
Don't mess with the training rotation

ØYVIND STOPLE SIVERTSEN

oyvind.stople.sivertsen@tidsskriftet.no

Øyvind Stople Sivertsen, medical editor of the Journal of the Norwegian Medical Association, GP at Bjølsen Medical Centre and board member of the Norwegian Association of General Practitioners.

Yet again proposals have been put forward to alter the set training rotation for the first stage of specialty training after medical school. It's a bad idea.



Photo: Sturlason

Bærum Hospital, February 2016: It is just after 3.30am. I am about to clock off after a twelve-hour shift as duty doctor on the medical ward. Earlier that night, I had already dealt with four incoming patients with chest pains, and two patients with COPD flare-ups. Yet another patient now presents with shortness of breath.

Båtsfjord, a few weeks later: I am the only medical practitioner on duty in the area. The senior doctor on call has been taken ill, and due to adverse weather conditions, it is impossible to get a replacement. The roads are closed, and all planes are grounded. The village is cut off. A patient arrives at the emergency room with chest pains. I am the house officer, so it is my responsibility to assess and treat him.

The above example is not unique. There are 356 local authorities in Norway, and most of them have medical centres and emergency departments that are staffed, in part, by recently qualified doctors in specialty training. They used to be referred to as house officers; these days they are foundation doctors. These trainees have considerable knowledge but often have little practical experience. During the first stage of their specialty training, foundation doctors are required to work twelve months in a hospital, followed by six months in general practice, so that they will experience high patient volumes as well as a wide range of conditions. By doing so, they will learn skills, procedures and interaction techniques, to ensure that the 101 learning outcomes are achieved [\(1\)](#).

Government regulations stipulate that the first stage of the foundation doctors' specialty training must involve twelve months of supervised clinical practice in the specialist health service followed by six months of work for the primary health service [\(2, section 2\)](#). At least, this has been the case until now.

Earlier this year, a discussion was re-opened by the fast-working expert committee that was set up by government to review arrangements for general practitioners, a discussion I was convinced had been put to bed. One of the measures recommended by their report, was to empower local authorities to create jobs for foundation doctors. This proposal would also allow employers, when appointing doctors for these jobs, 'to use their discretion as to whether there is a need to comply with the current training rotation structure' [\(3, measure 46\)](#). The Norwegian Association of Local and Regional Authorities (KS) were quick off the mark to announce their backing. In their consultation response to the expert committee, KS wrote that they 'take a positive view on proposals to depart from the set training rotation structure' [\(4, p. 6\)](#). This is despite the fact that as recently as in 2021, the Directorate of Health examined the case for changing the set training rotation for foundation doctors [\(5, pp. 63 and 64\)](#). With broad support from medical circles, the Directorate recommended that the existing training rotation structure be kept. This was to maintain the standard of service, but even more importantly: it was out of concern for patient safety.

«The need for local authorities to provide cover for shifts must never be prioritised above safe working conditions and satisfactory patient safety»

Two years later, the expert committee uses words like 'flexible' and 'adaptable' when they explain why they have put forward their recommendations. This is followed by their main argument that they want a programme that can be 'responsive to scenarios

where hospitals and primary health services suddenly experience a greater demand and more openings for foundation doctors' (3, p. 310). KS, on their part, do not put forward any arguments, but they may well be seeking greater stability of municipal labour supply and better access to doctors who can assist with the local authorities' efforts to meet their statutory responsibility to provide primary health services.

But whereas they want the *programme* to become more flexible, responsive, and adaptable for the employer, there will be adverse consequences for the doctors. They may well have to do exactly the same job as before, but drawing on even less experience in doing so. There is a vast difference between a foundation doctor who has completed a 12-month rotation in a hospital with duty rosters, in-house tuition and supervision, and one who has not. This is about safety – for doctors as well as for patients.

When listening to employers talk about the recruitment of young doctors, it is interesting to note their choice of words. It sounds far less alarming to be talking about 'softening the requirements' than about 'poor quality'. But poorer quality is exactly what we will get if we abandon the stipulated training rotation for foundation doctors.

Had I not experienced a large volume of COPD flare-ups and myocardial infarctions while working at the hospital, I would have been less of a doctor when on duty at Båtsfjord, and a more dangerous one at that. I might have made serious mistakes, mistakes that would continue to haunt me forever. I might never have had the courage to work another shift. Similarly, my mistakes would have impacted on the patients. For me, and for them, the set training rotation was essential.

We must never lower standards in order to increase capacity. It is high standards that have made doctors indispensable. The need for local authorities to provide cover for shifts must never be prioritised above safe working conditions and satisfactory patient safety. The skills that foundation doctors acquire while working in A&E and other hospital departments, are essential to enable them to work with the degree of independence that is required of medical practitioners in the primary health service. This is why we need to retain the set training rotation structure.

REFERENCES

1. Helsedirektoratet. Informasjon om endrede kliniske læringsmål for del 1. <https://www.helsedirektoratet.no/tema/autorisasjonog-spesialistutdanning/spesialistutdanning-for-leger/lis1/lis1-laeringsmal/informasjon-om-endrede-kliniske-laeringsmal-fordel-1> Accessed 8.9.2023.
2. Forskrift om spesialistutdanning og spesialistgodkjenning for leger og tannleger (spesialistforskriften). https://lovdata.no/dokument/SF/forskrift/2016-12-08-1482/KAPITTEL_1#KAPITTEL_1 Accessed 8.9.2023.
3. Helse- og omsorgsdepartementet. Gjennomgang av allmennlegetjenesten. <https://www.regjeringen.no/no/dokumenter/gjennomgang-av-allmennlegetjenesten/id2971896/> Accessed 8.9.2023.
4. Regjeringen. Høringssvar fra KS – gjennomgang allmennlegetjenesten. <https://www.regjeringen.no/no/dokumenter/horingrapporten-gjennomgang-av->

allmennlegetjenesten/id2986685/?uid=1be99dd8-c270-403c-afb8-6bb64e4c26c1
Accessed 8.9.2023.

5. Helsedirektoratet. Spesialistutdanning for leger - LIS1.

<https://www.helsedirektoratet.no/rapporter/spesialistutdanning-for-legerlis1/Spesialistutdanning%20for%20leger%20-%20LIS1%20-%20IS-3002.pdf>
Accessed 8.9.2023.

Publisert: 21 September 2023. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.23.0616

© Tidsskrift for Den norske legeforening 2026. Downloaded from tidsskriftet.no 11 July 2026.