WORLD INSTITUTE OF PAIN®

29th Annual Gabor Racz Advanced Interventional Pain Conference and Workshop

Budapest, Hungary August 24-26, 2026

Training the Next Generati
Do We Still Need "Traditio
Fellowships?

Prof. dr. Monique Steegers, MD, PhD
Amsterdam University, Medical Center
Amsterdam/Netherlands

Conflict of Interest

Full professor Amsterdam University Medical Centers, the Netherlands and head of the department Pain management and palliative care, part of Anesthesiology

Chair of the examination board FIPP CIPS

President chapter IASP the Netherlands, (PA!N)

Indepent Research grants Grunenthal, Viatris

Independent government research grants from ZonMw, NWO,

In Memory of
Dr. Gabor B. Racz

1937–2025

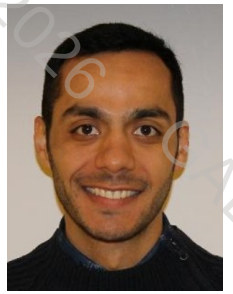
Thank you so much

Amsterdam UMC
Universitair Medische Centra

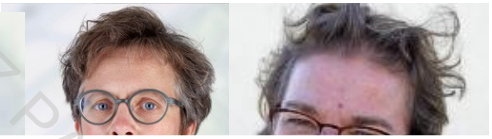
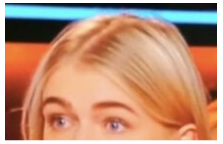













18 painspecialists+3 fellows + 5 pain residents:
13 FIPP
3 CIPS
3 EDPM

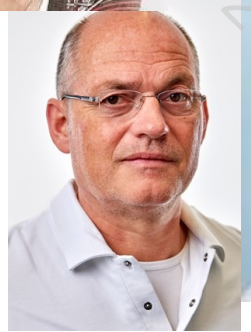
Natasja Klootwijk
Marisha Vodegel

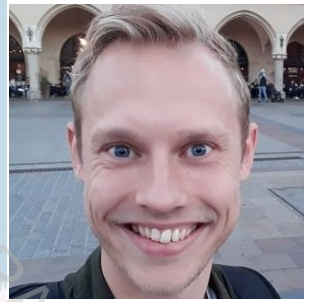







Eef van Duin
Medical Specialist,
Specialist,
Anesthesiology



Learning goals

1. **Effective Learning**
2. Effective Education
3. Effective examination: Improve FIPP and CIPS

Pupils in England are losing their thinking skills bec suggests

Two-thirds of secondary schoo core abilities such as writing and

Back to books - Sweden's schools cutting back on digital learning

15 April 2026

Share Save Add as preferred on Google

Maddy Savage
Business reporter, Nacka, Sweden

The result is the first generation less cognitively capable than their parents

AI 'slop' could cause cognitive decline and violent tendencies among kids, study says

OECD

PISA

Will science, reading and maths exam results continue to decline?

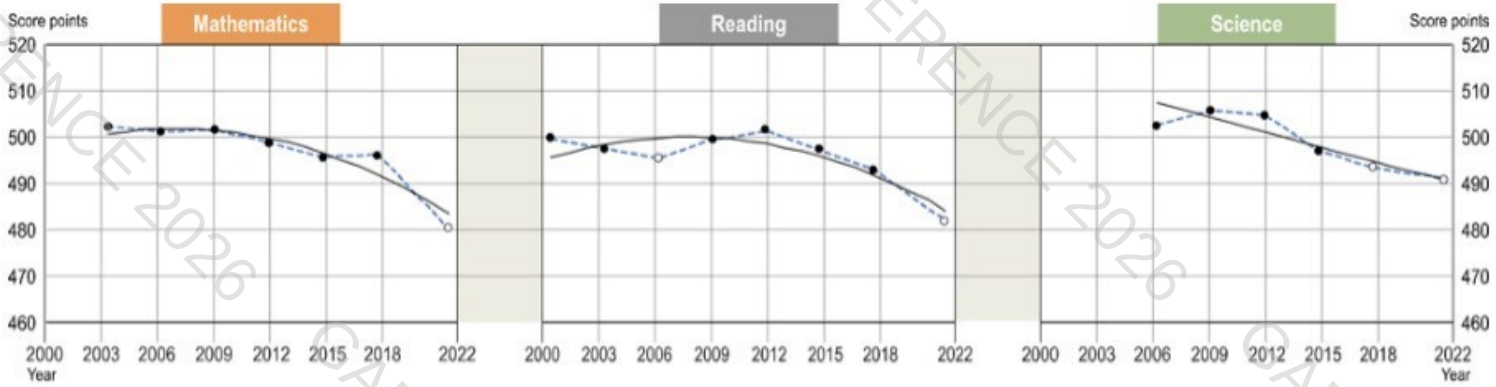
OECD average PISA scores in science, reading and maths

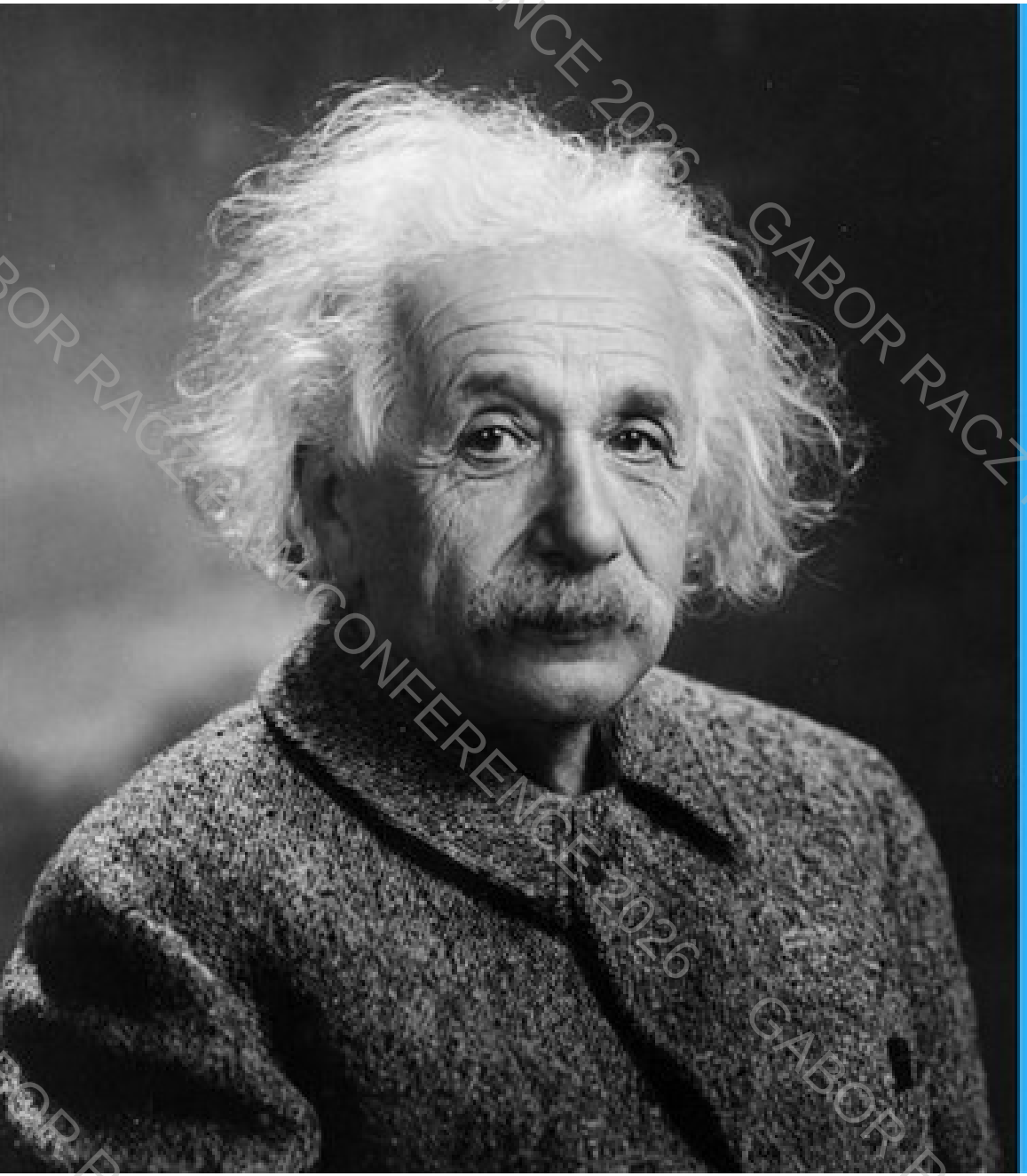
600 000 students

representing about **32 million** 15-year-olds in the schools of the **79 participating countries and economies** sat the **2-hour** PISA test in 2018

Figure I.6.1. Trends in performance in mathematics, reading and science since the first PISA assessment

OECD average-23



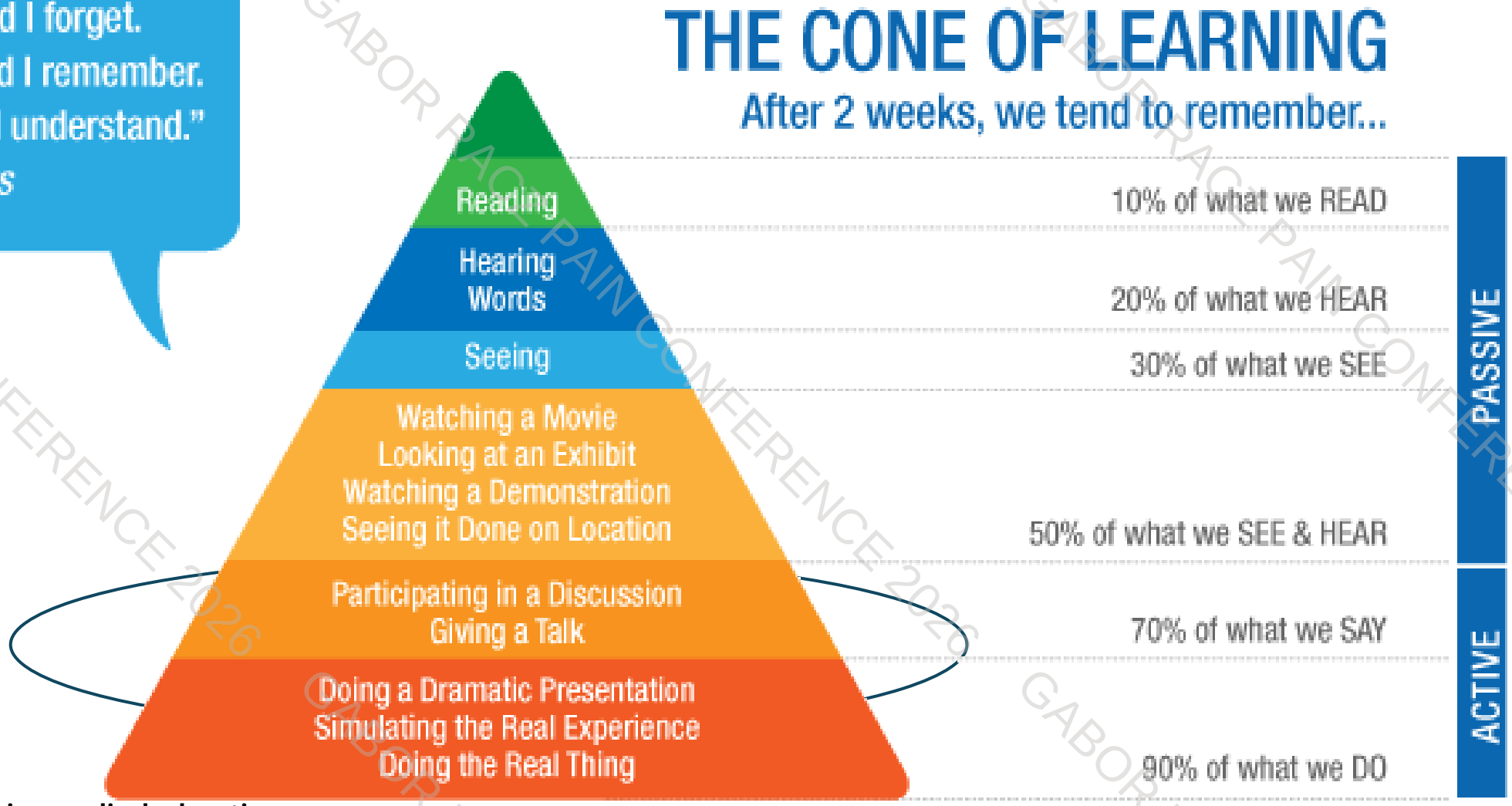


Once
you
stop learning,
you
start dying.

ALBERT EINSTEIN

Effective learning

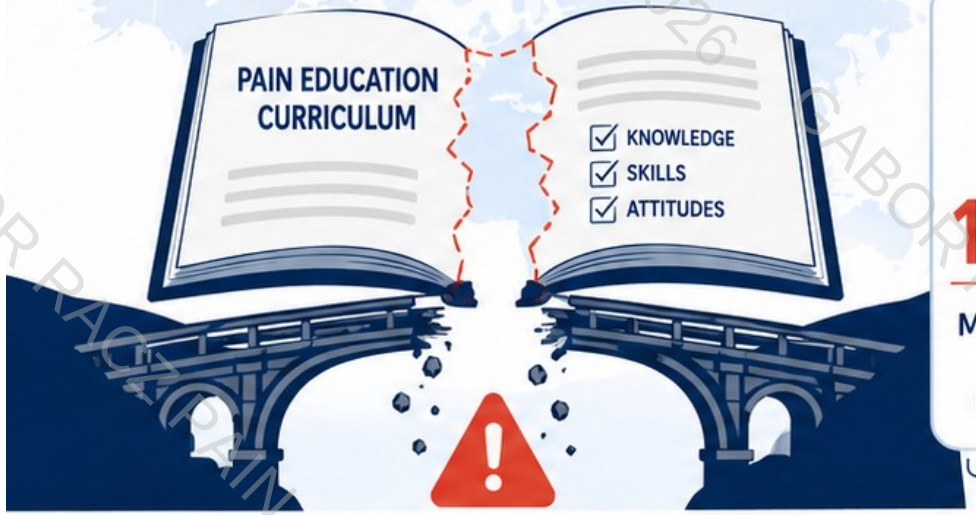
"I see and I forget.
I hear and I remember.
I do and I understand."
Confucius



Effectiveness of continuing medical education.
Marinopoulos SS et al, Evid Rep Technol Assess (Full Rep). 2007 Jan;(149):1-


LEARNING STYLES
VISUAL
• graphs
• flashcards
AUDITORY
• lecture
• music
PHYSICAL
• hands-on
• movement
VERBAL
• writing
• presenting
LOGICAL
• patterns
• statistics
SOCIAL
• collaboration
• teams
SOLITARY
• independent
• individual

Curricular Gaps and Barriers



Only 11–20 hours
Median pain teaching across the entire medical curriculum

80–96%
lack compulsory dedicated pain teaching

42%
lack specific pain-learning objectives

16%
are unsure whether pain is assessed

Only 8%
of graduate education studies measure patient outcomes

Shipton et al., 2018

Malik et al., 2022

Fragmented landscape

Medicine | Nursing | Physiotherapy | Psychology

Gaps in depth • consistency • delivery

Interprofessional learning remains rare

Skidmore et al., 2025

Curriculum priorities

1. **Standardized curricula**
   Use established resources such as EFIC
2. **Practical clinical placements**
3. **Qualified educators**

→ **Competency**

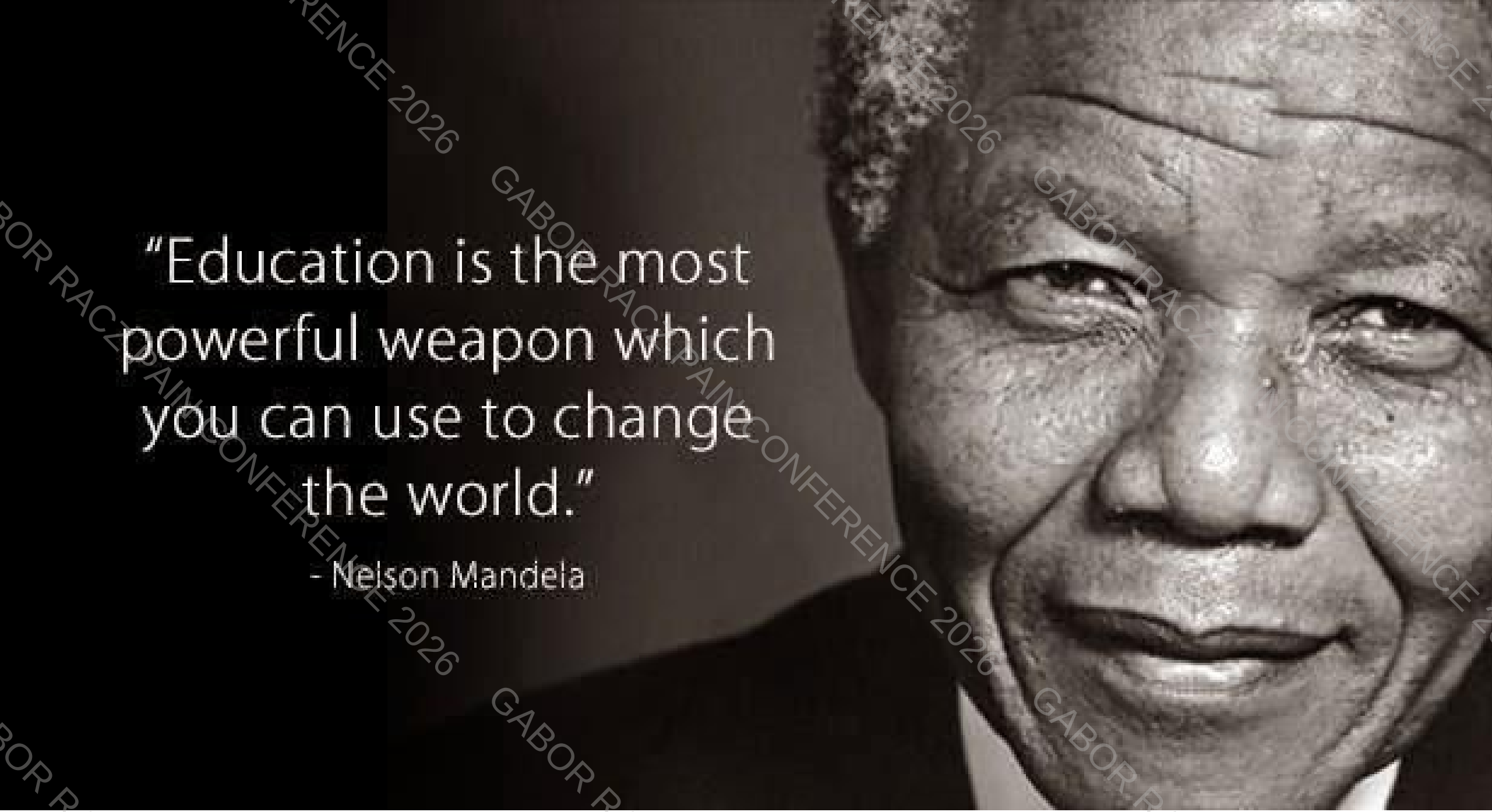
Simulation + case-based learning | interprofessional training | multidimensional assessment

Learning goals

1. Effective Learning

2. Effective Education/ fellowships

3. Effective examination: Improve FIPP and CIPS



29th Annual Gabor Racz Advanced Interventional Pain Conference and Workshop

A special tribute to education









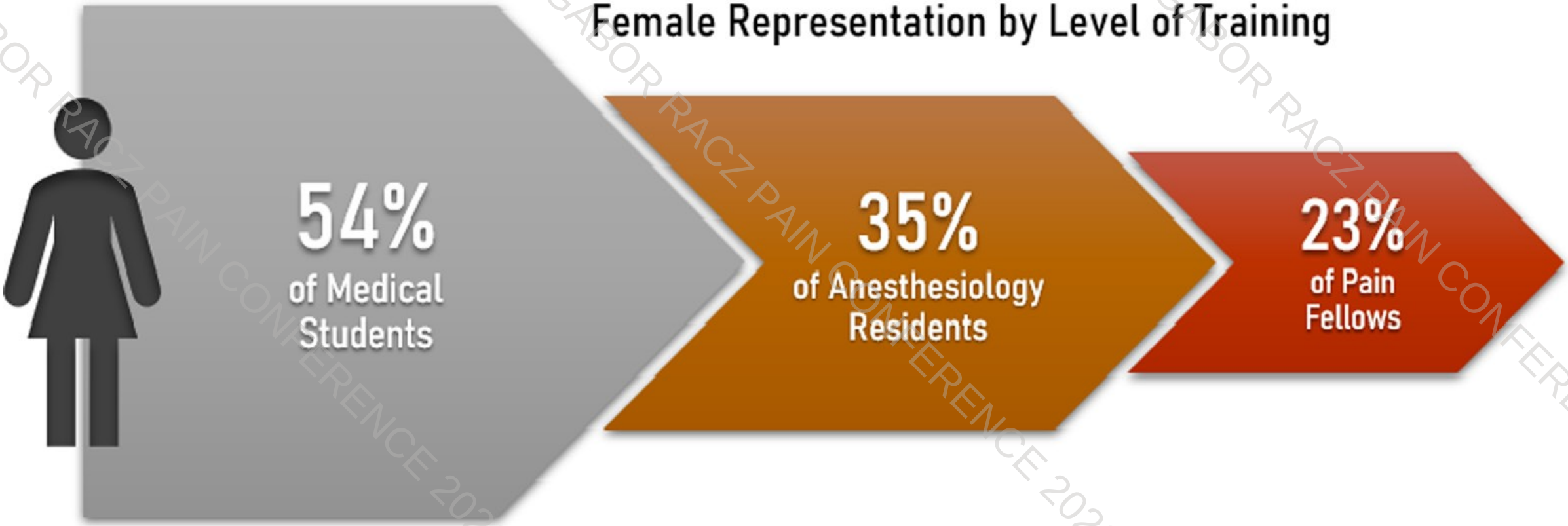

PAIN Practice

EDITORIAL

Not a match: Why women are not choosing pain medicine

Eliana Ege MD, Lakshmi Koyyalagunta MD, Saba Javed MD

First published: 03 June 2024 | https://doi.org/10.1111/papr.13381



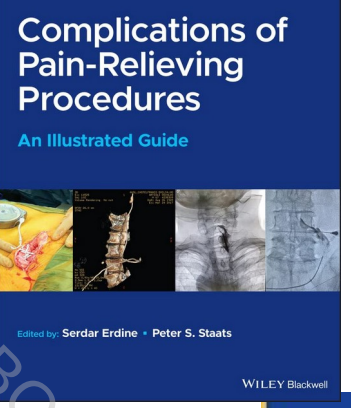
Ege, E., Koyyalagunta, L. and Javed, S. (2024), Not a match: Why women are not choosing pain medicine. Pain Pract. https://doi.org/10.1111/papr.13381

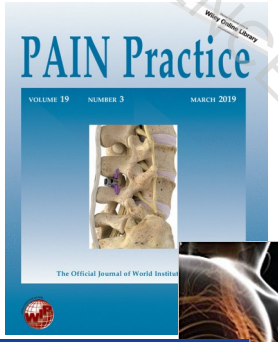
Involve Women!

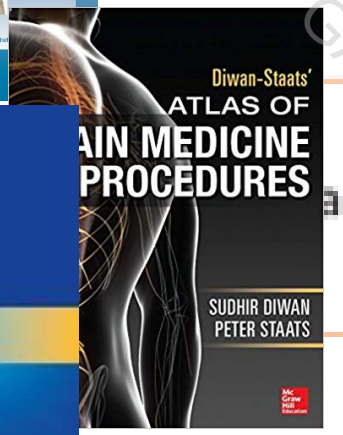
The WIP Mission

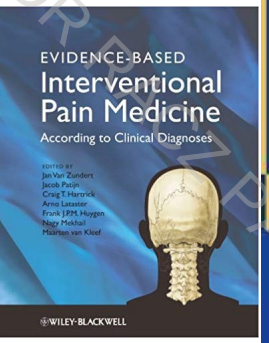
WIP provides pain medicine educational resources, specialized hands-on training and workshops, related conferences and seminars, exchange of clinicians, and is an international community of experts in the field. We promote personal and practice growth with the support of a global group that is passionate about patient care. Expand your accolades with the FIPP|CIPS Board of Examination certification.

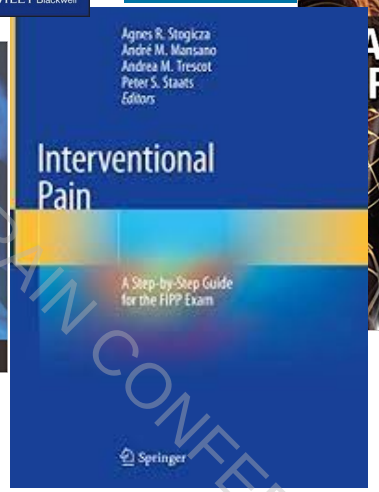
Improve quality of Pain Medicine

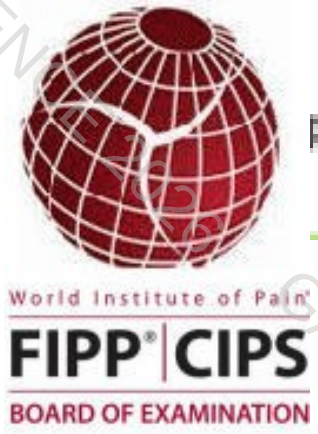












How to evaluate educational programs

REVIEW

Evaluating pain education programs: An integrated approach

Adam Dubrowski PhD[1,2,3,4], Marie-Paule Morin MD[1,5,6]

A Dubrowski, M-P Morin. Evaluating pain education programs: An integrated approach. Pain Res Manage 2011;16(6):407-410.

L'évaluation des programmes d'enseignement sur la douleur : une approche intégrée

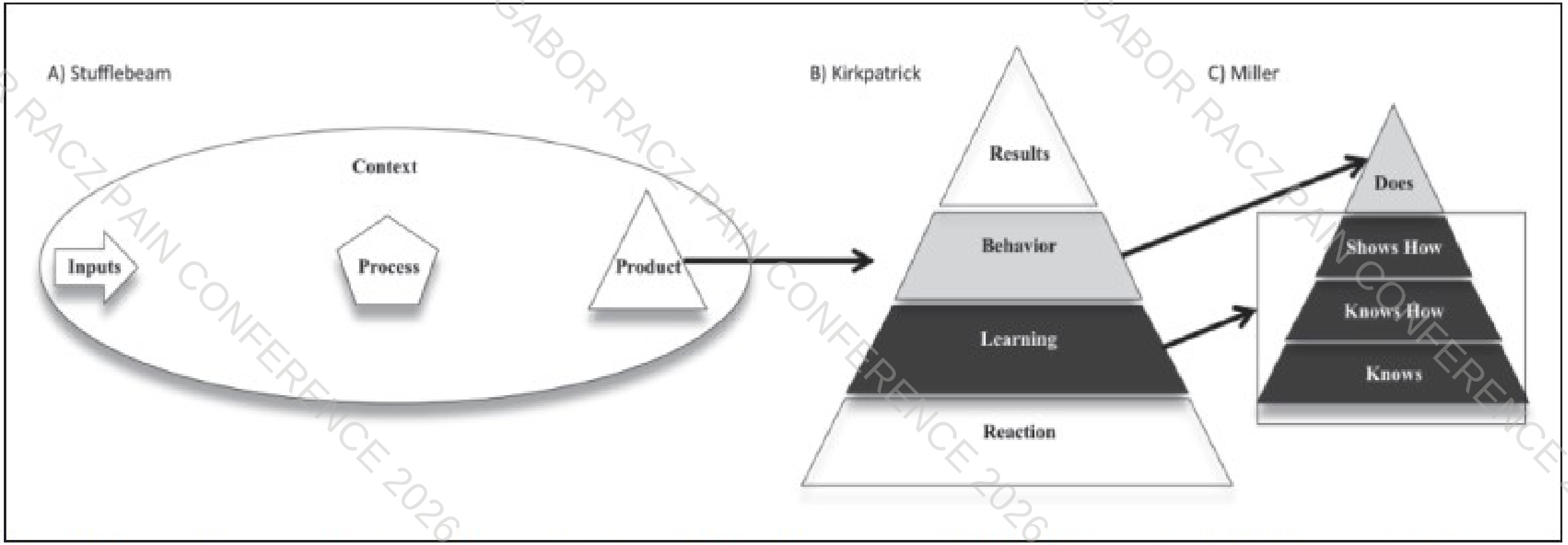
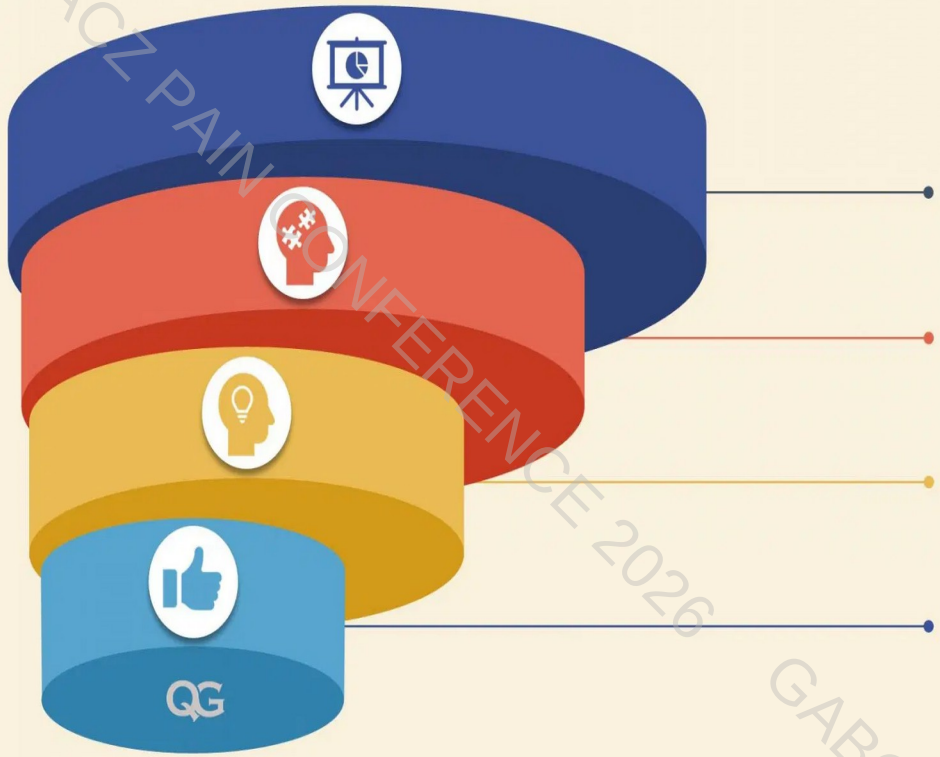
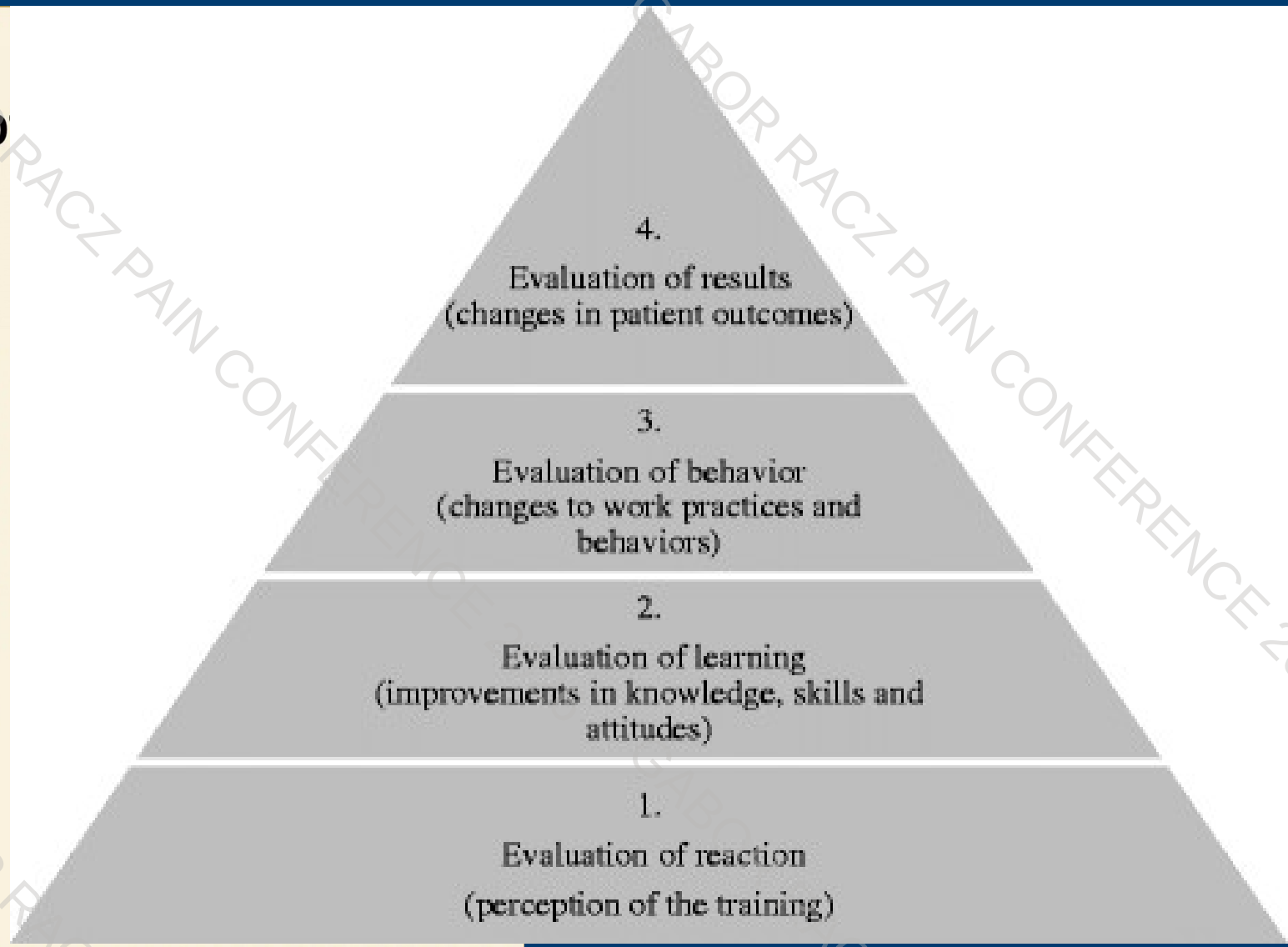
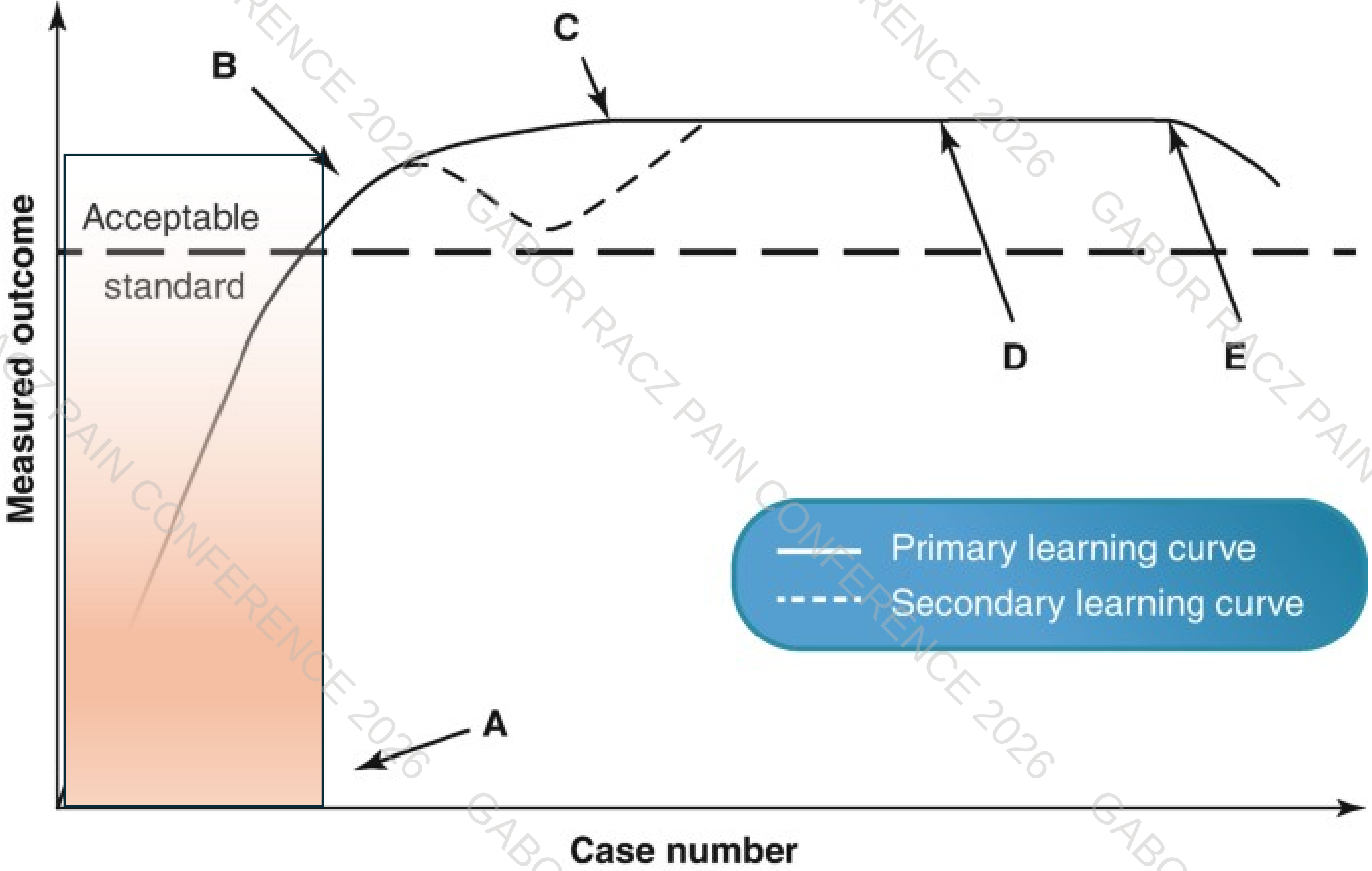


Figure 1) *Integrated program evaluation model. Panels* **A** *to* **C** *are the pictorial representations of* (**A**) *Stufflebeam et al's (8) CIPP (context, inputs, processes and products) model,* (**B**) *Kirkpatrick's Learning Evaluation Model (5) and* (**C**) *Miller's Clinical Assessment Framework (6). The CIPP is a process-based model in which outcomes or products are only part of the program evaluation. Kirkpatrick's model outcomes can help evaluators in reaching decisions about what outcomes to measure and where to measure them. Finally, according to Moore et al (14), Miller's framework can be helpful in deciding on the choice of assessments to address the specific outcomes*

THE KIRKPATRICK TRAINING EVALUATION MODEL







Teaching the Epidural Block, Chapter, First Online: 20 May 2020 pp 145–160

About simulation...

About simulation…

Angélique du Coudray (1712-1794)

La “Machine”
1755

She saved thousands of babies


GABOR RACZ PAIN CONFERENCE 2026

“Good judgement comes from experience, unfortunately, experience comes from bad judgement”

Unknown

Heliyon 9 (2023) e18249

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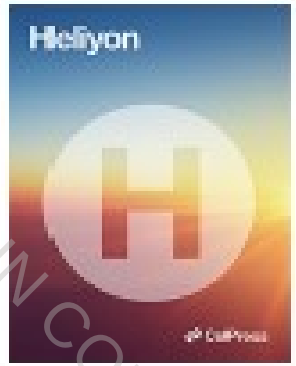


Review article

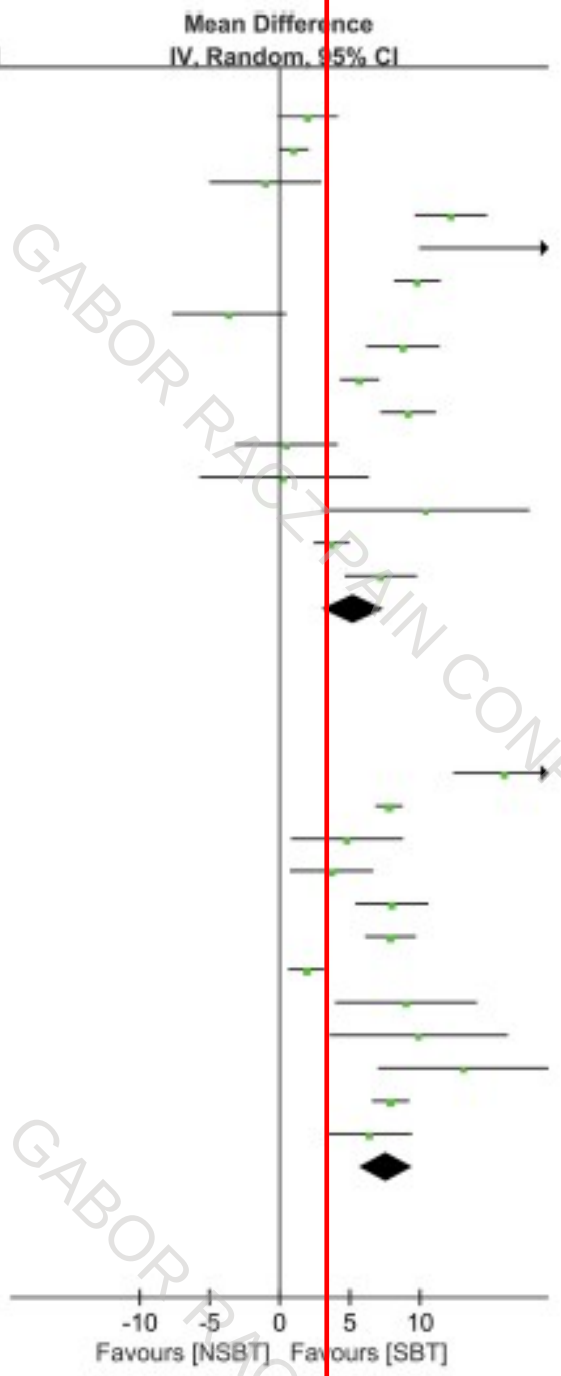
Simulation based training versus non-simulation based training in anesthesiology: A meta-analysis of randomized controlled trials

Yi Su, Yi Zeng *

Department of Algology, The People's Hospital of Dujiangyan, No 622 Baolian Road, Dujiangyan, Sichuan, 611830, China

Kirkpatrick 3

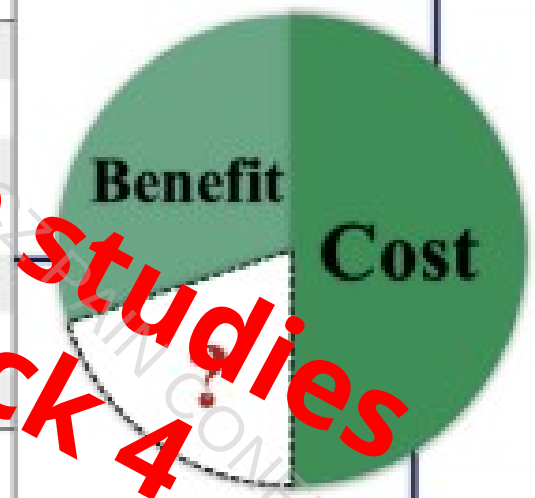
Study or Subgroup	SBT Mean	SD	Total	NSBT Mean	SD	Total	Weight	Mean Difference IV, Random, 95% CI
1.1.1 Theory test								
Cao 2020	88	4.2	24	86	3.4	24	7.5%	2.00 [-0.16, 4.16]
Gong 2016	85	3.5	107	84	4.5	107	7.9%	1.00 [-0.08, 2.08]
Guan 2016	80.6	3.6	10	81.6	5.3	10	6.4%	-1.00 [-4.97, 2.97]
Ke 2017	85.6	5.7	50	73.4	7.3	50	7.3%	12.20 [9.63, 14.77]
Li 2014	81.3	13.6	16	61.3	15.4	16	3.0%	20.00 [9.93, 30.07]
Lin 2015	89.9	5.2	67	80.1	4.5	67	7.7%	9.80 [8.15, 11.45]
Sheng 2016	79.1	3.9	10	82.7	5.3	10	6.3%	-3.60 [-7.68, 0.48]
Su 2019	89.76	5.17	25	80.97	4.14	25	7.3%	8.79 [6.19, 11.39]
Wang 2019	92.1	2.8	36	86.4	3.2	36	7.8%	5.70 [4.31, 7.09]
Wei 2015	90.25	3.71	29	81.1	3.95	29	7.6%	9.15 [7.18, 11.12]
Wu 2016	75.3	7.2	30	74.8	7.2	30	6.6%	0.50 [-3.14, 4.14]
Xie 2016	92.5	6.7	10	92.2	7.1	10	5.0%	0.30 [-5.75, 6.35]
Zhao 2017	79.3	11.5	20	68.9	12.3	20	4.3%	10.40 [3.02, 17.78]
Zhong 2018	89.2	4.5	108	85.5	4.7	99	7.9%	3.70 [2.44, 4.96]
Zou 2015	92.6	5.7	50	85.4	7.3	50	7.3%	7.20 [4.63, 9.77]
Subtotal (95% CI)			**592**			**583**	**100.0%**	**5.28 [3.06, 7.49]**
Heterogeneity: Tau² = 15.78; Chi² = 199.92, df = 14 (P < 0.00001); I² = 93%								
Test for overall effect: Z = 4.67 (P < 0.00001)								
1.1.2 Skill test								
Ferrero 2014	83	6	21	67	6	21	7.9%	16.00 [12.37, 19.63]
Gong 2016	89	3.2	107	81.2	4	107	10.7%	7.80 [6.83, 8.77]
Guan 2016	85.6	4.5	10	80.8	4.6	10	7.5%	4.80 [0.81, 8.79]
Sheng 2016	84.9	2.9	10	81.2	3.8	10	8.7%	3.70 [0.74, 6.66]
Su 2019	89.62	5.27	25	81.62	3.99	25	9.2%	8.00 [5.41, 10.59]
Wang 2019	91.5	3.2	36	83.6	4.5	36	10.0%	7.90 [6.10, 9.70]
Wei 2015	93.31	3.01	29	91.37	2.06	29	10.4%	1.94 [0.61, 3.27]
Wei 2018	95.84	3.29	19	86.84	10.72	19	6.3%	9.00 [3.96, 14.04]
Xie 2016	93.4	5.7	10	83.5	8.5	10	5.0%	9.90 [3.56, 16.24]
Zhao 2017	85.7	9.1	20	72.6	10.5	20	5.3%	13.10 [7.01, 19.19]
Zhong 2018	88.5	4.3	108	80.6	5.3	99	10.4%	7.90 [6.58, 9.22]
Zou 2015	89.6	8.4	50	83.2	6.9	50	8.7%	6.40 [3.39, 9.41]
Subtotal (95% CI)			**445**			**436**	**100.0%**	**7.63 [5.70, 9.57]**
Heterogeneity: Tau² = 8.90; Chi² = 96.16, df = 11 (P < 0.00001); I² = 89%								
Test for overall effect: Z = 7.73 (P < 0.00001)								



Patient outcome studies needed=Kirkpatrick 4

Kirkpatrick framework	Evaluation items	Meta-analysis results	GRADE quality
Reaction	Satisfaction	Favored SBT	Low
	Confidence	Favored SBT	Low
Learning	Skills	Favored SBT	Moderate
	Knowledge	Favored SBT	Moderate
Behavior	Short-term	Favored SBT	Low
	Long-term	?	-
Results	?	?	-

Reaction: how learners perceive the educational intervention
Learning: learning of skills and knowledge
Behavior: learners' behavioral changes in professional setting
Results: the effect of learners' actions



Huge

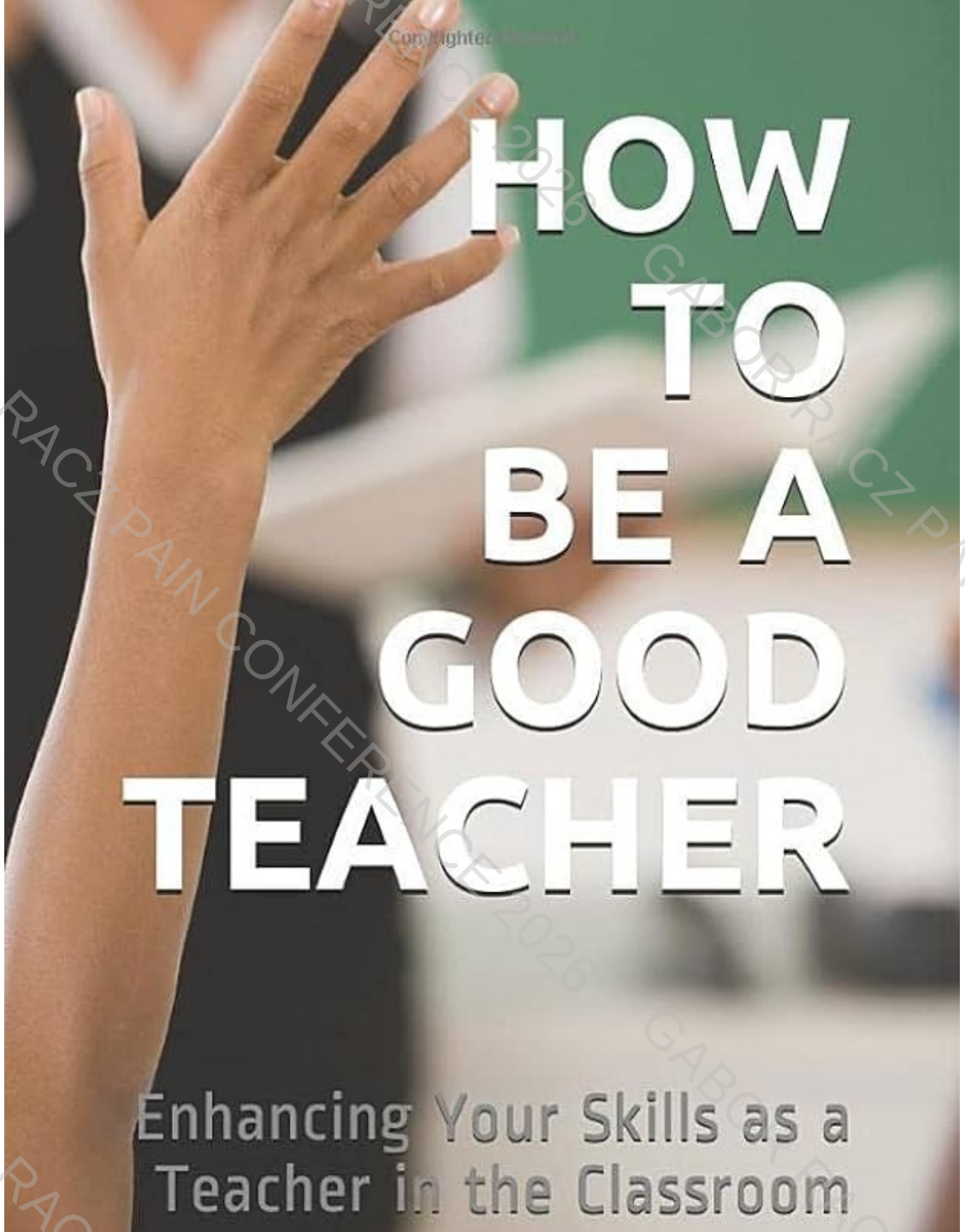
Investment	Gaps
Feedback	Evidence-based model, sound recording system
Simulation fidelity	High-fidelity and multi-model mannequins
Instructor training	Simulation teaching skills, mastery learning models, training for various devices

Hard

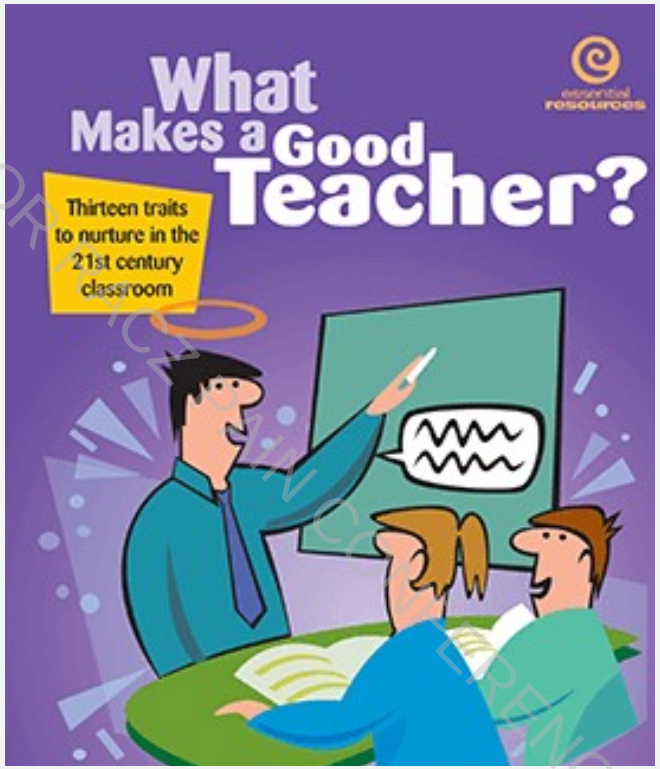
Implementation	Gaps
Deliberate practice	Sites, equipment, time for practice
Curriculum integration	Mix with existing learning modalities
Skill maintenance	Mechanism of skill decay and maintenance, follow-up evaluation

Fig. 3. A summary for the benefit and cost of simulation training.

MOST IMPORTANT - PATIENT OUTCOME: EFFECT AND COMPLICATIONS



Educator– certification?



1. Passionate and professional
2. Structure for growth
3. Optimistic
4. Communicator
5. Empathic listener
6. Facilitator
7. Ethical
8. Well prepared and group of educators must teach the same things
9. Good class room managers

CERTIFICATE OF RECOGNITION

Outstanding Teacher

This certificate is awarded to

Recipient Name

for exceptional skill and performance in the field of Teaching

Date

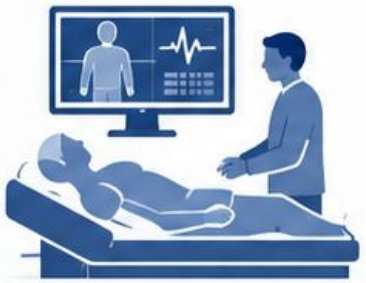
DATE

Your Signature

YOUR TITLE

Effective Educational Methods

1 Simulation-based curriculum



- Fellows
- Knowledge gain + transfer to clinical practice
- Kirkpatrick levels 1–3
- Sarno et al., 2022

2 Simulation + bedside teaching

- Medical students
- Better practical-exam performance
- Simulation-first outperformed ward-first
- Kurz et al., 2021

3 E-learning + simulation

- Medical students
- Greater knowledge + confidence
- Better than e-learning alone
- Poulsen et al., 2019

4 Hybrid course

- Nurses
- **39.7%** knowledge gain
- **86–89%** reported improved clinical skills
- Siddiqui et al., 2025

Knowledge → **Confidence** → **Competence** → **Clinical practice**

Educational interventions improve nurses' knowledge and attitudes: **SMD 2.41**

Yuan et al., 2024

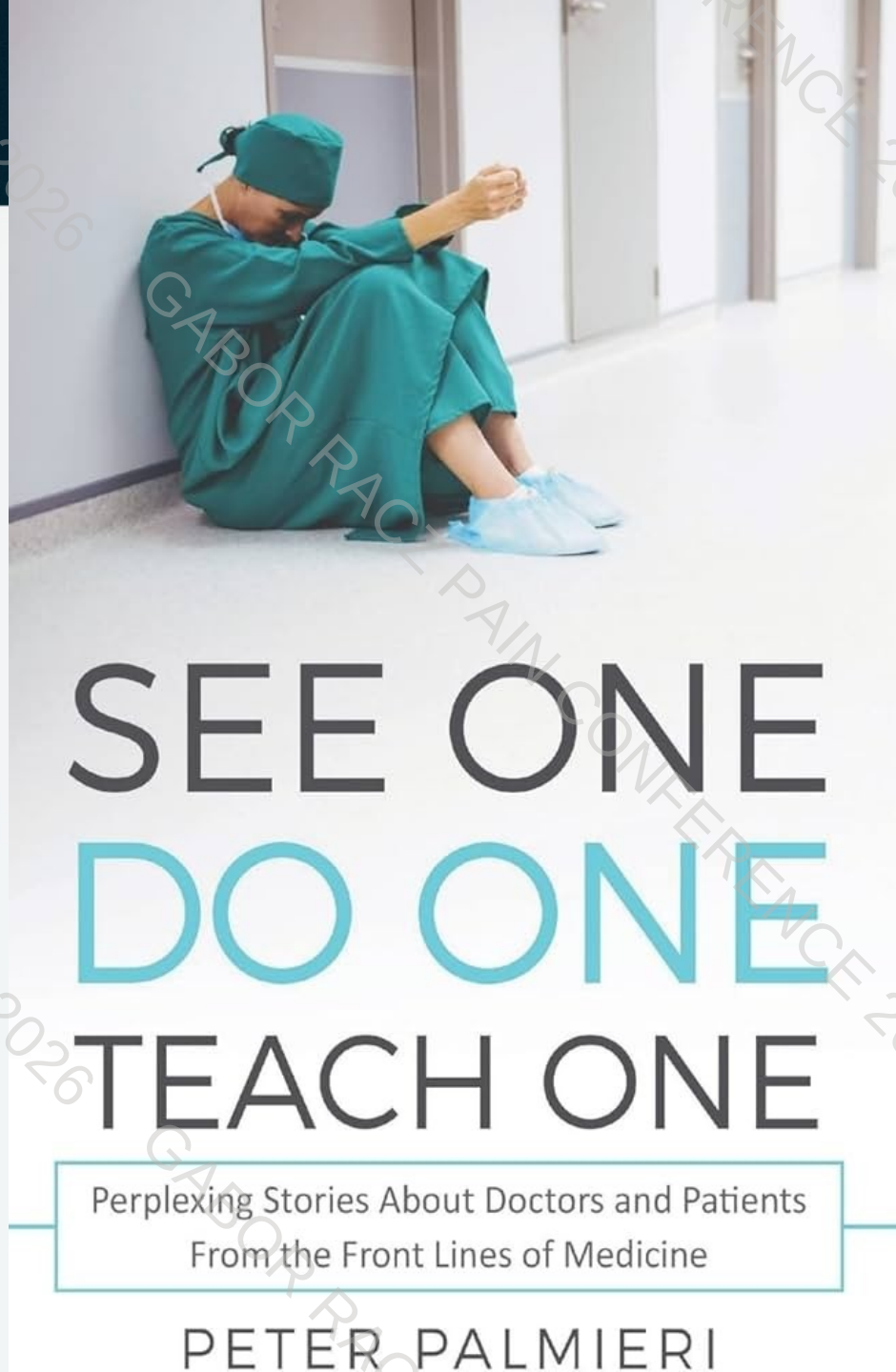
EVIDENCE BRIEFING · AUGUST 2026

Fellowships Interventional Pain Medicine

Master–apprentice model of education

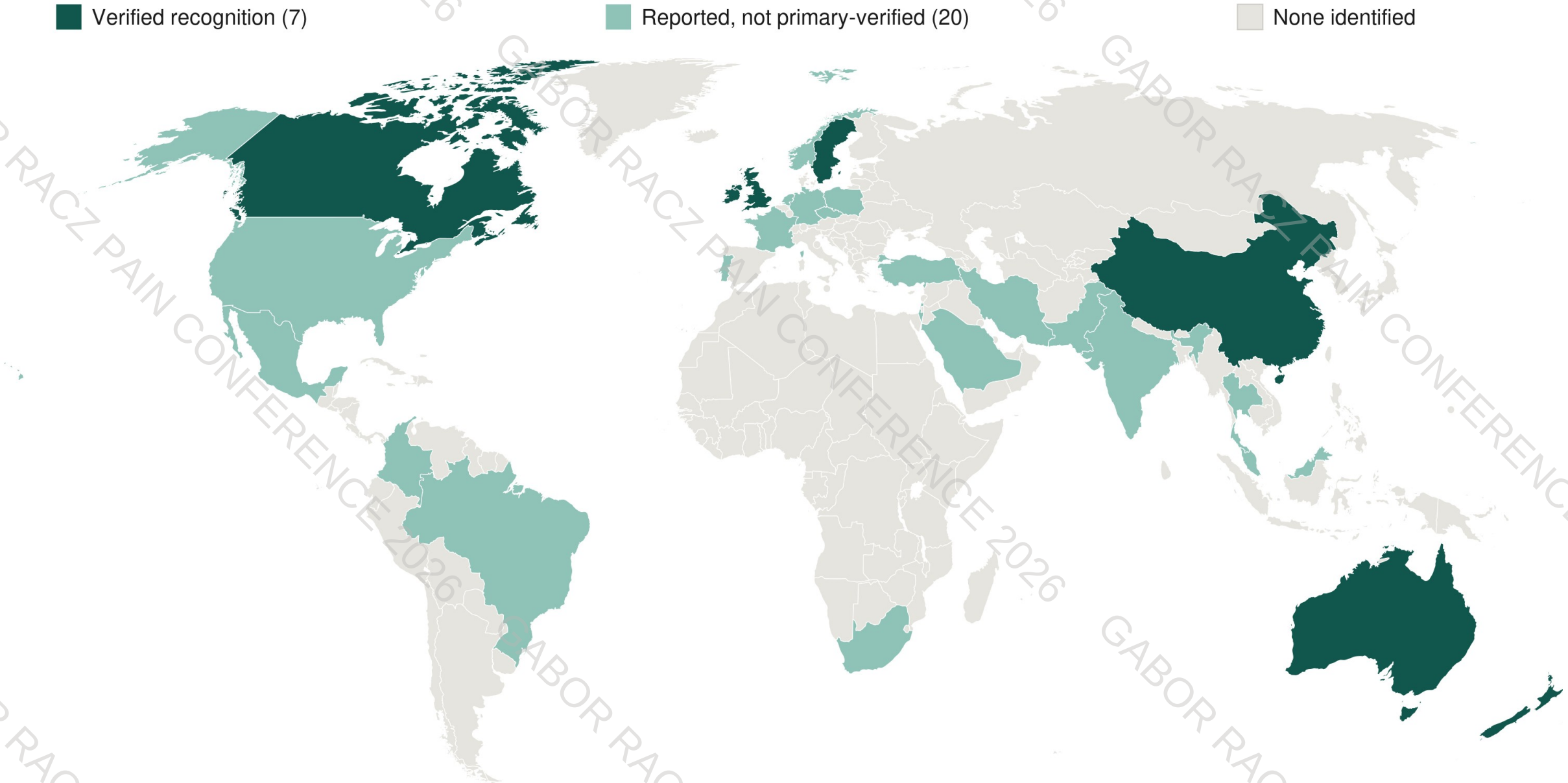
Three questions the title collapses: Is fellowship sufficient? Is it necessary? Is it the right shape?

See one, do one, teach one!



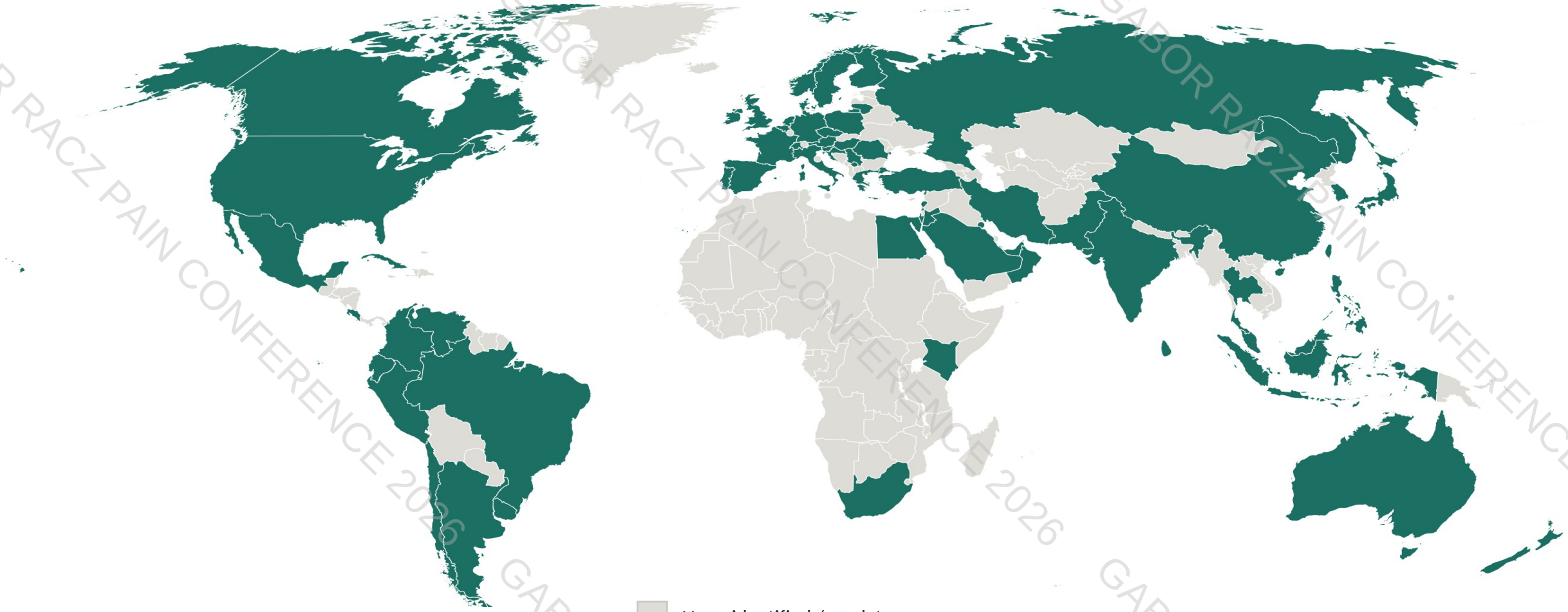
Government or statutory recognition of pain medicine as a trained field

Countries where a structured pain medicine training pathway is recognised by the state or its statutory medical regulator
Indicative compilation, August 2026 — no authoritative global registry exists



Meanwhile, many countries of the world has no pathway at all

Countries where at least one structured pain fellowship or formal training pathway was identified



Indicative compilation, Aug 2026 — no authoritative global registry exists. Grey does not prove absence. Verify before citing.

The debate over whether one year is enough is a debate available only to the shaded countries. Sub-Saharan Africa outside South Africa and Kenya, much of Central and Southeast Asia, and most of Central America have no identified pathway.

Traditional fellowships;

Two findings from the same 24-month window, rarely discussed together

7%

of employers say fellowship graduates are ready for independent practice

National survey of pain physician employers, n = 196 (2024)

17.7%

of accredited fellowship positions went unfilled

NRMP pain medicine match, AY2025 — 320 of 389 positions filled

A quality complaint and a demand collapse at the same time. Any argument that fellowship should be longer has to explain why a programme that already cannot fill its posts should ask for another year.

Wahezi et al., J Pain Res 2024;17:4573–82 · NRMP Match Results Statistics, Pain Medicine, AY2025 /

THE TRAINING GAP

HIGH-RISK SPINAL PROCEDURES DEMAND MORE THAN A SHORT COURSE.

Competent performance requires four essential domains.

COMPETENT SPINAL PROCEDURE PERFORMANCE REQUIRES FOUR DOMAINS

Some programs add two-week su

THE FELLOWSHIP MATCH DATA SHOW THE PROBLEM IS BECOMING MORE ACUTE

NRMP Data: Pain Medicine Fellowship Applications by Residency Background

PM&R applicants are now the largest single specialty group.

The fellowship is becoming more mixed in baseline preparation at the same time the procedures its graduates perform are expanding in complexity.

PATIENT SAFETY REQUI

PATIENT SAFETY REQUIRES MORE THAN GOOD INTENTIONS. THE STANDARD SHOULD BE COMPETENCY, NOT CREDENTIAL.

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Traditional One-Year [ACGME]-Accredited Fellowships

face growing pressure because they struggle to fit rapid advances in minimally invasive procedures and complex chronic care into a 12-month model.

THE CASE FOR REFORMING TRADITIONAL FELLOWSHIPS

1. TIME CONSTRAINTS

A single year forces programs to choose between deep clinical grounding and high-volume procedural training.

2. ADVANCED TECH GAP

Trainees often graduate with minimal exposure to complex devices like spinal cord stimulators or interventional spine implants, relying instead on post-graduate industry workshops.

3. MULTIDISCIPLINARY SHIFT

The applicant pool now includes diverse residencies (like PM&R, neurology, and emergency medicine), meaning trainees arrive with vastly different baseline skills.

WHY "TRADITIONAL" TRAINING STILL MATTERS

1. COMPLEX DECISION-MAKING

Safe intervention requires rigorous clinical reasoning, patient selection, and diagnostic accuracy that short weekend courses cannot replicate.

2. STANDARDIZED SAFETY

Formal programs ensure structured supervision in radiation safety, fluoroscopy, and complication management.

3. HOLISTIC CARE

Beyond procedures, fellowships teach essential opioid stewardship, behavioral health integration, and longitudinal patient management.

The arithmetic behind the complaint

One accredited fellowship year, decomposed

45
weeks
after leave, meetings, holidays

→

225
training days
split evenly between clinic and procedures

→

670
hours hands-on
procedural time, net of setup, consent, turnover

→

~130
hours
of advanced procedural training in the whole year

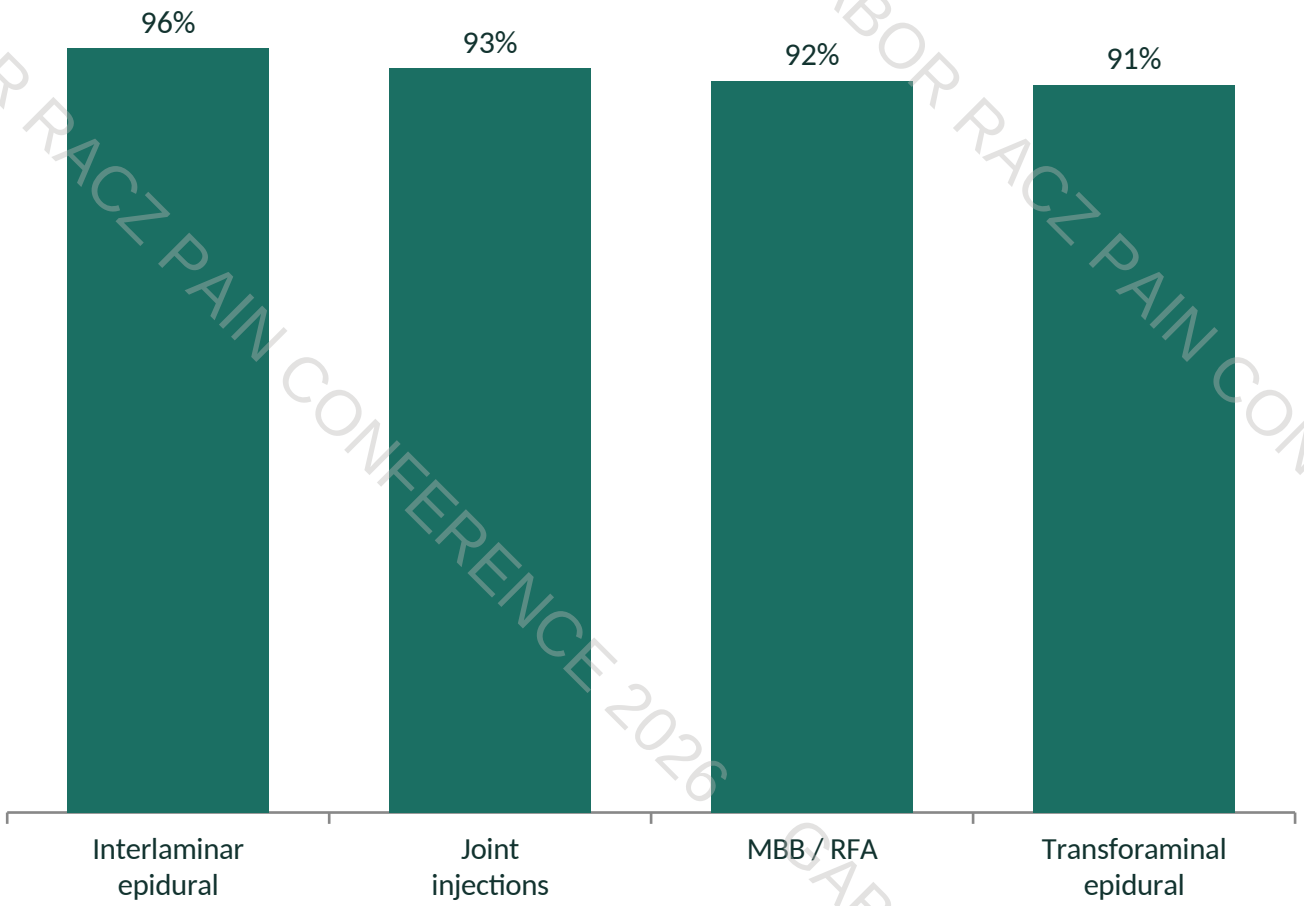
> *"The current fellowship structure can provide only introductory exposure, with the expectation that fellows will develop into competent pain physicians post-fellowship."*

Pritzlaff, Day, Wahezi & Schatman, on behalf of ~90 co-signatory Pain Medicine Luminaries — J Pain Res 2024;17:687

Figures as published; assumes advanced procedures ≈ 20% of procedural volume

What employers actually report

Graduates are rated competent at basic intervention — the gap lies elsewhere



Where the gap sits

- Advanced procedures — 73% rate SCS trials important; implantables and percutaneous spine procedures rated under-taught
- Billing, coding and practice management
- Psychological and behavioural aspects of pain treatment

85%

would not consider a candidate who was not procedurally trained during fellowship, while 79% say the practice, or industry, must provide further training after hire.

Wahezi et al., J Pain Res 2024;17:4573–82. Voluntary survey distributed via AAPM, ASIPP, NANS, ASPN; response rate not determinable

Three systems already train the next generation

Whatever accredited fellowship does not teach is being taught elsewhere

1

Non-accredited fellowships

Embedded in private practices. Apprenticeship-style, procedurally intensive. No external oversight of didactics, multidisciplinary rotations or breadth. Graduates face board-eligibility, credentialing and insurance-panel barriers.

2

Industry & society courses

Cadaver workshops, proctoring, device-specific training. Every programme director permits them; 59% actively encourage them. 54% say fellowship needs extending specifically to avoid depending on them.

3

Post-hire employer training

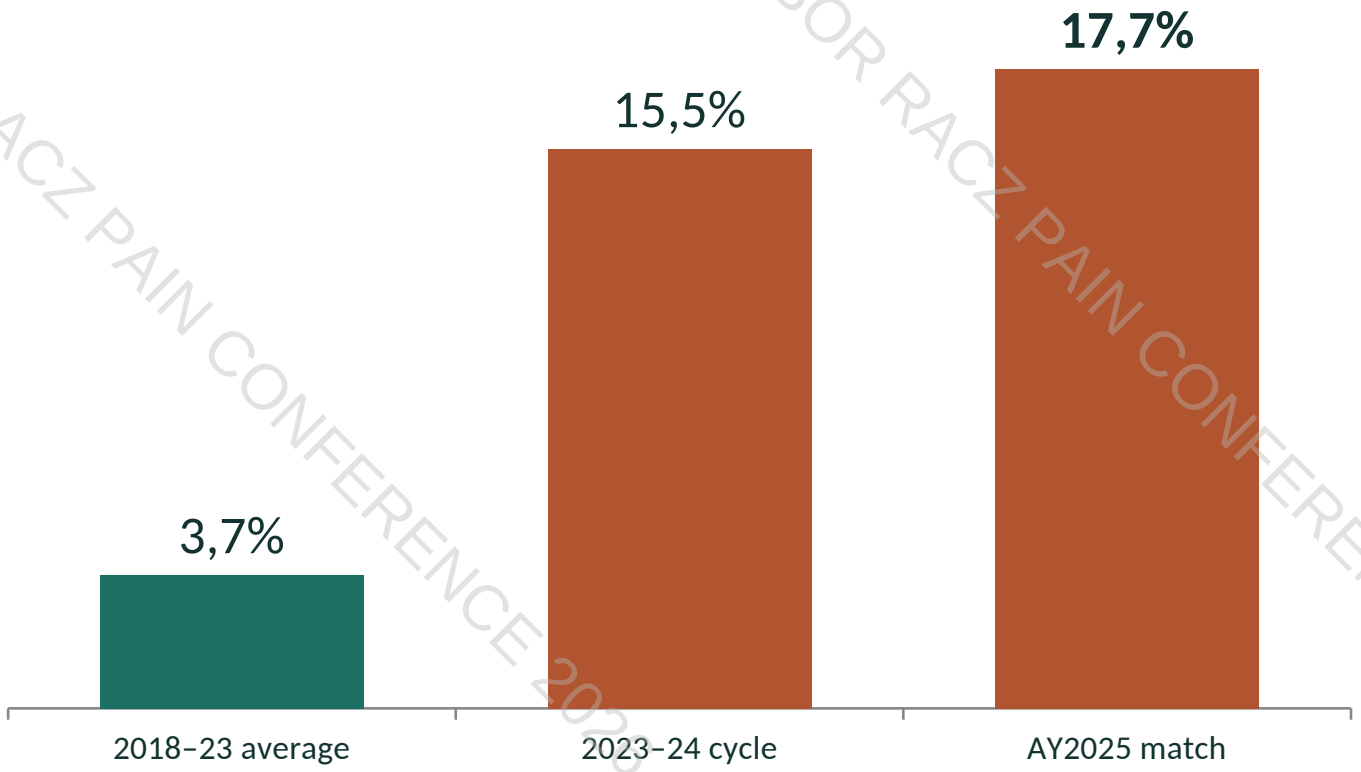
79% of employers say the practice, or industry, must complete the training after graduation. More than 70% of fellows report receiving more business education from industry than from their fellowship.

The training is happening either way. The live question is how much of it sits under independent oversight.

Tolba & Patel, ASRA News 2021 · APPD program director survey, Pain Pract 2024 · APPD trainee survey, Pain Physician 2024;27:E627–36

The market is answering independently of educators

Accredited fellowship positions left unfilled, by cycle



67.6%

of active programmes filled completely in the AY2025 match

Declining anaesthesiology applications, rising PM&R, neurology, psychiatry and EM entrants, a more heterogeneous cohort entering a fixed-length year.

NRMP Match Results Statistics, Pain Medicine AY2025 · Pritzlaff et al., Pain Pract 2025;doi:10.1111/papr.13441 — verify against NRMP report before citing

The question underneath the question

Traditional fellowships must change and become more attractive

What would actually resolve this

- Validated competency thresholds and EPAs, making training length an output, not an input
- Registry graduate case volume to complication and revision rates
- Track-based models tested, with independent accreditation (NOT industry based!)

Fellowships with evidence level Kirkpatrick 4 needed

Learning goals

1. Effective Learning
2. Effective Education and safe
3. **Effective examination: Improve FIPP and CIPS**


Cleveland Clinic
Crile Building
Patient Drop-Off

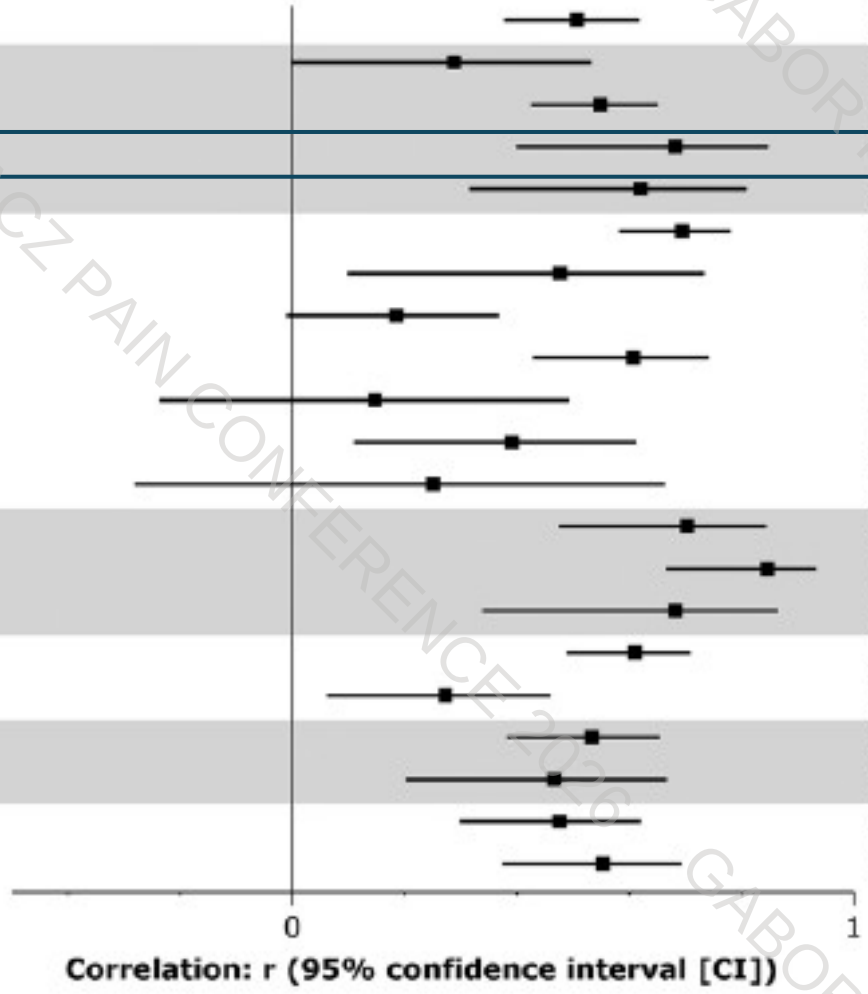
FIPP en CIPS

- FIPP started 2000
- CIPS first started in 2015
- Many other exam-locations started
- New exam-vignettes, other training and new questions
- Exams can be done in English, Spanish and in Portugese

Kirkpatrick 4

Simulation-based educational assessments

Feature	Subgroup	No. Studies (Participants)	r (95% CI)	I^2
All studies		27 (920)	0.51 (0.38, 0.62)	79
Trainees	Medical students	6 (364)	0.29 (0.00, 0.53)	83
	Postgraduate trainees	20 (549)	0.55 (0.43, 0.65)	64
	Physicians in practice	6 (164)	0.68 (0.40, 0.85)	83
	Nurse/nursing students	1 (27)	0.62 (0.31, 0.81)	
Task	Min. invasive surgery	10 (214)	0.69 (0.58, 0.78)	32
	Open surgery	6 (140)	0.48 (0.10, 0.73)	80
	Anesthesiology	6 (450)	0.19 (-0.01, 0.37)	72
	Bedside procedures	3 (72)	0.61 (0.43, 0.74)	0
	GI endoscopy	1 (28)	0.15 (-0.24, 0.49)	
	Nontechnical skills	1 (45)	0.39 (0.11, 0.61)	
	Airway management	1 (16)	0.25 (-0.28, 0.66)	
Instrument	FLS	3 (109)	0.70 (0.47, 0.84)	67
	GOALS	2 (26)	0.85 (0.67, 0.93)	
	OSATS	3 (44)	0.68 (0.34, 0.87)	48
Method of assessment	Direct observation	18 (435)	0.61 (0.49, 0.71)	65
	Rotation grade	8 (477)	0.27 (0.06, 0.46)	75
Timing (training)	Pre-training/none	20 (804)	0.53 (0.38, 0.66)	83
	Post-training	5 (99)	0.47 (0.20, 0.67)	45
Study quality	MERSQI>=13.5	16 (641)	0.48 (0.30, 0.62)	81
	MERSQI<13.5	11 (279)	0.55 (0.37, 0.69)	66



Linking simulation-based educational assessments and patient-related outcomes: a systematic review and meta-analysis. Brydges R[1] Acad Med. 2015 Feb;90(2):246-56.

FIPP & CIPS Alumni

1,680 FIPPs certified since 2001, from 69 countries

472 CIPSs certified since 2015, from 52 countries

- FIPP Pass Rate 2009-2023: 78.3% ± 0.1%

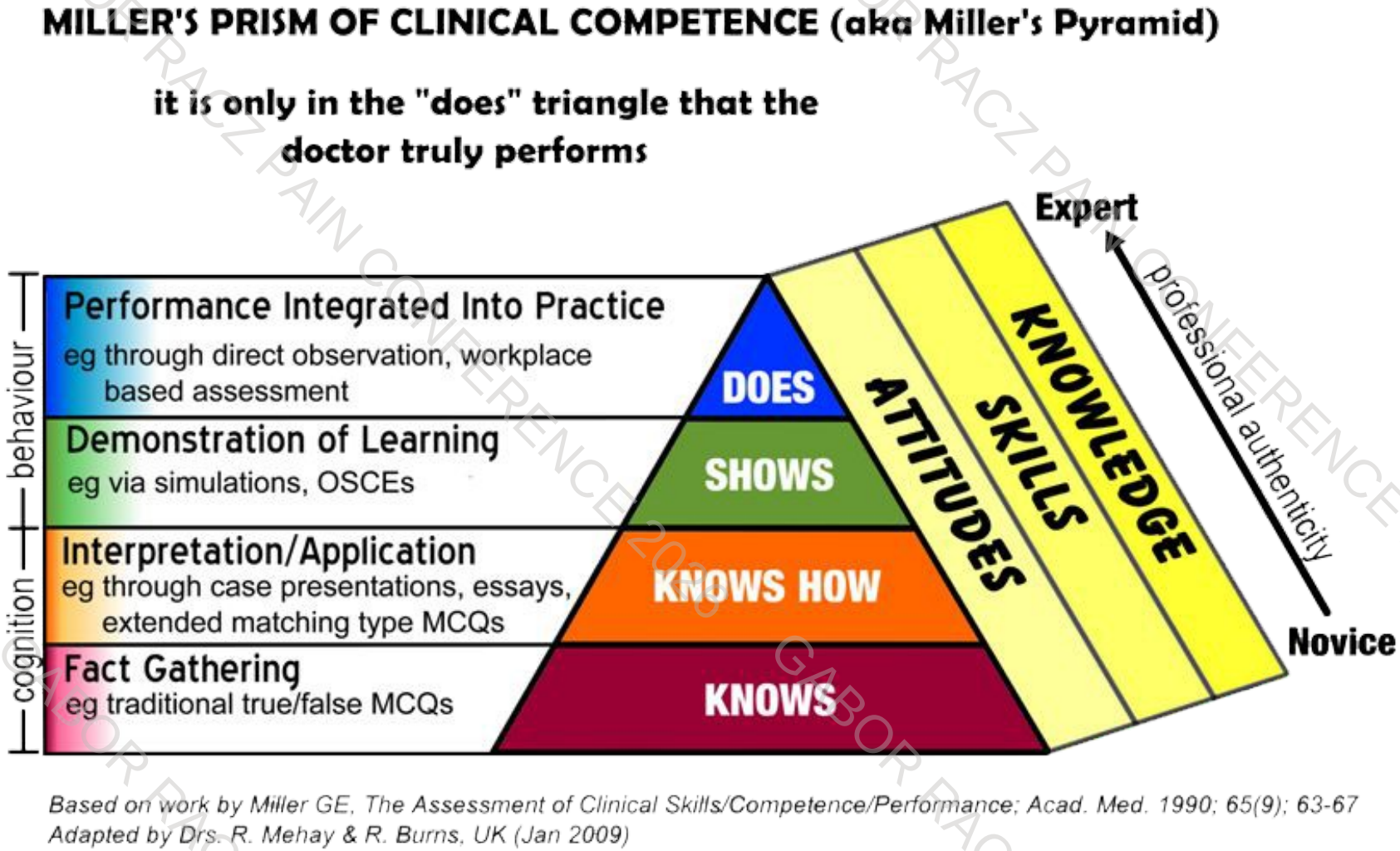
  -FIPP Pass Rate 2022-2025: 85.3% ± 0.1%

- CIPS Pass Rate 2015-2023: 75.6% ± 0.1%

  -CIPS Pass Rate 2019-2024: 78.4% ± 0.1%

What tests the exam FIPP&CIPS

Kirkpatrick 3



The Meaning of FIPP® & CIPS (i.e., Validity Argument)

WIP is making a claim:

- WIP affirms that Dr. < X > has demonstrated mastery of the discipline of interventional pain medicine, and we recognize and accept < him/her > as a rightful member of our fellowship of interventional pain practitioners.

WIP is confident in making this claim based on evidence of < his/her >:

- breadth of relevant clinical and scientific knowledge;
- depth of knowledge and clinical judgment/clinical decision-making; AND
- technical proficiency in the performance of essential interventional procedures.

Mark Tolliver, 2025

FIPP/CIPS Design

Breadth of Knowledge - Theoretical Component	100 MCQs
Clinical Judgment - Oral Component	1-2 Clinical Vignettes (2 Expert Examiners)
Technical Proficiency - Practical Component	4 Simulated Procedures (2 Expert Examiners)

Overall Assessment - Weighted Composite Score:

$$score_{wc} = .2z_{theo} + .2z_{oral} + .6z_{prac}$$

Mark Tolliver, 2025

Estimated Composite Reliability

Table 5: Overall Reliability Component Data			
Name	Theoretical	Oral	Practical
	.742	.640	.708

Overall Estimated Composite Reliability: *r* = .877

Exam	r	N /year
GRE	**.870-.950[1]**	**340k[2]**
IELTS	**.900[3]**	**~3.5M[4]**
TOEFL	**.950[5]**	**~1.5M**

[1]ETS, G. (2023). *Reliability and Standard Error of Measurement*. Educational Testing Service. https://www.ets.org/content/dam/ets-org/pdfs/gre/gre-reliability-standard-error-measurement.pdf
[2]https://blog.achievable.me/gre-exam/key-gre-statistics-from-the-2022-ets-gre-snapshot-report/
[3]https://ielts.org/researchers/our-research/test-statistics
[4]https://takeielts.britishcouncil.org/about/press/ielts-grows-three-half-million-year
[5]ETS, & TOEFL. (2020). *TOEFL® Research Insight Series, Volume 3: Reliability and Comparability of TOEFL iBT® Scores*. ETS.

Questionnaire FIPP

901 survey invitations sent, 335 responses were received (37.2%).

Importance of exam

Unimportant	Somewhat important	Important	Very important
6.7%(22)	20.1%(66)	26.5%(87)	46.6%(153)

Applies to practice

Not at all	To some extent	To a significant or great extent
0.6%(2)	24.5%(81)	74.8%(247)

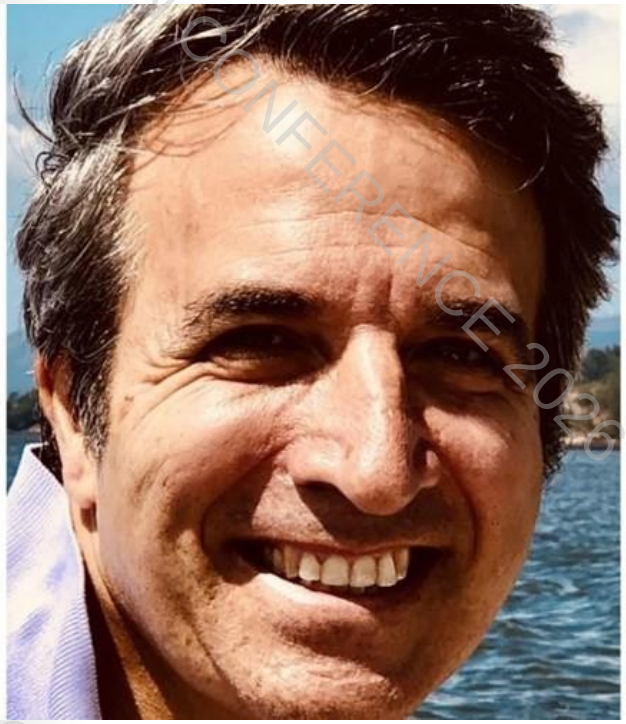
Exam component is valid	Yes	No	Uncertain
Written	90.3%(297)	2.4%(8)	7.3%(24)
Oral	94.2%(308)	1.5%(5)	4.3%(14)
Practical	96.6%(313)	0.9%(3)	2.5%(8)

Would recommend exam	Yes	No
	94.8%(312)	5.2%(17)

Interview done in 2018

Time to improve
Two registrars

FIPP

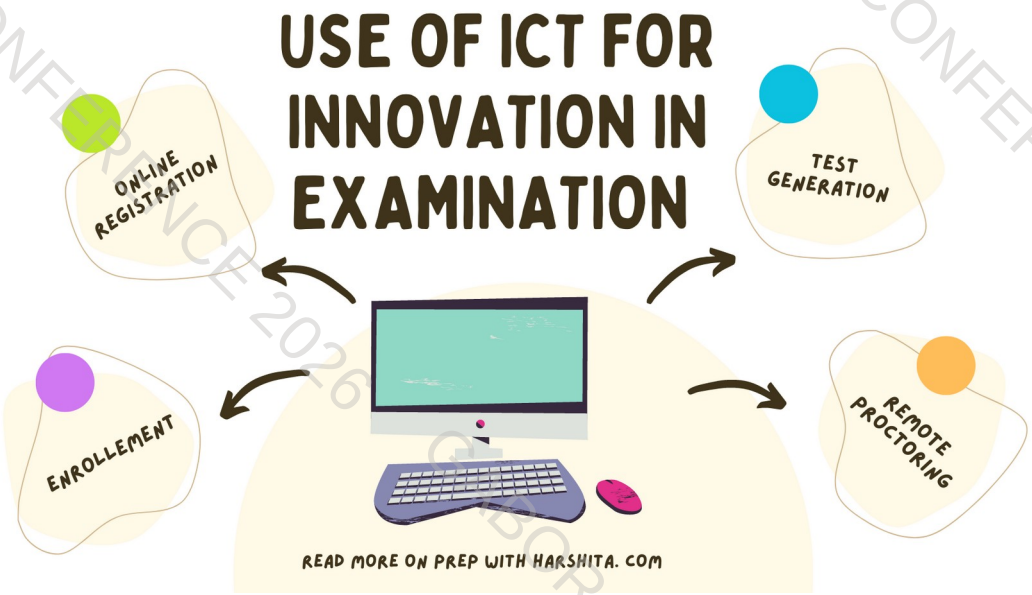


CIPS

What do we want to change in the exams of FIPP and CIPS?

Theoretical: new system for making questions

Online before the exam for FIPP and CIPS



Exam will be devided also in time in theoretical/oral/practical

We need a working-group for making exam-questions

>1000 exam questions

Oral online FIPP


We need a working-group for making vignets for FIPP and CIPS

Examiner-training – examiners school

Examiner certification


NATIONAL ASSOCIATION OF MEDICAL EXAMINERS

Grants Full Accreditation

of

Oakland County Medical Examiner's Office - Pontiac, Michigan [illegible]

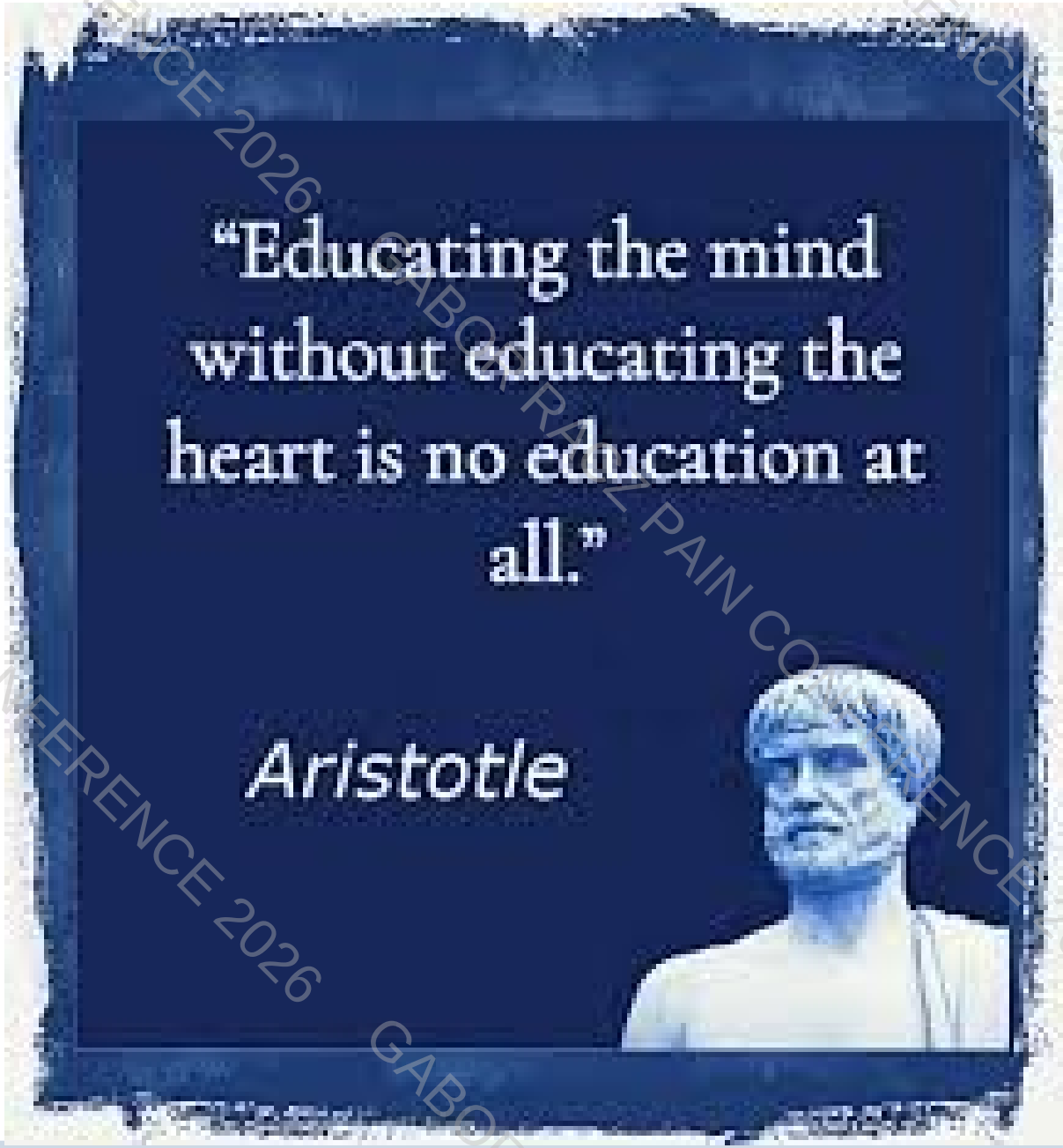
Inspected by and meets the Standards, Inspection, and Accreditation Criteria established by the National Association of Medical Examiners for providing and operating an effective Medicolegal Death Investigation System

Accreditation is granted for the period December 13, 20[illegible] to December 13, 2015.

Given this [illegible] day of May, 2012

The future

- Adding Augmented Reality
- Team training
- Patiënt training
- Kirckpatrick level 4 training and examining



Education and examination

1. **Traditional fellowships must change** and more open for other disciplinaries perspective (not only anesthesiology)

2. **Effective education and examination** in simulation improves patient outcome (Kirckpatrick 4)

3. **FIPP and CIPS are valid exams** but improvements are needed (Kirckpatrick 3)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