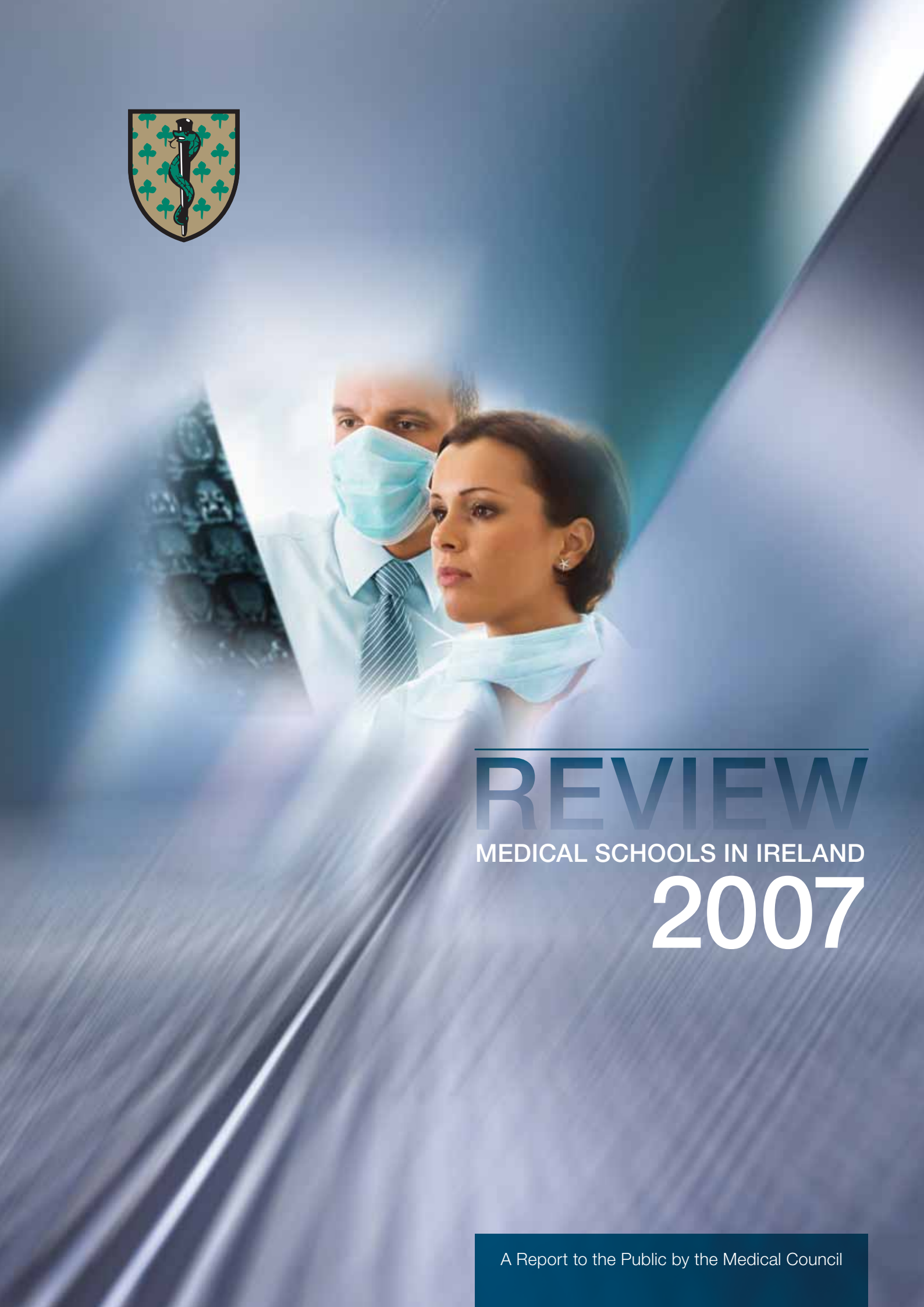

REVIEW

MEDICAL SCHOOLS IN IRELAND

2007

A Report to the Public by the Medical Council

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1. INTRODUCTION

1.1. Foreword

The safety of the public is at the heart of the work of the Medical Council. The ultimate purpose of all the Medical Council's responsibilities, including those in education and training, is to safeguard the well being of the public. The legislation currently in force, the Medical Practitioners Act 1978, requires the Medical Council to satisfy itself as to the quality of medical education in Ireland. The Medical Council ensures that medical students learn in education and training programmes that are approved and monitored by the Medical Council.

The Medical Council is therefore pleased to present its third report to the public on undergraduate medical education in Ireland. It is based on the findings of the Medical Council's visits to medical schools and to their associated hospitals in 2005, 2006 and 2007.

This report, like the previous Medical Council reports in 2001 and 2003[1], provides an overview of undergraduate medical education as revealed in the visits. It comes at an exciting time for medical education in Ireland, where the challenges and the opportunities are more apparent than ever before. This report identifies many areas of good practice as well as those where improvement is needed.

1.2. Acknowledgments

The quality assurance of medical education has demanded a significant commitment from members of the Medical Council. Thanks are due to all those members who gave of their time and energy. They include former President of the Medical Council Dr John Hillery, and former Chairman of the Education and Training Committee Professor Muiris X FitzGerald.

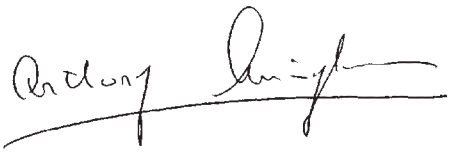
Special mention must be made of the role of external assessors Professor Tom O'Dowd, Dr Geraldine O'Neill, Professor Gordon Page, Dr Cillian Twomey, Professor Gerry Loftus, Professor Maurice Savage, Professor Gerry Bury, Mr Stephen McMahon, Professor Paul O'Neill, Professor Sir Graeme Catto, Ms Sheila Early, Professor Robert Sneyd, Professor Hans Sjöström and Professor Tony Weetman. They brought additional expertise and an international perspective to the Medical Council's work, and the Council is grateful for their contribution.

The Medical Council also thanks the medical schools in Ireland for their participation and co-operation. It recognises that the review of schools by the Medical Council involves a substantial amount of work for academic and support staff in the schools.

We also thank the students and interns who provide such valuable feedback in their role as consumers of the education and training that the medical schools provide.

The Medical Council also appreciates the assistance it received from staff in the Council's Education and Training Section, particularly Dr Anne Keane, Head of Education and Training, for her work in preparing this report.

Dr Colm Quigley
President of the Medical Council



Prof Anthony Cunningham
Chairman of the Education & Training Committee of the Medical Council

1 The Review of Medical Schools in Ireland 2001 and Review of Medical Schools in Ireland 2003 are available on the Medical Council website www.medicalcouncil.ie

2. EXECUTIVE SUMMARY; OVERVIEW AND RECOMMENDATIONS

OVERVIEW

After evaluating each medical programme within its jurisdiction, the Medical Council's conclusion is that all existing five and six year undergraduate courses are producing medical graduates with the knowledge, skills and behaviour to successfully undertake an internship, and thereafter to gain full registration with the Medical Council. All these undergraduate medical courses are therefore fully accredited by the Medical Council. The two recently introduced graduate entry medical programmes are provisionally accredited by the Medical Council, and can be considered for full accreditation once the first entrants have graduated from the programmes.

In 2007, substantial progress is evident in the five medical schools that were involved in the Medical Council's 2003 review. There is impressive evidence of widespread curricular development and reform, incorporating international best practice. Developments include:

- Movement from six to five year undergraduate programmes
- Defining specific learning outcomes for each part of the programme
- Earlier exposure to clinical experience
- Teaching that is integrated and based on the systems of the body
- A reduced emphasis on lecture-based teaching and more emphasis on interactive learning
- More student involvement in curriculum development and monitoring
- More effective assessment strategies
- More formal preparation of staff for their educational roles
- Effective use of instructional technology
- Some impressive new facilities
- A modest move to greater use of primary and community care sites for clinical teaching

Medical education is always "work in progress", however, and schools are in a transitional stage in terms of some key aspects: these areas include continuing the process of programme re-design, further extending the clinical skills element of the programme, refining methods of assessment, developing new educational facilities, strengthening formal arrangements with hospitals and hospital teaching staff, and expanding undergraduate training opportunities outside hospital settings. Work also continues in monitoring internships to see that they provide the appropriate educational and clinical training experience for all new doctors.

Resources, and the capacity of the health care system to educate and train students and new doctors, remain key issues. Undergraduate medical education in Ireland is still heavily dependant upon funding derived from fees from non-EU students, and this is a precarious foundation for the further developments that are needed.

This report amalgamates the Medical Council's findings on medical education in Ireland and does not report on individual schools.

RECOMMENDATIONS

NATIONAL AND STRATEGIC RECOMMENDATIONS

Recommendation (R.1) Medical education in Ireland should continue to be informed by and strive to reach the highest standards of international best practice.

R.2. Medical education should continue to be aligned with the evolving health care needs of the community.

R.3. There should be adequate funding and resourcing of medical education, including enhancing facilities for teaching and learning in medical schools, universities, hospitals and in the community; increasing the number of clinical academics, and providing incentives for a career as a clinical academic.

R.4. The issue of the continuing capacity of the system to provide a quality experience for students and interns should be given urgent attention.

R.5. More opportunities should be provided for undergraduate placements in general practice and in the community, and for intern rotations in areas other than medicine and surgery.

R.6. It would be preferable if the dependence of medical education on fees derived from non-European Union students was reduced.

RECOMMENDATIONS TO ALL MEDICAL SCHOOLS REGARDING UNDERGRADUATE MEDICAL EDUCATION

Mission and Objectives

Medical Schools should strive to / should continue to:

R.7 Develop a clear and current mission and objectives which are understandable to the general public

R.8 Develop a mission and objectives which include social responsibility and accountability, research attainment, and community involvement.

Educational Programme

Medical Schools should strive to / should continue to:

R.9 Improve consistency of experience across clinical training sites.

R.10 Ensure appropriate balance of exposure to real and simulated patients.

R.11 Increase existing opportunities for undergraduate rotations outside major teaching hospitals.

R.12 Enhance the role of professionalism in the undergraduate curriculum.

R.13 Maximise multi-professionalism teaching and learning.

Assessment

Medical Schools should strive to / should continue to:

R.14 Ensure assessment methods are linked to defined learning outcomes.

R.15 Ensure assessment of non-academic areas i.e. team working.

Students

Medical Schools should strive to / should continue to:

R.16 Build on the existing access programmes for students from disadvantaged backgrounds.

R.17 Ensure effective induction/pastoral support for home and overseas students.

R.18 Ensure student involvement in all relevant academic and non-academic decision making.

R.19 Address any instances of serious misconduct among medical students.

Staffing

Medical Schools should strive to / should continue to:

R.20 Address the issue of progression and promotion for clinical academics.

R.21 Establish contracts with teaching sites and trainers.

R.22 Foster medical education departments/units/centres in the medical school.

R.23 Foster staff development.

Educational Resources

R.24 Medical Schools should strive to / should continue to develop access to e-learning on clinical teaching sites.

Programme Evaluation

R.25 Medical Schools should strive to / should continue to develop systematic methods of obtaining feedback from students and from training sites and patients.

Governance and Administration

Medical Schools should strive to / should continue to:

R.26 Develop resource allocation models that maximise resources for teaching including funding of academic leaders and appropriate administrative expertise.

R.27 Ensure effective interaction with health service bodies.

Continuous Renewal

R.28 Medical Schools should strive to / should continue to ensure robust evaluation methods are in place.

RECOMMENDATIONS REGARDING INTERNSHIP

Recommendations for Medical Schools

Medical Schools should strive to / should continue to:

R.29 Ensure the undergraduate programme is an effective preparation for internship.

R.30 Review the possibility of providing Advanced Cardiac Life Support (ACLS) training for final year students.

Recommendations for Medical Schools and for Hospitals and Training Sites jointly

R.31 Medical Schools and Hospitals should strive to / should continue to collaborate to enhance and expand existing shadowing and induction opportunities for final year students as they become interns.

Recommendations for Hospitals and Training sites

Hospitals and training sites should strive to / should continue to:

R.32 Develop the role of the intern tutor.

R.33 Reschedule, or make available via e-learning, any cancelled educational sessions.

R.34 Ensure that interns do not act above/below grade including in the area of taking consent.

R.35 Ensure robust assessment of intern rotations.

R.36 Promote opportunities for interns to feed back on their experience.

R.37 Implement anti-bullying and dignity at work policies.

R.38 Maintain and foster an environment where interns can raise concerns or problems.

R.39 Ensure appropriate careers advice for interns (in conjunction with postgraduate training bodies).

3. THE NATIONAL CONTEXT: THE STRUCTURE OF MEDICAL EDUCATION IN IRELAND

3.1. Medical Schools

There are six medical schools in Ireland. They are University College Cork (UCC); University College Dublin (UCD), National University of Ireland Galway (NUIG); The University of Dublin, Trinity College (TCD); Royal College of Surgeons in Ireland (RCSI) and University of Limerick (UL).

UCC, UCD, NUIG, TCD, and UL are all university-based medical schools and are state-funded. University College Cork, University College Dublin, and National University of Ireland Galway are constituent Colleges of the National University of Ireland. The Royal College of Surgeons in Ireland is an independent institution.

3.2. Entry to Medical School

Medical schools in Ireland use the Central Applications Office points score as the sole criterion for school leaver entry. School leavers obtaining high points in the Leaving Certificate examination are the typical entrants to medical school, despite the introduction of graduate entry programmes. Traditionally, an Irish student enters medicine at the age of 18 or 19, often after repeating Leaving Certificate so they can gain enough points. The trend in points for entry to medical school over the past few years is shown in Appendix 1. Access programmes for (socially and educationally) disadvantaged students permit admission at a points level of 450 points or more.

There has been a significant increase in recent years in the number of female applicants and entrants to medicine. Women now form the majority of the annual intake to medical schools in Ireland[2].

3.3. Medical programmes

Programmes which are primarily for school leavers, and are of five or six years duration, are offered at University College Cork; University College Dublin, National University of Ireland Galway; University of Dublin, Trinity College; and the Royal College of Surgeons in Ireland. These programmes also have a minority of students who are mature and / or already have a non-medical degree. The two programmes that are exclusively for graduates - which are of four years duration, at RCSI and UL - are discussed in section 7 of this report.

Medical courses have traditionally been divided into two phases: a pre-clinical phase spent largely on campus, comprising the basic sciences such as physiology, biochemistry and anatomy, and a clinical component in the later years of the course, spent largely on placements or "rotations" in hospitals. As the report later discusses, this is now changing to a more modern integrated approach with the sciences and clinical experience running side by side.

Medicine continues to make heavy demands on the student with attendance at lectures, group work, tutorials, small group teaching, practical classes, seminars and clinical teaching, in addition to private study and electives during the summer vacation. After qualifying the new doctor begins several years of training in order to become an independent specialist.

3.4. Three Major Changes

The Fottrell Report

The Medical Council's 2003 report welcomed the establishment of a Working Group on Undergraduate Medical Education and Training under the chairmanship of Professor Patrick Fottrell. The Group's report "*Medical Education in Ireland; A New Direction*"[3] was published in 2006, and the Medical Council's 2003 report informed its discussion. Fottrell's vision of a medical education system that "nurtures and develops people of the highest calibre to become caring and effective doctors, who support the well being of the nation and the health of the community..." is shared by the Medical Council. The Fottrell Report contains a comprehensive overview of the national situation and extensive statistical information that is not repeated in this Medical Council report.

2 Figures are available on the Higher Education Authority website www.hea.ie

3 http://www.dohc.ie/publications/fottrell.html

The impact of the Fottrell report (and the parallel report on postgraduate education, "*Preparing Ireland's Doctors to meet the Health Needs of the 21st Century*")[4] will be felt for many years to come in a number of areas. A National Committee on Medical Education and Training, which includes representatives of the Medical Council, has been set up to take the process forward. The most immediately tangible impact of the Fottrell recommendations is the removal of the "cap" or ceiling on the intake of European Union students into medical schools in Ireland. This will increase the EU student intake from 305 in 2006 to approximately 725 students over the coming years. The capacity of the system to deal with increasing numbers of medical students is one of the issues raised in this Medical Council report.

Graduate Entry

In its 2003 report, the Medical Council strongly endorsed the place of graduates among medical students, (although it expressed some significant reservations regarding a wholly graduate entry). As noted, school leavers still form the overwhelming majority of entrants to undergraduate programmes. However, Graduate Entry programmes became a prominent feature of basic medical education in the period covered by this report, and this is discussed in section 7.

The Medical Practitioners Act 2007

The 2007 Medical Practitioners Act[5] is the most significant legislation in medical education and training since the establishment of the Medical Council thirty years ago. The new Act gives the Medical Council a number of key responsibilities in education and training at all levels. This Medical Council report is based on visits undertaken under the existing 1978 legislation. However, the Medical Council is very aware of its extensive responsibilities under the new Act, and it is examining the best way of carrying them out.

4 http://www.dohc.ie/publications/buttimer.html

5 A copy of the Medical Practitioners Act 2007 is available on the Medical Council website www.medicalcouncil.ie

4. THE INTERNATIONAL CONTEXT: WORLD FEDERATION FOR MEDICAL EDUCATION (WFME)

The WFME is a global organisation concerned with the education and training of medical doctors at all stages of their careers, and its primary objective to enhance the quality of medical education world-wide. The Medical Council has tapped into the work of the WFME in two main ways.

(i) The first is to adapt the WFME's document "*Basic Medical Education: Global Standards for Quality Improvement*" as an *accreditation instrument*. The Standards the WFME has devised are structured under nine headings:

1. Mission and objectives
2. Educational programme
3. Assessment of students
4. Students
5. Academic staff/faculty
6. Educational resources
7. Programme evaluation
8. Governance and administration
9. Continuous renewal.

In each category, the WFME sets out a Basic Standard and a more demanding Quality Standard. This allows medical schools and the Medical Council to measure each school against the Standard. The medical school and the Medical Council ask the fundamental question "is the provision in this area of this Medical School's work at the Basic level, or is it better than that, reaching the Quality level?" A questionnaire devised by the Medical Council sets out the Basic and Quality Standards, and the medical schools completes this as the first part of the accreditation process. A blank specimen copy is attached as Appendix 2.

(ii) The Medical Council also uses the WFME as a yardstick for the *organisation* of the assessment process. The Medical Council's procedures were developed in line with the World Federation for Medical Education's *Guidelines for Accreditation of Basic Medical Education*.

These Guidelines specify among other things that accreditation should be:

- Based on a sound legal footing
- Independent from government, the medical schools and the medical profession
- Trustworthy and recognised by all
- Fair
- Possess a high degree of transparency
- Involve assessors who are respected within the medical profession, and who are preferably of international standing.

The Guidelines state that the process of accreditation should include:

- Self-evaluation by the medical school
- External evaluation which includes a site visit by an accreditation Team
- Production of a final report by the Team, containing clear recommendations
- A decision on accreditation.

The Irish process is therefore informed by, and in line with, these Guidelines.

The Standards and the Guidelines were used in accreditation, i.e. the process of approving a programme - and in *monitoring*, i.e. following up on the issues raised during accreditation. In section 6 of this report, the Medical Council's findings and the issues arising are structured under the nine WFME Standard headings specified above.

More on the World Federation of Medical Education, including the Global Standards and the Guidelines, can be found on the WFME website - http://www.wfme.org.

5. INSPECTIONS OF MEDICAL SCHOOLS

5.1. Rationale

Accreditation visits by teams representing national and international perspectives on key aspects of medical education are increasingly used in most nations in the developed world. In Ireland, as in other countries, there is no doubt that they have a significant impact on the quality of medical education. In many instances the reports from the visiting teams provide the foundation, and sometimes a "lever" for discussions with other bodies. The very existence of accreditation visits encourages medical schools to think about, respond to, and deal with the strengths and weaknesses of their programmes, knowing that the body with statutory responsibility for monitoring the quality of medical education will be formally reviewing them. Reviews make demands on both medical schools and the reviewers, but are nevertheless very worthwhile.
The Medical Council views the visits as an essential component of its role in the quality assurance of medical education. A flowchart of the quality assurance process is shown in Appendix 3.

5.2. Schedule of visits

Twelve full scale visits have been undertaken by Medical Council Teams in the last two years, as follows:

November 2005

The accreditation of a new programme in an existing Medical School, i.e. the Royal College of Surgeons in Ireland's Graduate Entry Programme.

March 2006

The accreditation of existing undergraduate programmes at:

- UCD
- UCC
- NUIG
- RCSI
- TCD.

March 2007

Follow up, monitoring visits of existing undergraduate programmes at:

- UCD
- UCC
- NUIG
- RCSI
- TCD.

May 2007

The accreditation of a new programme in a new Medical School, i.e. University of Limerick's Graduate Entry Programme.

Additional visits have been undertaken to medical school's teaching sites to address specific issues.

5.3. A typical inspection

Members of all the Teams from the 2005 - 2007 visits are listed in Appendix 4. The composition of visiting teams can vary but has included lay and medical members of Council, lay members of the public, a patients' representative, and international experts in the field of medical education. Each Team has a Chairman, who is either the President of the Medical Council, the Vice-President of the Medical Council, or the Chairman of the Education and Training Committee of the Medical Council. A specimen agenda of a typical visit is shown in Appendix 5.

A central feature of every visit is the meeting between the Medical Council Team and the medical school's students and interns. These sessions are confidential, with no medical school staff present. Individual students or interns are never identified in the subsequent report.

Education and training facilities are reviewed on each visit with the Team touring education centres, clinical skills laboratories, library and IT facilities, lecture theatres, and tutorial and small group teaching facilities. "Non-academic" facilities for students such as residences, catering and sports facilities are also seen. In some cases, the venue for the visit, or for part of the visit, is a teaching hospital, and members of the team also see ward-based teaching areas and meet many of the doctors who are involved in teaching medical students.

6. ASSESSMENT OF UNDERGRADUATE MEDICAL PROGRAMMES AGAINST WFME STANDARDS

This section summarises the Medical Council's findings regarding the fully accredited five or six year undergraduate medical programmes, grouped under the nine areas of the WFME.

Area 1: Mission and Objectives

It is important that medical schools are clear about their mission and objectives and that these are easily understood by the community as a whole. The basic mission and objective of all medical schools is to produce competent doctors equipped for their first clinical role and ready for further training.
The quality element includes areas such as social responsibility; research attainment; community involvement, bringing interested parties including the public- into the process of defining objectives; and having defined educational outcomes.

The Medical Council is confident that all of the medical schools are fulfilling their basic mission and objectives and are producing competent graduates; that is why the medical schools are accredited by the Medical Council. Progress has been made in the implementation of the quality areas too, and in some cases medical schools have ensured that members of the public are involved. Irish medical schools are also taking a global perspective, and aiming at international best practice in medical education.

Area 2: Educational Programme

Overview of the curriculum

The message that comes through most strongly from the Medical Council's visits is that every medical school is in a process of changing its programme, sometimes quite radically. This is commendable, as it contrasts with the relative (by international standards) lack of movement up to 2001 and, in some medical schools, up to 2003. Much of this innovation is due to the initiative of the medical schools themselves, informed by national and international developments in medical education. Other major factors include the stimulus of the Medical Council's 2003 Review and later visits.

There is continuing transition from six-year, traditional pre-clinical / clinical, lecture-based, departmentally structured models to five-year, more integrated, systems-based / case-based / problem-based learning approaches, with earlier contact with patients, and more small group / tutorial teaching.
The schools are commended on the extent to which they have modernised.

Good practice

Some key indicators of good practice that the Medical Council found include:

- A more systematic approach to programme design and development
- Greater clarity about the structure and organisation of programmes
- Greater emphasis on the student as an active participant in learning and not a passive recipient of teaching
- Greater emphasis on developing students' communication and interpersonal skills
- Greater emphasis and exposure to team-working
- Development of early (i.e. first year) patient contact programmes
- Greater opportunities for electives; i.e. for students to study topics and undertake projects in subjects that particularly interest them
- Greater emphasis on ethical issues and ethical practice.

A number of issues arising are discussed below.

Teaching and Learning on clinical sites

The majority of students reported satisfaction with the clinical education and training programmes provided. Nevertheless, while universities and schools have by necessity invested heavily in the redevelopment of the first two to three years of their new programmes, the re-development of the clinical

years needs to be given similar attention. Ensuring "completeness" of students' experiences in their clinical years, and providing consistency in the quality of experience across the numerous undergraduate rotations and sites, is very important. There is variability in quality of teaching and clinical experience between hospitals. While many students speak very highly of the academic and clinical teaching and pastoral care they receive, there are other sites that are less impressive, and this is unfair to the students.

Clinical skills laboratories and real patients

Clinical skills laboratories are teaching facilities that look like wards and that have simulated patients in the form of sophisticated "dummies" that respond to being "treated" in the same way as a real patient would do. They are very helpful in enabling students to learn and practise clinical procedure in an uninhibited way with no risk to patients. They have enabled students to undertake early hands-on care of a "patient".

However, it is important that there is no retreat from genuine face-to-face clinical encounters. Traditional bedside examinations, which evaluate students' history-taking capability and patient interaction skills, still have a major role to play. Exposure to real patients remains crucial, and insurance / risk-management issues, and overcrowding in hospitals, should not compromise this.

However, care must be taken not to over-burden patients. Many patients generously co-operate in the education and training of medical students, but this must not be assumed or exploited.

Opportunities outside the teaching hospitals

Growing numbers of medical students learning in major teaching hospitals are putting a strain on the hospital system. There is pressure on hospital teaching resources and numbers of students around beds. This is discussed further later in this section (under area 6, Educational Resources).

There are alternatives outside the teaching hospitals, with suitable locations for teaching and learning in:

- Affiliated hospitals; that is, smaller hospitals which have not traditionally taken many students, and which are often outside the major cities
- Outpatient clinics
- Public health and community clinics
- General Practice.

There is also potential in hospices, rehabilitation units, drug treatment centres, and elderly care homes.

Affiliated hospitals in particular are playing an increasingly important part in the delivery of the undergraduate curriculum, and there has been some progress in the exploitation of the other areas named above. Some schools now use these alternative sites to a significant extent. However, there is room for further utilisation, particularly as the students who have experienced these settings generally speak favourably of them. The Medical Council urges that use of these settings continue and accelerate, provided that the chosen environment is of a satisfactory standard. Exposure to different surroundings enhances learning about the maintenance of good health and the prevention, diagnosis and management of disease, offering students a new perspective and a fresh context to explore and develop.

The teaching and learning of professionalism

Professionalism - the set of values, behaviours and relationships that underpins the trust the public has in doctors - should be integrated right across the curriculum in a very visible way. Professionalism includes recognition and maintenance of the well-being and dignity of individual patients, commitment to the highest standards of patient care, motivation to serve the needs of the community, recognition of the importance of continuing medical education, and awareness of the ethical principles and the medico-legal basis of practice.

It is vital to develop students' awareness of professional responsibilities. Effective assessment of these topics also need to be further developed, so students will perceive them as crucial parts of the curriculum, which are as important as gaining scientific and clinical knowledge and skills.

Multi-professional teaching and learning:

The Medical Council urges that all medical schools maximise multi-professionalism. Progress has been rather slow. There is an untapped resource in interacting with other health care disciplines in some areas of the curriculum, as well as in the areas of teaching staff and facilities.

E-learning

The exploitation of e-learning - the use of network technology to create, deliver and facilitate teaching and learning - varies significantly from school to school. While recognising that content is more important than the mode of delivery, the Medical Council believes that e-learning complements more traditional methods.

Area 3: Assessment

The Role of Assessment

Effective assessment is a key part of a medical programme. It provides information about the progress and performance of individual medical students as they go through the programme. This enables students and teachers to identify areas of strength and of weakness, and take appropriate action. Assessment can also be used to gather information about the quality of the medical programme or of particular elements of it; analysing overall students' performance and pass rates gives medical schools valuable data that can be used developmentally.

Assessments currently in use include Multiple Choice Questions (MCQ), Extended Matching Questions (EMQ), Objective Structured Clinical Examinations (OSCE), and continuous assessment of essays, group work, project work and electives. They are used for *formative and summative assessment*. Formative assessment is generally carried out throughout a course, or element of the course; is used to aid learning; and is not necessarily used for grading purposes. Summative assessment is generally used at the end of a course or element of the course, and is typically used to assign a student a mark or grade.

Good practice

Some key indicators of good practice in assessment that the Medical Council found include:

- Linking the assessment approach and content to defined learning outcomes and specific goals; focusing on the desired end-product and the best way to test that it has been attained
- Clear correlation and good "match" between content and assessment
- The definition and statement of the methods used for assessment, including the criteria used for passing and achieving distinctions
- An appropriate balance between formative and summative assessment
- Use of multiple assessment techniques i.e. a mix or range of different assessment methods
- Appropriate use of continuous assessment and team-based assessment
- Assessment methods that are appropriate for the topic (e.g. MCQ's may not be the best way of assessing ethics components of the programme)
- Assessment that includes robust evaluation of key "non-academic" areas such as professionalism and team-working skills
- An appropriate space between the learning experience and the assessment, without too long a "lag"
- Integrating the findings of assessment into the teaching and learning and assessment process
- Assessment of practical clinical skills
- Using student feedback to make changes
- Good communication with students, including providing timely information about scheduling of assessments and issuing of results
- The encouragement of a "reflective practice" process.

There is evidence of all of these in medical schools in Ireland, but it would be fair to say that not all of them have every one of them in place. There must be defined measurable learning outcomes which include

the details of assessment. The Medical Council urges schools to keep their assessment methods under continuous review, and ensure that as the new programmes develop, the methods of assessment develop in tandem. The emphasis should be on quality not quantity of assessment; assessment overload is to be avoided.

Area 4: Students

Students are generally positive about their experience in medical schools in Ireland, and usually feel that they have chosen the right career and the right medical school for them. Their teaching and learning generally takes place in a responsive and supportive environment.

Good practice

Some key indicators of good practice that the Medical Council found include:

- Access programmes to increase the number of medical students from disadvantaged backgrounds
- Good orientation and familiarisation sessions for new students
- Events held to make overseas students from different cultures feel welcome, and help with acclimatisation to Irish society
- A mentor being assigned to each student
- Effective student health services
- Effective support and counselling for struggling students
- The development of a system of full-time student coordinators to provide student support on major teaching hospital sites
- Robust anti-harassment and anti-bullying policies.

Student participation

There are active student affairs committees and a high level of student involvement in planning and delivery of programmes. In general there has been extensive consultation with students regarding the implementation of new curricula and there is usually a perception among students that their views had been listened to and taken on board. This is commended.

Listening to students' views

As noted above, medical schools have made welcome efforts to be responsive to students' views. The Council, too - in its education and training function as in its professional standards and fitness to practice remit - must listen to the voice of the consumer. Much of what students have to say to the Council about their undergraduate experience is very positive. But the Medical Council must be open and willing to listen to any concern that students might have. Very occasionally, these might appear to be trivial and to some extent self-centred. In the overwhelming majority of cases, however, the Medical Council has been impressed by the quality of the contribution of the young men and women who are currently students but who will be the next generation of doctors.

The Medical Council also appreciates the contribution of the student observer, Mr (now Dr) Raj Naidoo, to the Education and Training Committee.

Student conduct

It is important for medical schools and universities to take account of inappropriate medical student behaviour, without penalising youthful high spirits. There is some evidence that in cases where serious ethical breaches occurred later in a doctor's career, this had been preceded by a "track record" of poor conduct that began at medical school.[6] There may be a need for universities' generic disciplinary rules to be customised to take account of the professional responsibilities of medical students to behave appropriately when assigned to clinical sites.

6 (Papadakis, M. et al (2005) 'Disciplinary Action by Medical Boards and Prior Behaviour in Medical School'. Maine: New England Medical Journal: Volume 353; 2673-2682.)

Areas for Review

Some areas that schools and universities should continue to keep under close scrutiny include:

- Continuing efforts to ensure student representation and participation on all relevant committees
- Pastoral and academic support for students on placements in affiliated hospitals
- Career guidance for students
- Continuing vigilance regarding any "education by humiliation" in the clinical setting.

Area 5: Staffing

The need for more clinical academics

Clinical academics (also known as academic clinicians) are doctors with joint university (or medical school) and hospital appointments. They have contracts which include an agreement to allocate a defined number of hours to teaching activities.

Many more clinical academics are needed if they are to play the key role in medical education that is required. The Medical Council's 2003 report found that there were only 39 whole time equivalent academic clinicians in Ireland, which compares very unfavourably with the position other countries. The Fottrell report cited data that found that there was the equivalent of 40 whole time equivalent clinical academics.

This very limited number means that the delivery of clinical training - which comprises around 50% of the medical curriculum - relies, as it has always done, on the voluntary commitment and part-time efforts of clinicians. Most clinicians have no formal obligation to teach, and are in most cases carrying a busy clinical workload as well.

It is greatly to their credit that so many of them do choose to participate enthusiastically in the crucial work of training their successors. But such a heavy reliance on the goodwill of the teacher is not appropriate in the twenty first century. It makes it difficult for the teacher to deliver the quality of teaching that they would like, and that the student needs. The ethos and attitude of the staff involved in clinical teaching is a major factor in the degree of satisfaction that students feel. Yet the pressure of patient care, and the attractions of research, can make education the least attractive choice for a busy and ambitious clinician.

Incentives and rewards

There needs to be proper incentives for an academic career, in terms of progression and promotion to senior posts; a positive affirmative action programme is needed to create a career path for medical educationalists with a clinical background. There needs to be a clear message from the medical schools that a focus on education (as compared to a high profile in research) will not disadvantage an academic clinician.

Postgraduate training bodies could also play a part here; doctors in specialist training programmes should be given the opportunity to gain credit for structured educational posts, possibly with the incentive of a Masters degree conferred from time spent as a Lecturer / Tutor. There is currently variability among postgraduate training bodies in this respect, and the Council believes there is more scope for it.

Contracts

Schools should establish memoranda of understanding and preferably contracts with specific teaching and affiliated hospitals and with appropriate primary and community teaching sites. Contractual arrangements need to be in place for both the training site and the trainers. There are currently some formal contracts with hospital teachers, but not enough. Even where a member of staff plays a relatively small role in teaching, the medical schools should consider drawing up a form of contract with these clinicians that will identify their respective commitments to teaching, research and patient care, and which could serve as a basis for annual review and recognition.

Resources

The adequate resourcing of academic clinician posts is not solely - or even primarily - the responsibility of individual medical schools; national action is required. There has been some progress in this area in recent months, and the Medical Council hopes that this will continue and accelerate.

Staff appointments in general practice are vital if general practice is to have its rightful place in the undergraduate curriculum. General practice education is very labour intensive, with 1:1 and / or small group teaching on dispersed sites, and a significant amount of investment must be made.

Good practice

Some key indicators of good practice that the Medical Council found include:

- Significant new academic appointments in all schools; the fact that appointments have been made at professorial level to medical education posts is particularly gratifying.
- The creation of medical education departments / units / centres in medical schools; the Medical Council commends their establishment as they can play a vital role in curriculum and staff development, and in research in the discipline of medical education
- The appointment of clinical tutors
- Prizes to reward good teaching.

Development of skills in the science and art of teaching and learning

The Medical Council recommends that staff be encouraged and facilitated to undertake staff development and obtain qualifications in medical education and in generic teaching and learning competencies. The centres for teaching and learning that have been established in universities and schools are playing an important role in fostering expertise in education.

Area 6: Educational Resources

Progress

The *Medical Council's Review of Medical Schools in Ireland 2003* summarised the position in 2003 as follows: "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".

There has been progress in the interim and some impressive new facilities are now available, but this unevenness identified in 2003 remains one of the major issues to be tackled. There is still inconsistency of student experiences across clinical sites, and lack of resources plays a significant role in this. It is hoped that the work being done at a national level following the Fottrell and Buttimer reports will result in major improvements across the country. The HSE Audit Team's forthcoming report on the education and training facilities available in hospitals in Ireland should be useful in informing the debate and should provide impetus for increasing funding.

Capacity

Sufficient capacity and resources, including on clinical training sites, is a pre-requisite for quality medical education. There are a growing number of students in the long-established programmes, as well as students in the two newly established graduate entry programmes (and interns, discussed in section 8). Pressure on existing facilities will therefore increase and undue pressure of numbers could seriously compromise the education and training of undergraduates. There is already evidence of a serious capacity issue in some of the major urban teaching hospitals.

The Medical Council therefore reiterates that venues for clinical teaching that are outside the traditional hospital setting must be found. Greater use of ambulatory, out-patient, primary and community settings is needed, as well as the greater exploitation of institutional capacity in smaller hospitals.

The provision of educational facilities in these settings will provide a new challenge, particularly in respect of the funding and staffing of this more interactive form of clinical education. There are significant financial and logistical implications inherent in a move out of the acute hospital setting, and this must be appreciated when resources are being considered.

Careful attention should be given by medical schools to evaluating and planning the utilisation of private hospital facilities in order to develop the range of placements available, as this would be a departure from existing practice.

There is an issue on some campuses and in certain hospitals about education and training facilities for student nurses and other health professionals being accessed by medical students. The medical students are sometimes not able to take advantage of the facilities. While appreciating the pressure on these facilities, an inter-professional / multi-professional approach to use of facilities is needed.

Small rooms near wards, that could be used for informal teaching or, for example, situations where bad news has to be broken to patients, have tended to be diverted away from educational use because of clinical pressures. Efforts should be made to identify rooms that can at least be multi-purpose, used in the interests both of education and the dignity of patients.

Information and Communications Technology

E-Learning application varies significantly from school to school and from the "preclinical" early years to the hospital-based programme.

There has been considerable progress in the use of electronic learning environments such as Blackboard and Modular Object-Oriented Dynamic Learning Environment (Moodle). This has been a major development, enabling students to access teaching sessions that they are not able to attend or that had to be cancelled.

However, once students leave the campus environment to undertake clinical attachments, the access to this facility reduces or, in some cases, disappears. Thus many students who were used to (and appreciated) this electronic facility are no longer able to use it.

It is apparent that the use of these electronic learning environments is, if anything, *more* important to students who are away from the campus and that resources should be available for this purpose. Rotations in peripheral hospitals and extended clinical attachments are likely to become relatively more important in years to come and the facilities need to keep pace with this. It would be unreasonable to expect the facilities at peripheral or affiliated hospitals to match those of major urban teaching hospitals. However, electronic methods can be used to deliver a teaching session from a major teaching hospital to students in a smaller hospital, or even a GP practice. Resources should be available for this.

IT support staff are needed to exploit e-learning to the maximum, especially in affiliated hospitals.

Hospital library opening hours are often 9am - 5pm, and closed at lunchtimes and weekends. These hours are unsuitable for students spending time on the wards. It is hoped that these opening hours can be extended.

Some hospitals have unsatisfactory facilities for private study (e.g reading rooms that are too small, and / or noisy; not enough computer terminals; inadequate access to printers). It is not always possible for students to connect to the hospital network with their laptops. Improvements are needed.

The number of print journals taken has declined as online journal procurement becomes more widespread. This is acceptable provided that there is access to major medical databases and to an appropriate range of on-line journals.

Clinical Skills Laboratories

Despite the warning against over-reliance on CSLs sounded in area 2 of this section, Clinical Skills Laboratories are invaluable in allowing students to practice practical skills in a safe environment, and there have been gratifying developments in this. A number of very welcome physical developments derived from overseas income. The additional facilities generated from overseas income are very welcome.

Area 7: Programme evaluation

Feedback from students has become an accepted part of the review and quality assurance process and medical schools take considerable pains to gather it. The Medical Council has been impressed by the greater use of robust tools to obtain feedback in a systematic way; an example being Dundee Ready Education Environment Measure (DREEM). Feedback is now routinely obtained form students at various stages of the programme, often using standardised course questionnaires. This is to be acknowledged and applauded.

Integrating the findings of positive and negative feedback into teaching and learning is crucial; it is important that, when appropriate, findings are translated into action. Almost as important is making students aware that their feedback can result in changes; knowing that they can make a difference is likely to encourage students to take the time to express their views. The Medical Council will be looking to access the results of student feedback to inform its monitoring processes. Feedback from training sites and from patients about their experience of medical students is encouraged by the Medical Council.

Area 8: Governance and Administration

Good practice

Effective governance and administration plays a crucial role in medical programmes. It underpins the development, delivery and enhancement of the programme. The employment of administrative and management professionals enables academic teachers to concentrate on their area of expertise, and to focus on their primary mission.

Some key indicators of good practice in governance and administration that the Medical Council found include:

- More robust structures in academic and administrative leadership, with some key positions having been restructured or filled
- Control of the curriculum and assessment lying with a faculty / school committee, possessing executive power over the curriculum, with departments unable to 'veto' any aspects of curriculum development and monitoring
- Progress towards a transparent and effective relationship between the central authorities in the university and the medical school
- Signs that universities recognise the resource needs of a modern medical school. New funding mechanisms, or resource allocation models, are being implemented. The "weighting" scheme used may benefit relatively expensive programmes such as medicine, and optimise resources for teaching
- Funding that supports a substantial portion of academic leaders' time (especially vital in the developmental and roll out phases of new programmes)
- Recognition of the considerable professional administrative expertise needed to organise and co-ordinate complex medical programmes
- Regular, formal meetings with representatives of health service bodies.

Areas for Review

Some areas that schools and universities should continue to keep under close scrutiny include:

- The lines of accountability between the schools and the universities (in respect of the school's **functions**), and between the university and the school (in respect of **funding**); these require clarification in some cases
- Efforts should continue to ensure that resources derived from undergraduate fee income are used to support undergraduate teaching programmes, and are not diverted to other activities. There are concerns (also articulated by students) that in some cases income from undergraduate fees is not transparently spent on undergraduate education
- The Medical Council supports a parity of investment in Medical Schools for education compared to the large investments in research. Universities stress their role as "research-intensive" organisations, and this is perfectly laudable. Education is enriched by research. However, an emphasis on research should not result in a disproportionate amount of student-generated funds going to fund research rather than education. Undergraduate income should be devoted virtually 100% to teaching and education (personnel and facilities) and not diverted into research
- The universities and schools should ensure that changes in structure, most notably with the loss of departments, does not lead to an erosion of 'community' within schools and universities, and result in fragmentation

- Educational leadership should be sufficiently resourced in terms of dedicated sessions
- The continuing reliance on income derived from overseas students carries an element of risk: while this income has been instrumental in providing new and impressive educational facilities, repayments are dependent upon ongoing income
- Some schools need to develop their interaction with health service interests, and this should include links with the community sector as well as the acute sector
- The continued evolution of medical programmes (including an increase in undergraduate placements in affiliated hospitals and community and primary settings) is likely to increase the complexity of administration.

There have been changes in recent years in the internal structure of the universities in Ireland, and there is considerable diversity among them. In six medical schools, with differing histories and traditions, diversity is inevitable and indeed healthy. No one model is perfect and each school should maximise the efficiency and effectiveness of their governance and administration within the context of national and international best practice.

Area 9: Continuous Renewal

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

The Medical Council is aware that universities and medical schools have various forms of internal audit in place for reviewing their structures and activities. The changes that have taken place in medical schools in Ireland since 2003 are proof of renewal. Medical schools need to remain responsive to the changing environment. At least one medical school has found the assistance of an overseas expert that they engaged to assess them to be useful in this respect. The Medical Council will be following with interest the findings of internal and external reviews and the changes that result.

7. GRADUATE ENTRY PROGRAMMES

7.1. Introduction

In many countries, entry to medicine is primarily or even exclusively for graduates. The Fottrell Report envisages that within the next few years, 40% of entrants to medical programmes in Ireland will already be graduates, in disciplines other than medicine, entering four year programmes. These programmes will provide a path for more mature students. Students will include those who realise when taking another degree or pursuing a different career, that they want to study medicine, and those who did not get sufficient points for entry as a school leaver.

The Medical Council has provisionally accredited two graduate entry programmes; both are four year programmes. In 2005, it gave initial accreditation to the RCSI's graduate entry programme, and in 2007 it gave initial accreditation to the University of Limerick's graduate entry programme.

7.2. Admission to graduate entry programmes

Entry to the above programmes is for graduates who hold a minimum of a 2.1. honours degree or equivalent, in any discipline, who have also passed the GAMSAT (Graduate Australian Medical School Admissions Test) or MCAT (the US Medical College Admission Test).

All entrants will have some science knowledge because they have sat the GAMSAT or MCAT. Many entrants have a first degree in a scientific discipline, with other being arts, social sciences or humanities graduates. Some students have joined the graduate entry programmes immediately after graduating with their primary degree, while others were well established in their non-medical career before joining the course.

7.3. World Federation for Medical Education

The Medical Council's accreditation process for graduate entry programmes uses the same major elements as that for existing programmes; that is, use of World Federation for Medical Education Standards; participation of external assessors; documentation review prior to the visit; an accreditation visit, including meeting representatives of the College, University or Medical School for in-depth discussions; and inspection of the campus and of the teaching hospitals.

In line with Medical Council policy and procedure, the initial accreditation of the RCSI's and UL's programmes is *provisional*: full accreditation is not possible until the first cohort of students has successfully completed the four years of the programmes. RCSI students are now in the second year of their programme, and UL students are first years.

7.4. Monitoring

The Medical Council will monitor the graduate entry programmes as they roll out. Many of the issues that arise in graduate entry programmes are likely to be similar to those already described in section 6 of this report, Assessment of Undergraduate Medical Programmes. However, some issues may be directly related to the nature of graduate entry programmes including:

- The challenges and potential advantages of some students not having a science background
- The demands and pressure of an intensive four-year programme
- The impact of more mature and experienced learners on the medical school
- Interaction with medical students on traditional programmes
- The particular financial, academic and pastoral support needs (if any) of a graduate cohort.

The Medical Council will be particularly interested in the views of the students on these innovative programmes.

8. INTERNS

8.1. The framework for internship

On successful completion of a medical degree, graduates receive internship registration with the Medical Council[7]. The intern year is therefore the first year of postgraduate training. Interns take up an intern post that is intended to offer a combination of suitable education and training and responsibility for patient care. Although general practice is an option for interns (see below), the vast majority of intern posts are in hospitals. Interns retain some links with the medical school, chiefly through a medical school-based in intern coordinator. However, interns are no longer medical school students but are doctors, employees and trainees.

It is the Medical Council's responsibility to approve intern posts. Interns should only take posts that are approved by the Medical Council. Before it approves posts, the Medical Council has to be assured that the hospital and the programme of education and training are of a sufficiently high standard.

During the 12 months of internship, graduates must spend at least three months in an internship in medicine and three months in a surgery internship. The Medical Council will also approve suitable internship posts in obstetrics & gynaecology, emergency medicine, paediatrics, psychiatry, general practice, and perioperative medicine (which includes anaesthesia and pain management); interns can spend a minimum of two months and a maximum of three months in these rotations.

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 full registration with the Medical Council.

8.2. Prepared for Internship?

Does the content and delivery of the undergraduate medical programme prepare graduates to undertake internship? Does their undergraduate experience equip them to cross the threshold from undergraduate to postgraduate medical education and training and practice?

Several common themes emerge. The students about to graduate, and the new interns, acknowledge and appreciate that they have had the opportunity to experience at least some of the revised curruicula which provides earlier and more integrated exposure to clinical skills. In some cases they also had the opportunity to learn and practice their developing skills in the safe environment of clincal skills laboratories. Nevertheless, many interns still want more tuition in practical clinical skills before they become interns.

There seems to be positive movement in this area: at least some interns feel that the students they have contact with are much better prepared clinically than they themselves had been, and have stronger communication skills. They attribute this to a reduction in lecture-based teaching and increased exposure to patients, and simulated patients, at undergraduate level.

The Medical Council welcomes this apparent enhancement of clinical and communication skills.

8.3. Shadowing and induction

There is a short "handover" period from the undergraduate programme to internship. Just before the transition from student to intern, medical schools and hospitals cooperate to provide graduates with the opportunity to "shadow" an intern; that is, to follow and observe an intern at work. Induction sessions, which provide information about the context and practicalities of being an intern, are also provided. Shadowing is regarded as a helpful concept, and induction is appreciated by the vast majority of students. The Medical Council urges that the development of induction continues, and that it is informed by feedback from students and interns. Staff from the Medical Council are happy to participate in induction, to explain the Council's role in internship registration and education and training.

7 See Appendix 6

8.4. The early days of internship

Despite the exposure to clinical practice that occurs in the final years of a medical programme, the change from medical school to internship is still a significant one. Being nervous on the first day of a new job - particularly a first job - is natural. It is normal for new recruits to have to familiarise themselves with their role, their colleagues and their surroundings.

However, some of the interns that the Council met felt out-of-their-depth on their first day and expressed concerns - even fears - about their capacity to cope when beginning intern training. There is no evidence that these interns could not cope; and they may unjustifiably lack faith in their own abilities. Interns' confidence certainly significantly, and gratifyingly, increased with as little as two weeks experience. However, the Medical Council urges that both medical schools and hospitals do everything that they can to bridge the transition from medical school to work. There are steps that can be taken to make this easier.

- Intern tutors can play an important part. They are doctors who take on the role of mentoring interns in academic and sometimes personal issues. In many cases, interns have the highest praise for the commitment and effectiveness of their intern tutor. But the situation varies and in some hospitals there is no intern tutor or they have a low profile. Resource is an issue here; in many cases, the tutor has no dedicated time to perform their tutor duties and receives no remuneration for it.

  The Medical Council believes that intern tutor posts should be properly resourced. Hospitals should do everything that they can to assist intern tutors to perform their role. An effective intern tutor makes a significant difference to the quality of the intern experience. Tutors can be "cost effective" by dealing at an early stage with any concerns that arise, perhaps preventing escalation into major problems.

- Many interns feel that Advanced Cardiac Life Support training at the pre-intern stage would have lessened their anxiety about carrying a cardiac bleep on their first day at work. If it is not possible to have ACLS training as an undergraduate, the Medical Council urges that it take place at the beginning of the intern year.

8.5. Formal and protected teaching sessions

Interns identified the pros and cons of teaching hospitals and smaller affiliated hospitals, with more formal structured teaching and better facilities in the former, and in the latter more opportunity to be part of a team, and more "hands on" experience.

Learning through practical application of clinical skills is a key part of internship, and therefore ward-based experiential learning is crucial. However, the intern is a trainee and regular, pre-arranged formal education and training sessions are very important. Intern learning opportunities may include:

- Lectures
- Supervised consultation in outpatient clinics, day care hospitals, community visits
- Small group case presentations and discussion
- External courses
- Personal study, including electronic and distance learning.

The Medical Council's 2003 report stated that lack of protected time for teaching was a problem. There is considerable variation in the extent to which teaching time is bleep free or bleep protected (i.e. with interns not being interrupted by being bleeped to deal with a clinical issue). It is gratifying, however, that in many instances considerable efforts are made by the hospital to maximise the time that interns can concentrate on formal education and training without disturbance.

Not all scheduled teaching sessions take place; it is important that in these instances every effort is made to reschedule sessions, or to use electronic means to deliver them.

8.6. Appropriate levels of responsibility

The Medical Council has some concerns about interns sometimes being asked to act 'above grade' i.e. at a level which is not appropriate for a new and inexperienced doctor. The specific issue of taking consent is discussed below. But there are other instances in which interns are called upon to undertake clinical procedures which they should not be asked to do. The Medical Council's Guide to Ethical Conduct and Behaviour (2004)[8] states that junior doctors should never be asked to perform tasks for which they are not fully competent, except under the direct supervision of senior colleagues. The Medical Council reiterates this.

At the opposite end of the spectrum, there remains a perception among some interns that they perform too much low level work. Interns must recognise that they are new doctors and that performing routine tasks is an important part of the learning process. However, it is not a good use of time and resources for interns to perform tasks that are more appropriately undertaken by other staff.

8.7. Consent

A patient's consent must be obtained prior to any medical procedure being carried out on him/her (except in emergency, life threatening situations or where the patient is incapable of giving consent, in which case other criteria apply). The ethical and legal rationale behind this necessity to obtain consent is to respect the patient's autonomy and his/her right to self-determination. A patient has the right to decide what happens to their own body.

A patient's decision about giving consent has to be informed by a knowledge of the diagnosis, the prognosis, the various options for treatment or management of the condition, including the option not to treat; common and serious risks and side effects; the likely benefits and the probabilities of success.

Doctors play a central role in enabling patients to give - or withhold - consent. In most cases, it is the doctor who is best placed to ensure that a patient has the knowledge they need to give their consent, and the doctor who can discuss and answer a patient's questions about the above issues. It is therefore crucial that the doctor taking consent has full knowledge of all the relevant issues. As the Medical Council's Ethical Guide states, informed consent can only be obtained by a doctor with sufficient training and experience to be able to explain the procedure, risks and benefits, and possible alternatives. The Medical Council reiterates this policy.

However, there is some evidence that interns are taking consent for procedures that they do not fully understand. The argument that "real" consent is obtained by a more senior doctor earlier or later in the process, and that the taking of consent by an intern is purely "mechanical" or "administrative" is rejected by the Medical Council. Interns should take consent only for those procedures that are within their level of competence, where they can explain to the patient the procedure, risks and benefits, and possible alternatives. The Medical Council's revised Ethical Guide and the Medical Council's document "Good medical practice in seeking informed consent to treatment" which will soon be issued will reflect this.

8.8. Assessment

Assessment of interns is a vital part of the intern year. At the end of the year, the Dean or Head of the relevant medical school certifies that the intern has successfully completed their internship, and it is on that basis that the intern is given full registration by the Medical Council. It is therefore crucial that the decision to sign off and register an intern is based on a proper assessment of an intern's performance and competence. Formative assessment assists the intern by highlighting their areas of strength and those areas where further development is needed, and allows them to address the issues as the intern year unfolds.

Currently, the robustness of assessment varies. In some cases it is systematic and thorough, and takes place after each rotation. In these cases, the intern and the relevant consultant discuss the rotation; feedback is given to the intern, and, in some cases, the intern has the opportunity to make their comments on

8 The Guide to Ethical Conduct and Behaviour is available on the Medical Council website at www.medicalcouncil.ie

their experience. The Medical Council's 2003 report states that interns requested more feedback on their performance. While progress has been made since then, more needs to be done. In some cases, Medical Council visiting teams were informed by the hospital that assessments took place at the end of each rotation, but the interns were under the impression that it only took place at the end of the year. There may therefore be some communication issues involved as well.

Under the Medical Practitioners Act 2007, medical schools will no longer have responsibilty for signing off the intern as having completed their intern year. This responsibility will fall to the Medical Council and the Medical Council is looking at the best way of ensuring that assessment at the end of each rotation becomes an accepted part of every internship.

This review will include the issue of the Medical Council's Intern logbook. Interns are supposed to keep the logbook as a record as they go through their intern year, to diarise their experience and acquisition of skills. In practice this is not always done. It may be that a paper-based logbook format is no longer suitable for an age of greater electronic communication, and that changing the format would encourage greater use among interns.

8.9. Bullying and dignity at work

The Medical Council's 2003 report stated that "The Council was concerned at the level of bullying of our interns... bullying and harassment of interns is completely unacceptable ..." In 2007, the Medical Council reiterates its zero tolerance policy on this issue: there is an obligation on all doctors to treat all colleagues with dignity and respect.

In general interns do feel respected by their colleagues. However, while there has been continuing progress in the development of anti-bullying and dignity at work policies, the Council still found examples of bullying taking place. Systematic bullying of interns as a group appears to be rare, although assigning the intern completely inappropriate duties can, in some cases, be an example of a more subtle form of bullying. Instances where the unacceptable behaviour of an individual went unchecked were relatively rare, but must be dealt with promptly and appropriately. There is some evidence of friction between interns and other health care professionals, but many other examples of excellent inter-professional team working and mutual respect at all levels of clinical practice.

As well as addressing issues as they arise, it is important for hospitals to foster an anti-bullying environment. It is crucial that in the instances where bullying is or may be occurring, interns have the support they need to raise these issues, and the confidence that employers and medical schools will deal effectively with the problem.

8.10. Ethical dilemmas

It is possible that as a new doctor, an intern may find themselves in a situation where they have concerns about the behaviour, clinical skills or health of a colleague. The Medical Council urges that interns who have concerns about a colleague's or the behaviour of a third party raise these concerns. Patient safety may depend on an intern acting on their concerns.

Most interns had not had to face an issue of this type. Those that had stated that they would be reluctant to raise such an issue with a consultant, feeling that this should be left to someone more senior. They do not always feel they had a "safe" advisor or mentor with whom to discuss the issue. There is some concern among interns that raising difficulties would lead to their being perceived as a trouble maker.

The Medical Council appreciates that it can be difficult for inexperienced junior doctors to raise an issue like this. However, all doctors, however junior, have an obligation (as stated in the Ethical Guide) to express their concerns initially to a colleague, if that does not deal with the issue to raise it via local systems, and after that where necessary to refer the issue to the Medical Council.

8.11. New rotations

There are very few interns in the newer rotations of obstetrics and gynaecology, emergency medicine, paediatrics, psychiatry, general practice, and perioperative medicine. Students and interns would generally welcome experience in approved rotations other than medicine and surgery, and those that have had the opportunity feel it has been valuable. The Medical Council believes that on the grounds of quality education and training, there should be more opportunity for internships in these subjects. There are resource issues involved, particularly in internships in General Practice. But the promotion of educational diversity, as well as capacity, means that these should be addressed.

8.12. Careers advice

Interns are keen to obtain careers advice at the earliest possible stage, and some hospitals have developed careers information and advice events aimed at interns. However, this is an issue that needs more attention, and is an area where the postgraduate training bodies could play a useful part.

8.13. Projects

Two Medical Council projects on the intern year have been funded during the lifetime of the current Medical Council. The first, funded by the Department of Health and Children, has been completed, and is on the Medical Council's web-site[9]. It provided some key data and an in-depth analysis of the shape and pattern of internships across the country.

The second, current, project, has been funded by the Health Service Executive, and this project is looking at the ways in which the Medical Council can undertake its responsibilities under the new 2007 Act.

The Council appreciates the funding of these projects, and believes that they will play a key role in improving the intern experience.

8.14. Internship summary

The majority of Interns are satisfied with the clinical training and education programme provided. There is work to be done, however; and via its on-going Intern Project, and under the new Act, the Medical Council will be supporting developments to tackle some of the issues raised above.

A note of warning must be sounded here. Individual interns expressed concern to the Medical Council regarding the capacity of the health system to accommodate significant expansion of intern numbers. The Medical Council shares these concerns. The pressure on the system is already evident, and the projected increase in the number of medical students will add to it. Fottrell also recognised that additional intern positions needed to be provided in line with need. All the interested parties must search for ways of absorbing this increase without detriment to education and training or to patient care.

9 www.medicalcouncil.ie Intern Coordinator and Tutor Network Project Report - A Review of the Intern Year (October 2006)

9. CONCLUSION

The Medical Council recognises the substantial achievements in medical education since 2003 and section 2 of this report makes recommendations as to how the momentum for change can be maintained.

In many instances the medical schools welcome the Medical Council's comments, and have already taken action to address the issues raised in this report. Medical schools are commended for their positive and energetic approach.

There is much to be proud of in medical education in Ireland, but there is no room for complacency on the part of any of those involved in the planning, delivery and regulation of medical education, including the Medical Council. Much has been delivered; much more is planned and promised. The Medical Council will continue to monitor progress and looks forward to providing another review of medical schools in the years to come.

Your Views

We hope you found this report to be useful. Some of the terms used in the document, and links to relevant websites, are included in Appendix 7. If you have any comments about the report's content or presentation, or any questions about any of the issues raised in it, please contact the Medical Council at educationandtraining@mcirl.ie, or write to Anne Keane at the Education and Training Section, Medical Council, Lynn House, Portobello Court, Lower Rathmines Road, Dublin 6, Ireland.
Your views are very welcome. Go raibh maith agat as ucht do chuid oibre.

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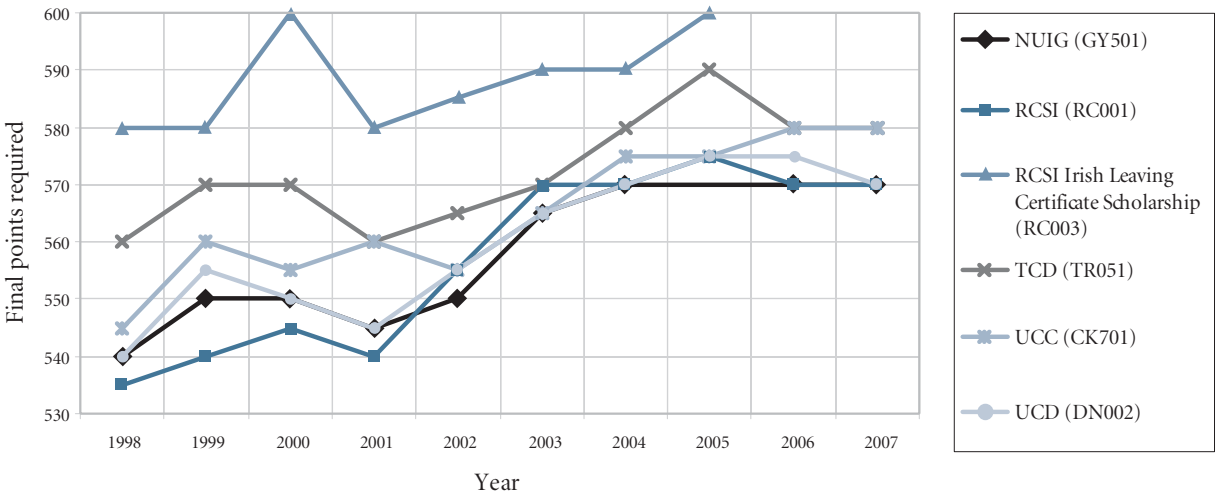
APPENDIX 1

Final Round points for Medicine



Source www.cao.ie

APPENDIX 2

Medical Council Questionnaire for completion by medical schools

1. *This questionnaire utilises the World Federation for Medical Education's document "Basic Medical Education: Global Standards for Quality Improvement" (WFME, 2003). Each section of the questionnaire summarises the relevant WFME Standard, whether Basic ("B") or Quality ("Q"), usually indicated by a "must" and a "should" respectively.*
2. *The questionnaire asks the respondent to provide information about the various elements of the existing programme, and to assess and demonstrate whether they comply with the Basic or with the Quality Standard. In some instances, the question includes a request for specific information on a particular aspect of the Standard.*
3. *Where the Medical Council has previously made recommendations relating to the programme (e.g. following its 2003 round of visits to schools), an update on the situation / progress made should be given in the appropriate part of the questionnaire.*
4. *Relevant additional documentation can be provided by the Medical School as an annex to the completed questionnaire.*

1. Mission and Objectives

1.1 Statements of Mission & Objectives

B: Mission & Objectives must be defined and made known to the constituency; Mission & Objectives must describe the educational process that produces competent doctors who are equipped for their clinical role and have an appropriate foundation for further training in any branch of medicine.

Q: Mission & Objectives should encompass social responsibility, research attainment, community involvement, and address readiness for postgraduate training.

Please describe the Mission & Objectives of the programme.

1.2 Formulation of Mission & Objectives

B: Mission & Objectives must be defined by principal stakeholders (e.g. Dean; members of faculty board, university, government, medical profession).

Q: Mission & Objectives should be based on input from a wider range of stakeholders (e.g. representatives of staff, students, the community, education and health care authorities, professional organisations, postgraduate training bodies).

Please define and describe the role that stakeholders have played / continue to play in the formulation of the Mission & Objectives of the programme.

1.3 Academic autonomy

B: There must be a policy, for which the staff is responsible, within which they have freedom to design the curriculum and allocate resources necessary for implementation.

Q: All academic staff should be able to contribute to this process; the educational resources should be distributed in relation to educational needs.

Please analyse academic autonomy in the context of the programme.

1.4 Educational outcome

B: The competencies that students should demonstrate on graduation must be defined.

Q: Competencies on graduation should be specifically linked to competencies to be acquired in PG training.

Please describe the defined educational outcomes of the programme, with reference to knowledge and understanding of the basic, clinical, behavioural and social sciences; medical ethics; attitudes; practical clinical skills; readiness for continuing medical education and professional development; the needs of the community as a whole.

2. Educational Programme

2.1 Curriculum model(s) and instructional methods

B: Curriculum model(s) and instructional (teaching and learning) methods must be defined

Q: The models and methods should ensure that students have responsibility for their learning process, and should prepare them for life long self-directed learning.

Please describe the curriculum model(s) and instructional methods intended for each stage of the curriculum, highlighting the rationale for the balance of the methods used.

2.2 Scientific method

B: The principles of scientific method and evidence-based medicine, including analytical and critical thinking, must be taught throughout the curriculum.

Q: The curriculum should include training in scientific thinking and research methods, which may include elective research projects;

Please describe the role of scientific method and EBM in the various stages of the curriculum.

2.3 Biomedical Sciences

B: The programme must include the basic biomedical sciences to create understanding of the knowledge underlying medicine.

Q: The biomedical sciences in the curriculum should be adapted to scientific, technological, and clinical developments, and to the health needs of society.

Please describe the role of biomedical sciences in the various stages of the curriculum, including their integration with clinical sciences.

2.4 Behavioural and Social Sciences, including Ethics

B: The contribution of relevant aspects of the behavioural and social sciences, and medical ethics and jurisprudence must be incorporated into the curriculum to foster communication, clinical decision making and ethical practices.

Q: The contributions of these subjects should be adapted to scientific developments, changing demographic and cultural contexts, and society's health needs.

Please describe the role of Behavioural and Social Sciences (including ethics, public health, epidemiology and biostatistics) in the curriculum.

2.5 Clinical Sciences and Skills

B: Students must have patient contact and acquire the clinical knowledge and skills needed for clinical responsibility after graduation.

Q: Every student should have early patient contact leading to participation in patient care. The different components of clinical skills training should be structured according to the stage of the study programme.

Please describe the role of clinical sciences and skills in the programme.

2.6 Structure, composition, and duration

B: The content, extent and sequencing of the constituent elements of the programme must be defined, including the balance of core and optional content, the role of preventative medicine, health promotion and rehabilitation, and any complementary medicine component.

Q: Basic and Clinical Sciences should be integrated in the curriculum.

Please describe the structure, composition, and duration of the programme. Detailed information is sought on the core curriculum, including subjects taught, hours / weeks / months allocated to them, and the balance between lectures, small group teaching, tutorials, seminars, laboratory work and patient contact time. Information on opportunities for electives / special study modules / student selected components should also be provided, for each stage of the course. It would be helpful if the information could also be supplied in diagrammatic / tabular form.

2.7 Programme management

B: A curriculum committee must have the responsibility and authority for planning and implementing the curriculum.

Q: The committee - which should include student, staff and other stakeholders - should be provided with resources for: planning and implementing methods of teaching and learning; assessment of students; evaluation of the curriculum; and innovation.

Please describe the management of the programme, with particular reference to the curriculum committee.

2.8 Linkage with medical practice and the health care system

B: There must be operational links between the programme and the subsequent stages of training or practice.

Q: The curriculum committee should seek input from the environment in which graduates will practice, and modify the curriculum appropriately.

Please describe this articulation.

3. Assessment

3.1 Assessment methods

B: Methods of assessment used must be defined and stated, with explicit pass criteria.

Q: The reliability and validity of assessment methods should be evaluated and developed.

Please describe the general policy on assessment, including the timing, weighting and criteria for progression through the programme. The formative and summative assessment methods used at each stage of the programme should be outlined. It would be helpful if the information could also be supplied in diagrammatic / tabular form.

3.2 Relationship of assessment and learning

B: Assessment principles, methods and practices must be clearly compatible with educational objectives and must promote learning.

Q: The number and nature of assessments should encourage integrated learning. The need to absorb excessive amounts of information, and curriculum overload, should be avoided.

Please describe the relationship between assessment, objectives and learning.

4. Students

4.1 Admission policy

B. There must be a clear selection and admission policy.

Q: The policy should be reviewed to ensure that it remains relevant to the needs of the institution and to those of society as a whole. The relationship between selection, the educational programme, and desired qualities of graduates, should be stated.

Please summarise the admission policies of the programme, including your policy on the admission of students with disabilities. Please include information on assessment of relevant non-academic factors, including motivation for a career in medicine.

4.2 Student intake

B: The size of student intake must be defined and related to capacity.

Q: The size and nature of the intake should be reviewed in consultation with relevant stakeholders and revised where necessary to meet the needs of the community and society.

Please provide data.

4.3 Support and counselling for students

B: Student support, including counselling, must be offered.

Q: Counselling should be provided based on monitoring of student progress and should address students' social and personal needs.

Please describe the student support, welfare and counselling services available.

4.4 Student representation

B: There must be a policy on student representation and appropriate participation in the design, management and evaluation of the curriculum and other matters relevant to students.

Q: Student activities and organisations should be encouraged and facilitated.

Please describe the mechanisms used to ensure that the views of students on the course are heard.

5. Staffing

5.1 Recruitment policy

B: There must be a staff recruitment policy which outlines the type, responsibilities and balance of academic staff required, including the balance between medical and non-medical staff; and between full and part-time staff. Their responsibilities must be explicitly specified and monitored.

Q: A policy should be developed for staff selection criteria, including scientific, educational and clinical merit, relationship to mission, economic considerations, and local issues.

Please describe the policy, and the profile of the staff allocated for the programme, specifying whether medical / non-medical, full time or part time.

5.2 Staff policy and development

B: There must be a staff policy that addresses the need for a balance between teaching, research and service functions, and assures appropriate recognition for effectiveness in these areas.

Q: Staff policy should include teacher training, development and appraisal. Teacher-student ratios and teacher representation on relevant bodies should be taken into account.

Please describe the policy and the development opportunities available.

6. Educational Resources

6.1 Physical facilities

B: There must be sufficient physical facilities to enable curriculum delivery.

Q: The learning environment should be regularly updated and extended to match developments in educational practice.

Please provide details of the facilities and learning environment for the programme, including lecture theatres, tutorial rooms, laboratories, library and IT facilities, social; and recreational amenities. When these are shared with another course / programme, whether medical or otherwise, please make this context clear.

6.2 Clinical training resources

B: There must be facilities for adequate clinical experience, including sufficient patients.

Q: The facilities should be adjusted and improved to meet changing needs, including the needs of the population in the geographically relevant area.

Please provide a detailed breakdown of the available resources, including university-based facilities (e.g. clinical skills laboratories), and hospital, clinic, community, and primary care-based facilities, and patient mix.

6.3 Information Technology

B: There must be a policy on the effective use of information and communication technology.

Q: Teachers and students should be enabled to use IT for self-learning, accessing information, managing patients and working in health care systems.

Please describe the policy on information / communication technology, and the role of IT in the programme. Please outline the opportunities for computer-based learning.

6.4 Research

B: There must be a policy that fosters the relationship between education and research and must describe the available research facilities and priorities.

Q: The curriculum should reflect the interaction between research and education, and students should be prepared and encouraged to engage in research and development.

Please describe the policy, and role of research in the programme, and provide details of the facilities available for research.

6.5 Educational expertise

B: There must be a policy on the use of educational expertise in planning and development

Q: There should be access to educational experts and evidence demonstrated of the use of expertise in staff development and pedagogical research.

Please describe the policy, and the role of expertise.

6.6 Educational exchanges

B: There must be a policy for collaboration with other educational institutions and for the transfer of educational credits.

Q: There should be regional and international exchange of staff and students, appropriately resourced.

Please describe the collaboration policy, the scope for credit transfer, and opportunities for exchange.

7. Programme Evaluation

7.1 Mechanisms for programme evaluation

B: There must be a mechanism for programme evaluation that monitors the curriculum and student progress, ensuring that concerns are identified and addressed.

Q: Evaluation should address the context of the educational process (e.g. organisation, resources, culture and learning environment); the specific components of the curriculum (including student performance); and the general outcomes (including career choice and postgraduate performance).

Please provide details of valid and reliable mechanism(s) used for evaluation, remediation of concerns, and quality enhancement.

7.2 Feedback

B: Teacher and student feedback must be systematically sought, analysed, and responded to.

Q: Teachers and students should be involved in programme evaluation and in integrating the results of this into the curriculum.

Please provide details of this involvement and mechanisms.

7.3 Student performance

B: Student performance must be analysed in relation to the curriculum, mission and objectives.

Q: Student performance should be analysed in relation to student background, conditions and entrance criteria, and should be fed back to the committees responsible for selection, curriculum and student support.

Please describe the policy and mechanisms for analysing student performance.

7.4 Stakeholder involvement in programme evaluation

B: Programme evaluation must involve the governance and administration of the medical school, and its staff and students.

Q: A wider range of stakeholders (e.g. educational and health care authorities, community representatives, professional organisations, and postgraduate training bodies) should be involved.

Please describe the part played by internal and external stakeholders.

8. Governance and Administration

8.1 Governance structures

B: Governance structures (including University / college / faculty school relationships) must be defined.

Q: Governance structures should set out the committee structure and reflect representation from staff, students and other stakeholders (including external stakeholders).

Please describe the governance structures relating to the programme. It would be helpful if the information could also be supplied in diagrammatic / tabular form.

8.2 Academic leadership

B: The responsibilities of the academic leadership for the programme must be clearly defined.

Q: The academic leadership should be evaluated on a regular basis to assess progress towards mission and objectives.

Please describe the responsibilities of the academic leader(s), and monitoring arrangements.

8.3 Budget and resource allocation

B: There must be a clear line of responsibility and authority for the curriculum and its resourcing, including a dedicated educational budget.

Q: There should be sufficient autonomy to direct resources, including staff remuneration, in an appropriate manner to achieve objectives.

Please detail the structures for resource allocation. This should include information as to the degree of autonomy in the use of designated resources.

8.4 Administrative staff and management

B: The administrative staff must be appropriate to support the programme and related activities, and to ensure good management and resource deployment.

Q: The management should be regularly reviewed and quality assured.

Please summarise the administrative staff resources available to support the programme.

8.5 Interaction with health sector

B: There must be constructive interaction with health and health-related sectors of society and government.

Q: This collaboration should be formalised.

Please describe any relevant interaction of this nature.

9. Continuous Renewal

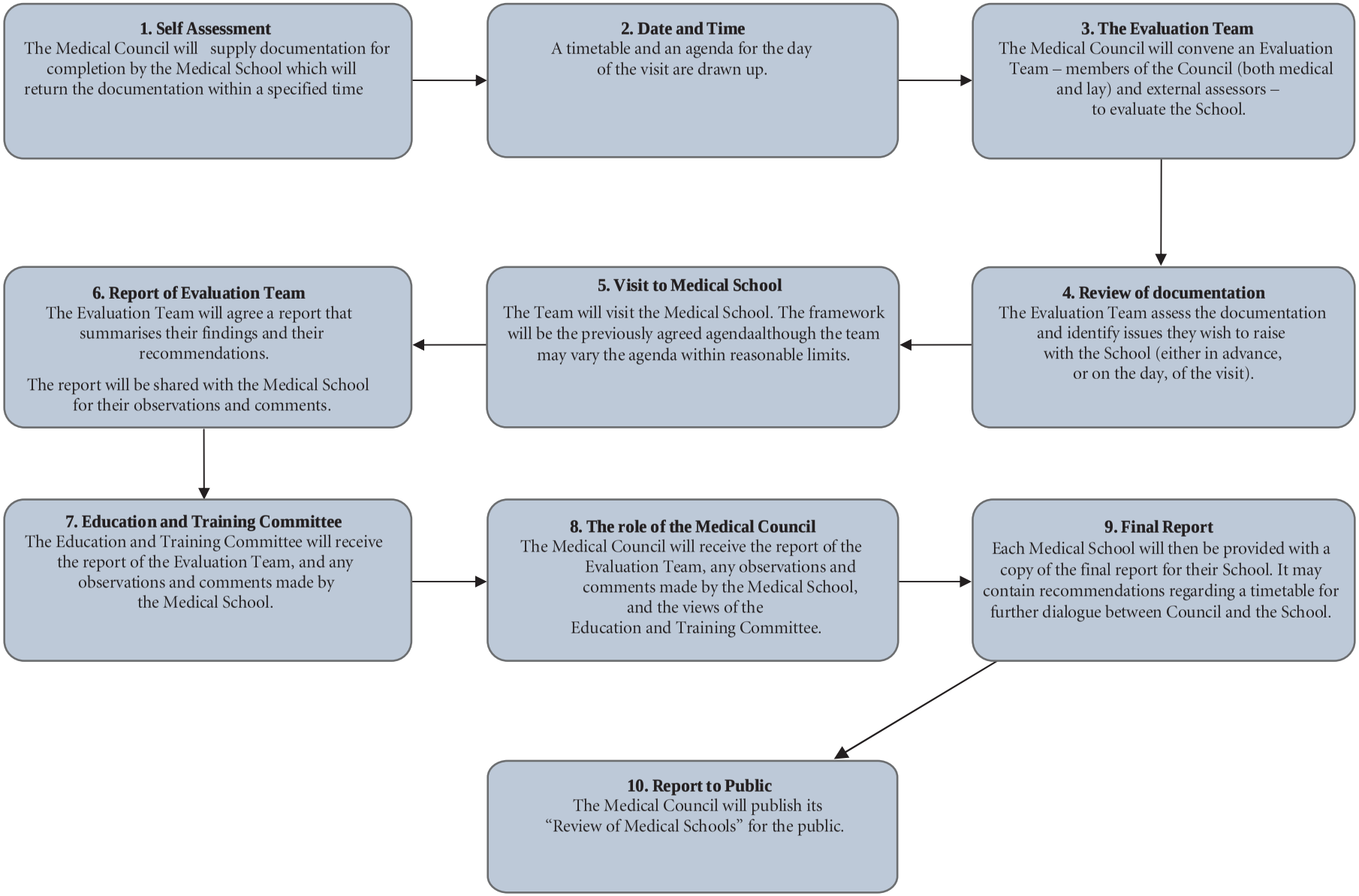
B: The medical school must, as a dynamic institution, initiate procedures for regular reviewing and updating of its structure and functions, and must rectify identified deficiencies.

Q: The process of renewal should be based on prospective studies and analyses and should lead to the revisions of the policies and practices of the medical school.

Please describe the arrangements for continuous renewal, in areas such as student recruitment and selection; the mission and objectives of the programme; the required competencies of the graduating students; the curricular model, elements and instructional methods; assessment; staffing recruitment and policy; educational resources; quality assurance; and governance structures

Thank you for completing this questionnaire

APPENDIX 3 Flowchart of Medical Council's Evaluation process for Medical Schools



APPENDIX 4

Composition of Medical Council Accreditation and Assessment Teams 2005 - 2007

2005

ACCREDITATION OF POSTGRADUATE ENTRY PROGRAMME ROYAL COLLEGE OF SURGEONS IN IRELAND

Assessment Team

- Dr John Hillery (President of the Medical Council and Chair of the Assessment Team)
- Professor Muiris FitzGerald (Chair of the Education and Training Committee)
- Professor Tom O'Dowd (Department of Public Health and Primary Care TCD and former Chairman of the Medical Council's Education and Training Committee)
- Ms Margo Topham (lay member Medical Council)

Accompanied by

- Mr John Lamont (Registrar)
- Dr Anne Keane (Head of Education and Training Section)
- Ms Karen Willis (Senior Executive Officer, Education and Training Section)
- Professor Sir Graeme Catto and Professor Paul O'Neill (General Medical Council) acted as external assessors in the documentation review.

2006

NATIONAL UNIVERSITY OF IRELAND GALWAY

2nd March 2006

Assessment Team

- Professor Muiris FitzGerald (Chair of Education and Training Committee and Chair of Assessment Team)
- Dr Ailis Ni Riain (Council Member)
- Professor Tom O'Dowd (External Assessor)
- Dr Geraldine O'Neill (External Assessor)
- Professor Gordon Page (External Assessor)
- Dr Cillian Twomey (External Assessor)

Accompanied by

- Dr Anne Keane (Head of Education and Training Section)

ROYAL COLLEGE OF SURGEONS IN IRELAND

3rd March 2006

Assessment Team

- Professor Muiris FitzGerald (Chair of Education and Training Committee and Chair of Assessment Team)
- Dr Deirdre Madden (Council Member)
- Dr Ailis Ni Riain (Council Member)
- Professor Tom O'Dowd (External Assessor)
- Professor Gordon Page (External Assessor)

Accompanied by

- Dr Anne Keane (Head of Education and Training Section)

THE UNIVERSITY OF DUBLIN, TRINITY COLLEGE

1st March 2006

Assessment Team

- Professor Muiris FitzGerald (Chair of Education and Training Committee and Chair of Assessment Team)
- Dr Anna Clarke (Council Member)
- Dr Asam Ishtiaq (Council Member)

- Professor Gerry Loftus (External Assessor)
- Dr Geraldine O'Neill (External Assessor)
- Professor Maurice Savage (External Assessor)

Accompanied by
- Mr John Lamont (Registrar)

UNIVERSITY COLLEGE CORK

2nd March 2006

Assessment Team
- Dr Colm Quigley (Vice President of the Medical Council and Chair of Assessment Team)
- Dr Asam Ishtiaq (Council Member)
- Professor Gerry Bury (External Assessor)
- Professor Maurice Savage (External Assessor)

Accompanied by
- Mr John Lamont (Registrar)
- Ms Karen Willis (Senior Executive Officer Education and Training)

UNIVERSITY COLLEGE DUBLIN

1st March 2006

Assessment Team
- Dr Colm Quigley (Vice President of the Medical Council and Chair of Assessment Team)
- Dr Ailis Ni Riain (Council Member)
- Ms Margo Topham (Council Member)
- Mr Stephen McMahon (External Assessor)
- Professor Gordon Page (External Assessor)

Accompanied by
- Mr David Hickey (Head of Registration / Assistant Registrar)
- Dr Anne Keane (Head of Education and Training Section)

2007

NATIONAL UNIVERSITY OF IRELAND GALWAY

9th March 2007

Assessment Team:
- Professor Anthony Cunningham (Chair of Education and Training Committee and Chair of the Assessment Team)
- Dr Anna Clarke (Council Member)
- Dr Deirdre Madden (Council Member)
- Professor Kieran Murphy (Council Member)

Accompanied by
- Dr Anne Keane (Head of Education and Training Section)

ROYAL COLLEGE OF SURGEONS IN IRELAND

7th and 8th March 2007

Assessment Team:
- Dr John Hillery (President of the Medical Council and Chair of the Assessment Team)
- Professor Tom O'Dowd (External Assessor)
- Ms Margo Topham (Council Member)

Accompanied by
- Dr Anne Keane (Head of Education and Training Section)
- Ms Karen Willis (Senior Executive Officer Education and Training)

THE UNIVERSITY OF DUBLIN, TRINITY COLLEGE

16th March 2007

Assessment Team:

- Dr Colm Quigley (Vice-President of the Medical Council and Chair of the Assessment Team)
- Professor Anthony Cunningham (Chair of Education and Training Committee)
- Ms Sheila Early (Lay Assessor)

Accompanied by

- Dr Anne Keane (Head of Education and Training Section)
- Ms Karen Willis (Senior Executive Officer Education and Training)

UNIVERSITY COLLEGE CORK

14th March 2007

Assessment Team

- Dr Colm Quigley (Vice-President of the Medical Council and Chair of the Assessment Team)
- Professor Anthony Cunningham (Chair of Education and Training Committee)
- Ms Sheila Early (External Assessor)

Accompanied by

- Dr Anne Keane (Head of Education and Training Section)

UNIVERSITY COLLEGE DUBLIN

5th March 2007

Assessment Team

- Professor Anthony Cunningham (Chair of Education and Training Committee and Chair of the Assessment Team)
- Professor Robert Sneyd (External Assessor)
- Professor Ian Graham (Council Member)
- Ms Sheila Early (External Assessor)

Accompanied by

- Dr Anne Keane (Head of Education and Training Section)
- Ms Karen Willis (Senior Executive Officer Education and Training)

ACCREDITATION VISIT
UNIVERSITY OF LIMERICK'S PROPOSED GRADUATE ENTRY PROGRAMME

29th and 30th May 2007

Assessment Team

- Dr Colm Quigley (Vice-President and Chair of the Assessment Team)
- Professor Hans Sjöström (Extern)
- Professor Tony Weetman (Extern)
- Professor Anthony Cunningham (Chair of Education & Training Committee)
- Mr Asam Ishtiaq (Council Member)
- Dr Deirdre Madden (Council Member)

Accompanied by

- Mr John Lamont (Registrar)
- Dr Anne Keane (Head of Education and Training)
- Ms Karen Willis (Senior Executive Officer Education and Training)

APPENDIX 5

SPECIMEN AGENDA FOR MEDICAL COUNCIL VISITS

Review of

[name of Medical School]

[date]

[venue]

10.30-10.45
Introduction and overview of the day

10.45-12.45
Discussion of major issues arising from:

- Changes since the Medical Council's 2003 Report
- Evidence previously provided by the Medical School (including response to questionnaire)
- The future context of Medical Education in Ireland, in light of the Fottrell Report

This aim of this session is interaction with those most closely involved in medical education and training.

13.30-14.30
Private meeting between Medical Council Evaluation Team and students and interns
This group is to include student representatives from each year of the undergraduate programme, and interns.

14.30-15.15
Review of education and training facilities (to include short tour of relevant aspects of site; e.g. clinical skills laboratories, library and IT facilities, and teaching and study areas).

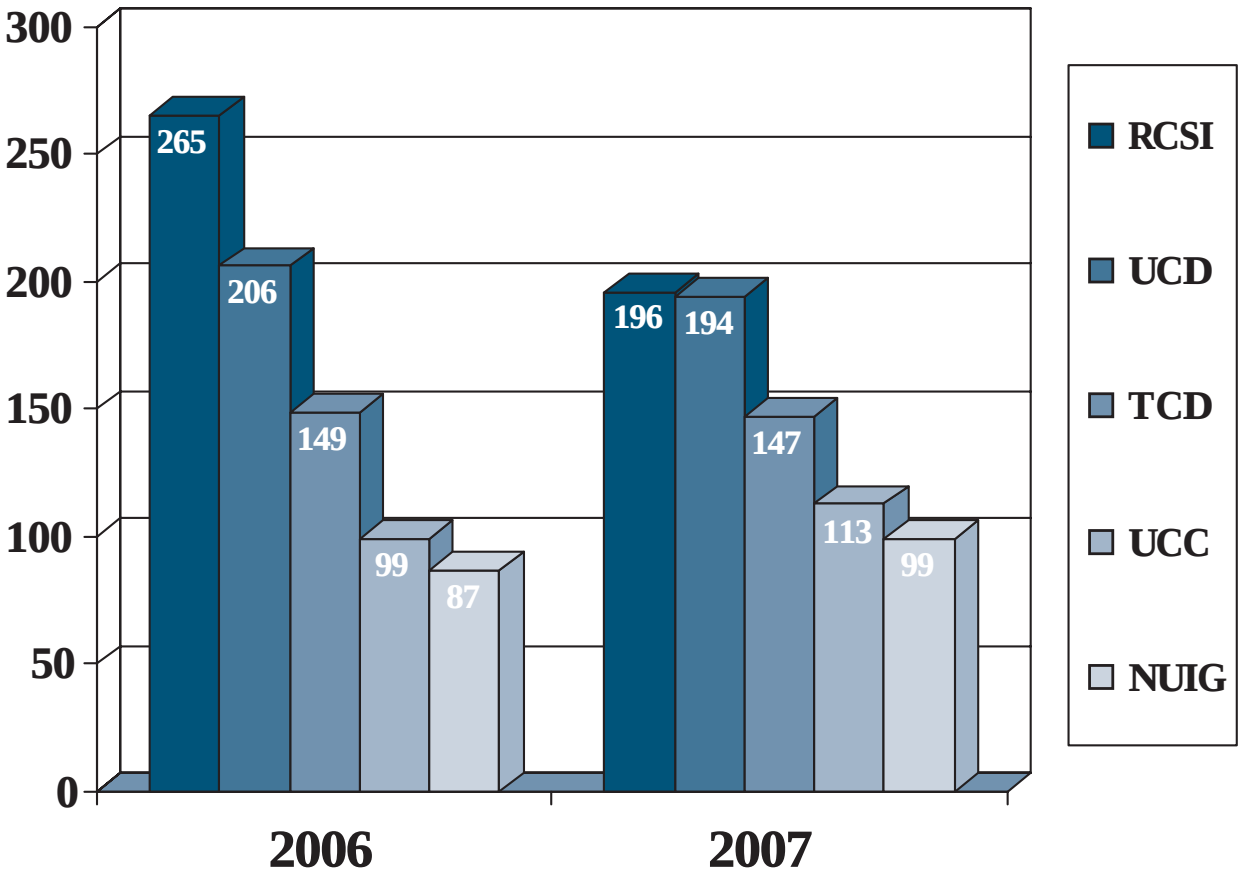
15.20-15.50
Summary session (Medical Council Team only)

15.50-16.00
Closing session

APPENDIX 6

Doctors holding internship registration by Medical School

QUALIFIED IN/AT:	JUL-06	JUL-07
RCSI	265	196
UCD	206	194
TCD	149	147
UCC	99	113
NUIG	87	99
Total No. of Interns registered from Irish Medical Schools	806	749
Total No. of Interns registered	820	754



Source: Medical Council statistics for registration 2007 www.medicalcouncil.ie

APPENDIX 7

GLOSSARY OF SOME TERMS / ABBREVIATIONS USED IN THIS REPORT, AND RELEVANT LINKS

ACLS
Advanced Cardiac Life Support

Blackboard
Blackboard is a Virtual Learning Environment (VLE). It allows lecturers and tutors to establish an online presence for their teaching module.

CAO
The **Central Applications Office (CAO)** has been delegated by the higher education institutions in the Republic of Ireland the task of processing centrally applications to their first year undergraduate courses. (www.cao.ie)

DOHC
Department of Health and Children (www.dohc.ie)

DREEM
Dundee Ready Education Environment Measure

EMQ
Extended Matching Questions

GEP
Graduate Entry Programme - A four year undergraduate medical programme for graduates in disciplines other than medicine.

GAMSAT
Graduate Australian Medical School Admission Test - (www.gamsat.edu.au)

HEA
The **Higher Education Authority (HEA)** is the statutory planning and development body for higher education and research in Ireland. (www.hea.ie)

HSE
The **Health Service Executive (HSE)** provides health services and social services for the people of Ireland. (www.hse.ie)

ICT
Information and Communications Technology

MCAT
Medical College Admission Test (www.aamc.org/students/mcat/)

MCQ
Multiple Choice Questions (and **EMQ** - Extended Matching Questions) - forms of assessment in which those being tested are asked to select one or more of the choices from a given list.

Moodle
Modular Object-Oriented Dynamic Learning Environment - is a software e-learning platform (also known as a Course Management System (CMS), or Learning Management Systems (LMS), or Virtual Learning Environment (VLE).

MPA
The Medical Practitioners Act 2007

NUIG
National University of Ireland Galway is one of the Medical Schools in Ireland. (www.nuig.ie)

OSCE
Objective Structured Clinical Examination is a type of practical examination often used in medicine to test skills such as communication, clinical examination, medical procedures, prescribing and interpretation of results.

RCSI
Royal College of Surgeons in Ireland is one of the Medical Schools in Ireland. (www.rcsi.ie)

TCD
University of Dublin, Trinity College is one of the Medical Schools in Ireland. (www.tcd.ie)

UCC
University College Cork is one of the Medical Schools in Ireland. (www.ucc.ie)

UCD
University College Dublin is one of the Medical Schools in Ireland. (www.ucd.ie)

UL
University of Limerick is one of the Medical Schools in Ireland. (www.ul.ie)

WFME
The **World Federation for Medical Education (WFME)** (www.wfme.org)

WHO
The **World Health Organisation (WHO)** is the directing and coordinating authority within the United Nations system for health (www.who.int)

NOTES