

Chapter 7

GENERAL DISCUSSION

In the introductory chapter of this thesis, we suggested the method of strategic planning for exploring the tailoring of the CanMEDS framework to a local situation. The research performed in this thesis started off with an exploration of the competency needs for the current and future practice of Dutch medical specialists in Obstetrics and Gynaecology (ObGyn). Next, we researched the factors underlying the problems in collaboration between ObGyn specialists and midwives in contemporary ObGyn practice.

Do the CanMEDS competencies meet the competency needs of Dutch gynaecological practice?

In this thesis, we explored the competency needs of ObGyn specialists from the perspective of the ObGyn specialists themselves, their patients and professional groups with whom they collaborate, such as specialized ObGyn nurses, community midwives, general practitioners and members of hospital boards. Subsequently, the competency needs were compared to the content of the competencies described in the CanMEDS framework. These analyses led to several insights, some of which were new while others confirmed what other researchers had previously reported in the literature. The main new insight was that the CanMEDS framework to a large extent covers the competencies desired in Dutch ObGyn specialist's performance, but that it requires tailoring on some crucial points to define the outcomes needed by a Dutch ObGyn specialist for current and future practice. For the ObGyn specialists, the tailoring should address the need for more attention to entrepreneurship and the use of technology. The addition of the roles Entrepreneur and Advanced Technology User is advised by the ObGyn specialists to meet the predicted changes in the logistics and transparency of ObGyn care and to preserve the correct usage of technological possibilities by ObGyn specialists and patients. Moreover, the ObGyn specialists predicted an increasing importance of patient participation, complex interdisciplinary teamwork and leadership for the practice of the year 2025, which should be addressed in the different CanMEDS roles, i.e. Communicator, Collaborator and Manager.

The findings reported in this thesis confirm what earlier studies showed, i.e. that doctors (ObGyn specialists) have a different perspective than other groups (patients, nurses, etc.) on which competencies are important in the performance of a consultant (Graham et al., 2009; Jung et al., 1997; Green et al., 2009; Fones et al., 1998). The other (non-ObGyn specialist) groups stressed the importance of a greater focus on reflective practice than is currently the case in the CanMEDS framework. Reflection should not only comprise the performance of the individual ObGyn specialist, but also the performance of co-workers and of the department as a whole. In addition, the groups also stressed the need for a more holistic view on patient care and for addressing this in the competency based training of future ObGyn specialists.

The research of this thesis revealed a conceptual difference in the understanding of interprofessional collaboration between ObGyn specialists and the professionals that collaborate with them. Both groups stressed the importance of interprofessional collaboration, but they had different ideas about the role of the ObGyn specialist in this collaboration and about the competencies necessary to fulfill this role. The ObGyn specialists saw themselves as the leaders of a team of professionals, in which tasks are assigned to other health professions, such as nurses. The other professional groups saw the ObGyn specialist as a team member, rather than as a team leader. They expected the

ObGyn specialist to be a team player, who collaborates by making shared decisions based on equality, respect and knowledge of the work and responsibilities of the other team members.

In conclusion, our results support the use of the CanMEDS framework in the Netherlands. Yet, to make optimal use of the framework within the setting of Dutch ObGyn postgraduate training, tailoring is necessary to align the content of the framework with the competency needs of Dutch ObGyn specialists. Such a tailoring to the needs of a specialty would be unique within the field of Dutch postgraduate training. Following national legislation to provide for competency-based education (Central College of Medical Specialties (CCMS), 2010), all specialties have redesigned their training programs by including the CanMEDS competencies, and the competencies have been judged to be appropriate for Dutch medical practice in general (Rademakers et al., 2007). However, none of the medical specialties critically appraised the fit of the content of the competencies with their medical practice. This is in contrast with the practice in the homeland of the CanMEDS framework, Canada, where each specialty has made its own modifications to the general CanMEDS framework to better align the training with the practice of that specialty (RCPSC, 2014b). For the Dutch specialties, it might therefore have been more appropriate to have used this modified framework for the design of their training. Even so, using the modified framework for the design of the ObGyn training program would still not have guaranteed an optimal fit with the competency needs of Dutch ObGyn practice, because the organization and practice of the ObGyn specialty in Canada and the Netherlands differ in several aspects. Therefore, a one to one fit of the competency framework could not have been expected.

In the literature on the applicability and validity of the CanMEDS framework outside Canada, authors predominantly chose the perspectives of doctors or medical students for evaluating the relevance of the CanMEDS competencies for their practice (Ringsted et al., 2006; Rademakers et al., 2007; Wangler, 2009). By contrast, our research showed that different groups can have conflicting views on the professional role of a doctor and on the competences that are needed. Therefore, if competency frameworks are to be tailored to a local situation, a broader view should be taken by including not only the doctors' perspectives but also the perspectives of multiple stakeholders. This will result in a more accurate view of the competencies which are required for a doctor (Bowden, 1995).

The problems in collaboration in obstetrical care

Within the setting of Dutch maternity care, we know that the collaboration between ObGyn specialists and midwives is sub-optimal, which contributes to a diminished quality of maternity care (Europeristat project, 2008; Adviesgroep Zwangerschap en geboorte, 2009). However, it remains unknown what specific aspects of the collaboration exactly cause the collaboration to become ineffective at times, and what role the ObGyn specialist has in this collaboration.

The importance of effective collaboration is reflected by the fact that the CanMEDS framework has indicated 'Collaborator' to be one of the seven essential Roles in the performance of a doctor (RCPSC, 2014c). The description of this role features all the competencies a doctor has to master to adequately collaborate in medical practice. However, it cannot be expected that mastering these general competencies will fully solve a collaborative problem within in a specific context. The studies performed to answer our first research question already revealed that ObGyn specialists had different perceptions of collaboration than the groups with which they collaborate in daily practice. This difference in perception of, for example, each team member's role in the team might be a contributing factor in the problematic collaboration between ObGyn specialists and midwives.

To deepen our insight into the collaboration in which ObGyn specialists engage in daily maternity care practice, we conducted three studies on the causes underlying the problems in collaboration in Dutch maternity care. We supposed that insight into the complexity of the problems would help us to better judge the collaboration competency needs of ObGyn specialists.

We aimed to deepen our understanding of the collaborative problem from the perspectives of both professions. For this, we validated two questionnaires on the process and outcome of collaboration for our specific context in which hospital-based doctors collaborate with community-based midwives. Using these questionnaires, we evaluated the perceptions of both professions of the practice and effectiveness of contemporary maternity care. The results showed that both professions perceived the sharing of activities and the coordination of the joint care they provide as suboptimal and in need of improvement. We also found that the professions neither act well as a team nor perceive themselves as being an integral part of a team. Clarity on each profession's role and responsibilities within the collaboration seemed to be lacking, which led to a sub-optimal coordination of the collaboration.

We expected that the roots of the collaborative problems could be found in the historical development of both professional groups. We therefore analysed the influence of the historical development of the collaboration between Dutch ObGyn specialists and community midwives. The results of this historic analysis showed that the historical roots of the collaboration did not support the development of a truly 'interprofessional' collaboration in which all team members are equal and in which the shared patient is at the center of attention. Over the last centuries, both groups strived for autonomy and independence. Nevertheless, the doctors dominated over the midwives for the majority of the time, both in midwifery practice and in education.

We used D'Amour's model for interprofessional collaboration (D'Amour et al., 2008) to deepen our insight into the midwives' perspectives on the collaboration as being the

historically suppressed profession in the collaboration. It became apparent that midwives have unmet needs in both the organizational and relational domain of their collaboration with ObGyn specialists. On the organizational level, they expressed a need for shared protocol development and critical discussions on how to optimize maternity care. From a historical perspective, these needs were easily explained, as both professions were united in separate societies, each of which strived for preservation of autonomy and unidisciplinary protocol development instead of shared maternity care. Within the relational domain, midwives perceived in ObGyn specialists a lack of trust and familiarity with the practice and competencies of a midwife. Also, a strong power imbalance, with the ObGyn specialists as dominating party, was reported to negatively influence shared maternity care. These perceptions were explainable from the historical perspective of doctors' domination over midwives and the continuous disputes over midwives' authorities. The results within the relational domain in particular can be interpreted as the midwives' request for improvement in the collaborative performance of ObGyn specialists, and thus these results reflect specific competency needs.

In conclusion, we gained more insight into the collaborative problems between ObGyn specialists and midwives in the Netherlands and found clues on how to improve this collaboration. For example, there appears to be a lack of clarity on the role and responsibilities of the team members. Individual team members do not have the feeling that they belong to a team. Furthermore, the midwives reported that ObGyn specialists demonstrate a lack of trust in the midwives' abilities and assume a hierarchical attitude. This last point was also observed by other professional groups that collaborate with the ObGyn specialists such as ObGyn nurses and general practitioners. As these observations all refer to aspects of the performance of individuals, several competency needs in the performance of ObGyn specialists can be deduced. For example, to effectively collaborate with midwives, ObGyn specialists should at least familiarise themselves with the abilities and responsibilities of the midwives. They should also learn about their own role and responsibilities in the team and how to optimally make use of both their own and their team members' qualities.

When comparing these competency needs to the competencies described for the Role Collaborator of the CanMEDS framework (RCPSC, 2014c), we see that these competency needs are included in this role but they are listed as so-called 'enabling' competencies. Within the Role Collaborator, two 'key' competencies are described which a doctor has to develop to 'master' the Role Collaborator. For each 'key' competency, several 'enabling' competencies are defined, describing in further detail how to master each 'key' competency. When comparing the overall content of the CanMEDS Role Collaborator to the content described in the role 'Collaboration' of the Dutch version of the CanMEDS framework (KNMG (Royal Dutch Medical Association), 2014), we notice three things. First, the Dutch version defines not two but four 'key' competencies within the role 'Collaboration'. Second, the Dutch version has not defined any 'enabling' competencies to explain in more detail how to master the 'key' competencies. Third, the content of the Canadian 'enabling' competencies greatly resembles the competency needs found in our research. Yet, this content is not included in the Dutch version of the framework, and thus competencies that are very relevant and important for Dutch ObGyn practice seem to have been lost in translation.

Implications for educational theory

The work of this thesis has implications for the academic discussion about curriculum design and is in line with the international efforts that are currently made in the redesign of the current CanMEDS framework, the CanMEDS 2015 project. This project is a highly ambitious and comprehensive example of collaborative work on creating an optimal and sustainable competency framework. In the project, many Canadian educators as well as the professionals within a large international network are giving their professional input in a highly structured program led by the Royal College of Physicians and Surgeons of Canada (RCPSC). Currently circulating drafts promise important improvements over the former versions of the framework. Moreover, several of the competency needs found in the research of this thesis are recognizable in the CanMEDS 2015. For example, competence in health care informatics is viewed as critical for doctors, and more attention is paid to quality improvement and patient safety. Also, within the Role Collaborator, more emphasis is placed on interprofessional collaboration, in which the relationship with other professionals is presumed to be the centre of the model of care. Therefore, the work done in this thesis shows that such a comprehensive and firmly research-based framework as the CanMEDS 2015 version would fit well with our Dutch curriculum design of specialty training.

Our contribution to the literature is twofold. On the one hand, we emphasized that one size does not fit all when it comes to competency frameworks and competency-based education. Each local situation has its specific problems and thus its specific competency needs. If we regard medical education as one of the tools to solve problems in health systems, an international framework should be tailored to the local situation to meet the local needs. In this thesis, entrepreneurship was one of the suggested alterations. Due to changes in Dutch legislation, the ObGyn specialist of the future will be confronted with challenges to cope with a health services market. The entrepreneurial skills needed to with the market demands are often not available in the current training programs, and curriculum design should address this subject. Little attention was paid to these specific skills in the CanMEDS framework 2005, and the draft of the 2015 version of the framework also barely includes entrepreneurial skills. This might be explained by the less autonomous positions of specialists in countries other than the Netherlands, where most medical specialists are members of autonomous partnerships within a hospital. Such a partnership is responsible for its own business, including finance, medical staff and logistics surrounding the provision of care. Consequently, entrepreneurial skills are vital for the members of the partnership. This example demonstrates that national differences in the organization of health care may provide compelling reasons for tailoring the framework for medical education.

A second contribution to the literature is the way we studied interprofessional collaboration. There is a need to study the requirements of local health systems with specific tools for measuring current performance. We validated tools for measuring interprofessional collaboration between doctors and other health professionals working within different health care settings, because the Dutch collaboration between obstetricians and midwives is perceived as substandard. We believe that the medical education literature should pay more attention to the methods and materials needed for the diagnosis of local health systems issues that deserve attention during training.

Reflections on interprofessional collaboration and interprofessional education

When thinking about using educational interventions for solving some parts of the problem in collaboration, this might not be as simple as it looks. First of all, one should realize that specific collaborative problems may be deeply rooted, as they are within maternity care, and that they may have developed over centuries. Interventions aimed at overcoming collaborative problems should therefore not be focused on simple, rapid improvements.

In our example, both professions have arrived at a way of thinking about the other profession, and their approach to collaborating is engrained into their system. Moreover, without consciously realising it, they contribute to perpetuating the problem. For example, in their training, the residents' learning and professional identity development are strongly influenced by the role modeling of their supervisors (Benbassat, 2014; Helmich & Dornan, 2012). To prevent the development of a narrow perception of interprofessional collaboration and their role in it, it is important for the residents to have supervisors with different perspectives on interprofessional collaboration. Also, experiencing the interprofessional collaboration first hand and from the perspective of all professions involved might help expand the resident's perspective on the collaboration. Within the ObGyn residency, an initiative was recently started in which ObGyn residents experience midwifery practice in the community under supervision of a community midwife, and thus they are role modeled from a different perspective (van de Ven et al., 2012).

Although this intervention promises to contribute to the residents' knowledge and perception of midwifery practice, an educational intervention alone is not enough to actually improve the collaborative performance of residents. The residents' supervisors should also reflect on the collaborative stance they implicitly and explicitly role model, and they should discuss this with their residents. If a supervisor teaches the residents that collaboration should be based on respect and equality between professions but meanwhile comments every step a midwife takes, this will result in skeptical instead of collaborating residents.

Second, as both the midwives and the ObGyn specialists are involved in the problems, it would be appropriate to not only address the problems in the training of ObGyn specialists but also in the training of midwives. For some aspects of the suboptimal collaboration it may be best to implement a shared educational intervention, in which both professions learn together. This kind of shared education is also known as interprofessional education (IPE), in which professional groups are supposed to 'learn with, about and from each other to improve collaboration and the quality of care' (Goldman et al., 2009).

Before engaging in the development of an interprofessional intervention, however, one should carefully look around for best practices. In the Netherlands, there is limited experience with interprofessional education (IPE) and interprofessional practice (IPC). Other countries, such as the UK, North America and Australia, are far ahead and have gathered a fair body of knowledge about IPE and IPC (Freeth, 2005; Reeves et al., 2010; Hean et al., 2012; Zwarenstein, 2000). For example, in the United States, several team trainings have been developed which aim at improving team members' knowledge, skills and attitudes and thereby at improving communication, coordination, cooperation, role clarity, team leadership and situational awareness within the team (Weaver et al., 2010).

At the same time, the literature remains inconclusive about the efficacy of IPE, mostly due to the fact that its purposes and intended outcomes are often unclear and its effects are often self-reported by the participants of IPE (Kuper & Whitehead, 2012). Researchers have even suggested that IPE aimed at 'getting to know each other through contact' does not support interprofessional practice at all. Instead, it appears to reinforce professional stereotyping and professional boundaries, as doctors and future doctors subconsciously protect their dominant position, whereas other professions try to increase their power (Baker et al., 2011). Moreover, when poorly designed, IPE appears to limit students' interest in interprofessional practice (Rosenfield et al., 2011). Therefore it is suggested that contemporary IPE is insufficient to help solve contemporary collaborative problems (Kuper & Whitehead, 2012).

The literature is more positive about interventions in the processes of the interprofessional practice itself. In their review, Zwarenstein et al. described studies showing that organizational interventions such as interprofessional rounds, meetings and audits do have the ability to improve patient care (Zwarenstein et al., 2009). In the case of the collaborative problem in Dutch maternity care, we found problems in both the organizational and the relational domain of collaboration. Interventions should therefore address both domains when aiming to improve the collaboration. This means exploring ways to improve the mutual acquaintanceship and the trust in each profession's abilities and activities as well as critically assessing the processes within current practice.

Third, the research on interprofessional education and practice and the search for best practices and interventions is complicated by a profusion of terminologies and theories. For example, in Dutch there is only one word for collaboration, namely 'samenwerken', which simply stands for working together. In English, on the other hand, terms like networking, cooperation, partnership, collaboration and teamwork all imply a slightly different way of people interacting with one another. Also, the process of collaboration is covered by many different descriptions and definitions, depending on the theoretical background (Reeves et al., 2011). For example, in social exchange theory, collaboration is the process of exchange and negotiation in which people join a group with special benefits for them and in return they help the group obtain certain objectives (Gitlin, 1994). Alternatively, within organisational sociology, collaboration is described as 'human interactions that lead to a collective action' (D'Amour et al., 2005). The terminology becomes even more complex when it comes to the collaboration between different kinds of professionals. The literature distinguishes several levels of collaboration, i.e. multidisciplinary, interdisciplinary, and transdisciplinary collaboration, each representing a different interaction and dependency between the professionals involved (D'Amour et al., 2005).

Summarizing, the literature considers collaboration to be a complex phenomenon that is influenced by many factors. This should not discourage researchers from entering this important field of research and using the body of knowledge that already exists. Instead, they should be aware of the complexity of the field and consent within the team on the preferred terminology, the paradigm and on the aspects of collaboration they want to research or find best practices for.

Reflections on the use of strategic planning for tailoring a competence framework

In this thesis, we used the approach of strategic planning to guide our research on how to tailor the CanMEDS framework to ObGyn practice. The first step in this approach is a situational analysis of several factors inside and outside the organization and its environment. In this respect, Prideaux's inventory of factors that (Prideaux, 2003) are important for investigating the content of a curriculum was very helpful to us, as it gave us an overview of the kind of factors to consider.

The strategic planning approach recommends prioritization of those fields of practice whose evaluation is most valuable and necessary. In our research, we focused on the collaborative problem in maternity care, but this is not the only problem within ObGyn practice that can be labeled as a priority. ObGyn care is faced with many problems and challenges, such as the feminization of the workforce, the need for subspecialization and the need for cost-effectiveness of care (Hakvoort, 2004; Legrand-van den Bogaard & Rooijen, 2009). Each of those problems might have been eligible for an in-depth analysis to identify the underlying causes and the specific competency needs of gynecologists. Still, our analysis can be seen as an example of how to execute such an analysis from different perspectives.

Of those perspectives, the historical perspective in particular helped us to gain insight into the origin of the collaborative problems. This perspective, however, is often neglected in the analysis of problems in the medical and educational field (Kuper et al., 2013). We therefore recommend adding the factor 'History' to the factors to be analyzed in the situational analysis.

We found the strategic planning approach a suitable and informative tool for thoroughly investigating the needs and problems in a field of practice and to perform an in-depth analysis when found appropriate, but more experiences are needed for fine-tuning this approach for tailoring curriculum design. In our research, we predominantly focused on step 1 (draw step) and 2 (see step) of the strategic planning approach. The third step (think step) involves a reflection on what actions are needed to close the gap between the desired and the current curriculum. This step is necessary to actually effectuate the implementation of our results of step 1 and 2 in a new curriculum. We conclude that the strategic planning approach provides curriculum designers with a guideline to broadly and extensively explore a local situation and its competency needs and to define concrete actions and recommendations on how to customize the CanMEDS framework to a local situation.

Strengths and Limitations

As far as we know, this thesis is the first report on tailoring the CanMEDS framework to the local situation of Dutch postgraduate training for a specific medical specialty. Although the applicability of the framework to Dutch medical practice has been researched before (Rademakers et al., 2007), our research is the first to actually define the specific competency needs of a specialty and to give recommendations on how to tailor the CanMEDS framework to a local situation. Our research already had an impact on the international academic discussion on competency-based education in specialty training. The impact was especially noticeable in social media like twitter and podcasts. For example, on the 4th of December 2012, Brian Hodges, a highly respected professor in

medical education at the University of Toronto in Canada, twittered: 'Interestingly, as the Dutch adopt CanMEDS they feel something is missing. Rebirth of the physician as person. Stay tuned for the paper?reflection is back'. And in January 2014, Jason Frank and Linda Snell, two highly respected clinical educators deeply involved in the development and implementation of the CanMEDS framework in Canada, discussed the study described in chapter 2 in a podcast on the website of the Royal College of Physicians and Specialists Canada (RCPSC, 2014a).

Moreover, we used the strategic planning approach to guide the tailoring of the CanMEDS framework to our context. When applied to medical education, we found this approach helpful in structuring the steps that need to be made in determining the content of a curriculum. The strategic planning approach also helps curriculum designers to shift their mindset from reactive towards proactive curriculum design. Until now, most major changes in the field of medical education have been a reaction to signals within society about a decreased level of medical education and health care. The strategic planning approach, on the other hand, helps design a curriculum that anticipates potential problems in society and medical practice before they actually become problematic. Moreover, this approach requires a critical reflection on the profession and its education, including a critical appraisal of everything within and surrounding the profession and an investigation whether the current purpose and content of the profession still suits the profession's environment. All this is not routinely done within the field of postgraduate education or the practice of a medical specialist.

Another strength of our study is the empirical exploration of future practice from the perspectives of a large sample of professionals. Mostly, trends for the future are not predicted by the professionals who actually experience the changes in practice first hand, but by highly-placed iconic individuals (Harden, 2007; Bakas, 2011) or legislative and governmental institutions (van Rijn et al., ; Legrand-van den Bogaard & Rooijen, 2009; Raad voor de Volksgezondheid en Zorg (Council for Public Health and Health care), 2012). Although we perceive the predictions of our target group to be valuable, one should thoughtfully interpret and use these predictions for future practice. After all, predictions are not facts, and thus they might not come true. Therefore, we should use them to proactively design our curriculum, but maintain flexibility to make adjustments when necessary.

A limitation of the research performed in this thesis is that it does not comprise all the steps of strategic planning, nor does it cover all the factors of the situational analysis, as the extent of such a comprehensive endeavor was considered to stretch beyond the scope of one PhD thesis. Nevertheless, our results indicate that we have chosen an adequate focus to evaluate the necessity of tailoring the CanMEDS framework to a local situation.

Another limitation of the present research is that we explored the need for tailoring of the CanMEDS framework for the specific setting of the ObGyn specialty in the Netherlands, leaving out all the other Dutch medical specialties and all the other countries that might want to use or are already using the framework for their postgraduate training programmes, while acknowledging that such an exploration might be useful for them as well.

Moreover, in the research performed in this thesis, our explorations on contemporary and future competency needs did not include all the perspectives in and the problems in collaboration. Sometimes, we focused on the perspective of the ObGyn specialist or the midwife or other stakeholders. After exploring these perspectives, we acknowledged that insight into the perspectives of the other involved professionals on, for example, the future of ObGyn practice would be very valuable, as would the perspective of the ObGyn specialists on their own contemporary performance. However, these explorations were considered to extend beyond the scope of this thesis.

Also, to quantitative researchers, our sample sizes might appear small. Yet, in each of the qualitative studies, data saturation was reached, and thus our findings can be considered accurate reflections of the perceptions of our participants.

Future research

Future research connected to the work of this thesis can be performed in three directions. The first direction regards a more thorough study of current and future health systems problems. A first example of Dutch problems not adequately addressed by our postgraduate training is the introduction of value-based practice. Doctors of the future have to be able to prove the quality of their work, but they also have to show their contribution to the efficiency of the care provided. A second example is the aging of society. Many elderly show up with multiple problems and need care from teams with a wider perspective than just the medical. A more holistic view is urgently warranted, but often not available on the training site. A third example is the difficult transition to patient participation. Despite extensive efforts, patient participation in Dutch health care remains limited. We therefore need a better diagnosis of what hampers the implementation of patient participation, and how to prepare health professionals for this vital task.

The second direction for future research is change management. The concept of change management as a tool for implementing the CanMEDS framework or other frameworks is an important topic for future research. At this moment, the alignment of the curriculum on paper and the curriculum in action appears to be insufficient in our situation, and experiences and research on suitable ways to approach this issue are not easily found in the international literature (Kelly, 1977). Therefore, the work performed in this thesis had two intentions: firstly, tailoring of the CanMEDS framework based on a better understanding of our local needs, and secondly the reinvention of parts of the framework. According to Rogers, reinvention is a key process in change management that is needed to successfully implement a change (Rogers, 1983). This process is needed to internalize the change and to fully understand the usefulness of the change. In our case, we experienced the process of reinvention surrounding the implementation of competency-based education and the CanMEDS framework within the context of Dutch ObGyn postgraduate training. In our process of reinvention, the professional ObGyn society discussed, amended and finally tailored the original framework. That process generated a feeling of ownership. Also, the usefulness of the CanMEDS framework for the ObGyn context became apparent. For some, the way the Dutch ObGyn curriculum was designed, and the kind of research performed for the tailoring of CanMEDS may have given the impression that the Dutch wanted to improve the international CanMEDS framework. Yet, that would have asked for a completely different approach.

The third direction of future research is a continued exploration of the collaborative problem in maternity care, since educational interventions are not the only key to improving the collaboration between gynecologists and midwives. As became clear from our studies, improvements could be made at the relational level, but also at the organizational level. The collaboration might already be significantly improved by practical interventions aimed at improving the coordination of maternity care, the means of communication, the clarity about professional boundaries and the sharing of information and activities. In practice, these organizational aspects of the problem can probably be addressed more easily and quickly than the relational aspects. Still, they require consensus of both professions on the desired and appropriate intensity and execution of collaboration. Therefore, future research should explore if both professions are in general agreement when it comes to collaborating within maternity care, or if each strives for a different kind of collaboration with different goals and conditions.

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