



MEDICAL EDUCATION, TRAINING AND PRACTICE IN IRELAND

2008-2013

A PROGRESS REPORT



Comhairle na nDochtúirí Leighis
Medical Council

Table of Contents

FOREWORD	4
EXECUTIVE SUMMARY	5
SECTION 1 The Framework of Education and Training	6
SECTION 2 The Spectrum of Competence	9
UNDERGRADUATE EDUCATION AND TRAINING	13
SECTION 3 Overview	14
SECTION 4 Standards and Guidelines	16
SECTION 5 Quality Assurance	17
SECTION 6 Key Themes	21
SECTION 7 Curriculum Issues and Content	28
INTERN EDUCATION AND TRAINING	32
SECTION 8 Overview	33
SECTION 9 Standards and Guidelines	34
SECTION 10 Quality Assurance	36
SECTION 11 Stakeholders	38
SECTION 12 Training Programme and Remediation	40
SECTION 13 Summary	41
POSTGRADUATE EDUCATION AND TRAINING	42
SECTION 14 Overview	43
SECTION 15 Standards and Guidelines	45
SECTION 16 Quality Assurance	47
SECTION 17 Recognition of Medical Specialties	50
SECTION 18 The Next Phase	52
PROFESSIONAL COMPETENCE	53
SECTION 19 Overview	54
SECTION 20 Council's Structures and Processes	56
SECTION 21 Key Themes	58
CONCLUSION	61
ENDNOTES	63

FOREWORD

The role of the Medical Council is to protect the public by promoting and ensuring the highest professional standards among doctors. Since the commencement of the Medical Practitioners Act 2007, the Medical Council has had a significantly enhanced role in the setting and monitoring of standards for the professional development of doctors. Professional competence requirements have been introduced, making it a legal obligation for all doctors to keep their knowledge and skills up-to-date throughout their professional lives. Processes for setting and monitoring standards at undergraduate, intern and postgraduate levels have been streamlined to ensure that educational standards in Ireland benchmark against the highest international standards.

This report is based on Council's work in education, training and professional competence over the last five years. I am pleased to report that medical education and training in Ireland is of generally high quality. It produces doctors who have been educated and trained to standards that deliver a foundation from which they provide care which is both safe and of the highest possible quality throughout their careers. Indeed, our own research suggests that most people in Ireland have generally positive experiences with their doctors, who are the most trusted profession in Ireland.



I would particularly like to acknowledge the contributions of the Chairs of the Professional Development Committee (Professor Bill Powderly, 2008-2012; Dr Anna Clarke, January-May 2013), the Chair of the Professional Competence Committee (Dr David O'Keeffe), the Head of Education and Training (Dr Anne Keane), the Director of Professional Development and Practice (Dr Paul Kavanagh) and members of Council and the Executive for their commitment, dedication and support.

I am confident that the new Medical Council will continue to prioritise the professional development of doctors to ensure they are equipped with the necessary knowledge and skills to contribute to a health system that prioritises patient safety above all other concerns.

A handwritten signature in black ink that reads "Kieran Murphy". The signature is fluid and cursive, with the first name "Kieran" and last name "Murphy" clearly distinguishable.

Professor Kieran C. Murphy
President

EXECUTIVE SUMMARY

The four main stages of the medical practitioner's lifecycle - undergraduate, intern, postgraduate education and training, and professional competence - form the framework for this review. This report consolidates into one document the findings of a five-year cycle of quality assurance activity undertaken by this Council. The Report:

- Explains the concept of the [Eight Domains of Good Professional Practice](#), which have been developed by Council as the framework for undergraduate, intern and postgraduate education and training, and for professional competence
- Provides an overview of the current and evolving context of undergraduate, intern, postgraduate education and training, and of professional competence structures
- Summarises the rules, standards, criteria and guidelines that Council uses as its yardstick for evaluation
- Outlines the processes for accreditation of programmes of medical education and training and professional competence schemes, and for the bodies which deliver those programmes and schemes
- Highlights the accreditation activity which has been undertaken in the lifetime of this Council, activity which has included the evaluation of medical schools, the inspection of hospital and community-based clinical training sites, the assessment of postgraduate training bodies and specialties, and the establishment of professional competence schemes
- Discusses the main findings arising from this work
- Makes recommendations to maintain and improve the generally good quality of education and training.

Significant advances in key areas are highlighted in the report. They include:

- Promoting the model of education, training and competence as a continuum that stretches from a student's first day in medical school until a doctor's final day of practice, with associated implications for continual self-reflection and lifelong learning
- Emphasising the importance of developing and maintaining medical professionalism, recognising that medical knowledge and skills by themselves are not enough, but have to be supported and reinforced by professional attitudes and behaviours
- The entry into the medical workforce of the first cohort of students from programmes tailored for entrants who were already graduates
- Positive changes to the structure and content of the intern year, the critical bridge between graduating from university and entering further postgraduate training
- The first in-depth evaluation of the postgraduate medical training bodies that are responsible for training in over 50 medical specialties
- The introduction of mandatory maintenance of professional competence that recognises the importance of doctors keeping up-to-date and fit-for-purpose.

This Report marks the end of the term of the current Council, but the Medical Council's role in ensuring and enhancing the quality of medical education and training and professional competence will continue. This Report captures the developments that have taken place over the last five years and aims to provide some signposts for further progress.¹

1. THE FRAMEWORK OF EDUCATION AND TRAINING

1.1 Council's remit and role

The Medical Council regulates the medical profession in Ireland. [The 25-member Council](#) consists of 13 non-medical members and 12 medical members. It has a statutory role to protect the public by promoting the highest professional standards amongst doctors practising in the Republic of Ireland. The [Medical Practitioners Act 2007](#) (MPA 2007) is the key piece of legislation involved in setting out Council's obligations; the provisions of Part 10 (Education and Training) came into force in March 2009, and the provisions of Part 11 (Professional Competence) in May 2010; these are the most relevant sections in the context of this Report.

Education and training that develops and maintains competence is at the core of good medical practice and effective health care. The MPA 2007 gave Council specific powers and responsibilities to regulate all stages of medical education and training.

Council sets and monitors standards in undergraduate, intern and postgraduate education and training in Ireland and is also required to satisfy itself as to the ongoing maintenance of doctors' professional competence. Council accredits the bodies that deliver medical education and training and professional competence schemes against robust and validated international standards; and it ensures through monitoring that accredited bodies maintain and improve their standards.

1.2 Council committees

Council's Professional Development Committee (PDC) advises and makes recommendations to Council on

medical education and training issues. Its responsibilities range across the spectrum of medical education and training. Because of the range of its remit, PDC established sub-committees and working groups, which include external experts in particular fields to provide additional advice.² A Professional Competence Committee deals with strategic and policy issues in that area. The Council is very keen to include patients and their advocates in its education and training and competence activities, and they are represented in the committee and sub-committee system that Council has set up.

1.3 Stakeholders

The delivery of effective medical education and training is a collaborative effort. As the regulator, the Medical Council is part of a matrix of organisations, each with a distinct role to play. They include:

- Department of Health
- Department of Education and Skills
- Health Service Executive (HSE)
- Universities and medical schools
- Medical postgraduate training bodies
- Clinicians, educationalists, managers and administrators at clinical training sites
- Patient advocate groups
- Other regulatory agencies

There are regular formal and informal meeting with these bodies, exchanging information, developing joint approaches, and finding shared solutions to challenges.

The Medical Council also has strong links with international developments in the area of accreditation of medical education and training. The Council's undergraduate Standards (discussed in more detail later in the Report) are based on those of the [World Federation for Medical Education](#) (WFME), an international organisation linked to the [World Health Organisation](#) (WHO); a WFME nominee has acted as an external assessor for the Medical Council on medical school visits over a number of years; and a member of the Medical Council Executive has acted as a WFME advisor on accreditations in Moldova and Turkey. The postgraduate standards are informed by those of the Australian Medical Council.

Internationalisation in regulation and quality assurance is welcome on the grounds that it drives up standards through sharing of good practice and facilitates input from external experts. Council has built good relationships with regulators in other countries, both individually and through the [International Association of Medical Regulatory Authorities](#).

2. THE SPECTRUM OF COMPETENCE

- The spectrum of competence is a continuum of skills and knowledge that an individual possesses, ranging from basic to advanced.
- It is a measure of an individual's ability to perform a task or solve a problem.
- The spectrum of competence is a dynamic and evolving concept, as individuals can develop new skills and knowledge over time.
- The spectrum of competence is a key factor in determining an individual's career path and potential.

- The spectrum of competence is a key factor in determining an individual's value to an organization.
- The spectrum of competence is a key factor in determining an individual's potential for leadership.
- The spectrum of competence is a key factor in determining an individual's potential for innovation.
- The spectrum of competence is a key factor in determining an individual's potential for growth.

- The spectrum of competence is a key factor in determining an individual's potential for success.
- The spectrum of competence is a key factor in determining an individual's potential for fulfillment.
- The spectrum of competence is a key factor in determining an individual's potential for happiness.
- The spectrum of competence is a key factor in determining an individual's potential for well-being.

- The spectrum of competence is a key factor in determining an individual's potential for achievement.
- The spectrum of competence is a key factor in determining an individual's potential for excellence.
- The spectrum of competence is a key factor in determining an individual's potential for greatness.
- The spectrum of competence is a key factor in determining an individual's potential for legacy.

- The spectrum of competence is a key factor in determining an individual's potential for impact.
- The spectrum of competence is a key factor in determining an individual's potential for influence.
- The spectrum of competence is a key factor in determining an individual's potential for power.
- The spectrum of competence is a key factor in determining an individual's potential for wealth.

- The spectrum of competence is a key factor in determining an individual's potential for happiness.
- The spectrum of competence is a key factor in determining an individual's potential for well-being.
- The spectrum of competence is a key factor in determining an individual's potential for fulfillment.
- The spectrum of competence is a key factor in determining an individual's potential for success.

The Eight Domains of Good Professional Practice have been developed by the Medical Council and focus on the primary duty to promote patient safety and quality of patient care. The Domains (illustrated on the following page) encapsulate the range of competencies which support good medical practice.

The Medical Council has fostered the concept of a spectrum of competence based around these Domains. The responsibilities of medical students and doctors evolve over time. Accordingly, doctors' knowledge, skills, attitudes and behaviour must also evolve as they move through their career. The Domains act as a constant frame of reference throughout this continuum of growing expertise in professional development and practice.

The Medical Council – unlike some regulatory bodies – has statutory responsibility for the accreditation of the undergraduate, intern, postgraduate and professional competence stages of a medical student's and a doctor's career. It is therefore well placed to encourage this spectrum of competence. Council has promulgated use of the Domains by medical schools, interns, trainees and postgraduate training bodies. Council's accreditations have found an increasing level of awareness of the Domains, and integration of them into the curricula.

However, the spectrum of medical education and training needs to be more than a concept: facilitating transition from one stage of education and training to the next in a practical way is also important. Effective transition has to be founded in the student or doctor being justifiably confident and equipped with the knowledge and skills to make the transition to the next stage of their training and maintenance of competence. It also has to be underpinned by tangible support structures.

Council has stressed the importance of inductions to enable safe transition between the different phases of a student's and doctor's career cycle. Successful induction requires the collaboration of various stakeholders. Council will soon survey the views of students and trainees to obtain their perceptions on their preparedness for the next stage of their education and training. The further development of the spectrum of competence may have implications for teachers, who may have to develop common skill-sets that span all stages of education and training; for more collaboration among the bodies primarily responsible for undergraduate, intern and postgraduate education and training and competence; and for funding streams. In the meantime, Council will continue to recommend the Domains as the competencies that weave together to produce a professional, competent and caring medical practitioner.

To underline Council's commitment to this continuum of teaching and learning, a [symposium](#) on the topic 'From student to specialist - defining competencies across the professional development spectrum; implications for curricula, assessment, faculty and patients' was hosted by Council on 30th August 2012. It was designed to link with Council's work in setting and monitoring standards accreditation. Participants in the symposium included medical schools and postgraduate medical training bodies, patient advocates, senior health officials and HSE staff. Key messages that emerged from the workshop sessions were embedding the concept and practice of professionalism from the student stage; and the need to involve patients in education, training, and assessment. These themes are explored in this review.



The Eight Domains of Good Professional Practice
as devised by the Medical Council

The Eight Domains of Good Professional Practice as devised by the Medical Council

Patient Safety and Quality of Patient Care

Patient safety and quality of patient care should be at the core of the health service delivery that a doctor provides. A doctor needs to be accountable to their professional body, to the organisation in which they work, to the Medical Council and to their patients, thereby ensuring the patients whom they serve receive the best possible care.

Relating to Patients

Good medical practice is based on a relationship of trust between doctors and society and involves a partnership between patient and doctor that is based on mutual respect, confidentiality, honesty, responsibility and accountability.

Communication and Interpersonal Skills

Medical practitioners must demonstrate effective interpersonal communication skills. This enables the exchange of information, and allows for effective collaboration with patients, their families and also with clinical and non-clinical colleagues and the broader public.

Collaboration and Teamwork

Medical practitioners must co-operate with colleagues and work effectively with healthcare professionals from other disciplines and teams. He/she should ensure that there are clear lines of communication and systems of accountability in place among team members to protect patients.

Management (including Self Management)

A medical practitioner must understand how working in the healthcare system, delivering patient care and other professional and personal activities affect other healthcare professionals, the healthcare system and wider society as a whole.

Scholarship

Medical practitioners must systematically acquire, understand and demonstrate the substantial body of knowledge that is at the forefront of the field of learning in their specialty, as part of a continuum of lifelong learning. They must also search for the best information and evidence to guide their professional practice.

Professionalism

Medical practitioners must demonstrate a commitment to fulfilling professional responsibilities by adhering to the standards specified in the Medical Council's [Guide to Professional Conduct and Ethics for Registered Medical Practitioners](#).

Clinical Skills

The maintenance of professional competence in the clinical skills domain is clearly specialty-specific, and standards should be set by the relevant postgraduate training body, according to international benchmarks.

UNDERGRADUATE EDUCATION AND TRAINING

“Education is not the filling of a pail but the lighting of a fire.”

WB Yeats (apocryphal)

3. OVERVIEW

3.1 Medical schools and programmes

There are six medical schools in Ireland. Between them they deliver nine undergraduate programmes³ in Ireland, as follows:

- [University College Cork](#) (UCC): Direct entry programme (DEP) for students entering from second-level education, and graduate entry programme (GEP)⁴ for students entering from third-level education
- [University College Dublin](#) (UCD): Direct entry programme and graduate entry programme
- [National University of Ireland, Galway](#) (NUIG): Direct entry programme
- [Royal College of Surgeons in Ireland](#) (RCSI): Direct entry programme and graduate entry programme
- [University of Dublin, Trinity College](#) (TCD): Direct entry programme
- [University of Limerick](#) (UL): Graduate entry programme.

The increase in the number of approved programmes from five at the commencement of the term of Council in 2008 to nine programmes by May 2013 is one of the most significant changes in medical education in Ireland. The increase was due to the four graduate entry programmes which, from 2010 onwards, began to be fully approved by the Council and started to graduate students. Their impact on the landscape of medical education and training was very significant; this is discussed in detail in section 6.3.

All the above universities and the RCSI are approved by Council. So, too, are the undergraduate medical programmes they deliver.

Irish universities award medical degrees with different titles, due to the legal, historical and cultural context of their foundation and development, and this is recognised in the MPA 2007. However, regardless of the title, all Irish undergraduate medical degrees, whether direct or graduate entry, are of the same standard (i.e. Level 8 in Ireland's National Qualifications Framework).

3.2 Entering medical school

There are three different routes to an undergraduate medical programme, depending on origin of student and type of programme:

- **European Community applicants** must achieve a minimum academic standard in the Leaving Certificate or its equivalent - including meeting any specific entry requirements required by the individual medical school, e.g. passes in science subjects - and pass the [Health Professions Admissions Test](#) (HPAT) measuring candidates' logical reasoning, problem-solving skills, non-verbal reasoning, and interpersonal skills
- **Non-European Community applicants** must obtain the necessary standard in an equivalent to the Leaving Certificate, and additionally may be interviewed as part of the process
- **Graduate entry medical programme** entrants must obtain a minimum of an Upper Second Class honours degree (2.1) in a primary degree - in any subject - and reach a threshold score on [the Graduate Australian Medical School Admission Test](#) (GAMSAT) or [Medical College Admission Test](#) (MCAT). Non-European Community applicants may also be interviewed.

Overall, the historical gender imbalance in admissions has been transformed, with women forming the majority of entrants to medical schools. Universities have made

some commendable efforts to provide a route to medical education for groups with little history of participation in it. The universities with medical schools all participate in the Disability Access Route to Education (DARE) Project. Initiatives for enabling participation by members of the Travelling Community are also notable. The Council has and will continue to encourage the widest possible access for suitable candidates, as medicine benefits from and needs diverse sources of recruitment.

4. STANDARDS AND GUIDELINES

In the lifetime of this Council, [rules, criteria, standards and guidelines](#) for medical education and training, and for professional competence, have been produced. They form the bedrock of Council's role in setting and monitoring standards; they are the benchmarks against which the performance of bodies and programmes is measured. Reference will be made to rules, criteria, standards and guidelines at various stages throughout this review.

At an undergraduate level, the Council's standards are based on those of the World Federation for Medical Education. These [WFME Global Standards for Quality Improvement in Medical Education: European Specifications](#) 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 the performance of the school against the relevant Standard. The medical school and the Medical Council ask the fundamental question, "Is 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 self-assessment questionnaire completed by the school and the report produced by Council at the end of each accreditation reflect this nine-standard structure.

It should be noted that Council applies standards in a rigorous way, but not in an inflexible way. It is not overly prescriptive and recognises that bodies and programmes vary in the way they deliver medical programmes. This is inevitable and it is welcome, as students can apply to the medical school(s) which they feel are most appropriate to their particular expectations, preferences and learning styles. No two schools in Ireland are identical, but while their pathways toward their goal may differ, the goal is the same: producing graduates with the knowledge, skills, attitudes and behaviours to enter internship and be equipped for lifelong learning.

The way in which Council assesses medical schools against the standards and guidelines is discussed next.

5. QUALITY ASSURANCE

5.1 The value of accreditation

Accreditation is a feature of mature systems and ensures education and training is delivered to defined high standards, while also fostering institutional improvement and promoting high-quality experience. In the wider context of the quality assurance of third-level education in Ireland in general, a number of bodies play a key role (notably [Quality and Qualifications Ireland](#), established in 2012).

Universities are required to establish and undertake quality assurance and quality improvement programmes which are rigorous and robust, aimed at improving the quality of education and related services provided. Medical schools and universities have their own internal quality assurance processes that act as a lever for change.

The Medical Council's own regulatory performance has been externally reviewed and measured against international best practice by the [National Committee on Foreign Medical Education and Accreditation](#) of the United States Department of Education. It has affirmed that the Council's standards and processes were comparable (i.e. of the same high quality) to those used within the United States. Participating in the process has facilitated the Medical Council keeping the accreditation policies and procedures that it uses fit-for-purpose and up-to-date.

External accreditation therefore encourages organisations to think about, respond to, and deal with the strengths and weaknesses of their programmes; this had been recognised by previous Medical Councils, which had undertaken substantial accreditation activity at undergraduate level.

5.2 Accreditation by the Medical Council

The statutory responsibility for accrediting undergraduate medical programmes and the bodies that deliver the programmes lies with the Medical Council under Section 88 of the MPA 2007. The Council's major objective is to assess whether a medical programme is designed and delivered to a satisfactory standard. It is also keen to act as a quality enhancement agency, making recommendations which, while not essential to the delivery of a satisfactory programme, should be considered by the school as potential improvements.

At the end of the accreditation process for programmes and bodies, Council has a range of options open to it under the Act:

- a. Approval
- b. Approval with one or more conditions attached
- c. Amendment or removal of conditions previously attached
- d. Withdrawal of approval
- e. Refusal of approval (this option applies only to the body and not to the programme).

This Council completed an intensive schedule of accreditation of the bodies and the programmes the bodies deliver; a typical [agenda](#) for a visit, and the [schedule and outcomes of accreditations 2008-13](#) demonstrate the scope of the task that has been completed. As a result, Council is satisfied as to the overall high quality of undergraduate medical education and training in Ireland.

5.3 The accreditation process

The World Federation for Medical Education's [Guidelines for Accreditation of Basic Medical Education](#) recommend that accreditation should:

- Be based on a sound legal footing
- Be independent from government, the medical schools and the medical profession
- Be trustworthy and recognised by all
- Be fair
- Possess a high degree of transparency
- Involve assessors who are respected within the medical profession, and who are preferably of international standing.

According to the WFME Guidelines 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 Council's process reflects these international guidelines on best practice. The stages of the process are shown on the right.

Accreditation of Basic Programmes and Bodies 2013



Three aspects of accreditation are highlighted below.

- **The accreditation team:** Council's accreditation teams normally comprise a combination of lay and medically qualified members of the Medical Council and external assessors. The external assessors have expertise in medical education and / or quality assurance, or represent the public interest. They are drawn both from within Ireland and from other jurisdictions. Following a formal nomination and approval process, assessors become members of the Council's Assessor Sub-Committee. Since 2008, the Medical Council has substantially increased its pool of external assessors, and they have played a very valuable part in the accreditation process. Council appreciates the additional expertise and national and international perspective the external assessors brought to accreditation teams. The fact that in some cases the same team has made a number of accreditation visits to the same medical school and training site has provided valuable continuity and enabled teams to gain a particular insight into the progress made.
- **Dialogue with students:** This is a key part of virtually every visit. Council aims to meet students in each year of the programme and particularly encourages class representatives to attend. One of the key elements of the dialogue is that it is confidential, and this is emphasised to students at the start of every session. Discussions with students generally focus on the curriculum, the quality of teaching, assessment, academic and pastoral support, and access to learning resources. Professionalism and ethical issues always feature in the discussions, particularly

with students in the later stages of the course, who are experiencing in 'real life' (on the wards or in a general or community-practice setting) the type of scenarios they met in a more theoretical way earlier in the course. Students are generally very positive about their experiences, as well as very articulate. These sessions have been one of the most enjoyable and productive parts of the accreditation process, and give accreditation team members a real insight into the life of the medical school and of its students. Council greatly appreciates the input of students into the accreditation process in the period 2008-13.

- **Monitoring by Annual Return:** The Annual Return is a new monitoring tool introduced by Council in 2013. Each medical school will provide Council with an update on recommendations made by Council and report any relevant significant changes which are anticipated or are in the planning stage. Visits to a medical school will be arranged if the Annual Return indicates that this is advisable.

There is no doubt that accreditation has a significant impact on the quality of medical education and training and acts as a lever for improvement. Reviews make demands on medical school staff (whose positive and collaborative attitude was appreciated by Council) and on the reviewers, but they are nevertheless very worthwhile. Visits are an essential component of Council's quality assurance of medical education and training and inform the findings contained in this report. Some key common themes emerging from the 2008-13 quality assurance cycle are discussed below.

6. KEY THEMES

6.1 Theme 1: Professionalism

Learning about professionalism; learning to be professional; and observing professionalism in action are all essential to the development of a good doctor and are part of medical programmes in Ireland.

I. Council guidelines on students' conduct

The Medical Council has for many years produced ethical guidance for registered medical practitioners. During the lifetime of this Council, and for the first time, [Guidelines for Medical Schools on Ethical Standards and Behaviour appropriate for Medical Students](#) were published to support medical schools and students in developing pre-registration professionalism. The Guidelines address the areas of competence, confidentiality, personal and professional interactions, dress and health.



Guidelines for Medical Schools on Ethical Standards and Behaviour appropriate for Medical Students

The concept of professionalism evolves and needs to be kept up-to-date. For example, in the consultation with students that took place prior to the publication of the Student Ethical Guide students themselves highlighted the importance of professional behaviour in social media use.

The accreditation process since the publication of the Guidelines has assured Council that the Guidelines are being incorporated into medical schools' teaching, as part of the commendably high profile given by medical schools to student professionalism. In the various presentations given to students by members of the Council Executive, professionalism is always at the forefront; and an area for students on the Medical Council's website will underline the importance of professionalism at this formative stage of a doctor's career.

II. Role models

Formal instruction in professionalism is only part of the process of becoming professional. Unstated norms, values, and beliefs - not acknowledged or articulated - are a powerful 'hidden curriculum.' The hidden curriculum, "...what is implicitly taught by example day to day, not the explicit teaching of lectures, grand rounds, and seminars", can reinforce or undermine the formal messages of the 'declared curriculum'.⁵

Role models are a particularly important part of this hidden curriculum, with key elements of professionalism such as collegiality, patient-centred care and ethical practice susceptible to being strengthened or weakened by good or poor role models. A recent Canadian study concluded that role modelling continued to be the single most important component of the medical school experience

as it related to professionalism and the development of professional identity. This study also found that, in general, the attributes not highly emphasised by faculty are not highly valued by students.⁶

The majority of practitioners are good role models, and the importance of becoming and remaining a good role model is represented in medical school curricula. Council's experience in accreditations shows that the majority of students have excellent insight into the importance of role modelling, enthusiastically highlighting best practice in teaching and recognising and being disappointed by its opposite. Indeed, senior students recognised that they themselves can be role models for more junior students.

III. Dealing with professionalism deficits

As well as fostering good practice in student professionalism, it is important that medical schools take practical steps to deal with instances or patterns of unprofessional behaviour by students. There is a duty for schools to address the issue of students who are not demonstrating the required level of professionalism, having first established that unprofessional behaviour is not due to an underlying mental health problem or a particular psychological trauma, such as bereavement.

Tackling unprofessionalism is obviously intrinsically necessary if the quality of a medical programme and its graduates is to be maintained. But it is also crucial because there is compelling evidence that poor student behaviour is predictive of future poor performance; seminal research in the USA found that where serious ethical breaches occurred later in a doctor's career, this had often been preceded by a 'track record' of poor conduct that began at medical school.⁷ The potential patient safety implications

of this continuum of unprofessional behaviour continuing unchecked are obvious. The evidence underlines the need for medical schools to act during the early formative stages of medical education and training when behaviour may be more susceptible to change.⁸

Medical schools initially attempt remediation, e.g. in instances where the student may not understand that they are acting unprofessionally, or is willing to change. Medical schools are commendably keen to ensure that students who continue to display major deficits in professionalism despite the best efforts of the school are not allowed to graduate with a medical degree. Medical schools have therefore developed policies and procedures to tackle student unprofessionalism. Challenges remain in implementation. Where the medical school is part of a university, it is crucial that university procedures should reflect the fact that medical students (in common with students from other clinical disciplines) have a particular responsibility to behave appropriately, especially on clinical training sites.

Council is going to produce a thematic guide expanding on student professionalism; this will include guidance on best practice in student Fitness to Proceed processes. A workshop held under the auspices of the [Irish Network of Medical Educators](#) (INMED) provided valuable insight into professionalism issues arising in medical schools; as it develops further guidance Council aims to work closely with teachers who are particularly involved in this area.

6.2 Theme 2: Patient safety in the curriculum

Patient safety movements in recent years have had important implications for undergraduate medical education. Council encourages medical schools to use the

World Health Organisation's Patient Safety Curriculum and, particularly before a paediatric rotation, the Children First: National Guidance for the Protection and Welfare of Children.



WHO patient safety curriculum

There is some commendable patient safety activity ongoing in medical schools, using methods that include problem-based/small-group teaching, videotaped consultations, practical bedside teaching, 'debriefings' on patient safety issues as part of the feedback process, internet-based teaching, and lectures from leading practitioners. Crucially, these activities often involve patients or patient advocates.

There is still educational debate as to whether patient safety should be an explicit, 'badged' part of curricula, as compared to being more or less implicit in issues like clinical skills, communications and ethics. The Council is not prescriptive. However, where patient safety is explicit, care should be taken that it is not seen as a 'niche' interest, ring-fenced from the generality of education and training and future practice. Where it is implicit, care must be taken that it is not too 'submerged'. Whatever

the approach, Council urges that teaching and learning about patient safety must:

- Start early
- Recur and be reinforced throughout the programme
- Be assessed
- Involve different methods of teaching and assessment
- Have sufficient resources
- Have participation from patients or their advocates

Sensitive issues are inevitably involved in patient-safety teaching, including the inevitability of error, hierarchy issues in communication and 'organisational pathogens'. There are logistical teaching challenges, too, with competing educational demands and the dispersal of students in clinical placements. The importance of a local 'safety culture' in the clinical training environment is crucial, with significant potential to enhance or undermine success.

There must be encouragement and support for students to come forward if they believe they may have witnessed an event with patient safety implications. In discussions with students during accreditations, reports of witnessing such events are uncommon, but students generally understand that they must put patient safety first, and they would discuss concerns with their supervisor, mentor, or trusted other.

6.3 Theme 3: Graduate Entry Programmes

I. Genesis of GEPs

In some countries (e.g. the USA), entry to medicine has long been primarily or even exclusively for graduates. Other jurisdictions (e.g. the UK) have for some years had a 'mixed economy' of direct entry programmes and graduate entry programmes. A small number of graduates had always entered the longer (five or six year) direct entry programmes in Ireland, aimed primarily at school leavers, but these programmes were not tailored for graduates so were not time or cost effective.

National workforce needs, the fact that graduate entry was 'tried and tested' in other jurisdictions and that it provided access to a medical career for a more diverse cohort provided impetus to the establishment of exclusively graduate entry programmes in Ireland; the key [Fottrell Report](#),⁹ published in 2006, supported the introduction of graduate entry programmes and it became national policy.

In December 2005 the Medical Council provisionally accredited the first exclusively graduate entry programme in Ireland, designed for graduates and of four years duration. Council recognised that the programme was one which had been planned but had yet to be implemented, but determined that "the basic ingredients for a quality programme are present", emphasising that "assuring quality in delivery will be an on-going process".¹⁰

Shortly afterwards, and following a national bidding process, three more GEPs commenced and were similarly provisionally accredited by Council. One new medical school - the University of Limerick - was graduate entry only. At the conclusion of this Council's term, and following robust monitoring, all four GEPs are approved

by Council: RCSI (which graduated its first graduate entry cohort in 2010), UL (graduated its first cohort in 2011), UCC, and UCD (both graduated their first GEP cohort in 2012).

II. Structure

As noted, UL has a single, graduate entry cohort. RCSI, UCC and UCD each have two programmes and in their case the DEP student stream and the GEP student stream merge for the final two years of the degree programme. Direct entry students and graduate entry students reported to Council a very positive 'post-merger' relationship. During the final two years, both sets of students at RCSI, UCC and UCD have the same clinical exposure, sit the same exams, and if successful are awarded the same degree, the essential difference being that GEP students study medicine for two years before undertaking major clinical rotations, while DEP students study for three years prior to their major clinical rotations.

III. Findings

The majority of Council's inspections of Irish medical schools were to evaluate graduate entry programmes, as GEPs were new and innovative in their intake, in some of their programme content and delivery and in their four-year duration. The following section synthesises the main findings of the Council teams in respect of GEPs, as endorsed by Council. It should be emphasised as a preamble that the evidence of Council's accreditation is that direct entry students continue to be of the highest calibre.

IV. Student background

As noted, a GEP applicant's degree must be at least a

2.1 in any subject. Some entrants have come straight from university. A proportion has a physical sciences, biological sciences or medical sciences degree. A small number have practised as a healthcare professional, e.g. in dentistry or physiotherapy. Some have spent a number of years in a job entirely unrelated to medicine, and some have an arts, social sciences or humanities degree. The majority are graduates in science-related subjects, but all entrants have some science knowledge because they have passed the GAMSAT or MCAT. A minority have additional academic research experience; there are a number of GEP entrants with PhDs.

V. GEP student characteristics

Overall, GEP students:

- Are very motivated to study medicine (and are free from any parental pressure to do so)
- Demonstrate transferable skills; when they enter the programme they already have well-developed abilities to research, synthesise and analyse complex information, to undertake self-directed learning, to work as a team member, to write degree-standard reports, to communicate well and to make degree-standard presentations. They can concentrate on absorbing the content of the programme at a time when school-leaver entrants are – naturally and inevitably – still learning generic skills.
- Are conscious of the time commitment and financial commitment they have made and are determined to make it worthwhile
- Work very hard
- ‘Work smart’ too, using their developed study skills
- Have high expectations of themselves

- Have high expectations of the medical school
- Are very career-oriented.

VI. Early years of GEP programmes

Evidence suggests that the GEP students with a non-science background find the science-oriented parts of the programme particularly challenging, at least in the first couple of terms, and additional help can be provided by medical schools. Students without a science degree have some catching up to do; and they do catch up. By the time graduate entry students reach the predominantly clinical years three and four of their programme, there appears to be no discernible gap in performance between students from various academic backgrounds.

VII. Major clinical rotations part of the programme

Evidence suggests:

- GEP students are performing as well as direct entry students
- Medical Council teams are frequently advised by clinicians on site that GEP students are notable for their maturity and motivation
- GEP students have a deep understanding of the importance of professionalism.

VIII. Graduation

- In UCC, UCD and RCSI GEP students take the same final exams as the DEP students and GEP students perform comparatively well
- At UL they take exams which are appropriate for medical school exit and perform well.

IX. Conclusion

The Council's accreditation process has confirmed the value of the two-stream approach; traditional direct entry programmes and the new graduate entry route both have a role to play in graduating doctors with the appropriate knowledge, skills, attitude and behaviour. GEPs are educating a different type of student but they do not have an overt mission to produce a different type of doctor; the intended outcome of the graduate entry programmes is essentially the same as the outcome of the traditional direct entry programme: a competent doctor. Longitudinal research on any apparent and sustained differences between the cohorts would be interesting, and Council has asked medical schools to track the progress of graduates of GEP programmes. On current evidence it appears, however, that this major change in undergraduate medical education has been a success.

6.4 Theme 4: Internationalism

Curricula are enriched by international issues, including knowledge of global health issues, the skills needed for working in a global health context, the value of being a global citizen, commitment to health human rights, and being an advocate for the health of the individual and of the national and international community. Internationalism ideally includes students developing the linguistic skills necessary to access knowledge contained in sources in various languages (student selected components or electives can be an opportunity to develop these skills). Council encourages schools to continue their efforts in this area.

The Council also welcomes the fact that under [ERASMUS](#) - the European Community Action Scheme for the Mobility of University Students - students on medical programmes

in Ireland can spend a period of the programme studying abroad and students from other countries can come to Irish medical schools. Students from other countries also come to study for longer periods in medical schools in Ireland that have partnerships with overseas schools.

It is important for medical schools to ease the transition of overseas students between an Irish medical school and a medical school in another country, and provide effective induction for those with little experience of the educational or cultural environment in Ireland. Some excellent work has been done by medical schools in this respect.

International benchmarking of the performance of students in medical schools in Ireland is undertaken by some schools, which assess their students' performance against the performance of students in universities overseas that have the same or similar curricula.

6.5 Direct entry programmes

Graduate entry programmes have been dealt with at some length because they have all been fully approved and graduated their first cohort during the lifetime of the current Council. The maturation of the GEPs has undoubtedly been the outstanding change to the landscape of undergraduate medical education during this time. But the majority of students continue to access medical school from second-level education, without having done a degree, and that is likely to be the position for the foreseeable future. The standard of entrants, programmes and graduates continues to be impressive.

The curriculum issues highlighted in section 7 apply - unless otherwise stated - to both GEPs and to DEPS. But a DEP-specific issue is worth highlighting here: Applicants with a strong science background (particularly science graduates) may be exempted from the first or foundation year of a six-year programme. Where students do undertake a foundation year, it is important for medical schools to ensure that it provides an effective platform for transition into the remainder of the programme and that the programme is a coherent whole.

6.6 Accreditation of overseas basic programmes and bodies

Medical schools and medical programmes based overseas that award, or intend to award, an Irish undergraduate medical degree underwent an accreditation process by Council in 2012 and 2013. Students on some of these programmes spend part of their time studying in Ireland; other overseas programmes are delivered entirely outside Ireland. Council's accreditations were undertaken in the interests of ensuring the quality of the degrees awarded. The processes used were identical to those Council uses

in Ireland. While the context, culture and environment may be different to those in Ireland, Council expects overseas schools to meet Council standards, criteria and guidelines.

6.7 Anatomy responsibilities

The MPA 2007 gave Council responsibilities under the Anatomy Act 1832 for granting medical school staff licences to practise anatomy in the State, appointing inspectors of places in the State where anatomy is practised and receiving notification when a body is donated to medical schools for anatomical purposes. On the recommendation of the Anatomical Society of Great Britain and Ireland, the Medical Council appointed Professor Ceri Davies of Imperial College London as Inspector of Anatomy. He has advised and assisted the Medical Council in the performance of its statutory obligations in this area and inspected and reported on the anatomy facilities at medical schools, which are generally impressive.

7. CURRICULUM ISSUES AND CONTENT

In addition to the four main themes discussed in section 6, a wide range of other issues were raised and discussed during the accreditation process and are worthy of note. In each category, many of the good principles and practices that are referenced are now embedded in medical schools.

7.1 Curriculum design and delivery

Council encourages:

- An integrated, systems-based approach to curriculum design and development
- Emphasis on developing students' communication, team-working and interpersonal skills (case-based / problem-based learning approaches can be helpful here)
- Development of early (i.e. first-year) patient-contact programmes
- Integrated, systems-based / small-group / tutorial teaching
- Electives and student-selected components
- Participation by patients and patient advocates
- Emphasis on facilitated and self-directed learning
- Research exposure and opportunities
- Exposure to clinical audit
- An emphasis on fostering the skills for lifelong learning
- Enriching the curriculum *via* the arts and humanities; for example, accreditation teams saw many excellent and thought-provoking examples of project work in art and design, creative writing and music
- Intercalation opportunities (where students spend

additional years at medical school studying for an extra degree awarded in addition to their medical course)

- The use of portfolios, learning logs and reflective journals.

7.2 Assessment of students and feedback to them

The Council encourages:

- Connection of assessment methods to transparent defined learning outcomes
- Clear correlation and good 'fit' (and appropriate timing) between content and assessment
- Appropriate assessment of all elements of the curriculum, avoiding students developing a perception that there are 'hard' and (less important) 'soft' subjects
- An appropriate balance between formative and summative assessment
- Use of a range of different assessment methods
- Appropriate use of continuous assessment and team-based assessment
- Integrating the findings of assessment into the teaching, learning and assessment processes
- The timely release of information about scheduling of assessments and issuing of results.

Feedback to students on their performance should be routinely available and should not be associated primarily with poor performance by a student. Council appreciates that the number of assessments and number of students can make giving feedback time-consuming for teachers, but appreciation of feedback by students and their hopes

for more feedback, were constant themes of the dialogue with students at accreditations.

7.3 Teaching and learning on clinical sites

- Sufficient capacity and resources on clinical training sites are pre-requisites for quality medical education. Increasing numbers of students have increased pressure on traditional teaching hospitals, and Council has monitored and will continue to monitor the teaching and learning capacity within the system
- Clinical rotations are part of the continuum of the undergraduate programme. Teachers on sites should be made aware pre-placement of students' existing knowledge base and learning objectives in order to foster the coherency of the programme
- Ensuring completeness of students' experiences in their clinical years and providing consistency in the quality of experience across undergraduate rotations and sites remains challenging. Rotations should be planned to avoid repetition or students missing out on key areas of experience
- Progress in the use of electronic learning environments such as Blackboard and Moodle has been continued, and students welcome it. Exploiting it to its full potential outside the campus environment is still challenging for some schools on some sites, as is videoconferencing and streaming of lectures and grand rounds from major to affiliated hospitals. However, IT and an effective electronic learning environment are, if anything, more important to students who are away from the campus, and facilities need to keep pace with rotations outside major hospitals and with extended clinical attachments. Council recognises that it is not feasible for facilities at smaller hospitals to match those of major urban teaching hospitals. However,

electronic methods can be used to relay teaching sessions to smaller hospitals and community sites, and resources should be available for this

- The teaching environment must incorporate high standards in hygiene and infection control; there is no excuse for any shortfall in basic skills like hand-washing techniques or for unvaccinated students potentially transmitting vaccine-preventable diseases to patients or clients that they interact with.

7.4 Opportunities outside the teaching hospitals

There is increasing use of rotations in affiliated hospitals, that is, smaller hospitals which have not traditionally taken many students, and which are often outside the major cities. Necessity – in the form of increased student numbers and demand for clinical placements – has been one driver of this; but the experience students gain in affiliated hospitals can be very rewarding, with them citing to Council the attraction of feeling part of the team in a way which may simply not be possible in a big urban teaching hospital.

There are also educational opportunities in outpatient clinics, community clinics (including psychiatric clinics), hospices, rehabilitation units, drug treatment centres, and elderly care homes, and provided that the environment is of a satisfactory standard, Council encourages the use of these facilities, which can provide a fresh perspective and environment for development.

7.5 Relations with the health service

It is important that medical schools have effective interaction with health service bodies and regular, formal meetings with relevant representatives. Schools and

the HSE should do everything that they can to establish memoranda of understanding (MOU) and preferably contracts with training sites and the trainers on those sites. Schools should establish similar MOU with any private training sites that they use.

7.6 The student voice

There are active student-affairs committees and generally a high level of student involvement in medical school activity. Feedback from students has become an accepted part of schools' review and quality assurance processes, and Council has been impressed by the greater use of tools to obtain systematic feedback from students. Feedback is now routinely obtained from students at various stages of the programme, often using standardised course questionnaires.

It is important that students are made aware that their views have in some cases resulted in changes, as this encourages their contributions. The consensus among students was that their views have been listened to and taken on board. This is commended.

Council encourages schools to obtain feedback from patients about their experience of medical students.

7.7 Support for students

Academic support, student health services, student counselling, careers advice, recreational opportunities and other supports are generally readily accessible in medical schools. Two issues are worth noting:

- Students appreciated the personal support they got from more senior students- sometimes in a

mentoring or 'buddy' system - and from interns

- Providing effective pastoral and academic support for students on placements in affiliated hospitals may be more challenging but is if anything more essential.

7.8 Teacher and trainer development

It is important that teaching and training staff be encouraged and facilitated to undertake staff development and obtain qualifications in medical education and in generic teaching and learning competencies. There are a growing number of opportunities for formal training (in areas such as principles of adult learning, educational techniques, curriculum design, assessment, clinical supervision, educational research and programme evaluation) at Certificate, Diploma and Masters level. Council encourages these initiatives. The foundation and activity of the Irish Network of Medical Educators has also been a very positive development.

7.9 Resourcing of / incentives for clinical teaching

Delivery of the medical curriculum still relies on clinicians providing 'goodwill' teaching on a voluntary and part-time basis, and many do choose to participate enthusiastically. But the Council urges:

- An increase in the number of academic clinicians with joint appointments
- Progression and promotion prospects for teachers
- That educational leadership be sufficiently resourced in terms of dedicated sessions
- That 'goodwill' teaching results in at least some reward for efforts in terms of honorary appointments, which confer rights of access to library facilities, etc. for these teaching staff.

7.10 Inter-professional teaching and learning

When students become doctors they work as members of a healthcare team. Learning about, from, and with other (non-medical) healthcare students can enrich the medical curriculum and prepare the ground for future practice. 'Practical inter-professionalism' in the clinical training environment can be particularly rewarding for all the students concerned.

The Council does not underestimate the logistical challenges (including dovetailing of curricula content, scheduling and timetabling, and assessment) involved in expanding inter-professional teaching and learning opportunities. However, the accreditation process found a consensus among the students that they would welcome more opportunities to interact and collaborate with nurses and other healthcare professionals. The Council commends this as good practice.

7.11 Quality assurance

Medical schools must be dynamic institutions, initiating procedures for regular review and updating of curricula. There are generally effective quality assurance and enhancement structures in place in medical schools.

7.12 Libraries

There are still some examples of shortfalls in this area, with unsatisfactory facilities for private study (e.g reading rooms that are too small, and/or noisy, not enough computer terminals, inadequate access to printers). Hospital library opening hours can be unsuitable for students spending time on the wards, and innovative ways should be sought to increase access. WiFi access in study areas for students is essential. There have

been some notable improvements made in a number of hospital libraries but more is needed. The number of print journals taken has declined, as online journals have become the norm, and Council accepts this provided that there is appropriate online access for students.

7.13 Preparation for internship

The importance of transition has already been mentioned; a key part of this for final-year students is their preparation for internship, and some examples of good practice, including sub-internships and completion modules, have been introduced over recent years. Students' interaction with Council makes it clear that they are keen to feel as equipped as possible with basic clinical skills as they enter internship, the second part of basic medical training.

INTERN EDUCATION AND TRAINING

“In the hospital, you are working and you are trying to catch the learning train.”

Intern quoted in Peter Cantillon and Maeve MacDermott
“Interns in General Practice: An Evaluation of a Training
Innovation” December 2005

8. OVERVIEW

8.1 Context / background pre-2008

Intern training is a crucial formative stage in the development of doctors. It is a highly supervised period of education and training which many doctors will complete immediately following the award of their medical school degree, which is their primary medical qualification. Intern training is completed at a range of clinical sites, primarily hospital sites, under the supervision of intern tutors who in many cases will have a close working relationship with the medical schools where the interns completed their medical degrees. Interns are registered doctors and contribute towards the provision of clinical care and service at training sites, although there is a strong emphasis on supporting the development of interns' competencies through a mix of practical instruction and formal and informal teaching sessions.

Interns develop a broad set of competencies during training through completion of a number of training rotations in pre-determined specialties. In Ireland, interns have been required to complete a minimum period of training of 12 months and have generally had equal exposure to surgical and medical specialties. This broad experience has allowed doctors at the outset of their medical careers to consider which area of practice they wish to specialise in and in which to continue their medical training. Since the introduction of the MPA 2007, the Medical Council has brought greater definition to the

content of intern training, and the context within which it is delivered. These developments will be explored in further detail later in this report.

8.2 Summary of legislation

The introduction of the MPA 2007 greatly expanded the Medical Council's role to quality assure intern training in Ireland through the definition of an enhanced range of responsibilities, relationships and obligations.

Under Section 88 of the MPA 2007, the main functions of the Medical Council in this area are to:

- Specify the number of intern posts approved for the purposes of intern training
- Prepare and publish [guidelines \('the Guidelines'\) on medical education and training for interns](#)
- Specify and publish [Standards \('the Standards'\) for training and experience required for the granting of a certificate of experience](#) (CoE)
- Inspect the clinical sites supporting the delivery of intern training against the Standards and Guidelines.
- Issue feedback to management of those sites to address any required improvements or to address any other issues.

9. STANDARDS AND GUIDELINES

The Intern Standards and Guidelines, although separately required through the legislation, are very similar in theme and content, and bring greater definition to the requirements for the subject matter and delivery of intern training. The Standards and Guidelines each define requirements under the following headings:

a. Rotations

During their internship, which normally lasts 12 months, interns must spend a minimum period of three months training in general medicine and a minimum period of three months training in general surgery. This enables interns to develop a broad understanding and skill-set within core areas of medical practice. Interns can spend all of their internship in medicine and surgery. But as part of their internship they may complete rotations within a number of other defined specialties. Such rotations must be between two and four months in duration, and may be completed within one or more of the following disciplines:

- Emergency Medicine
- General Practice
- Obstetrics and Gynaecology
- Paediatrics
- Psychiatry
- Anaesthesia (including peri-operative medicine)
- Radiology

The introduction of greater variety in rotations, and the associated opportunities for interns to complete training and gain insight within a wider context of diverse hospital and primary care settings, has been a major development within the intern year. It has been very well received

by interns themselves. Council supports interns having access to internships in a wide range of clinical specialties.

b. Accreditation

Training sites must be formally affiliated with a training institution which itself has been formally recognised and accredited. In Ireland, the principle contributors to the content and delivery of intern training are medical schools and postgraduate training bodies.

c. Content of training

Intern training must be provided through an appropriate balance of formal and informal learning, which includes theoretical and practical training during service delivery. Interns must be supported to accept increasing levels of responsibility throughout training, at a pace which is appropriate to internship and to the competence of the individual intern. Interns will participate in on-call duties in hospital settings, and the extent to which they participate in these duties will be determined by the nature of their rotations, and by the service demands of individual training sites. Intern training must involve regular opportunities for interns to work in integrated and multi-disciplinary team settings, which will help to broaden their understanding of the roles of more senior medical colleagues, the roles of other healthcare professionals, and the necessity for collaboration.

d. Supervision

Interns must be fully supervised at all times, through the overarching supervision of senior medical practitioners, typically consultants, and through the direct supervision of medical practitioners of at least senior house officer level.

e. Assessment

Interns must be regularly assessed by those involved in the delivery of their training, and assessments must be accompanied by regular and constructive feedback.

f. Professionalism

Training sites must actively promote and emphasise professionalism and the ongoing development of the skills and competencies necessary for safe and appropriate practice.

g. Resources

Training sites must be properly resourced to provide all necessary educational, practical and pastoral supports that interns may need to avail of throughout training. In each rotation, interns must have access to an appropriate number and case mix of patients. In addition, interns must have access to private study areas and training literature. In the case of rotations that will require interns to participate in on-call duties, interns must have access to clean, private and secure accommodation and rest areas.

10. QUALITY ASSURANCE

10.1 Certificates of Experience

A significant development within the intern year and within intern training since the introduction of the MPA 2007 is the process by which certificates of experience are issued. Doctors in Ireland are required to have completed a period of internship in order to continue structured medical education and training. The CoE confirms that they have completed their internship to the standards specified by the Medical Council.

Under the previous legislation and up until May 2011, it was the responsibility of medical schools in Ireland to issue CoE upon satisfactory completion of intern training. Under the MPA 2007, from 1st June 2011 the responsibility for issuing CoE transferred to the Medical Council. However, in order for this transfer to take place, the Medical Council was obliged to inspect and approve if appropriate each clinical site involved in the delivery of intern training.

The inspection requirement was a significant undertaking, but was also a welcome opportunity for Council to engage with those involved in the delivery of intern training. Crucially, it enabled Council to meet a large number of interns to seek their views on their training experiences. More details are provided below.

10.2 Inspection of intern training sites

The first schedule of inspections of intern training sites in fulfilment of the aforementioned requirement took place between November 2010 and April 2011. During this time, Council assessment teams inspected 38 intern training sites in Ireland, the total number of such training sites involved in the delivery of intern training at the time of inspection. The standards that formed the basis of each

inspection were Council's Standards of Training and Experience required for the Granting of a Certificate of Experience to an Intern, cited previously.

In advance of each inspection, clinical sites were requested to complete a questionnaire to detail the specifics of the training being provided at each site and to clarify the medical and other personnel involved in training. The assessment teams were primarily constituted of external assessors who had been formally approved by Council on the basis of their experience and suitability to undertake such inspections. The involvement of appropriate external expertise is a cornerstone of Council's accreditation processes, and the input of the external assessors was, and continues to be, greatly appreciated by Council.

The format of each inspection was to meet with the interns who were on site at the time of inspection, to view the relevant clinical and academic site facilities, and to engage with staff involved in delivery of training. The interaction with interns and their feedback on each training site and the quality of their training were key determinants in the approval of each site and in the subsequent engagement with the management of each site. Following each inspection, a report was prepared by the assessment teams and a recommendation made to Council in respect of approval.

Following the inspections, each training site was subsequently approved by Council. Many sites were issued with strong recommendations in areas which in Council's view may help to ensure or enhance the quality of training. Each intern training site is obliged to engage with an annual return process with Council to ensure that standards are being maintained and to ensure

that Council is advised of significant changes that may impact upon the quality of training at sites. This annual return process has been a valuable way of tracking sites' responses to the recommendations and expectations of Council.

Following the initial inspection of training sites in 2010/11, a number of new training sites were proposed by the HSE to Council, which is the process that triggers inspection. Those sites were subsequently inspected and approved. As of 31st May 2013, [47 clinical sites](#) in the State have been approved by Council for the purposes of intern training.

Council greatly appreciates the input of interns into the inspection process in the period 2008-13 and the assistance of the staff on the sites.

10.3 Themes arising during the intern site inspections

Some of the issues that emerged through the inspection of intern training sites were:

- Interns not always receiving thorough site inductions
- Interns receiving varying degrees of supervision throughout training
- Training sites placing varying degrees of focus on formal teaching opportunities
- Training site having varying expectations of interns in terms of clinical participation.

Council has made it clear to sites that when there are deficits, Council expects them to be tackled. There is ongoing monitoring of sites *via* their annual returns, and Council may re-inspect at any time if it believes that it is necessary to do so. Council can, if it deems a site's deficiencies to be serious enough, remove approval from that site; but Council has not had to take that action. The issues identified above were not so serious as to warrant Council withholding or withdrawing approval from any site, and they occur in the context of an overall picture that includes many good sites providing excellent training.

11. STAKEHOLDERS

There are a number of stakeholders other than the Medical Council involved in the delivery of intern training in Ireland. This reflects the high degree of scrutiny that is placed on this important period of training and the statutory responsibilities given to various agencies in the MPA 2007. This section focuses on the body that employs the majority of interns and the new structure that coordinates training and support.

11.1 The Health Service Executive

As the principal employer of health professionals in Ireland, the HSE has a pivotal role to play in the delivery of intern training. Under the MPA 2007, it is the responsibility of the HSE to propose intern training posts to the Medical Council on an annual basis for approval. These posts are proposed to Council with direct reference to Council's intern rules, standards and guidelines.

National Intern Matching Scheme

The HSE has established a National Intern Matching Scheme, which is the culmination of a significant collaboration between the HSE, Irish medical schools, the Medical Council and postgraduate medical training bodies. Before the introduction of this system, intern posts were devised and allocated on a regional basis, aligned to each medical school. It was agreed that a national arrangement would drive consistency and transparency in this area, and accordingly the national matching system was established.

The matching process takes account of several factors in its allocation of training posts, including an applicant's academic performance. The process also takes account of an applicant's post preferences. The success of the

matching system reflects the significant resources which the HSE have allocated in this area, and the high value that is placed on supporting medical graduates to continue their training.

Intern Employment Eligibility Test

To ensure that applicants for intern training posts have sufficient understanding of the structure and cultural framework within which clinical care is delivered in Ireland, the HSE introduced the Intern Employment Eligibility Test (IEET) in 2013. The IEET is intended to maintain patient safety by confirming prospective interns' knowledge of the Irish healthcare system in which they wish to practise. All graduates of medical schools which are located outside of the Ireland, and who are eligible to apply for intern posts in Ireland, must pass this pre-employment test in order to demonstrate that they can safely practise medicine in Ireland. The standard and content of the test has been benchmarked against the standards and content of the final year of medical degrees delivered in Ireland. The Medical Council acknowledges the diligence and professionalism with which the IEET has been introduced, and fully supports the test's focus on patient safety.

11.2 Intern Training Networks and Network Coordinators

Intern Training Networks have been established. Each is aligned to a medical school and to the intern training sites associated with that school. Each Network has a nominated Network Co-ordinator, who is a medical specialist, and a formal support structure.

In support of the establishment of these Networks and to foster consistency in this area, the Medical Council defined a set of [criteria](#) for Intern Networks and formally

evaluated each Network against the criteria. Following this assessment, the Intern Networks were formally approved by the Medical Council.

The Intern Training Networks that have been established are as follows:

Network	Aligned with
1. Dublin/Southeast	University of Dublin, Trinity College
2. HSE South	University College Cork
3. HSE Dublin/Mid-Leinster	University College Dublin
4. Mid-West	University of Limerick
5. West/Northwest	National University of Ireland, Galway
6. Dublin/Northeast	Royal College of Surgeons in Ireland

The establishment of the Intern Networks has introduced a more structured and uniform approach within intern training, which enhances the previous individual contributions of those involved in its delivery. The Network structure fosters good communication and information exchange among Networks and the introduction of shared best practice. It provides a focal point for engagement between the Co-ordinators, who are linked to medical schools and other stakeholders, including the Medical Council, the HSE and the postgraduate training bodies responsible for the specialty-specific aspects of intern training. The establishment and activity of the Network and its Co-ordinators marks a major positive step in intern training in Ireland, and Council appreciates their significant contribution to the enhancement of internship in Ireland.

12. TRAINING PROGRAMME AND REMEDIATION

12.1 National Intern Training Programme (NITP)

Following reform of the intern year and the establishment of Intern Training Networks, it was agreed that the Intern Training Networks would work together to provide a nationally agreed intern educational programme. The resulting curriculum is the result of collaboration between the Intern Coordinators from each Network in conjunction with those involved in intern training within their network, the postgraduate training bodies and the other stakeholders represented on the Medical Council's Intern Training Sub-Committee (ITSC). The [NITP](#) was developed with explicit reference to the Medical Council's Eight Domains of Good Professional Practice and the Guide to Professional Conduct and Ethics for Registered Medical Practitioners. The curriculum includes a clinical judgement module, incorporating components relating to clinical history and examination, clinical skills and prescribing. The NITP is helping to ensure that all interns are receiving a broadly similar training experience, underpinned by a common curriculum, knowledge of relevant national legislation and guidance, and standard assessment. It is another major positive advance in intern training in Ireland.

12.2 Remediation of interns

The intern year is an important transition and formative year, which can present some unique challenges to newly-qualified graduates as they become junior doctors. These challenges may include having to adapt rapidly to a very busy working environment in a relatively short period of time, working as part of a multi-disciplinary clinical team, often under pressure, and dealing in a professional and empathetic way with patients who may have complex clinical and personal issues. Some of these challenges can be addressed through a comprehensive induction programme at the start of rotations and at

each new training site. Close supervisory arrangements and encouragement to raise concerns with their trainers at the earliest opportunity will also play a key role in ensuring a smooth transition throughout intern training.

In general, most interns cope well with these challenges and exit the intern year well prepared for the next stage in their training and practice. However, each year a small number of interns may experience behavioural, performance or educational difficulties; remediation is the process of addressing such difficulties after the difficulties have been assessed. To date, it has been custom and practice to address remediation locally using various tools and this has, in many instances, been effective. The establishment of the Intern Training Networks provided an opportunity to harmonise and promote greater effectiveness of activities in this area.

In order to standardise the approach to those interns who may require remedial supports, the Medical Council developed [Guidelines on Remediation of Doctors in the Intern Year](#). These guidelines were developed under the auspices of Council's ITSC with input from the Intern Training Networks, postgraduate training bodies, the HSE, doctors' representative groups and patient groups. It provides a good platform for maintaining professionalism among interns.

13. SUMMARY

The period 2008-13 saw something of a transformation in the structures, organisation and content of the intern year. The mode for entry to the year became more structured and transparent; the Network structure provided a robust framework; there are clear Council standards and guidelines; all training sites were inspected by Council to Council standards; there is ongoing monitoring of sites by Council; there is a programme; and there is a remediation policy and process. These are all major achievements. The reform that took place demonstrated the value of inter-agency working and a collaborative approach among the various bodies and individuals involved in the development, delivery and regulation of intern training.

Council has committed to surveying all interns in the country in 2013/2014, with the purpose of informing Council thinking, standards and guidelines. Interns will be asked to provide feedback on their internships to date, and to assess the extent to which their undergraduate education prepared them for internship. The findings will in turn inform the ongoing review of undergraduate standards and accreditation. Change and improvement have been features of intern training 2008-2013, and it is intended to consolidate and maintain momentum for further improvement. High-quality internship provides a springboard for the next stage of the continuum, postgraduate medical education and training.

POSTGRADUATE EDUCATION AND TRAINING

“The reward for work well done is the opportunity to do more.”

Jonas Salk MD

14. OVERVIEW

14.1 Context / background pre-2008

Postgraduate specialist medical education and training in Ireland is pursued by doctors who wish to continue their medical careers in structured training, with the aim of registering in the Specialist Division of the Medical Council's Register of Medical Practitioners. Specialist medical training is provided by postgraduate medical training bodies that have been recognised by the Medical Council for that purpose.

In Ireland, there are [13 postgraduate training bodies](#), with combined responsibility for the delivery of programmes of specialist training in [52 recognised medical specialties](#). Some institutions involved in the delivery of specialist training are long-established, with a rich history of contribution to the practice of medicine and to the health system. Other institutions, by comparison, have been established quite recently.

Specialist training is typically delivered in two stages. The initial stage - basic specialist training (BST) - provides a foundation training in those competencies best suited to prepare doctors for the second stage of training - higher specialist training (HST). Entry at each stage is competitive and is subject to the entry criteria defined by the relevant training body for each training programme. There are generally fewer training posts available at HST than at BST stages of training. This 'bottleneck' between different stages of training is more pronounced in certain specialties than in others and is a product of many factors, including national demand for consultants within particular specialties.

Specialist training is delivered at clinical sites that meet defined criteria for the delivery of specialist training, with specialty-specific criteria defined and monitored by each training body. Trainees will typically rotate through different clinical locations, with rotations lasting six or 12 months.

It should be noted that some programmes of specialist training are delivered by training bodies at HST stage only. In these instances, training bodies will determine which BST courses meet entry criteria for the HST stage of training. In the case of specialist training in general practice, there is currently a single programme of training of four years' duration, with no separate BST or HST stages.

Completion of specialist training leads to the award of a Certificate of Satisfactory Completion of Specialist Training (CSCST), and doctors who have been awarded a CSCST are entitled to register and practise as medical specialists.

14.2 Summary of legislation

The introduction of the Medical Practitioners Act 2007 greatly expanded the Medical Council's role to assure the quality of postgraduate medical education and training in Ireland through the definition of an enhanced range of responsibilities, relationships and obligations.

Under Section 89 of the MPA 2007, the main functions of the Medical Council in this area are to:

- Define standards for specialist medical education and training
- Define guidelines for specialist medical education and training
- Inspect places with posts attached
- Approve programmes of specialist training
- Approve bodies delivering the above programmes.

These responsibilities are discussed in sections 15 and 16.

15. STANDARDS AND GUIDELINES

15.1 Accreditation standards and guidelines

The requirement for Council to produce standards and guidelines in the area of postgraduate medical education and training resulted in its '[Accreditation Standards for Postgraduate Medical Education and Training](#)'. These Standards were approved by Council in June 2010 and revised in October 2011. In defining the Standards, Council considered and was influenced by a number of international postgraduate medical accreditation benchmarks. The Standards, which are applied to programmes of specialist training and to the bodies which deliver those programmes, define Council's requirements, as detailed below.

15.2 Context of education and training

This aspect of Council's standards ensures that accredited bodies governance arrangements and committee structures bring the appropriate degree of focus to different aspects of the training programme, including curriculum development, continuous assessment, education and training etc. Training bodies are also required to collaborate with relevant institutions both domestic and international in order to ensure that its training benchmarks are appropriate, and to benefit from international best practice.

15.3 The outcomes of the training programme

Training bodies must actively demonstrate their explicit commitment to improving standards of medical practice, training, research and social responsibility. Training programmes must be devised and delivered with a view to doctors achieving specific competencies. These competencies must be well-matched to service-user and workforce requirements.

15.4 Curriculum content

Training programmes must have defined objectives for each stage of training, must promote opportunities for flexible training (including less-than-full-time training) and must support trainees to pursue research opportunities.

15.5 Teaching and learning

Training must be practice-based, with trainees supported to accept increasing degrees of independence and responsibility as they progress through training.

15.6 Assessment of learning

Training bodies are obliged to assess trainees on an ongoing basis to ensure that competencies are being developed, to ensure that trainees' needs are being met and to engage in a robust process of soliciting and issuing constructive feedback. Assessment methods used must be appropriate to competencies being assessed and to the programme curriculum in order to identify knowledge gaps and to maintain best international practice in this area.

15.7 Monitoring and evaluation

Training programmes must be kept under review to confirm the ongoing appropriateness of curriculum content and assessment methods and to ensure that the quality of teaching and supervision is maintained. Each training body is also required to maintain records of the career progression of its trainees.

15.8 Implementing the curriculum - trainees

Training bodies must have clear admission and selection policies and must provide formal opportunities for trainees to become involved in the governance of training. Communications with trainees must be regular and informative. There must also be appropriate processes in place to address training problems and disputes.

15.9 Delivery of educational resources

Training bodies must have sufficient resources in place to deliver high-quality training and to ensure that trainees at different training sites are having a broadly similar training experience. Supervisors must be selected and assessed against set criteria, in order to maintain consistency of trainer inputs. Training sites must meet defined criteria and be regularly assessed for ongoing suitability.

15.10 Continuing professional development

Training bodies are obliged to support affiliated doctors to continue their professional development and to meet statutory obligations in the area of maintenance of professional competence (discussed further in sections 19-21 of this report).

16. QUALITY ASSURANCE

16.1 Postgraduate accreditation schedule 2011-2013

The MPA 2007 requires the Medical Council to approve or otherwise programmes of specialist training. Council is also required to approve, or otherwise, the bodies responsible for the delivery of those programmes. Each of the thirteen training bodies and their respective training programmes were recognised under previous legislation but had never been formally approved upon completion of an accreditation process. Each training body continues to be recognised until such time as a formal accreditation has been completed.

Council developed its postgraduate accreditation process and engaged with each training body in order to develop an accreditation schedule. Between 2011 and 2013, twelve of the thirteen training bodies completed the accreditation process, with the accreditation of the final training body deferred until 2014. Council valued the constructive and cooperative approach of the staff of the participating postgraduate training bodies.

The accreditation process for a body being accredited can be summarised as follows:

- The body is asked to complete a self-evaluation based upon the standards, and present this in documentary form to Council
- The body is asked to nominate a single, indicative training programme which will be accredited in tandem with the body
- The Medical Council assembles an accreditation team, led by a Council member and comprising external expertise from within and outside the State. Council appreciated the additional expertise and national and international perspective provided by externs
- The body is invited to an **accreditation meeting** with the accreditation Team to discuss the body's submission, so that the Team can explore issues and concerns and seek any necessary clarifications from the body.

An important step in the process is a private meeting between Council's accreditation Team and trainees at different stages of the training programme. Council greatly appreciates the contribution of trainees to the accreditation process in the period 2008-13.

After the accreditation meeting, a recommendation is formulated by the accreditation Team and a report is prepared for Council. In parallel with undergraduate education and training, Council has a suite of options open to it under the MPA 2007:

- a. **Approval**
- b. **Approval with one or more conditions attached**
- c. **Amendment or removal of conditions previously attached**
- d. **Withdrawal of approval**
- e. **Refusal of approval (this option applies only to the body and not to the programme).**

Council will make a decision to approve, or otherwise, the programme of specialist training and the training body. Council's decision is then submitted to the Minister of Health for their consent.

Council's final report is then shared with the training body, and this commences an ongoing quality assurance engagement between Council and training bodies. Council will engage with each training body to monitor progress made against the recommendations that typically form the basis of accreditation reports.

Full details of the [postgraduate accreditation process](#) are available on the Medical Council website.

2011-2013 Postgraduate accreditation schedule:

NAME OF BODY	PROGRAMME	ACCREDITATION MEETING
The College of Anaesthetists of Ireland	Specialist Training in Anaesthesia	Jul-11
The College of Psychiatry of Ireland	Specialist Training in General Psychiatry	Jul-11
Royal College of Surgeons in Ireland	Specialist Training in General Surgery	Oct-11
The Faculty of Radiologists	Specialist Training in Diagnostic Radiology	Nov-11
Irish Committee on Higher Medical Training	Specialist Training in Endocrinology and Diabetes Mellitus	Mar-12
The Faculty of Public Health Medicine	Specialist Training in Public Health Medicine	Apr-12
The Institute of Obstetricians and Gynaecologists	Specialist Training in Obstetrics and Gynaecology	Jun-12
The Faculty of Occupational Medicine	Specialist Training in Occupational Medicine	Sep-12
The Faculty of Paediatrics	Specialist Training in General Paediatrics	Oct-12
The Irish College of General Practitioners	Specialist Training in General Practice	Feb-13
The Irish College of Ophthalmologists	Specialist Training in Ophthalmology	Feb-13
The Faculty of Pathology	Specialist Training in Histopathology	Mar-13
Faculty of Sports and Exercise Medicine	Sports and Exercise Medicine	Early 2014

An executive summary of the outcomes of each of these accreditation outcomes will be available on the Medical Council's website in due course.

16.2 Themes arising from the accreditation schedule

Council's accreditation of postgraduate medical education and training is at a different stage of maturity to the undergraduate accreditation cycle. As a result of the accreditation activity that has now taken place, there will be a significant opportunity to assess the common features of postgraduate training bodies, including shared themes and challenges. These features may be addressed through direct engagement with training bodies, through the provision of supplemental thematic guidance or through the revision of rules, guidance and standards.

Some of the features that emerged through the postgraduate accreditation cycle include the need for all training bodies to:

- Ensure that their governance arrangements include appropriate trainee, public and lay involvement
- Continue to actively seek feedback from trainees throughout the training programme and to demonstrate that feedback has been acted upon
- Use assessment methods appropriate for the skills and competencies being assessed
- Ensure robust governance arrangements with any 'parent' or 'umbrella' body
- Ensure trainers' inputs are standardised and assessed by training bodies
- Encourage trainees to raise concerns at the earliest opportunity and support trainees through the resolution of any training disputes.

17. RECOGNITION OF MEDICAL SPECIALTIES

17.1 Context and background

Under the MPA 2007, the responsibility for recognising medical specialties rests with the Medical Council. All specialties that were recognised before the introduction of the MPA 2007 have continued to be recognised, and there are 52 such specialties. The recognition of specialties is closely linked to the approval of programmes of specialist training, and the approval of the bodies that may deliver those programmes, as described earlier in this report. The programmes of specialist training for which Council is obliged to complete a formal accreditation process are programmes leading the award of a Certificate of Satisfactory Completion of Specialist Training (CSCST) in a recognised specialty.

During the 2008-13 term of Council, expressions of interest were received from individuals and organisations seeking Council's recognition of a number of medical disciplines as medical specialties. Council formalised its policy in this area by establishing a [policy and process](#) which would assess the strength of each application against a series of criteria.

17.2 Recognition process

The two-stage process by which the Medical Council evaluates applications from aspirant specialties can be summarised as follows:

- a. At stage one, applicants are required to provide documentary evidence to Council that the proposed specialty meets specified minimum criteria, or indicators as they are referred to in the documentation. These indicators are grouped under four broad themes, and require each application to establish the following -
 - I. That the proposed specialty is a well-defined, distinct and legitimate area of medical practice with a sustainable base in the medical profession
 - II. That specialisation in this area of medicine is demonstrably contributing to substantial improvements in the quality and safety of healthcare
 - III. That specialisation in this area of medicine is demonstrably contributing to substantial improvements in the standards of medical practice
 - IV. That recognition of the specialty would be a wise use of resources
- b. If an application is considered to have met these criteria, the application will proceed to stage two. Stage two involves a more detailed analysis of the application and involves a period of public consultation during which all interested parties may view the application documentation and provide feedback. In addition, Stage two includes the use of external assessors from outside the State. All feedback received will be considered by Council in reaching its final decision to approve, or otherwise, the application.
- c. Before reaching its final decision, Council will seek to determine the support that currently exists, or that will exist, for the development of a programme of specialist training in the proposed specialty. Therefore, as part of the evaluation process, Council will seek evidence that recognition of the discipline as a specialty has the formal support of a recognised postgraduate training body. In addition, Council will engage with the Health Service Executive to establish the health service need for proposed specialties, the funding which may be available to support training programmes and training posts, and the sustainability of training.

- d. Having made a final decision to recognise, or otherwise, a proposed specialty, Council is required to seek the consent of the Minister of Health.

17.3 Recent developments

Since 2011, there have been significant developments in relation to Council's assessment of applications from aspirant specialties. A number of aspirant specialties completed the first stage of the two-stage recognition process, which means that those specialties have established an initial case for recognition. They will undergo a second-stage assessment in 2013. Two specialties successfully completed the second stage of the recognition process in 2012; Council will now engage with a number of stakeholders to clarify the proposed delivery of postgraduate training in these two specialties before making its final decision to approve, or otherwise.

18. THE NEXT PHASE

18.1 Continuing postgraduate accreditation

Completion of the postgraduate programmes and bodies accreditation schedule described earlier has enabled the Medical Council to assess the strengths of individual training bodies, and the challenges which they face. The knowledge gained will now support the development of a Council accreditation schedule to approve or otherwise, the remaining programmes of specialist training being delivered in Ireland. This latter schedule will focus primarily on the assessment of the specialty-specific aspects of the training programmes and will build on the momentum of the earlier accreditation schedule, which has allowed Council to form a view on the general abilities of training bodies to deliver specialist training.

Council will also monitor training bodies by using an annual return process that will parallel that used for medical schools. Postgraduate training bodies will provide Council with an update on recommendations

made in Council's accreditation reports and will advise Council of any relevant forthcoming significant changes. Monitoring meetings with a postgraduate training body will be arranged if the annual return process indicates that this is required.

The programme of work evaluating and adjudicating on the recognition of specialties will continue.

18.2 Inspection of training sites

The MPA 2007 obliges Council to inspect clinical training sites that are involved in the delivery of specialist training. Council will continue to develop its inspection criteria in this area and will engage thoroughly with the HSE and postgraduate training bodies in the development of any inspection schedule.

PROFESSIONAL COMPETENCE

“...mastering the reality of today does not prepare students for the challenges of tomorrow.”

Gro Harlem Brundtland, former Director-General, World Health Organisation, Opening Address, WFME, Copenhagen 2003

19. OVERVIEW

19.1 Context / background pre-2008

The relationship between the public and doctors is underpinned by trust. [Research](#) conducted by the Medical Council highlighted that doctors are the most trusted professional grouping in Ireland. The public's trust assumes that doctors have the necessary knowledge and skills coupled with the appropriate conduct and behaviour to provide care that is safe and clinically sound.

The establishment and maintenance of a register of doctors is the cornerstone of the role of the Medical Council. Entry to that register provides the public with confidence that a doctor is appropriately qualified and in good standing. But doctors have not traditionally had an ongoing professional relationship with the Medical Council regarding their continuing professional development (CPD) and maintenance of their competence. This has changed during the lifetime of this Council.

The impetus for change was the enhancement of patient safety. In recent decades, the quantity and quality of medical knowledge has increased dramatically: it is no longer feasible for knowledge gained through undergraduate, intern and postgraduate education and training to sustain a medical practitioner through his or her professional life.

Research supports the extent of this new challenge. While practice may make perfect, there is evidence to show that knowledge, skills and quality of care may deteriorate over time. Encouragingly, though, evidence also shows that interventions like CPD and clinical audit can be effective in maintaining knowledge and skills and improving the quality of patient care.

Many countries have established systems for regulating the maintenance of professional competence. For example, in North America, recertification of specialist status through re-examination by specialty boards is now mandatory; participation in professional competence programmes is a requirement for all registered medical practitioners in Australia and New Zealand; and the UK has introduced an ambitious system of licensing and revalidation based on periodic assessment.

Since the late 1990s, the Medical Council has been leading debate on the establishment of systems for maintaining professional competence in Ireland. This culminated in the 2006 position statement [Performance in Practice: Maintenance of Professional Standards](#), based on consensus built by the Council with the public, medical practitioners, postgraduate training bodies, employers and a range of other interested parties. Following almost a decade of consultation, research and piloting of methods, 2010 saw a step-change in the Medical Council's role in education, training and CPD when the Minister for Health and Children [signed an order](#) bringing Part 11 of the Medical Practitioners Act 2007 - Maintenance of Professional Competence - into effect from 1st May 2010. Commencement of that legislation placed new duties on registered doctors and the Council regarding maintenance of professional competence. It will impact on medical professionalism for years to come.

19.2 Summary of legislation

The part of the Act relating to maintenance of professional competence is founded on three complementary duties:

- First and foremost, it places a duty on registered medical practitioners to maintain professional

competence; the practitioners must pursue a professional competence scheme which is applicable to them and must cooperate with rules set by Council. The Act provides for the Council to invoke complaint and fitness to practise procedures if a registered medical practitioner is found to fail in this duty

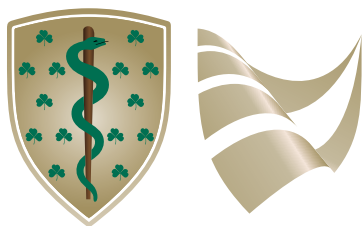
- Secondly, it places a duty on the Medical Council to satisfy itself as to the ongoing maintenance of the professional competence of registered medical practitioners. To achieve this, the Act provides for the Council to establish professional competence schemes. The Council may recognise education and training bodies for the purpose of provision of schemes. Importantly, the Act also requires these schemes to be reviewed, with recommendations on any steps required for their improvement to be made to the Minister
- Thirdly, it places a duty on the Health Service Executive and other employers to facilitate the registered medical practitioner's maintenance of professional competence.

Part 11 of the Act also makes specific provisions to safeguard the confidentiality of information collected in the operation of professional competence schemes.

20. COUNCIL'S STRUCTURES AND PROCESSES

In order to give effect to these new legal requirements, the Medical Council published Rules for the Maintenance of Professional Competence ([S.I. No. 171 of 2011](#)). This was preceded by communication, engagement and consultation with the public, the profession and other stakeholders, so that they had an opportunity to contribute to the formation of the Rules.

With these Rules in place, Council invited applications from bodies approved under Part 10 of the Medical Practitioners Act 2007 for the purposes of education and training to be recognised for the purposes of assisting the Medical Council in its new duties through the operation of a professional competence scheme. Following review of these applications against standards specified in Rules, the Medical Council [formally recognised 13 postgraduate training](#) bodies to operate a [professional competence scheme](#), and [arrangements](#) were established for this purpose.



Comhairle na nDochtúirí Leighis
Medical Council

Professional Competence
Reaching for Improvement

The Medical Council also published [Guidelines for Doctors](#) explaining how new professional competence arrangements would operate. In brief, the requirements for doctors were to:

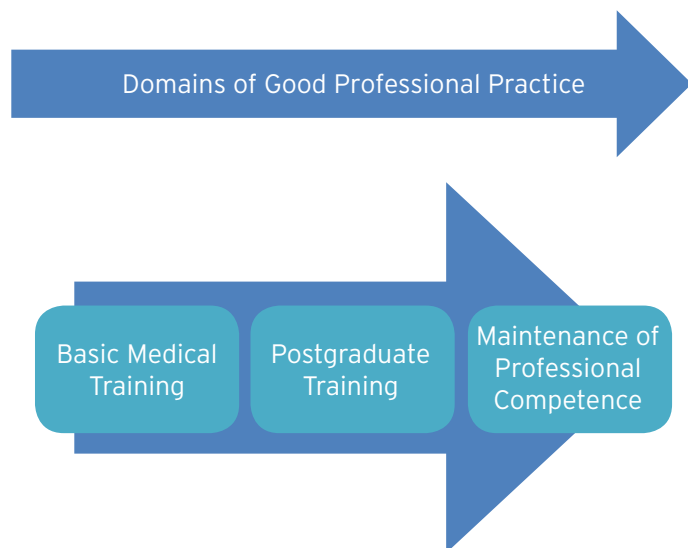
- Contact the postgraduate training body most relevant to their day-to-day practice and enrol in a professional competence scheme
- Engage in 50 hours of CPD and one clinical audit per year
- Retain documentation relating to their maintenance of professional competence activities.



From 2012, doctors enrolled in professional competence schemes began to receive a statement of participation from that scheme, setting out the amount and types of activity the doctor had undertaken in the previous year.

From 2012 doctors were also required to declare to the Medical Council that they were maintaining professional competence and some doctors were asked to participate in a [professional competence audit](#), in which they provided evidence to support their declaration.

The Medical Council's arrangements for maintenance of professional competence make it clear that doctors should focus their planning, activity and reflection on the outcomes set out in Council's Domains of Good Professional Practice. Since these Domains also define expectations regarding professional development outcomes at an undergraduate, intern and postgraduate level, the Medical Council reinforced its concept of a continuum of professional development.



21. KEY THEMES

21.1 Building on a recognised professional responsibility

The establishment of new arrangements to support doctors’ maintenance of professional competence has marked a significant development in the role of the Medical Council. Since these arrangements became operational, Council’s professional competence focus has been on ensuring that the systems in place are straightforward, relevant to a doctor’s day-to-day practice, and focussed on achieving the outcome of good professional practice.

A key success factor has been to ensure that the new arrangements have the support of doctors. This support was confirmed by [research](#) undertaken by Council which found that:

- 99% of doctors believe that lifelong learning is the professional responsibility of all medical practitioners
- 96% of doctors are confident that they will meet requirements to maintain professional competence
- The key factors which doctors believe will influence

their ability to maintain professional competence are support from employers, ability to find time to complete activities and access to professional development supports.

Since 2011, professional competence schemes have been operated across 13 recognised postgraduate training bodies, which have both directly provided and formally recognised maintenance of professional competence activities. Schemes have been available to doctors across the country.

21.2 Future developments

The new professional competence arrangements are now important elements of the structures which Council operates to maintain trust between the public and doctors. However, the current arrangements are only a starting point in the development of systems to help ensure doctors are remaining fit to practise.



In the second half of 2012, Council reviewed and reflected on the early experience with its functions in the area of maintenance of professional competence. It examined the development of professional competence arrangements which are ongoing in other jurisdictions, and engaged with key stakeholders so as to understand their views on the impact of its work in this area and opportunities for further development.

A spectrum of maintenance of professional competence systems was found to be in place for doctors in different health systems, and the arrangements which Council has in place had a lot in common with current international practice. Stakeholders felt that culture and practice regarding maintenance of professional competence was definitely changing and was becoming a more deliberate and reflective process which was challenging doctors to focus on areas of need across domains of good professional practice as much as areas of interest. The lead role which Council has played in driving this agenda was noted. Stakeholders viewed maintenance of professional competence as largely synonymous with participation in educational activities and thought that this was an evolving agenda. That view corresponded with Council's overview of international practice which found that systems in different countries were changing and that there was a need for careful monitoring so that Council could continue to develop its arrangements.

The review found that:

- The current arrangements in place for professional competence are generally fit for purpose given the relatively recent commencement of Part 11 of the MPA 2007, and provide a basis for further development.
- In further development, there will be a need to reflect on whether or not the current approach, which is based on trying to raise standards of practice for all doctors, should develop to one which is more focussed on identifying and ensuring early management of doctors whose performance may be a cause for concern. A way to support this development could be to focus more on assessment activities in professional competence schemes. These activities could include Multisource Feedback (a workplace-based assessment method which collects views from medical and non-medical peers and from patients regarding a doctor's day-to-day practice); and Peer Review (a range of workplace-based assessment and quality assurance activities wherein colleagues examine aspects of a doctor's day-to-day practice so as to provide feedback).
- While Council arrangements are similar for specialists and non-specialists, there may be a need to consider approaches which are more tailored to the different needs of different doctors.

- Where possible, opportunities should be sought to target professional competence arrangements to areas of risk. In particular, opportunities should be identified to promote learning points for doctors which arise from the Medical Council's experience of managing concerns about doctors' practice through its Preliminary Proceedings and Fitness to Practice Committees. Learning in the area of professionalism is an especially important focus.

In conclusion, the professional competence activity of the Council, employers, and doctors themselves has laid the foundation for future development of professional competence and the enhancement of patient safety.

CONCLUSION

The safety of the public is at the heart of the work of the Medical Council and is the ultimate purpose of all Council activity. Developing and maintaining high standards through education, training, and professional competence plays a key role in protecting the public. This is particularly important in an environment of rapidly changing scientific knowledge, high patient expectations and increasingly sophisticated healthcare delivery systems. Patients and the public rely on education, training and professional competence to produce the high quality doctors that they need and deserve.

Council's work over the last five years as described in this report demonstrates the importance that Council attaches to education, training, and professional

competence. It is also testimony to the effort that other key stakeholders have put into the design and delivery of medical education and training and professional competence, and the positive outcomes that have been achieved as a result.

None of the organisations involved - including the Medical Council - can rest on their laurels. There are still challenges ahead. Nevertheless, naming this review a progress report is appropriate: 2008-13 has been a period that has seen evolution and advancement in education, training and professional competence, which are the foundation and the scaffolding for high-quality healthcare.

ENDNOTES

1. The length of the undergraduate section of the report in comparison with other sections reflects the fact that Council's role in formal accreditation of postgraduate programmes and bodies and of professional competence schemes commenced relatively recently.
2. PDC's current sub-committees are the Setting Standards Sub-Committee, the Monitoring Standards Sub-Committee, the Intern Training Sub-committee, and the Examinations Sub-Committee.
3. Graduate entry medical programmes are sometimes colloquially termed 'postgraduate': but in reality they are undergraduate medical programmes as entrants do not have a prior medical qualification.
4. Of the various programmes in Ireland, some are termed 'graduate entry programmes' (GEPs) and others 'graduate entry to medicine programmes' (GEMs). The difference is purely one of nomenclature, and the term GEPs is used in this review.
5. Sally C. Mahood, MD [Medical education: Beware the hidden curriculum](#) Canadian Family Physician September 2011 vol. 57 no. 9 983-985.
6. Anna Byszewski et al. [Wanted: role models - medical students' perceptions of professionalism](#) BMC Medical Education 2012;12:115.
7. Maxine A Papadakis et al. [Unprofessional Behaviour in Medical School is Associated with Subsequent Disciplinary Action](#) by a State Medical Board Acad Med. 2004; 79:244-249. Maxine A Papadakis et al. Disciplinary Action by Medical Boards and Prior Behaviour in Medical School N Engl J Med 2005; 353:2673-2682.
8. Students are not registered medical practitioners and therefore cannot be subject to the Medical Council's Fitness to Practice processes.
9. Working Group on Undergraduate Medical Education and Training 'Medical Education in Ireland; A New Direction' 2006.
10. Extract from letter from Dr. J. A. Hillery, President of the Medical Council to Professor Alan Johnson, Dean, Faculty of Medicine and Health Sciences, Royal College of Surgeons in Ireland, December 2005.

Medical Council, Kingram House, Kingram Place, Dublin 2.

T: +353 1 4983100

F: +353 1 4983102

E: info@mcirl.ie

www.medicalcouncil.ie



Comhairle na nDochtúirí Leighis
Medical Council