Workshop Implementing the two-cycle Bologna degree system in medical education
The Structure of Medical Education in Europe – implementing Bologna
International HRK conference 10-11 October 2008

The two-cycle model in medical education

Should we be afraid of this big bad wolf?

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First:

- **Medical education did *not* invent the 2-cycle model – would have probably never thought of doing so…**
- **But if asked: *can* it in any way be useful to do so..?**

Overview

- What was Bologna Declaration again?
- How does it fit with medical education
- What progress has been made with implementing the 2 cycle model in general, and in medical education?
- How creative can we be with the 2 cycle model?
- About wolves and cycles

Bologna Process

- [Sorbonne 1998]
- Bologna 1999
- Prague 2001
- Berlin 2003
- Bergen 2005
- London 2007
- Leuven 2009

Core aims of the Bologna Declaration

2000-2010:

- **Harmonize higher education in Europe**
- **Use comparable degrees**
- **3-cycle model: Bachelor-Master-Doctorate**
- **Use similar credit units: ECTS (28 hrs)**
- **Standardise quality assurance**
- **Stimulate international mobility**

Would these aims enhance Med Ed quality?

Current situation of EU's Med Ed

EU directives:

- **6 year course ("5500 hours")**
- **Mutual recognition of MD license**

In practice:

- **No similar objectives**
- **Different length before license**
- **Different diploma terminology**
- **Different curricular models and varying extent of horizontal and vertical integration**
- **Limited student mobility**

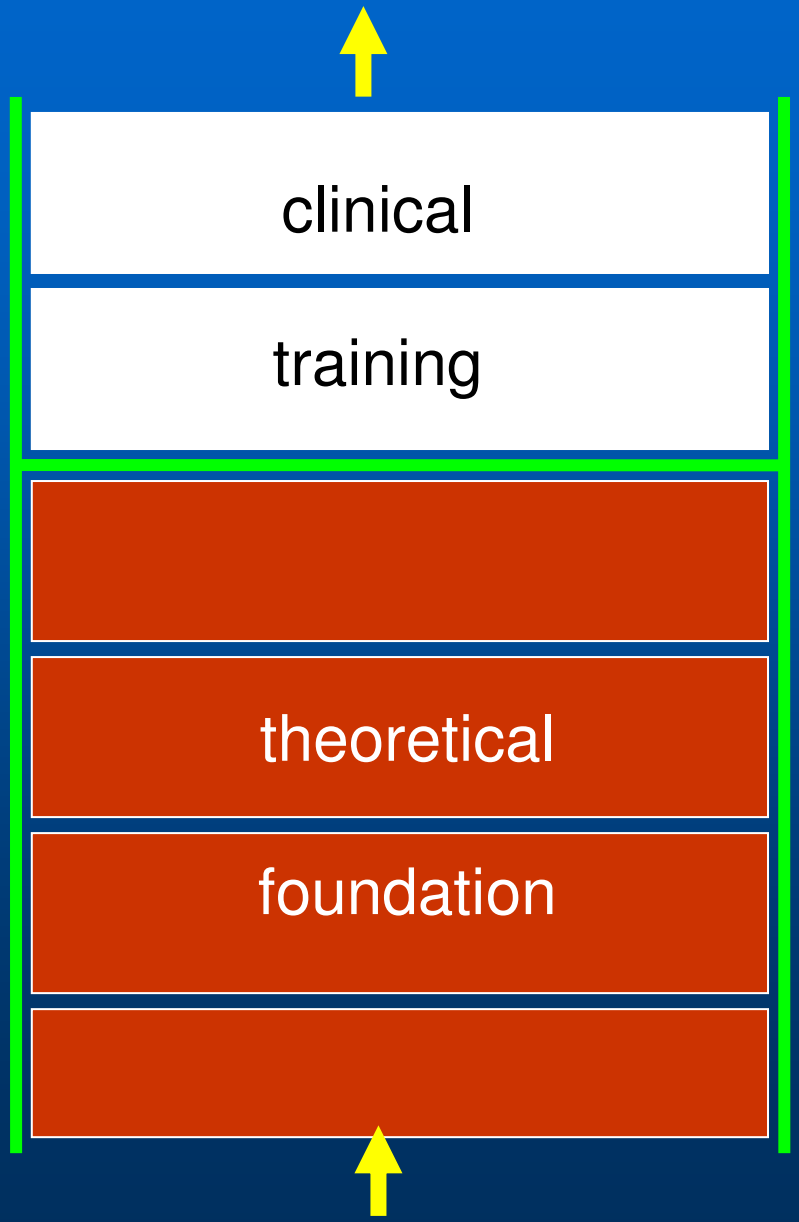
Has modernisation of medical curricula enhanced international harmonisation?

Trends in medical education development

Harden's SPICES model

- **S tudent-centered**
- **P roblem-based**
- **I ntegrated**
- **C ommunity-oriented**
- **E lectives**
- **S ystematic clinical teaching**

Example: Dutch curricula, developing from H to Z structure



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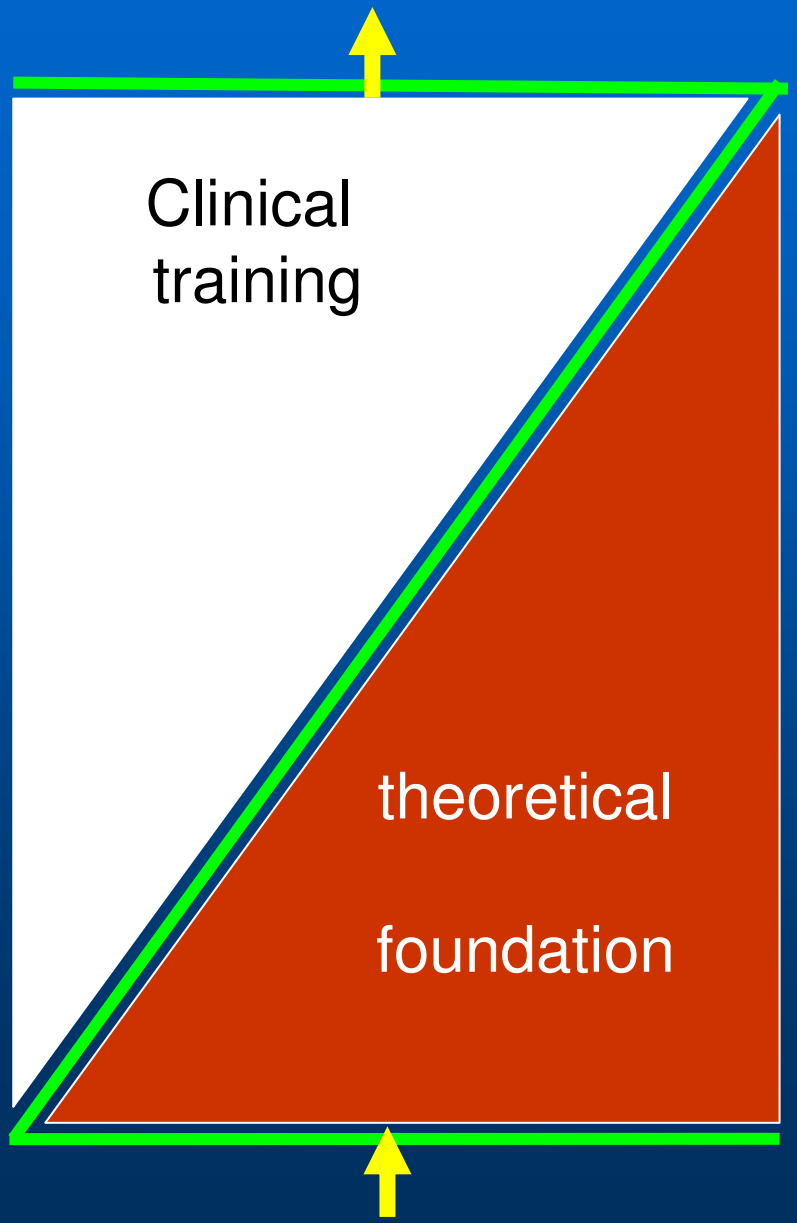
little guidance; much responsibility



much guidance; little responsibility

Trends in curriculum development

basic science

clinical theory

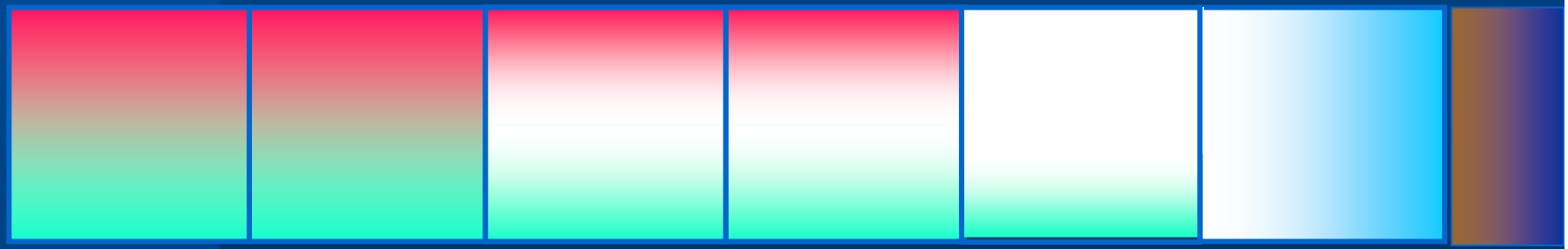
clinical clerksh

pre-registr. practice

specialty training

traditional curricula

innovative curricula



Trends in medical education development versus Bologna aims

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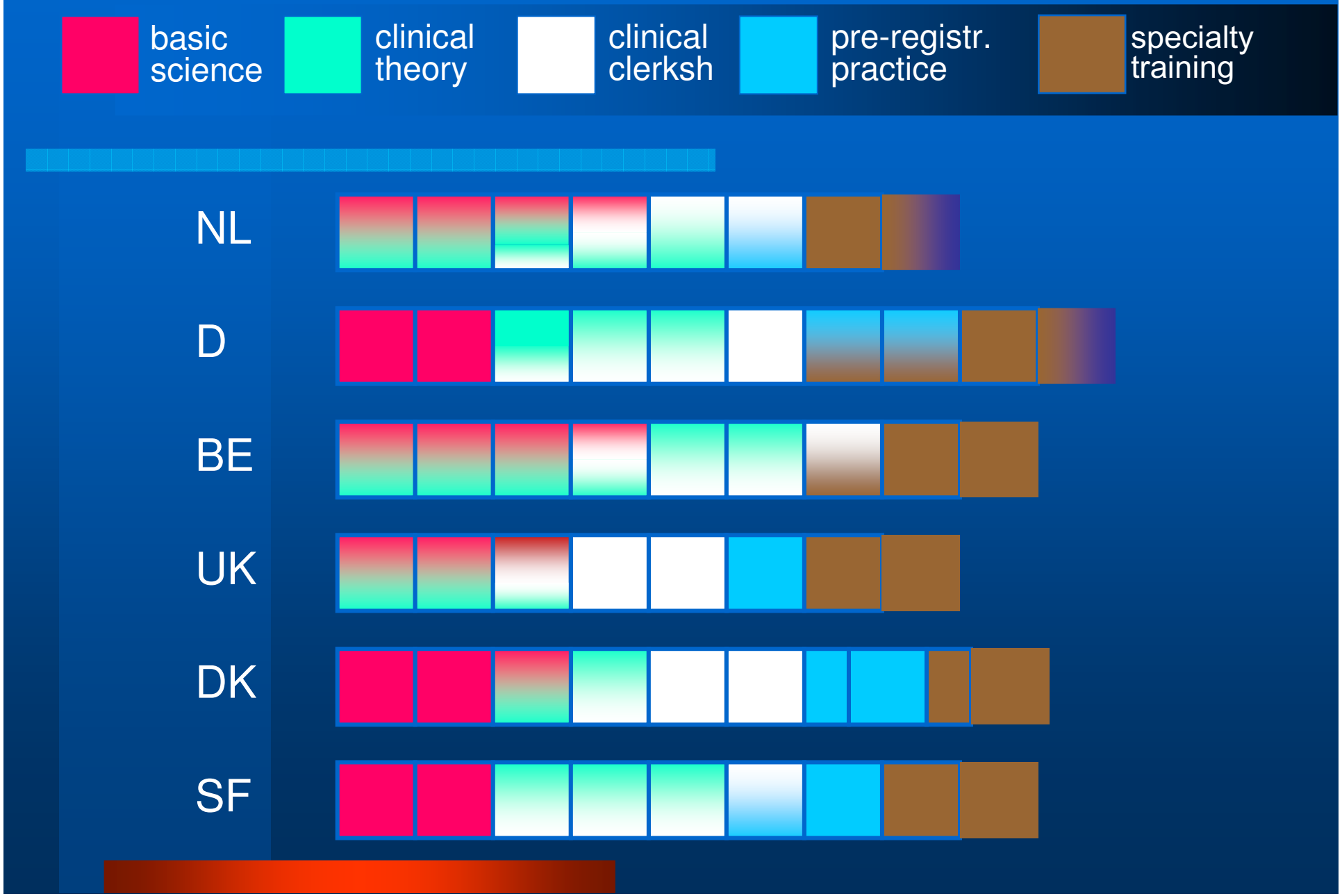
How do EU curricula concord?

Examples of recent curricular structures in Europe (AMEE 2001)



Problems, internationally

Integration has reduced

- **..common educational language**
- **..recognition potential of courses**

There is diversity of transitions from under-graduate to gradute medical education

Assessment of international medical graduates differs greatly

--> Harmonisation would be welcome!

Why harmonise in med ed?

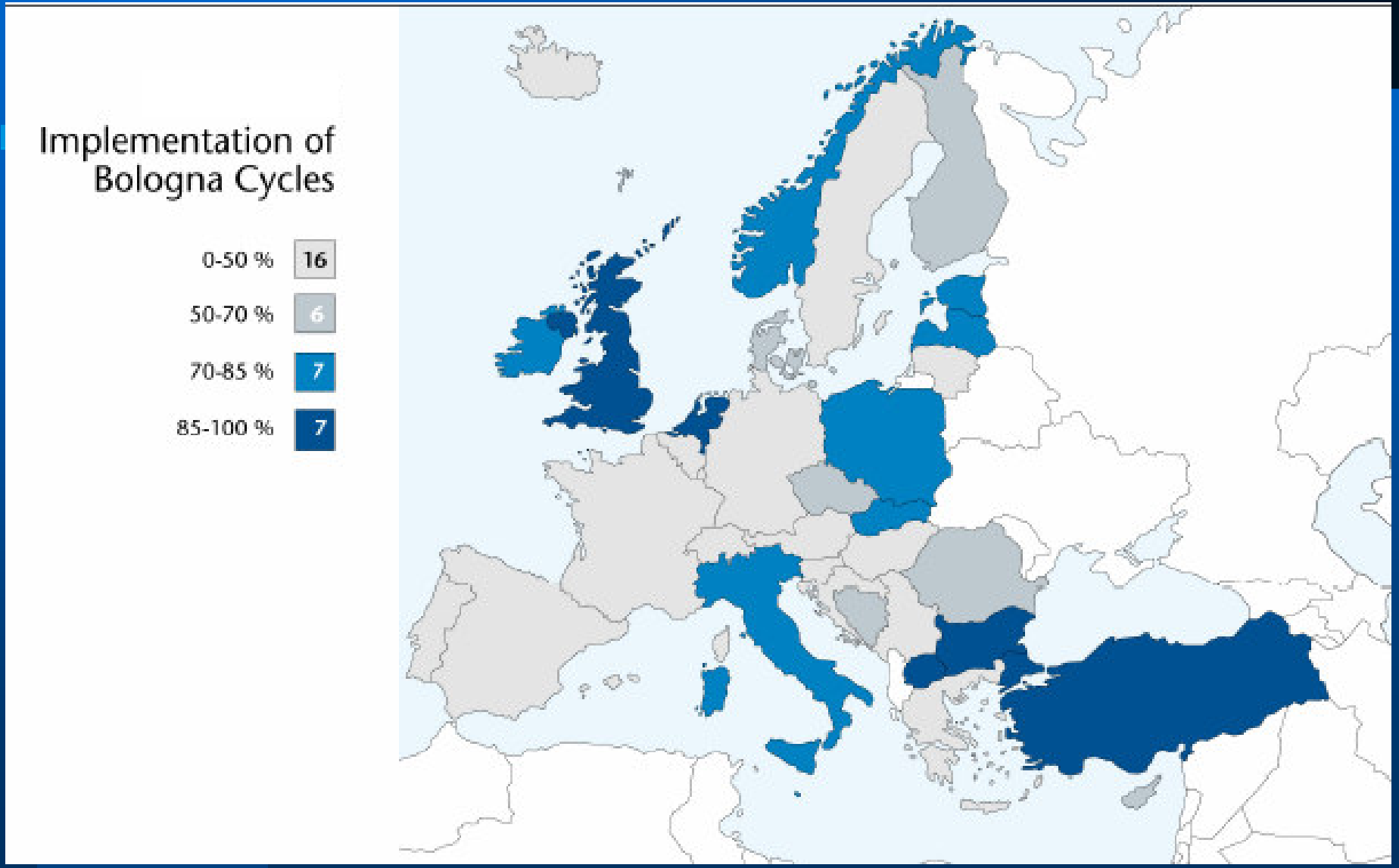
- Little information exchange on details of curriculum content
- Horizontal integration leads to phantasy names of curriculum units
- ECTS exchange is hampered if no common language of med ed exists
- Assessment of international medical graduates should roughly be equal

A few statements so far

- Several agruments in favour of international dialogue and “calibration” of medical education
- But restructuring should stimulate educationally sound principles and not hamper intrinsic development of med ed
- Curricular change and improvement often do not happen spontaneously; external forces can trigger change

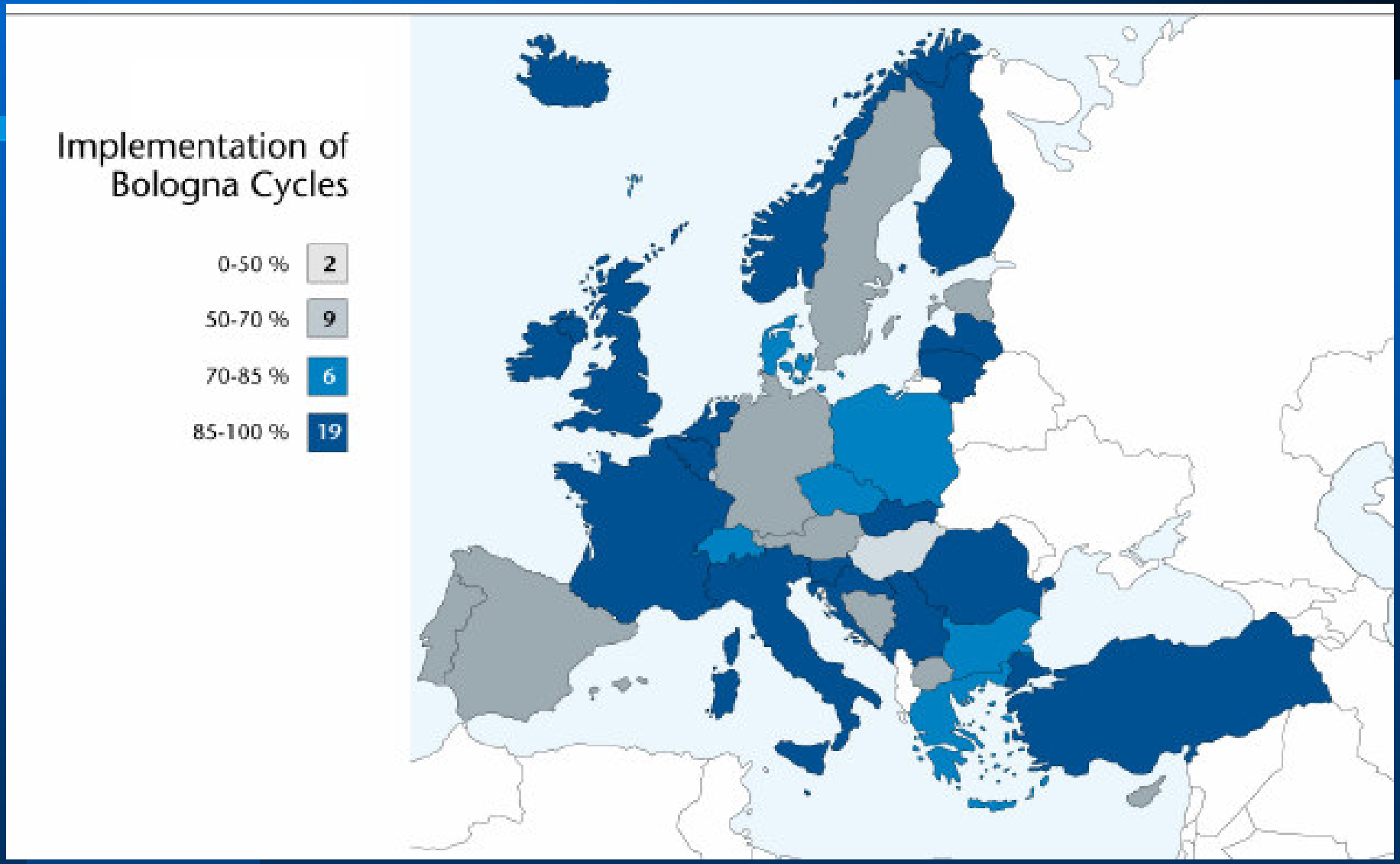
What progress did the Bologna cycles model make in the EU in general?

General progress 2002



www.ond.vlaanderen.be/hogeronderwijs/bologna/documents/EUA_Trends_Reports.htm

General progress early 2006



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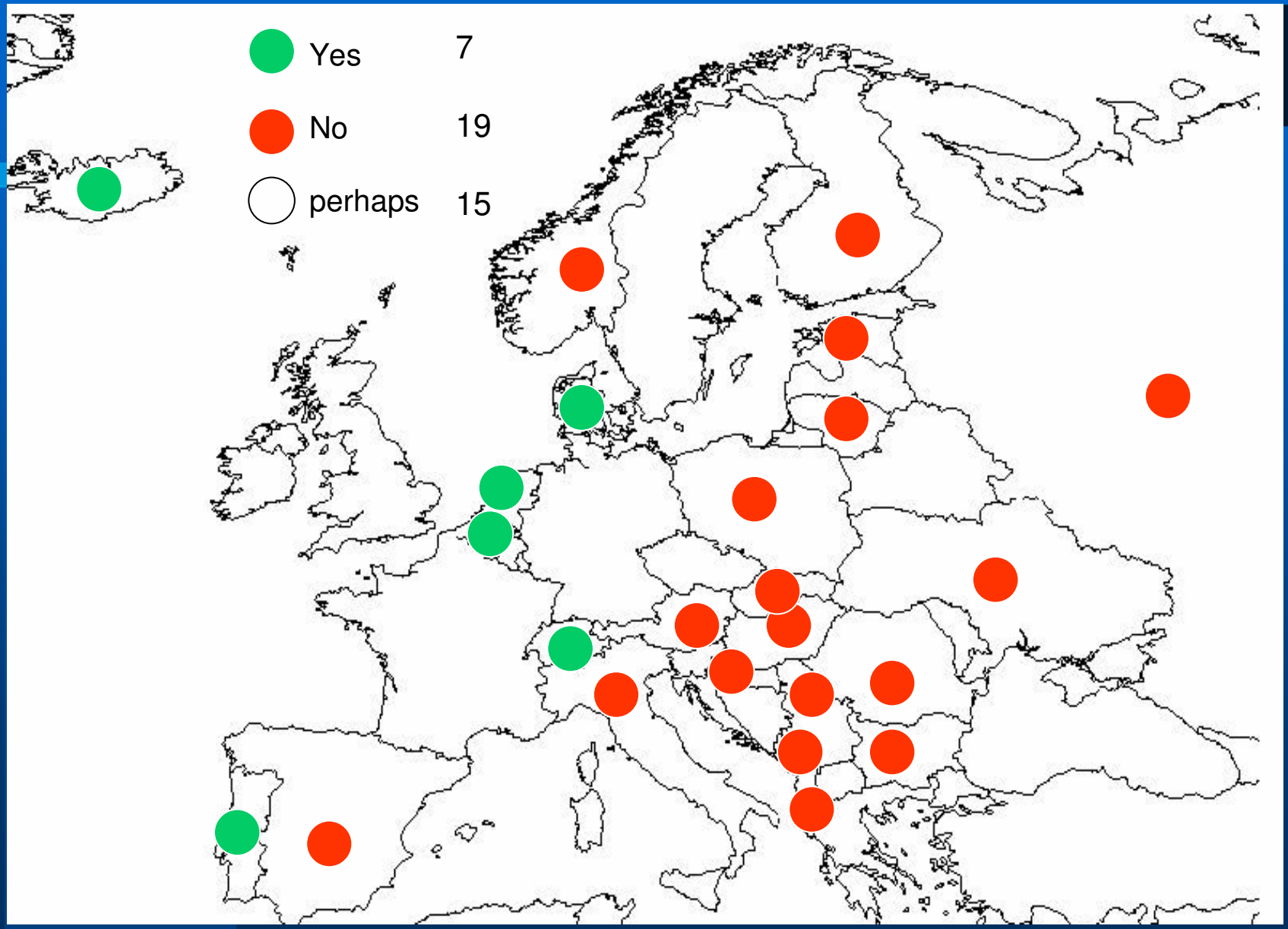
What progress did the Bologna cycles model make in the EU in medical education?*

*Patrício et al. Med Teacher 2008; 30: 597-605

Should med ed transform into 2 cycles?



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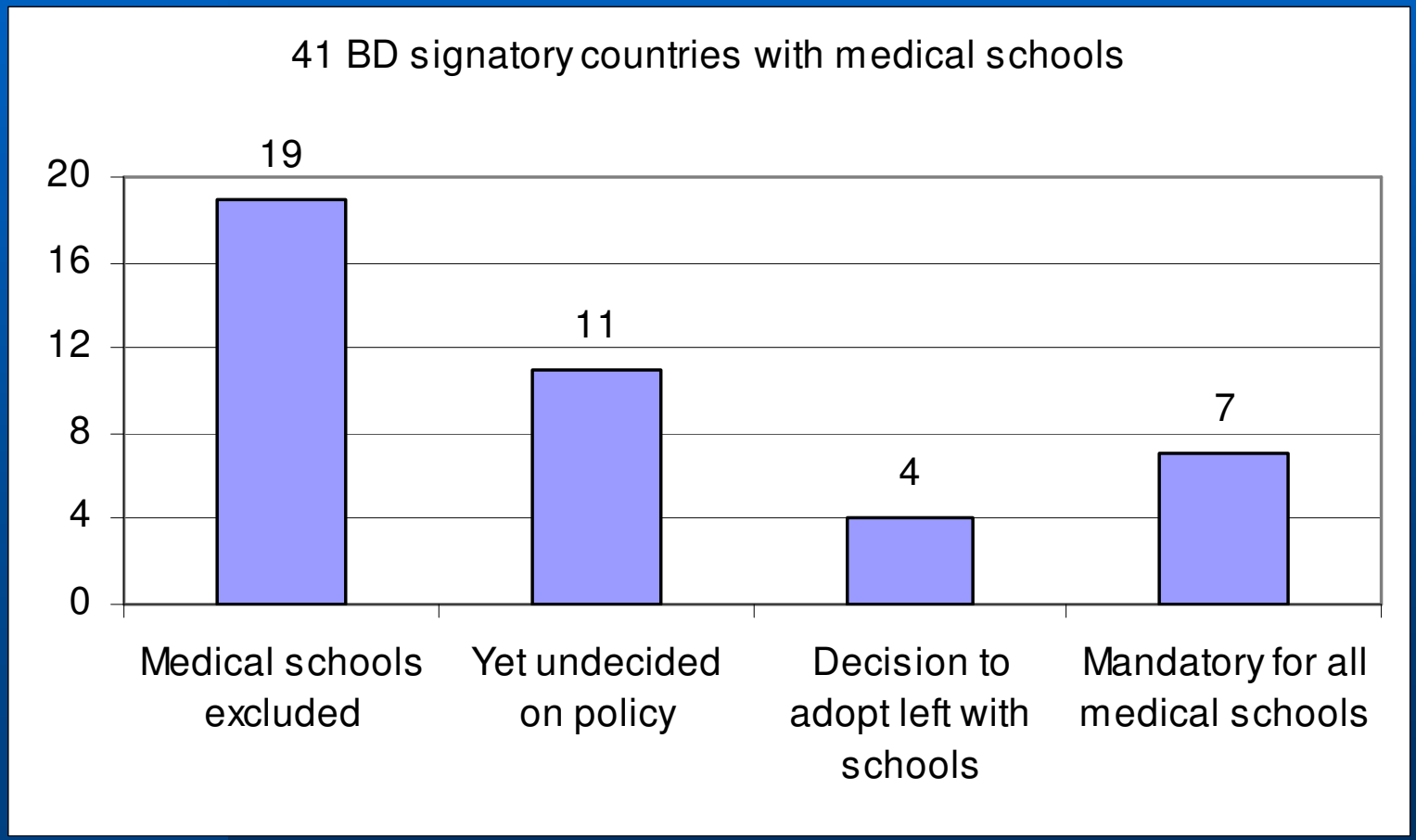
2007 country policies



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Arguments pro

- It can stimulate development of international standards
- It can enhance student mobility if bachelor objectives are comparable
- Students with a Ba degree can pursue a science Ma degree (+/- continue medicine)
- Graduate entry into an extended medical master phase may be possible
- A master diploma can stimulate research interest in doctors

Arguments against

- It does not fit with a horizontally and vertically integrated curriculum
- Early clinical contact is not meant for those who will not become a doctor
- Training medical bachelors is a waste of resources
- Society has no employability for medical bachelors

How creative can we be?

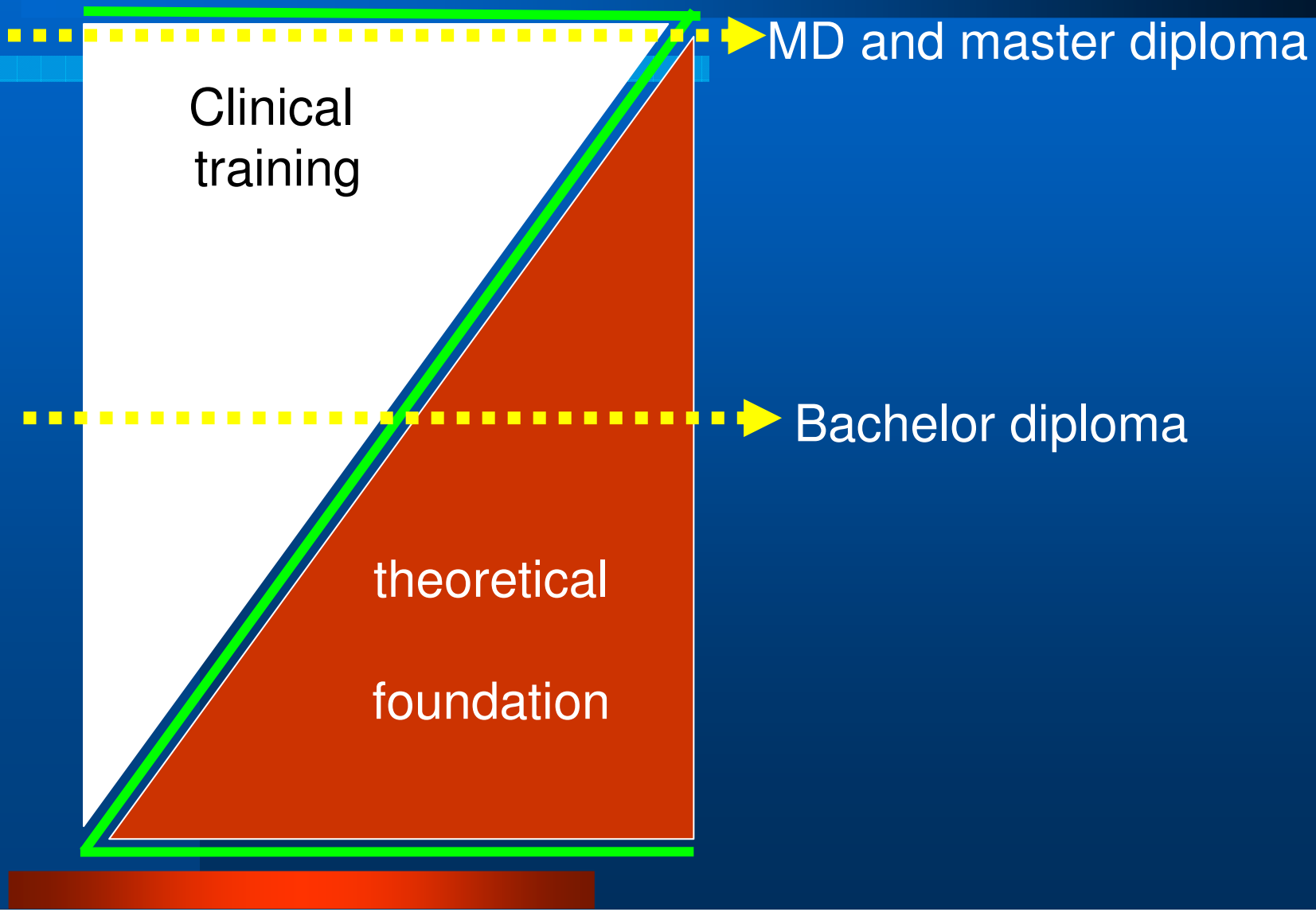
- **Dutch government issued the two-cycle model for medical education**
- **What has happened since?**

- No schools have compromised their curriculum principles
- The Dutch Blueprint of Objectives was used to derive a global bachelor level description
- Wherever suitable, “Dublin Descrip-tors” were used to adapt curriculum

Dublin decriptors

- Established March 2004
- Describe general qualifications of Bachelors, Masters and Doctorates
- Ba: general academic abilities
- Ma: specific academic (scientific) abilities

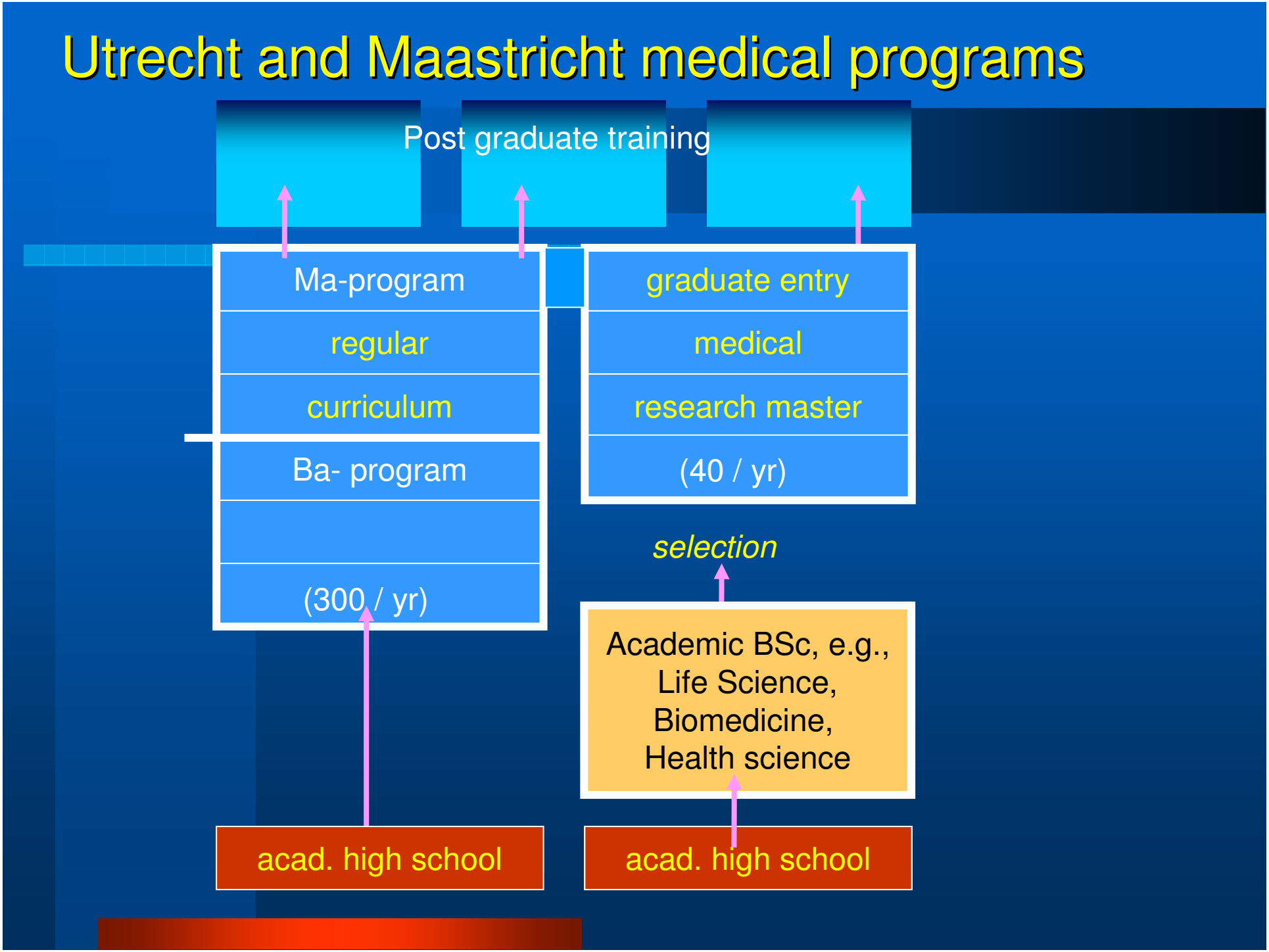
The Bachelor cut at UMCU



Graduate entry

- Two schools have started a four year graduate entry second track
- A four year “medical research master program” is now established in legislation

Utrecht and Maastricht medical programs



Other possibilities

- Students may interrupt medical school to pursue a master's degree
- Career switch: students retain a diploma in stead of being a medical drop-out
- International medical graduates without a recognized diploma may start in the master's phase to obtain a Dutch diploma

Afraid of the BaMaWolf?

Afraid of the EU BaMaWolf?

Holland in short

- **Not afraid of changes**
- **No wolves**
- **Many bi-cycles**

The Dutch bi-cycle model