hindamistulemuste põhjal residentidele õigeaegse, konkreetse, konstruktiivse ja õiglase tagasiside andmise.** | 1 | 1 | 2 | | -0.99 | -1.18 | -0.02 |
| **4. Teadustöö roll residentuuriõppes** | EE | LV | LT | | EE | LV | LT |
| **4.1. Õppeprogrammid ja -protsess tagavad, et resident õpib kasutama teaduslikku põhjendamist ning rakendab valitud meditsiinieriala teaduslikke aluseid ja meetodeid.** | 3 | 3 | 3 | | 1.33 | 0.92 | 1.31 |
| **4.2. Õpe hõlmab kirjanduse ja teaduslike andmete kriitilise hindamise õpetamist.** | 2 | 2 | 2 | | 0.17 | -0.13 | -0.02 |
| **4.3. Residente julgustatakse osalema meditsiinilises teadustöös ning tervishoiu ja tervishoiusüsteemi kvaliteedi arendamises.** | 2 | 2 | 3 | | 0.17 | -0.13 | 1.31 |

# **Lisa 5.** Compliance of PME with WFME International Standards in Estonia, Latvia, and Lithuania[36]

## 1. Legal and organisational aspects of postgraduate medical education

### 1.1. The organisation of PME in the country is clearly regulated

**Estonia**

Rating: 3 / 1.33

There are two main bodies that shape the organisation of PME in Estonia: The University of Tartu is the institution that organises PME and provides theoretical courses, while the Estonian Ministry of Social Affairs is the government body responsible for the funding of medical residency, workforce planning and its legal framework development through multilateral negotiations. Additionally, speciality associations are involved in the development of respective curricula[37]. PME consists of work-based training in healthcare institutions and theoretical education. Throughout the residency, residents are in a contractual relationship with their training base and participating in the provision of healthcare services. The residents have an opportunity, to a reasonable extent, to choose their training base from a list stated in the speciality programme.

The Organisation of PME is clearly regulated via the following legislation: University of Tartu Act[38] §7; RT I 1995, 23, 333, Entry into force 01,01,2017, RT I, 20.17 2016, 5; The Act of Minister of Social Affairs No. 56 of 04.06.2001 "Framework requirements of residency and procedures for conducting residency"[39]. The Act entered into force 03.02.2017, RT I, 31,01,2017, 28; University of Tartu Senate's Act No. 2 "Regulations of Residency"[40]. Entry into force 26.05.2017.

While the organisation of PME is clearly regulated in legislation, in practice there are several shortcomings, e.g. lack of minimum standards for training bases and definition of the content of supervision.

**Latvia**

Rating: 2 / -0.3

Medical Treatment Law[41], Section 1, subsection 19 defines “residency - education of a doctor who has employment legal relations with a healthcare institution implementing an educational programme, for the acquisition of a speciality in the official state language in accordance with an accredited professional residency educational programme in medicine;” Cabinet of Ministers Regulations No. 685 of August 30, 2011 “Regulations on admission and distribution of residents and financing of residency”[42], Article 11 brings universities into the organisational framework of residency and quite clearly defines the

[36] The words ‘resident’ and ‘trainee’ are used in this appendix interchangeably.

[37] Praxis (2013). Ülevaade arstlike erialade arengukavadest. Lk 40. Tallinn: Poliitikauuringute Keskus Praxis. Available: http://www.praxis.ee/wp-content/uploads/2015/03/Arengukavade_%C3%BClevaade.pdf

[38] https://www.riigiteataja.ee/en/eli/528122016001/consolide

[39] https://www.riigiteataja.ee/akt/131012017028

[40] https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[41] Entry into force: 01.01.2018., Retrieved 29.07.2018., Available: https://likumi.lv/doc.php?id=44108

[42] Entry into force 20.04.2018., Retrieved 29.07.2018., Available: https://likumi.lv/doc.php?id=235421

responsibilities of universities organising PME in Latvia. Furthermore, Cabinet of Ministers Regulations No. 685 also requires that the universities have contracts with hospitals where the everyday practical carrying out of residency is ensured, regulating that the contracts state names of supervisors and doctors responsible for organising residency in each speciality in each hospital, as well as the procedure for submitting evaluation forms of residents and supervisors to the university. However, stakeholders express that parts of the regulatory documents should be updated to make the organising of residency more clear, transparent and easy for all parties involved. For example, the financing of residency in Cabinet of Ministers Regulations No. 685 could be made more transparent by defining how expenses for residents' theoretical and practical learning can be spent. There are possibilities to improve the regulatory documents on a newer aspect of PME – residency funded by physical persons or legal entities. Some requirements that do not work in practice, such as the evaluation forms, should be changed. Lastly, Cabinet of Ministers Regulations No. 268 of March 24, 2009 "Regulations regarding competency in medical treatment and volume of theoretical and practical knowledge for medical practitioners and students acquiring first or second level professional higher medical education programmes"[43] should be updated to improve the content of speciality study programmes.

**Lithuania**

Rating: 3 / 1.31

According to the "Ruling on doctors' training", a medical residency is considered to be a higher degree of medical education, during which a resident is both studying and working within the limits of his/her legal ability. Because of this, the principal stakeholders involved in the process of postgraduate medical training include the Ministry of Health, the Ministry of Education and two universities – the Lithuanian University of Health Sciences and Vilnius University. The Ministry of Health predicts the future demand for doctors of different specialities and provides their suggestions to the Ministry of Education on a yearly basis. The universities, together with the Ministry of Health, decide upon the requirements for application for a specific residency programme. The universities define and agree on the common specifications for all residencies ("Regulations of Residency"), in addition, specific details are added in every programme (decided upon by university-appointed residency committees (commissions)). The universities implement these documents by appointing coordinators of residency programmes, who are responsible for each residency programme. There is a body (Centre for Assessment of Study Quality) designated to accredit the residency programmes.

Unfortunately, the situation described in the aforementioned documents often does not reflect the reality, as the implementation of the documents depends on each specific committee and coordinator, who often interpret the recommendations differently. As one resident summed up, "It's chaotic and does little to prepare me as a surgeon. On paper it may look good, but it is far from reality."

### 1.2. The basic principles of organisation of PME and intended educational outcomes of the programmes are approved by all principal stakeholders

**Estonia**

Rating: 2 / 0.17

[43] Entry into force: 29.06.2018., Retrieved 29.07.2018., Available: https://likumi.lv/doc.php?id=190610

Legislatively, all smaller changes to the programmes must be approved by the council of the Faculty of Medicine, and major changes by the university's senate. University of Tartu Act[44] §2 section 3 stipulates that "University senate is up to twenty-one members elected by the university, and at least one fifth of them are students." The council of the Faculty of Medicine has five student representatives and one residents' representative[45]. This means that, technically, student representatives are involved in decision-making e.g. Tartu University senate has five student representatives, of whom two represent the Faculty of Medicine[46]. Although junior doctors do not have student status, the residents can approach them to communicate concerns.

The current programmes state, in general, all principles of organisation and intended educational outcomes. However, there are significant problems with the organisation of individual residency rotations, which do not have stated outcomes and therefore often trainees and supervisors have no idea as to what competences the residents should achieve during their time in the department.

In the Ministry of Social Affairs' and the University of Tartu's residency committees, which provide the input for changes, the representatives of all principal stakeholders are included. However, this does not ensure the involvement of all stakeholders in the organisation and alteration of PME programmes. From qualitative data, it was found that there are communication problems between the stakeholders, which raises tensions. For example, the multilateral communication between the ministry, university and junior doctors takes place only once a year and often it is more dependent on bilateral talks. Currently, there is also no evidence that the systematic evaluation of programmes takes place, yet alone with the involvement of principal stakeholders. There is also no exhaustive information on how much the opinion and expertise of junior doctors are taken into consideration.

**Latvia**

Rating: 2 / -0.3

From the interviews with the stakeholders, some tension regarding the responsibilities in organisation and carrying out of residency is visible because of the divide between the two separate sides involved in organising and carrying out residency – universities and hospitals.

The universities are the formal organisers of the residents' education and hospitals carry it out in practice. From the interviews with stakeholders, this results in frustration on the universities' side because of the universities' inability to accurately evaluate the quality of the practical studies and seminars, impact the motivation of supervisors and enforce the removal of a supervisor. On the hospital's side, there can be frustration regarding days for theoretical lectures when the residents are not available for work at the hospital and the amount of time which residents are required to spend on filling in paperwork (thus, bureaucracy) required by the university.

However, some of the people involved in organising residency state that in their opinion in Latvia's situation the principles of organisation of residency are optimal, albeit with a need for an increase in trust between the stakeholders and improvement in some processes within residency or related to it. One of the processes in need of improvement is the intended educational outcomes of the speciality

[44] https://www.riigiteataja.ee/en/eli/528122016001/consolide

[45] Members of the council of the Faculty of Medicine. Retrieved 22.11.2018. Available: https://meditsiiniteadused.ut.ee/et/teaduskonnast/teaduskonna-noukogu-0

[46] Members of Tartu University Senate. Available: https://www.ut.ee/en/university/structure-and-staff/university-governance/senate Retrieved: 22.11.2018

programmes described in Cabinet of Ministers Regulations No. 268 of March 24, 2009 "Regulations regarding competency in medical treatment and volume of theoretical and practical knowledge for medical practitioners and students acquiring first or second level professional higher medical education programmes"[47].

These regulations are followed by all institutions involved in organising of residency; however, Regulations No. 268 are highly heterogeneous. To provide an illustration of this, the section on family doctors contains around 6,705 words (with notes about when the law was changed) from which around 5,933 words are devoted to knowledge acquirable during residency and includes a very detailed list of the diagnoses, symptoms, manipulations, diagnostic methods, etc. that a family doctor learns during residency. In comparison, the section on the competence of surgeons contains only around 193 words (with notes about when the law was changed) from which 73 words are devoted to the intended educational outcomes of residency, listing only broad fields of medicine in which a surgeon is to gain theoretical and practical knowledge. Thus, the stakeholders indicate that coordinated action is necessary in order to improve the content of the intended educational outcomes for specialities in the Cabinet of Ministers Regulations No. 268 that are the basis for the intended educational outcomes of the PME programmes.

**Lithuania**

Rating: 2 / -0.02

The basic principles of organisation of PME and intended educational outcomes of the programmes appear to be somewhat held in disapproval by the final consumers of the educational system – the residents – and some of their direct supervisors. The assessment of whether the trainees have achieved the educational outcomes, which in all specialities come in the form of a final exam, unfortunately, lacks objectivity, as the final exams for all trainees are organised by the educational staff from the same departments in which the trainees were taught. According to the respondents of our survey, the residency training is somewhat chaotic in real life. When asked if the PME on their speciality is organised in line with their understanding of it should be provided, 54.1% of residents either disagreed or strongly disagreed with the statement.

### 1.3. The form(s) of PME and the intended educational outcomes of the programmes constitute a coherent whole with the needs of the health system

**Estonia**

Rating: 2 / 0.17

The needs of the health system are not fully covered in the educational outcomes. The current system maps out general outcomes in the programmes but does not state the intended educational outcomes of individual rotations, which in several specialities has led to the rotations consisting solely of observing and thus having no training value. In addition, certain aspects of the curriculum do not necessarily meet the needs of a speciality or a resident specialising in a narrower field. Qualitative evidence shows that in terms of acquiring practical experience and supervisor's attention, residents specialising in the same field as their supervisor have an advantage, thus their experience varies extensively depending on whether they are undergoing their own speciality's rotation or are the so-called guest residents in the department.

[47] Entry into force: 29.06.2018., Retrieved at 30.07.2018., Available: https://likumi.lv/doc.php?id=190610

The junior doctors expressed doubts that current postgraduate medical education provides sufficient skills for them to manage as independent physicians. The lack of emphases on so-called soft skills such as communication, teamwork and medical jurisprudence is considered problematical. Focus groups revealed this leads to specialists who, after finishing PME, do not feel comfortable with working independently at the level that is expected by the health system. Nonetheless, according to Labour Force Monitoring and Forecasting System OSKA report "Future view of labour and skills needs: healthcare"[48], employers consider the qualifications of the doctors coming from the education system to be very high. They further stated the fact that doctors moving abroad are able find professional work in high-level hospitals also indicates this.

The lack of coherent educational outcomes affects the family medicine speciality the most. Since the duration of the training is short, only 3 years and 4 years from July 2019[49], and the speciality being broad-based, the training should be to the point. Considering the increasing role of the family medicine specialist as a gatekeeper[50], the knowledge of most common health problems and their treatment and the grasp of socio-economic aspects of healthcare currently received does not fulfil the requirements of the medical specialists and the health system. The interviews revealed that individual PME rotations for family medicine trainees consist principally of observing, and often the supervisor has no knowledge of what the trainee should gain from the rotation.

**Latvia**

Rating: 2 / -0.3

Residency itself is ubiquitously involved in the current health system as residents work in hospitals during their residency. However, as mentioned in standard 1.2., the intended educational outcomes set by Cabinet of Ministers Regulations No. 268 are generally very broad, while some are very detailed; many have not been updated since 2009 and, because of their broadness, seem to have too limited a connection with the needs of the health system. A resident expressed in the survey: "Nearing the end of my residency I believe, overall, that the training that we receive in my speciality does not prepare us for the functions which ought to be carried out after the receiving of the certification." However, a supervisor's view is diametrically opposite: "The acquired theoretical knowledge and practical skills allows residents to work independently in speciality after graduation."

**Lithuania**

Rating: 2 / -0.02

One of the most important needs of the healthcare system is a sufficient number of competent specialists, ready to address the needs of their patients. The exact competencies each specialist has to have at the end of their residency are determined by the residency programme committees (commissions), which base their descriptions of residency programmes on national and international documents and recommendations. However, as mentioned, the situation described in these documents often does not reflect the reality. When asked if the overall structure, composition and duration of the programme on their speciality is sufficient to prepare competent specialists, 60.4% of residents either disagreed or strongly disagreed with the statement. Many respondents emphasised the short durations of some of the residencies, and the lack of clinical practice. A resident stated: “It was not sufficient, too

[48] Available: http://oska.kutsekoda.ee/wp-content/uploads/2016/04/tervishoiu_uuringu_terviktekst.pdf

[49] https://www.riigiteataja.ee/akt/128062018017

[50] https://www.sm.ee/et/uudised/perearstide-ja-odede-roll-tervisesusteemis-suureneb

much paperwork, no clinical practice. Only 3 years, not enough time." Another trainee agreed: "It's too short and superficial, not enough practical training. Very extensive programme oriented towards theory but not enough time to master practical skills and not enough time to prepare for even the theoretical level. Practical work mostly consists of legal issues and social problem solving, during our training we have very little coverage of these topics." Another resident shared similar opinions: "The programme is the same as Europe as a whole, but the time of training is 2 years shorter."

Even though 55% of the supervisors either agreed or strongly agreed with the statement that the overall structure, composition and duration of the programme on their speciality is sufficient to prepare competent specialists, supervisors of several specialities agreed that the duration of the programmes is too short.

### 1.4. The trainees are selected, and programmes delivered in accordance with principles of equality

**Estonia**

Rating: 1 / -0.99

Conflicting evidence exists. Admission is based on the University of Tartu Senate's Act[51] No. 2 "Regulations of Residency" Ch. II Point 17, which states "The residency vice dean, on the proposal of the programme director of the speciality, appoints three to five members of the admissions examination committee. At least one of the members of the admission committee must be from outside the university", but it does not mean the third party should be outside the university hospital, which is legally a separate institution. Students are involved with the hospital during basic medical education, consequently this reduces objectivity of the commission. Point 24 states that the admission committee will make the results known within 3 working days, but it does not state the points should be made public.

Residents have raised concerns that PME admission exams are subjective; male candidates or "familiar faces" are preferred. Regarding the delivery of programmes, 40% of specialist trainees said they have experienced unequal treatment. [52] Furthermore, the interviews revealed that there are cases where persons accepted to certain specialities are determined before admission exams and the programme places are created especially for these people. Several female residents also expressed that they have encountered sexual harassment during residency.

There is also a great deal of unwarranted variation between programme deliveries that is highly dependent on the speciality of the trainee. It has been mentioned that trainees who are not doing their speciality rotations are treated as observers and not given sufficient supervision and practice, or are not taught at all. In addition, in some specialities, residents are treated as free labour and their on-call hours are not paid.

**Latvia**

Rating: 2 / -0.3

[51] Entry into force 25.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[52] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 24–28. Tallinn: Poliitikauuringute Keskus Praxis.

Rīga Stradiņš University's "Admission Regulations for the Second Level Professional Higher Education Programme "Residency in Medicine" in a Study Place Funded by State Budget"[53] (and its counterpart on Study Places Funded by Physical Persons or Legal Entities) state that "The university has these obligations during the admission process: … Not to allow discriminatory attitudes towards applicants". Equally, "Admission regulations in the University of Latvia"[54] state that "UL's duties are: ... Not to allow differing attitude towards applicants". In the survey 29% out of 138 residents have expressed that they strongly disagree or disagree that "the process of selecting trainees is transparent and fair". Comments from residents include: "Unfortunately, there are people who 'have to get in training'"[55]. Moreover, interviews before selection are "quite subjective.", "The interview part of the process holds too much weight and favouritism is a big part of that process, one that no one is even trying to hide." "In some specialities it is (fair), but in some other factors may play role." A total of 34% out of 112 residents agree, 10% strongly agree, and 28% neither agree nor disagree with the statement: "During residency my co-residents and I are treated equally, and our rights have not been violated." A recent graduate states: "Overworking and burnout are present [during the study process], but bullying or other kinds of violence is not." There are also 19% who disagree and 9% who strongly disagree with the comments below: "Sexism, personal feelings, friendships and other components strongly detract from disturb equality.", "There are more and least favourite residents. The ones who are 'chosen' are able to get more practical training, communication with supervisors, etc. In my speciality everyone knows that and lives with this system. I've talked with others and this kind of system has been there for years.", "There is always a list of the most likable and the second class.'"

**Lithuania**

Rating: 3 / 1.31

A part of the final score in the process of selection into a residency programme includes a "motivational score", which consists of an evaluation of the applicant's engagement in research, volunteering experience and personal characteristics. The process occurs when the applicant has an interview with the "selection committee", made up of the head of the department, several members of the educational staff and one representative of the trainees. The two universities each have their own recommended structure and means of evaluation of these components. However, as the research team concluded from interviews with focus groups, some departments in both universities do not adhere to the recommendations, paving the way for subjectivity in the process, as the motivational score, in some cases, determines the final outcome of the application (for instance, in one of the universities, an applicant is removed from the process of application if their motivational score is not high enough). When asked if the process of trainee selection is transparent and fair, an equal percentage of respondents (35.4% (strongly) agreed and (strongly) disagreed with the statement.

A trainee explained their opinion: "The points given during the 'motivational interview' depend heavily on who the interviewers want to accept. Some residency vacancies are 'promised to someone' which means that all the other candidates usually get a lesser grade. Depending on the residency programme it can be difficult to get a substantial number of points when applying for a residency in a different

[53] Approved in Rīga Stradiņš University Senate on 21.11.2017. Retrieved 26.07.2018., Available: https://www.rsu.lv/sites/default/files/imce/Dokumenti/noteikumi/uznemsanas-noteikumi-rezidentura-2018.pdf

[54] Approved in University of Latvia Senate on 30.05.2016., retrieved on 26.07.2016. Available: https://www.lu.lv/par/dokumenti/noteikumiunkartibas/uznemsanas-noteikumi-latvijas-universitate/

[55] The citation conveys the view that some medicine students might be securing the residency places because they are viewed by the admission commission as in some way "superior" to other candidates, e.g. being the children of doctors.

university from the one you graduated from." A supervisor added: "It is a totally chaotic process. Nobody knows who is deciding. Usually the decision is taken by the heads of the departments and all these commissions are only formalities."

The principle of equality in the process of delivering the programmes is not emphasised in any of the related documents. When asked if the trainee and their co-trainees have been treated equally and their rights were not violated, 43.6% of the respondents either disagreed or strongly disagreed with the statement. It appears that a part of the mistreatment is due to sexism and sexual misconduct in the surgical specialities, as one trainee explained: "Male residents are allowed to operate more than female residents." Another trainee added: "I would say I strongly agree if not for the surgical rotation. Male doctors there are sort of 'soviet mentality' and they hit on young female residents a lot, like grabbing them in the hallways, using inappropriate phrases, etc."

It is important to mention that because of a recent report of sexual misconduct in the university hospital, one of the main PME centres is currently establishing a body for dealing with such problems.

### 1.5. A policy is formulated and implemented on the criteria and the process for selection of trainees

**Estonia**

Rating: 3 / 1.33

University of Tartu Senate's Act[56] No. 2 "Regulations of Residency" Ch. II and the Act of Minister of Social Affairs No. 56 "Framework requirements of residency and procedures for conducting residency"[57] clearly formulate the selection process which is fully implemented.

The candidate must have graduated basic medical or dentistry education. The candidate can apply for two PME specialities, indicating their speciality preferences on the application. The admission exams take place once a year. The exams have a written and an oral part and are in Estonian. The substantive requirements and procedures of the admission examinations are established by the council of the Faculty of Medicine. The vice dean of PME, on the proposal of the programme director of the speciality, makes up the admissions examination committee of three to five members. At least one of the members of the committee must be from outside the university.

The acceptance is based on a ranking based on the final exam results of basic medical or dentistry education and the outcome of the admission exam. In the case of equality of admission results, the candidate with a doctorate in the corresponding field is firstly preferred, the candidate who has submitted a doctoral thesis in the corresponding field secondly and the candidate with a higher number of points received for admission thirdly. Still, as mentioned above, while the regulation has been formulated, residents have expressed that the admission process is not as transparent and objective as it seems on paper.

**Latvia**

Rating: 4 / 1.96

Both Rīga Stradiņš University and the University of Latvia have each formulated a different policy on the criteria and process for the selection of trainees in PME:

[56] Entry into force 25.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[57] https://www.riigiteataja.ee/akt/131012017028?leiaKehtiv

1) Rīga Stradiņš University's "Admission Regulations for the Second Level Professional Higher Education Programme "Residency in Medicine" in a Study Place Funded by State Budget"[58]. A similar document is available on the website of Rīga Stradiņš University regarding study places funded by physical persons or legal entities;

2) University of Latvia's Order No. 1/173 of June 12, 2017 "On Admission Requirements and Criteria for the Second Level Professional Higher Education Programme "Medicine" in academic year 2017/2018"[59] defines the admission requirements and criteria, while the process for selection of trainees is visible from this document, albeit in less detail.

Filing an appeal regarding the admission results is an option in both universities (based on aforementioned documents), therefore it is concluded that the policy on the criteria and the process for selection of trainees is implemented[60].

**Lithuania**

Rating: 3 / 1.31

Both universities include similar criteria into their process of trainee selection and renew them annually. This year, the criteria in the Lithuanian University of Health Sciences include the final exam score, the score of the internship exam, the average grade of the subjects during the 6 years of medical school, in addition to a score for research activities and the motivational score. The criteria in Vilnius University are very similar. However, they do not include the score for the internship exam, as it is included into the grade average, although they additionally include a separate score for the average grade for the "speciality" exams – that is to say, the subjects in medical school that are especially relevant to the specific residency programme. In addition, the motivational score is not mandatory for application in Vilnius University.

The criteria have been repeatedly criticised and are renewed almost annually to reach an agreement amongst all stakeholders. In addition, the aforementioned guidelines for trainee selection are not implemented in some departments.

### 1.6. The intake of trainees and the education capacity are in balance, the number of education positions is proportionate to the clinical/practical training opportunities and capacity for appropriate supervision

**Estonia**

Rating: 2 / 0.17

University of Tartu Act[61] §7 secunda sect. 1: "Ministry of Social Affairs provides proceeds the provision of residency places from the proposals of healthcare providers, doctors and dentists' specialist organisations and the university, as well as from the availability of state budget funds." According to

[58] Approved in Rīga Stradiņš University Senate on 21.11.2017 retrieved 05.06.2018.Available: https://www.rsu.lv/sites/default/files/imce/Dokumenti/noteikumi/uznemsanas-noteikumi-rezidentura-2018.pdf

[59] Retrieved 05.06.2018., Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/zinas/2018/Maijs/1-189_2018_Par_uznemsanas_prasibam_un_kriterijiem_otra_limuna_profesionalas_augstakas_izglitibas_studiju_programma_Medicina__2018.-2019._akad._gadam.pdf

[60] More information on the trainee selection process for the University of Latvia can be obtained from "Admission regulations in the University of Latvia". Approved in University of Latvia Senate on 30.05.2016., retrieved 05.06.2018., Available: https://www.lu.lv/par/dokumenti/noteikumiunkartibas/uznemsanas-noteikumi-latvijas-universitate/

[61] Available: https://www.riigiteataja.ee/en/eli/528122016001/consolide

information collected in focus groups with residents, there is no clear and transparent process currently in place. Annual postgraduate medical education committee meetings take place, but different stakeholders have expressed concerns that the outcome of these meetings is not in accordance with actual training and supervision opportunities and labour market needs. There are currently no interdisciplinary minimum standards for planning of education positions.

Interviewees mentioned, in some specialities, the number of accepted trainees is high in order to cover for the lack of labour needed. On the other hand, in some training institutions the trainees do not have allocated work spaces and computers due to overcrowding. Lack of supervisors and supervision and practical training opportunities were also highlighted as major concerns by residents.

**Latvia**

Rating: 2 / -0.3

Cabinet of Ministers Regulations No. 685 of August 30, 2011 "Regulations on admission and distribution of residents and financing of residency"[62], Article 3 stipulates that the Ministry of Health calculates the residency places fundable by state budget based on: "3.1. information on the number of doctors needed, supplied by the healthcare institutions; 3.2. the number of doctors who do not work in their speciality; 3.3. the number of unemployed doctors; 3.4. the predictable number of doctors who will reach the retirement age within 5 upcoming years; 3.5. the reciprocal analysis of the statistical data on the provision of European Union member states' doctors; 3.6. the demographic situation and the development forecasts; 3.7. prognoses for full-time work places of medical treatment persons." As can be seen above, the Ministry of Health is not required to consider the educational capacity of the hospitals and the universities before making the decision on the number of the state-funded residency places for the next year. However, the interviews with university representatives revealed that the Ministry might enquire as to the capacity of the universities and hospitals to train residents in specialities. The universities themselves determine the number of PME places funded by physical or legal persons. From the interviews, it can be seen these decisions are taken based on information on the available capacity for training. However, from discussion during the national workshop, there might be cases where the interests of the university (in taking an additional resident and receiving the tuition fee) and the hospital (seeing that there is no more capacity to supervise and ensure an adequate learning environment for the resident) clash. Some resident comments from the survey provide evidence of lack of time on the supervisors' side or lack of available rooms for residents in certain departments: "Shortage of staff -> doctors don't have time -> residents are treated as secretaries.", "Mostly there is no room for residents to work with a computer or papers on wards, no room for studying, no room for rest between shifts.", "Most supervisors have 2-4 jobs and don't have time for residents, students, patients, etc."

**Lithuania**

Rating: 2 / -0.02

When applying for the position to become a residency base, a healthcare institution must provide the Residency Base Assessment Committee with the number of staff able to work as supervisors for the residents in addition to the number of certain medical procedures that are performed in the institution, in order to decide whether or not the residency base is sufficiently equipped for the resident to take part in their education process. However, as it appears from interviews with focus groups, the working conditions described on paper often do not reflect the reality. In addition, most of the educational

[62] Updated 20.04.2018., Retrieved 29.07.2018., Available at: https://likumi.lv/doc.php?id=235421

processes take place in the two university hospitals, where clinical wards are often either overcrowded or understaffed with residents because of the imbalanced distribution of residents between departments in hospitals, which in turn occurs due to the large number of residents and lack of proper management of hospitals and PME.

### 1.7. There is a clear policy formulated and implemented for recruiting and selecting trainers, supervisors and teachers

**Estonia**

Rating: 1 / -0.99

According to The Act of Minister of Social Affairs No. 56 of 04.06.2001 "Framework requirements of residency and procedures for conducting residency"[63] §8, the only clear criterion is that the trainer must be a doctor with scientific and work experience in the area for at least 5 years and have up to two trainees at a time. A part of the criterion is not clearly stated; it could be understood that the trainer should have either studying or teaching experience. There are no clearly stated criteria for pedagogical expertise, being up-to-date with scientific discoveries and academic literature, having good interpersonal skills and ethical knowledge, etc., to which the trainers must comply. It was mentioned during interviews that often doctors are forced to become supervisors due to lack of medical specialists, which leads to a reluctance to teach.

Professional competency criteria are developed by specialist organisations/associations (§4 of the Act of Minister of Social Affairs No. 128 of 15.12.2004 "Quality assurance requirements for health services"[64]), but their assessment is voluntary, unregulated and not periodical[65]. Therefore, work experience by itself cannot guarantee competency of the trainer.

**Latvia**

Rating: 0 / -2.23

Section 2(1) of the Article 33 of the Medical Treatment Law[66] states that “Any medical practitioner certified in basic speciality, sub-speciality or additional speciality whose work experience in the relevant basic speciality, sub-speciality or additional speciality after acquisition of a medical practitioner's certificate is not less than 5 years has the right to carry out training of residents at healthcare institutions according to accredited residency educational programmes in medicine.” The researcher was unable to find a more clearly defined policy for recruiting and selecting trainers, supervisors and teachers for PME.

**Lithuania**

Rating: 2 / -0.02

The criteria for resident supervisor and coordinators are described in the respective university’s "Regulations of Residency". A resident supervisor is a university employee and/or a doctor working in a residency base, with at least 5 years of clinical experience. A coordinator of a residency is a university

[63] The Act entered into force 03.02.2017, RT I, 31,01,2017, 28. Available: https://www.riigiteataja.ee/akt/131012017028

[64] RT I, 06.11.2013, 6. Entry into force 01.01.2014. Available: https://www.riigiteataja.ee/akt/828314?leiaKehtiv

[65] Praxis. Ülevaade arstlike erialade arengukavadest. pp. 39–40 Tallinn: Poliitikauuringute Keskus Praxis, 2013.

[66] https://likumi.lv/doc.php?id=44108 version as of 01.01.2018, retrieved 29.07.2018.

employee, with or without an academic degree, appointed by the faculty. There are no other criteria, including qualitative (specific skills and competences), for selecting the resident supervisor.

### 1.8. The trainees can, to a reasonable extent, choose the institution and/or its subunit where to pass (parts of) their training

**Estonia**

Rating: 3 / 1.33

The Regulations of Residency Act states that the training takes place according to individual curriculums, with practical training in base institutions that have contracts with the university (the University of Tartu Senate's Act[67] No. 2 "Regulations of Residency" Ch. IV, pt. 32, 34.) According to programmes of specialities[68], there is an option to choose from a list of institutions, but there is no written clause that the resident has the opportunity to choose between the institutions. In some specialities, the programme director decides where the trainee can undertake some of their training. On the other hand, in some specialities the trainee looks for opportunities that are approved by the programme director.

Additional comments in the survey expressed conflicting opinions. According to the survey, over 35% of respondents do not agree that PME considers their individual needs. Based on comments by residents, the lack of flexibility in the choice of location of rotations can be highlighted in certain disciplines, and the presence of families and children is not taken into account when determining location and rotation places.[69]

**Latvia**

Rating: 4 / 1.96

The junior doctors can choose to which of the two universities they apply, keeping in mind the fact that in certain specialities each university provides residency at different institutions. However, some specialities are only available at one of the universities. Furthermore, the interviews with university representatives revealed that trainees are allowed to choose between training institutions when there is such a possibility. Additionally, there are possibilities to complete part of the training abroad through Erasmus+.

**Lithuania**

Rating: 2 / -0.02

The extent of freedom to choose the institution and/or its subunit to pass a part of the residency is determined in the descriptions of individual residency programmes. However, as the research team concluded from interviews with focus groups, the actual implementation of this freedom often depends on the decision of the coordinator of the residency.

[67] Entry into force 25.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[68] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[69] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 120–123. Tallinn: Poliitikauuringute Keskus Praxis.

## 2. The quality of postgraduate medical education

### 2.1. The form(s) of PME ensure the training of medical doctors who are competent to undertake appropriate medical practice in the defined field of medicine and capable of working in a professional manner

**Estonia**

Rating: 2 / 0.17

The programmes of PME are compiled in a way that best supports the training of competent medical doctors with broad-based curriculums and rotations in different specialities[70]. According to the Labour Force Monitoring and Forecasting System OSKA report "Future view of labour and skills needs: healthcare", employers consider the qualifications of the doctors coming from the education system to be very high. They stated the fact that doctors moving abroad are able find professional work in high-level hospitals also indicates this.[71]

Although 60% of junior doctors stated that PME in their speciality is organised in accordance with their vision of PME,[72] evidence suggests that current postgraduate medical education by itself does not provide sufficient skills for graduates to confidently become independent physicians. Only 27% of respondents agreed that, during the residency, residents are given sufficient feedback that supports their becoming a professional doctor.[73] Furthermore, the lack of focus on “soft skills” and constructive feedback from supervisors leads to junior doctors not feeling sufficiently confident and skilled to practise medicine independently. The lack of communication and teamwork training was also mentioned. They expressed that, in order to achieve competency, additional training is often required and is gained through voluntary and unpaid on-call duties outside regulated PME programmes.

**Latvia**

Rating: 3 / 0.92

A majority of 65% of supervisors agree that "The overall structure, composition and duration of the programme on my speciality is sufficient to prepare competent specialists" and 15%) strongly agree. Approximately half of the comments are supportive of this view, such as: "According to European standards.", "The programme is aligned with the European speciality programme. We have the appropriate bases, resources and lecturers.", "The current number of years is enough for my speciality." Still the remaining supervisors' comments reveal that changes in the study programmes are needed or the length of the programme or specific rotations needs to be modified: "All is included, but still some updates are necessary.", "Maybe too long. Not sufficient time for one rotation.", "The duration of training is sufficient (and possibly too long), but the content of training is not sufficient.", "Should be 5-year residency.", "3 years now, 4 is necessary." Recent graduates' answers to the same statement signal the need to adapt some study rotations: "There are some unnecessary rotations/courses during the first years of residency.", "Some study rotations should be changed (updated), some introduced."

[70] University of Tartu Faculty of Medicine, Specialities programmes. Available https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[71] Available: http://oska.kutsekoda.ee/wp-content/uploads/2016/04/tervishoiu_uuringu_terviktekst.pdf

[72] Residentuur 2017. Hindamise koondaruanne. Lisa 1. Tallinn: Poliitikauuringute Keskus Praxis

[73] Residentuur 2017. Hindamise koondaruanne. Lisa 1. Tallinn: Poliitikauuringute Keskus Praxis.

**Lithuania**

Rating: 2 / -0.02

The criteria to finish one's residency only includes a pass on the final residency exam and (although not in all cases) a research paper, therefore many residents achieve their licence as a specialist without having all the required competencies determined by the residency programme committees, which base their descriptions of residency programmes on national and international documents and recommendations. However, due to a lack of resources and/or time, in reality the trainees are not able to reach the described outcomes. When asked if the overall structure, composition and duration of the programme on their specialty is sufficient to prepare competent specialists, 60.4% of residents either disagreed or strongly disagreed with the statement. Many respondents emphasised the short durations of some of the residencies and the lack of clinical practice. A resident stated: "It was not sufficient, too much paperwork, no clinical practice. Only 3 years, not enough time." Another trainee agreed: "It's too short and superficial, not enough practical training. Very extensive programme, oriented towards theory but not enough time to master practical skills and not enough time to prepare for even the theoretical level. Practical work mostly consists of legal issues and social problem solving, during our training we have very little coverage of these topics." A resident shared similar opinions: "The programme is the same as Europe as a whole, but the time of training is 2 years shorter."

Even though 55% of the supervisors either agreed or strongly agreed with the statement, supervisors of gastroenterology, family medicine, radiology and paediatric oncology agreed that the duration of their respective programmes is too short.

In addition to hard competencies, working in a professional manner also includes the ability to provide sufficient healthcare to patients of all races, genders, cultural and religious backgrounds. The development of some of these soft skills, if at all, is included into the residency programmes. However, when asked if the trainees are prepared to recognise gender, cultural and religious specifications and to interact appropriately, 48.6% of the respondents either disagreed or strongly disagreed with the statement, adding: "Our population is still quite homogenous, so we lack experience in interacting with different cultural and especially religious specifications." and "the ability to recognise gender, cultural and religious specifications depends solely on you, if you had experience abroad or have read a lot".

Other necessary soft skills, such as communication and teamwork, are not nurtured sufficiently – over half of the residents disagreed with the statement that during PME sufficient attention is paid developing skills that support working in a team with colleagues and other healthcare professionals. While many expressed a lack of fostering of communication skills throughout the survey, soft skills such as these are still to be considered an equally important part of medical education.

## 2.2. The form(s) and duration of PME ensure the training of medical doctors who can work unsupervised and independently in the defined field of medicine

**Estonia**

Rating: 3 / 1.33

According to Ch. I sub-point 2 of University of Tartu Senate's Act[74] No. 2 "Regulations of Residency" PME is post-medical and post-dentistry training that is designed to give residents the knowledge and practical skills to be an independent specialist doctor. There have been some concerns about the length

[74] Entry into force 26.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

of PME in family medicine. Currently it is only 3 years. Trainers and residents say that this is insufficient time to gain a complete overview of such a wide speciality.[75] This changes to 4 years from July 2019[76]. A total of 60% of junior doctors stated PME in their speciality is organised in accordance of their vision of PME[77].

The current system maps out general educational outcomes in the programmes but does not state the intended educational outcomes of individual rotations, which, in several specialities, have led to the rotations consisting solely of observation, thus having no training value. Moreover, certain aspects of the curriculum do not necessarily meet the needs of a speciality or a resident specialising on a narrower field. Thus, in order to gain medical specialists who can work unsupervised and independently, simply changing the duration of PME is not sufficient. Consequently, PME programmes must be organised in a way that residents gain the most from their training.

**Latvia**

Rating: 2 / -0.3

Around 48% out of 136 residents agree and 10% strongly agree with the statement: "During postgraduate medical training professional autonomy of doctors is fostered to a level necessary to enable the doctor to act in the best interests of the patient and the community.", while 29% neither agree nor disagree, and 13% disagree. However, only negative comments were supplied for this statement, arguing that the amount of responsibility and autonomy within the residency is extremely variable: "Depends on the doctor I am working with. Also, tasks are sometimes overly low or high, some doctors do not allow us to try something, to practise, regardless that in the programme I should be able to do it already.", "Again, it depends. There are rotations where you have a good balance of autonomy and responsibility and a chance to ask advice if needed. But in other rotations the resident becomes more of a personal secretary, doing paperwork and with no time left to discuss the actual case. This is not due to the residents' qualities – all report equal experiences with certain doctors and this makes everyone feel equally useless and that they're wasting time.", "Autonomy isn't encouraged." Mostly doctors try to spread out the burden of responsibility, calling for numerous unnecessary consultations and hiding behind consultations performed by uninterested doctors.", "The quality of education is very low and after graduating from residency only a few are prepared to work independently." A majority of 30 out of 44 supervisors agree or strongly agree to the statement. Since most trainees and supervisors agree with this statement, but there are only negative comments from the trainees regarding it, the evaluation of this standard is 2.

**Lithuania**

Rating: 2 / -0.02

The criteria to finish one's residency only includes a pass on the final residency exam and (although not in all cases) a research paper. Therefore, many residents achieve their licence of a specialist without having all the required competencies determined by the residency programme committees, which base their descriptions of residency programmes on national and international documents and

[75] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 138–143. Tallinn: Poliitikauuringute Keskus Praxis.

[76] Act of Minister of Social Affairs No. 32 of 25.06.2018 "Changing of Act No. 110 of the Minister of Social Affairs of 28.11.2001 "List of Additional Specialist Degrees for Special Medical Specialities and Specialities" and Act No. 56 of the Minister of Social Affairs of 04.06.2001 "Framework Requirements for Residency and Procedure for Conducting a Residency". Entry into force 01.07.2019. Available: http://adr.rik.ee/som/dokument/5821511

[77] Residentuur 2017. Hindamise koondaruanne. Lisa 1. Tallinn: Poliitikauuringute Keskus Praxis.

recommendations. However, due to a lack of resources and/or time, in reality the trainees are not able to reach the described outcomes. When asked if the overall structure, composition and duration of the programme on their specialty is sufficient to prepare competent specialists, 60.4% of residents either disagreed or strongly disagreed with the statement. Many respondents emphasised the short durations of some of the residencies (especially Family Medicine, Physical Medicine and Rehabilitation, Otorhinolaryngology, and Ophthalmology, which all last for 3 years), and the lack of clinical practice. A resident said: “It was not sufficient, too much paperwork, no clinical practice. Only three years, not enough time.” Another trainee agreed: “It’s too short and superficial, not enough practical training. Very extensive programme, oriented towards theory but not enough time to master practical skills and not enough time to prepare for even the theoretical level. Practical work primarily consists of legal issues and social problem solving, during our training we have very little coverage of these topics.” A resident shared similar opinions: “The programme is the same as Europe as a whole, but the time of training is 2 years shorter.”

When asked for general comments, one resident stated: "Programmes of residencies are very different, some are better, some are worse. I am very disappointed about my speciality and especially residency of my speciality, because I didn't get enough knowledge and practical skills for my future work."

Even though 55% of the supervisors either agreed or strongly agreed with the statement, supervisors of gastroenterology, family medicine, radiology and paediatric oncology agreed that the duration of their respective programmes is too short.

### 2.3. The form(s) of PME ensure the training of medical doctors who can work within professional and interprofessional teams when relevant

**Estonia**

Rating: 2 / 0.17

The following related PME outcomes are stated in all residency specialist programmes[78]: "[Resident] knows the boundaries of their professional competence and is able to integrate the medical system optimally into the best way to solve the problems of doctors of other specialities and other healthcare professionals; is able to work together with relatives of patients, social system, etc., to support networks; is able to communicate the medical knowledge and the conclusions drawn from it to both patients, colleagues and the general public; is able, in cooperation with doctors of other specialities, to carry out differential diagnostics in case of complicated cases optimally using modern medical instruments and laboratory diagnostic possibilities."

There is critique from both residents and PME trainers. In this regard, 42% of residents disagree with the statement that in residency sufficient attention is paid to developing teamwork skills with other doctors, and 23% express that it is difficult to say. Moreover, 44% of residents disagree with the statement that during residency sufficient attention is paid to developing teamwork skills with other specialists (nurses, midwives, technicians, psychologists), and 25% claim that it is difficult to say.[79]

Different stakeholders see these skills to be acquired through everyday work and taught by supervisors. There is no training provided on teamwork and communication skills. Interview results state that often supervisors themselves do not have these skills, yet alone teach them to residents. In addition, communication and teamwork is seen as something not worth focusing on. Furthermore, it has been

[78] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[79] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 28, 36. Tallinn: Poliitikauuringute Keskus Praxis.

mentioned that development of these skills is dependent on the department where the resident is in rotation. In some departments, residents can participate in departmental training. Residents and supervisors have also mentioned that it is highly dependent on several factors. In specialities which require constant cooperation between different healthcare professionals, teamwork and communication is an important part of training, although it is learned through practical training in teams. However, these cases are uncommon[80]. Therefore, it can be concluded that teamwork and communication skills are not developed during PME.

**Latvia**

Rating: 2 / -0.3

Both the University of Latvia's "Overview of study branch "Healthcare" for 2016/2017" chapter "Medicine. Second level professional higher education (short progr.) 48721" and Rīga Stradiņš University's "Characterisation of study programme. Second level professional higher education study programme "Residency in Medicine" for 2015/2016 mention "ability to integrate within a team" among the intended educational outcomes of the programme. However, 138 residents' ratings of the statement: "During postgraduate medical training sufficient attention is paid developing skills that support working in a team with other health professions (nurses, midwives, technicians, psychologists)" is divided almost evenly into thirds (33.3% disagree or strongly disagree, 30.4% neither agree nor disagree, and 36.2% agree or strongly agree). The majority of the submitted residents' comments state that there is no formal course on communications (with exceptions in some speciality courses where teamwork is discussed in specific situations) and that the learning of teamwork skills on a daily basis depends on the resident's own initiative to learn from their colleagues. However, evidence from the supervisor comments is mixed. While one supervisor comments on teamwork with other doctors: "Very little multidisciplinary teamwork exists in practice, so trainees do not get enough experience in this modality of practice." Another supervisor maintains: "A lot of training is done on teamwork."

**Lithuania**

Rating: 2 / -0.02

The importance of the ability to work within a team is described in the individual descriptions of residency programmes. However, when asked if during postgraduate medical training sufficient attention is paid developing skills that support working in a team with colleagues, 54.3% of respondents disagreed or strongly disagreed with the statement. As one resident put it:

“Not yet. Very few are team-oriented. Most of residents are working individually. Only a few possibilities to learn teamwork are available. In my opinion, the academic staff are poorly prepared themselves to teach it or to provide enough knowledge about it (although there are a few exceptions, for instance, PICU, ER, oncology).”

Another trainee added:

“You learn it from practice or you don’t learn it at all.”

In addition, 54.9% of respondents disagreed or strongly disagreed with a similar statement suggesting that during PME sufficient attention is paid developing skills that support working in a team with other health professions (nurses, midwives, technicians, psychologists). A trainee explained their opinion:

[80] Residentuur 2017. Hindamise koondaruanne. Lisa 1. Lk 36-41. Tallinn: Poliitikauuringute Keskus Praxis.

“As my speciality is about working in a team, we spend quite a lot of time talking and discussing with other members of the team, but I couldn't say that somebody taught us how to work in a team. Everything came ‘naturally’, nobody taught any skills.”

A supervisor had similar opinions:

“I do think the level is quite low, with a few exceptions. No team-oriented meetings or discussions are held. Discussions are held internally – doctor-doctor level (in most of the cases with few exceptions) or nurse-nurse level.”

### 2.4. The form(s) of PME ensure the training of medical doctors who are committed and prepared for lifelong learning and participation in continuing medical education and continuing professional development

**Estonia**

Rating: 2 / 0.17

The following related PME outcome is stated in all residency specialist programmes[81]: "Resident recognises the need to continue to improve the medical knowledge and skills during their professional career and is prepared for lifelong learning.”

Approximately 35% of residents do not agree and 40% agree with the claim: "Residents’ skills and habits that support their constant professional development after the completion of the residency, are systematically developed during the residency." Respondents commented that it is highly dependent on the person and their supervisor, and it is very far from being systematically developed.[82]

Approximately 40% of residents do not agree with the claim: "During the residency the professional aspects of being a doctor are handled: skills for lifelong learning and maintaining competency, ethical behaviour, ethical behaviour, altruism, empathy, ability to work with others, compliance with ethical codes, patient safety."[83] Residents have noted the following: “The learning is rather hectic, it largely depends on the day-to-day practice and skills of the supervisor.“, “This topic is not directly touched upon, you learn while working.“, “It is considered rather a natural part of work, it is not specifically brought up or discussed with residents.“, “Depends on the supervisor.“[84] Another resident stated the following: “Unfortunately, this is not the case. Those who are interested in self-improvement, they see to it. Those who are not, they do not, and it has no consequences. These skills-habits are left entirely to the resident’s own concern.” There are no seminars or other theoretical training offered in relation to this, therefore it can be said the educational outcome in PME programme is not fully implemented.

**Latvia**

Rating: 2 / -0.3

Around 50% (69) residents agree and 15% (20) strongly agree that "During postgraduate medical training the trainees are prepared for lifelong learning and participation in continuing medical education/continuing professional development." One supportive comment reads: "I think more yes than no. We are advised to participate in conferences and other continuing medical education events

[81] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[82] Residentuur 2017. Hindamise koondaruanne. Lisa 1, p 41-42. Tallinn: Poliitikauuringute Keskus Praxis.

[83] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 41, 52. Tallinn: Poliitikauuringute Keskus Praxis.

[84] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 52–53. Tallinn: Poliitikauuringute Keskus Praxis.

of any kind. You quickly notice that it takes lifelong learning in order to stay 'up-to-date' and practise evidence-based medicine." The remaining 26% (35) of the residents neither agree nor disagree, but 9% (13) residents disagree, commenting: "Rarely do people look at recent publications, research and guidelines. Mostly everyone practises like they have done for many years, failing to update their knowledge. Often this thinking is accepted by residents.", "Depends on the trainee. Most prospective graduates have this quality by default. The programme does not nurture lifelong learning in residents (I personally believe that is the responsibility of the individual).", "We are only told that it's going to be a lifelong experience if you are smart enough and work hard. I think nothing can prepare you in the medical school. Only your practical experience.", "It's the trainees' own initiative.", "Depends on the rotation." Recent graduates of PME express a very similar distribution of answers and there is another valuable comment: "Sort of, you are obliged to because recertification requires conference attendance and other activities." From the high agreement with the statement it can be deduced that most residents believe that they are prepared for lifelong learning and participation in continuing medical education after finishing PME. The clear majority of the comments, however, point out that this readiness to continue one's medical education is primarily achieved on one's own, not as a result of systemic practices.

**Lithuania**

Rating: 3 / 1.31

When asked if during PME the trainees are prepared for lifelong learning and participation in continuing medical education/continuing professional development, 35.6% of residents agreed or strongly agreed with the statement, 31.3% neither agreed nor disagreed, followed by 33.2% who disagreed or strongly disagreed with the statement.

A trainee explained their opinion:

"There are opportunities for seminars, workshops and internships."

Another trainee added:

"They are prepared to learn because the knowledge we gain is not enough to work successfully on our own immediately."

and,

"Learning to participate in continuing medical education depends on your efforts."

When the supervisors were asked the same question, an overwhelming 65.7% agreed or strongly agreed with the statement.

## 2.5. The trainees have appropriate working conditions to maintain their own health

**Estonia**

Rating: 2 / 1.33

General working conditions and rest time are regulated by Occupational Health and Safety Act[85], Employment Contracts Act[86] and other corresponding acts. On-call times are individual and depend on

[85] Available: https://www.riigiteataja.ee/en/eli/ee/511112013007/consolide/current

[86] Available: https://www.riigiteataja.ee/en/eli/ee/530102013061/consolide/current

specialities and are stipulated in the residency specialist programmes[87]. There are no specific guidelines for PME.

Approximately 38% of respondents do not agree with the claim: "Residency studies are organised in such a way as to maintain the resident's mental and physical health" and 20% claim that it is difficult to say. Residents have brought up that it is individual and how they handle stress very much depends on personal characteristics. Residents or residency graduates have said the following: "During the period of residency, you will be exploited, and the work days are busy with the speciality rotations. If you need to read the treatment guidelines or articles, then you have to do it during your free time.", "There is normally no organised option to take a sick leave or, for example, unpaid leave. It is only possible to take a vacation for the whole month." Another resident responded that in order to achieve minimal competency, the average working week should be 70+ hours.

According to Occupational Health and Safety Act §8 sect. 2: “An employer shall implement measures to provide protection from biological hazards present in a workplace, taking account of the infectiousness of the hazard, “ §9 sect. 2: “Psychological hazards are /--/ poor work organisation, working alone for an extended period of time, and other similar factors that may gradually cause changes in the mental state of an employee,” §11 sect. 2: ”Non-workrooms for employees shall be constructed and furnished taking account of the working conditions and the number and gender of the employees.” It has been mentioned that in base training hospital departments there are no workplaces for trainees, and they have to find themselves a computer to work on. In addition, often there are no lockers in the coatroom where they could store their clothes.[88] Similar problems with workplace conditions were mentioned in several interviews. Notably, focus group results revealed that often residents are not provided with clean scrubs required for safe working so they must provide and clean their clothes by themselves. This causes additional stress to residents and may, in the long term, affect their mental and physical health. There is currently no actual inspection by the University nor the Ministry of Social Affairs in relation to whether the trainees have adequate working conditions.

**Latvia**

Rating: 1 / -1.18

The statement: "The trainees have appropriate working conditions to maintain their own mental and physical health." has the second lowest weighted average in the survey amongst residents – 2,85. Here, 31% of the total of 124 residents disagree and 13% strongly disagree with it, 21% neither agree nor disagree, while 30% agree and 5% strongly agree. The distribution of answers between recent graduates is almost the same, with a weighted average of 2,75. The supervisors' perception of the same statement is more favourable: 7 disagree with it, 13 neither agree nor disagree, but 19 agree and 3 strongly agree, with a weighted average of 3,43. This statement also has the highest number of residents' comments, 23. Most commentators stress the low salary paid to residents, because this factor results in the junior doctors taking on several jobs and thus negatively affecting the working conditions by detracting from the energy and time attributable to residency. Most characteristic comments in this regard include: "The salary is too low, trainees have to have a second job.", "300+ hours in a month. 36+ hour workday.", "By working in three jobs simultaneously no one can have appropriate working conditions.", "Another very important issue is the fact that residents work at several hospitals/institutions because the pay is very low – this has a detrimental effect on their physical and mental health, as well as on the

[87] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[88] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 75–82, 156. Tallinn: Poliitikauuringute Keskus Praxis.

quality of their work." Moreover, supervisors' comments stress the effect of residents working in too many places: "Not always, as they should work parallel in different roles to maintain their family or themselves. Often, they are very tired.", "Residents are too often overloaded with simultaneous tasks – residency, duties during residency, academic work and additional work in outpatient departments to maintain their material needs." However, one supervisor specifically underlines the residents' workload as part of the study process: "Sometimes they are overloaded with work: preparation for seminars, case analysis and work with patients." Some residents also mention that they stay in the hospital to finish work after their official workday is over: "Shifts are often longer than officially said to be and there is lack of time to read and search for deeper thorough knowledge.", "If a trainee is working in the emergency department for 24 hours, the next day he is not allowed to go home and have a rest. He has to work in speciality department next day. This means that a trainee at least twice a month has to work 36 hours continuously." Besides, there are departments with inappropriate facilities: "Mostly there is no room for residents to work with a computer or papers on wards, no room for studying, no room for resting between shifts.", "Not all of us have a place to stay/rest/eat/sleep between work and night shift or night shift/seminars/classes. I often find myself dozing off in the middle of the hospital somewhere on a chair although I could easily spend my 3 free hours before the night shift napping. Some – not all – departments have rooms for residents.", “Lots of residents don’t even have a place where they can change into their working scrubs...", "The working conditions usually are critically bad, no computers, no individual work space, even no changing rooms!" In some cases, the planning of rotations as well as the accessibility of IT systems for residents is a problem: "Sometimes in one unit there are a lot of residents in one period of time – simply no physical place to work.", "Hospital has not planned for the option that there will be doctors – residents. IT systems don't work for them, as well as a lot of limitations for what residents can even do with patients – prescribe medicines etc." Moreover, junior doctors also mention various reasons for mental stress: "The lack of supervision from the early stages of traineeship increases the mental stress. There is no training on communication and ethics, especially when dealing with patients and delivering bad news. There is no real tradition to offer psychological support after ‘traumatising’ events, such as losing a patient, conflicts, medical mistakes made by the trainee.", "Working conditions at the hospital are usually without any psychological support and there is a high risk of burnout amongst supervisors as well as residents, some supervisors already have features of burnout such as lack of interest, or lack of time for conversations with relatives. Physicians are involved in the resolution of patients' social problems because there is no system in place for how social care questions should be solved.", "It is hard to be in the emergency department. On the one hand, it is the perfect place to gain knowledge, but also there is also high stress if, at the beginning, I do not know right way to treat patients. The problem is that we residents cannot discuss all cases with our teachers/doctors, because they do not have time."

**Lithuania**

Rating: 2 / -0.02

The importance of maintaining physical and mental health is not emphasised in any of the residency-related documents. When asked if the trainees have appropriate working conditions to maintain their own mental and physical health, 60.1% of residents disagreed or strongly disagreed with the statement, while 58.3% of their supervisors agreed or strongly agreed with the same statement.

A trainee explained: “As residency hours are (officially) rather short, yes. However, since most of the residents have additional jobs and responsibilities, they are mostly overstressed. I do not know of any person or service where a resident could come for mental health issues. Physical health as well – to get vaccinated for influenza, it takes a lot of effort and persistence.” Another resident added: “Resident

physicians in university hospitals are not regarded as having equal employee rights because the hospital doesn't pay their salaries (the money comes from the Ministry of Health and the Ministry of Education). Because of this, depending on the ward, resident physicians are not provided with a working space, a space for resting (e.g. a bed to sleep during shifts), or working tools (computer)."

A supervisor also shared their opinion: "A lot of overtime. Shifts are somehow okay, but work organisation is very chaotic, as extra hours can appear without any planning in advance."

## 2.6. The programmes are up-to-date and in accordance with the latest developments on the selected field of medicine

**Estonia**

Rating: 2 / 0.17

According to §5 sect. 1 and 2, a medical resident or, before 2001/02, a person matriculated in residency undergoes a residency programme based on an individual residency programme consisting of rotations outlined in the speciality programme. The individual curriculum in the basic institutions is drawn up by a university-appointed representative together with the resident and the university approves it for each academic year individually.[89] Changes to PME programmes can be made every academic year, with the changed residency programme being the corresponding version for the academic year.[90] The initiative and input of change should come from the programme director, who presents this to the university's committee for PME. If the committee approves, it is given to the council of the faculty to vote upon and if the change is significant, it needs the approval of the university's senate.

There are no regulations that state the time or period when programmes should go through evaluation. Updating of the programmes depends on the available time and motivation of the programme director. Therefore, there is a great deal of unwarranted variance in the quality and timeliness of the programmes. According to the information on the Faculty of Medicine's webpage, over half of the available PME specialist programme versions were last updated in 2011.[91] The university representatives stated that the programme director in charge of the specialist has a wide network of specialists who they should go to in order to keep the programmes up-to-date. There are no official job descriptions or documents that would support the claim and ensure the programme directors are aware of this.

**Latvia**

Rating: 3 / 0.92

University representatives confirmed that in their opinion the programmes are up-to-date and each year study rotations are updated with current information. Each speciality study programme in each of the universities has a study programme manager who is in charge of renewing and updating the programmes. All 106 study programme managers were approached by e-mail and a reminder and five provided an answer as to whether in their opinion the current content of the study programme in their speciality is up-to-date. They all state that the study programmes are up-to-date; moreover, some

[89] The Act of Minister of Social Affairs No. 56 of 04.06.2001 "Framework requirements of residency and procedures for conducting residency". The Act entered into force 03.02.2017, RT I, 31,01,2017, 28. Available: https://www.riigiteataja.ee/akt/131012017028

[90] Univesity of Tartu Senate's Act nr. 2 "Regulation of residency". Ch III, sect. 30. Enrty into force 26.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[91] https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid, viewed on 06 August 2018

added that the programmes are in accordance with the pan-European specialites associations' current recommendations. However, some resident comments from the survey point to drawbacks: "I agree, partly, but it depends somewhat on the rotation. Some are really good, some less so. I would appreciate more qualitative, more organised, practically and clinically based teaching on the one hand and more responsibility and independence when it is appropriate. Residency programme design should be less determined by academic staff and more by clinicians.", "All the rotations are necessary during my training, but, during some of them, I feel that I learn nothing that would be suitable for my speciality."

**Lithuania**

Rating: 2 / -0.02

Residency committees (commissions) have an opportunity to renew residency programmes yearly, but not all of them take that opportunity. Although it is worth stating that most programmes have been recently updated to meet the latest developments in their fields, however, as mentioned earlier, the reality seldom reflects the descriptions in the documents. In addition, the Centre for Assessment of Study Quality also includes the criteria of meeting the newest scientific developments in their process of assessment.

### 2.7. Renewal of the programmes is systematic and takes place in cooperation with all stakeholders

**Estonia**

Rating: 2 / 0.17

Residency committees with stakeholder representatives have been established in the Ministry of Social Affairs and Tartu University. To update the programmes, the input is obtained from the programme director of the residency programme, but there is no more detailed evidence of involvement of other stakeholders (e.g. professional associations, junior doctors). Programmes must be approved only by the council of the Faculty of Medicine in case of minor changes, or, in the case of major changes, approval of the university's senate in required. There are students' representatives in both governing bodies. The council of the Faculty of Medicine has five student representatives and one residents' representative[92]. This means that, technically, student representatives are involved in decision-making e.g. Tartu University senate has five student representatives, of whom two represent the Faculty of Medicine[93]. Although junior doctors do not have student status, the residents can approach them to communicate concerns.

In addition, the content of the programmes has never been discussed at the ministry level, only programme length. According to the junior doctors, the ministry officials do not always know who they should involve in the discussions.

**Latvia**

Rating: 1 / -1.18

According to university representatives, the renewal of the programmes takes place before the accreditation of the study programmes (once every 6 years). However, according to the university

[92] Members of the council of the Faculty of Medicine. Retrieved 22.11.2018. Available: https://meditsiiniteadused.ut.ee/et/teaduskonnast/teaduskonna-noukogu-0

[93] Members of Tartu University Senate. Available: https://www.ut.ee/en/university/structure-and-staff/university-governance/senate Retrieved: 22.11.2018

representatives there are minor changes in the programmes every year (e.g. in the recommended literature, new technologies) and also when the requirements of Cabinet of Ministers Regulations No. 268 change; study programme managers are in charge of creating and renewing the programmes. No evidence was found on requirements to involve other stakeholders in the process of renewal of the programmes. Stakeholders expressed that there are cases when speciality associations are involved in the renewal of the programmes in cases where the programme manager is actively involved in the association, although this is not by rule.

**Lithuania**

Rating: 2 / -0.02

The structures responsible for the periodic renewal of residency programmes are the residency programme committees (commissions), which must include a representative of the residents. However, as the research team concluded from interviews with focus groups, some of the committees do not meet regularly, if at all. The committees must include a representative for the residents. However, there have been cases where the resident takes part in the process only on paper. Nevertheless, Vilnius University noticed the aforementioned problems and is planning to implement systemic changes to ensure the proper functioning of the committees.

## 2.8. The framework of postgraduate medical education is built on the acquired outcomes of existing basic medical education

**Estonia**

Rating: 3 / 1.33

A majority of 60% of residents agree with the claim that: "The skills and knowledge obtained in the basic medical education are in line with the necessary skills and knowledge of my speciality's residency programme", while 18% find it difficult to say. However, residents and trainers emphasised that students do not have sufficient practical knowledge and experience after finishing basic medical education. In interviews residents expressed that basic medical education does not cover many issues that are necessary in residency and while practising medicine (e.g. knowledge on medication dosages etc.). One resident stated: "The theoretical part of the [basic] medical training is comprehensive enough, but I believe that the practical learning outcomes of basic training should be better established and respond to the general practitioner's skills and knowledge", and another resident mentioned: "In some specialities, there is a very good approach, you get enough knowledge. However, in my speciality, the general practitioner's knowledge is very limited, because it is a very narrow area."[94]

The university has started to improve the quality of basic medical education in terms of increasing the proportion of practical training. Since 2016, the sixth year of basic medical education has been dedicated to practical training. Nevertheless, this can only partially fill the vacuum of the acquisition of practical skills before PME.

**Latvia**

Rating: 3 / 0.92

Out of 138 residents, 12% strongly agree, 47% agree, 23% neither agree nor disagree, 17% disagree and 1% strongly disagree with the statement: "The skills and knowledge acquired during basic education of medical doctors are relevant to the skills and knowledge necessary to continue postgraduate medical

[94] Residentuur 2017. Hindamise koondaruanne. Lisa 1, lk 8–15. Tallinn: Poliitikauuringute Keskus Praxis.

training on my speciality." Residents' comments to the above statement can be divided into several groups. Most commentators believe that more practical skills should be gained in basic medical education in order to be better prepared for postgraduate education. Characteristic comments include: "I believe I received only theoretical knowledge, besides, my speciality rotation as such was very short.", "Theoretical knowledge is far-off from actual clinical practice, where cases are complicated and not easily diagnosed, especially in subjects where teachers aren't everyday practising doctors.", "There is a lack of skills to communicate and cooperate with patients, their family and colleagues.", "Theoretical knowledge is more applicable in postgraduate training. Skill-set taught in med school, not too much.", "In my opinion education was too wide-ranging. Of course, it is important to gain an idea about all specialities, but 6 years was too much. I would prefer 4-5 years' education as it was, including one research work, but also 1-2 'pre-residency' years with more training of practical skills and practical work with patients (e.g. putting in catheters, injections etc.; nursing skills to understand the whole process)." There are also respondents who argue that the broad knowledge gained in medical school is also instrumental in narrow specialities. One typical example of such comments is: "Basic knowledge of general illnesses is also important for specialists of narrow specialities, since usually the patient has multiple comorbidities which possibly impact his/her main illness due to which he/she currently is in the medical institution or is seeking my consultation." There were also a few respondents who expressed an opinion that the knowledge gained in specific speciality courses within basic medical education is not sufficient: "My speciality course during the basic medical education (6 years) and the internship in my university lasts around a month. So, you get just very basic knowledge of the speciality and all the rest of what you want and need to know for your future work in this field is up to you to learn depending on your level of enthusiasm.", "A week of speciality course doesn't allow you to feel comfortable continuing the postgraduate studies." In addition, recent graduates offer similar comments: "Weak course of my speciality during medicine studies" and "Our university prepares general medicine doctors, if you plan to do another specialisation the only way how to learn more is to work as a volunteer or nurse's assistant at the same field. But I think it's the right thing to do." Out of 45 supervisors, eight strongly agree with the statement, 27 agree, seven neither agree nor disagree, two disagree and one strongly disagrees. The supervisors express similar views to the residents. More practical training is needed: "Those residents who have practical skills are easy to train in the specific field." Another supervisor comments that the speciality course is too short.

**Lithuania**

Rating: 3 / 1.31

On paper, the residency programmes are built based on the acquired undergraduate medical education. When asked if that knowledge is relevant to the skills and knowledge necessary to continue PME on their speciality, 50.7% of residents agreed or strongly agreed with the statement, while 32.5% either disagreed or strongly disagreed with the statement. Similarly, 57.9% of supervisors agreed or strongly agreed with the statement, while 21.1% strongly disagreed with it. When elaborating on their opinions, the respondents claimed that usually the knowledge gained during undergraduate training is not sufficient, in addition to emphasising the lack of development of practical and communication skills. As one trainee put it: "Most of it is theoretical knowledge which is of little or no use in the clinical setting. Almost no attention is focused towards communication and practical skills." A trainee added: "Some knowledge is relevant such as basic and common diseases and their basic treatment, but we did not have much experience with the medical law system and how to manage syndromes and how to communicate with the patient (skills needed in family medicine)." A supervisor also shared their opinion that: "More practical knowledge is needed, more basic skills and practical skills assessment together with theoretical background."

## 2.9. The training relies on the intended educational outcomes of the programme and the needed qualifications of the trainees

**Estonia**

Rating: 2 / 0.17

Residency specialist programmes[95] stipulate the precise specialist knowledge, skills, and general competences the resident must have to successfully finish residency. The training is strongly reliant on the supervisors, as stated by the survey respondents and §8 sect. 3 of The Act of Minister of Social Affairs No. 56 of 04.06.2001 "Framework requirements of residency and procedures for conducting residency"[96]. Around 70% of responding supervisors agree that they base their teaching on the educational outcomes and expected qualifications of the trainees. Some have mentioned that they base their training on the individual needs of the trainee and the amount of time they have available. Some supervisors also mentioned they do not have an overview of the educational outcomes the trainees are supposed to have achieved at the end of their training.[97] Furthermore, it has been mentioned that the supervisors teach in addition to everyday work, not as an integral part of it. Therefore, the quality of teaching often suffers due to the lack of time available to dedicate to the residents and following the PME programmes.[98]

The main problem that PME faces is unwarranted variance of the quality of specialist programmes. The PME is rotation-based, but only general outcomes are defined. This leads to the training and experience gained in different base training institutions being uneven and potentially insufficient. Junior doctors have mentioned that not having educational outcomes for each rotation has led to situations where trainees simply have nothing to do or are not given tasks when they are not in their specialist rotations, since neither the supervisors nor the trainees have any idea of what they should achieve at the end of the rotation.

**Latvia**

Rating: 2 / -0.3

Cabinet of Ministers Regulations No. 268 of 24 March 2009 "Regulations on competency in medical treatment and volume of practical knowledge of medical treatment persons and students who are acquiring first or second level professional higher medical education programmes"[99] list the competency and theoretical and practical knowledge required of students in the various specialities of PME. However, as argued in standard No. 1.2., some specialities in the Regulations No. 268 are very broad. The speciality study programmes of universities are built on the abovementioned Cabinet of Ministers Regulations No. 268 – thus, they are shaped by the intended educational outcomes and attainable competencies. However, the study programmes are not publically available.

The only comments supplied by supervisors on the statement: "The learning outcomes and expected skills outlined in the residency programme serve as a basis for supervising and training the residents" range from complete agreement: "Training is always carried out in accordance with the programme."

[95] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[96] The Act entered into force 001.07.2018, RT I, 28.06.2018, 21. Available: https://www.riigiteataja.ee/akt/131012017028?leiaKehtiv

[97] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 148–149. Tallinn: Poliitikauuringute Keskus Praxis.

[98] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 150–152. Tallinn: Poliitikauuringute Keskus Praxis.

[99] Entry into force: 29.06.2018., Retrieved 29.07.2018., Available: https://likumi.lv/doc.php?id=190610

to partial agreement: "We have to work on formulating the learning outcomes. We are more focusing on competences." to pointing out weaknesses: "No real portfolio is created. Only a log book with a list of patients." While there is a supervisor who strongly states, "The successful graduation of the programme allows residents to independently, competently carry out the work in the speciality.", some residents express disagreement that the training prepares the residents for the intended educational outcomes: "Lack of standards and goals that must be reached during learning process.", "There is too little opportunity to do practical work. After the 5-year residency you can't work as a doctor in my speciality because you do not have enough practice. The resident education is entrusted to people who are not interested in it.", "In summary, I believe that the training we receive in my speciality programme does not prepare us for the functions which would need to be carried out by a specialist after certification. [...] In rotations where our training has been formally carried out by other speciality doctors, the answer that I have received to my questions has been 'this is not work for your speciality' [...] It can be felt very strongly that not all doctors should train others and rarely do we end up under supervision of such a doctor who has an understanding of how to use our speciality as a resource."

**Lithuania**

Rating: 1 / -1.36

As established earlier, the educational outcomes listed in the residency programmes often do not reflect the reality of postgraduate medical training in Lithuania. When asked if the overall structure, composition and duration of the programme on their speciality is sufficient to prepare competent specialists, 60.4% of residents either disagreed or strongly disagreed with the statement. Many respondents emphasised the short durations of some of the residencies, and the lack of clinical practice. When asked for some general comments about the situation in Lithuania, a trainee stated:

"The dominant feature is that the paper programme is completely different from the real education that we get."

Another trainee added:

"The quality of postgraduate medical education is highly dependent on the teaching hospital/centre and the chosen speciality. There is no gradual systematic progression in education. There is no evaluation of competencies gained during the training. Usually the trainees are thrown into the system with the hope of them not drowning. No direct supervisor for career/learning or any other kind of counselling is available."

However, when the supervisors were asked if the learning outcomes and expected skills outlined in the residency programme serve as a basis for supervising and training the residents, 81.3% of the respondents agreed or strongly agreed with the statement.

## 2.10. The educational framework of postgraduate medical education is organised in a systematic and transparent way

**Estonia**

Rating: 2 / 0.17

Educational frameworks of residency specialist programmes are available on the University of Tartu's Faculty of Medicine's webpage[100]. The programmes list rotations and theoretical courses the trainees must pass in order to become a specialist doctor, along with additional elective courses and rotations.

[100] https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

Nevertheless, it cannot be said the programmes are systematic and clear, because they only list the courses and rotations without stating the expected educational outcomes or any logical following of the rotations.

Around 50% of PME graduates agreed and 20% found it difficult to say whether medical residency has an organised structure, that the rotations follow a logical order.[101] The main comments were that the rotations are organised haphazardly and according to available places in different institutions and do not follow any logical progression of training. The junior doctors are, in some cases, responsible for their own planning. First year trainees frequently do not have sufficient information to independently compile their own curriculum. In addition, it has been mentioned that in several specialities there are rotations that do not seem to be relevant to the specialty, while others are lacking some that are clearly needed or expected, e.g. there is no cardiology rotation in the cardio surgery speciality.

**Latvia**

Rating: 2 / 0.92

Most supervisors agree or strongly agree with the statement: "Residency is organized systematically; study cycles are in a logical sequence." Their comments range from complete agreement with the statement (e.g. "No comments. Agree to the statements.", "The program is adapted in accordance with European recommendations.") to distinguishing of incongruities (e.g. "The study courses are too short in every subspecialization with another supervisor, only one month and then resident has to change for next subspecialization and supervisor.", "The cycles of the main speciality training are more or less in a logical order, however in the sub-speciality training there is much room for improvement."). Respondents among recent residents equally distributed between the three main types of answers (disagree/strongly disagree, undecided, agree/strongly agree). The following quotation reflects the situation in the residency: "Situation is very inhomogeneous. Although residency is organized very well in my field in my hospital, situation may be very different in other specialties and other hospitals. Quality of training during residency mainly depends on supervisor on specialty, not so much on systemic structural guidelines."

**Lithuania**

Rating: 2 / -0.02

The residency programmes are renewed periodically, although there are exceptions, as the process of renewal often depends on the coordinator of the residency, who is often also the head of the Residency Programme Committee. In addition, as mentioned, even if the residency programmes are systematically renewed, it does not necessarily reflect the real situation.

### 2.11. Appropriate instructional and learning methods are applied, and integration of practical and theoretical components ensured throughout the course of training

**Estonia**

Rating: 2 / 0.17

According to the responses to the claim: "In my speciality's residency programme, there is a fair balance between practice and theory" 51% of residents and 69% of supervisors agree with the claim, while 21% of residents and 22% of supervisors find it difficult to say. Several residents have mentioned that there

[101] Residentuur 2017. Hindamise koondaruanne. Lisa 1. Tallinn: Poliitikauuringute Keskus Praxis.

is not enough time or emphasis on theoretical learning. A supervisor claimed that it: "Depends on the programme director. Practical training is just the normal work in the department, [where] I have not observed learning per se. It is, however, a matter for the departments, not for the residents."[102]

The policy brief based on the survey results states: “Medical residency as a form of postgraduate specialisation should focus on learning. At the same time, the residency must be integrated with service provision, i.e. residents participate in the service provision but, through this, also have sufficient learning opportunities. Residents of various specialities have indicated that, in their field, clinical work without additional learning value dominates the residency. According to the original idea of medical residency, residents should provide healthcare services and, in turn, receive teaching. In practice, however, the former sometimes occurs without the latter.” [103]

Trainers and trainees have mentioned that the supervisors do not have the time and skills to provide proper supervision. Interviewed trainees said that supervising doctors often do not give feedback, or the trainees themselves are asked to fill out the feedback forms about themselves that the supervisors have to submit, or they are sent directly to the university without giving feedback to the trainee. One of the probable reasons stated was the lack of pedagogical training.

**Latvia**

Rating: 2 / -0.3

Although 43% of the total of 120 residents agree or strongly agree with the statement: "Supervisors use instructional and learning methods that are appropriate and ensure integration of practical and theoretical components.", and 34% neither agree nor disagree, the residents' comments reveal a variety of opinions with more argumentation supporting the 23% who disagree or strongly disagree: "Depends on the supervisor.", "Some supervisors are using such methods, some not.", "The exceptional ones try." The comment that states the idea expressed most frequently, however, is: "There is a frequent lack of supervision, but when there is a certified supervisor, they are not always trained in how to educate the trainees and therefore the quality of education is very variable – some supervisors prefer not to talk much to the trainee, others like to discuss some of the aspects of the clinical cases the trainee encounters." Out of 40 supervisors who rated the statement: "I have been trained to be a supervisor in my chosen field of medicine.", 38% have not received training how to be a supervisor in their chosen field of medicine and 3 do not know. Second, the residents' comments on the statement: "The postgraduate medical training on my speciality is organised in line with my understanding of how postgraduate medical training should be provided." also stress the lack of time or interest for teaching on the supervisors' side. To give just a few of the comments in this regard: "There is lack of supervision early on in the residency because of lack of certified specialists in my field. Most of the clinical skills are not systematically taught, but the resident is expected to learn them as they go along in the residency, half the time without the supervision of certified personnel or supervised by older residents in the best-case scenario. There are many residents at the same hospital, so persons most involved in the education process have limited time to spend with each individual resident to discuss the theory behind practice or train them in procedures/manipulations.", "Mostly I was just following the training doctor. There are few possibilities to get new practical skills or learn procedures. Some courses are too short, some too long.", "I would appreciate more qualitative, more organised, practically and clinically based teaching

[102] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 96–100. Tallinn: Poliitikauuringute Keskus Praxis.

[103] http://www.praxis.ee/wp-content/uploads/2017/02/Residentuur_Eestis_analyys.pdf

on the one hand and more responsibility and independence, when it is appropriate, on the other. Residency programme design should be less determined by academic staff and more by clinicians." Residents also express a lack of theoretical learning components: "In my speciality unfortunately it seems like I am learning on my own, as no help or theoretical discussion groups/sessions are provided. There is a lack of interest from the residency programme supervisor. Practical skills are easier to learn, but also based on self-initiative." Moreover, general comments by residents reveal a lack of theoretical teaching: "Lack of feedback, case studies, good-quality seminars, mentoring and support, critical scientific information reading. Most of the supervisors are not educated on how to teach residents or they are not interested, or they simply don't have time for that.", "Chaotic, low level of theoretical basis, low level of practical procedures.", "Situation varies from speciality and centre. More theoretical basis is needed in every speciality in the first years. Introduction to clinical work in hospital is needed, because currently first year residents are just thrown into clinical work unprepared."

**Lithuania**

Rating: 2 / -0.02

The residency programme descriptions describe the educational outcomes, in addition to the ways and methods to acquire them, including clinical work and various seminars. Unfortunately, the educational outcomes, both concerning the practical and theoretical set of skills, are often only reached on paper. In addition, when asked if supervisors use instructional and learning methods that are appropriate and ensure integration of practical and theoretical components, 40.3% of the trainees disagreed or strongly disagreed with the statement, the majority of them mentioning that the quality of education strongly depends on the supervisor's personality and willingness to teach. In addition, the requirements for resident supervisors only include being a university employee and/or a doctor with at least 5 years of experience. Having been trained to become a supervisor is not included in the requirements. When asked if they have been trained to be a resident supervisor, 40.9% of supervisors either disagreed or strongly disagreed with the statement. A supervisor explained:

“If this means ’supervisor of residents’, I haven’t been trained as a supervisor. Working in a university hospital as a faculty member means – you are a supervisor.”

## 2.12. Trainee-centred approach is used that stimulates, prepares and supports trainees to take responsibility for their own learning process and to reflect on their own practice

**Estonia**

Rating: 1 / -0.99

Conflicting evidence has been found regarding trainee-centeredness of PME. Approximately 45% of residents think that PME is organised in a way that considers their individual needs and wishes. They emphasised that the rigidity of the system, especially leave-taking options, reduces the motivation to study and conduct medical research.[104] It was brought up that too much time is being spent observing supervisors, especially during non-specialist rotations, which is not considered to provide sufficient understanding and practical experience.[105] The interviews revealed that the trainees often do not receive supervision, and with very limited or no feedback.

[104] Residentuur 2017. Hindamise koondaruanne. Lisa 1, lk 120-123. Tallinn: Poliitikauuringute Keskus Praxis.

[105] Residentuur 2017. Hindamise koondaruanne. Lisa 1, lk. 138–143. Tallinn: Poliitikauuringute Keskus Praxis.

According to Ch. VI sect. 42 of University of Tartu Senate's Act No. 2 "Regulations of Residency"[106] "The resident is required to keep a residency diary reflecting the completion of theoretical training of the resident and the acquisition of practical skills in accordance with the individual curriculum and the residency programme." However, residents mentioned that the current diary system is outdated and does not fulfil its purposes.[107] The diary functions as a paper record where the trainee notes down all the procedures performed, etc., but it does not in any way involve formative self-assessment or reflections on their own practice and, according to residents, it is a formal requirement without clear purpose (e.g. supervisors sign it without reading it; resident diaries are collected by the university, but the information is not analysed). Thus, it can be claimed that there is scant evidence the PME meets the standard. It has been mentioned that a few progressive programme directors are trying to implement newer, more effective, methods.

**Latvia**

Rating: 1 / -1.18

In the survey residents present several issues that endanger a trainee-centred approach in PME. One issue that stands in the way of a trainee-centred approach is the view held by some supervisors that residents are their future competitors and might take their own place in the hospital in a few years' time: "In Latvia the main problem with residency is the problem that people do not teach the residents. The attitude towards residents from the beginning is that of towards competitors.", "Although most supervisors gladly work with residents, you can feel some limits of their responsiveness. Some have even told us that we are their future competitors, which I think is nonsense." The doctors' workload in the hospital also stands in the way of residents being in the centre – residents claim that often they are given mundane daily tasks instead of encouraged to learn: "The quality of study rotations depends on each supervisor. In many cases the resident serves as a secretary to fill out the paperwork, and an insufficient amount of time is dedicated to the discussion of clinical cases and integration of theory into clinical practice. Some rotations are supervised very strongly, and the resident is not involved in the decision-making, but in some other rotations there is little or no supervision.", "Supervisors have no time for supervision. The residents are usually working and making decisions alone without supervision and no feedback.", "Old fashioned, rigid. More work and filling in for the teaching doctors, less learning/teaching." There are also comments that state that trainees are not prepared, stimulated and supported to take responsibility for their own learning: "Everyone for himself – rarely do doctors teach residents. If you want the knowledge, you must read yourself (which is normal), but residents who don't read are treated the same as educated residents. There is no incentive to learn additionally.", "The trainees can learn a lot, because they mostly do a lot of the doctors' work, often very independently. But guidance, supervision and feedback are lacking. Also, the financial situation forces trainees to have at least one other job, so there is not enough free time to study theoretically and recreate.", "Because of the general lack of certified doctors/supervisors residents are frequently left on their own in the clinical setting, thus not only lowering the quality of education, but also endangering patient safety. There is a strong tradition that the resident should be able to manage on their own and only the newest generation of supervisors are bringing more interaction during clinical training." One junior doctor mentions limits to access information of interest: "Your education is in your hands (which is good). No one can force you to become competent. But you always have to balance your interests with the limits you can squeeze out of the system. Sometimes if you really want to learn something or become

[106] Entry into force 26.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[107] Residentuur 2017. Hindamise koondaruanne. Lisa 1, lk. 159–181. Tallinn: Poliitikauuringute Keskus Praxis.

competent in something, you won't be able to find someone willing to teach you. The hope is to find a small field to master, one that can feed you after you graduate. The real studying actually starts when you get your diploma and finally have the time to go to courses and become competent in the field you actually like."

**Lithuania**

Rating: 1 / -1.36

Even though the residency programmes talk about nurturing the residents to systematically increase their knowledge and abilities, when asked about their general opinions towards PME, many residents brought up the status of the trainee, as they are often solely regarded as an extra workforce. As one trainee put it:

"Postgraduate medical education is rarely centred on what resident really needs but mostly on what is beneficial for the hospital. A lot of time is wasted on non-medical duties and residents are not treated as equal fellow doctors".

"We are technically students (and workers), but even if there is the 'studying' part, it is often done by residents themselves (resident to resident). In many departments, residents are being used as a cheap (free, really) labour force to fill papers and such (highly prevalent in the surgical department). You are thrown into a workplace and have to figure out how to work there, with some guidance provided. In many departments, residents work extra hours for no pay, or work the next day after a 24h shift (often paperwork)."

This is partially related to the fact that due to the overwhelming amount of bureaucracy within the healthcare system. Supervisors often do not have the time to properly teach the trainees. When asked if their supervisors have/had time for supervision and teaching, 47.9% of residents disagreed or strongly disagreed with the statement, some adding that the time dedicated to teaching also depends on the supervisor. As one trainee put it:

"It depends on the supervisor – some would make time even if there is physically no time at all."

## 2.13. Gender, cultural and religious specifications are recognised by the programme provider(s) and trainees are prepared to interact appropriately

**Estonia**

Rating: 2 / 0.17

Over 65% of residents do not agree with the claim: "During residency I was instructed to prevent and solve communication problems or (potentially) conflict situations arising from gender-, culture- or religion-related differences." and approximately 15% find it difficult to say. Residents said that the topic has a very marginal or even non-existent part in PME, and it depends very much on the supervisor/trainer.[108] Only paediatric (including additional specialities) residency programmes bring up the following in sect. 20 point 6 that is related to the standard: "[Physician] is able to work efficiently in case of emergency to deal with diseases/conditions and knows how to handle special situations in a condition if a child's life is threatened (e.g. Jehovah's Witnesses)".[109] Many of the supervisors

[108] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 113–115. Tallinn: Poliitikauuringute Keskus Praxis.

[109] Available: https://meditsiiniteadused.ut.ee/sites/default/files/med/pediaatria4a2011.pdf and https://meditsiiniteadused.ut.ee/sites/default/files/med/ped-res-programm-2012.pdf

themselves have not had training in this area. Moreover, many of those teaching such topics lack the required teaching skills.

The university's representatives added that the topics mentioned in the standard are focused upon in basic medical education. Currently, a course of patient-centred communication takes place during the autumn semester of the third year of basic medical education (which only started in the 2015/2016 academic year[110]), when students do not yet have sufficient context to understand and implement the topic. Furthermore, the semester is very intense due to several pre-clinical subjects, and there is a real danger that the students do not achieve all the required learning objectives. Moreover, conflict prevention and communication skills teaching should be implemented into PME. It is more relevant when the residents are already doing clinical work.

**Latvia**

Rating: 2 / -0.3

Around 42% of 120 residents agree and strongly agree, 31% neither agree nor disagree, and 27% disagree or strongly disagree with the statement: "The trainees are prepared to recognise gender, cultural and religious specifications and to interact appropriately." As can be seen, the statement itself does not include a link to the programme providers – whether this preparedness to recognise the above specifications of patients stems from actions of the programme providers or the preparedness of trainees themselves. Most comments by residents point out that there have not been systematic efforts within the programme to prepare them to recognise gender, cultural and religious specifications: "Well I am prepared, but it has nothing to do with the residency programme.", "There is no such training, the trainee is expected to gain these skills on their own.", "Issues not addressed at all!", "Depends on the trainee." One resident commented: "That is not very popular and necessary in Latvia. We are not very cosmopolitan." And in a way this commentator is right – the differences between the genders are recognised in medicine as a whole and the vast majority of minorities (Russians, Belarussians, Jews, Poles, etc.) living in Latvia are culturally close and/or easily understandable to the junior doctors. Besides, there is only one main religion, Christianity, with other religions represented in very small numbers. However, these views could potentially also reflect some rigid thinking and a future workforce could face different minorities and cultural difficulties that they are ill-prepared to encounter. The answers provided by residents point to the view that these issues are not included in the programmes. However, because there are 42% residents who agree with the statement, it could be that in some programmes or with some supervisors they are recognised within the daily operations of PME.

**Lithuania**

Rating: 1 / -1.36

The development of some of these so-called 'soft skills', if at all, is included into the residency programmes. However, when asked if the trainees are prepared to recognise gender, cultural and religious specifications and to interact appropriately, 48.6% of the respondents either disagreed or strongly disagreed with the statement, adding: "Our population is still quite homogenous, so we lack experience in interacting with different cultural and especially religious specifications." and "The ability to recognise gender, cultural and religious specifications depends solely on you, if you had experience abroad or have read a lot".

[110] Curriculum of Medicine. Available in The University of Tartu Study Information System.

## 2.14. The foundation and methodology of medical research, including clinical research and clinical epidemiology are introduced in the programme

**Estonia**

Rating: 2 / 0.17

A slim majority of 56% of residents and 58% of supervisors agree with the claim: "Scientific approach has a central role in my field of residency. Medical research, including the basics of clinical research and clinical epidemiology have been tackled.", while 15% and 24% accordingly disagree. A resident observed that: "Scientific approach is definitely central. It usually requires the resident to read treatment guidelines/recommendations and articles. The supervisor rarely directs us towards new articles to read." Several residents and a supervisor mentioned that an intuitive approach is still preferred, and experience-based learning remains central. Research is thought to be something that is part of PhD studies.[111] In family medicine residency, designing and presenting a research project is obligatory.[112] Although medical research and methodology are taught in basic medical education[113], due to a lack of prior knowledge and relevant experience, the students might not be able to learn everything that will be needed later.

Junior doctors mentioned in the interviews that they are encouraged to read journal articles and present cases, but, since they mostly have to do it in their free time, the quality is lacking. However, in some residency programmes there are weekly meetings where the residents have to present articles and discuss them with others. While residents value the knowledge and discussion, the main problem is that there is usually no time allocated for it during their working hours. They also mentioned that doctoral studies are very difficult to combine with PME, since there is no option of taking them part time. It was also mentioned that involving medical research with PME is also difficult due to the lack of research experience of many supervisors. Few PME programmes have included training in medical research, although this should be made available to all residents.

**Latvia**

Rating: 2 / -0.3

A supervisor commented on the statement: "Throughout postgraduate medical training, trainees achieve knowledge of and the ability to apply the scientific basis and methods within their chosen field of medicine; the foundation and methodology of medical research in their chosen field of medicine, including clinical research and clinical epidemiology are introduced provided that the residents achieve abovementioned knowledge by creating a scientific research work.", by stating "At the end of the studies residents create an independent research work and defend it in front of a commission." According to the Rīga Stradiņš University's "Residency Studies Rules of Procedure"[114], and "University of Latvia's Residency Regulations"[115] residents in both universities are required to complete a scientific

[111] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 87–91. Tallinn: Poliitikauuringute Keskus Praxis.

[112] Family medicine residency programme. Available: https://meditsiiniteadused.ut.ee/sites/default/files/med/peremeditsiini_residentuuriprogramm_2016_2.pdf

[113] Curriculum of Medicine. Available in The University of Tartu Study Information System.

[114] Approved in Rīga Stradiņš University Senate on 15.05.2018, Retrieved 30.07.2018, Available: https://www.rsu.lv/sites/default/files/imce/Dokumenti/studijas/Rezidenturas_studiju_reglaments_II-29.05.2018..pdf

[115] Approved in University of Latvia Senate on 28.11.2005, Retrieved 30.07.2018, Available: https://www.lu.lv/gribustudet/rezidentura/dokumenti/

research study during their PME. Nonetheless, residency organisers state during the discussion that the quality of resident's scientific research work is dependent on the supervisor's research experience. Thus, the amount of knowledge residents receive through research differs: 43% of 120 residents agree or strongly agree, 28% neither agree nor disagree, and 28% disagree or strongly disagree with the aforementioned statement. Residents' comments on the above statement reveal a variety of experiences. One resident commented that it is a part of residency during the first years: "All the knowledge is in the first years of medical training. In later years there is no information.", while another states the opposite: "Not yet so far in the first 6 months in residency. Very limited knowledge of research in my speciality." Another comments that the course provides general knowledge: "There is a brief course in statistical data analysis, but it is not specific to the chosen field." Others suggest that this knowledge is obtained by personal initiative: "It depends on the motivation level and interest of the trainee.", "It is rather due to "learning by doing" as resident research work is mandatory for finishing training. But some seminars/consultations for this purpose would really be helpful.", "…also very few of supervisors are conducting research.", "I learned all this during my Erasmus exchange.", "But it is gained by your own motivation. In our medical education we really skip the part where someone professional could give us lectures about types of research, explaining basic information and introducing the resident to evidence-based medical studies." Recent graduates' answers on the statement provide a similar reasoning: "It is up to the person. If the resident wants it, he can do it. But they have to do it by themselves – no one helps. If the resident reads something and asks questions, doctors might help him.", "On my own.", "Yes we are encouraged to study science if we have time."

**Lithuania**

Rating: 2 / -0.02

The foundations of medical research were taught during the undergraduate medical education. However, further education on this topic depends on the residency programme. When asked whether, throughout postgraduate medical training, trainees achieve knowledge of and the ability to apply the scientific basis and methods within their chosen field of medicine; the foundation and methodology of medical research in their chosen field of medicine, including clinical research and clinical epidemiology, are introduced, 37.7% of trainees both (strongly) agreed and (strongly) disagreed with the statement. Some emphasised the poor quality of research: "Yes, but the quality is rather low, as the process is chaotic and concentrates on quantity, not quality of output and research," and "There is no competent person to teach that."

Unfortunately, some residents did not have the opportunity to deepen their knowledge on the subject: "We had to do a research project for the end of residency, but we had no extra lectures about epidemiology, statistics, etc." and "We are told to do science, yet no one explains how and where to do so."

### 2.15. The programme and process of training ensures that the trainee becomes familiar with evidence-based medicine through exposure to a broad range of relevant clinical/practical experience in different settings in the chosen field of medicine

**Estonia**

Rating: 3 / 1.33

The main focus of these topics lies in basic medical training. All basic medical training graduates must have achieved the study outcomes stated in the curriculum. Outcomes relevant to this standard are that the graduate:

7) is capable of working in the healthcare system and feels the need for continuous improvement of their knowledge and skills;

8) is able to assess the psychological and social aspects of a patient's illness and treatment and knows the peculiarities of communication with different parties in medicine;

9) is able to search and critically evaluate evidence-based information and use evidence-based information in clinical practice;

10) understands the nature of the scientific method, knows the principles of laboratory work and statistical analysis and is able to perform independent research;

11) understands the principles of medical ethics and medical law and applies them in clinical practice.

Although most of the courses focusing on these topics are elective (e.g. courses such as statistics and medical ethics are obligatory, but introduction to medical research is not), it is difficult to definitively state the level of knowledge of graduates regarding these outcomes as many of these are not measured[116].

Regarding the practice in different settings, the characteristics of the Estonian health system must be considered. For example, it is not feasible to carry out rotations in county hospitals in certain narrow specialities due to the lack of supervisors and patients in the field.

**Latvia**

Rating: 3 / 0.92

Both university representatives confirm that, in general, the programme and process of training ensures that the trainee becomes familiar with evidence-based medicine through exposure to a broad range of relevant clinical/practical experience in different settings in the chosen field of medicine. All 106 study programme managers in both universities were approached by an e-mail and a reminder and five provided an answer in e-mail and one in an interview confirming that in most situations the above statement holds true. In addition, Cabinet of Ministers Regulations No. 685 of August 30, 2011 “Regulations on admission and distribution of residents and financing of residency”[117], Articles 12 to 14 require that at least a part of the residency programme needs to be attained in a hospital or healthcare institution which is not the main training institution for the resident (an issue discussed in more detail in standard 2.22.) However, a resident's comment from the survey expresses a different opinion: "Unfortunately, in our clinic ’evidence-based’ is less valued than it should be. There are a lot of inconsistencies of medical treatment. Evidence-based is used when convenient. It’s very hard to change that."

**Lithuania**

Rating: 3 / 1.31

When asked if the programme in their chosen field of medicine includes clinical work and relevant theory or experience of clinical decision-making, 61% of residents either agreed or strongly agreed with the statement. However, some mentioned the overall lack of evidence-based decisions in the hospital. As one trainee explained:

[116] Curriculum of Medicine. Available in Tartu University Study Information System

[117] Entry into force 20.04.2018, Retrieved 29.07.2018, Available: https://likumi.lv/doc.php?id=235421

"Sometimes there are too many opinions of different supervisors on a specific decision. This comes from a lack of protocols and algorithms that would be approved by our department, and sometimes also a lack of evidence-based decisions."

### 2.16. The content of the programme is adjusted to scientific developments

**Estonia**

Rating: 1 / -0.99

Residency specialist programmes' goal[118] stipulates: "[resident] is capable of providing high-quality specialised medical care in the field of [speciality] that is in line with the latest achievements of medical science and high ethical standards". The updating of the programmes depends on available time resources and motivation of the programme director. Therefore, there is a considerable amount of unwarranted variance in the quality of training and whether the programmes are up-to-date and it cannot be claimed that all the programmes are adjusted to scientific developments. It was revealed from the focus groups that the organisers of PME consider that the residents should keep themselves up-to-date by reading journal articles and treatment guidelines, but often this is performed during the trainees' free time. Thus, the compliance with this standard is highly dependent on several factors and is not met by every specialist programme.

**Latvia**

Rating: 4 / 1.96

According to the views expressed by stakeholders – representatives of both universities and several study programme managers (106 approached by e-mail, but five answered by e-mail and one in an interview), the content of the programme is adjusted to scientific developments and the resources available to the healthcare institutions are also considered. Several study programme managers and supervisors from the survey indicate that study programmes in their fields have been updated in accordance with recommendations of the European speciality associations within their field.

**Lithuania**

Rating: 2 / -0.02

Residency committees (commissions) have an opportunity to renew residency programmes yearly, but not all of them take this opportunity. Although it is worth saying most programmes have been recently updated to meet the latest developments in their fields, as mentioned earlier, the reality seldom reflects the descriptions in the documents. In addition, the Centre for Assessment of Study Quality also includes the criteria of meeting the newest scientific developments into their process of assessment.

### 2.17. The programme includes clinical work and relevant theory or experience of basic biomedical, clinical, behavioural and social sciences, preventive medicine, public health, medical jurisprudence, managerial disciplines

**Estonia**

Rating: 2 / 0.17

[118] sect. 20 No. 1 available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

The focus on these topics is within basic medical training. All basic medical training graduates should have achieved study outcomes stated in the curriculum. Outcomes relevant to this standard are that the graduate:

7) is capable of working in the healthcare system and feels the need for continuous improvement of their knowledge and skills;

8) is able to assess the psychological and social aspects of a patient's illness and treatment and knows the peculiarities of communication with different parties in medicine;

9) is able to search and critically evaluate evidence-based information and use evidence-based information in clinical practice;

10) understands the nature of the scientific method, knows the principles of laboratory work and statistical analysis and is able to conduct independent research;

11) understands the principles of medical ethics and medical law and applies them in clinical practice.

Courses focusing on these topics are generally elective. Therefore, it is difficult to say what the level of knowledge the graduates have obtained would be, since it is not assessed.[119] Emphases on medical jurisprudence and managerial disciplines in PME are taught as a part of theoretical studies in only a few specialities[120].

Students in basic medical education are given a strong foundation in biomedical and clinical sciences, since the first 3 years of basic medical education are strongly focused on these topics. The background is significantly weaker in behavioural and social sciences, preventive medicine, public health, medical jurisprudence and managerial disciplines, because these subjects are mainly elective and their importance is not sufficiently highlighted. According to the university's representatives, they are prepared to organise (theoretical) training on topics if junior doctors request it, but interviews revealed that junior doctors are not aware of this option. Furthermore, focus groups revealed the need for these subjects in everyday working life, but social subjects and so-called 'soft skills' are treated as irrelevant by supervisors and older colleagues.

**Latvia**

Rating: 2 / -0.3

The speciality programmes are neither available to the public in Rīga Stradiņš University nor the University of Latvia. All 106 study programme managers in both universities were approached by e-mail. Out of six study programme managers (five answered by e-mail and one in an interview), five confirm that the programme in their speciality covers clinical work and relevant theory or experience of basic biomedical, clinical, behavioural and social sciences, preventive medicine, public health, medical jurisprudence as relevant for their speciality. One study programme manager stated that these issues are partly covered. In the interview process a university representative and another study programme manager revealed that management skills training is not included in the programme and it is necessary to include them. The study programme manager added that preventive medicine, public health, and medical jurisprudence are also not included in study programme in his/her field and it would be necessary to include them.

[119] Curriculum of Medicine. Available in Tartu University Study Information System

[120] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

**Lithuania**

Rating: 2 / -0.02

The residency programmes include a significant amount of clinical work. However, medical jurisprudence, preventive medicine, public health and managerial disciplines are usually covered during undergraduate medical education, very rarely are these topics included into residency programmes. According to the survey, some residents feel the lack of knowledge in these areas. As one trainee stated:

"The programme is quite good, but there was a lack of seminars about law regarding my speciality; rules for filling various types of medical documentation."

## 2.18. The programme includes clinical work and relevant theory or experience of clinical decision-making, medical ethics and patient safety

**Estonia**

Rating: 2 / 0.17

Conflicting evidence exists: the topics are mentioned in PME programmes, but the survey results give reasons to believe that it is not implemented in real life. Section 20 (study goals) No. 2 of residency specialist programmes states that the: "[physician] has the attitudes necessary for the vocation, sufficient professional knowledge, skills and clinical experience". Point No. 3 states that the physician "knows and adheres to the principles of scientific ethics, medical ethics and evidence-based medicine."[121]

Around 40% of residents and over 55% supervisors agree that the aspects related to the autonomy of a doctor are sufficiently managed during the residency, including the right to make informed medical decisions which are best for the patient and society, while over 25% of residents and approximately 30% supervisors find it difficult to say. Approximately 35% of residents and over 55% supervisors agree that during the residency the professional aspects of being a doctor are managed: skills for lifelong learning and maintaining competency, ethical behaviour, ethical behaviour, altruism, empathy, ability to work with others, compliance with ethical codes, patient safety, while approximately 25% of residents and 30% supervisors find it difficult to say. Respondents have brought up the lack of systemic approach to the topic. It varies and is strongly dependent on the base institutions and supervisors. Thus, these subjects should be taught to all trainees in a systematic way.

**Latvia**

Rating: 3 / 0.92

The speciality programmes are neither available to the public in Rīga Stradiņš University nor the University of Latvia. In this regard, 16% out of 119 residents strongly agree, 54% agree, 20% neither agree nor disagree, and 10% disagree with the statement: "The programme in my chosen field of medicine includes clinical work and relevant theory or experience of clinical decision-making." The comments reveal that the inclusion of the theory of clinical decision-making depends on the supervisor: "Very dependent on supervisor.", "It's only clinical work. It is mostly self-education.", "Something you pick up along the way. More like self-learning.", "I'd like to have more possibilities to be involved in outpatient management rather than in Clinical University Clinics, however, there are no such possibilities in Latvia.", "Only if we ask for it from older doctors." Recent graduates are positive about the clinical experience received - there are no evaluations of "disagree" or "strongly disagree" amongst

[121] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

the 18 who answered to this question. One respondent explains that: "You see a lot of complex cases in the university hospital – it prepares you for real life." Since there is a high agreement rate amongst residents and an even higher one amongst recent graduates, the rating given here is 3, since there are still comments expressing that it depends on the supervisor or the motivation of the trainee to learn on their own, or that the different settings used could be expanded. The University of Latvia's "Overview of study branch "Healthcare" for 2016/2017" chapter "Medicine. Second level professional higher education (short progr.) 48721"[122] mentions that the PME education aims to "teach principles of medical ethics and deontology to be used in their professional work." It was confirmed by the University of Latvia's representative that all residents have a common lecture course on medical ethics and patient safety. Rīga Stradiņš University's "Characterisation of study programme. Second level professional higher education study programme "Residency in Medicine" for 2015/2016[123] lists, amongst the tasks of the study programme, "To deepen understanding of issues of biomedicine, ethics, communication skills." A representative of Rīga Stradiņš University informed that medical ethics and patient safety are offered as optional lectures and seminars to the residents.

**Lithuania**

Rating: 2 / -0.02

The residency programmes sometimes mention medical ethics and patient safety in the descriptions. However, when asked whether the aspects related to the professionalism of the doctor are addressed during postgraduate medical training, i.e. skills of lifelong learning and maintenance of competencies, ethical behaviour, altruism, empathy, service to others, adherence to professional codes, consideration of patient safety, 37.7% of residents disagreed or strongly disagreed with the statement, while 67.5% of supervisors agreed or strongly agreed with it. As one trainee put it:

"The issues are only addressed retrospectively, when problems start to appear or accumulate. Ethics, empathy, professional codes are largely ignored – of course, individual supervising doctors (mentors) sometimes pay attention to that, but not systematically."

Another trainee added:

"Soft skills are mostly ignored with most attention paid to medical expertise/knowledge."

## 2.19. The programme includes clinical work and relevant theory or experience of communication skills, doctor's self-care and the interface with complementary medicine

**Estonia**

Rating: 1 / 0,12

All programmes in sect. 20 set as a goal: "…[resident] is able to conclusions drawn from the medical knowledge and communicate it to patients, colleagues and the general public". Programmes[124] do not mention interface with complementary medicine other than the availability to co-operate with other

[122] Approved in University of Latvia's Senate on 08.01.2018, Retrieved 30.07.2018, Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/dokumenti/parskati-un-zinojumi/Pasnovertejumi/2017/VESELIBAS_APRUPE_2017_PUB.pdf

[123] Released 15.08.2016, Retrieved 30.07.2018, Available: https://www.rsu.lv/sites/default/files/docs/Rezidentura_medicina_raksturojums_2015-16rev.pdf

[124] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

healthcare professionals e.g. physiotherapists, nurses, midwives. There is no mention of doctor's self-care.

Only 32% of residents think that sufficient attention is spent on teamwork with other healthcare professionals and 35% think that sufficient attention is spent on teamwork with other doctors. A large majority of 75% of respondents stated that they have never had access to competent counselling on career planning, burning out or solving conflict situations with colleagues.[125] The junior doctors mentioned the lack of education on communication and self-care. They also mentioned that, if you happen to be given a very good supervisor, then they might teach these skills, including self-care, but other than that, these are skills that are considered by superiors to be something that should be obtained while working.

**Latvia**

Rating: 2 / -0.3

Both Rīga Stradiņš University in "Characterisation of study programme. Second level professional higher education study programme "Residency in Medicine" for 2015/2016[126] and the University of Latvia in "Overview of study branch "Healthcare" for 2016/2017", chapter "Medicine. Second level professional higher education (short progr.) 48721"[127] list communication skills amongst the intended educational outcomes of the programmes. Of 123 residents, 38% agree or strongly agree with the statement: "During postgraduate medical training, systematic attention is paid to developing skills to communicate with colleagues, other healthcare professionals, patients and their relatives." while 28% neither agree nor disagree, and 33% disagree or strongly disagree. Interestingly, all the responses that residents provided to the above statement are negative. They range from comments stressing that communication skills are not taught: "Sadly, nobody teaches that to you; you either have the natural ability to communicate or you don't.", and "The trainee is expected to develop these skills on their own." to "Yes, but again it is all in the "good example" rather than lectures.", which implies that it would depend on the supervisor whether this example is provided, and to: "If you make a mistake in communication you will be informed. 'Systematic' or 'development' are not the words I would use." Recent graduates' comments are in line with the comments provided by the residents, reiterating that training in communication skills is lacking: "No training on this.", "It is up to the person.", "Not in my speciality. Maybe in others, I don't know." Somewhat validating this, a couple of supervisors agree with residents: "I think we need behaviour training." and "In my speciality residents don't have to communicate with patients too often." However, another two supervisors disagree, pointing out: "These issues are reflected in lectures and seminars organised by the university." as well as "Communication is one of the most important chapters in the postgraduate training." While 38% residents agree or strongly agree with the statement and there are two supervisors who argue that training in communication skills is provided and, based on a comment, there are supervisors who teach by example, 33% residents disagree or strongly disagree with it and there are only negative comments by residents. Therefore, the evidence is mixed and is rated with 2. Stakeholders mentioned in interviews that doctors' self-care and complementary medicine are not specifically included in the programmes

[125] Residentuur 2017. Hindamise koondaruanne. Lisa 1. Tallinn: Poliitikauuringute Keskus Praxis.

[126] Released 15.08.2016, Retrieved 30.07.2018, Available: https://www.rsu.lv/sites/default/files/docs/Rezidentura_medicina_raksturojums_2015-16rev.pdf

[127] Approved in University of Latvia's Senate on 08.01.2018, Retrieved 30.07.2018, Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/dokumenti/parskati-un-zinojumi/Pasnovertejumi/2017/VESELIBAS_APRUPE_2017_PUB.pdf

but could be brought up by a good supervisor in case of need. Consequently, it seems that these skills are, at least, not systematically taught to all trainees.

**Lithuania**

Rating: 2 / -0.02

Communication skills are often mentioned in the descriptions of the residency programmes; however, the research team did not manage to find a document that even mentions the importance of doctors' self-care or the interface with complementary medicine. Since the lack of knowledge in good communication and proper self-care have previously been noted, there have been several one-off occasions where the residents have had lectures on these topics, but these are usually organised by medical non-governmental organisations, not the universities. Fortunately, some leading residency programmes are now starting the formal teaching of communication skills.

### 2.20. The training has an apprenticeship nature of professional development integrating training and service

**Estonia**

Rating: 2 / 0.17

As stated in §2 of The Act of Minister of Social Affairs No. 56 The purpose of residency is to prepare vocationally and professionally competent specialist physicians through theoretical and practical training. §5 sect. 3 Individual curriculums must include theoretical training at the university and practical training in the base institution. Theoretical training is up to 20% and practical training is at least 80% of the total amount of the residency.[128] All medical residents have on-call duties in the capacity stated in residency specialist programmes (sect. 22 and sect. 24)[129]. However, it has been stated in the interviews that often the service part exceeds the educational part due to the lack of labour force. Supervisors have mentioned they lack the time to properly teach residents; they must do it in addition to their everyday work[130].

**Latvia**

Rating: 2 / -0.3

Formally, yes, the training has an apprenticeship nature of professional development integrating training and service. Each trainee is assigned a supervisor, and, according to Cabinet of Ministers Regulations[131] No. 685, article 17, no more than three trainees can be assigned to a particular supervisor at the same time. However, multiple comments submitted in the survey by residents attest that in practice the balance depends on whether the supervisor has time – numerous residents state that their supervisor does not have time to teach and in some cases lacks interest in teaching him/her. For illustration just one of several similar comments claims: "In my speciality there is not enough guidance and adequate supervision. Most doctors don't have time to guide us. Mostly we are left by ourselves trying to learn the basics of our speciality." There are many other similar comments that can be seen in

[128] The Act of Minister of Social Affairs No. 56 of 04.06.2001 "Framework requirements of residency and procedures for conducting residency". The Act entered into force 01.07.2018, RT I, 28.06.2018, 21. Available: https://www.riigiteataja.ee/akt/131012017028

[129] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[130] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 150–152. Tallinn: Poliitikauuringute Keskus Praxis.

[131] Entry into force 20.04.2018, Retrieved 29.07.2018, Available: https://likumi.lv/doc.php?id=235421

the argumentation for the other standards; they express the same idea – limited supervision. If the trainer is not present, naturally the training loses its apprenticeship nature. Besides, as described in the argumentation of standard 2.24, the service currently dominates over education in residency in Latvia. Therefore, the rating is 3 – formally the training has the apprenticeship nature; however, lack of supervisors' presence and a dominating service position can make the apprenticeship nature non-existent.

**Lithuania**

Rating: 2 / -0.02

The residency programme descriptions include the proportion of time a trainee is supposed to spend performing clinical work and studying. However, in reality, the situation depends on the specific residency programme. According to the results of our survey, in reality the "clinical work" part of the programme often includes residents covering for tasks that the supervisor has no time or willingness to perform. In addition, the quality of supervision is often somewhat poor and lacks structure. As one resident noted in the general comments:

"We are technically students (and workers), but even if there is the 'studying' part, it is often done by the residents themselves (resident to resident). In many departments, residents are being used as cheap (free, really) labour force to fill papers and such (highly prevalent in the surgical department). You are thrown into a workplace and have to figure out how to work there, with some guidance provided. In many departments, residents work extra hours for no pay, or work the next day after a 24h shift (often paperwork)."

Another resident added:

"Two university hospitals have a monopoly on postgraduate medical training. There are absolutely no standards or competencies that a resident needs to demonstrate during his training. There is a final exam at the end of the residency programme which is purely theoretical knowledge based. Universities take no responsibility for the quality of the specialist that they prepare."

## 2.21. The PME prepares trainees for all the roles of a doctor in the health sector

**Estonia**

Rating: 2 / 0.17

Residency educational outcomes describe preparation for all the roles of the doctor[132]. However, residents have pointed out that the residency programme does not pay sufficient attention to skills such as communication, teamwork, feedback, management, lifelong learning, etc. One of the interviewees indicated that the university is ready to organise training sessions when residents take the initiative. However, residents were unaware of such opportunities and no previous training sessions on this have been offered. Focus group interviews revealed that, in reality, no systematic courses take place. There are some courses organised for a few specialities, but the lack of theoretical training directed at trainees is visible. Several residency programmes state that the trainees have to undertake a certain amount of European Credit Transfer and Accumulation System credits for theoretical courses, but these are the same as are read as electives in basic medical education.

**Latvia**

[132] Residency programmes. Sect. 20. available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

Rating: 3 / 0.92

Rīga Stradiņš University in "Characterisation of study programme. Second level professional higher education study programme "Residency in Medicine" for 2015/2016"[133] within the intended educational outcomes additional to medical knowledge mentions: "[Resident] is able to work in the healthcare system, as well as in medical education and research." Similarly, University of Latvia in "Overview of study branch "Healthcare" for 2016/2017", chapter "Medicine. Second level professional higher education (short progr.) 48721"[134] amongst the intended educational outcomes lists: "Is able to apply their acquired knowledge by not only working in clinical positions, but also in healthcare organisation, research and education." The clinical functions of a doctor are discussed in other standards and there are shortcomings, but in general the researcher concludes that the PME does prepare the junior doctors to fulfil the medical treatment functions. Rīga Stradiņš University's "Residency Studies Rules of Procedure" states in article 3.1.5. that pedagogical work is a mandatory component of residency. The University of Latvia's representative stated during the interview that the university is considering making pedagogical work mandatory for its residents.

Every resident in Latvia has to complete his or her own scientific work, so while there could be improvements, every resident is taking on the role of a researcher during residency.

The University of Latvia's representative states that management skills are not currently included on a satisfactory level in all speciality study programmes. Rīga Stradiņš University's representative states that management skills training is offered as an optional course to those residents who are interested in it.

**Lithuania**

Rating: 2 / -0.02

Current residency programmes lack the proper teaching of the necessary soft skills, such as management, teamwork, communication, feedback, advocacy, patient safety and others. As one resident put it:

"There is not enough attention for competences and skills during every year of training. Too little teaching and guidance in the field of research. There is no attention at all paid to communication skills and the psychological state of residents."

Since this problem has been a concern for the stakeholders for some time now, there has been a proposal to implement soft skills training into all residency programmes. Starting next year, the Lithuanian medical education system will be organised based on EPAs (entrustable professional activities), which will hopefully enable the residency programmes to pay better systematic attention to the skills necessary for every role of a doctor.

## 2.22. The trainee is exposed to a broad range of experiences, including multi-site education and adequate exposure to different aspects of the chosen field of medicine

**Estonia**

[133] Released 15.08.2016, Retrieved 30.07.2018, Available: https://www.rsu.lv/sites/default/files/docs/Rezidentura_medicina_raksturojums_2015-16rev.pdf

[134] Approved in University of Latvia's Senate on 08.01.2018, Retrieved 30.07.2018, Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/dokumenti/parskati-un-zinojumi/Pasnovertejumi/2017/VESELIBAS_APRUPE_2017_PUB.pdf

Rating: 3 / 1.33

Residency rotations take place in different base hospitals/departments, which are stated in residency programmes[135]. The content and duration of residency programmes is sufficient for the preparation of competent specialists in the opinion of 53% of residents and 76% of supervisors. It was mentioned that in Estonia, there is lack of patients with specific conditions and due to time constraints, it is not possible to give all residents, for example, practical experiences in procedures (this is especially the case of very narrowly defined specialities).

Additionally, it was brought up that too much time is being spent observing supervising doctors, especially during non-specialist rotations, which does not provide a thorough understanding and practical experiences.[136] Focus groups revealed this is highly relevant in regards to family medicine trainees, who have a significant amount of one-month-long rotations, where they are treated, in a best-case scenario, as silent observers and not given instruction. The interviewees mentioned this might be caused by the lack of knowledge of supervisors regarding what the residents are supposed to learn during the short rotations.

**Latvia**

Rating: 3 / 0.92

Cabinet of Ministers Regulations No. 685 of August 30, 2011 "Regulations on admission and distribution of residents and financing of residency"[137], Articles 12 to 15 require that at least part of the residency programme needs to be attained in a hospital or healthcare institution which is not the main training institution for the resident: "Nr 12: The universities, at least in the residency programmes of Surgery, Internal Medicine, Paediatrics, Gynaecology, Obstetrics and Family Medicine (general practitioner) offer an opportunity for the residents to attain part of the study programme in general hospitals or family (general practitioner) doctors' practices outside of Riga. Nr 13: A general hospital has contracts with university hospitals and specialised hospitals, providing the necessary cooperation in residents' training in the respective study programme. Nr 14: If the residency takes place in the Pauls Stradiņš clinical university hospital or in the Riga Eastern clinical university hospital, the university, depending on the speciality, ensures no less than 20% of the residency training time in another university hospital or in a different healthcare institution in the respective speciality. Nr 15: In residency programmes of basic specialities[138], the resident works 3 months within 3 years' duration in the intensive care or emergency department." In the same regulations, Article 26 also states that in addition to the assigned supervisor, other doctors working in the same institution can also be involved in resident education, therefore diversifying the experience gained. The Erasmus+ exchange is available, although from the survey only 14 out of 138 residents who answered (10%) stated that they have undertaken part of their training in a foreign country. Additionally, one resident has expressed in the survey that they would have wanted to work more in the outpatient clinics during their training, but this was not possible.

**Lithuania**

[135] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[136] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 138–143. Tallinn: Poliitikauuringute Keskus Praxis.

[137] Entry into force 20.04.2018, Retrieved 29.07.2018, Available: https://likumi.lv/doc.php?id=235421

[138] In Latvia there are basic specialities (which can be acquired immediately after finishing basic medical education – the sixth year studies) and subspecialities, which require an acquired basic speciality first. For example, subspeciality "child psychiatry" currently requires an already acquired basic speciality "psychiatry".

Rating: 3 / 1.31

Since most of the teaching process takes place in university hospitals, the residents are exposed to a broad range of clinical cases. However, the learning experience can be very different. Rotations in some specialities are often inadequate – in some units there are too many trainees, while in others there can be too few – which makes the level of experience gained very unequal. In addition, because of the overwhelming amount of bureaucracy within the medical system and the lack of proper management within the hospitals, residents are often forced to spend the majority of their time on paperwork. Even though the number of training centres is relatively high, when asked if the quality of supervision amongst different training centres is homogenous, an overwhelming 63.4% of trainees disagreed or strongly disagreed with the statement. As one trainee put it:

"Very, very, very strongly varied. Some departments are oriented towards education and others just exploit residents as a free workforce."

One supervisor also expressed an opinion that:

"There is no future-oriented concept, and no-one is really paying attention how many specialists we need and how many residents should be trained. Moreover, trainees are not trained to learn and to get the most knowledge out of their residency, but instead they are trained to have duties not rights, to exist and to finish without questioning the quality of the system. The system is not motivating, not supportive and very destructive in a way that there is a lot of paperwork-based training, little or no evidence-based teaching, no soft-skill fostering, etc."

### 2.23. Before starting postgraduate education, the basic medical education provides a high-level understanding of basic biomedical sciences

**Estonia**

Rating: 3 / 1.33

The first 3 years of basic medical education are pre-clinical, with a strong emphasis on biomedical sciences. Feedback from employers (including residency supervisors) states that graduates have shortcomings in one or another skills and knowledge areas; however, they are generally satisfied with the graduates. Feedback from different stakeholders has been taken into account when changing the content of basic medical education, and the curriculum is changed accordingly[139]. For example, since the 2015/2016 academic year, patient-centred communication is an obligatory course, and since 2016 the last year is an internship in different departments[140]. A majority of 60% of residents and 69% of supervisors agree that the skills and knowledge obtained in the basic medical education are in line with the necessary skills and knowledge of their speciality's residency programme[141].

**Latvia**

Rating: 4 / 1.96

Basic medical education in Latvia corresponds to EC Directive 2005/36/EC, law “On regimented professions and recognition of professional qualification.", Cabinet of Ministers Regulations No. 268

[139] Section 5.7. of Basic medical education internal evaluation report 2017/2017. Available in Tartu University Study Information System.

[140] Curriculum of Medicine. Available in Tartu University Study Information System.

[141] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 8–15. Tallinn: Poliitikauuringute Keskus Praxis.

and doctor's professional standard. Moreover, the University of Latvia in "Overview of study branch "Healthcare" for 2016/2017", chapter "Medicine. Second level professional higher education (short progr.) 48721"[142] among the intended results for basic medical education, states: "After successful completion of the basic medical education, according to the doctor's professional standard[143], the graduate has knowledge, skills and competences: 1. To use principles of biomedical science, methods and knowledge in anatomy, biochemistry, cell biology, genetics, immunology, microbiology, molecular biology, pathology, pharmacology and physiology [...] in medical practice." A similar statement was not found for Rīga Stradiņš University's study programme in medicine. However, there is no reason to believe that the level of understanding of basic biomedical sciences in Rīga Stradiņš University's programme would be lower, since graduates of Rīga Stradiņš University's and the University of Latvia's programme later apply and are accepted for PME programmes in the other university. Moreover, 64% of residents and 63% of supervisors agree that the skills and knowledge obtained in the basic medical education are in line with the necessary skills and knowledge of my speciality's residency programme.

**Lithuania**

Rating: 3 / 1.31

Even though undergraduate medical education programmes are always accredited by external institutions, the quality of undergraduate medical education has now been a topic for discussion for many years. When asked if the skills and knowledge acquired during basic education of medical doctors are relevant to the skills and knowledge necessary to continue postgraduate medical training in their speciality, 50.7% of residents and 57.9% of supervisors agreed or strongly agreed with the statement; however, many emphasised the lack of in-depth knowledge of basic sciences:

"The basic medical knowledge was too poor, had to study lots of things from the beginning. Some of them are left unclear."

"The knowledge acquired during basic medical education is too minimal to continue postgraduate training in my speciality."

### 2.24. The training process is versatile, and the trainees participate in all medical activities relevant for the education, including on-call duties, without the service components of the trainee positions dominating

**Estonia**

Rating: 3 / 1.33

Practical training includes work in out-patient and in-patient wards, participation in colloquiums, meetings within the department, and specialist procedures stated in the residency programme. All medical residents have on-call duties in the capacity stated in residency specialist programmes (sect. 22; 24)[144]. It has also been mentioned by stakeholders that the service component is, in some cases, dominating over education and training.

[142] Approved in University of Latvia's Senate on 08.01.2018, Retrieved 30.07.2018, Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/dokumenti/parskati-un-zinojumi/Pasnovertejumi/2017/VESELIBAS_APRUPE_2017_PUB.pdf

[143] Available: https://visc.gov.lv/profizglitiba/dokumenti/standarti/ps0382.pdf

[144] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

Participation in medical activities depends on the speciality of the trainee and the rotation they are performing. Often trainees, who are not doing their specialist rotation, are left to observe without supervision and not given opportunities to participate.

**Latvia**

Rating: 1 / -1.18

Out of 124 residents who rated the statement, "There is a fine balance between educational, research and service functions in postgraduate medical training on my chosen field of medicine.", only 33% of residents agree or strongly agree with it. Thus, in 38% residents' experiences there is not a fine balance between the educational, research and service functions. The comments emphasise that the service functions are dominating and add that the extent of the educational activities depends on the supervisor and whether he or she has time: "It is mostly service functions.", "Could be more research." and "Again, depends on doctor I am working with. I have been lucky until now, but it is really not that good with others."

Moreover, the low salary requires the residents to take on additional jobs, increasing the service function even further: "Due to low salary in residency – 430 EUR per month – I have to have a second job because I have a family and I have to maintain monthly expenses of living; it is not possible to cover monthly expenses of living with such a salary of 430 EUR net per month." Comments from the general comments' section emphasise even further that the dominating service functions is one of the most pronounced problems in residency in Latvia: "There are too many patients for one resident; not on every training rotation of course, but in most cases. No time for every patient in order to properly investigate their concerns. This year our salary is better but anyway we are working in no less than three jobs.", "Residents lack theoretical knowledge in medicine. Most of the residents are pulled into the daily routine and forget that the main task is to learn something new and become a better specialist.", "The salary is so small, that residents have to work many jobs to earn enough for essential living expenses. This leaves no time for research and scientific work and learning a theoretical basis.", "Teachers are not interested in training new colleagues. University workshops are good. […] Compared to the experience gained abroad, residents' training is very different." Cabinet of Ministers Regulations No. 685 of August 30, 2011 “Regulations on admission and distribution of residents and financing of residency”[145], Article 15 regulates that residents do participate in the on-call duties: "In residency programmes of basic specialities, residents work 6 months within the 3-year programme in the intensive care or emergency department." However, a resident described cases of him/her being taken out of the current rotation because of a shortness of staff in the emergency department: "I can only speak about my hospital – due to shortness of staff the doctors don't have time to teach the residents, or discuss the patients and the cases (even if they wanted to). For the same reason, residents are used as secretaries and are more likely to fill in various forms and documents instead of really learning how to treat the patients. Also for the same reason residents are forced ‘voluntarily’ to spend one to several months in the emergency department. Sometimes they are yanked from other departments just to ‘put out the fire’ (shortness of staff) in the emergency department. Finally, due to the awful salaries (that are not enough to support a family) doctors and residents are forced to take several (at least two to three) jobs which leads to exhaustion and thus a lower quality of work/residency..." Another resident mentions that extra work places are also taken in order to gain experience outside in a different institution: "Almost every resident has one or two additional work places to gain money and experience."

[145] Entry into force 20.04.2018, Retrieved 29.07.2018, Available: https://likumi.lv/doc.php?id=235421

**Lithuania**

Rating: 2 / -0.02

The training processes are described in the residency programme descriptions, and in most cases are somewhat versatile. However, these descriptions often do not correspond to the real-life situation in the residencies, as the educational goals are frequently not met. Because of the high number of residents, the number of patients to practise on is often insufficient. In addition, since most of the teaching process historically takes place in university hospitals, they rely heavily on the workload of residents, which, in turn, does not leave enough time for other training activities. When asked if there is a fine balance between educational, research and service functions in postgraduate medical training in their chosen field of medicine, 50.8% of trainees disagreed or strongly disagreed with the statement, while 61.1% of supervisors agreed or strongly agreed with it. As one resident put it:

"It is mostly clinical work. You study during seminars or on your own. You do research on your free time."

and,

"Service > Education > Research."

A supervisor agreed, stating that it showed:

"No balance at all."

### 2.25. The trainers have access to pedagogical education and tutor/supervisor training

**Estonia**

Rating: 1 / -0.99

Pedagogical training is not a prerequisite for being a supervisor or mandatory for current supervisors. Approximately 51% of trainers disagree with, and 20% find it difficult to say, in relation to the claim that they have received sufficient continuous pedagogical education, which allows them to be a good supervisor. Several supervisors have added that the information about training courses comes too late to be able to fit it into their schedules, and that such training is rare and not systematic. Some mentioned that they have themselves learned while training residents.[146] There is no public information available about pedagogical education availability especially for supervisors.

**Latvia**

Rating: 1 / -1.18

A majority of 55% of supervisors agreed and strongly agreed with the statement: "I have been trained to be a supervisor in my chosen field of medicine." However, interviews with stakeholders provided evidence that no pedagogical education/supervisor training is provided to trainers upon commencing educating the junior doctors. Moreover, the trainers' answers to the statement above confirmed that the pedagogical education they have received is acquired because of their own initiative and is not a special course from the universities: "But I have got a master's degree in pedagogy myself.", "Annually I receive this training abroad. These are short teaching courses.", "I have several European learning diplomas in my field."

[146] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 152–154. Tallinn: Poliitikauuringute Keskus Praxis.

**Lithuania**

Rating: 1 / -1.36

The criteria for residents' supervisors and coordinators are described in the respective university's "Regulations of Residency". A resident supervisor is a university employee and/or a doctor working in a residency base, with at least 5 years of clinical experience. A coordinator of a residency is a university employee, with or without an academic degree, appointed by the faculty. Unfortunately, the fostering of supervisors' pedagogical skills lacks any systematic approach, as merely being a university employee is considered sufficient to be able to teach residents. When asked if they have been trained to be a supervisor, 40.7% of supervisors disagreed or strongly disagreed with the statement. As one of them put it:

"If this means "supervisor of residents" – I haven't been trained as a supervisor. Working in a university hospital as a faculty member means you are a supervisor."

## 2.27. There is a balance between trainers' and supervisors' clinical workload and training obligations, allowing enough time for teaching, supervision and learning

**Estonia**

Rating: 2 / 0.17

Residents and supervisors have expressed that supervisors do not have adequate skills and time to provide sufficient training and supervision to residents. Approximately 55% of responding supervisors agree that their workload is balanced, while approximately 38% disagreed and 7% find it difficult to say. One supervisor admitted that "Instructing is done in addition to normal work, not instead/alongside. Time [and] energy for residents is chronically low." Another supervisor mentioned: "Workload exceeds 1.0; there is too little time for self-development within the active working day and limited training opportunities due to lack of funds."[147]

**Latvia**

Rating: 1 / -1.18

The Cabinet of Ministers Regulations No. 685 of August 30, 2011 "Regulations on admission and distribution of residents and financing of residency"[148], Article 17 states: "A doctor mentioned in article 11.5.2. of these regulations, by coordinating with the manager of the residency programme in the university and with the doctor responsible for organising residency in each speciality in the healthcare institution, can supervise no more than three residents at the same time." Thus, the legislation has imposed a limit on the maximum number of residents that a doctor is allowed to supervise at the same time and this could be seen as an effort to also give the supervisor sufficient time for clinical work. On the other hand, stakeholders involved in organising and carrying out residency express that no practical steps are taken to ensure that trainers also have time for teaching, supervision and learning. It is stated that the supervisors' contracts with healthcare institutions do not differentiate between time that has to be spent on clinical work and time to be spent teaching, supervising and learning. Instead, these responsibilities overlap and are carried out in parallel. Around 58% of supervisors agreed or strongly agreed with the statement: "My clinical workload is organised in a way that also ensures time for teaching, supervision and learning." The three comments submitted to the statement above by

[147] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 150–151. Tallinn: Poliitikauuringute Keskus Praxis.

[148] Entry into force 20.04.2018, Retrieved 29.07.2018, Available: https://likumi.lv/doc.php?id=235421

supervisors share: "Nearly in all cases.", "But it takes 13 hours per day, 5 days per week.", "Much more emphasis on clinical work, very little chance for other endeavours." Residents' comments, as listed in argumentation for other standards, also hint at a significant lack of time for teaching on the supervisors' side. One of the stakeholders expressed during an interview that, from their point of view, possibly the biggest problem in residency in Latvia is the supervisors also having several jobs which require them to divide the day between multiple offices and, consequently, they are available in the institution where residents work only part of the time. Similarly to junior doctors, multiple jobs are often taken by the doctors because of the need to earn a living.

**Lithuania**

Rating: 1 / -1.36

Unfortunately, the balance is not kept in harmony. Supervisors have a huge clinical workload, which takes up time that could be dedicated to trainees. In addition, supervisors frequently lack motivation, as the salaries they receive as supervisors are low. Most of the learning process is "learning by doing" or "learning by observing"; however, the time dedicated to the process of teaching and its quality strongly depends on each individual supervisor. When asked if trainers have/had sufficient time for supervision, 47.9 % of trainees disagreed or strongly disagreed with the statement. As trainees put it:

"Almost no time for teaching or supervision. The supervisors usually have other projects needing their attention. The best one can hope for is a few short answers from the supervisor to specific questions. No seminars or lectures for residents."

"Depends on the supervisor – some would make time even if there is physically no time at all."

### 2.28. Feedback from the trainee to the trainer is used in periodic evaluation of trainers

**Estonia**

Rating: 1 / -0.99

There is no information on the requirement of feedback from the trainee to trainers. The only mention of feedback is in Ch. VI sect. 42 of University of Tartu Senate's Act No. 2 "Regulations of Residency"[149] where "the resident is required to keep a residency diary reflecting the completion of theoretical training of the resident and the acquisition of practical skills in accordance with the individual curriculum and the residency programme", but this does not say that feedback must be provided to trainers, it only requires that the resident keeps written track of their own training. A residency base and trainers' evaluation form is available on the Faculty of Medicine webpage[150], but no regulatory evidence of feedback requirement and obligation. At the end of the rotations, the university collects feedback forms for residents and trainers, but there is no evidence of its systematicity and periodicity. In interviews, residents expressed that it is important to create a feedback system that would really help supervisors and themselves to perform their work more effectively. However, they also brought up that, currently, providing critical feedback is difficult as it is impossible to stay anonymous, especially in residency programmes of narrow specialities where there might be one or two residents in one year and since there are limited workplaces in the field, it is essential to get along with the supervisors and therefore providing critical feedback might obstruct being hired after residency. Thus, if the feedback system should be reviewed, it should take all these remarks into account.

[149] Entry into force 26.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[150] https://meditsiiniteadused.ut.ee/et/dokumendivormid

**Latvia**

Rating: 1 / -1.18

The Cabinet of Ministers Regulations No. 685 of August 30, 2011 “Regulations on admission and distribution of residents and financing of residency.”, Article 11 require the trainees to submit evaluation forms of trainers: "11.5.3. Residents and doctors mentioned in article 11.5.2. of these regulations electronically submit residency evaluation forms […] to the university“. Moreover, these regulations require the university to describe the procedure of how the summaries of evaluations to the healthcare institution are made available. The university ensures that: “11.5.3.1. evaluation forms submitted by residents on their supervisors are anonymous until the end of residency programme or interruption of the residency programme; 11.5.3.2. The supervisor is introduced to the evaluation results in cases where four or more evaluation forms have been filled in; 11.5.3.3. a resident can become acquainted with the evaluation form filled in by the supervisor after submitting his/her evaluation form on the respective doctor. […]" The above regulations require the evaluation forms to be submitted monthly. Although the system seems to formally accomplish the aim of the standard perfectly, during interviews stakeholders and residents alike point out that, in most cases, it does not work in practice. Several reasons were offered for this: the fact that very few residents fill in the evaluation forms, since they are electronic, they are anonymous and, with the current system, impossible to enforce; if the evaluation form is filled in on paper, the resident's name is mentioned on it and it is filled in cautiously, because honest feedback might result in negative consequences for the resident; in small specialities it is filled in accurately, because the supervisor might guess who the evaluator was. Additionally, the current system provides a large administrative burden to universities and the evaluation results might not get to the supervisor in question. Besides, reportedly, some doctors are simply not interested in how residents have evaluated them.

Stakeholders report that there are only a few cases when feedback submitted by residents has been the basis for changing a supervisor – in cases of serious violations on the supervisor's side. Although it is not officially required in legislation, some institutions report asking the residents to fill in the institution's own forms. These initiatives tend to give positive results, as the additional evaluation forms tend not to fulfil a formal purpose but aim to seek out and also reward the best supervisors monetarily, in order to maintain and encourage a supportive environment for the residents. This is also a much more realistic way of carrying out evaluations, as there will not be two institutions involved, with the necessity to share results.

**Lithuania**

Rating: 1 / -1.36

"Unfortunately, there is no systemic approach to address this issue. A supervisor is evaluated only if a certain number of complaints has been received.”

However, a pilot study in the Lithuanian University of Health Sciences has recently been conducted, where an instrument for providing feedback to trainers (the EFFECT questionnaire) was implemented. Unfortunately, after completion in some departments the idea was abandoned due to a lack of human resources.

## 2.29. The trainees have access to up-to-date professional literature

**Estonia**

Rating: 3 / 1.33

A significant majority of 71% of residents and 82% of supervisors agree with the claim: "I/residents have good access to specialist scientific literature.", while 13% of residents and 14% supervisors found it difficult to say. Residents advise that access in Tartu is good through university hospital computers, The University of Tartu's proxy servers and The Centre for Medical Information. In other base hospitals, access to literature is lacking or a complicated process.[151]

**Latvia**

Rating: 3 / 0.92

The statement: "Trainees have access to up-to-date professional literature." shares the highest weighted average in the survey among residents with another statement, at 3,76. Looking at it quantitatively, 70% of 124 residents agree and strongly agree that they have access to up-to-date professional literature. This can be seen in the overwhelmingly positive comments expressing the residents' satisfaction with the available databases: "Yes – this is really great! Several clinical databases are available through the university e-study system. I use them a lot. I don't know what I am going to do after graduation without this access.", "Thank you, university for providing the access to all the web pages! I am absolutely pleased with being able to obtain the latest articles and brand new books in my specialisation.", "All literature is available in the university library – various international journals, electronic journals like UpToDate, NEJM, DynaMed, I have downloaded several applications on mobile – MedScape, BMJ, etc." However, there are also some narrow, specific issues pointed out, such as a lack of specific database, no access to speciality journals, or a lack of books in some specialities or healthcare institutions: "The university ensures access to some of the biggest databases online, but there isn't a system to ensure access to speciality journals – the trainee has to pay for them if they want access.", "We have an up-to-date database available in our hospital and clinical key database available through the university library, but there are a lot of clinical guidelines, position statements, scientific statements which are published in scientific literature not available through our libraries. And as for the newest scientific books... well, this is another story.", "We do have some databases. We had UpToDate, which is the easiest to use, but the hospital cancelled it. Moreover, those who do have a private UpToDate account cannot access it via any of the hospital computers.", "Internet resources are good, books cost too much.", "We have some access to new publications. It is better in other fields."

**Lithuania**

Rating: 4 / 2.76

Access to major professional literature sites are granted by universities. A huge majority of 73.9% of trainees and 91.7% of supervisors agreed or strongly agreed that they have access to up-to-date literature. However, some emphasised the lack of specific literature:

"With limits to some specific literature, there is a good access."

## 2.30. The programmes are routinely monitored and evaluated and data about key aspects of the programme are collected for ensuring that the education is on track and for identifying any areas in need of intervention

**Estonia**

Rating: 1 / -0.99

[151] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 91–95. Tallinn: Poliitikauuringute Keskus Praxis.

The monitoring and evaluation of residency programmes is not regulated. This initiative is taken by the programme director of the speciality and its regularity depends on them or the residency council of the Faculty of Medicine. Internal evaluation of the programmes is not carried out and only four residency programmes out of 42 (Anaesthesiology and Intensive Care, Family Medicine, Obstetrics and Gynaecology, Urology) have gone through the external evaluation.

There is no systemic approach to gathering feedback about programmes. There are no guidelines and methods described of identification of areas in need of intervention. It is thus highly dependent on the time and motivation of the programme director.

**Latvia**

Rating: 2 / -0.3

The Cabinet of Ministers Regulations No. 685 of August 30, 2011 “Regulations on admission and distribution of residents and financing of residency”[152], Article 16 requires that: "16. University ensures that study programme manager of each speciality: 16.1. At least once every six months together with a resident they evaluate the progress of the residency programme, and determine problems and possible changes in the process of the residency programme. Such an evaluation is documented in a protocol by the residency programme manager; 16.2. At least once in a year meet with the person who is responsible for the process of residency programmes in the university as a whole and evaluate the progress of the relevant residency programme, to determine problems and necessary improvements, as well as agree on consecutive action if improvements to the residency study process are needed." During interviews with stakeholders it was determined that, in practice, article 16.1. is carried out in different ways. It could either be carried out by a study programme manager simply meeting the resident and writing down his/her evaluation for the rotation/study year (this is requested by Rīga Stradiņš University's "Residency Studies Rules of Procedure") or it could also be a lengthier conversation where both residents’ progress and problems and possible improvements in the study programme are discussed (not required in any documents available to the researcher). Furthermore, the programmes are evaluated yearly by the universities by carrying out additional surveys amongst their residents. Rīga Stradiņš University's survey states that its aim is to "ascertain the residents' satisfaction with the practical and theoretical training as well as the organisation of residency in general."[153] The University of Latvia's survey aim is to ascertain residents' satisfaction with quality of studies ("Overview of study branch "Healthcare" for 2016/2017", chapter "Medicine. Second level professional higher education (short progr.) 48721"[154]) Both university representatives also stated that a survey among directors of medical institutions is carried out, thus collecting employers' feedback about residents' performance. Additionally, university representatives state that the number of applications to specific programmes is analysed and programmes with low application rates are investigated in order to find out if the programme content is relevant and competitive or if there are any other issues with the programme. Moreover, university representatives state that dropout rates at exams are analysed. The researcher

[152] Entry into force 20.04.2018, Retrieved 29.07.2018, Available: https://likumi.lv/doc.php?id=235421

[153] Rīga Stradiņš University's "Overview on actions carried out to perfect second level profesional higher educational study programme "Residency in medicine" in academic year 2016/2017" Available at: https://www.rsu.lv/sites/default/files/imce/Studiju%20virzienu%20raksturojumi/Studiju%20programmu%20raksturojumi/2LPSP_RezidenturaMedicina_2016_2017_parskats_IGrope.pdf approved in Rīga Stradiņš University Senate on 23.01.2018, retrieved on 25.07.2018.

[154] Approved in University of Latvia's Senate on 08.01.2018, Retrieved 30.07.2018, Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/dokumenti/parskati-un-zinojumi/Pasnovertejumi/2017/VESELIBAS_APRUPE_2017_PUB.pdf

did not find evidence that, outside of the meetings between study programme managers and residents, data on average actual duration of education, scores, as well as time spent by the trainees on areas of special interest would be collected and analysed.

**Lithuania**

Rating: 2 / -0.02

Since residency is considered to be a higher degree of medical education, when it comes to outside evaluation the residency programmes follow the same set of rules as other study programmes in Lithuania. Outside evaluation, performed by the Centre for Assessment of Study Quality should take place every 3 to 6 years, depending on the result of the previous evaluation. This year, the evaluations have been postponed due to the implementation of competency based training. The procedure of outside evaluation includes a self-analysis of the programme. However, not all of the programmes have been through the process of outside evaluation. The process of regular inside evaluation of the residency programmes depends on the residency programme committees (commissions), hence only a few of the programmes have been known to continuously improve the quality of their programme.

## 2.31. Concerns identified during monitoring and relevant results of evaluation are systematically addressed

**Estonia**

Rating: 1 / -0.99

There are no written internal regulations in this area. Real practice involves the following: in case of problems, the programme director approaches the residency committee or the vice dean of residency and proposes certain changes. It is highly dependent on the time and motivation of the programme director.

**Latvia**

Rating: 4 / 1.96

The Cabinet of Ministers Regulations No. 685 of August 30, 2011 “Regulations on admission and distribution of residents and financing of residency”[155], Article 16 requires that the study programme manager: "16.2. At least once in a year meets with the person who is responsible for the process of residency programmes in the university as a whole and evaluates the progress of the relevant residency programme, determines problems and necessary improvements, as well as agrees on consecutive action if improvements to the residency study process are needed." Thus, there is a requirement by legislative documents to address the concerns identified during meetings between residents and study programme managers. Since this is the main channel of monitoring and evaluating programmes, it is evaluated alone and because the regulations require that the parties agree on consecutive action, the evaluation is 4. No more evidence on the situation in reality was found during the research.

**Lithuania**

Rating: 1 / -1.36

The respective "Rules of Residency" in both universities define the parties responsible for changing and approving the residency programmes. There is no document to address the importance of and give guidelines for collecting systematic feedback about these programmes and providing adequate

[155] Entry into force 20.04.2018, Retrieved 29.07.2018, Available: https://likumi.lv/doc.php?id=235421

procedures for their regular review and update. That said, only 19.1 % of the trainees who took part in our survey agree to the statement that “The postgraduate medical training on my specialty is organised in line with my understanding how postgraduate medical training should be provided.”, while 54.1% do not. The results of the survey were reversed (56.1% and 16.9%) when the supervisors/mentors were asked the same question. This shows that there is a significant gap in communication between the trainees and their mentors and that even though these principal stakeholders have ideas on how the programmes should be improved, there is a lack of appropriate procedures to effectively discuss and implement these changes.

### 2.32. Feedback about programmes is collected from trainees, trainers, employers and qualified doctors and its results are used for programme development

**Estonia**

Rating: 0 / -2.15

The collection of feedback about the programmes is not systematic or regular. Oral feedback from a limited number of individual residents is sporadically collected after the final exam. There is neither evidence nor information for it being analysed nor any changes based on the feedback being implemented.

**Latvia**

Rating: 2 / -0.3

As seen in standard 2.30, the feedback about study programmes is likely to be collected in the meeting between the resident and study programme manager according to Cabinet of Ministers Regulations No. 685 of August 30, 2011 “Regulations on admission and distribution of residents and financing of residency”, Article 16. Both universities also carry out yearly surveys among their residents where feedback is gathered. Although the researcher did not find requirements in the legislation to collect feedback regarding the programmes from employers, both university representatives stated that feedback on their residents is also gathered from employers – directors of medical institutions. No evidence was found that formal feedback about the programme is being gathered from trainers, employers and qualified doctors. However, it is possible that some feedback is being transmitted from the trainers to the study programme director of the relevant speciality as part of the regular work process. The stakeholders mentioned during interviews that in some specialities national specialist associations are involved in creating and updating the study programme in their speciality because the study programme manager is actively involved in the association or is its head. However, this depends on the study programme manager and the speciality association, as there is no systemic structural requirement.

**Lithuania**

Rating: 0 / -2.69

There is no document to address the importance of and give guidelines for collecting systematic feedback about residency programmes and provide adequate procedures for their regular review and update. Since the process of collecting feedback about the quality of the programmes is not controlled systematically, it strongly depends on the coordinators of the programme. Most of them do not collect feedback at all, and those who do are not doing it regularly and/or systematically.

## 2.33. The results of course and programme evaluation are made available for principal stakeholders

**Estonia**

Rating: 1 / -0.99

There are no internal evaluations of the programmes. The external evaluation has been conducted on only four programmes out of 42. The results can be seen by submitting a corresponding request to the Faculty of Medicine. This, however, requires previous knowledge of the existence of these evaluations and the Faculty of Medicine is not obliged to share these with other stakeholders. The information of the existence of external evaluation is not publically available.

**Latvia**

Rating: 2 / -0.3

Cabinet of Ministers Regulations No. 685 of August 30, 2011 "Regulations on admission and distribution of residents and financing of residency"[156] require that the study programme manager "16.2. At least once in a year meets with the person who is responsible for the process of residency programmes in the university as a whole and evaluates the progress of the relevant residency programme, determines problems and necessary improvements, as well as agrees on consecutive action if improvements of the residency study process are needed." Thus, the university is informed of the evaluation of each speciality programme performed by the programme manager. The researcher did not find evidence that this evaluation would be made available to other stakeholders. Rīga Stradiņš University's "Overview on actions carried out to improve professional higher educational study programme "Residency in medicine" in academic year 2016/2017" and the University of Latvia's "Overview of study branch "Healthcare" for 2016/2017", chapter "Medicine. Professional higher education (short progr.) 48721"[157] makes the results of each university's yearly residents' survey on residents' general satisfaction with the programme publically available.

**Lithuania**

Rating: 1 / -1.36

The results of the external evaluation of residency programmes must be readily available in the websites of the universities according to the rules of the Centre for Assessment of Study Quality. However, the research team did not manage to find such information.

## 2.34. There are procedures for regularly reviewing and updating the process, structure, content, outcomes/competencies, assessment and learning environment of the programme

**Estonia**

Rating: 1 / -0.99

[156] Entry into force 20.04.2018., Retrieved 29.07.2018., Available: https://likumi.lv/doc.php?id=235421

[157] Approved in University of Latvia's Senate on 08.01.2018, Retrieved 30.07.2018, Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/dokumenti/parskati-un-zinojumi/Pasnovertejumi/2017/VESELIBAS_APRUPE_2017_PUB.pdf

The responsibility to review and update residency programmes lies with the programme directors, however it is not done systematically or regularly, nor is there evidence of any procedures put in place.

**Latvia**

Rating: 2 / -0.3

The requirement of the Cabinet of Ministers Regulations[158] No. 685 of August 30, 2011 that the study programme manager "At least once in a year meets with the person who is responsible for the process of residency programmes in the university as a whole, and evaluates the movement of the relevant residency programme, determines problems and necessary improvements, as well as agrees on consecutive action if improvements of the residency study process are needed.", constitutes a procedure to update the process, structure and to some extent also the learning environment of the programme. According to the university representatives, each year there are small changes in the study programme content to keep them up-to-date. Major reviewing of programmes is performed once every 6 years before programme accreditation. However, the research team did not find any specific procedures for this.

**Lithuania**

Rating: 2 / -0.02

The only clearly regulated procedure of evaluation of the residency programmes is conducted by the external institution, the Centre for Assessment of Study Quality. The internal evaluation is not clearly regulated, as it depends on each individual residency programme committee (commission), making it virtually non-existent.

## 3. Assessment and feedback during postgraduate medical education

### 3.1. The selection process of trainees is transparent and in accordance with the formulated selection policy

**Estonia**

Rating: 3 / 1.33

Admission criteria and process is clearly formulated in the University of Tartu Senate's Act No. 2 "Regulations of Residency"[159] Ch. II. According to the University of Tartu Medicine Faculty Council Act "Residency admission examination substantive requirements, execution procedures, and admission exam points division between oral and written parts"[160] point 2, admission exam points are divided in the following way: written exam max. 10 points and oral exam max. 20 points except in specialities stated in point 3 (allergology-immunology, dermatovenereology, endocrinology, oncology, orthodontics, pulmonology, restorative dentistry, oral and maxillofacial surgery, obstetrics and gynaecology). In those specialities entry exam points are divided as follows: written exam max. 20 points and oral exam max. 10 points. The substantive requirements and procedures of the admission examinations are established by the Council of the Faculty of Medicine. The vice dean of PME, on the proposal of the programme director of the specialty, makes up the admissions examination committee

[158] Entry into force 20.04.2018, Retrieved 29.07.2018, Available: https://likumi.lv/doc.php?id=235421

[159] Entry into force 25.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[160] Entry into force 16.03.2016. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-vastuvotueksamite-sisulised-nouded-sooritamise-kord-punktide-jagunemine

of three to five members. At least one of the members of the committee must be from outside the university.

Residents have expressed their concerns about the transparency and subjectivity of the admission process.[161] Furthermore, the oral exam is not reproducible: although protocolled, the exact content of the exam cannot be reproduced.

**Latvia**

Rating: 3 / 0.92

Submitting an appeal regarding the admission results is an option in both universities. Therefore, it is concluded that the selection of trainees takes place in accordance with the formulated selection policy. In addition, Rīga Stradiņš University's "Admission Regulations for the Second Level Professional Higher Education Programme "Residency in Medicine" in a Study Place Funded by State Budget"[162], Article 43 specifically states: "University has these duties in the admission process: 43.1. to ensure fair admission in accordance with these Regulations and other normative acts." Residents have submitted these comments regarding transparency: "In addition, interviews before selection are somewhat subjective.", "The interview part of the process holds too much weight and favouritism is a big part of that process, that no one is even trying to hide." Another resident criticises the frequent changes in admission criteria: "The rules of application for the residency programme are published in the university homepage and one can become acquainted with them and prepare. However, some of the rules have been changed several times less than one year before graduating (e.g. time spent volunteering in the desired speciality, count or type of publications preferred...etc.). Also, a slight change could eventually significantly change your chances to get the place." Supervisors have, in contrast, commented that: "The competition is organised by the university, it has several stages and is fully transparent.", "The process is reasonably transparent [...]."

**Lithuania**

Rating: 2 / -0.02

The selection process of trainees is defined in several documents: the "Ruling on doctors' training" and the respective "Rules of Residency" in both universities. However, these documents only provide guidelines on which university structures are responsible for the admission procedures. Each university defines its own scoring system for the selection of candidates. A part of the final score in the process of selection into a residency programme includes a "motivational score", which consists of an evaluation of the applicant's engagement in research, volunteering experience and personal characteristics. The process takes place when the applicant has an interview with the "selection committee" made up of the head of the department, several members of the educational staff and one representative of the trainees. The two universities each have their own suggested structure and means of evaluation of these components. However, as the research team concluded from interviews with focus groups, some departments in both universities do not adhere to the recommendations, paving the way for subjectivity in the process, as the motivational score, in some cases, determines the final outcome of the application (for instance, in one of the universities, an applicant is removed from the process of application if their motivational score is not sufficiently high). The difference in the perception of

[161] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 24–28. Tallinn: Poliitikauuringute Keskus Praxis.

[162] Available at: https://www.rsu.lv/sites/default/files/imce/Dokumenti/noteikumi/uznemsanas-noteikumi-rezidentura-2018.pdf, approved in Rīga Stradiņš University Senate on 21.11.2017, retrieved at 29.07.2018.

transparency between different residency programmes is also reflected in the survey – some think that the selection process is fair (34.1 % of the trainees and 65.8 % of the supervisors), yet a relatively large proportion of the respondents (34.1 % of the trainees and 12.2 % of the supervisors) believe that unfair advantages are given, for example, to male candidates or those who have relatives working in the field. Moreover, inequalities are being seen according to the university from which you have graduated, for instance if you graduated from Vilnius University, your overall marks in motivational interview in the Lithuanian University of Health Sciences might be lower.

### 3.2. The intended educational outcomes of the programmes are defined with respect to achievements at a postgraduate level regarding knowledge, skills and attitudes and future roles in the health sector

**Estonia**

Rating: 2 / 0.17

General educational outcomes regarding knowledge, skills and attitudes that the doctor should have after completing PME are defined in the programmes.[163] The knowledge, skills and attitudes the resident should have in the end of each academic year are mapped out in only a few specialities' programmes. The outcomes are general and do not reflect the given qualification or the speciality. Furthermore, no educational outcomes are defined for the individual rotations from which the PME is built. Consequently, it is impossible to know how the resident is supposed to acquire the knowledge, skills and attitudes required and needed, and whether this is achieved.

**Latvia**

Rating: 3 / 0.92

Attitudes and future roles in the health sector are discussed in only a very few specialities in Cabinet of Ministers Regulations No. 268 of March 24, 2009 "Regulations on competency in medical treatment and volume of theoretical and practical knowledge for medical practitioners and students who acquire first or second level professional higher medical education programmes"[164]. The regulations No. 268 state the attainable knowledge and skills for each speciality, but the attitudes and future roles are not specifically distinguished. In those rare cases when they are mentioned it is as part of the skills and knowledge to be gained. The University of Latvia does list the knowledge, skills and competences (including aspects of attitudes) as education aims in its "Overview of study branch "Healthcare" for 2016/2017", chapter "Medicine. Second level professional higher education (short progr.) 48721"[165]. Future roles in the health sector are only partly discussed. Rīga Stradiņš University's "Study programme characterisation. Second level professional higher education study programme "Residency in Medicine. Academic year 2015/2016" lists generic educational outcomes for all programmes, including knowledge, skills and attitudes. The researcher did not have access to speciality programmes.

**Lithuania**

Rating: 2 / -0.02

[163] Resindency programmes. Sect. 20. Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[164] Entry into force: 29.06.2018., Retrieved 29.07.2018., Available: https://likumi.lv/doc.php?id=190610

[165] Approved in University of Latvia's Senate on 08.01.2018, Retrieved 30.07.2018, Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/dokumenti/parskati-un-zinojumi/Pasnovertejumi/2017/VESELIBAS_APRUPE_2017_PUB.pdf

The respective "Rules of Residency" in both universities define the parties responsible for creating, changing and executing the residency programmes, namely the residency committee and residency commission. However, these documents do not elaborate on the precise intended educational outcomes – they are to be defined by the residency commissions in individual departments. When analysing different residency programmes, it can be seen that while the educational outcomes related to the medical knowledge/skills are programme-specific, the outcomes concerning the soft skills, such as working in a team, attitude towards the patient, communication, lifelong learning, etc. are highly similar between different programmes. Yet, according to the survey, in a great majority of departments, there is no systematic approach in teaching the required medical skills, and even less so in fostering the soft skills. To quote one of the respondents, “Soft skills are mostly ignored with most attention paid to medical expertise/knowledge.“

### 3.3. The intended educational outcomes of the programmes are defined with respect to generic and discipline/speciality-specific components

**Estonia**

Rating: 4 / 2.49

Educational outcomes stated in residency programmes define both generic and discipline-specific components. The general outcome stated in every PME programme is that: “The main goal of the PME is to bring the resident’s knowledge, expertise and practical skills to a level that enables them to work as an independent specialist. Acquired education allows the graduate to work in the healthcare system as [speciality name].” The speciality-specific components are stated in subsection 20 of every PME programme.[166]

**Latvia**

Rating: 3 / 0.92

Cabinet of Ministers Regulations No. 268 of March 24, 2009 "Regulations on competency in medical treatment and volume of theoretical and practical knowledge for medical practitioners and students who acquire first or second level professional higher medical education programmes"[167] do not divide the educational outcomes to be acquired for each speciality's doctor between generic and discipline/speciality-specific components but concentrate on listing speciality specific components. The University of Latvia does list generic intended educational outcomes (for all speciality programmes) in its "Overview of study branch "Healthcare" for 2016/2017", chapter "Medicine. Second level professional higher education (short progr.) 48721"[168], Rīga Stradiņš University's "Study programme characterisation. Second level professional higher education study programme "Residency in Medicine". Academic year 2015/2016" lists generic educational outcomes for all programmes. The researcher did not have access to speciality programmes.

**Lithuania**

Rating: 3 / 1.31

[166] Resindency programmes. Sect 14; 20. Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[167] Entry into force: 29.06.2018., Retrieved 29.07.2018., Available: https://likumi.lv/doc.php?id=190610

[168] Approved in University of Latvia's Senate on 08.01.2018., Retrieved 30.07.2018., Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/dokumenti/parskati-un-zinojumi/Pasnovertejumi/2017/VESELIBAS_APRUPE_2017_PUB.pdf

The respective "Rules of Residency" in both universities define the parties responsible for creating, changing and executing the residency programmes, namely the residency committee and residency commission. However, these documents do not elaborate on the specific intended educational outcomes – they are to be defined by the residency commissions in individual departments. When analysing different residency programmes, it can be seen that while the educational outcomes related to the medical knowledge/skills are programme-specific, the outcomes concerning the soft skills, such as working in a team, attitude towards the patient, communication, lifelong learning, etc. are highly similar between different programmes. Yet, according to the survey, in a great majority of departments, there is no systematic approach to teaching the required medical skills, and even less so in fostering the soft skills. To quote one of the respondents, “Soft skills are mostly ignored, with the most attention paid to medical expertise/knowledge.“

### 3.4. During postgraduate medical training, the trainee is guided by means of supervision and regular appraisal and feedback

**Estonia**

Rating: 1 / -0.99

Residents are dissatisfied with the current feedback system. The University of Tartu Senate's Act[169] No. 2 "Regulations of Residency" Ch. VI sect. 43 states that at the end of a rotation, the resident's supervisor must give written feedback, but residents have mentioned that this is not sufficient and there is not constant feedback.

According to Ch. VI sect. 42 of University of Tartu Senate's Act No. 2 "Regulations of Residency"[170], "the resident is required to keep a residency diary reflecting the completion of theoretical training of the resident and the acquisition of practical skills in accordance with the individual curriculum and the residency programme." Currently, residency diaries exist and are a part of summative assessment, but they do not fulfil their function. Given feedback is not comprehensive. The residency diaries are often filled out by supervisors only using tick-boxes or the residents themselves are asked to fill them in. Only in selected specialities does interim examination take place. Thus, no or very little evaluation/assessment is performed before the final exam.

Only 27% of residents agree and 22% find it difficult to say that, during the residency, residents are given sufficient feedback that supports their becoming a professional doctor[171], while 54% of residents agree with the claim: "During residency, supervisors always have/had sufficient time for me" and 18% find it difficult to say[172].” The claim: "The assessment of the knowledge, skills and attitudes of me and my co-residents has been carried out fairly, transparently and in accordance with the proposed learning outcomes and applied supervision methods." was agreed with by approximately 50% of residents, but approximately 40% found it difficult to say. They mentioned that very little evaluation is done before the final exam and feedback is given hurriedly and erratically.[173] Interviewed trainees said that supervising doctors often do not give feedback, the trainees themselves are asked to fill out the

[169] Entry into force 25.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[170] Entry into force 26.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[171] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 63–68. Tallinn: Poliitikauuringute Keskus Praxis.

[172] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 115–118. Tallinn: Poliitikauuringute Keskus Praxis.

[173] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 131–132. Tallinn: Poliitikauuringute Keskus Praxis.

feedback forms about themselves that the supervisors have to submit, or they are sent directly to the university without giving feedback to the trainee. One of the probable reasons stated was the lack of pedagogical training.

**Latvia**

Rating: 2 / -0.3

Theoretically, yes, each resident is assigned to a supervisor in each rotation. In addition, the Cabinet of Ministers Regulations[174] No. 685 requests that the supervisor fills in feedback on the resident at the end of the rotation. However, although it looks good on paper and works in some specialities (resident comments: "We do have regular meetings with supervisors, receive feedback, and have the opportunity for discussion." and "The supervisors are very supportive and inspiring, especially if you show eagerness to acquire thorough knowledge. Supervisors are always eager to give the best advice in practical skills."), in others the practical realisation is flawed. Out of 124 residents who rated the statement: "The trainees are guided by means of supervision and regular appraisal and feedback that supports their development to a professional doctor", 4% strongly disagree with it, 26% disagree, 27% neither agree nor disagree, 33% agree, 10% strongly agree with it. Again, there are many resident comments (21), most mentioning the lack of supervision in their experience: e.g. "They don't have time to communicate with residents.", "Sometimes even no supervision at all." Many residents also stress the lack of feedback: e.g. "There is poor feedback culture.", "Theoretically. In reality feedback is quite hard to acquire." And again, according to the residents, the quality and amount of feedback depends on the speciality and the supervisor: e.g. "It varies from specialities and different clinical rotations.", "Strongly depends on the tutor." Another resident argues that the current system of supervisors filling in official feedback forms on residents does not work: "[...] There is no real tradition of giving appraisal, it depends on the personality of the supervisor. […]". Another resident reveals that constructive feedback is rarely given: "[…] There is only one doctor I know that gives each resident at the end of month constructive criticism and explains what could be done better."

**Lithuania**

Rating: 2 / -0.02

Providing supervision and feedback for the trainees is under the responsibility of supervisors of the trainee and, to some extent, residency coordinator of each individual department. These guidelines are outlined in the "Ruling on doctors' training" and the respective "Rules of Residency" in both universities. However, these documents only state that the resident supervisor “has to evaluate the resident at the end of each rotation on the acquired theoretical and practical skills“. On the other hand, according to official description of many residency programmes, mechanisms for continuous supervision and feedback have to be put in place and are mandatory. Yet, according to the survey, as the level and availability of supervision varies between different departments – only a small portion of the trainees (22.7 %) stated that they receive enough feedback during their training and even for the ones that do, it is often hazardous, negative and lacks a constructive approach. As one trainee stated: "Feedback is not so much a part of our educational culture as yet".

### 3.5. The degree of independent responsibility of the trainee is increased as skills, knowledge and experience grow

**Estonia**

[174] Entry into force 20.04.2018., Retrieved 29.07.2018., Available: https://likumi.lv/doc.php?id=235421

Rating: 2 / 0.17

The University of Tartu Senate's Act[175] No. 2 "Regulations of Residency" Ch. IV sect. 32 states that training is based on individual curriculums and sect. 37 states that they are drawn up in the beginning of every academic year. No further regulations related to responsibility were found. The claim: "The resident's responsibility in the provision of healthcare services is increased gradually, according to their enhanced skills and knowledge." was agreed with by 55% residents and 73% supervisors, whereas 16% residents and 12% supervisors found it difficult to say. It was mentioned that the level of independence varies more between specialities and supervisors' permission rather than residents' experience.[176] In addition, the independence of the resident may increase, but the supervisor stays legally responsible. The Health Services Organisation Act states the following: "A resident physician may participate in the provision of specialised medical care, general medical care and emergency care with the purpose of acquiring a profession, under supervision and at the responsibility of a medical specialist who has at least 5 years of work experience in the specialty of specialised medical care corresponding to the practical training passed by the resident physician.[177]"

Junior doctors have mentioned that it is common to have been thrown "head first into water" due to the lack of workforce in healthcare and therefore, the service component of PME is dominating.

**Latvia**

Rating: 2 / -0.3

Cabinet of Ministers Regulations No. 268 of March 24, 2009 "Regulations on competency in medical treatment and volume of theoretical and practical knowledge for medical practitioners and students who acquire first or second level professional higher medical education programmes."[178] states: "11. In the first and second years of residency a resident who acquires basic speciality can work under the direct supervision of a specialist whose work experience in the relevant speciality (after receiving a medical licence) is no less than 5 years, by documenting the acquired clinical experience and receiving feedback for the work done." The duties and rights of a resident in the medical treatment process are determined by the head of the medical institution, taking into account resident's knowledge and skills, which have been acquired and evaluated during medical education, as well as based on the recommendation by the relevant head residency programme manager and specialist whose work experience in the relevant speciality is no less than 5 years. The regulations require that resident's degree of independent responsibility is increased when starting the third study year. However, the terms "under direct supervision of a specialist" and "under the leadership of a specialist" used in the regulations are not clearly defined and left for interpretation of medical institutions. According to the stakeholders, currently an evaluation of residents' skills following the second study year is lacking (it is not defined what the resident should be able to do independently), which can result in a wide variety in the residents' allowed independence level between different specialities and healthcare institutions. Regarding the practical application of this standard, 65% of residents agreed or strongly agreed with the statement: "The degree of independent responsibility of the trainees is increased gradually as skills,

[175] Entry into force 25.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[176] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 69–74. Tallinn: Poliitikauuringute Keskus Praxis.

[177] Health Services Organisation Act, § 4 tert. section 1 prim. Passed 09.05.2001. RT I 2001, 50, 284. Entry into force 01.01.2002, partially 01.01.2003 and 01.01.2005. Available: https://www.riigiteataja.ee/en/eli/ee/514112018001/consolide/current

[178] Entry into force: 29.06.2018., Retrieved 29.07.2018., Available: https://likumi.lv/doc.php?id=190610

knowledge and experience grow." Some argue that it "…depends on the personality of training doctor." and "It depends on the supervisor of each department." Another stance that has also been reflected in other standards is that the degree of independent responsibility is increased "Not gradually, but suddenly". In addition, it is argued that there are departments where the resident is not allowed to work independently in order to learn: "Not necessarily – in some departments also first year residents are quite on their own. In others, you always stay a 'secretary'." Still, there are residents whose experience of increasing their independence is extremely positive: "A doctor starts to teach carrying out a specific surgery by assisting him first, then by starting the surgery. […] In the end the work is checked, and comments are provided." Meanwhile recent graduates believe that there are: "A lot of opportunities to work independently." and that "The work amount and complexity of work depends on how good/bad you are."

**Lithuania**

Rating: 2 / -0.02

According to The Law of Medical Practice, the resident acquires his/her competence after fulfilling whole or a part of the residency programme. Moreover, according to national documents, and in accordance with the "Rules of Residency", both universities differentiate the trainees into junior and senior residents, depending on their year of training. However, only 31.8% of the trainees agreed with this statement (compared with 63.4% of the supervisors). To quote one of the respondents of the survey, the degree of responsibility "completely depends on the supervising physician because the legal base does provide substance for increasing competencies of the resident". However, it is worth mentioning that recently the law defining the responsibilities of the trainees was changed so there will be a legal basis for residents to practise procedures (if they are competent) with their own responsibility.

### 3.6. The principles, purposes, methods and practices for assessment of trainees are defined, stated and published

**Estonia**

Rating: 1 / -0.99

According to residency programmes'[179] sect. 28 the evaluation takes place twice a year in compliance with "Regulations of Residency". Additional evaluation is performed by the supervisor at the end of every rotation. However, according to residents this is not substantive, but formal. Evaluation is based on written reports and the residency diary submitted by the residents that describe participation in theoretical courses, practical rotations.[180] A few specialities have interim examinations, but these are summative and not considered relevant in assessing the progress of the resident.

No detailed evaluation principles, purposes, methods and practices were found except for the final exam evaluation, which is explicitly explained in specialist programmes. According to the survey results, no or very little evaluation, either summative or formative, is actually undertaken. Residents have emphasised the lack of day-to-day feedback from the supervisors that would enable them to improve their skills[181].

[179] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[180] The University of Tartu Senate's Act No. 2 "Regulation of residency" ch VI. Entry into force 25.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[181] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 69–74. Tallinn: Poliitikauuringute Keskus Praxis.

**Latvia**

Rating: 1 / -1.18

Rīga Stradiņš University's "Residency Rules of Procedure" state: "4.4. Assessing residents' knowledge, skills and competences is organised by the medical institution. Principles and basic questions of the assessment directly and precisely stem from each speciality's requirements and the volume scheduled in the outline of the study course. In each study course, the resident's practical skills and theoretical knowledge is evaluated. The assessment is written down in a log book and the responsible person for speciality in the medical institution confirms it with a signature." The University of Latvia's "Residency Regulations" does not state any purposes, methods or practices for assessment of trainees, while "Overview of study branch "Healthcare" for 2016/2017", chapter "Medicine. Second level professional higher education (short progr.) 48721"[182] only states methods for assessment of trainees: "After each study course a test of theoretical knowledge in the form of multiple-choice test and/or questions, clinical case analysis. Mandatory (100%) fulfilment of practical work and 100% seminar attendance." The researcher did not have access to speciality programmes or course outlines.

**Lithuania**

Rating: 2 / -0.02

The methods and processes for the assessment of trainees are defined in "Ruling on doctors' training" and the respective "Rules of Residency" in both universities. However, these documents cover only the process of the final assessment of the trainees, at the end of the residency programme. More details on the assessment and evaluation of acquired skills and competences after each rotation are provided in each individual residency programme description. Yet these processes, neither the final assessment nor in-between rotation evaluations are organised systematically and there is great variation between different departments (there are cases of only formal exams, while other clinics provide a thorough and strict examination). This sentiment is also reflected in the survey, where 20.5% of the trainees agreed with the statement that: "The assessment covers knowledge, skills and attitudes and is conducted fairly, transparently and in accordance with the proposed learning outcomes and supervision methods.", while 28.2 % did not.

### 3.7. A comprehensive set of assessment methods and formats are used (there is a consideration of the balance between formative and summative assessment, the number of examinations and other tests, the balance between different types of examinations (written and oral), the use of normative and criterion-referenced judgements, and the use of personal portfolio and log books and special types of examinations, e.g. objective structured clinical examinations (OSCE) and mini clinical evaluation exercise (MiniCEX))

**Estonia**

Rating: 1 / -0.99

[182] Approved in University of Latvia's Senate on 08.01.2018., Retrieved 30.07.2018., Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/dokumenti/parskati-un-zinojumi/Pasnovertejumi/2017/VESELIBAS_APRUPE_2017_PUB.pdf

Ongoing assessment is primarily based on written reports and residency diaries submitted by residents and supervisors.[183] Additional exams are provided erratically. Only final exam modes and criteria are stated clearly and explicitly in sections 30 and 31 of specialist programmes.[184] A few specialities have interim examinations, but these are summative and not considered of relevance in assessing the progress of the resident. According to the survey results, no or very little evaluation/assessment is done before the final exam and concurrent feedback from supervisors is sporadic[185]. There is no evidence that other assessment methods are used.

**Latvia**

Rating: 1 / -1.18

The researcher did not find a list of assessment methods and formats that are used to test residents' knowledge in either university's publically available documents (speciality programmes and course outlines were not available to the researcher). From the national workshop and interviews with residents and stakeholders, only limited evidence of different assessment methods and formats was found: theoretical multiple-choice tests and essays after the end of rotation and practical skills checking by the supervisor during the rotation, and a log book about patients was seen. Stakeholders presented several different forms of evaluation used for the state exam in different specialities: multiple choice questions, clinical tasks, essays, questions, and a practical part. There was no evidence on formative assessment being used, although it is possible that some supervisors might use it informally.

**Lithuania**

Rating: 2 / -0.02

The evaluation of assessment methods in both universities is conducted by the external institution, the Centre for Assessment of Study Quality, which checks the assessment methods in universities and gives advice on areas of improvement. It is documented on paper, but in practice no significant changes have been observed.

The "Rules of Residency" in both universities provide general residency assessment methods concerning the final examination and intermediate residency tests, which should only be oral or written.

Different residency programmes choose different assessment methods and formats, but there is usually no balance between different types of examinations, residents generally have written examinations. Some of residency programmes have special examinations (e.g. emergency medicine in the Lithuanian University of Health Sciences). Some of programmes have relatively good assessment methods on paper, but in practice it is usually different.

### 3.8. The assessments cover knowledge, skills and attitudes

**Estonia**

Rating: 1 / -0.99

[183] The University of Tartu Senate's Act No. 2 "Regulation of residency" ch VI. Entry into force 25.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[184] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[185] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 69–74. Tallinn: Poliitikauuringute Keskus Praxis.

According to residency programmes'[186] sect. 28, the evaluation takes place twice a year in compliance with the "Regulations of Residency". Additional evaluation is performed by the supervisor at the end of every rotation. However, according to residents this is not substantive, but formal. Evaluation is based on written reports and a residency diary submitted by the residents that describes participation in theoretical courses and practical rotations,[187] which do not assess skills or attitudes. Few specialities have interim examinations, but these are summative and are not considered relevant in assessing the progress of the resident.

No detailed evaluation principles, purposes, methods and practices were found except for the final exam evaluation, which is explicitly explained in specialist programmes. According to the survey results, no or very little evaluation, either summative or formative, is actually undertaken. Residents have emphasised the lack of day-to-day feedback from the supervisors that would enable them to improve their skills[188].

**Latvia**

Rating: 2 / -0.3

Rīga Stradiņš University, in its "Residency Studies Rules of Procedure", Article 4.5. states "In each study course resident's practical skills and theoretical knowledge are evaluated. The grades of evaluation are written down in the log book and the supervisor who carried out the checking of knowledge and skills signs." University of Latvia in "Overview of study branch "Healthcare" for 2016/2017", chapter "Medicine. Second level professional higher education (short progr.) 48721"[189] states "After each study course a test of theoretical knowledge in the form of multiple-choice questions and/or open questions, clinical case analysis is done." None of the universities officially mention assessing residents' attitudes. Only 36% of residents agree or strongly agree that “the assessment covers knowledge, skills and attitudes and is conducted fairly, transparently and in accordance with the proposed learning outcomes and supervision methods“.

**Lithuania**

Rating: 2 / -0.02

The "Ruling on doctors' training" and the respective "Rules of Residency" in both universities cover only the process of the final assessment of the trainees at the end of the residency programme. More details are described in the different residency programmes. When asked if the assessment covers knowledge, skills and attitudes and is conducted fairly, transparently and in accordance with the proposed learning outcomes and supervision methods, 35.9% of respondents disagreed or strongly disagreed with the statement, explaining:

"Depends on the clinic. Some do a very strict and transparent exam, some do it mild and easy."

"The assessment is very formal. It doesn't provide you information about personal improvement."

[186] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[187] The University of Tartu Senate's Act No. 2 "Regulation of residency" ch VI. Entry into force 25.05.2017. Available: https://meditsiiniteadused.ut.ee/et/residentuur/residentuuri-eeskiri

[188] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 69–74. Tallinn: Poliitikauuringute Keskus Praxis.

[189] Approved in University of Latvia's Senate on 08.01.2018., Retrieved 30.07.2018., Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/dokumenti/parskati-un-zinojumi/Pasnovertejumi/2017/VESELIBAS_APRUPE_2017_PUB.pdf

"Assessment evaluates purely theoretical knowledge (same as undergraduate medical education)."

### 3.9. The reliability, validity and fairness of assessment methods are evaluated and documented

**Estonia**

Rating: 0 / -2.15

No information about the evaluation and documentation of the reliability, validity and fairness of assessment methods.

**Latvia**

Rating: 0 / -2.23

The researcher did not find any proof of evaluating and documenting the reliability, validity and fairness or assessment methods.

**Lithuania**

Rating: 0 / -2.86

Unfortunately, after the analysis of the documents and written enquiries the research team was not able to find any evidence of the reliability, validity and fairness of assessment methods being systematically evaluated and documented.

### 3.10. The assessment principles, methods and practices are clearly compatible with intended educational outcomes and instructional methods and ensure adequacy and relevance of education

**Estonia**

Rating: 1 / -0.99

Concurrent assessments are principally based on residency diaries and written reports submitted by residents and their supervisors. Additional exams are conducted and feedback from supervisors is received erratically. Only the procedures and criteria for carrying out the final exam are clearly stated. In addition, the final examination only assesses clinical skills and no other relevant knowledge. There is no evidence that the methods and practices of even the final exam match the intended educational outcomes and, as mentioned, many of the outcomes (especially soft skills) are not assessed (or taught) at all. Therefore, it cannot be said that the assessment principles and methods are compatible with all educational outcomes.

According to the survey results, no or very little evaluation, either summative or formative, is actually performed before the final exam, and only a few specialities have interim examinations. Residents have emphasised the lack of day-to-day feedback from the supervisors that would enable them to improve their skills[190]. There is no evidence that other assessment methods are used. Regarding feedback to supervisors, assessment forms are available, but they are voluntary and rarely submitted. Focus groups have revealed that residents are afraid of submitting feedback to supervisors and training bases due to concerns over a lack of anonymity and future problems in securing a position.

[190] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 69–74. Tallinn: Poliitikauuringute Keskus Praxis.

**Latvia**

Rating: 2 / -0.3

Rīga Stradiņš University's "Residency Studies Rules of Procedure", Article 4.4. states: "Testing of residents' knowledge, skills and competences is organised by the healthcare institution. Principles and basic questions of the testing directly and precisely stem from each speciality's requirements and the volume scheduled in the outline of the study course. [...]" No similar publically available regulations were found for the University of Latvia. Rīga Stradiņš University's requirement for the assessment principles to stem from each speciality's requirements seem to fulfil the standard. However, since the variety of the assessment methods used seems to be limited (see standard 3.7.), it is doubtful whether they are compatible with intended educational outcomes and instructional methods.

**Lithuania**

Rating: 2 / -0.02

The "Ruling on doctors' training" and the respective "Rules of Residency" in both universities cover only the process of the final assessment of the trainees at the end of the residency programme. More details are described in each individual residency programme description. When asked if the assessment covers knowledge, skills and attitudes and is conducted fairly, transparently and in accordance with the proposed learning outcomes and supervision methods, 35.9% of respondents disagreed or strongly disagreed with the statement, elaborating:

"Depends on the clinic. Some do a very strict and transparent exam, some do it mild and easy."

"The assessment is very formal. It doesn't provide you information about personal improvement."

"Assessment evaluates purely theoretical knowledge (same as undergraduate medical education)."

### 3.11. The assessment principles, methods and practices promote trainee learning and ensure that the intended educational outcomes are met by the trainees

**Estonia**

Rating: 1 / -0.99

Residency regulatory documents do not state that the assessment methods, principles and practices should promote learning and learning outcomes and do not state the goals of them. In a few specialities, some interim examinations are conducted, but, according to qualitative information, the results are not affecting the continuation of PME and are not usually taken into account.

**Latvia**

Rating: 1 / -1.18

The researcher did not find a strong connection between assessment principles, methods and practices in the regulatory documents. The only allusion to it found is in Rīga Stradiņš University's "Residency Rules of Procedure", Article 4.4: "Principles and basic questions of the testing directly and precisely stem from each speciality's requirements and the volume scheduled in the outline of the study course." Study programme managers approached by e-mail in response to the question of whether in their opinion the current assessment methods promote trainee learning and ensure that the intended educational outcomes are met by the trainees provided diverse answers. One study programme manager stated: "I think so, yes. Methods are adjusted in accordance with study year and the programme acquirable in it. Methods help to determine each resident's competences in clinical work."

Another study programme manager stated that the current assessment methods partly promote learning and ensure meeting of intended educational goals, another agreed that the assessment methods serve this purpose, but there are opportunities to improve them. One study programme manager replied that "…discussions between teaching staff and residents have led to thinking about introducing an assessment system that also serves as one of means to achieve educational outcomes." The same manager also mentions that in his/her speciality, hands-on materials are prepared to introduce different evaluation methods. Yet another study programme manager stated that assessment methods need to be updated to provide both formative assessment during the rotation and summative assessment after it. Another study programme manager proposed the introduction of formative evaluation taken electronically by residents themselves.

**Lithuania**

Rating: 2 / -0.02

The "Ruling on doctors' training" and the respective "Rules of Residency" in both universities cover only the process of the final assessment of the trainees at the end of the residency programme. More details are described in each individual residency programme description. When asked if the assessment covers knowledge, skills and attitudes and is conducted fairly, transparently and in accordance with the proposed learning outcomes and supervision methods, 35.9% of respondents disagreed or strongly disagreed with the statement, explaining: "Depends on the clinic. Some do a very strict and transparent exam, some do it mild and easy.", "The assessment is very formal. It doesn't provide you information about personal improvement.", "Assessment evaluates purely theoretical knowledge (the same as undergraduate medical education)."

### 3.12. The assessment principles, methods and practices ensure timely, specific, constructive and fair feedback to trainees based on assessment results

**Estonia**

Rating: 1 / -0.99

Residency regulatory documents do not state that the assessment methods, principles and practices should ensure timely, specific, constructive and fair feedback to trainees based on assessment results. Trainees must submit residency diaries twice a year. It also contains feedback from the supervisor. Qualitative data show that the feedback is mostly sent directly to the university and residents do not see it. Another common practice is that the residents are asked to write the feedback about themselves and the supervisor only signs it. According to the survey results, no or very little evaluation/assessment is performed before the final exam and concurrent feedback from supervisors is erratic[191]. In a few specialities, some interim examinations are conducted, but according to qualitative information, the results do not affect the continuation of PME and are usually not considered.

There is no evidence that other assessment methods are used.

**Latvia**

Rating: 1 / -1.18

Rīga Stradiņš University's "Residency Studies Rules of Procedure", Article 3.1.2.1. requires that residents' skills, competences and knowledge is tested after each study course: "[...] After the study course the healthcare institution's responsible person, under whose supervision the resident carries

[191] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 69–74. Tallinn: Poliitikauuringute Keskus Praxis.

out practical training, tests acquired skills, competences and knowledge. [...]" University of Latvia's "Overview of study branch "Healthcare" for 2016/2017", chapter "Medicine. Second level professional higher education (short progr.) 48721"[192] also requires testing of knowledge after each study course: "After each study course a test of theoretical knowledge in the form of multiple-choice test and/or questions, clinical case analysis. Mandatory (100%) fulfilment of practical work and 100% seminar attendance." From the above it can be concluded that the summative assessments at the end of each course provide timely evaluation. Still, several stakeholders express that the summative evaluation at the end of the study course is somewhat subjective (it is stated that evaluation usually ranges from 8-10) and only represents the general impression the resident made. Consequently, constructive and specific feedback is lacking. The researcher did not find any requirements in the documentation for formative assessments performed during the study courses and thus, no requirements for timely, specific, constructive and fair feedback during the study course.

**Lithuania**

Rating: 2 / -0.02

The "Rules of Residency" of Vilnius University provide that a resident should be assessed and receive feedback in the resident's electronic diary after each rotation, while the equivalent of this document in the Lithuanian University of Health Sciences states that the supervisor must assess knowledge and practical skills of the trainee, in addition to writing the characteristics about the resident. However, the implementation of these rules depends on the residency programme. When asked if the trainees are guided by means of supervision, regular appraisal and feedback that supports their development to a professional doctor, 51.1% of residents disagreed or strongly disagreed with the statement, while 58.3% of supervisors agreed or strongly agreed with the same statement. When asked to comment on this issue, the residents stated:

"We had some paperwork in which after each rotation the supervisor had to give feedback about us, but basically no one took it seriously."

"Residents are being supervised well enough. The practice lacks appraisal from the supervisors – they are rare and irregular. The feedback is non-existent unless you make a mistake – in such a case you are being given a lot of negative feedback leaving you emotionally affected, sometimes without any advice on what to do next time."

A supervisor also shared their opinion:

"No feedback processes! No debriefing! No constructive criticism."

## 4. The role of scientific research in postgraduate education

### 4.1. The programmes and process of training ensure that the trainee becomes able to use scientific reasoning and applies the scientific basis and methods of the chosen field of medicine

**Estonia**

Rating: 3 / 1.33

[192] Approved in University of Latvia's Senate on 08.01.2018., Retrieved 30.07.2018., Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/dokumenti/parskati-un-zinojumi/Pasnovertejumi/2017/VESELIBAS_APRUPE_2017_PUB.pdf

Scientific reasoning and methods are more emphasised in basic medical education (Curriculum of Medicine. Available in Tartu University study information system). A few specialities e.g. family medicine and laboratory medicine, teach them as a part of theoretical education (Residency programmes[193]). Some programmes expect their residents to publish a research paper as a precondition to sitting their final residency exam. The expectations from this paper, however, vary: it could be an article in the local *Eesti Arst*, a peer-reviewed scientific magazine of general medicine, a paper published in a peer-reviewed international journal, or it could be a monograph written as the result of pursuing a PhD degree. Even where there is a formal requirement to publish, the research and writing is expected to be completed in the resident's spare time, in addition to the normal working hours of their residency. In some departments, clinical seminars take place where (primarily) residents make presentations and introduce new discoveries and directions in the field of medicine to other residents and medical specialists.

The claim: "Scientific approach has a central role in my field of residency. Medical research, including the basics of clinical research and clinical epidemiology have been tackled." was agreed with by 56% of residents and 58% of supervisors, while 19% and 24% respectively found it difficult to say. Residents mentioned that they agree with the first part of the claim i.e. scientific reasoning and that it is mainly used and emphasised, although intuitive reasoning is still used by some older doctors. Training in scientific methods is more thought to be a part of basic or doctoral studies.[194] Therefore, it can be said that there is no structured training in scientific methods and reasoning for all residents.

**Latvia**

Rating: 3 / 0.92

Currently, according to Rīga Stradiņš University's "Residency Studies Rules of Procedure" and the University of Latvia's "Overview of study branch "Healthcare" for 2016/2017", chapter "Medicine. Second level professional higher education (short progr.) 48721"[195] writing a scientific research paper is mandatory in order to graduate from residency in all speciality programmes in both universities. Thus, as one supervisor comments, the statement: "Throughout postgraduate medical training, trainees achieve the knowledge and ability to apply the scientific basis and methods on their chosen field of medicine; the foundation and methodology of medical research on their chosen field of medicine, including clinical research and clinical epidemiology are introduced." is covered by "At the end of the study, residents write an independent research paper and defend it in commission." The process of writing the research work should guarantee that the residents become able to use scientific reasoning as well as apply the scientific basis and methods to their chosen field of medicine. However, 28% of residents answered they disagree or strongly disagree with the statement: "Throughout postgraduate medical training, trainees achieve knowledge of and ability to apply the scientific basis and methods on their chosen field of medicine; the foundation and methodology of medical research on their chosen field of medicine, including clinical research and clinical epidemiology are introduced." and 19% of supervisors also answered they disagree or strongly disagree to the statement above, providing evidence that there are situations when the programme and process of training does not ensure the

[193] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[194] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 87–91. Tallinn: Poliitikauuringute Keskus Praxis.

[195] Approved in University of Latvia's Senate on 08.01.2018., Retrieved 30.07.2018., Available: https://www.lu.lv/fileadmin/user_upload/lu_portal/dokumenti/parskati-un-zinojumi/Pasnovertejumi/2017/VESELIBAS_APRUPE_2017_PUB.pdf

fulfilment of the above. The residents argue that some residency speciality programmes include a course in research methods: "There is a brief course in statistical data analysis, but it is not specific to the chosen field" and other programmes do not: "In our medical education we really skip the part where someone professional could give lectures about types of research, explaining basic information and introducing the resident with evidence-based medical studies." Another resident comments: "It is rather due to "learning by doing" as resident research work is mandatory for finishing training. But some seminars/consultations for this purpose would really be helpful."

**Lithuania**

Rating: 3 / 1.31

The skill of applying scientific reasoning is, in general, covered during undergraduate education. However, different programmes of residency provide that trainees should be able to apply evidence-based medicine, which is basically taught during clinical work. When asked if the programme in their chosen field of medicine includes clinical work and relevant theory or experience of clinical decision-making, 61.0% of the residents agreed or strongly agreed with the statement, elaborating:

"Sometimes there are too many opinions from different supervisors on a specific decision. It comes out of a lack of protocols and algorithms that would be approved for our department. Sometimes a lack of evidence-based decisions."

"You hear some bits here, some bits there, glue them together to paint a picture."

### 4.2. The training includes formal teaching on critical appraisal of the literature and scientific data

**Estonia**

Rating: 2 / 0.17

Formal teaching on critical appraisal of the literature and scientific data is handled in basic medical education (Curriculum of Medicine. Available in Tartu University study information system). It is not separately handled in PME. Programmes include it as independent theoretical education or recommended literature (Residency programmes[196]. Sect. 26, 32.). Around 40% of residents agreed with the claim: "During residency, I have received teaching/supervision for the critical assessment of specialist academic literature and databases.", while 13% found it difficult to say. Residents mentioned that the skill comes from personal experience or from doctoral studies, but it is, in most cases, not formally taught even though they feel the need for it.[197]

**Latvia**

Rating: 2 / -0.3

Comments expressed by residents in the survey testify that few speciality programmes include a specific study course on medical research. However, since every trainee completes a research project during residency and has a supervisor, the supervisor might give some teaching and advice on critical appraisal of the literature and scientific data. An observation was expressed in the national workshop that if the supervisor has a doctoral degree, the trainee's research project ends up being much more valuable. Around 32% residents disagree or strongly disagree, 29% neither agree nor disagree, and 39% agree or

[196] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[197] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 109–111. Tallinn: Poliitikauuringute Keskus Praxis.

strongly agree with the statement: "The programme in my chosen field of medicine includes formal teaching on critical appraisal of the literature and scientific data." The comments include that there are "…4 weeks of basics learning", "…we have a 4-lecture course, yes", "…some elective courses", "On paper, yes, in reality – no", and "It also depends on yourself – if you have an interest, nobody will refuse to support your initiatives". Thus, it is concluded that some programmes include this training, and some do not. However, some training is acquired while carrying out the mandatory scientific research work.

**Lithuania**

Rating: 2 / -0.02

The formal teaching of critical appraisal of literature is covered to some extent during undergraduate education, and during postgraduate education depends on each individual residency programme, making this practice somewhat rare. Journal Clubs have been recently established in the Lithuanian University of Health Sciences (but only in some departments), where trainees gather informally to learn this skill.

When asked if the programme in their chosen field of medicine includes formal teaching on critical appraisal of the literature and scientific data, equal proportions of residents (36.7%) (strongly) agreed and (strongly) disagreed with the statement. As one trainee put it:

"One seminar in 4 years does not prepare one for that very well."

and,

"It lately includes self-teaching on critical appraisal because of Journal Club seminars, which was implemented by me with the help of a young doctor after seeing an example of it abroad."

And,

"Most people do it informally. It is also covered to some extent in undergraduate education, although the level of quality is debatable."

### 4.3. The trainees are encouraged to engage in medical research and quality development of health and the healthcare system

**Estonia**

Rating: 2 / 0.17

Quality development of health and the healthcare system is stated as one of educational outcomes in all programmes. Only a few specialities, e.g. family medicine and laboratory medicine, include it, and also research, as a part of theoretical education. (Residency programmes[198]). Around 41% residents agreed with the claim: "During residency, I had/have the necessary preconditions for performing specialist scientific research on a topic of my interest.", while 31% found it difficult to say. Some residents mentioned they are not interested in research. It was mentioned that research is only possible and encouraged while conducted in addition to residency, i.e. during one's free time. Residents said that they do not simply have enough free time. It is more seen as a part of doctoral studies than residency.[199]

**Latvia**

[198] Available: https://meditsiiniteadused.ut.ee/et/residentuur/erialade-programmid

[199] Residentuur 2017. Hindamise koondaruanne. Lisa 1, pp. 106–108. Tallinn: Poliitikauuringute Keskus Praxis.

Rating: 2 / -0.3

As mentioned in standard 4.1., a scientific research project is mandatory in both universities' PME programmes, thus trainees do need to engage in medical research. Rīga Stradiņš University also organises an annual resident scientific research work conference which can be seen as an encouraging factor. Moreover, there are opportunities for residents to attend conferences in their specialities abroad and this is financially supported by the hospitals or universities. One resident's comments that: "There are a lot of opportunities for research papers and conferences in Latvia and abroad for residents. The universities encourage residents and students, but our government and hospitals don't." A majority of 57% residents agree or strongly agree with the statement: "The trainees are encouraged to engage in medical research on a topic of their choice.", but 26% neither agree nor disagree and 17% disagree or strongly disagree. The disagreement is supported by comments such as: "...forced more than engaged; not necessarily in the field of their choice.", "We don't have a lot of possibilities and varieties. The topics are the same every year.", "Our supervisor is mostly pushing the topics that are more interesting to him/her.", "...only very few supervisors do research that is published in representable medical journals.", and "The professors want us to write papers, so they can fulfil their quota. If you have an interest – do it on your own time." The topic of the lack of time for medical research is a recurring theme: "Almost no medical research, no encouragement. You can do it if there is any free time for that and you have your own interest, but usually no help or support."

**Lithuania**

Rating: 3 / 1.31

Most of the residency programmes provide that trainees must perform research in order to complete their studies. After discussions in focus groups we came to the conclusion that there is huge diversity in different departments regarding this issue – some of the departments have compulsory research work for every trainee, while in others it is optional. In addition, research is encouraged by prioritising the mobility funds for conferences for trainees who are actively participating by presenting their research. When asked if the trainees are encouraged to engage in medical research on a topic of their choice, 51.4% of the respondents agreed or strongly agreed with the statement. When elaborating on their answer, some trainees emphasised the lack of teaching of this skill and the mandatory nature of it in some cases:

"Trainees must produce research work, but do not get so much help to do it."

"The trainees are not exactly encouraged – they are made to engage, and they are given penalties if they don't make the deadlines on time."
"Yes, if you want to, you can do that freely."