

# Review of Medical Schools in Ireland 2003



A report to the public by the Medical Council

Comhairle na  
nDochtúirí Leighis



Medical  
Council

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## FOREWORD

We are pleased to present our second report to the public on undergraduate medical education in Ireland. It is based on the findings of our recent visits to the medical schools, which have been ongoing since 1996.

An Irish medical degree allows doctors to work in a local or international context. Doctors trained in Ireland are highly valued by their patients both in Ireland and overseas. Such doctors are good ambassadors for a profession with high standards and ideals.

Producing highly trained doctors is a strategic national asset that reflects well on the country, attracts the brightest and best school leavers from home and abroad and caters for our health needs. As a national asset it requires attention, development, high standards and the esteem and confidence of the public. We have not, alas, looked after medical education in a manner that allows us to reassure the public that all is well.

The last report drew the public's attention to the chronic under-funding of medical education. This situation has deteriorated, with increasing reliance on foreign students to fund the training of our own doctors. The Medical Council has significant concerns about the sustainability of this dependence. We think it is time that Ireland paid its way in producing its own doctors for its own needs.

There are real concerns about the quality of medical education in Ireland. We make no apology for applying international standards to our medical courses. Medical education is changing rapidly and Irish medical schools are struggling with standards. The Council's judgement is that we still produce competent graduates but in circumstances that require heroic commitment from the staff of our medical schools.

The Government is now taking the future of medical education more seriously with the establishment of a working group on medical education under the chairmanship of Professor Patrick Fottrell. This is welcomed as serious intent and the Medical Council will advise the public on progress. The Medical Council has now established its own Directorate of Education under the guidance of Professor Paul Finucane. The Director will have the job of working with the medical schools in meeting international standards of best practice in medical education.

The Medical Council has significant concerns about exclusive graduate entry courses as recently proposed by government; these include:

- The exclusion of school leavers may deter some students from a career in medicine
- Structures for curricular change are not in place

- The proposed timescale is not adequate to allow preparation
- Graduate entry may not be equitable as the funding arrangements have not been clarified and may require entrants to be self-funding
- A graduate course must be compatible with national and EU legislation
- Reducing the numbers of graduates (no entry in 2005 and 2006) has significant manpower implications and will lead to shortages

The Medical Council strongly endorses the place of graduates among medical students; however the case for exclusive graduate entry remains to be made.

We wish to acknowledge the generous input of lay and medical colleagues who have helped in preparing this report. We also acknowledge the expert input of Professor Maurice Savage, Queen's University Medical School in Belfast and Professor Gordon Page, University of Vancouver Medical School, Canada. We wish to acknowledge the organisational skills of Ailbhe Mealy in organising the visits and the presentational skills of Deirdre Handy in getting this report together – both of Trinity College Dublin. Finally we acknowledge the heroic efforts of all the Deans of our medical schools and their dedicated administrative and teaching staff in trying to modernise medical education in circumstances that are very tough.

**Professor Gerard Bury**  
*President*

**Professor Tom O'Dowd**  
*Chair Education & Training*

## SUMMARY OF RECOMMENDATIONS

### National/strategic recommendations

- Medical education in Ireland should conform to international best practice
- Medical education should be aligned with the needs of the health services in Ireland
- Medical schools need to develop social accountability to the public
- Medical schools need to be involved in manpower planning for the future
- Governance and administration in our medical schools needs development
- Modernisation of medical education needs to continue at an increased rate
- The intake of medical students is capped to 2003 levels for each medical school as capacity has been reached under our current teaching methods
- Take immediate steps to renew capacity
- The case must be made for adequate funding
- The reliance on overseas funding must be reduced
- Accredited standards for staff, facilities and learning
- Implement recommendations to schools

### Recommendations to schools

- Provide coherent, integrated planning and delivery of education
- Improve governance and administration
- Curriculum evaluation is essential
- Bullying and student isolation must be addressed
- The dominance by medicine and surgery of clinical teaching must be balanced by teaching in other disciplines and settings
- Exposure to general practice/primary care is deficient and must be improved
- Further development of electronic teaching and learning is needed
- The network of affiliated hospitals for student training should be further developed

### Next steps in accreditation

- Differential licensing of schools for two, three or four years will commence in 2005
- Real-time monitoring of medical schools will be established
- Regular, benchmarked self-assessments will be carried out by schools
- Planned inspections will continue (including student and lay involvement)
- Prior Medical Council approval will be required for significant changes
- Publication of data will occur from the accreditation process

## MEDICAL EDUCATION IN IRELAND

### Background

There are five medical schools in Ireland based in University College Cork, National University of Ireland Galway, University College Dublin, Trinity College Dublin and Royal College of Surgeons in Ireland. The medical schools either have or are moving to five year courses which produce medical graduates who are conferred with degrees of MB (Bachelor of Medicine) BCh (Bachelor in Surgery) and BAO (Bachelor in the Art of Obstetrics).

Two Malaysian medical schools are also accredited by the Medical Council. Penang Medical College provides clinical training to students who have completed their initial courses at UCD and RCSI. The International Medical University (Kuala Lumpur) provides the initial years of training for students who then receive clinical training in Ireland.

On graduation the new doctor works as an intern in Irish hospitals or recognised hospitals elsewhere, during which time they receive internship registration with the Medical Council. On successful completion of the internship they are issued with a Certificate of Experience by the Dean of the medical school and are then entitled to proceed to full registration with the Medical Council.

An Irish student enters medicine at 18 or 19 years of age, commonly after repeating his / her leaving certificate in order to secure enough points for entry to the course. There has been a gradual increase in the number of females with two thirds of each annual intake now being female.

In 2003 some medical schools required 575 points in the Leaving Certificate examination to enter medicine. The current Minister for Education & Science has indicated that from 2007 a primary degree will be needed for entry to medical school and this is referred to as 'graduate entry'.

The medical course has traditionally been divided into a pre-clinical phase, comprising the basic sciences of physiology, biochemistry and anatomy, and a clinical course comprising most of the subjects in Table 2.

Medicine makes heavy demands on the student with attendance at lectures, practical classes, seminars and clinical teaching, in addition to private study and electives during the summer vacation. After qualification the new doctor, on completing an internship, then begins several years of training in hospital or the community in order to become an independent specialist.

## **Student Origins**

### ***EU and Ireland***

This year we obtained information about the origins of Irish medical students from some of our medical schools. The 2003 classes at UCD and TCD originated from 26 and 25 counties respectively on the island of Ireland with the majority coming from non-fee paying schools. In UCD nearly three out of four entrants (71%) came from non-fee paying schools and in TCD the figure is two out of three (66%). Interestingly, of the 21 students coming from the so-called grind schools to UCD in 2003, 71% attended non-fee paying schools prior to their grind school (data from Professor MX Fitzgerald, UCD). The 2003 medical student entry at NUI Galway is almost entirely from non-fee paying schools.

### ***Overseas students***

Irish medical schools also attract large numbers of overseas students and in 2003 the numbers of overseas students outnumbered those from the European Union area. These students are referred to as non-EU students in this report. Over 30 countries can be represented in Irish medical schools bringing a wide range of cultural, personal and healthcare beliefs to each class. These students are also an important economic factor in the running of Irish medical schools, and indeed in the Irish economy.

## **The Medical Council's Role**

The 1978 Medical Practitioners Act requires that the Medical Council satisfies itself as to the content and delivery of medical education in Ireland. The Medical Council has placed education at the heart of its mission to protect the public interest. Since 1996 it has arranged regular visits to the medical schools to inspect the courses and to meet the teaching faculty and students.

Following each visit a report is issued to the individual medical school and recommendations are made which are then reviewed on subsequent visits.

This report follows on the 2001 Report to the Public and presents information on the changing nature of medical education in Ireland.

## **The accreditation process**

In 2003, the Medical Council formally adopted a proposal to accredit medical education in Ireland. This decision represents a natural evolution from the annual or biannual inspection using informal criteria to a licensing system based on internationally recognised standards for medical education. In this case, the

World Federation for Medical Education's (WFME) Basic Medical Education standards were adopted, having been contextualised for the Irish setting. This process introduces key criteria which must be fulfilled and draws on the independent assessment of medical educationalists from other countries.

The accreditation process began in 2003 with the introduction of formal standards, international externs and structured evaluation instruments. Its further implementation will involve a range of steps spelled out later in this document but ultimately resulting in a transparent, rigorous and individualised evaluation of each medical school.

### **International dimension**

Ireland has a long and honourable tradition of producing doctors who have worked in many parts of the world. University College Dublin and the Royal College of Surgeons in Ireland are associated with Penang Medical College, and TCD and NUIG are associated with the International Medical University; both schools are in Malaysia.

### **The accreditation visits**

Following the Medical Council visit to the medical schools in 2001 a follow up visit in 2003 was planned before this Council ends its current term of office in April 2004. Detailed preparation for the visit began in August 2003 with the submission of a questionnaire based on the WFME guidelines for medical schools. The WFME guidelines shaped both the objectives of the visits and the nature of the data collected from the medical schools. This approach has the potential to allow some degree of international comparison.

The World Federation of Medical Education international guidelines on Basic Medical Education are available at the WFME website – <http://www.wfme.org>.

The visits have become increasingly professionalised, demanding significant commitment from both the medical schools and the Medical Council. Council assembles a team of visitors with experience of previous visits and interest and expertise in medical education (listed in Appendix 3). In addition to Medical Council members, Council co-opts members with special expertise. In 2003 the visiting teams included lay and medical members of Council, lay members of the public and a patients' representative. They also included international experts in the field of medical education, namely Professor Gordon Page, University of British Columbia, Vancouver, Canada, and Professor Maurice Savage, Queen's University Belfast. Each visiting team had a core of visitors who took part on all visits.

There was an average of eight visitors to each school, who contributed 109 days work to the process. We met 149 teachers and hospital, health board and university management personnel, 97 student representatives and 63 interns or first year doctors.

The costs of the visits were borne by the Medical Council and came to around €30,000 – although not analogous, it is useful to note that this represents less than the costs of two days Fitness to Practice hearings. The Irish visitors were not remunerated for their work.

Each visitor completed an evaluation instrument covering:

1. Organisation and staffing (four sub-themes)
2. Educational quality approach (four sub-themes)
3. Delivery of teaching (four sub-themes)

The overall results from the evaluation are included in this report but are not reported individually for each school.

The first day of each visit was hosted by the Medical Council at Lynn House in Dublin or at independent venues in Cork and Galway, in October 2003. The second day of the visit was conducted at a major teaching centre associated with the medical school, where meetings were held with senior clinical staff, hospital management, university management, interns and students.

A key part of each visit was a confidential meeting between the visiting teams and representative groups of students without any staff members present. Students had the opportunity to prepare submissions or speak informally and information from these meetings was approved by the students before being reported. A similar approach was taken when meeting interns.

## **AIMS AND OBJECTIVES OF THE VISITS**

### **Overall aim**

To apply international standards to medical education in Ireland.

### **Objectives**

Our objectives during each visit were to review:

1. Responses to the Medical Council 2001 recommendations.
2. Governance, administration and academic environment of the Faculty and medical school.
3. The educational objectives, course structures and planning processes, curricular materials, recruitment and preparation of teachers.
4. The curriculum as taught including societal issues, assessment procedures and examination results.
5. Curricular management resources and evaluation.
6. Medical school structures for wider relationships.
7. The medical school's strategic direction.
8. Intern reform.

### **1. The 2001 Recommendations: Summary of progress**

Table 1 presents the current implementation status of previous Medical Council recommendations by the medical schools. There has been progress in the areas of behavioural science and medical ethics with partial implementation in all schools. There are some Special Study Modules in some schools in which students can study an area of special interest in-depth. There has been a significant improvement in the area of student representation which is in place in all schools. However many of the other areas still fall into the categories of 'partial implementation' or 'awaiting implementation'.

**Table 1. Current implementation status of Medical Council recommendations (1996 to 2001) by medical schools.**

|                               | Fully Implemented | Partially implemented | Awaiting implementation |
|-------------------------------|-------------------|-----------------------|-------------------------|
| <b>Curriculum</b>             |                   |                       |                         |
| Core definition               |                   |                       |                         |
| Content balance               |                   |                       |                         |
| Medical ethics                |                   |                       |                         |
| Behavioural sciences          |                   |                       |                         |
| Special study modules         |                   |                       |                         |
| Factual load reduced          |                   |                       |                         |
| Evaluation of change          |                   |                       |                         |
| <b>Facilities</b>             |                   |                       |                         |
| Clinical skills laboratory    |                   |                       |                         |
| Teaching and study facilities |                   |                       |                         |
| Library space                 |                   |                       |                         |
| Student representation        |                   |                       |                         |

## **2. World Federation of Medical Education benchmarks**

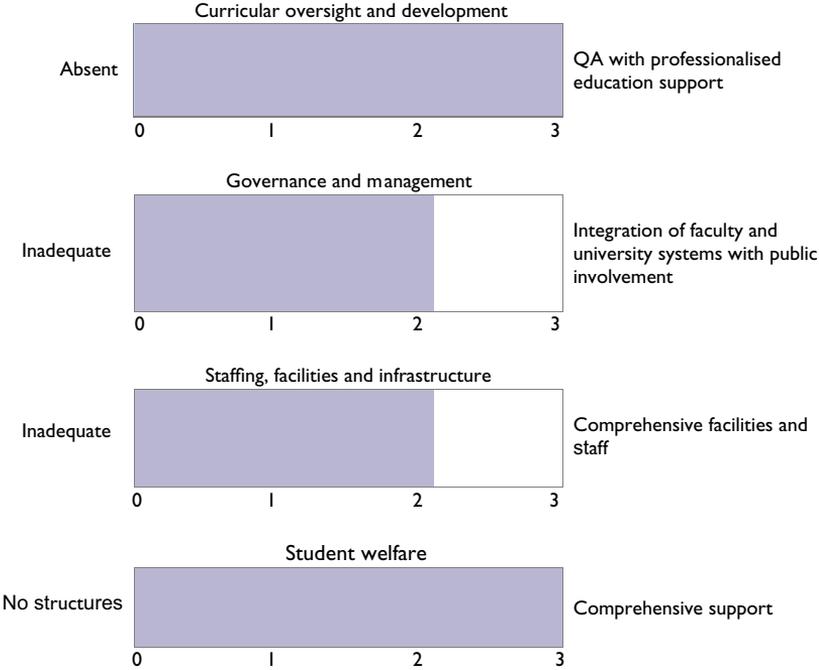
Each medical school visitor was asked to complete an evaluation instrument based on the WFME guidelines, as applied to the Irish context. The themes and sub-themes were:

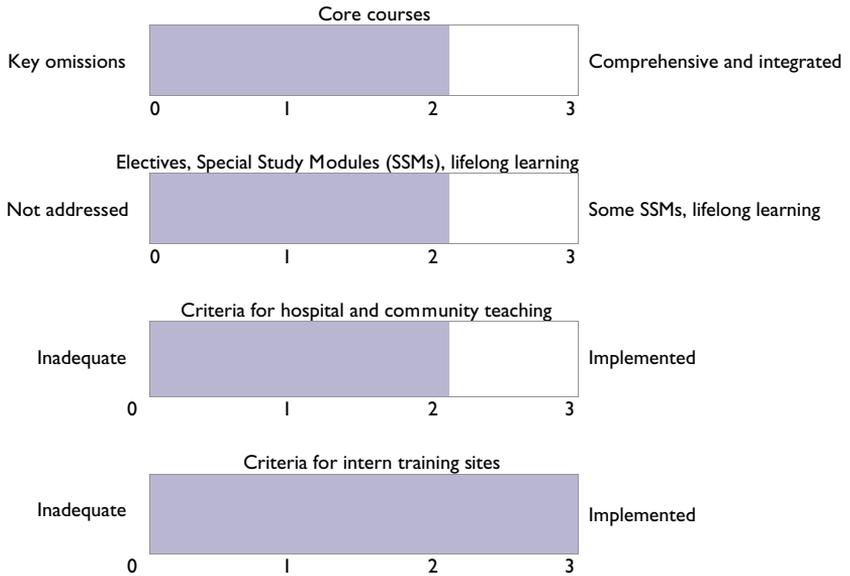
1. Organisation and staffing
  - Curricular oversight and development
  - Governance and management
  - Staffing, facilities and infrastructure
  - Student welfare
  
2. Educational quality approach
  - Core courses
  - Electives, SSMs and lifelong learning
  - Criteria for hospital and community teaching sites
  - Criteria for intern teaching sites
  
3. Delivery of teaching
  - Teaching methods
  - Core content
  - Course integration
  - Exams/assessment

The findings from the evaluation show variable achievements in the schools. Some schools scored highly on individual factors but few schools scored highly across the three themes and their subsets. Overall the findings indicate that some schools are falling below some of the WFME international benchmarks.

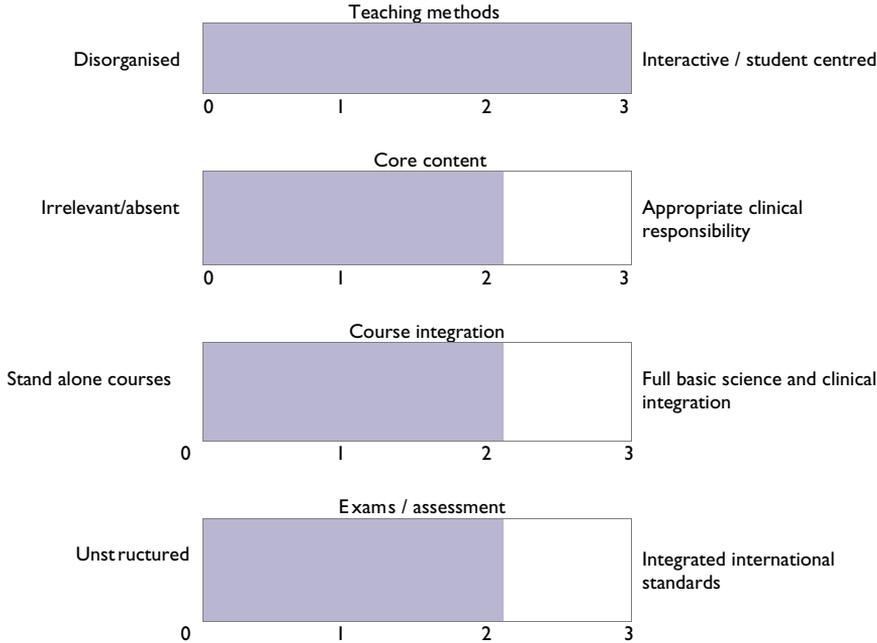
The following figures present the range of scores (0-3) awarded by visitors to all schools for each of the three main themes (each with four sub-themes) used in the evaluation instrument.

**Figure 1. Theme I: Organisation and staffing (range 0 to 3)**



**Figure 2. Theme 2: Educational Quality Approach (range 0 to 3)**

**Figure 3. Theme 3: Delivery of teaching (range 0 to 3)**



### **3. Core curriculum**

Since 1997 the Medical Council has urged that medical schools define their core curriculum for each subject area and for the overall curriculum. By this, Council means that each qualifying doctor should have a guaranteed minimum level of knowledge and skills and have completed a common set of programmes. Significant progress has been made in the pre-clinical area but Council is not satisfied that a core curriculum is in place in the clinical area of undergraduate education.

Teaching methods are still disorganised with insufficient interactive, student centred learning. In modern medical education it is now accepted that learning in small groups is the best method for the development of professional attitudes, retention of knowledge and learning new skills. In all schools there is still extensive reliance on the lecture as a teaching tool despite the international evidence on its educational limitations. Lectures are unsuited to areas such as attitudinal development, acquisition of skills in medicine, problem identification, problem solving or professional development.

Council has concerns that student assessments are not in line with international best practice and is urging the schools to introduce a menu of formative and summative assessment methods that more fairly and reliably tests student abilities and learning.

### **4. Curricular quality and development**

On this round of visits it was obvious to the visitors that the pressure on the health services has diluted the enthusiasm of teaching staff in the medical schools. Most clinical teachers have major contracts with the health services and minor or non-existent contracts with the universities, which allows the Dean little or no leverage to introduce modern teaching and learning methods. Governance and management in some schools is weak with insufficient integration of the faculties or schools within their universities. Some schools have little or no control or oversight of their curricula with stand-alone, non-integrated courses being all too common. While all schools are committed to quality assurance, in reality there is little professional support and time for this despite the evident benefits to those schools which are involved in QA.

### **5. Curricular balance**

The clinical curriculum in the main is dominated by a small number of specialities which have served well in the past but which must now be reviewed to ensure a broader range of experience for students. Future doctors need a

balance of clinical learning opportunities in order to allow them to respond to the changing needs of society. There is evidence that the balance of curriculum in the clinical areas has shifted in some schools with an even greater reliance on medicine and surgery than in 2001 (Table 2). While there has perhaps been insufficient time since the 2001 visit to introduce major change in the clinical curriculum, the absence of any change is disappointing. While all schools now include medical ethics in their programme, it often allows little opportunity for small group discussion and is not integrated with the clinical disciplines. Appendix 4 outlines this data in more detail.

**Table 2. Range of time spent (%) on clinical specialties in 2001 and in 2003 across the medical schools.**

|                            | <b>2001 Range</b> | <b>2003 Range</b> |
|----------------------------|-------------------|-------------------|
| Medicine                   | 15 – 24           | 15 - 27           |
| Surgery                    | 14 – 28           | 14 - 32           |
| Obstetrics and Gynaecology | 6 – 22            | 6 - 12            |
| Paediatrics                | 7 – 10            | 9 - 13            |
| General Practice           | < 1 - 15          | 2 - 5             |
| Public Health Medicine     | < 1 – 7           | < 1 - 7           |
| Ethics                     | < 1 – 2           | < 1 - 2           |
| Psychiatry                 | 5 – 9             | 6 - 8             |
| Laboratory Sciences        | 6 – 9             | 2 - 10            |

The influence of behavioural science in medicine is continually emphasised by Council and is now established in all medical schools. However Council has anxieties that the science of behaviour is not a sustained and integrated part of undergraduate teaching. Council cautions against behavioural science being used solely as a programme for personal development for students. While undoubtedly challenging student attitudes, psychology and sociology have a body of knowledge that is of similar importance to the more traditional clinical subjects in educating and preparing our students for the future.

Little progress has been made on Special Study Modules, whereby students can undertake in-depth study of a relevant area that particularly interests them in an assessed, well prepared module.

## **6. Primary care / general practice**

General practice remains a minor part of the curriculum in most medical schools in Ireland. There is significant international healthcare interest in primary care and many national governments, including Ireland's, are encouraging a shift to a primary care model; however this is not reflected in medical education in Ireland. Since the 2001 visit there has been minimal increase in community exposure for our students, with many medical students experiencing only 8 – 10 days in general practice throughout their entire medical course. There is virtually no exposure to community based paramedical specialties or to the delivery of public health medicine.

While current funding arrangements prevent the full realisation of the potential of general practice and primary care in the medical schools, the Medical Council urges Deans and faculties to include more general practice and primary care in their curricula in order to achieve more balance in medical education. In addition, over half of all graduates apply for general practice training and it is important that they gain more GP experience in order to make an informed career decision.

## **7. Teaching facilities and Information and Communication Technology (ICT)**

Some medical schools have state-of-the-art lecture theatres, seminar rooms with video conferencing and ICT facilities. In other schools facilities are shabby, overcrowded and simply inadequate. Most schools have used the non-EU income to develop their infrastructure and those schools late into the non-EU market are suffering most. There has been little state investment in the infrastructure of our medical schools. Council has encouraged medical schools to develop clinical skills laboratories where students can be taught skills and practice them in a safe, non-pressurised environment before they enter the hospital wards or community. Such laboratories are in place in most schools and are in regular use. Again there is variation in the development of such laboratories with some having clinical teachers present when needed and others allowing restricted access to students.

There are interesting examples of good quality developments in electronic learning systems in some schools; this development is strongly encouraged.

## **8. Permanent and part-time teaching staff**

In the 2001 report the Council drew attention to the fact that the teaching of medicine to undergraduates is often delivered by part-time and occasional teaching staff who are often poorly remunerated and recognised by the medical schools. The five Irish medical schools have tiny numbers of perma-

ment teaching staff. This is estimated to be 39 full time equivalents in Ireland compared to 2,500 in the UK. The permanent staff rely for support on part-time and occasional teachers who themselves have many conflicting demands on their time.

The recent large increase in research funding in medical schools has meant that senior professors may not now be normally involved in curricular design or delivery of teaching. On this visit we found increasing evidence that staff enthusiasm for teaching is being affected by managerial, regulatory and clinical pressures and that it is still common for lectures and clinical teaching to be cancelled without adequate warning. Students report that 'no-show' rates of 30% for clinical teaching sessions are the norm.

In the regional and general hospitals outside the main teaching centres we noted that teaching is working well with staff who, although poorly remunerated for teaching, are enthusiastic to teach and patients who are accepting of students. In the 2001 report we encouraged the medical schools to nurture this development and this has happened in some schools. However, medical schools will need to recognise the efforts and commitment of the management, nursing and medical staff and invest in teaching facilities and accommodation for medical students in such centres. A process of affiliating such centres to the medical schools needs to increase in pace.

Teaching outside the main academic centres places significant financial burdens on students as they usually have to bear accommodation costs in two places simultaneously. This additional cost is recognised and refunded by some schools and not by others. Similar expenses are incurred by students attached to general practices outside their medical schools.

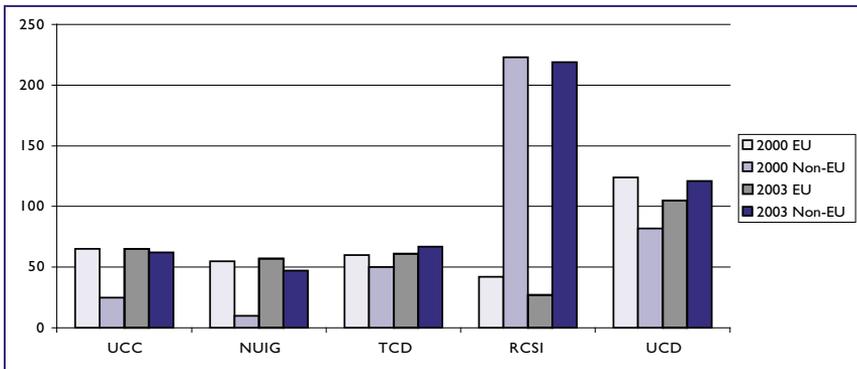
## 9. Student numbers

Figure 4 (EU and non-EU admissions 2000 and 2003) demonstrates the change in student numbers with 831 medical students in the 2003 intake, which is an increase of 14% on the 2000 figure of 736 students. There has however been a decrease of 9% (31) in the EU intake since the year 2000, from 346 to 315 students; 516 non-EU students were admitted. However it must be pointed out that all schools are fulfilling their HEA allocated quota of EU medical students which is:

|      |            |
|------|------------|
| UCC  | 60 places  |
| NUIG | 54 places  |
| TCD  | 60 places  |
| RCSI | 25 places  |
| UCD  | 106 places |

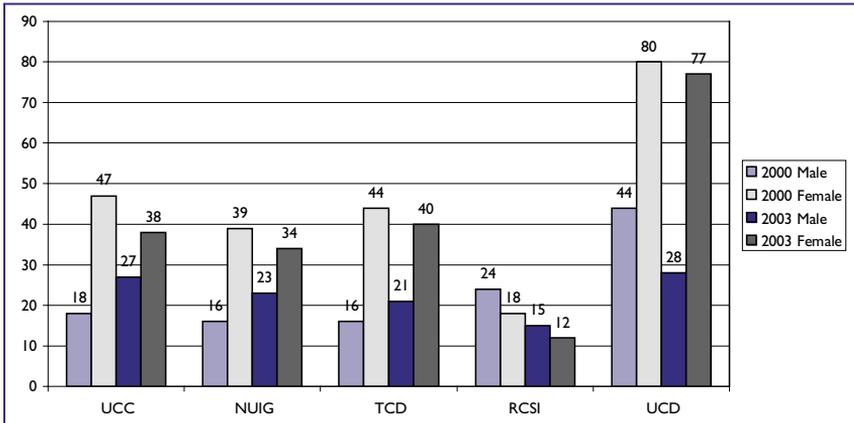
This quota agreement (the origins of which are 'buried in the mists of time') takes no account of current manpower needs and is in need of urgent revision. Meanwhile there has been a 32% increase in the intake of non-EU students from 390 in 2000 to 516 in 2003. In the three Dublin medical schools there are now more non-EU than EU students in the 2003 class intake. Both NUIG and UCC are headed in a similar direction.

**Figure 4. EU and Non-EU admissions 2000 and 2003**



### 10. Gender and workforce planning

In line with other developed and developing countries medicine in Ireland is feminised, (Figure 5 ) with about two thirds of the 2003 intake being female. This has significant implications for workforce planning and adds to an already complex workforce situation. While the recent Hanly Report (2003) on workforce planning sees a significant reduction in the numbers of junior doctors, the European Working Time Directive to be implemented in August 2004, may damage attempts to reduce junior doctor numbers. The Hanly Report in attempting to align medical training numbers with future staffing requirements concludes that we need 767 undergraduates annually to satisfy our medical needs over the next few years. This model seems to be based on the traditional male dominated medical profession and may not adequately address the future work patterns of both men and women which will include more flexible jobs with career breaks, maternity leave and job sharing. It seems to Council that the calculation of 767 doctors is unreliable and is probably an underestimate, given the current gender data from our medical schools.

**Figure 5. EU intake by gender 2000 and 2003**

## 11. The funding of medical education

In the 2001 report the Medical Council highlighted the variation in allocation of fees of non-EU students by universities to their medical schools. Significant changes have now occurred in fee allocation particularly in NUI Galway and Trinity College Dublin, with improvements in access by the faculties to non-EU fee income. The fears about sustainability of non-EU funding in 2001 continue to apply in 2003. Non-EU student income has subsidised Irish student education, staffing and facilities and there is an increased reliance on this income by our medical schools.

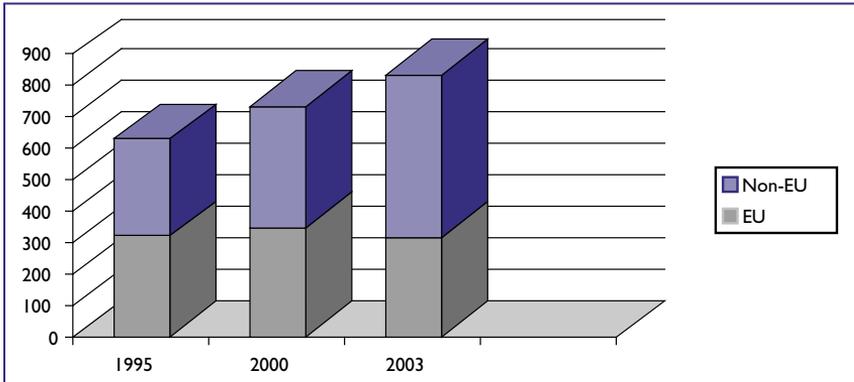
**Table 3. Annual income per student in Ireland, Northern Ireland and Canada**

| <b>Medical school location</b>         | <b>Annual income per student to school</b>   |
|--|--|
| EU students: Ireland                   | Range €8,000 – 12,500  |
| Non-EU students: Ireland               | Range €21,000 – 31,000   |
| Queens University Belfast              | Non-clinical Stg£5,880 (including a £1,125 student contribution)<br><br>Clinical Stg£13,230 (including a £1,125 student contribution) plus clinical lump sum to Clinical Trusts of Stg£25 million (£1,700 per week per clinical placement) |
| University of British Columbia, Canada | Can\$74,500 (including a \$14,500 student contribution)  |

At present, medical schools receive between €8,000 and €12,500 annually per EU student through their university HEA grant; the variability between medical schools is unexplained. A mean annual contribution of approximately €9,000 per EU student in medical school is acknowledged by the HEA in comparison with a sum of €26,604 provided by the HEA in respect of veterinary medicine students. The HEA is said to explain the huge difference between these sums in that “training costs are often met by the health services whereas a large proportion of these costs for veterinary studies are met by the colleges themselves.” However, the Medical Council has been unable to identify any protected funding by the Department of Health & Children, Health Boards or voluntary hospitals in the education of medical students. In fact the converse seems to be the case, as the inspections identified many members of staff within the health sector who are employed by the medical schools; these include clinicians, librarians and administrative staff.

In 2001, the Medical Council drew the public’s attention to the chronic underfunding of medical education which at the time we considered to be interfering with attempts to reform and modernise the medical schools. The funding situation has deteriorated further with cuts in HEA funding in 2002 and 2003 and there must now be concern for the very viability of the medical schools. In response to this deterioration, the schools have adopted an increasing reliance on non-EU students. The 2003 non-EU intake of 516 medical students represents an increase of 32% on the 2000 figure of 390 students, which itself is a significant increase on the mid-90s figure.

**Figure 6. National medical student intake in 1995, 2000 and 2003**



Financial planning in medical schools is now significantly dependent on expansion of the numbers of non-EU students. In 2003 the EU intake had declined by 9%, which has further implications for medical manpower planning in Ireland.

**Figure 7. Estimated income from 315 EU and 516 non-EU entrants in 2003 (€m)**

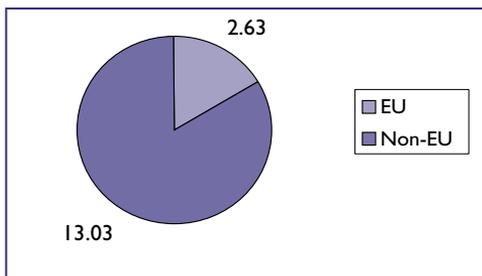


Figure 7 shows the Medical Council estimate that the first year income to medical schools in 2003 for 315 EU students is €2.63 million while the estimated income in 2003 for 516 non-EU students is €13.03 million, a total of €15.66 million. Of €15.66 million total first year income to the schools in 2003, €2.63 or 16.8% comes from the national exchequer.

Ireland has now moved from a situation in which non-EU students were subsidising the education of Irish students to one in which there is now an absolute reliance on international funding. This issue is one of national strategic importance and one which must be debated by the public, by those who provide and rely on Irish health services and by students themselves. In the view of the Medical Council, this dependence is inappropriate and unacceptable. It exposes medical education in Ireland to the vagaries of international developments in commerce, politics, public health or international politics. At the same time it throws into confusion the key question of the purpose of the medical education which students receive – is that education to be tailored for the Irish health services, for the services of the more than 30 nations from which students come or for some generic international norm which is currently undefined?

The teaching of foreign medical students is seen as profitable internationally and Ireland is likely to face increasing competition by better-resourced medical schools which makes the absolute reliance on non-EU income a dangerous strategy. A confluence of factors outside the control of a small open economy could lead to a decline in overseas students which could destabilise our medical schools. We are now producing over 700 medical graduates per annum, but nearly half of these have to leave Ireland to return to their home countries because of sponsorship agreements with their governments and other factors. The Medical Council has significant and informed concerns about shortages of doctors in the near future. From the time a student enters medical school until his or her accreditation as a specialist takes a minimum of 10 years for a general practitioner and 13 years for most hospital specialties. With such extended 'lead-times', the issue of national medical manpower needs becomes a pressing one for government, health services and the public in 2004.

## **12. Capacity issues**

While greater use is being made of affiliated hospitals for medical education there is significant pressure on the major teaching hospitals. There is increasing pressure on patients, teaching staff, and seminar rooms in hospitals. In modern hospitals turnaround time for patients is more rapid and there are fewer opportunities for students to meet patients in an unhurried and detailed manner.

Patients themselves are less willing to be examined by numbers of students and a minority of patients are too sick for any clinical teaching. A very small proportion of undergraduate clinical training occurs in the community setting; although much potential for training exists in the community this cannot be immediately mobilised. In the 2003 visits to the medical schools, students were vocal about the inability of the current hospital system to provide them with adequate clinical exposure; 30% 'no-show' rates for clinical teaching sessions were widely reported, principally because the clinicians involved have simultaneous clinical commitments. The Medical Council shares this anxiety.

Council has therefore accepted the recommendation of the visitors that numbers of medical school places are capped at 2003 levels for each medical school, pending the urgent implementation of measures to improve clinical teaching capacity.

### **13. Department of Health and Children**

The 2001 report drew the public's attention to the fact that the Department of Health and Children has no role in undergraduate medical education. This is despite the fact that many graduates of the medical schools are eventually employed, in one way or another, by the Department of Health and Children. This anomalous situation whereby the major employer of the medical workforce has no say in the nature of medical education or in the numbers being produced continues, and is again a source of major concern to the Medical Council.

### **14. Action on medical education**

During the 2003 visits, the Medical Council met with the Higher Education Authority, the Department of Education & Science and the Department of Health & Children to explore policy issues and to point out manpower and other anomalies in Irish medical education. The Ministers for Education and Health have established a Working Group on the future of medical education under the chairmanship of Professor Patrick Fottrell. The terms of reference and membership are available as Appendices 1 and 2 and the Working Group is due to report to the Ministers by September 2004. The Medical Council has membership of the Working Group and has supplied it with the data from the medical schools included in this report.

## 15. Graduate Entry

In the late summer of 2003, the Minister for Education and Science announced that from 2007, only graduates will be admitted to medical courses in Ireland and that there will be no entrants in 2005 or 2006. This was a surprise announcement; the opinions of the Medical Council, the medical schools or the Department of Health and Children were apparently not sought in advance. Currently, all medical schools take in small numbers of graduates who bring much prior experience, who generally perform well and whose academic performance often receives favourable comment. All graduate entrants have to complete the same five or six year courses as the usual school entrants as the course is not modified on their behalf. Many make considerable sacrifices to obtain a medical degree.

During our visits to the medical schools it became apparent that the schools had not considered the ministerial announcement in detail but all believed the proposal to be flawed in important respects. All are committed to increasing the numbers of graduates within the schools but see serious difficulties in converting to an exclusive graduate-only method of entry. Some preliminary work on a separate graduate-only entry stream is being undertaken by several schools but the exercise is likely to propose a parallel mechanism, rather than an exclusive one.

A medical education course solely for graduates is very different from a course geared to school leavers; many graduate courses last for only four years and use a problem based methodology which capitalises on the maturity and prior knowledge of graduates. Such courses are mostly conducted in small group formats, which are expensive but effective learning mechanisms. All graduate entry courses, regardless of teaching methods, require considerable skills in curricular planning and staff training. The time and skills required to deliver this change do not appear to be generally available in our medical schools at this time. Furthermore it is obvious that the current attempts to modernise their courses have largely consumed the managerial, intellectual and emotional energies of the leaders in our medical schools.

The 1978 Medical Practitioners Act does not permit abbreviated medical training. This is in line with European legislation. The Medical Council encourages diversity in educational effort and strongly welcomes the goal of increasing the numbers of graduates being educated as doctors. However, Council has serious concerns about the appropriateness of converting to exclusive graduate entry, which include:

- The exclusion of school leavers may deter some students from a career in medicine
- Curricular change structures are not currently in place

- The proposed timescale is not adequate to allow preparation
- Graduate entry may not be equitable as the funding arrangements have not been clarified and may require entrants to be self-funding
- A graduate course must be compatible with national and EU legislation
- Reducing the numbers of graduates (no entry in 2005 and 2006) will have significant and negative effects on health service manpower

The Medical Council strongly endorses the increased recognition of the place of graduates as doctors of the future. However, the case for exclusive graduate entry remains to be made and the practical obstacles to its implementation are formidable. Council has received information from the medical schools which indicates that some are working towards a target of increasing graduate entry to 25% over the next couple of years; for example in the 2003 EU intake, UCD has 16%, RCSI has 42% and TCD has 15% who are graduates.

## **16. Student issues**

Many issues raised by students have been dealt with in previous sections of this report. However, a number of specific issues of concern should be reported separately.

In a small number of cases, visitors were disturbed to hear of cases of bullying of students by those responsible for their education. These issues have been discussed fully with senior management of the agencies involved and Council is monitoring the actions taken. Serious bullying of students is intolerable and will be dealt with using all of the resources at Council's disposal. In other cases, it is clear that poor training, inadequate communications or pressures of work have resulted in poor working relationships – these issues must also be dealt with.

The internationalisation of the student body raises social, cultural, religious and welfare issues. The personal cost to students from very different societies who must integrate not only into complex third level education but also into a new society is considerable. The rapid increase in absolute numbers of medical students and the numbers of countries represented poses novel problems for medical schools and universities. The schools are responding but are reminded of their responsibilities not only for their students' education but also for the welfare and personal and professional development of these individuals.

Students are increasingly well represented on decision making bodies of the medical schools. However, vigilance is needed to ensure that with rapidly evolving structures students continue to have a voice at all levels.

### **17. Models of best practice**

Inevitably, a report such as this highlights areas of concern and issues for action. It is also important to emphasise that much high quality work is being carried on within the medical education sector. Among the many examples of best practice identified were:

- State-of-the-art electronic teaching and learning
- Integrated courses between disciplines and years
- Student welfare as a priority
- Self-learning facilitated
- Valuing 'non-teaching hospitals'
- Preparation for the intern's role

The schools are encouraged to share such models and to support each other in developing areas of expertise. The Medical Council welcomes the establishment of the Council of Deans of medical schools which is actively working towards this goal, in addition to its many other areas of activity.

### **18. Overall conclusions**

- i. The medical schools continue to produce safe, competent graduates
- ii. New governance and curricular development structures are showing evidence of benefit
- iii. Reform of the early years of the programmes is welcome; less change is seen in the clinical years
- iv. Underfunding and dependence on overseas income are serious threats to medical education
- v. The capacity of the clinical courses has been exceeded; pressures on part-time or unfunded clinician teachers are growing and contribute to this capacity problem
- vi. Exclusive graduate entry courses are not an obvious solution to existing problems in medical education
- vii. Accreditation mechanisms must be further developed

### **19. Progress on the internship**

After qualifying with a medical degree new doctors are allowed to practice with internship registration from the Medical Council. They are traditionally required to complete a 12 month internship usually comprising 6 months in medicine and 6 months in surgery. However the Medical Council has recently broadened the scope of the internship. Interns can now work in psychiatry, emergency medicine, paediatrics, obstetrics and gynaecology and general practice for a minimum of two or three months each with appropriate training and supervision.

The Medical Council requires the intern year to be an educationally sound clinical experience. The Council has produced a job description and logbook for the interns. It requires that each intern is provided with an employment contract and that intern tutors are put in place in each hospital in order to supervise the educational content of the internship.

The Medical Council has also supported the establishment of a network of intern co-ordinators and tutors to supervise intern education and training nationally. There is now an intern co-ordinator for each of the medical schools and one or more intern tutors for each of the 40 hospitals where interns work. The Council regards the network as the key forum within which intern education and training is fostered.

During its visit to each of the medical schools the Medical Council spent a half-day inspecting the intern training programmes and meeting with intern representatives, intern tutors and co-ordinators and the consultants who have interns on their staff. The inspection was informed by the recent Medical Council survey of 400 interns which sought feedback on the current internship experience in Ireland in the light of recent changes. The majority of the 300 interns who responded provided positive feedback on many aspects of their education and training, their work environment and their professional relationships. Lack of protected time for education is still a problem and the Medical Council is encouraging the network of interns, tutors and co-ordinators to keep this issue under review. There are insufficient formal educational programmes – an area which also needs to be kept under review. Students work in a stressful environment and requested more feedback on their performance.

The Council was concerned at the level of bullying of our interns. Interns are vulnerable and can easily become the butt of the frustrations experienced by other staff grades in hospital. Bullying and harassment of interns is completely unacceptable and while hospitals have policies in place interns had not usually benefited from them. The Medical Council is reassured by the seriousness with which management, medical and nursing staff have taken the issue of bullying and it will be kept under review.

It is evident that a minority of interns are using the log diary. The network has agreed to review the log diary as a priority. The Council now requires all Deans to satisfy themselves of satisfactory completion of the log diary prior to signing the Certificate of Experience which entitles the intern to full registration with the Medical Council.

The Council intends to continue evaluation of the internship and hopes to see the outstanding issues being addressed in the near future.

## NATIONAL AND LOCAL RECOMMENDATIONS

Each medical school has received an individual confidential report following the Council visit; the reports contain between 18 and 40 recommendations and each school has been asked to submit an implementation report by 1st March 2004. Council has considered the individual reports, its meetings with relevant bodies, data from other sources and the advice of its international advisors in drawing up a series of recommendations under three broad themes:

- (a) National/strategic recommendations
- (b) Individual school recommendations
- (c) Accreditation recommendations

### (a) National/strategic recommendations (1-12)

1. Medical education in Ireland should conform to international best practice.
2. Medical education should be aligned with the needs of the health services in Ireland.
3. Medical schools need to develop social accountability to the public.
4. Medical schools need to be involved in medical manpower planning for the future.
5. Governance and administration in our medical schools must be further developed.
6. Modernisation of medical education needs to continue at an increased rate.

*Comment: This group of general recommendations reflects the overall themes of this report.*

7. Schools must cap numbers entering schools at 2003 levels
8. Schools must take immediate steps to renew capacity

*Comment: Section 12 of this report outlines the rationale for these recommendations which have implications for medical schools, government departments, the health services, the HEA and Central Applications Office and school students. A number of practical steps have been identified which will enable new clinical teaching capacity to be developed in the short to medium term. In the interim, the medical education sector cannot cope with additional students.*

## **9. The case must be made for adequate funding**

*Comment: This report indicates that 83% of current funding for medical education comes from the fees of overseas students. The strategic implications of this situation are potentially very serious and require an immediate response from government. A public debate on the place of medical education in Irish society is needed to inform how government should respond; the case for investment in medical education must be clearly presented in this debate. The Working Group on Medical Education has a substantial role to play in this debate.*

## **10. The reliance on overseas funding must be reduced**

*Comment: While the internationalisation of the student body and of the process of medical education is welcome, clear direction is needed on the relationship between medical education in Ireland and the Irish health services. The current complete reliance on overseas funding prevents any effective relationship at present.*

## **11. Accredit standards for staff, facilities and learning**

*Comment: The variability in staff/student ratios, staffing levels, facilities, ICT resources and professional educational support is unacceptable. Standards must be set at national level for these resources. These standards should draw on comparable standards in other countries as well as on the available Irish data. This process can be undertaken by the Medical Council or the Working Group but the Council's Office of Education will in future enforce these standards during the accreditation process.*

## **12. Implement recommendations to schools**

*Comment: While the tasks facing each of our medical schools must be their own responsibility, it is clear that few have the resources to tackle these tasks without outside help. The Working Group has a crucial role to play in addressing these tasks.*

## **(b) Recommendations to schools (1-8)**

### **1. Coherent, integrated planning and delivery of education**

### **2. Governance and administration to be improved**

*Comment: Earlier parts of this report have emphasised the importance of governance, consistent policies and integration as themes in the better delivery of medical education.*

### **3. Curriculum evaluation**

*Comment: Change has little value without evaluation of its impact and further improvement. Much curricular change is currently underway or recommended. It is essential that robust evaluation mechanisms using international best practice standards are in place.*

### **4. Bullying and student isolation**

*Comment: The preparation of students for their lives as doctors depends on many factors. Students who are bullied or who cannot develop their personal lives will suffer personally and as the doctors of the future. Schools have a responsibility to protect their students from bullying at all levels. Anti-bullying policies in the workplace apply as fully to students as to employees of hospitals and universities and must be implemented equally.*

### **5. The dominance by medicine and surgery of clinical teaching must be balanced by teaching in other disciplines and settings**

### **6. General practice/primary care, learning skills deficient**

*Comment: The clinical training environment is dominated by hospital based practice, particularly that of medicine and surgery. These are crucial elements in the training of any doctor but should be complemented by a broader range of disciplines and settings. The current very limited student exposure to primary care, to interdisciplinary training and to teamwork must be addressed. Effective Special Study Modules (including perhaps options in the humanities) should be developed.*

### **7. Further development of electronic teaching and learning is needed.**

### **8. The network of affiliated hospitals for student training should be further developed**

*Comment: These practical developments will require planning and investment.*

### **(c) Next steps in accreditation by the Medical Council (1-6)**

#### **1. Differential licensing for two, three or four years**

*Comment: The introduction of accreditation by the Medical Council will, in the next round of inspections in 2005, be reflected in periods of licensing of medical schools which are determined by their standards of education. Initially, licensing for two, three or four years will be used, although longer approval may be available in the future.*

#### **2. Real-time monitoring of schools**

*Comment: In addition to formal inspections, the Office of Education will establish monitoring structures in association with each of the schools to collect information on qualitative and quantitative issues. Examples include information on student numbers, funding, course content and delivery, governance mechanisms and process and outcome measures. With the introduction of student registration, links will also be established with the study bodies in each school. In certain circumstances, monitoring data may trigger a further formal inspection of the school.*

#### **3. Regular, benchmarked self-assessments by schools**

*Comment: The medical schools remain independent, self-governing bodies and their independence will be fostered by a requirement for self-assessment on a regular basis. Using elements of the benchmarked standards for staff and facilities, the self-assessment exercise can contribute to planning development.*

#### **4. Planned inspections (NB student and lay roles)**

*Comment: Regular formal inspections have served the schools and Medical Council well. However, as the accreditation process matures, the place of structured inspections becomes just one part of the process. In future, inspections should occur at planned intervals in association with the licensing period and should include representation from students and lay people.*

#### **5. Prior approval for significant changes**

#### **6. Publication of data**

*Comment: These recommendations reflect the continuing maturation of the accreditation process. Data on structures and performance within individual schools should be available to the public in a way that offers genuine insights and real evidence of activity.*

**Appendices**

## Appendix I

### WORKING GROUP ON UNDERGRADUATE MEDICAL EDUCATION AND TRAINING

#### Terms of Reference

The Minister for Health and Children and the Minister for Education and Science have decided to establish a working group to examine undergraduate medical education and training in Ireland. This group will have the following terms of reference:

“Having regard to the programme for Government, including strategic changes set out in the Health Strategy, 2001, and to the importance of a high quality system of medical education and training, the Working Group will examine and make recommendations relating to the organisation and delivery of undergraduate medical education and training in Ireland, with particular reference to:

- course curriculum / syllabus,
- teaching methods / delivery mechanisms,
- professionalisation of undergraduate medical teaching,
- the scope for the promotion of greater inter-disciplinary working between professionals through the development of joint programmes at the initial stages of undergraduate training (ref. Health Strategy action 104),
- such other issues relating to the organisation and delivery of undergraduate medical education and training, as the Working Group considers relevant. These other issues would include any resource implications, insofar as they arise. The Working Group's recommendations will, insofar as is possible, be framed within the context of existing resources. Where this is not feasible, the various means, other than Exchequer provision, by which the resource implications might be funded, shall be identified.”

**In examining these issues, the Working Group will have regard to**

- The Programme for Government
- The Health Strategy
- The Medical Council's Review of Medical Schools in Ireland 2001
- Recent proposals from the Dean Of UCC medical school
- The recommendations of the National Task Force on Medical Staffing

## Appendix 2

### MEMBERSHIP OF WORKING GROUP ON UNDERGRADUATE MEDICAL EDUCATION AND TRAINING

- 1 **Professor Gerard Bury**, President, Medical Council
- 2 **Dr Jane Buttimer**, Chair, Medical Education and Training Advisory Group, National Task Force on Medical Staffing
- 3 **Mr Bernard Carey**, Joint Chair, Health Service Reform Programme
- 4 **Dr Anthony Carney**, Dean, Faculty of Medicine, National University of Ireland Galway
- 5 **Mr Stiofan De Burca**, Vice Chairman, Chief Executive Officers Group, Mid Western Health Board
- 6 **Ms Rowena Dwyer**, Secretary, Working Group on Undergraduate Medical Education and Training
- 7 **Professor Muiris Fitzgerald**, Dean, Faculty of Medicine, University College Dublin
- 8 **Professor Pat Fottrell**, Chair, Working Group on Undergraduate Medical Education and Training
- 9 **Dr Tony Holohan**, Deputy Chief Medical Officer, Department of Health and Children
- 10 **Professor Alan Johnson**, Undergraduate Dean, Royal College of Surgeons in Ireland
- 11 **Mr Leo Kearns**, External Consultant, Working Group on Undergraduate Medical Education and Training
- 12 **Professor Cecily Kelleher**, Department of Public Health Medicine and Epidemiology, University College Dublin
- 13 **Mr Paul Kelly**, Assistant Secretary, Department of Education and Science
- 14 **Ms Mary Kerr**, Deputy Chief Executive, Higher Education Authority
- 15 **Mr John Lamont**, Chief Executive Officer, Beaumont Hospital
- 16 **Professor Geraldine McCarthy**, School of Nursing and Midwifery, University College Cork
- 17 **Mr Kevin McCarthy**, Higher Education, Department of Education and Science

- 18 **Mr Tony McNamara**, General Manager, Cork University Hospital Group
- 19 **Professor Aidan Moran**, Vice President and Registrar, University College Cork
- 20 **Professor Michael Murphy**, Dean, Faculty of Medicine, University College Cork
- 21 **Ms Ann Nolan**, Education and Science Votes Section, Department of Finance
- 22 **Professor Thomas O'Dowd**, Department of Public Health and Primary Care, Trinity College Dublin
- 23 **Mr Larry O'Reilly**, Personnel Management and Development Directorate, Department of Health and Children
- 24 **Mr David Redmond**, Registrar, National University of Ireland Maynooth
- 25 **Professor Derry Shanley**, Dean, Faculty of Medicine, Trinity College Dublin

## Appendix 3

### TEAM OF VISITORS FOR MEDICAL SCHOOL VISITS OCTOBER 2003

#### Medical Council visitors

Professor Gerard Bury, President, elected member  
Professor Tom O'Dowd, Chairman, Education and Training, TCD nominee  
Dr Abdul Bulbulia, Ministerial nominee  
Ms Mary Gilsean, Ministerial nominee  
Dr Ailis Ni Riain, Ministerial nominee for General Practice  
Professor Kevin O'Malley, RCSI nominee  
Dr John Hillery, Vice President, elected member

#### External assessors

Professor Gordon Page, University of British Columbia  
Professor Maurice Savage, Queen's University Belfast

#### Co-opted visitors

Dr Joe Barry, TCD/ERHA  
Professor Cecily Kelleher, UCD  
Dr Emer Shelley, Department of Health and Children  
Mr Michael Lyons, AMiNCH  
Mr Stephen McMahon, Irish Patients' Association  
Dr David Orr, St James's Hospital  
Dr Fergus O'Ferrall, Adelaide Hospital Society  
Dr Lelia Thornton, National Disease Surveillance Centre  
Dr Cillian Twomey, Cork University Hospital  
Professor Anthony Cunningham, RCSI  
Dr Geoff Chadwick, UCD  
Dr Chris Luke, Cork University Hospital

#### Observers

Professor Paul Finucane, Director of Medical Education, Medical Council  
Mr David Hickey, Acting Registrar  
Mr William Kennedy, Legal Services  
Ms Una O'Rourke, Administration, Education and Training

## Appendix 4

## Percentage of curriculum time spent on clinical subjects in 2001 and 2003

|                        | UCC  |      | NUIG |      | TCD  |      | RCSI |      | UCD  |      |    |
|------------------------|------|------|------|------|------|------|------|------|------|------|----|
|                        | 2001 | 2003 | 2001 | 2003 | 2001 | 2003 | 2001 | 2003 | 2001 | 2003 |    |
| Medicine               | 15   | 15   | 24   | 23   | 24   | 32   | 24   | 24   | 25   | 20   | 27 |
| Surgery                | 14   | 14   | 24   | 23   | 28   | 32   | 24   | 24   | 25   | 20   | 27 |
| Obs & Gynae            | 6    | 6    | 13   | 13   | 8    | 9    | 22   | 12   | 7    | 7    | 11 |
| Paediatrics            | 10   | 10   | 9    | 9    | 10   | 13   | 9    | 9    | 9    | 7    | 9  |
| General Practice       | 5    | 5    | 5    | 5    | <1   | 2.5  | 3    | 4.3  | 2    | 3    | 3  |
| Public Health Medicine | 7    | 7    | 2    | 2    | <1   | 1    | 1.4  | 1.5  | <1   | <1   | <1 |
| Ethics                 | 2    | 2    | 2    | <1   | <1   | <1   | <1   | 0.9  | <1   | <1   | <1 |
| Psychiatry             | 8    | 7    | 9    | 7    | 7    | 7    | 5    | 5.8  | 7    | 8    | 8  |
| Laboratory Sciences    | 8    | 9    | 6    | 6    | 7    | 2    | 9    | 9.8  | 6    | 8    | 8  |

## Appendix 5

10th February 2004

Mr. Noel Dempsey  
Minister for Education & Science  
Marlboro Street  
Dublin 2

Dear Minister

I write to raise issues in relation to your plan announced last year for the introduction of graduate-only entry to Irish medical schools. The Medical Council has recently completed a series of accreditation visits to Irish medical schools and I enclose an extract from the 'Report to the Public on Medical Education' which will be published in 2004; the extract outlines the Medical Council's position in relation to your proposal.

Section 35(1)b of the Medical Practitioners Act 1978 requires the Medical Council to satisfy itself as to the content, quality and delivery of undergraduate medical education by Irish medical schools. Council has established mechanisms for the accreditation of Irish medical education and has recently completed a series of inspection visits to all schools using these criteria.

The Medical Council has taken careful note of your 2003 statement that, from 2007 onwards, entry to Irish medical schools would be by the graduate route only and that no intake to the schools should occur in 2005 and 2006. Council is represented on the Task Force on Medical Education and has raised a number of concerns about this statement at meetings of the Forum. The Medical Council strongly supports the inclusion of graduates in the undergraduate student body, but has to date seen graduates as one component of a broadly based group which includes school leavers, mature students and others.

At its meeting on 5th February, Council noted the increasing urgency of the matter – I therefore write to outline Council's current views.

### ***The current situation***

Numbers entering medical schools have increased rapidly in recent years, although the increase is confined exclusively to fee-paying non-EU nationals. This situation arises because medical schools now rely for the large majority

of their funding on fee-paying overseas students. Schools admit both school leavers and graduates, who both take similar courses although graduates may be exempted certain components.

Council is currently preparing a report to the public on medical education which will include some data on the numbers of graduates entering Irish medical schools.

### ***The legal environment***

EU Directive 93/16 requires that all graduates of Irish medical schools complete 5,500 hours or six years of education prior to graduation; at least half of that education must be provided within the state, although two non-national schools are currently recognised.

The Medical Practitioners Act 1978 implies that a single format of medical education be available within the state – previous legal advice has indicated that courses tailored for particular groups of students are not allowed for by the Act.

### ***Accreditation***

The Medical Council has developed accreditation mechanisms for undergraduate education which focus on international best practice in medical education. Any new undergraduate courses must receive accreditation approval from Council prior to implementation. Accreditation mechanisms for graduate-only courses have not been developed in Ireland and will require considerable diversion of time, resources and expertise if they are to be acceptable and effective.

Council has been informed that some medical schools are examining graduate-only courses; none is sufficiently developed to be presented for accreditation. Such novel courses are likely to require considerable preparation if they are to conform to international best practice norms.

### ***Resources***

The current inadequate resourcing of Irish medical education has been well documented. The development and implementation of completely new courses raises significant resource issues. The availability of these resources (primarily for the schools themselves) has not been clarified.

***Other issues***

Further matters such as the implications for current school leavers, the absence of two graduating intern years, issues of access and equity issues and longterm funding mechanisms are among issues of concern to Council. There is no data to examine the potential impact on patients and healthcare services in Ireland of a transition to graduate-only entry to medical school.

***In summary***

Council's prime concerns at present relate to legal issues, accreditation and the appropriateness of a graduate-only student body to Ireland's health care needs. Given the proposed timeline and the specific legal responsibilities of the Medical Council, I would be grateful for an early opportunity to explore these issues more fully with you.

I look forward to hearing from you.

With best wishes.

Yours sincerely,

Professor Gerard Bury  
*President*

## Appendix 6

17th February 2004

Mr. Noel Dempsey, T.D.  
Minister for Education and Science  
Department of Education and Science  
Marlborough Street  
Dublin 1

Re: Clinical capacity issues in Irish medical schools

Dear Mr. Dempsey

The Medical Council has recently completed a series of accreditation visits to each of the Irish medical schools. That process is centred on the application of international standards of best practice in medical education and involves the collection of extensive data from the schools and a two-day inspection by a Medical Council team, which includes international externs. Each school receives a detailed confidential report, but the Council will also publish a 'Report to the Public' in April 2004.

The Task Force on Undergraduate Medical Education has received a summary report of the accreditation visits.

I write to inform you of a specific concern arising from the accreditation visits in relation to the capacity of the medical schools to deal with students in the predominantly clinical phase of their education. Council has accepted the data from the accreditation process which indicates that the clinical capacity of the Irish medical schools has now been exceeded; the evidence for this includes:

- Up to 30% of clinical teaching sessions are designated as "no shows", usually because the clinician involved is committed to service tasks.
- The very steep rise in numbers of medical students without commensurate increase in facilities.

- The likely impact on the availability of clinicians of the implementation of the European Working Time Directive within hospitals on 1st August 2004.

Council has now formally requested each of the medical schools to cap its 2004 intake at 2003 levels until the capacity issues can be resolved. Council expects that each of the schools will comply with this request and also believes that relatively short-term interventions can be undertaken to address this specific problem.

It is essential that the cap on intake be observed and that close monitoring be established of the potential for further increases in student numbers to exacerbate a range of problems affecting Irish medical education.

I would be happy to provide any additional information which you require, but will of course provide you with a copy of the Report to the Public as soon as it is published.

With best wishes.

Yours sincerely,

Professor Gerard Bury  
*President*

