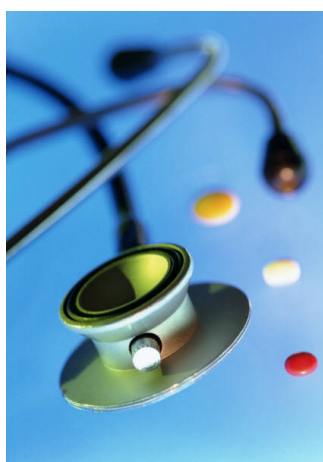


Final Report

Quality Improvement in Basic Medical Education

EVALUATION OF THE IMPLEMENTATION IN PILOT SITES OF THE WORLD FEDERATION FOR MEDICAL EDUCATION'S INTERNATIONAL STANDARDS



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TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	3
SUMMARY	4
1 BACKGROUND TO THE EVALUATION.....	6
2 THE STANDARDS.....	7
3 AIMS OF THE EVALUATION	8
4 SETTING UP THE EVALUATION.....	9
4.1 Selection criteria for pilot sites.....	9
4.2 Financial Resources	9
5 METHODOLOGY	9
6 PILOT SITES	10
6.1 Characteristics of the pilot sites.....	10
7 IMPLEMENTING THE EVALUATION LOCALLY.....	11
RESULTS	13
8 STANDARDS ADDRESSED	13
9 DATA COLLECTION METHODS	13
9.1 Problems with data collection.....	14
10 WERE THE STANDARDS MET?	14
10.1 Challenging standards.....	17
11 BENEFITS AND DISADVANTAGES OF THE PILOTS.....	19
12 CONCLUSIONS	19
APPENDIX 1: THE STANDARDS	21

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SUMMARY

The World Federation for Medical Education developed standards for basic medical education that were intended for use in medical school self-studies worldwide. Eleven medical schools agreed to use the standards and provide evaluation information about this by means of questionnaires returned electronically.

The overall aims of the evaluation were to determine:

- Whether the standards are universally applicable.
- If basic standards can be met by all schools in the pilot study.
- Which level each pilot school has achieved in quality development.
- The value of the self-study to the participating schools.

These international pilot studies of the WFME standards for basic medical education have demonstrated clearly that the standards as set are realistic and correctly divided between basic and quality development levels.

Schools could work with these standards and, overall, found them comprehensible. There is, however, a need to translate them into the appropriate language.

Where standards are more challenging, this is sometimes because the national system, local conscious choice or other contextual factors do not allow the necessary activities or processes. Where this is the case, consideration should be given to modification or even omission of the standard with an explanation for that.

Collecting data as evidence of attainment of the standards often simply meant reference to existing data bases. Where this was not so, the development of questionnaires and interviews seemed to provide the necessary information. However, where schools comprised distributed facilities, collection of data was often very difficult.

Whether or not data collection was straightforward, it always took organisation and staffing. Self-studies require committees and high-level backing. They also require dedicated staff and a realistic timescale. These pilots took far longer, in general, than we had estimated. Self-studies need to be conducted as a properly managed project with involvement of the stakeholders.

The necessary scale of activity for a self-study also implies costs, either in terms of time, extra staff payments or opportunity costs.

The range of reported attainment of the standards and the difference between attainment of basic and quality development levels, along with the internal committee and process structures, does suggest honesty and objectivity of the self-studies. The free comments often suggested reasons for lack of attainment or plans to move forward on the standard.

The pilot studies all suggest that undertaking a self-study using standards is a positive event with many immediate and lasting constructive consequences. The difficulties

cited are generally organizational and resource-related, although some difficulties also relate to local interpretation and relevance.

Overall, this evaluation has suggested that the intentions of the standards have been fulfilled.

1 BACKGROUND TO THE EVALUATION

The World Federation for Medical Education (WFME) considered the subject of international standards in medical education. The Executive Council published a position paper on this topic in *Medical Education* 1998; 32:549-558. Subsequently, an international Task Force was established by WFME with the purpose of defining international standards for basic [undergraduate] medical educational programmes as part of the Federation's project on "International Standards in Medical Education: Assessment and Accreditation of Medical Schools' Educational Programmes". The main purpose of the Task Force was to develop undergraduate medical education standards that would be internationally applicable and useable by all medical schools as a basis for institutional evaluation and quality improvement.

In late 1999, a working party of the Task Force with representatives of eight countries and five continents met to begin the definition process.

Key considerations in developing the standards were as follows:

- Standards should serve as an impetus for review and perhaps change through institutional self-evaluation.
- Standards must take account of the variations in medical education between countries; due to differences in teaching tradition, culture, socio-economic potential, the health and disease spectrum, and different forms of health care delivery systems.
- Standards should not dictate content, drive quality down, prohibit educational methodology experimentation, rank schools or be used for political purposes.
- Standards should emphasise the universality of the scientific basis of medical education and that the task of medical education is to prepare physicians to care for the healthy, the ill, the disabled and the injured citizens of the world.
- Standards may serve to establish a system for national or international accreditation of medical education programmes.

In 2000, a World Federation for Medical Education working party finished its first draft of standards for basic medical education, which was published in *Medical Education* (2000,34,665-675). Subsequently the Standards were further refined based on comments received from an international panel of advisors and from a number of conferences around the world at which the initial document was presented.

The Standards and Guidelines for their use are now presented as a WFME adopted document: *Quality Improvement in Basic Medical Education WFME International Guidelines*. This document can be found on the WFME website: <http://www.wfme.org>

Subsequently, the WFME commissioned an evaluation [reported here] of the implementation of these standards in a number of sites worldwide.

2 THE STANDARDS¹

The International Standards address 9 areas of a medical school's work. Each area has sub-areas, as follows:

1. *Mission and objectives*
 - 1.1 Statement of mission and objectives
 - 1.2 Participation in formulation of mission and objectives
 - 1.3 Academic autonomy
 - 1.4 Educational outcome
2. *Educational programme*
 - 2.1 Curriculum models and instructional methods
 - 2.2 Scientific method
 - 2.3 Basic biomedical sciences
 - 2.4 Behavioural and social sciences and medical ethics
 - 2.5 Clinical sciences and skills
 - 2.6 Curriculum structure, composition and duration
 - 2.7 Programme management
 - 2.8 Linkage with medical practice and the health care system
3. *Assessment of students*
 - 3.1 Assessment methods
 - 3.2 Relation between assessment and learning
4. *Students*
 - 4.1 Admission policy and selection
 - 4.2 Student intake
 - 4.2 Student support and counselling
 - 4.4 Student representation
5. *Academic staff/faculty*
 - 5.1 Recruitment policy
 - 5.2 Staff policy and development
6. *Educational resources*
 - 6.1 Physical facilities
 - 6.2 Clinical training and resources
 - 6.3 Information technology
 - 6.4 Research
 - 6.5 Educational expertise
 - 6.6 Educational exchanges
7. *Programme evaluation*
 - 7.1 Mechanisms for programme evaluation
 - 7.2 Teacher and student feedback
 - 7.3 Student performance
 - 7.4 Involvement of stakeholders
8. *Governance and administration*
 - 8.1 Governance
 - 8.2 Academic leadership
 - 8.3 Educational budget and resource allocation
 - 8.4 Administrative staff and management
 - 8.5 Interaction with the health sector
9. *Continuous renewal*

¹ The full statement of standards is given in Appendix 1.

Each sub-area has a defined standard using two possible levels of attainment:

- *Basic standard.* This means that the standard should be met by every medical school and fulfilment demonstrated during evaluation of the school. These standards are expressed as 'must.'
- *Quality development.* This means that the standard is in accordance with international consensus about best practice for medical schools and basic medical education. Medical schools should be able to demonstrate fulfilment of some or all of these or plans to do so. Fulfilment of quality development standards will vary with the stage of development of the medical schools, their resources and educational policy. Even the most advanced schools might not comply with all standards. Quality development standards are expressed by a 'should.'

Annotations are used to clarify, amplify or exemplify expressions in the standards.

3 AIMS OF THE EVALUATION

The overall aims of the evaluation were to determine:

- Whether the standards are universally applicable.
- If basic standards can be met by all schools in the pilot study.
- Which level each pilot school has achieved in quality development.
- The value of the self-study to the participating schools.

The specific aims of the evaluation of the implementation of the International Guidelines thus were to:

- Provide WFME with absolute and comparative data about the implementation of the International Guidelines in selected pilot sites.
- Describe and compare the experiences of different schools.
- Describe methods of and barriers to implementation of the Guidelines.
- Document which standards [basic and quality development types] were assessed by each pilot school and explain the reasons for inclusion and exclusion of some standards in the pilot study.
- Gather data on the staffing requirements of each school for implementation of the Guidelines.
- Estimate the cost of implementation of the Guidelines in terms of staff time and office/administrative costs.
- Document the data collection methods, including administration, used by each school for each standard.
- Document difficulties and solutions experienced in data collection.
- Gather data about the outcomes of the local self-studies in terms of meeting the standards set i.e. strengths and areas of concern for the each school.
- Document the effects of using the standards on practice within the pilot schools.
- Evaluate the ease of using the WFME Guidelines and collect suggestions for improvement.
- Make recommendations to WFME for further refinement of the system, if required.

4 SETTING UP THE EVALUATION

It was decided that to join in the pilot study, the medical education programme must be conducted by a university medical school listed in the Seventh Edition of the World Health Organisation Directory of Medical Schools and must be voluntary. The applicant school must prepare a process to conduct a self-study of their institution's medical educational programme standards as they relate to the proposed WFME International Standards. The process should allow for designation of several committees, including a steering group to assign committee members and topics for study. Committee membership may include any stakeholder in the educational process. The chair of the committee should organise how the evaluation shall be conducted. WFME will provide guidelines on setting up this institutional basis for the self-study, as part of the evaluation programme.

The project was to be completed in eight consecutive calendar months and pilot sites agreed to this in advance. In the event, the pilot studies took over one year in some cases, completing by March 2003.

4.1 Selection criteria for pilot sites

Criteria for selection of a successful applicant School, then, were based on:

- Listing in WHO Directory of Medical Schools
- Commitment to participate by Dean and University Official
- Proposed plan for institutional self-study with organisational chart and time lines
- Geographic location

4.2 Financial Resources

An award of USD \$2,500, provided by the ECFMG Foundation for the Advancement of International Medical Education and Research [FAIMER], was made for each successful school to offset the clerical costs to produce evaluation data for submission to the WFME. However, the applicant school did commit other resources, such as people and space, to complete this self-study.

5 METHODOLOGY

Data were collected by means of standard questionnaires containing both closed and open questions. The questionnaires were delivered electronically to the site co-ordinator in each school whose responsibility was to ensure systematic completion of the questionnaires according to an agreed timetable.

In addition, the WFME evaluators kept in regular contact with each site co-ordinator to ensure that progress was being made and that instruments were being completed and returned on time. Such project management was essential to the success of the evaluation.

The data collection instruments collected data [related to the aims of the evaluation] as follows:

- Description of the pilot school, including staffing levels, disciplines and student numbers etc.
- Infrastructure, staffing and costs [time and salary] for implementing the self-study.
- Local selection and use of standards [using a template of the WFME Guidelines].
- Local data collection methods [using a template of the WFME Outline for Data Collection].
- Outcomes of the self-study [using a template of the selected standards].
- Use and utility of the WFME materials.
- Recommendations for improvement of the system.

The instruments were carefully constructed and designed to allow both qualitative, descriptive answers and quantitative [closed ended] questions. Attention was paid at the design stage to issues of effective data input and analysis.

Eventually, 4 questionnaires were developed which addressed:

- Basic descriptive information about the school
- Which standards the school chose to address and a report of the experience of using each
- How the pilot study was organised within the school
- The benefits, disadvantages and consequences of the pilot study.

6 PILOT SITES

In the end, 11 medical schools took part in the evaluation from the following countries:

- Bahrain
- Colombia
- Iran
- Italy
- Kazakhstan
- Mexico
- South Africa
- Spain
- Sri Lanka
- Sweden
- Venezuela

6.1 Characteristics of the pilot sites

All medical schools were part of a university rather than being privately owned. Six were governed at federal level and 5 at state level. Only one school had a governing board that was separate from the university. Four were ancient schools, while three were 20th century but pre-1960. Four were post-1960. The schools varied in size from 499 to more than 5,000 students. All schools enrolled foreign nationals.

7 IMPLEMENTING THE EVALUATION LOCALLY

Eight of the 11 schools set up a special committee to undertake the pilot studies. In all cases, the membership was chosen by the Dean [or equivalent], or his nominee or superior. The pilot studies were taken very seriously. The committees were chaired at an equivalent level. The committees met once a month [3 schools], or twice a month [2 schools], or weekly [4 schools]. The committees comprised between 3 and 22 members, depending on its remit.

The remits of the committees varied but all were within the intentions of the standards. Remits were as follows:

- To perform the pilot studies for future international accreditation and to keep in touch with other pilot schools.
- To comply with university legislation.
- To develop a plan for formative and summative evaluation of the curriculum.
- To select chairs of working groups, supervise the study and approve the final report.
- To evaluate faculty performance and examine the possibility of using the study as a starting point for further evaluation and research.
- To analyse findings and ensure that data were collected.

Membership of committees included:

Dean	8 schools
Vice Dean	2 schools
Senior faculty	8 schools
Junior faculty	6 schools
Non-clinical teachers	5 schools
Students	3 schools
Administrators	3 schools
Externals/university reps	2 schools

Staffing the pilot studies was quite an undertaking. The following table gives the schools' descriptions in detail.

SCHOOL	STAFF
1	Vice Dean - 30 days Non-clinical teacher - 120 days Senior staff teachers [2] - 16 each
2	Academics - 50 days Translator - 15 days Advisers - 15 days
3	1 x lecturer supported by the Dean • 160 hours = 21 workdays (only compiling information - most of the self-study work was done before the time as part of the self-evaluation process of the School with a view to the accreditation visit paid to the School in April 2002 - i.e. most of the information had been collected for another purpose and was fairly readily available). • The compilation of information and completing the questionnaire were done in between other tasks, that is, the staff member (co-ordinator) did not devote 21 days in sequence to this. Most of this was done after hours over a period of 3 months.

Continues>>>>

>>>> *continued*

4	Chairman (Professor) - 25 days Dean (Professor) - 10 days Member 1 (Professor) - 12 days Member 2 (Professor) - 12 days Member 3 (Professor) - 12 days Secretary to Chairman - 2 days Secretary to Dean - 4 days Secretary to Member 1 - 3 days Secretary to Member 2 - 3 days Secretary to Member 3 - 3 days
5	Academic staff (50 people) - 523 days Administrative staff (10) - 30 days Clerical staff (3) - 45 days Students (7) - 40 days
6	Associated Dean - 15 days Administrator officer - 10 days
7	The Vice-Dean - 15 days Full Professors - 21 days Associate Professors - 7 days Administrative staff: secretarial - 5 days Administrative staff: clerical - 10 days
8	Vice-dean of undergraduate education - 1 day. Senior lecturer - 15 days. Several people, teachers in the programme, staff at the office of medical education and in administration of the faculty, have contributed each a couple of hours in reading and discussing the answers - 5 altogether.
9	Dean, Educational Executive Secretary, Former Dean, Former director of administrative processes, Director of the academic medicine program, Director of the biomedical research centre, Secretary, A curriculum committee (14 members), Sub-unity of evaluation studies (7 members) - Each member used to work in the study, 8 hours per week, during 25 weeks, giving a total hours of 200. An assistant secretary worked 2 hours/week/25 weeks = 50 hours. <i>Note: the numbers described above are an approximation; we still have to make a definitive report. It should be taken into account that before our study, there was a report about institutional evaluation made by faculty members, students and secretaries. The information generated by this group was useful in the present study. The time taken to prepare that study is not included here.</i>
10	Rector of the National Medical University - 2 days Deputy to the Rector on Science - 5 days Deputy to the Rector in the Clinical Department - 5 days Deputy to the Rector on Scholastic Process - 5 days Deputy to the Rector on Education - 5 days Head of the Department of Control and planning scholastic process - during the whole period of pilot studies. Dean of the Department for therapists - during the whole period of pilot studies. Dean of the Paediatric department - during the whole period of pilot studies. Dean of the Stomatalogic Department - during the whole period of pilot studies. Dean of the Sanitary-Hygienic Department - during the whole period of pilot studies. Dean of the department of foreign students - during the whole period of pilot studies. Secretary - during the whole period of pilot studies.
11	No data

The studies also took different lengths of time, as shown in the next table which also offers the pilot sites' judgments of that time. There seems to be little relationship between the time taken and whether or not this seemed reasonable:

SCHOOL	MONTHS TAKEN	OPINION
1	17	A reasonable amount of time
2	18	A reasonable amount of time
3	5	A reasonable amount of time
4	7	A lot of time
5	13	A lot of time
6	9	A reasonable amount of time
7	7	A lot of time
8	7	A reasonable amount of time
9	9	A reasonable amount of time
10	17	A reasonable amount of time
11	No data	No data

Funding for the project was spent on office expenses, meetings and staff salaries.

Seven sites produced a report in addition to the reports produced for the evaluation.

RESULTS

8 STANDARDS ADDRESSED

36 standards were set out at basic and quality development levels. At basic level, there was an overall 95% uptake rate. At quality development level, there was an overall 90% uptake. There was no common choice of standard not addressed. Where standards were not addressed, reasons were that:

- the school knew that it could not be met because, for example, this was an area of activity in early development.
- the standard was not yet relevant, for example, the school had not yet become active in the given area.

Overall, most schools addressed all standards and no pattern of uptake or rejection of standards was observable.

9 DATA COLLECTION METHODS

For each standard addressed, the pilot sites reported their data collection methods. Sites were asked if they collected data by:

- Analysis of existing documents
- Using existing data-bases
- Developing special questionnaires or other survey instruments
- Interviews
- Other methods

There was no correlation between particular standards and methods cited. Overall, 3 or more methods of data collection were cited for each standard. Data were collected proportionately as follows:

METHOD	FREQUENCY OF USE
Analysis of existing documents	49%
Using existing data-bases	18%
Developing special questionnaires or other survey instruments	4%
Interviews	22%
Other methods	7%

So, in 67% of cases, no original data were collected.

9.1 Problems with data collection

For each standard, respondents were asked if they had difficulty in collecting the necessary data. In 85% of cases, no difficulties were reported. In 10% of cases, schools reported difficulty in collecting data for specific standards and the standard that gave the greatest difficulty was *6.1 Physical facilities*. Five of the 11 schools encountered problems, usually because there were no records and no particular person who had overall knowledge of or responsibility for this aspect of the school. Most schools seemed to have solved this problem.

Overall, however, there were no systematic problems with data collection. A variety of obstacles were reported:

- Shortage of documents/information
- Deciding level of data collection
- Data unavailable
- Standard not relevant so no data e.g. adaptation of behavioural and social sciences to medicine
- Lack of faculty commitment
- Difficult to summarise data
- No written data - just experience
- Low response rates to questionnaires
- Scattered information
- Limited access to databases.

10 WERE THE STANDARDS MET?

The following table shows that there is a difference in the attainment of basic and quality development standards. As would be expected, the greater attainment is in relation to the basic standards. Eighty-five percent of the pilot schools met all or most aspects of the basic standards, while 64% of them met all or most of the quality development standards. - this does suggest that the formulation of the standards is correct.

LEVEL OF ACHIEVEMENT	BASIC STANDARD	QUALITY DEVELOPMENT
Met all aspects	60%	43%
Met most aspects	25%	21%
Met some aspects	12%	22%
Met few aspects	2%	10%
Did not meet standard	0.3%	5%

The following table [overleaf] gives further details showing those basic and quality development standards for which most or all aspects were met. It can be seen that the rate of achievement of the basic standards is very high indeed. Only in the area of research [research facilities and the relationship between research and teaching] did fewer than 7 schools meet the basic standard [standard 6.4]. This is further discussed below. Perhaps the whole area of programme evaluation looks less well developed than other areas of curriculum governance and quality assurance - although budgetary matters and resource allocation also are less widely secure than other aspects of governance.

The overall results might suggest that medical schools are well advanced in terms of the core of mission and outcomes definition, educational programming and student matters [with the exception of student representation] and basic governance issues. Programme evaluation and specific aspects of governance still require some development in a number of schools.

The most challenging standards are discussed in section 10.1 below.

STANDARD	NO. OF SCHOOLS ATTAINING MOST/ALL ASPECTS AT EACH LEVEL [n=11]	
	BASIC	QUALITY DEV.
1. Mission and objectives		
1.1 Statement of mission and objectives	10	9
1.2 Participation in formulation of mission and objectives	9	7
1.3 Academic autonomy	9	7
1.4 Educational outcome	11	5
2. Educational programme		
2.1 Curriculum models and instructional methods	11	7
2.2 Scientific method	10	8
2.3 Basic biomedical sciences	11	9
2.4 Behavioural and social sciences and medical ethics	11	6
2.5 Clinical sciences and skills	10	10
2.6 Curriculum structure, composition and duration	10	8
2.7 Programme management	8	6
2.8 Linkage with medical practice and the health care system	8	6
3. Assessment of students		
3.1 Assessment methods	9	4
3.2 Relation between assessment and learning	9	6
4. Students		
4.1 Admission policy and selection	9	4
4.2 Student intake	10	6
4.2 Student support and counselling	10	6
4.4 Student representation	7	6
5. Academic staff/faculty		
5.1 Recruitment policy	7	7
5.2 Staff policy and development	8	6
6. Educational resources		
6.1 Physical facilities	10	7
6.2 Clinical training and resources	9	6
6.3 Information technology	9	6
6.4 Research	6	5
6.5 Educational expertise	8	7
6.6 Educational exchanges	8	6
7. Programme evaluation		
7.1 Mechanisms for programme evaluation	8	6
7.2 Teacher and student feedback	8	6
7.3 Student performance	8	4
7.4 Involvement of stakeholders	8	4
8. Governance and administration		
8.1 Governance	10	8
8.2 Academic leadership	9	5
8.3 Educational budget and resource allocation	7	7
8.4 Administrative staff and management	8	4
8.5 Interaction with the health sector	8	9
9. Continuous renewal		
	9	9

10.1 Challenging standards

The pattern of less well-attained standards [6 or 7 medical schools reporting all or most aspects attained] has its own implications. These areas were:

- 4.4 Student representation
- 5.1 Recruitment policy
- 6.4 Research
- 8.3 Educational budget and resource allocation.

For each of these, co-ordinators' free comments are illuminative:

4.4 Student representation

- Students have some participation in several of the relevant bodies of the medical school, but they have not had participation in the design, management and evaluation of the curriculum until now.
- Low student involvement in curriculum-related activities.
- Students are represented in all committees of the medical Faculty, but they have (or they complain to have) little if any role in decision-making inherently to curricular matters. Teachers don't really think they can learn from students in matters concerning their courses.
- Student self-government within the Faculty, in addition to their participation in faculty committees, is a good suggestion that we pick up from this standard. Neither the students nor the teachers have thought of it till now, very likely due to the absence of a residential campus in our medical school.
- Students are represented in all major committees dealing with matters relevant to students, e.g. phase committees, year committees, Faculty board.
- Students show a lack of interest in some of the meetings and do not attend regularly, perhaps also due to the fact that meeting times often clash with lecturing times.

5.1 Recruitment policy

- The ratios are not well-defined. No systematic evaluation of recruitment policy and processes.
- In principle the medical school meets the described standards, but the committee feels that there is a discrepancy with their practical application.
- Recruitment of professors depends on University and Ministry decisions. Recruitment of clinical associates is very limited by the budget. The Faculty has a very limited capacity to select when, who and how many professors can contract. Tenure has sometimes very negative effects.
- The research organisation has a strong interest in the recruitment policy. No policy for selection by clinical merits.
- Basic Level: The staff recruitment policy does not contemplate neither a proportion between medical and non medical doctor staff, nor time or dedication. Hiring is made based on necessities of the institution, developmental projects and numerical criteria. Quality Level: There are not racial, religious or gender type limitations for staff recruitment. By constitutional law there is not any type of discrimination.

6.4 Research

- The research productivity of the faculty is not high due to the small number of full-time faculty, who are intensely involved in small group teaching, which leaves little time for active research.
- Research mission is defined nationally by the Ministry of Health. No evaluation data on the impact of student research on learning medicine. Lack of flexibility towards the balance of research and teaching activities.
- Despite the fact that good quality research exists both in basic sciences and clinical disciplines, research facilities and research priorities at the institution have not yet been described in a way easily accessible to students (programs to activate an Internet Faculty site exist). Research is considered the realm of the Departments, with the Faculty playing a secondary, ancillary role. Research does play a role in education, but due to the undertaking of the teachers, many of which are active researchers. The curriculum does not encourage students to do research before starting working at the thesis.
- Because there is no formal mechanism to ensure that research activities are reflected in the Curriculum.
- Facilities and areas of research priorities are not described explicitly in policy.
- Interaction between research and education is in terms of competition on professor's schedule. Organisation of research is a statutory competence of departments. Research is almost uniquely considered for professors' appointment.
- Independently from the organisation of the curriculum, which does not foster research by the students, the vast majority of the medical students have little interest in engaging in research, both basic and clinical, the number of medical students choosing a research career has dropped tremendously in the last 15 years (a trend common to all our medical schools, correlating with the introduction of curricula which put an emphasis on teaching and considered research a postgraduate choice).
- Students are prepared for and trained in research from the early years by means of Special Study Modules and project work. Research methodology is addressed in the training in general skills. Research projects run in all departments. Postgraduate studies are offered in all departments. Medical education research receives ample attention in the master's and Ph. D. programme in Health Professions Education. A forum exists in the Faculty where research results are presented annually (students and staff) (a prestigious 3-day event with national evaluators).
- We believe that the separation of competencies between Faculty (education) and Departments (research) runs quite well.

8.3 Educational budget and resource allocation.

- Autonomy in regulating the budget is limited.
- Central governmental budgeting. Lack of medical school autonomy. No regular evaluation of budgeting system. No involvement of curriculum committee in budgeting and resource allocation.
- Our school is held on a state basis standard, developed by the state department of financing.
- % of the Faculty budget controlled direct or indirectly by the Faculty. Government is less than 0.5% of total costs. Funding criteria are controlled by University with few difficulties.
- The medical school is at some level dependent on the needs of the research organisation, which has to finance their employees.
- There is a partial autonomy, basically to cover costs of functioning.
- The standard can be applied to our situation, with the caveat that the medical schools, being part of the universities, have only limited budget autonomy.

11 BENEFITS AND DISADVANTAGES OF THE PILOTS

Participants listed the main benefits to them of the pilots. These commonly included the following and are in line with the WFME intentions for use of the standards:

- To know our own school's qualities
- To compare with national accreditation processes
- Systematic approach to overall school evaluation
- Stimulates interaction and reflection between school members
- Provides feedback against an international benchmark
- Gave clear indication of standards
- Stimulates internal review and development
- Identifies strengths and weaknesses
- Increases faculty knowledge of medical education and management. Provides international links.

One school described the positive consequences of the pilot:

'Having completed the pilot study, the College did not stop its work there, but continued to explore the qualities of the curriculum, undertaking a larger scale evaluation of the specific areas where improvement was required. In this process it involved all full-time faculty, who, at a workshop following a preliminary questionnaire survey, examined each priority concerned in turn and made suggestions for improvement. These suggestions were studied by the Program Evaluation Committee, and recommendations made to the College Council for action. The College hopes that these recommendations will be implemented next year, where found to be feasible and desirable.'

This process is exactly what WFME was hoping would happen.

The disadvantages and difficulties largely derived from time, cost, data accessibility, and clarity of standards, as follows:

- Time to do it
- Dispersed sites making data collection difficult
- Cost because no-one could fit it into their work-schedule
- Lack of staff
- The evaluation was time-consuming on top of the data collection
- Degree of repetition across standards
- Some standards are regulated by law so there is nothing a faculty can do: requires local adaptation
- Some standards difficult to interpret
- Some information not accessible
- Difficult to work in English

12 CONCLUSIONS

The international pilot studies of the WFME standards for basic medical education has demonstrated clearly that the standards as set are realistic and correctly divided between basic and quality development levels.

Schools could work with these standards and, overall, found them comprehensible. There is, however, a need to translate them into the appropriate language.

Where standards are more challenging, this is sometimes because the national system, local conscious choice or other contextual factors do not allow the necessary activities or processes. Where this is the case, consideration should be given to modification or even omission of the standard with an explanation for that.

Collecting data as evidence of attainment of the standards often simply meant reference to existing data bases. Where this was not so, the development of questionnaires and interviews seemed to provide the necessary information. However, where school comprised distributed facilities, collection of data was often very difficult.

Whether or not data collection was straightforward, it always took organisation and staffing. Self-studies require committees and high-level backing. They also require dedicated staff and a realistic timescale. These pilots took far longer, in general, than we had estimated. Self-studies need to be conducted as a properly managed project with involvement of the stakeholders.

The necessary scale of activity for a self-study also implies costs, either in terms of time, extra staff payments or opportunity costs.

The range of reported attainment of the standards and the difference between attainment of basic and quality development levels, along with the internal committee and process structures, does suggest honesty and objectivity of the self-studies. The free comments often suggested reasons for lack of attainment or plans to move forward on the standard.

The pilot studies all suggest that undertaking a self-study using standards is a positive event with many immediate and lasting constructive consequences. The difficulties cited are generally organizational and resource-related, although some difficulties also relate to local interpretation and relevance.

Overall, this evaluation has suggested that the intentions of the standards have been fulfilled.

APPENDIX 1: THE STANDARDS

The Standards can be found under WFME Activities on this website.