REPORT ON ACCREDITATION VISIT
UNIVERSITY COLLEGE CORK'S
GRADUATE ENTRY TO MEDICINE (GEM) PROGRAMME
20TH NOVEMBER 2008

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Note: Recommendations are numbered and in *bold italics*

A. PREFACE

1. Context of the visit

The University College Cork (UCC) has established a new four year programme leading to the award of an MB BCh BAO. It is at undergraduate (basic in WFME terminology) level with an exclusively graduate entry. UCC currently delivers a direct entry medical programme of five years duration which leads to the award of the same degree. The two "streams" will merge at the start of the Graduate Entry to Medicine (GEM) students' third year, and the direct entry students' fourth year, and spend the following two years gaining clinical experience. The UCC's GEM is derived from a common template devised by the Irish Universities Medical Consortium, which is in turn informed by the *Scottish Doctor* model.

Normally the Medical Council accredits programmes before they start, but given the exceptional circumstances arising from the changeover to a new Medical Council, it was not possible in this case and an agreement was reached that the GEM would commence, without accreditation, in September 2008.

An accreditation Team representing the Medical Council therefore undertook an initial visit on 20th November 2008. Its remit was to assess the programme and to formulate a recommendation on accreditation to the Medical Council's Professional Development Committee.

2. The Team

The Medical Council Accreditation Team is listed on the title page of this report. Special mention must be made of external assessors Professor Hans Sjöström (Denmark) and a documentation review by Professor Tony Weetman (UK), who have extensive experience of working with the World Federation of Medical Education (WFME) and the General Medical Council's Education Committee respectively. They brought additional expertise in quality assurance of medical education and an international perspective to the accreditation process, and the Medical Council appreciates their contribution. In addition, the Medical Council wishes to thank Professor Tom O'Dowd (previous Medical Council member and previous Chair of the Education and Training Committee).

The Medical Council also thanks the University College Cork Team, led by Professor David Kerins, Head of the University's Medical School, and Professor Eamonn Quigley, Interim Director of the GEM 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 two major documents produced by UCC: one written for the Medical Council: *Graduate Entry Medical Programme - Submission for Accreditation* and the other being UCC's bid document produced for the Higher Education Authority (HEA) - *Proposal for a Graduate Intake to Medical Education, January 2007*. The first document is structured in the WFME Standards format (submitted to the Medical Council in February 2008, while the latter reflects the HEA's template.

4. Schedule

The accreditation visit included a UCC presentation (by Professor Eamonn Quigley), an in-depth discussion between the Council Team and representatives of the University and a private session with students. As a number of Medical Council visits have inspected the UCC campus and some of the major Teaching Hospitals in Cork previously, it was agreed that an inspection of facilities was not necessary on this occasion.

5. Appendices

The agenda for the visit is attached as **Appendix 1**. A copy of the UCC presentation is attached as **Appendix 2**. The UCC staff who took part in the process are 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*),* informed by 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, and there are some statements by the Team about the level of UCC's attainment. However, in many cases it would be premature at this stage to assess whether the standard met is "B" - Basic - or "Q"- Quality - and in many cases the Team reserves its judgement. In a few cases, the B / Q definition is set out for information but with no comment attached.

7. Additional comments by the Team

(i) Additional documentation

The Team would have welcomed, prior to the visit, documents updating them on the changes that had taken place since UCC's original submission. Extensive documentation was provided by UCC on the day of the visit. However, the Medical Council Team was not in a position to read it. It appears that the material tabled differed in some significant respects from the earlier documentation, particularly in relation to the later years of the programme, and it would have been advantageous for the Team to have had prior knowledge of this. The Team will expect to receive any relevant updated documentation well in advance of the next visit.

(ii) Meeting with consultants from clinical sites

The Team was not able to meet consultants from some of the peripheral clinical sites, due to an oversight by UCC. This is regrettable and the Team will expect to meet them on its next visit. It is acknowledged that some staff present - including Professor Kerins and Professor Quigley - have clinical commitments at these sites.

B. SUMMARY AND GENERAL ASSESSMENT

1) Conclusion of Council Team

On the evidence of analysis of the documentation and the accreditation visit, the Accreditation Team have formed the opinion that the UCC programme is satisfactory and is designed in a way that appears likely to produce doctors who are ready to undertake an internship.

2) Main findings of Council Team

The Team make three *main* recommendations; the priorities identified for UCC are:

(a) Relations with teaching hospitals / access to clinical placements

The Team recommend that ***UCC provide information regarding Memoranda of Understanding or formal contracts with clinical teaching sites*** (although the Team recognise that these would be likely to be in respect of UCC medical students in general and not UCC GEM students in particular). The Team believes these arrangements are needed to place medical education and training on a sound footing. The Medical Council must be assured that the commitment to deliver the major clinical placements is available to UCC. ***The Team recommends that the timely recruitment of suitable staff for clinical sites should be assessed at the next visit, and should be a pre-requisite for the continuation of Medical Council provisional accreditation.***

(b) Capacity

The Medical Council recommends that ***any increase in the number of students – European Union or non-European Union - be carefully evaluated in light of the available resources, ensuring that resources – human and physical, campus and training sites – can cope with any increase without compromising quality.*** The capacity on clinical sites was a subject for Council concern in its 2006 and 2007 reports on the direct entry programme. The Medical Council must be assured that there will be sufficient capacity for the planned intake.

(c) Staff identification and assignment

The impact of any delays in appointments could be seriously detrimental. In view of the critical importance of sufficient high-calibre staff, the Team recommends that ***the timely identification and assignment of suitable staff should be a major priority for UCC.*** The Medical Council must be assured that the required staff will be in place.

3) Recommendations additional to the major recommendations (a) – (c) above:

1) ***Consider including team working, more explicit links with postgraduate training, and patient safety among the objectives.***

2) ***Find ways of increasing input from other external stakeholders, including professional organisations, postgraduate training bodies, the public, and relevant lay organisations.***

3) ***Ensure that the number of students in clinical demonstrations continues to be kept as low as possible.***

4) ***Provide appropriate guidance and direction on sources of information, depth of knowledge, and level of detail that students are expected to acquire in the various elements of the programme.***

5) ***Students should have knowledge of the general principles, language and experimental methods of the different traditional disciplines (anatomy, biochemistry, etc).***

6) ***Consider making the psychology module less theoretical and more applied.***

7) ***Consider introducing a 'history taking in sensitive areas' component.***

8) ***Monitor the number of real patients: number of students in terms of future capacity.***

9) ***Look to enhance interaction with direct entry students, to the advantage of both cohorts.***

10) ***Take care that multiple assessment pathways does not lead to 'over-assessment'.***

11) ***The issue of timely notification of offer of a place be addressed by the relevant authorities, principally the Central Applications Office.***

12) ***Consider if any action can be taken regarding the impact of financial pressure on students.***

13) ***Introduce mentorship at the commencement of the course.***

14) ***Continue staff development in Problem–Based and small group teaching.***

15) ***Production (if not already in place) of guidelines/ rules for safe learning environments.***

16) ***Maximise potential for primary and community experience.***

17) ***Develop audio-visual links to peripheral sites.***

18) ***Maximise access to library facilities.***

19) ***Consider an expanded role for General Practitioners and external examiners to contribute their expertise.***

20) ***Maximise patient and lay person involvement in the programme and its governance.***

4) ***<u>The Team commends UCC for:</u>***

1) A Student centred case-based programme

2) Early clinical exposure, clinical skills, and laboratory facilities

3) Committee arrangements for liaison regarding clinical issues

4) Role of behavioural and social sciences

5) Students' impressions of the programme, which are generally very positive

6) Looking for ways to involve patients

7) Student involvement in decision making

8) The profile of communication skills in the programme and their assessment

5) ***<u>The Team request the following information/ clarification from UCC:</u>***

1) Where in the programme the basic element of design of epidemiological studies is taught.

2) Comments on the issue of whether / why optional content is only ten credits.

3) Number of credits accruing from the four weeks summer elective in Year 2 and the six weeks summer elective in Year 3.

4) How many of the teachers on the GEM are active researchers.

5) The definition of the different outcome terms (understand, define, describe, outline, perform and so on) in relation to assessment requirements.

6) Whether the curriculum committee has oversight of both the GEM and direct entry programmes.

7) Clarification regarding the role of molecular biology or gene technology in the programme.

9) The amount of time spent on examinations (student and teacher perspective).

10) Clarification on the University policy on students with disability.

11) Whether / why UCC anticipates some delay in the roll-out of some of the new appointments for Years 3 and 4.

12) Balance of recruitment (medical and non-medical staff, full and part-time) staff.

13) Collaboration with any other educational institutions (outside of the IUMC framework).

14) (In due course) the results of evaluation, both interim and at the end of Year 1.

6) **<u>The Team's recommendation to the Medical Council Professional Development Committee</u>**

***The Visiting Team recommends that the Professional Development Committee recommend to the Medical Council the provisional accreditation of University College Cork's graduate entry programme*.** This is contingent upon an assurance that the University will address the issues raised in this Report, and that the University will ensure that the three major issues identified are satisfactorily resolved.

In line with Medical Council policy and procedure, full accreditation is not possible until the first cohort of students has successfully completed the programme.

7) Recommended Further action

On-going engagement with UCC will be a key part of the quality assurance process. ***The Team recommend a monitoring re-visit in early summer 2009 (at a time when the Team can meet the students).*** At this visit, the Team will assess progress, have discussions with the first cohort of students as they finish their first year, hold discussions with teachers (including clinical teachers), and visit clinical training sites.

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 Team felt that overall, the mission and six major objectives are defined and are congruent with the educational process that will produce competent doctors as defined above.

The Medical School are convinced of the value of the two stream approach; the Team endorses the view that both the traditional five year direct entry and the new graduate entry routes have a role to play in student recruitment.

UCC's perspective is that in the graduate entrants they are educating a different type of student but do not have a mission to produce a different type of doctor; the intended outcome of the graduate entry programme is essentially the same as the outcome of the traditional direct entry programme, a competent doctor.

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

The Team recommend ***(Recommendation – R 1) that consideration be given to including team working (possibly linked to multi-disciplinary student interaction), more explicit links with postgraduate training, and patient safety among the objectives.***

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 mission statement appears to be based on input from relevant internal stakeholders including the basic science faculty, clinical faculty, education leaders and administrators.

*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).*

Input from graduates on the direct entry programme, and from colleagues within the Irish Universities Medical Consortium was apparently obtained. ***UCC could consider, in addition, finding ways of increasing input from other external stakeholders, including professional organisations, postgraduate training bodies, the public, and relevant lay organisations (R 2).*** The Team appreciate that the lead in time for the commencement of the programme was reduced from a planned one of approximately

two years to six months, and that this may have had an impact here, but it should be borne in mind for the future.

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.*

UCC states that the Medical School had complete autonomy in developing the programme's mission and objectives, its design and 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 agreed learning outcomes centre on four major themes and 12 learning objectives.

The Team feel that these are generally well described and appropriate, although some clarification of the definition of the different outcome terms (understand, define, describe, outline, perform and so on) would be helpful in relation to assessment requirements.

The material provided was not homogeneous and a complete set of learning outcomes will be analysed by the Team in the future.

The indicative learning objectives as presented in the original document appear to require some corrections and streamlining (e.g. GEM 12001; Cardiovascular Health & Disease) and the Team would welcome clarification as to whether this has been revisited.

Furthermore, the Team believe that it is very important that all teachers adhere to the same standards in terms of the learning outcomes to ensure consistency across the spectrum.

*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.*

Under the Irish system, all medical schools have an active role in the intern year, with the Deans signing off the experience of interns at the end of their first postgraduate year. The role, under the Medical Practitioners Act 2007 will fall to the Medical Council. There will be active engagement between the hospitals, the Medical School and the Medical Council in the development of guidelines for interns.

There did not appear to be any reference to the European Tuning Project MEDINE.

2. Educational programme

2.1. Curriculum models and instructional methods

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

UCC stresses the integrated nature of the programme, with integration of medical and behavioural sciences with early exposure to clinical practice, that it is a one cycle system and is in compliance with the EU Directive 2005/36/EU. The information provided by UCC appears to support this.

The various instructional methods (five) are described. The Team note that there appear to be no laboratory practicals or individual anatomy dissections and these are replaced by demonstrations. The students in the Graduate Entry Programme engage in more laboratory 'wet' practicals than any other cohort of students in the Department of Physiology. They attend anatomy and/or histology laboratory sessions once or twice each week. The laboratory is well equipped and teaching sessions are interactive in nature, consisting of small-group demonstrations and periods where students examine anatomical dissections, histological slides and other resources. ***The Team recommend that the number of students in demonstrations should continue to be kept as low as possible (R 3).***

The instructional methods during clinical rotations appear to be less well described and should be a matter for later review.

The students also have the flexibility to design some modules to reflect their specific interests.

*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.*

This is a feature of graduate entry programmes in general, and is evident in both the UCC and the students' approach.

While the students welcome the opportunity to be responsible for their own learning process, ***some of the students expressed uncertainty regarding the level of detail that is required of them in some elements of the course***. This may be due to the fact that the course has only recently commenced, and it may become clearer after assessment; ***but UCC should address it (R 4).***

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.*

The Team felt that the curriculum is based on the principles of scientific method and evidence-based medicine.

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

The Team felt there was an emphasis on training in scientific thinking and research methodology with opportunities for elective research projects. However, it is important

that a significant amount of teaching is given by teachers who have a research background and current research profile (although not necessarily exactly within the field taught), as this enriches the student experience. The Team acknowledges UCC's track record in research but would like clarification as to how many of the teachers on the GEM are active researchers.

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.*

In terms of the challenge of teaching students without a traditional science background, the Team were assured by the students that those without a science background felt supported and that help was available where needed. The first semester of Year 1 is designed to familiarise all students with the basics of human biology, and the Team recognises the importance of these early introductory sessions.

The Team recognise that in more modern programmes, the amount of medical science in the curriculum may be less "obvious" than in the more traditional departmentally delivered pre-clinical / clinical programmes. The Team feel that ***students should have knowledge of the general principles, language and experimental methods of the different traditional disciplines such as anatomy, biochemistry, physiology, pharmacology and pathology, and UCC should monitor this (R 5).***

There is clear integration between medical science and clinical sciences and the Team endorses this approach of applying scientific knowledge to clinical problems rather than teaching them in isolation. In this context, the curriculum has a reasonable amount of biomedical sciences, with some possible exceptions. The terms molecular biology or gene technology do not appear and these are areas of great importance in medicine today. The Team would welcome clarification.

*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.*

The Team welcomes UCC's acknowledgment of the key role of behavioural and social sciences, and notes the relevant modules and topics including Person, Culture and Society, Health and Disease in Society, and Cognitive and Behavioural Science.

The Medical Council urges that communication skills are at the core of all medical programmes and is generally satisfied with the UCC programme in this respect. Communication skills are assessed during the OSCE examinations. The overall impression is that communication skills are a high priority and are an integral part of assessment process and the Team commend this approach. It is important that UCC do everything possible to reinforce the message to students that communication is not a "soft" subject, but is a key part of patient safety, given that poor communication skills are a major factor in many examples of clinical error. The Team will be interested in the students' views in this respect as the programme rolls out.

The Team suggests that the psychology module, while very good, could be less theoretical and more applied (R 6). The student response to psychology appeared to be mixed.

A lecturer, qualified in law, is involved in the teaching of ethics. With regard to learning about sensitive issues, the students are learning about their own stress management, breaking bad news and other issues, in the life skills programme. ***The difficulties students and young doctors may have with sensitive issues (e.g. suspected drug or alcohol abuse, HIV status, child abuse etc) could be addressed via a 'history taking in sensitive areas' component at the appropriate stage, using a bank of scenarios and preferably cases picked up in clinical attachments (R 7).***

It was noted that the issue of involving non-medical experts and advocates (e.g. patients with relevant health or lifestyle backgrounds) in the programme had been explored, and the Team encourages this.

In the original documents the Team do not find basic epidemiological terms as cohort, intervention study, case/control in the content/outline and would welcome such clarification as to where the basic element of designs of epidemiological studies is taught, although some clarification was provided in the documentation presented to the Medical Council on the day of the visit.

*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.*

UCC acknowledged that there had been something of a deficit in practical clinical skills in the curriculum of medical schools in Ireland and the programme aimed to address this. The first contact with hospitals was in the middle of November and students on the UCC Graduate Entry Programme were due to undertake their first clinical exposure in General Practice later in November, with real patients. Three attachments of six weeks each begin in Year 2. UCC therefore fulfil the need in a modern curriculum for early patient contact and the students seemed eager to experience it.

Some patients from the teaching hospitals have agreed to take part in the learning experience of the students and they meet with the students to talk about the impact of illness, disease and symptoms on their lives and the lives of their families.

The Team flagged the importance of medical students learning with and from other health professions and were assured there is a multi-disciplinary approach, facilitated by the multi-disciplinary nature of the Brookfield Health Sciences Complex.

The Team accept that the clinical skills laboratory is well-planned, equipped and frequently used. However it cannot replace the real patient contact. ***The number of real patients in relation to the number of students must be monitored by UCC in terms of future capacity (R 8).***

The Team note that a first aid course for students is planned for January or February 2009 as part of the GM1004 module, during which they will engage in first aid and basic procedural skills.

*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 context, extent and sequencing of the constituent elements appear to be defined, including the balance between core and optional elements.

The balance between elective and compulsory modules was noted: as far as the Team can see from the material distributed during the assessment meeting, optional content is only ten credits. The Team appreciates that this must be seen in terms of the graduate intake, where the students often have project experience from other fields, but would welcome UCC's comments on the issue.

The curriculum uses the European Credit Transfer System (ECTS). The allocation (which appears to have changed since submission of the original questionnaire) now seems to be 75 + 75 + 60 + 60 = 270 credits. This appears to make the number of credits for the first two years larger than the average recommended, and presumably reflects an intensive workload and long semesters in the first two years. The calculation is however, somewhat unclear as it is difficult to find out the duration of some modules.

The nature of the four weeks summer elective in Year 2 and the six weeks summer elective in Year 3 mentioned in the original material is unclear in relation to calculation of credits and the Team would welcome clarification.

*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.*

The Team feels that this is satisfactory. There is a curriculum and student affairs committee (obviously without resources of their own). However, the Team would welcome confirmation or otherwise of its impression that the curriculum committee has oversight of both the GEM and direct entry programmes. The Team has no settled view on the advisability or otherwise of this, but it assumes that UCC will keep it under review as the GEM programme rolls out. ***Interaction between the student cohorts should be fostered (R 9).***

*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.*

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.*

The Team acknowledges that the programme has recently commenced. The graduate to intern transition is dealt with elsewhere, as is the issue of campus/clinical sites teaching. The Team commend the hospital and community liaison committee within the School and direct representation of the Health Service Executive in the College at School level. The practical impact of these links will become clearer as the programme progresses and UCC and the Medical Council should keep them under review.

*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.*

There is a broad spectrum of assessment methods which aim to ensure that all aspects (knowledge, skills and attitudes) are assessed. Details of assessment are outlined in the document "Marks and Standards 2009" given to the Team during the visit.

There are multiple assessment pathways and ***the Team recommend that the Medical School should take care that this does not lead to 'over-assessment' (R 10)*.** The Medical School assured the Team that they listen to the student feedback in this area and that the students' view is that there is no over-assessment.

However, the Team asks the Medical School to quantify the amount of time spent on examinations from both the student and teacher perspective. There is potential for the students could be on permanent 'exam footing' and for teachers to be over-burdened with examining, especially with project marking.

These are potential rather than actual concerns as it is difficult to evaluate, at this stage, whether there is too much assessment in the programme, but the Team recommends that UCC and the Medical Council monitor it. It is equally important that both UCC and the Medical Council monitor the balance of formative and summative assessment.

There is participation of external examiners and their tasks and obligations are determined by the rules of University College Cork. External Examiners are appointed by the Senate of the National University of Ireland following nominations submitted by a Head of Department or a Head of School to the Head of College or Dean of Faculty for approval. They are normally appointed for a three year period.

It was noted that the appeals procedure was that followed in all UCC programmes.

*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.*

Students expressed some concern that because this is the first year of the Graduate Entry Programme, there are no past exam questions from which to prepare for the examinations. Ensuring that that students are clear as to what level of detail they are to be examined in links in with R 4.

The Team was gratified to note that students will not pass the clinical components of the programme – and therefore the programme as a whole - if they are assessed as being unable to communicate appropriately with patients.

*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.*

A final evaluation of the relationship between educational objectives and assessment, must await an analysis of the examinations given.

4. Students

Overview

The Team met all 38 students from the Graduate Entry Programme. The students feel that they are working well together as a group and that there is a supportive rather than a competitive element to the group. The profile of students is approximately 70:30 science to non-science backgrounds and the students felt that some of the non-science graduates may have had more to do than the science graduates, but that overall, they were coping well with the workload.

The students wished to have some overlap with the direct entry programme, to prepare them for integration in Year 3, and this appears to have been successfully managed thus far.

The students were concerned that they received an offer of a place at very short notice, and felt that this placed additional pressure on them in terms of working out notice at previous jobs and organising accommodation in Cork. The international students, in particular, felt that the late confirmation resulted in them being disadvantaged in terms of the allocation of campus accommodation.

The students felt that the timing of the Graduate Medical School Admissions Test (GAMSAT) is a critical issue. They pointed out that it is currently held in Ireland in March, whereas it is possible to sit it in September in the UK. The date of the GAMSAT may not be the key issue in the delay in notification, despite the students' perception. However, the Team does share the students' concern about the delay and ***the Team urges that the issue of timely notification of offer of a place be addressed by the relevant authorities, principally the Central Applications Office (R 11).***

There was significant discussion with the students regarding their financial situation and students had been informed by the University that their fees are subject to inflation. The students are aware that any increase in fees, and fluctuating exchange rates, could result in additional pressures on them, and perhaps adversely affect drop-out rates. The Team recognises that the students cannot be protected from financial pressure, ***but urges UCC to do everything that it can to mitigate its adverse impact (R 12).***

The feedback from students was generally very positive and enthusiastic about their experience thus far. The students were particularly complimentary about the supportive and empathetic interactions with staff.

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.*

The admissions policy at UCC is clear; it is based on a minimum of a 2.1 degree and the results of the Graduate Medical School Admissions Test (GAMSAT).

*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 Team acknowledges that pre-entry assessment of relevant non-academic factors, including incentive for a career in medicine, is difficult; although the maturity of the

students and the financial and other commitments they are making would suggest a high level of motivation.

There was some discussion as to whether interviewing should be included as part of the admission policy, in terms of identifying those unprepared or unsuitable for the programme. It was noted that in other jurisdictions, GAMSAT is regarded as a prelude to interview. However, in line with all other medical schools in the State, UCC does not interview prospective students. The team did not find mention of students with disability and would like clarification on the University policy.

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.*

UCC have revised their plans to take 25 European Union students next year; the number will remain at 20 and non-European Union numbers have been increased to make up the shortfall. The issue of capacity is discussed further elsewhere. The size of the student intake is not specified in relation to the needs of the community, but it is appreciated that it is not the role of UCC to analyse the future workforce needs of the Irish health system. The Medical Council urges the relevant authorities to undertake this, in terms of both supply and demand.

*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 students and the Team feel that the UCC services are satisfactory. At Medical School level, students felt that the staff were very attentive to their needs. ***Students have a mentor, but felt that mentorship was arranged some way into the term and that it may have been of more value if their mentor had been appointed at the commencement of the course. UCC should review this (R 13).***

There was detailed written information on UCC Student Health Department provided to the Medical Council Team on the assessment day.

*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.*

Overall, the students felt that they have the power to influence the Medical School, both through formal processes and day-to-day interactions and that the School responds positively to their suggestions, where possible. The students felt that issues they raise are listened to and addressed.

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

5. Academic Staff/Faculty

5.1. Recruitment policy

*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.*

There are UCC guidelines on policy on staff recruitment and employment.

The Team were assured by UCC that despite financial constraints, the Medical School and the University are committed and are able to deliver the programme as outlined. The Medical Council will monitor this.

In terms of recruitment, there have been some new appointments made for Year 1 and Year 2. ***The Team's perception was that UCC anticipated some delay in the anticipated roll-out of some of the new appointments for Years 3 and 4, and seeks clarification of this. In view of the critical importance of sufficient high-calibre staff, the Team recommends that the timely identification and assignment of suitable staff should be assessed at the next visit, and should be a pre-requisite for the continuation of Medical Council provisional accreditation (Main finding (c)).***

It was noted that Professor Quigley is the interim Director, and that UCC expect to make a permanent appointment in the near future.

In the original material there is a specification on appointments in different disciplines. The Team were informed that the appointments of new faculty for this programme were made within the departmental structures within UCC and of the PhD appointees, many hold PhDs in the basic disciplines. In addition, all appointees are research active. Two lecturers have been recruited for anatomy, two lecturers in physiology, one lecturer in biochemistry, one lecturer in pathology, one lecturer in pharmacology and therapeutics, one lecturer in behavioural science and one senior lecturer in epidemiology. However, there did not appear to be specifications on the balance of recruitment between medical and non-medical staff and full and part-time staff. The Medical Council would welcome clarification on this.

*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.*

There are several initiatives for training of both new and existing teachers: UCC provide postgraduate Certificate, Diploma and Masters qualifications in Higher Education, a staff enhancement development committee and training days. It is especially noted that there is a GEM facilitators' training day, with examples of training material given to the Team during the assessment meeting. It was noted that UCC have a cadre of staff trained in Problem–Based and small group teaching, ***and the Team emphasise that UCC should***

have on-going staff development to develop expertise in this relatively new approach to teaching and learning(R 14).

*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 Team were assured by UCC that the Brookfield Health Sciences Centre was designed to include the numbers now envisaged for the graduate entry programme. It is also anticipated that the Western Gate building (currently under construction) will enhance resources.

Members of Medical Council Evaluation Teams have previously visited the facilities at Brookfield and many of the teaching hospitals associated with University College Cork (including CUH), so those facilities were not inspected on this occasion.

However, it is emphasised that all facilities must meet the capacity requirements of the new GEM students, for this and future years. The Team urges that both UCC and the Medical Council give a high priority to monitoring this, and that ***on-going provision of suitable facilities, on and off campus, should be a pre-requisite for the continuation of Medical Council provisional accreditation (Main finding (a)).***

The Team urges the production – if they are not already in place – of guidelines and rules for safe learning environments (R 15).

*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.*

On the evidence available, there appears to be a reasonable mix of clinical settings and rotations through disciplines. It is noted that some clinical placements at the Midwestern Regional Hospital Limerick are likely be occupied by students from the University of Limerick, but plans for training in Tralee and Clonmel are progressing as planned.

The Team sought, and was given, an assurance on the availability of clinical training resources. ***However, the Team urges that both UCC and the Medical Council monitor this very closely as the programme progresses towards major clinical attachments (Main findings (a) and (b))***. The Team think that it should be a major focus of the Medical Council's next visit.

The Team also urges more primary care engagement, both to exploit the potential of these sites and to enhance the students' educational experience (R 16).

*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.*

This appears to be up-to-date with an effective Blackboard system and a teleconference facility in the main lecture hall. The University has a computer centre and a computer training centre. There should be wireless access throughout the campus. ***The Team recommends that audio-visual links to peripheral sites is a necessity and that progress should be monitored at the next Medical Council inspection (R 17).***

Library access - the opening hours of the Health Sciences Library - appears to be an issue with students, particularly access in the evenings and outside "normal" college term times, when the graduate entry students are still studying. ***The Team recommends that UCC do everything that it can to accommodate the needs of the students(R 18)****;* the use of student invigilators in libraries was mooted by students as one possible solution.

*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 physical research facilities are described by UCC. The need for research activity to inform teaching is dealt with under Item 2.2 of this report. The Team appreciate that the profile of research on the GEM might differ significantly from that on the direct entry programme, for two main reasons:

- The fact that students are graduates has given them much more prior opportunity to undertake research than is the case for direct entry students.
- The intensiveness of the course may make it more difficult to find opportunities.

The Team's impression is that UCC is aware of the role to be played by research, and of the need for students to engage with it. Fostering a spirit of enquiry is one of the six major objectives.

There appears to be sufficient opportunity for research activities in two five-credit electives in Year 2 and Year 3 along with research skills workshops in Year 1 and Year 2. Details on a final year project are given in the material distributed during the assessment meeting.

*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.*

The Team recognise the internal expertise of those involved in planning and development, including the Head of Medical Education, a part-time lecturer in Medical Education and Administrative support at Kerry and Tipperary and a planned medical education centre in a new Clinical Centre. The Team looks forward to the appointment of a permanent Director of the Graduate Entry Programme.

There appears to be good educational facilities for General Practitioners with educational support days and training the teacher at peripheral sites. ***However, the Team wonder if there could be an expanded role for General Practitioners and external examiners to contribute their expertise and recommends that UCC consider this (R 19).***

*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.*

The Team is aware that the GEM uses a common IUMC "template". The Team would welcome any additional information about collaboration with any other educational institutions.

As noted, the programme operates within the European Credit Transfer System.

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

The Team would welcome more detail on plans.

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.*

The mechanisms for programme evaluation are detailed and are presented in line with the above. However, as the programme has only just commenced, the Team would like the results of evaluation, both interim and at the end of Year 1, to be provided to the Medical Council.

*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 students were satisfied with current arrangements. The Team believe this has the potential to develop into a very systematic two way process, and will follow developments with interest.

*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.*

Student performance will be analysed with respect to student satisfaction, pass rates, dropout rates, and career choices. Obviously analysis of long-term student outcome is not yet possible but there are plans to initiate it in due course, along with some special analyses relevant to the graduate entry cohort. The Team will be especially interested to assess any identifiable significant differences in outcome between UCC's direct and GEM cohorts.

*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.*

The Team notes the range of stakeholders.

*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.*

The Team notes that there is some exciting work being done (e.g. by the Picker Institute in the UK) with regard to involving patients, and this might be explored by University College Cork.

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 structures and relationships are generally clear and include a description of Medical School committees. The Team were pleased to see that the Director of the Graduate Entry Programme will be a member of all relevant committees.

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

The Team felt that participation by external stakeholders seems to be limited and recommends that the Medical School explore the role for lay people in governance (R 20).

8.2. Academic leadership

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

The academic leadership is well defined.

*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.*

This appeared to be clearly described. It was noted that fiscal responsibility had been devolved to the Head of the College, but that management responsibility for human resources (with the exception of some staff promotion-related functions) were not devolved.

UCC acknowledged that the GEM programme is not immune to the impact of the national economic downturn. As previously mentioned, the Team were assured that despite the financial constraints inherent within the current climate, the Medical School and University College Cork are committed and are able to deliver the programme as outlined.

The Team are aware that the less didactic, more student-centred approach to teaching and learning – which the Medical Council fully endorses – is more resource intensive than traditional methods. However, the Team notes that the programme has been started on a small scale, and deliberately so.

The Medical Council recommends that any increase in the number of students – European Union or non-European Union - be carefully evaluated in light of the available resources, ensuring that resources – human and physical, campus and training sites – can cope with any increase without compromising quality (Main findings (a) and(b)).

*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.*

It is noted that in addition to the existing staff of the School, a new executive assistant has been recruited, who has primary responsibility to support the programme and its related activities. Job descriptions are subject to regular review. UCC will no doubt monitor any additional requirements necessary to support the GEM, and the extent to which the GEM and the direct entry programme will or will not have to be administered "separately" due to inherent differences.

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

It is noted that this is UCC policy.

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*.

This issue has been commented upon earlier.

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

The Team would welcome clarification regarding Memoranda of Understanding or formal contracts with clinical teaching sites, whilst recognising that these would be likely to be in respect of UCC medical students as a whole general and not UCC GEM students in particular. The Team believes these arrangements are needed to place medical education and training on a sound footing (Main findings (a) and (b)).

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.*

There are mechanisms, for this which are described by UCC, and the Team are pleased to note that there is a UCC standard for ongoing renewal.

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

End of report

SECTION D

APPENDICES

APPENDIX 1. AGENDA FOR VISIT

ASSESSMENT OF GRADUATE ENTRY PROGRAMME

DATE: THURSDAY 20TH NOVEMBER 2008
VENUE: UCC BROOKFIELD HEALTH SCIENCES COMPLEX

8.30 am	Start
8.30 - 9.15 am	Private meeting of Team
9.15 - 9.45 am	Presentation by UCC and overview of new programme
9.45 - 10.45 am	Meeting between Medical Council Team and UCC representatives; including academic staff, senior administrative staff and staff from main teaching hospitals
10.45 - 11.15 am	Tea/Coffee
11.15 - 12.15 pm	Meeting with students
12.15 - 1.00 pm	Lunch
1.00 - 1.30 pm	Clarification session between Medical Council and UCC representatives. To include any issues arising from meetings between Medical Council team and students
1.30 - 2.00 pm	Private meeting of Team and departure of Team

APPENDIX 2. PRESENTATION BY UNIVERSITY COLLEGE CORK

UCC

Graduate Entry to Medicine University College Cork

Presentation to Medical Council
November 20th 2008

UCC

History

- UCC first admitted medical students in 1849
- Change from 6- to 5-year programme, with the elimination of the pre-medical year
- Curriculum review and reform of 5-year, direct entry, programme completed 2005; now up to year 4
- Move to Brookfield HSC 2005
- Creation of College of Medicine and Health June 2008

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UCC

GEM at UCC

- Long tradition of graduates in direct entry programme (Non-EU and Mature)
- Committed to **both** direct and graduate entry streams
- Developed outline GEM programme 2006
- Co-applicants, IUMC application January 2007

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UCC

National Graduate Medical Education Programme

A New Perspective in Medical Education

National University of Ireland, Galway | University of Dublin Trinity College | University College Cork | University College Dublin

UCC

National Graduate Medical Education Programme

- Covers all of Ireland
- Aligns broadly with HSE map
- 4 Centres with satellite clinical facilities
- Opportunity for North/South Collaboration

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UCC

- April 2007
  - HEA invites IUMC to re-apply
- November 2007
  - UCC and UCD granted permission to initiate GEM in September 2008
    - Student numbers UCC:
      - EU: 20, 25, 29 over 3 years
      - Non-EU: 20-25
- January 2008
  - Approval UMG/UMT at UCC
  - Notification to HEA of availability of places

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Mission Statement

- To provide graduate students with an integrated, holistic, student-centered medical curriculum based on the principles of adult learning and emphasizing professionalism and life-long learning skills

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Learning Outcomes

- Diagnose, explain and manage health problems using the current scientific principles, knowledge and understanding that underpin medicine whilst demonstrating a sound knowledge of the biological, social and psychological basis of health and disease
- Communicate effectively and compassionately with patients, carers, colleagues and society in all relevant media necessary to provide high quality and scientific patient care
- Perform a range of clinical skills and procedures safely, reliably, unsupervised and to the standard of a pre-registration doctor
- Identify, evaluate and apply evidence to their practice of medicine whilst demonstrating an understanding of how such knowledge is created, shaped, appraised and shared

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Learning Outcomes

- Apply their knowledge of the ethical, regulatory and legal framework within which they operate to their practice of medicine whilst recognising the roles and contributions of other healthcare professionals to the provision of high quality holistic patient care
- Provide the highest levels of ethical, rational and humane care to all patients they encounter whilst managing effectively the resources available to them
- Apply effectively knowledge of principles of health promotion and disease prevention at individual and population level to their practice of medicine
- Manage their own personal development and demonstrate an ability to contribute effectively to the teaching and development of other health care professionals

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General Principles

- Entry criteria and admissions determined centrally through CAO for EU; through International Student Office and Atlantic Bridge for non-EU
- Integrated, systems-based course
- Clinical contact *ab initio*
- Emphasis on:
  - learning and self-directed learning
  - small group learning
  - community-based experience
  - professionalism
  - research skills

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Basics

- 4-years
  - Year 1: 40 weeks
  - Year 2: 40 weeks
  - Year 3: 35 + 6 weeks
  - Year 4: 35 weeks

    Total: 150 weeks + 6 (>5500 hours)

    270 credits
- 45 students per year, *ab initio*,
  - 20 EU (21)
  - 20 per year, non-EU (North American) (22)

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Structure

- **Four Streams**
  - Biomedical Science
  - Clinical Science and Practice
  - Person, Culture and Society
  - Student-Selected Components (SSC's)
    - Research Projects
    - Electives

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UCC

Learning Methods

- **Sign-Post Seminars**
  - To:
    - Deliver essential didactic material, basic concepts
    - Set goals and objectives for module/section/ activity
    - Guide student reading
    - Define assignment objectives
      - 25 mins duration, each morning
      - Faculty delivered

UCC

- **Small-Group Learning**
  - **The core learning activity**
  - 7 students per group
  - Case-based
    - Cases written to integrate and apply biomedical sciences, link basic science to clinical practice and place problems in social context
  - Each group to meet twice per week
    - Mon-Thurs or Tues-Fri
    - Duration 1 hour
    - Faculty facilitated
    - Additional case-based encounters in other topics

UCC

- **Demonstrations**
  - Biomedical Science
  - Computer lab/Biostats
  - Clinical or Communication Skills
  - Clinical/Bedside
    - Duration 2 hours
    - Faculty-led
    - Clear objectives

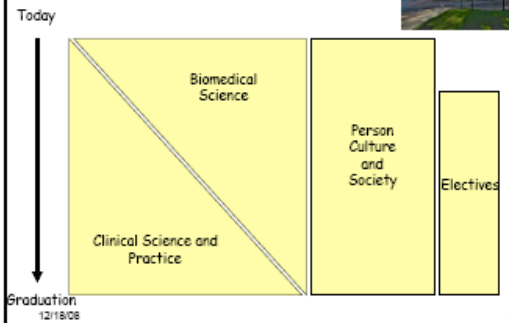
UCC

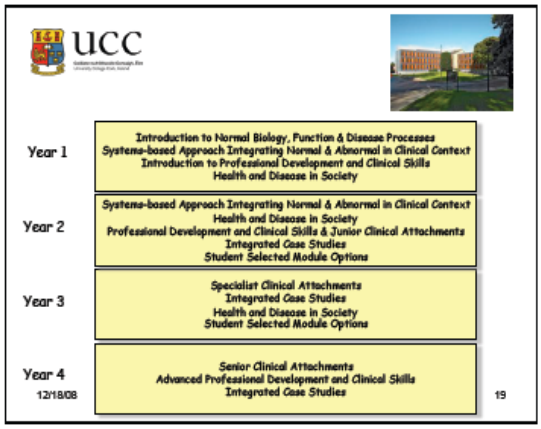
- **Experiential**
  - Clinical rotations
  - Electives
  - Clinical Skills Lab
    - All have defined goals and specified outcomes
      - Duration varies
      - Student led, faculty assisted

UCC

- **Self-Directed**
  - Laboratory
  - Computer lab
    - Computer-Assisted Learning
  - Clinical skills lab
  - Communication skills lab
  - Library- and web-based (e.g. histology)
  - Research-based
  - Projects
    - All have defined goals and specified outcomes
      - Duration varies
      - Student led, faculty assisted

UCC




UCC
Year 1
Introduction to Normal Biology, Function & Disease Processes
Systems-based Approach Integrating Normal & Abnormal in Clinical Context
Introduction to Professional Development and Clinical Skills
Health and Disease in Society
Year 2
Systems-based Approach Integrating Normal & Abnormal in Clinical Context
Health and Disease in Society
Professional Development and Clinical Skills & Junior Clinical Attachments
Integrated Case Studies
Student Selected Module Options
Year 3
Specialist Clinical Attachments
Integrated Case Studies
Health and Disease in Society
Student Selected Module Options
Year 4
Senior Clinical Attachments
Advanced Professional Development and Clinical Skills
Integrated Case Studies
12/18/08
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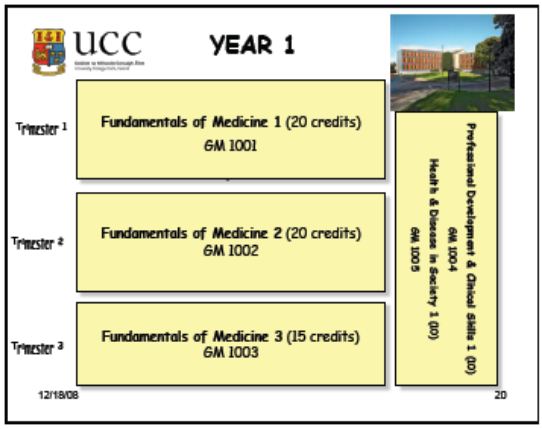
UCC
YEAR 1
Trimester 1
Fundamentals of Medicine 1 (20 credits)
GM 1001
Trimester 2
Fundamentals of Medicine 2 (20 credits)
GM 1002
Trimester 3
Fundamentals of Medicine 3 (15 credits)
GM 1003
Professional Development & Clinical Skills 1 (10)
GM 1004
Health & Disease in Society 1 (10)
GM 1005
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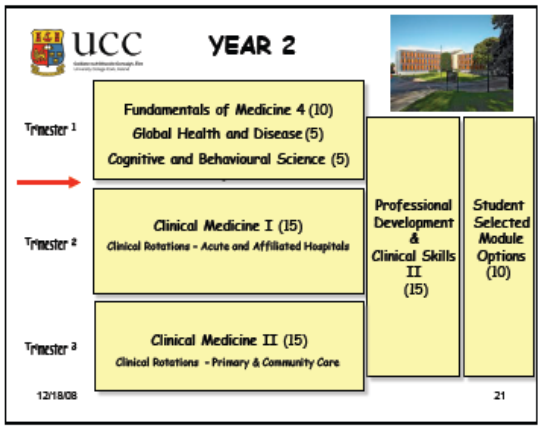
UCC
YEAR 2
Trimester 1
Fundamentals of Medicine 4 (10)
Global Health and Disease (5)
Cognitive and Behavioural Science (5)
Trimester 2
Clinical Medicine I (15)
Clinical Rotations - Acute and Affiliated Hospitals
Trimester 3
Clinical Medicine II (15)
Clinical Rotations - Primary & Community Care
Professional Development & Clinical Skills II (15)
Student Selected Module Options (10)
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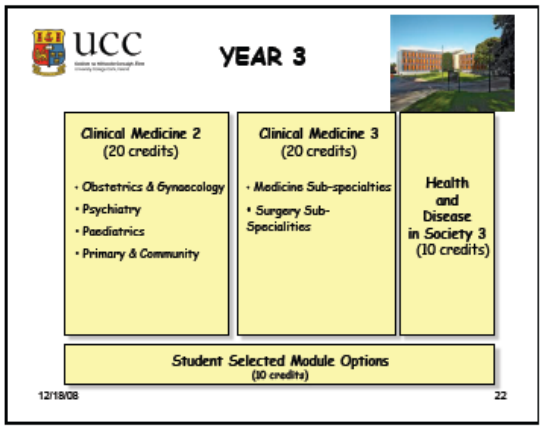
UCC
YEAR 3
Clinical Medicine 2 (20 credits)
• Obstetrics & Gynaecology
• Psychiatry
• Paediatrics
• Primary & Community
Clinical Medicine 3 (20 credits)
• Medicine Sub-specialties
• Surgery Sub-Specialities
Health and Disease in Society 3 (10 credits)
Student Selected Module Options (10 credits)
12/18/08
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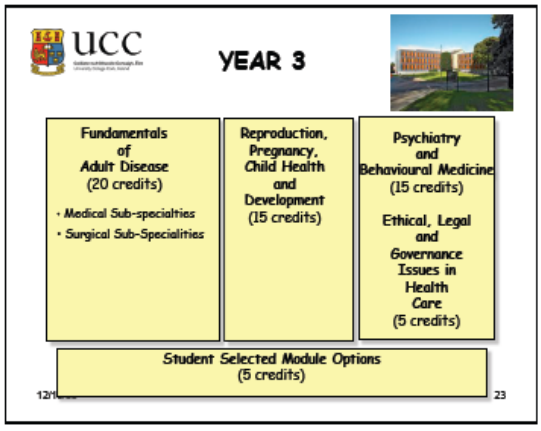
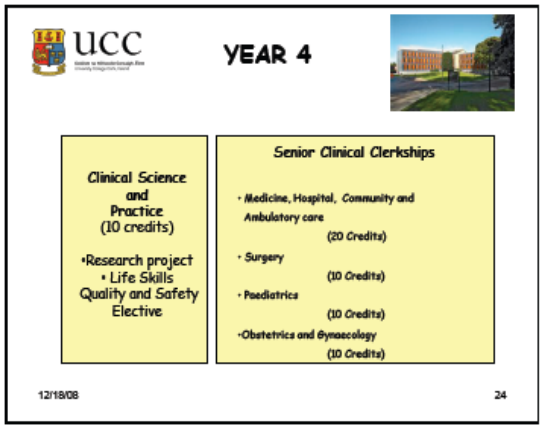

UCC
YEAR 3
Fundamentals of Adult Disease (20 credits)
• Medical Sub-specialties
• Surgical Sub-Specialities
Reproduction, Pregnancy, Child Health and Development (15 credits)
Psychiatry and Behavioural Medicine (15 credits)
Ethical, Legal and Governance Issues in Health Care (5 credits)
Student Selected Module Options (5 credits)
23


UCC
YEAR 4
Clinical Science and Practice (10 credits)
•Research project
• Life Skills
Quality and Safety
Elective
Senior Clinical Clerkships
• Medicine, Hospital, Community and Ambulatory care (20 Credits)
• Surgery (10 Credits)
• Paediatrics (10 Credits)
•Obstetrics and Gynaecology (10 Credits)
12/18/08
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2008-2009
Term dates
Year I: 40 Weeks

Term 1
1 September – 12 December
(includes 1 week of assessment: 8 – 12 December) = 15 weeks

Term 2
5 January – 24 April
(includes Easter week + 1 week of assessment 20 – 24 April) = 15 weeks

Term 3
27 April – 3 July
(includes 1 week of assessment: 29 June – 3 July) = 10 weeks

Assessment

- Knowledge
- Skills
- Attitudes

Assessment

- Outcomes
  - Knowledge
    - EMQ's/MCQ's – essential understanding, interpretation, application
    - OSCE's – clinical knowledge and interpretation
    - End-of year exams – knowledge and interpretation
    - Assignments (portfolios, book reviews, essays) – knowledge and interpretation

Assessment

- Outcomes
  - Skills
    - OSCE's – clinical, procedural, communication and interpretative skills
    - End-of year clinical exams – clinical, diagnostic and therapeutic skills
    - Procedural skills log book
    - Projects – enquiry, independent research, evaluation and writing skills
    - Assignments and portfolios – writing, independent thought and understanding skills

Fifth Medical Year
CP5002
Practical Procedures
Logbook 2006/2007

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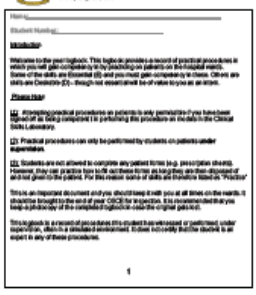
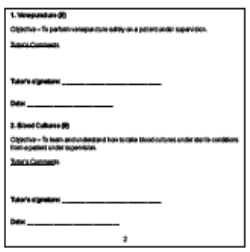
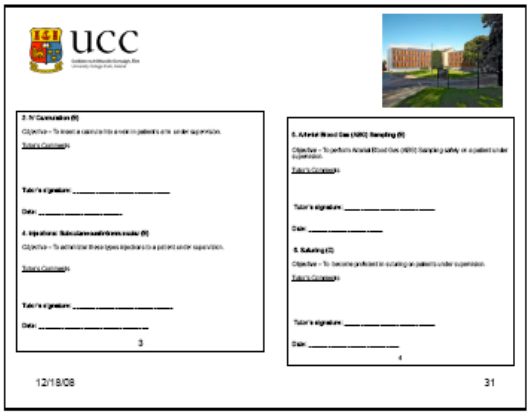
The Medical School,
Brookfield Health Sciences Complex,
College Road, UCC)



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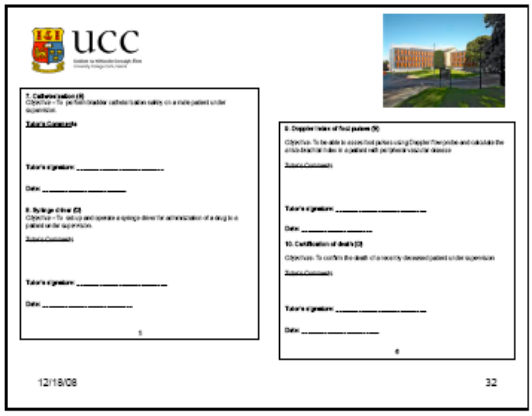
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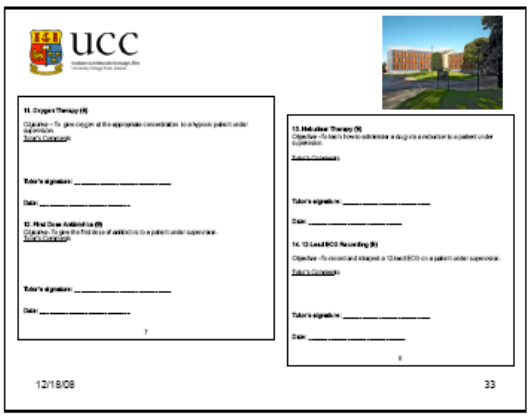
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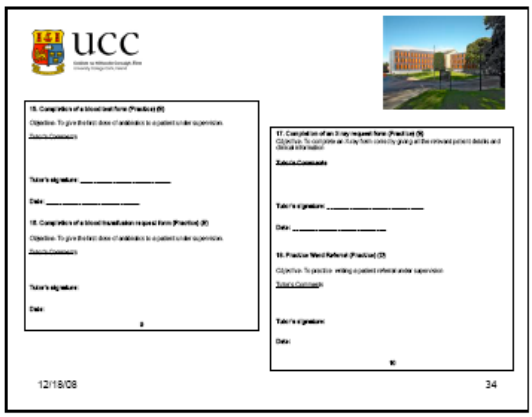
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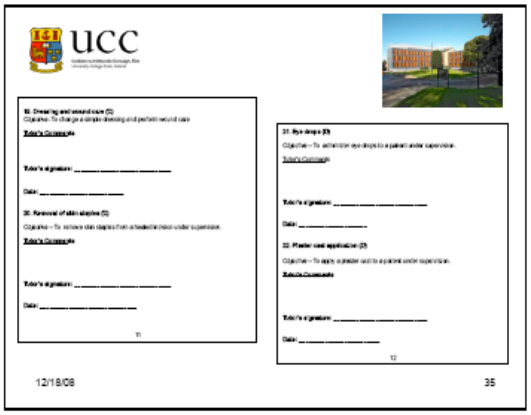
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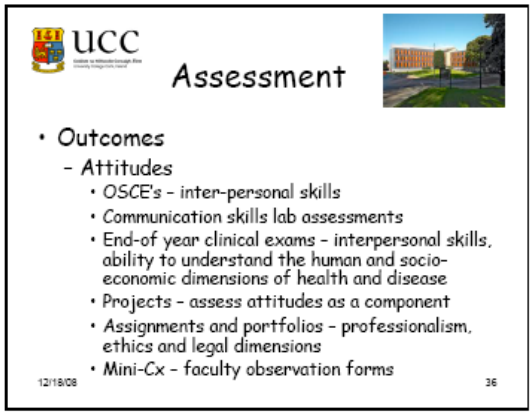
UCC
Assessment
• Outcomes
– Attitudes
• OSCE's – inter-personal skills
• Communication skills lab assessments
• End-of year clinical exams – interpersonal skills, ability to understand the human and socio-economic dimensions of health and disease
• Projects – assess attitudes as a component
• Assignments and portfolios – professionalism, ethics and legal dimensions
• Mini-Cx – faculty observation forms
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ASSESSMENT

GM 1001-1003
MCQ at the end of each trimester (200/150 marks)
Summer exam to feature integrated case and EMQ's (200/150 marks)

GM 1004
MCQ/OSCE (100 marks)
Summer Exam EMQ's (100 marks)

GM 1005
Continuous Assessment: Project, Portfolio, Book Review (160 marks)
Summer Exam (40 marks)

No marks for attendance at Small Group sessions and no grading for these sessions.
100% attendance expected; falling below a threshold of 75% will trigger review and potential for exclusion from Summer exam

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Resources/Support

- New Staff
- Administrative assistant
  - Helen Joustra
- Library
- Web
- Module Coordinators
- Mentorship
- Staff support, training and peer-mentoring

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New Staff

- To date, focus on Years 1 and 2:
  - Anatomy x 2
  - Physiology x 2
  - Biochemistry x 1
  - Pathology x 1
  - Pharmacology x 1
  - Behavioural Science x 1
  - Epidemiology and Public Health x 1
- Proposal included requests for additional staff in years 3 and 4

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GEM Staff

Ahameda	Ahmad	Physiology
Brint	Elizabeth	Pathology
Browne	Gemma	Epidemiology
Carmody	Ruaidhri	Biochemistry
Evans	Dylan	School of Medicine
Hyland	Niall	Pharmacology & Therapeutics
O'Keeffe	Gerard	Anatomy
O'Mahony	Siobhan	Anatomy
Rae	Mark	Physiology

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Feedback

- Through Small Groups
- MARK CLASS®; from Quality Promotion Unit UCC
- Formal evaluations
  - DREEM questionnaire
  - End-of-Year focus groups
  - CLASS (Cork Life-Skills Assessment Systems)
- Informal evaluations
  - One minute feedback in class
- GEM Oversight Group
- Reps to School:
  - Reps committee
  - Student Affairs
  - Curriculum


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Thank you!
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APPENDIX 3 - UNIVERSITY COLLEGE CORK TEAM

1. Dr Anne Harris, Module Coordinator GEM1001, Senior Lecturer in Medical Education, School of Medicine
2. Dr Kieran McDermott, Module Coordinator GEM1002, Senior Lecturer Department of Anatomy
3. Dr Frank van Pelt, Module Coordinator GEM1003, Head Department Pharmacology and Therapeutics
4. Dr Rossana Kennedy, Module Coordinator GEM1004, Lecturer in Medical Education, School of Medicine
5. Dr Gemma Browne, Module Coordinator GEM1005, Senior Lecturer in Epidemiology and Public Health
6. Professor David Kerins, Dean, School of Medicine
7. Dr Siun O'Flynn, Director of Medical Education, UCC
8. Professor Eamonn Quigley, Interim Course Director Graduate Entry to Medicine Programme
9. Professor Edward Johns, Head Department of Physiology
10. Professor Nollaig Parfrey, Head Department of Pathology
11. Dr Sinead Kerins, Lecturer Department of Biochemistry
12. Dr Geraldine Boylan, Senior Lecturer School of Medicine
13. Dr Denis O'Mahony, Senior Lecturer Department of Medicine
14. Dr Margaret O'Rourke, Director Behavioural Science, School of Medicine
15. Dr Kieran Doran, Senior Healthcare Ethics Lecturer; Head of Student Mentoring and Welfare Programme, School of Medicine
16. Professor Ivan Perry, Epidemiology and Public Health
17. Ms Helen Joustra, Executive Assistant, School of Medicine

Apologies

Professor Richard Greene, Head Department of Anatomy

Dr Frank van Pelt replaced by Dr Niall Hyland for the afternoon session
Dr Sinead Kerins replaced by Dr Ruaidhri Carmody for the afternoon session

End of appendices