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Greathouse, Robin

From: Griffiths, Carol
Sent: Monday, August 18, 2003 7:36 AM
To: James, Bill; Greathouse, Robin
Cc: LeBold, Bonnie
Subject: FW: (No subject)

USDoE.doc

The Ireland response

-----Original Message-----
From: (b)(6)
Sent: Saturday, August 16, 2003 5:44 AM
To: carol.griffiths@ed.gov
Subject: (No subject)

Medical Council response to:
US Department of Education - Draft Staff Analysis July 2003

Introduction

The material submitted by the Medical Council earlier in 2003 is intended to be considered in conjunction with previous submissions by the Medical Council in 1996/1997 and with the various publications cited in these submissions.

This document is a response to the draft Staff Analysis of July 2003 and clarifies the outstanding issues raised in that analysis. Any further questions can be addressed as required.

The third level education sector in Ireland

It may be of value to initially review third level education structures in Ireland, of which the five medical schools are a part.

(i) Four affiliated colleges of the National University of Ireland have medical schools :

1. University College Dublin
2. University College Cork
3. National University of Ireland, Galway
4. Royal College of Surgeons in Ireland

(ii) The University of Dublin, Trinity College also operates a medical school.

Each college operates on the basis of legislation passed by parliament, which sets out the relationship between the governing authority of the university and government itself and establishes clear accountability by that authority to the Department of Education & Science, the Higher Education Authority and the Central Applications Office.

Admission to medical school

All citizens are entitled to apply for university places which are awarded on the basis of academic merit. If successful, university fees are paid by the statewhich has a close relationship with the third level education sector.

Government has established the Higher Education Authority (HEA) which is the funding body for the third level sector. The HEA establishes the funding resources annually available to the universities from the Department of Education & Science and sets limits on the numbers of EU nationals who may be admitted to each course, including medicine.

The Central Applications Office (CAO) is an agency of the Department of Education & Science, which in conjunction with the universities annually sets the academic targets to be met by applicants for individual courses. These targets primarily relate to student achievement in Ireland's Leaving Certificate examination for school leavers. For example, in 2002, the target for entry to medical school was 575 points of a maximum possible 600 points; this was the highest standard of all university courses. The number of available places

in Irish medical schools for EU nationals was exceeded more than four times by the numbers of applicants who achieved this standard. All students admitted to Irish medical schools meet this academic target; the selection of applicants is then usually rank ordered by performance. A small number of places are reserved for university graduates with comparable academic standards but without current Leaving Certificate (or equivalent) points.

Each of the five medical schools also admits non-EU nationals who do not have Irish government subsidised places but instead pay fees to the university. Each of these applicants must also meet the same academic standard or its national equivalent. The number of non-EU nationals admitted annually is decided by individual medical schools in conjunction with that college's governing authority.

The role of the Medical Council

The Medical Council has no authority or legal responsibility for the operations of the Department of Education and Science, the HEA or the CAO. Nor does it have control of the universities within which the medical schools exist. The Medical Council has a legal responsibility to monitor the suitability and standards of undergraduate education within Irish medical schools. It does so on the basis of published standards and guidance, regular inspections of the schools, negotiations with the Department of Education & Science, the HEA, university governing authorities and by reports to the agencies involved and public.

The Medical Practitioner's Act 1978 established the Medical Council and simultaneously accredited the primary qualifications of the five medical schools. The continuing accreditation of these qualifications requires that the Medical Council is satisfied with their courses and assessments. If the Medical Council is sufficiently dissatisfied, it may recommend to government that recognition of a specific primary qualification be rescinded by parliament.

Inspections by the Medical Council are followed by a detailed report with recommendations to the medical school/university involved. Implementation of these recommendations is required but it is acknowledged that the timelines for certain issues may be multi-year ones and that certain issues are best undertaken by the medical schools working in concert. It is also clear that certain issues such as government funding of the university sector through the HEA are outside the direct control of any of these agencies but must be negotiated at a number of levels.

Part I. The Entity Responsible for the Accreditation/Approval of Medical Schools

No questions arise.

Part II. Accreditation/approval standards

Section 1

There is no legal requirement on individual medical schools to publish a 'mission and objectives' although some have chosen to do so. However, each medical school is publicly

committed to the provision of first class medical education and to meeting the needs of the societies from which students are drawn. Each points to long and well recognised traditions of doing so since their founding dates which range from 1592 to 1850.

Section 2

Parliament has established the relationships between universities and government agencies. The management of each medical school is legally and financially accountable to its university governing authority (or College Council in the case of RCSI) which itself is accountable to the state. The Medical Council interacts with both the management of the medical school and the university itself in assessing the acceptability/delivery of the curriculum and the assessments in use.

Medical schools are therefore legally and financially accountable to the state through university management and educationally accountable to the Medical Council.

Section 3 (a,b,c)

The relationships between medical schools and outside agencies have been considered above. Each school appoints a Dean who is the senior administrative and academic officer of the school. Deans are appointed by the members of Faculty of the school concerned (made up of all tenured academic staff), using a range of competitive mechanisms to assess academic, research, administrative and personal qualities. The Dean is always a tenured senior academic. Staff appointed by the medical school, whether clinical or non-clinical, are responsible to their Department head, the Dean, the Faculty and ultimately the governing authority for their academic performance as teachers of medical students. Almost all academic staff are contractually involved in undergraduate teaching programmes.

The appointment and promotion of academic staff by Faculty is strictly governed by openand explicit mechanisms set out by the governing authority in accordance with the university's primary legislation. Criteria are explicit, competitive and subject to challenge by appeal mechanisms within the university or if necessary by external arbitrators such as the Employment Equality Authority or courts.

These roles are laid out, not by rules specified by the Medical Council, but by the statutes of the universities and the contracts of employment of staff members.

Section3 (d) Assessment of clinical teaching sites

All medical schools operate on a number of academic and clinical sites, which must be accredited, supervised and operated by the school for teaching activities. Clinical teaching sites include hospital and community based centres.

Teaching hospitals are usually regional or national centres with multiple sub-specialty services associated with high standard diagnostic and therapeutic facilities. They are subject to accreditation by a range of agencies including the Irish Health Services Accreditation Board, the medical postgraduate training bodies, the Medical Council (on a hospital by hospital basis in relation to medical postgraduate training) and ultimately the Department of Health & Children in relation to staffing, financial management and administration. A detailed description of the Irish health system and a statistical review of performance,

expenditure and vital statistics is available at www.doh.ie; an analysis of the Irish health system in comparison to others is available at www.oecd.org. The standards in use for hospital accreditation purposes are available at www.ihsab.ie and are modelled closely on those in use by Canadian health systems.

Teaching centres in the community are contractually linked to Irish Health Boards but are not yet accredited by any independent agency.

During medical school inspections, the Medical Council identifies all sites in use and catalogues their facilities. The Medical Council has not yet published its standards for the staffing, facilities and role of teaching hospitals; however the criteria in use include:

- All teaching must be led by senior clinicians of consultant standing with formal appointments to the medical school in question
- A significant portion of the programme must be consultant delivered
- Non-consultant teaching staff must be under the direction of a consultant with a formal appointment to the medical school
- A nominated tutor with secretarial support must have organisational control of the teaching program on-site
- Senior clinicians must have an input to the design and assessment of the clinical teaching programme within each medical school.
- Senior clinicians from each site must be involved in the medical school's summative clinical skills examination.
- A library staffed by professional librarian staff, linked to the main medical school library, with good quality IT facilities and standard texts and journals must be available
- A structured clinical teaching programme must be available for each of the clinical attachments provided
- Small group clinical teaching is the basis of teaching programmes on these sites. The numbers of students and teachers on each site is assessed to ensure that, in general terms, most patient based teaching sessions have a student/teacher ratio of 1:8 or less.
- Evaluation of student experience and achievement of clinical learning objectives for the clinical attachment must be performed by the medical school
- Students must be clearly briefed about their responsibilities to patients and staff and about their roles in the clinical environment. In certain clinical units, such as paediatrics, students must complete a prior police clearance procedure before being allowed clinical access to children
- Where a clinical teaching site is a major teaching hospital with responsibility for a significant part of the clinical teaching programme, formal university-hospital partnership agreements are encouraged which explicitly detail the legal, financial, educational and organisational responsibilities of each party; most are now in place

During medical school inspections, preliminary data is collected on each of the sites used by the school and visiting teams meet with the senior clinicians from those sites, together with visits to a sample of the units involved. This data is correlated with that collected from other sources e.g. Medical Council postgraduate site inspections or reports from other agencies.

A key part of each medical school inspection is an extended (private) meeting with student representatives who are asked to prepare comments in advance in relation to experiences at individual clinical teaching sites, in accordance with the criteria outlined above.

Section 4 (a,b) Clinical teaching programmes

All medical students are required to undertake a minimum period of 30 months clinical training during their five or six year undergraduate programme; previous submissions have detailed the educational aims and objectives established by the Medical Council for these programmes. Some schools provide considerably more clinical training opportunities than this and all now introduce some clinical training (such as communications skills and introductory clinical skills) at an early stage of the overall curriculum.

Block (i) Core clinical skills: The core clinical teaching programmes include:

- Internal medicine
- General surgery
- Psychiatry
- Paediatric medicine
- Paediatric surgery
- Emergency medicine
- General practice
- Obstetrics and gynaecology
- Otorhinolaryngology
- Anaesthetics
- Ophthalmology

Students are assigned in small groups for periods of two to eight weeks to consultants and specialty units in these disciplines. They take part in a planned teaching programme with clear knowledge, skills and behavioural objectives. Each student will participate, under supervision, in the full range of patient care activities of that team and will have numerous patient contacts in a range of settings. Skills such as synthesis of clinical information, care planning, team working and presentation skills are emphasised during these attachments, in addition to core clinical abilities.

Block (ii)Other clinical teaching programmes: All schools also provide other clinical teaching programmes with similar structures in disciplines such as public health medicine, genito-urinary medicine, genito-urinary surgery, neurology, neurosurgery, palliative medicine, orthopaedics, forensic medicine and medicine for the elderly. Elective periods or special study modules are often used to complete these attachments.

The Medical Council, like other regulatory bodies, is increasingly concerned at the potential for fragmentation of teaching and information overload. It therefore emphasises the importance of additional core clinical skills which may be horizontally and vertically integrated at a number of points in the curriculum. Schools are required to teach these programmes in addition to the discipline based courses outlined above; they include:

- Communications skills
- Legal medicine

- Clinical ethics
- Behavioural sciences (principally psychology and sociology of the individual and community)

An associated issue is the importance of life-long learning skills and attitudes –it is clear that the rapid pace of information turnover in medicine requires all doctors to be able to access, analyse and incorporate new information into their practices. Teaching methodologies such as problem-based learning, student oriented teaching and critical reasoning are therefore encouraged within clinical teaching programmes. The Medical Council has noted reforms introduced by medical schools to incorporate such teaching methods.

Block (iii) Non-clinical teaching programmes: The initial two or three years of each medical school's course must include courses in anatomy, biochemistry, physiology, pathology, pharmacology and therapeutics and information technology. In general, most schools now teach these programmes in horizontally-integrated systems-based modules with vertically integrated clinical inputs.

The internship

The 1998 Medical Council proposals on the internship have provided the basis for major reform which has been undertaken in partnership with the medical schools, the hospitals involved, the Department of Health & Children and interns themselves. That document identified possible options for the future of the internship including:

- Incorporation of internship into the undergraduate programme
- Incorporation of internship into postgraduate specialist training
- Maintenance of the current status but with radical reform

All parties have agreed that the internship should not become a further undergraduate or specialist training year but should be radically improved and made more relevant to the transition from undergraduate to specialist postgraduate training.

Among the key developments are:

1. Appointment of intern tutors in each hospital (consultant grade appointment by hospital, accredited by medical school)
2. Appointment of intern co-ordinators by each medical school (consultant grade appointment by medical school)
3. Introduction by employers of a national intern contract of employment
4. Introduction of an intern logbook and reflective diary
5. Introduction of protected teaching time for each intern (mean three hours per week)
6. Review of intern performance by intern tutors at the end of each post
7. Certificate of Experience signed by the relevant medical school Dean on the basis of evidence of satisfactory completion of the year provided by intern tutors to the intern co-ordinator
8. Accreditation of each hospital for internship training on the basis of an inspection of the teaching programme and facilities by the Medical Council
9. 2002 legislation allows internships in general practice, emergency medicine, radiology and obstetrics & gynaecology

10. Establishment of a national Intern Tutors and Coordinators Network with some government resources
11. Completion of a national survey of all interns in 2003; data currently being compiled

Items 1 to 8 constitute the criteria for approval of intern training programmes by the Medical Council and are reviewed during each medical school inspection.

Section 4 (c)

This section of the Draft Analysis appears to have misinterpreted the information provided in some respects.

All medical schools are required to have a Curriculum Committee as a component of the Faculty's structures, usually known as the Board of Undergraduate Studies. All medical schools evaluate the performances of individual students using both formative and summative assessments and assess the effectiveness of courses and teachers. All schools have appeal and repeat exam structures and provide remediation to poorly performing students.

Each school's Faculty is increasingly supported by medical education expertise and has ultimate responsibility for ensuring that teaching programmes achieve the required standards. In some medical schools, some foundation or basic science courses are taught by staff of the university science faculties; however, the medical faculty retains responsibility for these courses.

Formative and summative assessments are used in each school in each year of the undergraduate programme. Block (i) and (iii) courses above are each assessed individually in summative examinations with structured clinical skills examinations to assess student competence and safety for each core clinical course.

Schools are individually responsible for carrying out student assessments. The Medical Council requires a balance of:

- Sufficiently frequent but not disruptive assessments
- Formative and summative assessments
- Peer and criterion referenced assessments
- Assessment methods which range from open-book examinations to clinical OSCEs.
- Valid and reliable assessments
- Routine involvement of senior local and external examiners

The assessment standards set by schools are closely linked to other Irish and international medical schools by involvement of national and international external examiners with senior status within their own institutions. External examiners are selected on the basis of their academic status and achievements and are rotated after two to four year assignments. The appointment of external examiners within the medical school is confirmed by each university's academic council.

The Medical Council pursues international validation of educational structures and national end-point assessments. Examples include:

(i) In 2003 the Medical Council of Canada provided five-year comparative data on the performance of Irish and other graduates in its qualifying examinations, by medical school of graduation. Similar data is being requested from other medical regulatory authorities dealing with significant numbers of Irish graduates for assessment purposes.

(ii) In 2001 and again in 2003, senior international medical educationalists have been an integral part of the medical school inspection process. In 2003, in addition to membership of the teams visiting each medical school, the international members will meet with senior staff from the Departments of Education & Science and Health & Children, the HEA and senior university management.

(iii) As part of the training process for the 2003 visitor teams, members will be introduced to key elements of the assessment process in two other countries, Canada and the UK.

Section 5 (a,b,c)

This section of the Draft Analysis again appears to have misinterpreted some of the information provided.

Each medical school is required to assess the performance of individual students as outlined above. Although all students have opportunities for repeat assessments and remediation for all courses in all schools, each course must be successfully completed. Certain courses constitute 'hurdle' examinations and repeated failures will lead to failure of the undergraduate programme.

Data is supplied to the Medical Council on pass/fail/repeat performances in each year from each medical school and is closely monitored. This data forms a core area for exploration during inspections of the schools and is examined in the context of student and other evaluations of courses and peer performance reviews.

Poorly performing students must have access to review and remediation. These services are usually provided in the context of individual teaching programmes. However, decisions on summative assessments are made at faculty level. Irish constitutional law requires transparent systems of appeal/ultimate decision making in relation to students who fail 'hurdle' examinations. Medical Council inspections confirm these systems are in place within each university.

Each school is requested to establish mentoring systems at formal and informal (e.g. student 'buddy systems') levels. Such systems are in place within each school but are not subject to formal criteria established by the Medical Council. However, each university is required by law to have anti-bullying systems in place and the Medical Council requires evidence of effective compliance with these systems within each medical school.

Section 6 (a,b)

The Medical Council has expressed serious concern to government and to the public about the levels of funding provided to Irish medical schools. The schools maintain acceptable standards of academic performance through fee-paying non-EU students who effectively subsidise HEA funding. This unacceptable situation is to be addressed through a Forum on

Undergraduate Medical Education proposed by the Medical Council and agreed by government in July 2003. Its terms of reference include reviews of:

- Admission procedures and standards
- The relevance of educational programmes to the Irish health service
- Promoting inter-disciplinary and integrated programmes
- Funding levels and mechanisms
- Meeting projected staffing needs in the health services
- Relationships between all of the agencies involved

The membership of the Forum includes senior representatives of:

- Department of Education & Science
- Department of Health & Children
- HEA
- Each medical school
- Medical Council

The Forum will be chaired by a former president of an Irish university and is required to report to government during 2003.

Undergraduate education facilities are not prescribed by the Medical Council but are carefully reviewed by inspection teams. Lecture theatres, small group teaching rooms, science laboratories and library/IT facilities are usually integrated within the university campus and are available as required by the medical school. More specialised facilities include:

- Anatomy and physiology laboratories integrating modern audiovisual and IT facilities
- Computer Aided Learning laboratories
- Medial teaching and learning intranets
- Clinical skills laboratories
- Communications skills/video facilities
- Trained actors/patients
- Clinical teaching facilities
- OSCE facilities

All of these facilities are available in each medical school but significant variation exists in the development of individual facilities within individual schools. The Medical Council will submit minimum standards for each of these facilities to the Forum on Undergraduate Medical Education and will propose that investment by government should enable each school to meet these standards across the board.

Section 6 (c)

See Section 3 (a,b,c)

Section 6 (d)

See Section 3 (d)

Section 6 (e)

See Section 3 (d)

Part III. Accreditation/Approval Process and Procedures

Section 3

The Medical Practitioners Act 1978 requires the Medical Council to satisfy itself as to the content and quality of undergraduate medical education programmes. The Medical Council fulfils this role through the mechanisms outlined on page 2. Its 1997 Statement on Medical Education stated that annual inspections would be introduced for a period to ensure compliance with the reforms set out in that document. Following annual inspections until the 2001 series of inspections, a further inspection programme is now underway for 2003.

The Medical Council's Education & Training Committee has adopted the World Federation for Medical Education's Global Standards for Quality Improvement (Basic Medical Education 2001) as the basis for further inspections. In 2003, all medical schools havebeen advised that:

- the WFME 'basic standards' will be the 2003 targets but will be non-binding
- the 'basic standards' will become binding for subsequent inspections
- the 'quality development standards' will be the targets for the next round of inspections (scheduled for 2005)
- the 'quality development standards' will become binding for subsequent inspections

The implementation of this programme will link performance during inspections to accreditation. As the WFME Global Standards are further refined, they will be incorporated into the process of accreditation, thus providing a dynamic link to developing medical education standards internationally.