ROYAL COLLEGE OF SURGEONS IN IRELAND'S GRADUATE ENTRY PROGRAMME (GEP)

REPORTS OF MONITORING VISIT 16TH APRIL 2009 FOLLOW UP MEETING 28TH JULY 2009

The following Report of the Monitoring Visit on 16th April 2009 includes the RCSI responses to the Team's findings: these are highlighted throughout **thus**. The appendices and supplementary information referred to by RCSI are not included in this document but are available for reference.

This Report should be read in conjunction with the report of the Medical Council/RCSI meeting held on 28th July 2009 to discuss years 3 and 4 of the Programme. This Report is attached.

Following clarification of a number of issues at the July meeting, the Council meeting on 29th October 2009 approved the continuation of the provisional accreditation of the RCSI.

MONITORING VISIT 16TH APRIL 2009
ROYAL COLLEGE OF SURGEONS IN IRELAND'S GRADUATE ENTRY PROGRAMME

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MEDICAL COUNCIL MONITORING TEAM

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Note: Recommendations are numbered and in *bold italics*

A. PREFACE

1. Context of the visit

The Royal College of Surgeons in Ireland has established a four year graduate entry programme. It is at undergraduate (basic in WFME terminology) level with an exclusively graduate entry. The programme was initially provisionally accredited by the Medical Council following a visit in 2005 and the programme admitted its first students in September 2006. The Medical Council revisited in March 2007. Concerns raised by the Medical Council in the March 2007 visit included capacity for clinical placements, standards in some of the peripheral teaching hospitals, the academic/structural interface between the four and five year programmes and the potential for 'over-assessment'.

A Team representing the Medical Council undertook a visit on 16th April 2009. Its remit was to monitor the progress of the provisionally accredited programme and to formulate a recommendation to the Medical Council's Professional Development Committee. The visit took place at a crucial time, as the initial GEP intake of students are now in Year 3 and have therefore 'merged' with year 4 of the 5/6 year programme. The focus of the visit was therefore on clinical training, although the Team was also keen to hear the views of students on the first two years of the programme.

2. The Team

The Medical Council Team is listed on the title page of this report. Special mention must be made of external assessor Professor Hans Sjöström (Denmark), who has extensive experience of working with the World Federation of Medical Education (WFME). He brought additional expertise in quality assurance of medical education and an international perspective to the accreditation process, and the Medical Council appreciates his contribution. In addition, the Medical Council wishes to thank Dr Ailis Ni Riain (previous Medical Council member and previous Vice-President).

The Medical Council also thanks the Royal College of Surgeons in Ireland's Team, led by Professor Alan Johnson, Director of the Graduate Entry Programme, for their co-operation and hospitality. In addition, the Medical Council wishes to thank the students who met the Team on the day, whose feedback is most helpful in formulating this report.

3. Documentation

Prior to the visit, the Team reviewed the Royal College of Surgeons in Ireland's completed questionnaire 'Accreditation of Existing Medical Programmes WFME Questionnaire'.

4. Schedule

The accreditation visit began with a presentation by Dr Richard Arnett. The Medical Council Team met representatives of the University for an in-depth discussion regarding the programme. Private sessions were held with students in year one, year two and year three of the programme.

5. Appendices

The agenda for the visit is attached as **Appendix 1**. The University staff who took part in the process is listed in **Appendix 2**. The additional information sought by the Team and provided by RCSI following the visit is listed in **Appendix 3**.

6. The Report

The Medical Council's agreed policy is to use the World Federation of Medical Education's Standards to assess medical programmes. The section headings used in part C of this report are therefore those of the World Federation of Medical Education's *Global Standards for Quality improvement; Basic Medical Education (*2003*)* and the WFME's more recent *European Specifications* (2007).

The observations, comments and recommendations contained in this report are grouped under either the Basic or the Quality heading, but in some cases, the B / Q definition is set out purely for information. This report concentrates on *areas where changes have been made; areas where the Medical Council made recommendations on its previous visit; and the views of students.* It does not repeat information that can be found in previous reports.

B. SUMMARY AND GENERAL ASSESSMENT

1) Context of Recommendation

The focus of the WFME questionnaire provided by RCSI for the Medical Council concentrated on Years One and Two of the programme. On the day of the visit (and confirmed thereafter in writing) the Team therefore requested that additional specific information on Years Three and Four of the programme be provided after the visit. The RCSI were apparently under a misapprehension in this regard and did not realise the Team needed this information. The basis of this misunderstanding appeared to be the fact that the GEP stream has merged with the students on the five year 'school leaver' programme. That is, the curriculum followed by the GEP students in their *third and fourth year* is the same as that followed by students in the *fourth and fifth year* of the school leaver programme. The latter programme is accredited by the Medical Council, although it was last formally monitored in March 2007. However, the Team are required to validate the totality of the GEP programme, which is clearly identified by the RCSI as being a four year programme.

The team requested and subsequently received the additional information from the RCSI. Except where specifically stated, the report incorporates findings from this additional information.

2) Conclusion of Council Team

On the evidence of analysis of the documentation provided, the accreditation visit, and the documentation subsequently provided, the Medical Council Accreditation Team (the Team) have formed the opinion that the first two years of the RCSI Graduate Entry Programme is satisfactory. However, the fact that the team did not have the opportunity for an in-depth evaluation of the programme as a whole, results in the following recommendation.

3) The Team's recommendation to the Medical Council Professional Development Committee

In light of the above, the Visiting Team recommends that the existing provisional accreditation of RCSI's Graduate Entry Programme be continued pending further assessment of the third and fourth years of the Graduate Entry Programme. A final recommendation will then be made.

The Team ask that Professor Johnson and other relevant RCSI representative meet with Professor Bill Powderly (as Chair of the Professional Development Committee), Dr Anna Clarke (as Chair of the Visiting Team) and Dr Anne Keane, to clarify certain outstanding issues regarding Years Three and Four of the programme. These issues should include:-

- Overall structure of years 3 and 4
- Content of modules and their objectives / specified learning outcomes

- Clinical skills teaching and learning, including clinical placements
- Distribution / numbers of students on the various clinical sites
- Facilities for students on clinical sites
- Support - academic and pastoral - for students on clinical sites
- Staff resources for years 3 and 4, including recruitment of any new staff or dedication of existing staff specifically to years 3 and 4 of the GEP
- Assessment

4) Main findings of Council Team

The Team make 21 *main* recommendations and the priorities for RCSI identified by the Team are:

- Ensuring that any extra students can be accommodated within current clinical facilities and resources, or by ensuring additional resources

- Addressing the issue of consistency of experience in clinical attachments

- Ensuring that students have the opportunity to be exposed to a variety of experience, including an appropriate case mix

- Addressing the issue of consistency of experience and monitoring of clinical attachments

- Monitoring the management of contact hours on clinical sites to ensure that students are not under-occupied

- Reviewing the use of student logbooks, formalised through a clinical tutor system

- Addressing the issue of the standard of pharmacology teaching, which was identified by the majority of all three cohorts of students as being poor

- Ensuring that within the Theme Personal and Professional Development, the Health Behaviour and Society (HBS) and Health Disease and Society (HDS) components are appropriate

5) Recommendations *additional to the major recommendations* above:

The RCSI should also:

- Review the apparent decrease in the amount of early clinical exposure.

- Review the information provided for non-EU-students on Irish culture.

6) Commendation

The Team commends RCSI for the many positive features of the GEP, and these are highlighted throughout the report. The students are almost without exception very positive about their experiences, and RCSI is congratulated for this.

7) Recommended further / future action

The Medical Council will seek an update on the issues in this report, and the Medical School's timescale for implementing them, once the final report has been approved by the Medical Council and sent to RCSI. It is recommended that the issue of further evaluation of the third and fourth years of the GEP be discussed with the RCSI.

The Team recommend a monitoring re-visit in autumn 2009, when the first intake of GEP students will be in the final year of their programme. Consideration should be given to combining this monitoring visit with the full accreditation process for the RCSI's 5/6 year non-graduate entry programme. This accreditation is also due to take place in autumn 2009. In-depth re-assessment of the entire four years of the RCSI GEP will be needed in 2010 prior to the prospective full accreditation of the GEP.

C. EVALUATION OF THE GRADUATE ENTRY PROGRAMME, BASED ON WFME STANDARDS

1. Mission and Objectives

1.1. Statements of Mission and Objectives

*B: The Medical School **must** define its Mission and Objectives and make them known to its constituency. The Mission Statements and Objectives **must** describe the educational process resulting in a medical doctor competent at a basic level, with an appropriate foundation for further training in any branch of medicine and in keeping with the roles of doctors in the health care system.*

The use of an outcome-focused approach in the curriculum is based on RCSI Medical Graduate Profile (MGP) and the associated competencies in terms of exit outcomes. These encompass social responsibility, research attainment, community involvement and preparedness for postgraduate medical training and professionalism.

However, there did not appear to be any clear statement of the objectives of the different modules that comprise the curriculum and ***this needs clarification by the RCSI. The Team noted with concern that the students appeared sometimes not to be clear regarding the objectives of modules and what exactly they were to be examined in and recommend (R1) that this be monitored and addressed.*** Thus the modular outcomes are almost as general as the MGP curricula outcomes. They might be more concrete in relation to activity titles and activity outcomes, and it might also be advantageous to define which modules are responsible for the defined core clinical procedures under MGP 3.2.1.

Response:
RCSI delivers an outcomes-based curriculum. These outcomes are arranged in a hierarchy starting with a theme (level 1) which is broken down with increasing focus into level 2 and then further broken down into level 3. These 3 levels comprise the Medical Graduate Profile. The link between the MGP and the modules is via the module outcomes (level 4) which are defined at a level that is directly linked to assessments and activities. The module outcomes and the MGP are reviewed on an annual basis. The IMC were provided with a copy of the current MGP and outcomes for each module in the 4 year Graduate Entry Programme.
Outcomes for each module are available for students on the module homepage of Moodle. Assessment is defined by these outcomes.

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

1.2. Participation in Formulation of Mission and Objectives

*B: The mission statement and objectives of a medical school **must** be defined by its principal stakeholders (e.g. Dean, members of faculty board, university, government, medical profession).*

The Medical Council Team saw the MGP outcome objectives which have internal and external stakeholder involvement.

The MGP was developed by a Curriculum Outcomes Working Group (COWG) comprising 24 members from the Faculty. It is noted that the Junior Cycle Director, the Intermediate Cycle Director and the GEP programme manager are members, but the GEP Director and the Senior Cycle Director are not. The MGP was considered in detail by the Annual Curriculum Forum in March/April 2008, involving over 40 members of the Faculty and also representatives of the student body.

*Q: Formulation of mission statements and objectives **should** be based in input from a wider range of stakeholders (e.g. representatives of staff, students, the community, education and health care authorities, professional organisations, postgraduate training bodies).*

The MGP was circulated to key external stakeholders including patient organisations and Alumni. ***The RCSI is commended for this approach.*** Community involvement in the formulation of mission and objectives is important and ***the Medical Council recommends (R2) that continuing external stakeholder involvement be explicitly "planned in" to the evolution of the MGP and curriculum mapping.***

Response:
The continuing involvement of internal and external stakeholders is part of the review and renewal process for the MGP and module outcomes. This process is overseen by the Curriculum Outcome Working Group

1.3. Academic autonomy

*B: There **must** be a policy for which the administration and faculty/academic staff of the medical school are responsible, within which they have freedom to design the curriculum and allocate the resources necessary for its implementation.*

Curriculum policy is determined by the Curriculum and Assessment Board (CAB). The CAB includes the cycle directors, curriculum working group chairs, representative academics, class/student representatives and administrative support staff.

Different curriculum working groups report to the CAB: the Assessment Working Group (AWG), Curriculum Outcomes Working Group (COWG) with a Curriculum Mapping Team (CMT), an Evaluation Working Group (EWG) and the Medical Education Research Group (MERG).

This organisation applies both to RCSI's Direct Entry and Graduate Entry Programmes. Both the GEP director and manager are members of the CAB and there are opportunities for all the staff to influence the design of the curriculum.

*Q: The contributions of all academic staff **should** address the actual curriculum and the educational resources **should** be distributed in relation to the educational needs.*

1.4. Educational outcome

*B: The medical school **must** define the competencies that students should exhibit on graduation in relation to their subsequent training and future roles in the health system.*

The MGP includes knowledge and understanding of the basic, clinical, behavioural and social sciences, including public health and population medicine, medical ethics relevant to the practice of medicine; attitudes and clinical skills (with respect to establishment of diagnoses), practical procedures, communication skills, treatment and prevention of disease, health promotion, rehabilitation, clinical reasoning and problem solving and the ability to undertake lifelong learning and professional development.

*Q: The linkage of competencies to be acquired by graduation with that to be acquired in postgraduate training **should** be specified. Measures of, and information about, competencies of the graduates **should** be used as feedback to programme development.*

2. Educational programme

2.1. Curriculum models and instructional methods

*B: The medical school **must** define the curriculum models and instructional methods employed.*

The programme uses a range of instructional methods around a case of the week with simulated patients during the first year and real patients during the second year. Thus in the two first years the instructional methods, includes traditional lecture (about 13 hours a week), case based learning, small group tutorials, (both staff and student-directed), practical (e.g. anatomy dissection); computer assisted learning, bedside clinical teaching, grand rounds, shadowing, observation skilled workshops, tutorials, theatre attendance, ward attendance, home visits and thus follows modern adult learning theory. However, the Team would like clarification on how much of the learning in Years 1 and 2 is self-directed.

Response:
Additional Information contains a breakdown of the amount of time allocated to scheduled 'Autonomous' activities including online tutorials in histology, radiology etc. There are additional requirements for self-directed learning associated with Case of the Week in the form of group based discussions and case uploads. There are also individual and group projects each semester. During clinical attachments in the second year and in the Senior Cycle, most clinical programmes require students to upload cases which encourage research and reflection. It is harder to quantify the amount of additional self-directed learning that individual students undertake in order to assimilate the information provided in lectures and other activities. This will vary with students' academic background and learning style. The programme does however provide time and facilities to support student-directed learning.

The Medical Council Team feel that the case for early patient contact in the home setting has been well made in the international literature and was also mentioned in the 2007 Medical Council report on RCSI. ***The Team recommends (R3) that some element of home visits be brought in, to allow the students to get a sense of the meaning and impact of either a chronic disease or a new baby on a family.***

Response:
The initial stages of the Graduate Entry Programme are necessarily intensive. It is imperative to allow the diverse student body time to acquire the background knowledge, skills and attitudes that would allow them to benefit from exposure to community medicine. In semester 2 of year 1 of the programme students spend one afternoon per week attached to clinical teams in hospitals which gives them early clinical exposure to all aspects of medicine including the impact of chronic disease. They are also introduced to a variety of conditions including diagnosis, management and impact as part of Case of the Week. Many of these sessions are facilitated by GPs who are able to provide 'front-line' perspective. Year 2 of the programme is based on a hospital site where students have extensive clinical exposure integrated into the curriculum. This includes regular sessions facilitated by local GPs during

which they bring in patients to meet the students on the hospital site to discuss, in an interactive manner, the management of acute and chronic diseases in the primary care setting. The patients are also encouraged to discuss the impact of their conditions from their perspective and the patients' perceptions of the interactions between primary and secondary care are explored. In the Senior Cycle, all students spend 6 weeks on a General Practice rotation (see, Supplementary Information). As part of our continuing review procedures we are seeking information on how this topic is addressed elsewhere.

If it has not been presented earlier or is accepted via accreditation in the direct entry programme, the Team would like to have some further information on instructional methods during the senior cycle.

Response:
See Supplementary Information.

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

Students are encouraged to take responsibility for their own learning through the use of individual and group project work, e.g. engagement in supported peer review. The GEP students appear to be highly motivated in this area. However, unfortunately, some parts of these instructional methods, such as project writing and journal clubs, seem to have, after students' wishes, been diminished.

Response:
The number and distribution of projects throughout the programme was reviewed in relation to the time that students were spending on them and the contribution they made to overall marks. There is a minimum of 1 project per semester in years 1 and 2 of the programme which provides an appropriate balance between project-based and other teaching and learning activities.
The Journal Club activity was removed from the first year of the programme after numerous evaluations by the students identified that the level at which it was being delivered was below the level already present in Graduate Entry Students. Students do participate in regular Journal Club activities from Year 2 onwards.

2.2. Scientific method

*B: The medical school **must** teach the principles of scientific method and evidence-based medicine, including analytical and critical thinking, throughout the curriculum.*

There is emphasis on acquiring a sound knowledge of the sciences basic to medicine. Thus research methodology is included in the GEP Junior Cycle, which addresses design, sampling, and conduct of health research, statistics, and the ethical and social aspects of medical research, sampling, controlled (clinical) trials, cohort studies and studies of natural history and evaluating screening and diagnostic tests.

The students felt that they the learning in scientific method and training in scientific thinking and research methods was sufficient.

*Q: The curriculum **should** include elements for training students in scientific thinking and research methods.*

2.3. Basic Biomedical Sciences

*B: The medical school **must** identify and incorporate in the curriculum the contributions of the basic biomedical sciences to create understanding of the scientific knowledge, concepts and methods fundamental to acquiring and applying clinical science.*

The programme includes the basic biomedical sciences in an integrated way. All student groups stated that those from a non-science background were given the opportunity to have additional tutorials but did not need to avail of these. The Team is therefore satisfied with the contributions of the basic biomedical sciences in years one and two. However, it is important that basic sciences do not "disappear" in the latter years of the programme and ***it is recommended (R4) that RCSI should review this to ensure that the relevance of basic sciences in the clinical setting is reinforced***.

Response:
As part of the continual review of the MGP, the balance of all themes, including Biomedical Science & Research is continually being monitored via the Curriculum Database. Each theme has a 'Champion' to ensure they are represented throughout the programme at appropriate levels. The theme Champion for Biomedical Science & Research is the RCSI Professor of Medicine who has successfully integrated biomedical science revision as part of the Senior Cycle Clinical Programme. For example, a series of cases, accessible through Moodle, has been developed for students in the senior cycle as a formative assessment tool. These cases incorporate relevant elements of the basic sciences and research in additional to clinical medicine.

During the meeting with students it became clear that training in objective 1.1.3. (Understands the scientific underpinnings for use of common therapeutic interventions in health care) was deficient, ***and the Team recommends (R5) that RCSI urgently address the issue***.

Response:
The Curriculum Database currently lists 41 module outcomes throughout the programme that are linked to 1.1.3. This issue has not been highlighted by the students in the evaluation process. Based on the IMC feedback RCSI is currently reviewing the delivery of therapeutics throughout the programme.

The amount of anatomy taught is the same as for the five-year programme, with an emphasis on the structure and function of anatomy. There is a laboratory attachment also. Anatomy and physiology are emphasised and integrated well into the programme and the advantage of the small class numbers is good. "Appropriateness criteria" is also applied and all cases are clinically relevant at grand rounds. There can be a danger of data overload and the course organisers go to great lengths to prevent this.

However, students from all three years stated that teaching of Pharmacology appears to be a problem. ***The Team urgently recommends (R6) that this specific concern is addressed.***

Response:
There is very little evidence of any problems or dissatisfaction with this area based on assessment and evaluation activities. There is a minor issue in relation to the timing of some of the early pharmacology and RCSI is currently engaged in a review of the delivery of Pharmacology throughout the programme.

Awareness of patient safety is inbuilt in all areas and there is a Director of Clinical Governance.

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

2.4 Behavioural and Social Sciences and Medical Ethics

*B: The medical school **must** identify and incorporate in the curriculum the contributions of the behavioural sciences, social sciences, medical ethics and medical jurisprudence that enable effective communication, clinical decision making and ethical practices.*

These aspects take a relatively large part of the MGP (Population and International Health and Personal and Professional Development), and they are also specified here in relatively large detail. However, the Medical Council wish to receive more information about the content of the different learning sessions and level of details required in the assessments.

Response:
RCSI has recently completed a review of this theme in the first two years of the programme. This has culminated in the merger of the two HBS modules into one in semester 1 of year 1 and a new module, 'Population and International Health', in semester 2 of year 1. These 2 modules have increased amounts of project work and continuous assessment that is more appropriate to the delivery and assessment of this type of material.

There appears to be an active Personal and Professional Development theme working group

The work with the introduction of an e-portfolio for assessment including self and peer reviews, supervisor reports, a reflective journal, certification in skills such as prescription writing, informed consent, and death certification was reported to be promising during the meeting. The RCSI are piloting an e-portfolio for assessment, where cases can be uploaded and reviewed, in the form of an e-portfolio which includes a component on 'personal reflection' whereby the students can document seeing the patients and define the clinical skills used. This compliments the communication skills (written and verbal) programme in Senior Cycle 2.

In junior and senior cycles ethics is a continuing theme. There is particular emphasis on ethical dilemmas in the senior cycle. There are scenarios which look at consent

issues, anaesthetics etc and these are examined at an OSCE station in the final examination.

There is a Professor of Medical Ethics and there is a high exposure on an ongoing basis, particularly in the Cases of the Week component. Ethics is very popular in the student selected components and is frequently chosen by students. The Team are satisfied that there is ethics teaching throughout the course.

The Health Behaviour and Society (HBS) module and the Health Disease and Society (HDS) module were criticised by the students. ***It is recommended (R7) that the RCSI should review for relevance the topics used for projects.***

Response:
The nature of projects is reviewed annually based on evidence from the results of assessment and evaluation activities. However, students, especially those at the start of a programme, are not always in a position to recognise what is relevant to a well-rounded medical graduate and any changes are made as part of the 'big picture'.

*Q: The contributions of the behavioural and social sciences and medical ethics **should** be adapted to scientific developments in medicine, to changing demographic and cultural contexts and to health needs of society.*

2.5 Clinical Sciences and Skills

*B: The medical school **must** ensure that students have patient contact and acquire sufficient clinical knowledge and skills to assume appropriate clinical responsibility upon graduation.*

The Team note that a large portion of the curriculum is delivered by clinicians and many of the modules are consultant-led. The teaching of clinical sciences and skills appears to be satisfactory in Years One and Two.

Existing early patient contact using simulated patients in year 1 and real patients in year 2 is commendable, but the Team feel that the major deficiency is that it is limited to the hospital setting. It appears that when GPs are involved, they are brought into the lecture theatre rather than the students being taken out to the community, and ***the Team recommend (R8) that use of community settings be reviewed with a view to increasing opportunities in this area.*** In addition, the Team were of the view that the students have had relatively few opportunities to access and utilise the clinical skills laboratory at Beaumont Hospital *and* ***the Team recommend (R9) that the use of the clinical skills laboratory be encouraged.***

Response:
Re: Community Settings: In the current programme, opportunities for community placements have been further developed in the Senior Cycle and occur when students have acquired the appropriate knowledge, skills and attitudes.
Re: Clinical Skills Facilities: In the first two years on the programme students have access to dedicated tutorial rooms which are equipped for clinical skills teaching and practice. Equipment similar to that available in Beaumont is available on the Connolly site for teaching of practical skills during the second year. In semester 2 of

year 1, students utilise the Clinical Skills Lab. in Beaumont Hospital. These experiences are augmented in the Senior Cycle with an Essentials of Clinical Practice programme and Sub-Internship. This includes use of the high-fidelity METI Simulator.

However, as stated earlier, there are concerns regarding teaching in pharmacology.

In Year 1 and 2 there is early patient contact from week one. There are weekly small group "Clinical Competencies" sessions where the students learn to take histories and perform examinations; although the clinical competencies tutorials were rated relatively low in the student evaluations, the Team understands that action has been taken to correct this). In year 2 there are weekly ward-based small group tutorials at which students have the opportunity to take histories and develop clinical examination skills. In addition to the scheduled weekly sessions, students acquire a minimum of 160 hours of clinical attachments in year 1 and 320 hours in year 2.

The Team would like additional information on clinical teaching in the senior cycle.

The Team recommend (R10) that work on defining the relations between training of clinical competencies during the senior cycle and the internship should be stimulated.

Response:
The Essentials of Clinical Practice programme in SC2 is directly linked to the Sub-Internship programme. The objective of these components is preparedness for practice.

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

2.6. Curriculum Structure, composition and duration

*B: The medical school **must** describe the content, extent and sequencing of courses and other curricular elements, including the balance between the core and optional content, and the role of health promotion, preventative medicine, and rehabilitation in the curriculum, as well as the interface with unorthodox, traditional or alternative practices.*

The graduate profile they have developed applies to both programmes and both sets of students are aspiring towards and meeting the same standards. There are five themes all through programme though the weight shifts at the various stages. The team were assured that personal and professional development is a key part of curriculum – it is one of five main themes and it is taken seriously by students and is assessed.

The MGP is implemented *via* a junior cycle (comprising three semesters in direct entry and one year in graduate entry) and intermediate cycle (comprising three semesters in direct entry and one year in graduate entry) and a common senior cycle

(comprising two years). There are cycle committees for the three different cycles, covering both direct and graduate entry programmes.

During the meeting the curriculum mapping project was presented. This appears to be a very interesting and impressive approach, aiming to produce a searchable database of all teaching and learning activities including relevant assessment, which should be followed. The Team was impressed with the MGP and believe that the RCSI are taking a logical approach to curriculum mapping

There are Special Study Modules (although not in the Senior Cycle) which include six week long research options and medical education options. These have had a high uptake and include making case presentations as well as a written component, both of which are assessed. In the Senior Cycle there are electives 'outside' the formal programme, for example in the summer.

It is not quite clear whether there are also working groups, corresponding to the five different themes of the MGP, although the existence of a specific Personal and Professional development (PPD) group is mentioned. The Medical Council require clarification on this matter.

Response:
The existence of the PPD Working Group is in response to previous recommendations of the IMC. All theme 'Champions' are members of the Curriculum Outcomes Working Group and the Curriculum & Assessment Board where theme development takes place in a comprehensive and cohesive manner rather than individual themes developing in isolation.

There was a 16-week block before Christmas incorporating medicine and surgery. There is a 16-week block after Christmas incorporating acting-up, sub-internship and clinical practice.

The Senior Cycle One complete five six-week blocks in the following areas - Obstetrics and Gynaecology, Paediatrics, Psychiatry, Clinical Medicine and Community Medicine.

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

2.7 Programme management

*B: A curriculum committee **must** be given the responsibility and authority for planning and implementing the curriculum to secure the objectives of the medical school.*

Programme management appears to be satisfactory and the Team believe there are good structures in place. For the GEP management, there is a Programme Director and a Programme Manager. The Intermediate Cycle (corresponding to year 2) Director obviously also take an active part in the responsibility. Furthermore, it appears that year 1 and year 2 of the GEP have steering groups with Heads of departments and their representatives.

*Q: The curriculum committee **should** be provided with resources for planning and implementing methods of teaching and learning, student assessment, course evaluation, and for innovations in the curriculum. There **should** be representation on the curriculum committee of staff, students and other stakeholders.*

There is student representation on all committees and the students feel that they have a large input into curriculum development and revision. There are fortnightly meetings and the students vote on who their representatives should be.

2.8 Linkage with medical practice and the health care system

*B: Operational linkage **must** be assured between the educational programme and the subsequent stage of training or practice that the student will enter after graduation.*

There are appointed Intern Coordinators at each of the teaching hospitals and a sub-internship programme has been developed. Contact with internationally based graduates is established with the help of the Project Officer Medical Education Officer and an Alumni database.

*Q: The curriculum committee **should** seek input from the environment in which graduates will be expected to work and **should** undertake programme modification in response to feedback from the community and society.*

3. Assessment of Students

3.1. Assessment methods

*B: The medical school **must** define and state the methods used for assessment of its students, including the criteria for passing examinations.*

Each module must be passed. There is a standard pass mark of 50% for modules.

Professional Development is examined continuously, along with communication skills and ethical values. There are modular outcomes – in SC1 exam it usually involves eight stations including communication and procedure, where the students are evaluated on their approach, demeanour and so on. This is a 'barring exam' – ie a pass is necessary in order to move on.

The 'Breaking Bad News' element uses videotape and feedback to assess performance.

Some students, however, expressed uncertainty of what was expected in the examinations. Obviously much of the detailed objectives formulation occurred during the different lectures. It will therefore be dependent on the quality of these. A centralised formulation of objectives for the lectures would be preferable.

Previously, the Medical Council had concerns regarding over-assessment and these were outlined in the 2007 Medical Council report. However, this potential problem appears to have been avoided

The assessments are well-described and the reliability and validity discussed. There are continuous (formative) assessments during the semester and a summative assessment after each semester.

During assessments, the RCSI utilise a pool of patients, known as 'Friends of the RCSI' who take part in assessments, as well as the examiners, and evaluate the students. Frequently, the assessment by the patient matches almost exactly that by the examiner. This is an ongoing programme and the RCSI are learning a lot from this.

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

3.2 Relation between assessment and learning

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

The Medical Council have requested further details and examples of clinical examinations and more specified outcomes for the clinical module.

Response:
See Additional Information for an example of OSCE / TOSCE marking sheets.

There is an Assessment Working Group with 17 members but surprisingly (according to information supplied) without student representation, producing a dynamic document called Assessment Strategy. This seems to cover testing of student achievements of learning objectives and competencies and includes all domains; knowledge, skills and attitudes.

Response:
There is student representation on all Working Groups including the Assessment Working Group.

The Medical Council is pleased to note that the RCSI has applied to join the International Database for Enhance Assessment and Learning (IDEAL), giving the possibility for a larger bank of examinations and probably also a comparison of level/difficulty.

External examiners are used for the final semester examinations, and there is a Marks and Standards Document. Work to prevent assessment overload was obviously more connected to the identification of overlapping teaching during the programme, than to analyse the amount and level required in the examinations.

*Q: The number and nature of examinations **should** be adjusted by integrating assessments of various curricular elements to encourage integrated learning. The need to learn excessive amounts of information **should** be reduced and curriculum overload prevented.*

4. Students

All students were contacted by the RCSI and invited to meet the Medical Council Team.

Overall, the students praised the support they received from staff throughout the course, and especially the support provided to the non-science students. The students say that they are involved in the curriculum development and get a lot of support from the college. They are assigned staff to support them and the students have the opportunity to be on committees and feel that their voice is certainly heard. There is considerable mutual support amongst each other and any suggestions are acted upon by the College. There is a mentorship programme in place and each member of staff is available for dealing with any queries or concerns. In addition, the second years have been very supportive of the first years. Obviously there could be difficulties if a student needed time out for any particular reason, but the students stated that due to the teamwork and collaboration they experience, that they support each other as and when needed and that everyone wants to do well, as a group.

However, the Medical Council stresses that the RCSI should guard against the possibility of students in years one and two becoming isolated and they put an emphasis on involvement sports activities, Students' Union etc. However, the graduate entry students are very motivated and potential isolation does not appear to be a problem for them. Some of the class representatives, for example, are graduate entry students and they see themselves as being part of the bigger campus.

The North American students would, however, have liked some support explicitly in relation to moving to Ireland, as the North American system is very different to the Irish system. With regard to orientation, they believe that the information they received was not quite adequate although the website has been updated since and is now more helpful. Overseas students would appreciate guidance on nuances of use of language in the Irish context and the first year students, in particular, said that they feel it would be helpful to have a cultural awareness session at an early stage.

Response:
All overseas students for the Graduate Entry Programme are interviewed. The Irish Medical School consultants 'Atlantic Bridge' provide guidance and information for prospective students. Applicants are given the opportunity to contact current students and staff with any queries. RCSI is currently developing an expanded orientation programme.

There were no problems experienced as a result of students coming from different backgrounds (including non-science) and there appears to be no statistical difference in performance.

The following highlights themes common to all years, and those which are specific to Years 1, 2 or 3.

There appears to be some concern, across all three years, over the teaching of pharmacology (although the students felt it was no worse than the five-year programme). The students unanimously felt that pharmacology was not well taught

at RCSI, as they felt it was not integrated into the programme and that it sometimes comes before the pathology component. While the Council appreciates that it may be a difficult subject to teach and may be difficult to integrate it into the programme, ***nevertheless, the Team recommends (R11) that the teaching of pharmacology be urgently reviewed. In addition, the Team were not satisfied that the difficulties with the respiratory component of the cardio-respiratory module had been addressed and recommend (R12) that the RCSI address this.***

Response:
Re: Pharmacology: see section 2.3
Re: Cardio respiratory Module: This is currently one of the largest modules and we are currently investigating the possibility of splitting it which would alleviate most of the problems. We have also further integrated the teaching of cardiovascular and respiratory material between years 1 & 2.

All students praised the commitment and support of the Director of the Graduate Entry Programme.

However, students across all three years were critical of the Health Behaviour and Society module (HBS) and the Health Disease and Society (HDS) elements of the course which they felt were pitched at too low a level for graduate entry students and they questioned the relevancy of the project topics chosen as part of the course.

Response:
See section 2.4

Students praised, in particular, the early patient contact opportunities. There is patient contact from day one and the students agreed that meeting the patients in the medical school is very helpful. The group instruction with patients is very good and well organised. They mentioned that patients, particularly, noticed the difference between those on the school leaver programme and graduate entry programme students. A number of patients have come to the college to talk to them about their illnesses and this will be organised even more in the future. They have the opportunities to go through the patient history and ask questions.

The students unanimously felt that communication skills are taught very well and that they are learning about the different ways to approach sensitive issues. There are small group classes for communication skills and they use a combination of video-conferencing, actors and real patients. They are all aware of the importance of communication skills and they have a 'case of the week'.

Meeting with Students – Year 3

The Medical Council team met with 12 students from Year 3 – three male and nine female, comprising a mixture between EU and non-EU backgrounds and science and non-science backgrounds. The students assured the Team that the mix between science and non-science backgrounds has worked very well. The Year 3 students feel that the 'merger' with students on the longstanding programme had gone well and they do not feel a divide with the students on the school leaver programme.

There is a Vice-Dean of Student Affairs (whom we did not meet on the day). There is little interaction with the main campus of the College in Years 1 and 2 – however, the students assured the team that they had no problem integrating with the school-leaver stream and their social circle has now changed. There is a Disability Officer.

The students' considerable financial investment in the programme was highlighted. However, the students in general thought they were getting 'value for money'. The students stated that the course is very professionally run, and the atmosphere is very collaborative. They stated that from talking to the years behind them, that any suggestions they have made have indeed been acted upon.

There appears to be more clinical exposure in the graduate entry programme than in the school leaver programme. The students feel very comfortable in the hospital teams and believe that the small group feedback works very well and the students know what is expected of them and feel they are well prepared to take examinations. However, the students stated that they feel it is regrettable that interviews for graduate entry programme are not conducted any longer and that entry to the programme is on a points scoring basis alone.

Response:
All overseas GEP students are interviewed. The admissions process for EU students is determined by the HEA and is outside our control.

In terms of opportunities for research, they have done some research before and have the opportunity to participate in journal clubs, for example. Ethics is incorporated into the programme (not in a didactic manner) – researching literature and engaging in the process. There is excellent teaching of ethics and they are engaged in stimulating discussions which look at precedent and legal aspects.

The tutors all strive to meet best practice and they are seeing these issues now in the hospital settings more and more. Their feedback goes on the forms and they are honest and will not hesitate to name any individuals who fall below their expectations.

The issue of capacity caused concern for the Medical Council previously and the team were assured that capacity is satisfactory so far and that the selection of doctors is based on forecasting trends in capacity and is being monitored into the future. The students believe that the RCSI school in Bahrain should relieve some of the pressure on internship numbers. The students particularly praised the Beacon Hospital stating that those who had placements there all agreed it was an excellent opportunity and that there was a lot of patient interaction. However, ***the Team noted that the private hospital teaching sites were part of the conventional programme accreditation process and therefore express concern that students are being placed in a clinical training site that has not yet been approved by the Medical Council.*** In addition, the Team noted that there appears to have been a problem with MRSA testing in Cappagh Hospital and this resulted in reduced access to theatres in what is apparently their only orthopaedic rotation.

Response:
In response to the aspiration to provide the best clinical training facilities for our students RCSI has developed an internal quality review procedure to ensure all clinical sites meet our high standards. This includes ensuring staff and facilities are

appropriate for student needs. We jointly fund RMO / Tutor posts on-site in addition to providing training and support.
Re: MRSA / Orthopaedics: RCSI is obliged to abide by local hospital regulations and procedures. The MRSA screening issue in Cappagh has now been resolved in consultation with the RCSI Professor of Orthopaedics. Many students will get additional orthopaedic experience when attached to orthopaedic teams on future Surgery rotations.

Overall, the students were very positive about the course. They feel no feelings of isolation in either the Sandyford campus or Connolly Hospital.

Meeting with Students – Year 2

The Medical Council team met with 13 students from Year 2 – nine male and four female, comprising a mixture between EU and non-EU backgrounds and science and non-science backgrounds. Many had worked for some time before commencing the programme while others had come directly from their primary degree course.

They stated that library resources are very good. However, some students expressed concern over the arrangements in place for next year's placements.

Response:
RCSI has recently developed a Rotation Management Tool to ensure increased communication and parity of experience. This will be rolled-out in the coming academic year.

There is a balance between lectures, small group classes and individual study, although some students feel that they have too many lectures. The balance, however, tries to cater for all students and it is well structured. The issue of lecturers not showing up appears to have been addressed and it now happens rarely, if ever, and is rescheduled in any event.

The feedback from some of the placements was a cause for a concern – some students felt that there was not enough for them to do and this is at variance with other students who have had a good experience. ***The Team recommends (R13) that the variability of experience during placements be urgently addressed.***

Response:
Many of these concerns are being addressed by additional tutor appointments. Tutors report directly to Heads of Departments. Variability of experience is monitored via the Student Evaluations with information being fed back to relevant staff for action. It is worth noting that variability of experience is a fact of life and students are encouraged to be pro-active in their learning, especially in clinical settings. It is true to say that there is <u>never</u> 'not enough' for students to do at any point during their training at RCSI.

The Team also noted that there is not much opportunity for Student Selected Components and recommends (R14) that this be reviewed.

Response:
There is an element of choice in some of the projects that the students undertake in the first 2 years of the programme. With the intensive nature of the first two years of the programme there is no time for an expanded Student Selected Component. Students do get the opportunity to address personal avenues of interest when they do electives in the Senior Cycle. This possibility of a Student Selected Component within the first 2 years of the programme is currently being reviewed.

Meeting with Students – Year 1

The Medical Council team met with 18 students from Year 1 – eight male and ten female, comprising a mixture between EU and non-EU backgrounds and science and non-science backgrounds. They believed that the GAMSAT and MCAT is a good grounding for those students with non-science backgrounds.

There are time management challenges associated with the course, however, it is more with the volume of work than with the difficulty. There is good delivery of the programme. They have representatives who sit on some of the committees and are involved in the Students' Union.

They believe that they have involvement in the curriculum planning and have all given feedback into this. The campus at Sandyford was felt to be quite isolating for some students but on the other hand, it allows them focus more on their studies. For additional material, the library is all on-line. They feel that any problems are being addressed since last year's cohort and even since last term.

The students felt that some of the learning objectives were not quite as clear as they could be however, they do receive examples of exam questions.

The students were complimentary of the Grand Rounds video link system that is in place. For Medical Grand Rounds they listen to the cases and discuss them afterwards. For Surgical Grand Rounds, they are sometimes asked a question over the video link. They have more lectures this semester than last and they have group tutorials.

The issue of GAMSAT, CAO and late course notification came up, and they all felt that the notice they received put them under additional pressure to finalise plans and work out notice. However, they appreciated that this was an area that was outside the control of the college and the Medical Council.

There is also a skills laboratory and simulated patients for physical examinations – this will be undertaken in even more detail next year. The students stated that the social aspects of medicine were taught rather theoretically however (there did seem to be concern that some of the clinical teachers arrived with "200 slide shows" for one hour lecture), and they would like more practical work, less statistics and generally for it to be more connected with general body of knowledge. The students did not appear to have had much exposure to 'patient as expert' so far.

Response:
Re: Lectures: Staff development is a continuous process and we are constantly working to ensure content providers deliver appropriate material. The number of lectures that are delivered with large numbers of slides has decreased greatly in the last 3 years.

Re: Patients as Experts: First year students have access to patients as part of their Wednesday afternoon clinical attachments in semester 2 and greater access during their 4-week Intensive Clinical attachment between years 1 & 2. Most of their clinical experience in year 2 and beyond is via real patients.

Re: Content: RCSI engages with students as co-producers with the curriculum and its content. We also recognise that there is an understandable gap between what students 'think' they need to know / do to be a medical professional and the evidence used by the Faculty / Profession / other stakeholders in designing the curriculum

They believe, in general, that the standard of teaching is excellent and that a lot is expected of them. However, they feel reassured that all staff are very open to problems or suggestions.

4.1 Admission policy and selection

*B: The medical school **must** have an admission policy including a clear statement on the process of selection of students.*

There is a clear policy. As from the start of the programme, EU students require a degrees of 2nd Class, First Division or higher and a satisfactory Graduate Australian Medical School Admission Test (GAMSAT) score and enter *via* the Central Applications Office. Non-EU students are interviewed prior to admission to assess non-academic factors such as motivation for medicine and sit the Medical College Admission Test (MCAT). Confidential references and a personal statement are also used for non-EU students.

As noted in previous reports, the first two intakes were mostly from a science background. The 2008/9 intake has a bigger cohort from a non-science background although the Team do not have specific information on exact numbers. There was no noticeable difference between students from a science or non-science background and all students felt that they were coping.

However, the Team could not find information on the underlying rationale for admission policy and its advantages for the applicant, the School and the community, and reviewing of the admission policy with respect to needs of the institution and the society.

The Medical Council is of course aware that some of the findings from this visit are more of national rather than RCSI-specific relevance.

*Q: The admission policy **should** be reviewed periodically, based on relevant societal and professional data, to comply with the social responsibilities of the institution and the health needs of community and society. The relationship between selection, the educational programme and desired qualities of graduates **should** be stated.*

The RCSI is committed to reserving 5% of EU places on its programme to disabled students under the Access and Disability programme

4.2 Student intake

*B: The size of student intake **must** be defined and related to the capacity of the medical school at all stages of education and training.*

The Team appreciates the listing of RCSI teaching and affiliated hospital activity/capacity. It is noted that from September 2009, there will be 520 students in the Senior Cycle programme, as the first cohort of GEP students enter the final year of the programme and it is stated that a significant investment has been made to expand facilities and the teaching faculty. It might, however, still be difficult to get an impression of the patient/student and teacher/student ratio. Importantly, however, on the day of this visit, the Team did not hear complaints of capacity problems in terms of student: patient ratio or student to consultant ratio. ***However, the capacity issue will be carefully monitored.***

*Q: The size and nature of the intake **should** be reviewed in consultation with relevant stakeholders and regulated periodically to meet the needs of the community and society.*

4.3 Student support and counselling

*B: A programme of student support, including counselling, **must** be offered by the medical school.*

The programme of student support and counselling appears satisfactory. There is a Vice-Dean for Student Affairs and a Disability Officer. All of the staff emphasise that they have an open-door policy and all students may avail of whatever tutorials or one-to-ones that they need. The Team's perception is that students are often more inclined to approach the GEP staff with any issues. This is a reflection of the students' excellent relationship with and confidence in those staff. However, it would be advisable for GEP students' support and counselling needs to be integrated into the general RCSI support structures therefore easing the dependence on individuals over time. It is appreciated, however, that students will continue to exercise their freedom of choice in this matter.

Response:
Students are aware of and have access to both local and institutional support mechanisms and avail of them appropriately.

Students with academic difficulties, as reflected during monthly online assessments, are interviewed and advised accordingly. There is also mid-year feedback via interviews with GEP staff

Graduate students' issues tend to be slightly different from those (financial considerations being the primary concern). Awareness of stress and anxiety is included in the curriculum so that students can recognise it in themselves as well as in patients.

In terms of Professional Conduct, the tutors have identified difficult behavioural issues in a very small number of students and some students have been counselled on the area of attendance, for example.

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

4.4 Student representation

*B: The medical school **must** have a policy on student representation and appropriate participation in the design, management and evaluation of the curriculum, and in other matters relevant to students.*

The RCSI see the students as being co-producers of the programme as well as its consumers. There are student representatives on all committees (perhaps with the exception of the assessment working group) and there are a number of student representatives on the Students' Union and the Team were assured that they meet the GEP staff regularly. Specifically, they meet after evaluations to discuss the results and address how any problems identified could be handled. The students feel this is satisfactory.

The Team recommends (R15) that students become involved in Curriculum Working Group.

Response:
Students are involved in all Working Groups.

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

5. Academic Staff/Faculty

5.1. Recruitment policy

The RCSI confirmed that a number of additional staff appointments have been made, some of which are purely for the graduate entry programme (some are funded by the HEA while others are funded by the graduate entry programme). Many teachers appear to be 'funded' to teach on both GEP and five year programme while the tutors concentrate on GEPs. Some of the tutors have clinical commitments. Some of these staff appointments have been promotions for existing staff.

*B: The medical school **must** have a staff recruitment policy which outlines the type, responsibilities and balance of academic staff required to deliver the curriculum adequately, including the balance between medical and non-medical staff; and between full-time and part-time staff, the responsibilities of which **must** be explicitly specified and monitored.*

The RCSI staff recruitment and selection process is competence-based to ensure candidates possess the appropriate skills, knowledge and attributes in addition to the relevant qualifications and experience. The Dean, Cycle Directors and the Faculty Executive annually review the staff profile. In addition, there is an independent educationalist to advise the Human Resources Department and Faculty Executive on a Staff promotion policy.

However, the Team found it difficult to see numbers specifically assigned to the GEP and have requested more information on numbers of staff dedicated to the GEP and the proportion of their time spent on this programme, on teaching on the school leaver programme and on clinical duties. It would be valuable to have more detailed information on the profile of the staff with respect to ratios medical to non-medical, full-time, part-time, and academic profile. ***The Team recommends (R16) that structures be put in place to provide briefing for clinical teachers regarding their responsibilities to the students when they are on their clinical placements in years 1 and 2. The Team also recommend (R17) that processes are in place to identify deficiencies in clinical teachers and how to address them.***

Response:
Re: Staff numbers, see Supplementary Information.
Re: Clinical Teachers. RCSI has an orientation programme for new clinical staff and an ongoing development programme for existing personnel.

Re: Staff Monitoring: Students have the opportunity to provide feedback on all staff via the evaluation process. This information is provided in a confidential manner and forwarded to relevant Heads of Departments for investigation / action.

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

5.2. Staff policy and development

*B: The medical school **must** have a staff policy which addresses a balance of capacity for teaching, research and service functions, and ensures recognition of meritorious academic activities, with appropriate emphasis on both research attainment and teaching qualifications.*

The RCSI are to be commended on the promotion policy which recognises excellence in teaching and innovation, as well as research. There is a Leadership Programme available. There are also Performance reviews and teaching awards. In addition, there are a number of staff attending further Medical Education Course.

The tutors at RCSI attend a Train the Trainers course and the RCSI have commenced an initiative where the students are involved in writing sample MCQs.

There is a programme for tutors involved in teaching and there is an orientation programme. A number of new staff have been appointed since the Medical Council initially provisionally approved the programme in 2006, however, the Team were not provided with additional information.

The Team note an ongoing review of Academic Promotions Policy and Procedures, which will be in place 2009 and including a formal scoring system, linkage to annual performance and development review and the addition of external Assessor/Process Auditor to the Promotions Committee. There is also a Leadership Development Programme and an MSc in Leadership and Management for Researchers in place, and efforts are made to support and reward the part-time clinical teaching staff based in the hospitals and the community. There is a teaching award in recognition of teaching excellence and an RCSI Staff award in recognition and celebration of the extraordinary accomplishments of all staff. ***The Team commends the RCSI on its teacher training, development and appraisal development.***

Q: The staff policy should include teacher training and development and teacher appraisal. Teacher-student ratios relevant to the various curricular components and teacher representation on relevant bodies should be taken into account.

6. Educational Resources

6.1. Physical facilities

*B: The medical school **must** have sufficient physical facilities for the staff and the student population to ensure that the curriculum can be delivered adequately.*

The facilities in Years One and Two are impressive. However, the Medical Council have requested additional information on Years Three and Four.

Response:
See Supplementary Information.

Year 1 students are based in a dedicated state-of-the-art facility at Reservoir House in Sandyford. Year 2 students are based in the RCSI/Connolly Hospital Graduate Entry Building. There is a library (the city-centre-based Mercer Library) which has common access to electronic resources, and there are plans to transform library space into learning spaces including multi-use, flexible-use spaces equipped for small and large groups combined with individual study space. The physical separation between Connolly Hospital and the Mercer Library was not reported to be problematic by the students, who also had the use of a library at Connolly hospital.

There is an RCSI safety statement.

*Q: The learning environment for the students **should** be improved by regular updating and extension of the facilities to match developments in educational practices.*

6.2. Clinical training resources

*B: The medical school **must** ensure adequate clinical experience and the necessary resources, including sufficient patients and clinical training facilities.*

The Medical Council have requested additional information on Years Three and Four.

Response:
See section 6.1

General practice

In year 2 there is teaching from local GPs on hospital sites. There are formal attachments to community facilities in the Senior Cycle.

Clinical medicine in the community setting involves, for example, an ENT programme linked to a general practice programme with shared outcomes.

These opportunities are welcomed by the Team but there is still considerable scope for further utilisation of community and primary-care based facilities and the RCSI should review this. It is acknowledged that this under-utilisation is a common feature across the medical education system in Ireland.

Hospitals

The Team noted that there is a possible under-utilisation of the Beaumont Hospital clinical skill laboratories and recommend (R18) that this be addressed.

Response:
Beaumont Hospital is one of our main teaching hospitals and is utilised to its full capacity. See also section 2.5.

The students have the opportunity to attend Kilkenny, Mullingar, Navan, Cavan and Loughlinstown hospitals for their placements and again, the emphasis is on teamwork.

The RCSI has made a considerable investment in Waterford and in Connolly Hospital and they also utilise clinical training resources in the Beacon Hospital and St Michael's University Hospital in Dun Laoghaire. There are very small numbers in the Beacon Hospital and the RCSI acknowledges that it is a privileged environment. This is echoed by the students, who appreciated the consultant-led teaching. However, ***the Medical Council recommends (R19) that RCSI monitor the patient mix and guard against a possible lack of exposure to social issues.***

Response:
RCSI is cognisant of the need to provide a realistic patient mix and are confident that this is accomplished by students spending time in a range of clinical training sites both public and private.

Private Hospitals

While the students particularly praised the Beacon Hospital stating that those who had placements there agreed it was an excellent opportunity, ***the Team are concerned that students are being placed in a clinical training site that has not yet been approved by the Medical Council.***

Response:
See section 4.

Clinical capacity at hospital level

The Team are convinced that this requires further assessment, either on a 'stand alone' visit to the GEP clinical facilities or in conjunction with an assessment of the five/six year programme.

Response:
RCSI welcomes the opportunity to showcase the programme and its facilities.

*Q: The facilities for clinical training **should** be developed to ensure clinical training which is adequate to the needs of the population in the geographically relevant area.*

6.3 Information Technology

*B: The medical school **must** have a policy which addresses the evaluation and effective use of information and communication technology in the educational programme.*

The Team identified no issues of concern in information technology and the students praised the Moodle e-learning software platform / course management system. All students are issued with their own laptop. Information seeking skills are continuously taught. Teachers and students are supported through regular workshops and a help desk.

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

6.4 Research

*B: The medical school **must** have a policy that fosters the relationship between research and education and **must** describe the research facilities and areas of research priorities at the institution.*

The students are prepared to participate in research project work: however, the Team would like more information about the placement and formalities. The publication of a student journal with publications of student projects is an interesting innovation. There is the opportunity of student placements in order to carry out research. However, many of the students have already carried out research. The RCSI assured the Team that there is a reflection in the curriculum of interaction between research and education, not least via the RCSI Research Institute specialising in Translational Medical Research linking clinicians and scientists.

Response:
In the first two years of the programme students are advised not to undertake additional activities such as research. Nonetheless, students who are keen and have demonstrated that their studies are not affected by additional commitments are accommodated appropriately.

*Q: The interaction between research and education activities **should** be reflected in the curriculum and influence current teaching and **should** encourage and prepare students to engagement in medical research and development.*

6.5. Educational expertise

*B: The medical school **must** have a policy on the use of educational expertise in planning medical education and in development of teaching methods.*

There is a Vice Dean for Medical Education; however, the Team did not have the opportunity to meet with her on the day. The Team would be interested to hear how the School feel that the appointment has impacted on the GEP. The Team would like

additional information on the tasks and achievements of the Medical Education Research Group.

There are a number of staff undertaking further courses in Medical Education and ***the Medical Council Team was pleased to see a culture of promoting medical education, expertise and experience and recommends (R20) that this continue.***

Response:
Following her appointment in 2007, the Vice Dean for Medical Education consolidated existing academic infrastructure and substantially increased participation and awareness of educational issues. The Graduate Entry Programme has benefited from this and has provided an opportunity for pedagogical innovation. The Medical Education Research Group, chaired by the Vice Dean for Medical Education, has provided a cooperation and communication forum for staff involved in medical education. Fu rther information on the activities / outcomes of the Medical Education Research Group can be found in additional information. This internal Education Publication is another initiative spearheaded by the Vice Dean for Medical Education.

*Q: There **should** be access to educational experts and evidence demonstrated of the use of such expertise for staff development for research in the discipline of medical education.*

6.6. Educational exchanges

*B: The medical school **must** have a policy for collaboration with other educational institutions and for the transfer of educational credits.*

There is said to be a long tradition supporting collaboration with other educational institutions and of supporting staff and students on international exchanges. The Team would be interested, however, in learning more about the RCSI modules that host students from abroad, and which modules that GEP students can take abroad.

Response:
Although there are opportunities for exchange between Ireland and Bahrain in the 5 year programme, there are currently no appropriate programme that could host GEP students. Students are supported in a diverse range of overseas electives in the Senior Cycle.

*Q: Regional and international exchange of academic staff and students **should** be facilitated by the provision of appropriate resources.*

7. Programme evaluation

7.1. Mechanisms for programme evaluation

*B: The medical school **must** establish a mechanism for programme evaluation that monitors the curriculum and student progress, and ensures that concerns are identified and addressed.*

There is an Evaluation Strategy. There is feed-back from Curriculum working groups and Cycle Committees via the Evaluation Working Group and CAB reporting to the Faculty Executive. ***For the evaluation of Years 3 and 4, it would be very important that the evaluation can identify malfunctioning wards/clinical themes and the Team recommends (R21) that this be actively monitored.*** The Medical Council Team have therefore requested further information.

Response:
The RCSI evaluation strategy gives all students the opportunity to provide feedback on any / all aspects of the programme. Each student gets a personal invitation to participate followed by a maximum of 2 reminders if they fail to take up the invitation. A series of core questions and the inclusion of opportunities for free-text comments allow the comparison of all modules / courses / clinical attachments throughout all levels of the programme. The quantitative data is immediately made available to all staff and students and the qualitative data is analysed and fed back to the Cycle Directors who identify issues and take appropriate action. The first year of the evaluation strategy has been very successful with a high participation rate which has generated large amounts of useful feedback.

Furthermore national agencies and regulatory authorities are involved in the evaluations. Preparedness for Hospital Practice Questionnaire and Graduate Tracking Study are currently underway.

*Q: Programme evaluation **should** address the context of the educational process, the specific components of the curriculum and the general outcomes.*

7.2. Teacher and Student Feedback

*B: Both teacher and student feedback **must** be systematically sought, analysed, and responded to.*

The Team were assured that student feedback is regularly sought at the end of modules and any issues highlighted are dealt with in a timely manner. Steps were taken to rectify the issues identified in the student evaluation survey, regarding the Health Behaviour and Society (HBS) project, for example. The Team are satisfied that this appears to be well-planned. It is noted that GEP has been particularly careful to ensure that over-evaluation is avoided. This addresses one of the issues previously raised by Council, the danger of over-assessment – in terms of examination of academic performance – and over-evaluation in terms of gathering feedback.

As part of the student feedback survey, there were some areas where poor feedback was identified. There is also the opportunity for free-text feedback in the survey and the results of the student feedback survey have been made available to students. The RCSI admit there was some dissatisfaction with some of the modules, but that this has been acted upon and the RCSI have made some positive changes, which they assured the team has benefited the students. There is significant interaction between the different years of students, so the students themselves know when something has or has not been resolved. In addition, the students are provided with feedback after examinations – as they are a high-achieving group, about half of them availed of the feedback and were happy with it.

*Q: Teachers and students **should** be actively involved in planning programme evaluation and in using its results for programme development.*

7.3 Student performance

*B: Student performance **must** be analysed in relation to the curriculum and the mission and objectives of the medical school.*

It was noted that analysis of the relevant statistical information provides regular and informal feedback to the committees responsible for student selection.

*Q: Student performance **should** be analysed in relation to student background, conditions and entrance qualifications, and **should** be used to provide feedback to the committees responsible for student selection, curriculum planning and student counselling.*

7.4 Involvement of Stakeholders

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

A wide range of stakeholders participate (e.g. educational and health care authorities, community representatives, professional organisations, and postgraduate training bodies)

The Medical Council were informed that external examiners were used. The RCSI is currently applying for membership of the International Database for Enhanced Assessments and Learning (IDEAL) consortium. Both students and faculty members are involved in the evaluation, but it is unclear to what extent a wider range of stakeholders participate (e.g. educational and health care authorities, community representatives, professional organisations, and postgraduate training bodies).

Response:
External stakeholders will continue to be involved in the development of the programme and any changes will be based on information from consultation, assessment and evaluation.

*Q: A wider range of stakeholders **should** have access to results of course and programme evaluation, and their views on the relevance and development of the curriculum **should** be considered.*

8. Governance and Administration

8.1 Governance

B: Governance structures and functions of the medical school must be defined, including their relationships within the University.

The governance structure is well-described. External stakeholders are represented in the Faculty Board.

*Q: The governance structures **should** set out the committee structure, and reflect representation from academic staff, students and other stakeholders.*

8.2. Academic leadership

*B: The responsibilities of the academic leadership of the medical school for the medical educational programme **must** be clearly stated.*

There is an Academic Leadership programme in place. The graduate entry programme is led by a Director, who reports to the Dean annually, and a Programme Manager. However, the Team could find no information on how the academic leadership is evaluated.

Response:
Academic leadership is provided by the Dean with guidance from the Faculty Executive and the various Working Groups.

*Q: The academic leadership **should** be evaluated at defined intervals with respect to achievement of the mission and objectives of the school.*

8.3 Educational budget and resource allocation

B: The medical school must have a clear line of responsibility and authority for the curriculum and its resourcing, including a dedicated educational budget.

The Cycle Directors are said to be the Cost Managers. The Team were informed that the Dean meets the Cycle Directors to review expenditure against budget and consider budgetary requirements, including staffing. It is somewhat unclear, however, how the budgets for the direct and graduate entry programme are inter-related.

Response:
The budget for the Graduate Entry Programme provides for the dedicated facilities needed for GEP students to achieve the same level of knowledge, skills and attitudes as their counterparts in the 5 year programme in a shorter period. There is a fluid movement of staff between the programmes. GEP students have the same access to

central facilities and resources as all RCSI students. There is no separate budget for GEP students in the Senior Cycle.

The Faculty Board (via the Faculty Executive) has the authority to access and direct resources to GEP to lead and manage curricular reform through the GEP director and the various committees.

*Q: There **should** be sufficient autonomy to direct resources, including remuneration of teaching staff, in an appropriate manner in order to achieve the overall objectives of the school.*

8.4 Administrative staff and management

B: The administrative staff of the medical school must be appropriate to support the implementation of the school's educational programme and other activities, and to ensure good management and deployment of its resources.

The administrative staff appears to be appropriate to support the implementation of the school's educational programme, but the Team could find no information on how the management is reviewed and quality assured.

Response:
All RCSI staff are subject to regular Performance & Development Reviews with their Line Manager.

Q: The management should include a programme of quality assurance and the management should submit itself to regular review.

8.5. Interaction with health sector

*B: The medical school **must** have a constructive interaction with health and health-related sectors of society and government*.

The Visiting Team would welcome information on whether the RCSI have Memoranda of Understanding or contractual arrangements with teaching sites and whether there are any representatives of hospitals on RCSI committees or any regular meets with hospitals.

Response:
RCSI have Memoranda of Understanding with all our affiliated Clinical Training Sites. Regular meetings take place with staff from all Teaching Hospitals and their Representatives also serve on RCSI committees.

*Q: The collaboration with partners of the health sector **should** be formalised.*

9. Continuous Renewal

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

*The process of renewal **should** be based on prospective studies and analyses and **should** lead to the revisions of the policies and practices of the medical school in accordance with past experience, present activities and future perspectives.*

The Team are satisfied that the GEP's continuous renewal standards are appropriate.

End of report

SECTION D

APPENDICES

APPENDIX 1. AGENDA FOR VISIT

ACCREDITATION VISIT TO
ROYAL COLLEGE OF SURGEONS IN IRELAND
GRADUATE ENTRY PROGRAMME

DATE: 16TH APRIL 2009
VENUE: CONNOLLY HOSPITAL, DUBLIN

08:15 – 09:15	Private meeting of Medical Council Team
09:15 – 11:00	Meeting between Medical Council team and RCSI representatives; including academic staff, senior administrative staff and staff from main teaching hospitals
11:00 – 11:15	Tea and coffee break
11:15 – 12:15	Meeting with 3rd year students
12:15 –1:15	Meeting with 2nd year students
1:15 – 2:00	Light Lunch to be provided for Team (in private)
2:00 – 3:00	Meeting with 1st year students
3:00 – 3:15	Tea and coffee break (in private)
3:15 – 4:15	Meeting between Medical Council team and RCSI representatives, which may include any issues arising from meeting between Medical Council team and students
4:15 – 4:45	Private meeting of Team to formulate recommendations
4:45 pm	End of visit and departure of team

APPENDIX 2 – ROYAL COLLEGE OF SURGEONS IN IRELAND TEAM (LIST PROVIDED BY RCSI)

RCSI Representatives

Prof. A. Johnson	Director GEP
Dr. R. Arnett	Programme Manager GEP

Connolly Hospital Representatives

Mr. E. Mulligan	Senior Lecturer in Surgery
Dr. E. Lean	Senior Lecturer in Pathology
Dr. E. O'Neill	Senior Lecturer in Microbiology
Dr. T. Duffy	Hon. Senior Lecturer in Medicine
Dr. J. O'Neill	Hon. Senior Lecturer in Medicine

Tutors

Dr. S. Lawler
Dr. A. Bajrangee
Dr. H. Furlong
Dr. D. Murphy

RCSI

Prof. G. McElvaney	Professor of Medicine
Prof. A. Hill	Professor of Surgery (from 10:00a.m.)
Ms. D. O'Mara	Curriculum and Education Officer
Prof. S. Sreenan	Coordinator Year 2 of the Programme and senior Academic Consultant (afternoon session only)

APPENDIX 3 - ADDITIONAL INFORMATION SOUGHT BY THE TEAM AND PROVIDED BY RCSI FOLLOWING THE VISIT

Information on the Evidence Based Medicine component of the course
Information on the Molecular Medicine component of the course
Information on the Content of all the modules in the curriculum of Years 1 and 2
Breakdown per week of lectures, small group work, individual work etc
Information on method of evaluation of Clinical Placements
Examples of Old MCQs
Balance of time spent by student on clinical placement in the different sites
Balance between the different sites vis-à-vis GEP RCSI Staff numbers, patient numbers, case mix and numbers of students assigned at any one time

End of appendices

RCSI GRADUATE ENTRY PROGRAMME

REPORT OF CLARIFICATION MEETING HELD ON 28TH JULY 2009

1. Present

Dr Anna Clarke, Vice President and Chair of the Visiting Team
Professor Bill Powderly, Chair of the Professional Development Committee
Dr Anne Keane, Head of Education and Training
Professor Alan Johnson, Director, Graduate Entry Programme
Dr Richard Arnett, Programme Manager, Graduate Entry Programme
Ms Denise O'Meara, Research Nurse, Graduate Entry Programme

2. Background

A Team representing the Medical Council visited The Royal College of Surgeons in Ireland's on 16th April 2009. The Team's remit was to monitor the progress of the RCSI's provisionally accredited four year graduate entry programme (GEP), and thereafter make a recommendation to the Professional Development Committee (PDC).

That visit took place at a crucial time, with the initial GEP intake now having 'merged' with year 4 of the 5/6 year programme. Both cohorts have now completed Senior Cycle One and are about to enter Senior Cycle Two.

3. Further investigation

The Team felt that on the 16th April visit it did not have the opportunity for an in-depth evaluation of the programme *as a whole*, and the Team withheld any recommendation pending further investigation. The PDC mandated representatives to hold a clarification meeting to specifically address the Senior Cycle issues including**:** overall structure; content of modules and their objectives / specified learning outcomes; clinical skills teaching and learning, including clinical placements; distribution / numbers of students on the various clinical sites; and facilities for students on clinical sites.

RCSI provided information on these issues before the meeting on 28th July.

4. Main points of discussion on 28th July

These included:

- The links between learning outcomes and the RCSI's Medical Graduate Profile

- The structured feedback obtained from students
- The investment in staff
- Clinical rotations
- Assessment strategy

The evidence was that there was a good relationship between students on the new GEP and those on the longstanding programme, with the two cohorts bonding well. Overall, there did not seem to be any identifiable significant differences between the levels of attainment of GEP and other students, or between GEP students from science backgrounds and those with humanities degrees.

5. Noted

- The Medical Council would be reviewing its processes for accreditation but these were likely to include more in-depth visits at five year intervals with more external assessors
- The Medical Council had to strike a balance between its quality assurance role to encourage and commend and support best practice in medical schools, and its statutory regulation and approval role
- It was intended that a Team from Council would undertake an accreditation programme beginning in the autumn which would include the RCSI's five year programme.

6. Recommendation to the PDC

The Medical Council representatives at the 28th July meeting conclude that the RCSI has provided the necessary further information. It is therefore recommended that the existing provisional accreditation of RCSI's Graduate Entry Programme be continued.

7. Subsequent Action

The above recommendation will be brought to the PDC on 29th September 2009, along with the Medical Council's draft report, and RCSI's response to the draft report, of the 16th April visit.

Professor B. Powderly
Chair
Professional Development Committee