STATEMENT ON

THE BOLOGNA PROCESS AND MEDICAL EDUCATION

February 2005

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The following statement on medical education in the Bologna process has been prepared by the Association for Medical Education in Europe (AMEE) and the World Federation for Medical Education (WFME) in consultation with the Association of Medical Schools in Europe (AMSE) and World Health Organization, Europe (WHO-Euro).

In preparation of this statement the policy statements of the medical students of Europe, adopted August 2004 (International Federation of Medical Students' Associations, IFMSA and European Medical Students' Association, EMSA: "The Bologna Declaration and Medical Education. A Policy Statement from the Medical Students of Europe") and the comments on the Bologna process by the medical profession, adopted November 2004 (Comité Permanent des Medecins Européens: "CPME comments on the Bologna process") has been taken into account.

Summary

The main points of the statement are:

- The organisations endorse the purpose of the Bologna declaration and support that medical education as a part of higher education should be fully involved in the Bologna process
- When implementing the Bologna objectives in medical education the specificity of medical curricula and the current situation of European medical schools must be considered
- Most objectives are in accordance with current practices and reforms in medical schools whereas a few need to be implemented with a broader scope and implementation of one action can have serious implications for medical education
- It is proposed that medical schools for the time being should not be obliged to adopt the two cycle structure and be allowed to continue having a long, integrated, one-tier structure. Alternatively they should be given the option to establish the first cycle as the first part of the medical programme without planning it for a special vocational use
- It is expected that work on quality assurance, recognition, accreditation or similar measures in medical education can continue in a broader, global perspective
- Finally, the organisations in medical education urge the countries and governments to make decisions of fundamental importance to medical education in Europe based on the necessary evidence and in dialogue with the medical schools and their stakeholders.

General remarks

The organisations acknowledge the initiative, the activities and achievements within the Bologna process. Medical education in Europe endorse the general purpose of the European Higher Education Area stated in the Bologna Declaration, developed in connection with the biannual meetings and specified during the process. In general, the efforts and actions will be as beneficial to medical education as to other programmes in higher education. However, one fundamental action, the introduction of the two-cycle structure are problematic and could even be harmful to medical education and its quality, to the medical schools, the students and the profession and in the last resort to the health care system and its patients.

Characteristics of medical education in the light of the Bologna process

Problems in implementing the Bologna objectives in medical education may be the result of contradictions between on the one hand the European or the trans-disciplinary nature of actions within the Bologna process and on the other hand the global nature of medical education, the special characteristics of medical education as a professional education with its strong relations to the health care systems and the trends in the ongoing quality improvement of medical education.

In the implementation of the Bologna objectives in medical education primarily 3 characteristics of the current situation at most medical schools in Europe have to be considered.

Firstly, most medical schools in the European region have especially within the last decade been actively engaged in reforming their medical programmes. This process of reform is still going on with a focus on aspects of the programme somewhat different from the issues in the mainstream of the Bologna process. The reforms of medical education and international cooperation on quality improvement have been occupied by issues such as the social responsibility and relevance of medical education, content/outcome/competencies or performance of graduates from the medical programmes, teaching/learning methods, especially problem-based learning and similar student-activating methods also with a view to train the students for lifelong learning, assessment methods, integration of the basic biomedical and the clinical disciplines, early contact with patients, and improving communication and clinical skills together with integrated research options.

The structure and duration of basic medical education as it is addressed in the Bologna process has not been high on the agenda in quality improvement of medical education since the adoption of the Directive No93/16/EEC, Art. 23 par.2 stipulating that medical education in the EU consists of 5.500 hours of structured schooling or six years. However, one broad topic is shared by the Bologna process and the reform process in medical education: quality improvement and assurance including standard setting, accreditation etc.

Secondly, it has to be noted that knowledge and understanding of the Bologna Declaration and involvement of medical education in the Bologna process is still somewhat lacking. An attempt to survey the level of information and reactions to the Bologna process among 236 medical schools in 19 countries was unfortunately confronted with an extremely low response rate. However, the survey seem to support the impression that information on the Bologna process among medical schools is unevenly distributed and generally at a low level. The reactions to the actions within the Bologna process are evenly distributed between support and rejection of the Bologna process. Late in 2004 financial support was obtained from EU to a 3 year project, "Medine" with the explicit purpose to elucidate how medical education can fit into the Bologna process. Most of the issues mentioned in the present statement and regarded as problematic for medical education will be addressed in the project.

Thirdly, it should be observed, that while the subject matter of medical education compared to other professional programmes often is perceived to be to a large extent identical in Europe and globally, the context and conditions in which the programmes operate are very diverse. It is frequently neglected that also the European region display differences in disease patterns, significant differences in health care delivery systems and in the composition of the health work force and consequently differences in the use of physicians and in the needed qualifications of

medical graduates. Even larger differences can be observed in the governance of medical education, in medical curricula and the resources allocated to medical education - differences firmly embedded in cultural traditions, political realities and economic development. During the implementation of the Bologna process the diversity in the European region would have to be taken into account, especially when objectives implicate a striving towards harmonisation of structure and function of European higher education. The organisations want to see harmonisation not as a process leading to uniformity but as convergence based on shared knowledge of best practice and respect for diversity and the autonomy of the institutions.

Medical education and the objectives of the Bologna Process

Most of the objectives of the Bologna Declaration and Process seem to be in line with considerations and recent changes in medical education and the implementation must be regarded as advantageous for most medical schools. This is the case regarding the following objectives:

- Adoption of a system of easily readable and comparable degrees
- Establishment of a system of credits such as in the European Credit Transfer System (the ECTS system)
- Promotion of mobility by overcoming obstacles to the effective exercise of free movement
- Promotion of European co-operation in quality assurance
- Promotion of the European dimension in higher education
- Lifelong education
- Involvement of institutions and students
- Promotion of the attractiveness of the European Higher Education Area
- Promotion of closer links between the European Higher Education Area and the European Research Area

It should be noted that it is expected that involvement of institutions and students can take place with a broader scope e.g. with involvement of other stakeholders primarily the profession and the health care system. Also, it is expected that co-operation in quality assurance can continue in a broader, global perspective.

One objective, the adoption of a system essentially based on two main cycles, undergraduate and graduate in medical education is by several countries and many medical schools regarded as problematic and potentially harmful to the quality of medical education. Implementing this objective will require careful analysis and considerations.

To some of the abovementioned objectives or action lines the following comments should be added:

Easily readable and comparable degrees. Most likely, all medical schools will favour easily readable degrees, including introduction of the long overdue Diploma Supplement and similar measures. However, to obtain comparable degrees it is not enough to use the same terms or names (bachelor and master). The competencies and the level achieved should be defined to make degrees comparable in reality. In several projects attempts are being made to develop qualification frameworks and descriptors for the different levels of accomplishment and in all

cases without regard to or participation of medicine. This endeavour is closely linked to the adoption of a system based on two main cycles and could confront medical education with abstract requirements out of line with recent quality improvements of medical education.

The ECTS system. Medicine was one of the 5 subject areas involved in the pilot scheme introducing and testing the ECTS system. Use of ECTS within medical education ought not to pose problems, provided that medical schools new to the ECTS system are assisted in clear understanding and the proper application of ECTS-credits. It should be noted that an ECTS credit is intended as a pure measure of the workload involved in a specific learning/teaching activity or unit in the curriculum e.g. a module, a course, a subject or discipline. The success of the ECTS pilot project depended to a large extent on the accompanying information package including a precise description of the unit in the curriculum, its content, level, learning/teaching methods and assessment. Consequently, recent discussions and developments within the Bologna process stressing the need in credit transfer as well as in credit accumulation to combine ECTS-credits with descriptors of content/outcome and of level are welcomed by medical education. The quantity of workload alone is for all practical purposes not a sufficient description of a unit in the curriculum.

Promotion of mobility. The organisations support continuous growth in international mobility and student exchange. It has to be acknowledged that the reforms of medical education tends to complicate international mobility. The new curricula are less known, transparent and comparable than the classical teacher, knowledge and discipline based medical curriculum. The commitment to mobility need to be expressed in efforts to overcome these and other obstacles.

Quality assurance. European co-operation in quality assurance is in itself necessary and laudable, but implementing the objective could be counterproductive to recent developments in medicine and to the still premature development towards global co-operation in accreditation of medical education.

Firstly, accreditation of medical education in Europe alone is not sufficient for all practical purposes and is maybe not even the main concern. Hence, co-operation on recognition and accreditation of medical education should from the very beginning encompass other regions such as America, Africa, Asia and the Middle East.

Secondly, the question of recognition and accreditation in medicine should not be handled by educational authorities alone (e.g. the Ministry responsible for higher education and the medical schools). The process should include the profession and the regulatory bodies responsible for authorisation or licensing of medical doctors in the individual countries and other stakeholders from the health care system.

Thirdly, there is the problem of the criteria or standards used in the evaluation and accreditation process. Medical education will most likely not benefit from using abstract criteria and standards developed by other or all subject areas in Europe. For recognition and accreditation of medical education fairly specific criteria and standards are needed with a national or regional adaptation or specification taking into account local conditions, resources, disease patterns and the organisation of the health care delivery system.

The need for specific criteria and standards is illustrated by existing accreditation systems (e.g.

in UK and North America) and the type of criteria and standards needed are illustrated by the WFME Global Standards for Quality Improvement in Basic Medical Education. The WHO-WFME Joint Task Force on Accreditation of Medical Education Institutions and Programmes established in 2004 will soon be able to submit a contribution to the further discussions of quality assurance, recognition or accreditation including guidelines for accreditation of basic medical education. These guidelines under preparation will be in accordance with present ENQA guidelines, the recommendation of the Council and of the European Parliament on European cooperation in quality assurance in higher education and with the coming joint UNESCO and OECD guidelines on Quality Provision in Cross-border Higher Education.

Lifelong education. Lifelong education in medicine is extremely important, but also a very complicated issue. Continuing medical education (CME) or the more comprehensive continuous professional development (CPD) has long traditions, resulting in a situation characterised by an extreme variety of activities between countries and within the individual countries. This complexity is composed by many different educational providers (public, private and private for-profit institutions, scientific societies, professional associations, private companies) and different forms of delivery (formal courses, seminars and conferences, distance learning, self-study etc.). Also the regulation of CME/CPD is very different, ranging from no regulation at all to highly developed systems of regulation specifying requirements directed towards the medical doctor and/or accreditation of providers/activities. Furthermore there are differences regarding the regulatory body, which can be under the auspices of the Ministry of Education or the Ministry of Health or a professional organisation. There is, however, need for European initiatives and agreements on this objective in professional medical education.

Involvement of institutions and students. The organisations strongly support this objective added in 2001. Without involvement and commitment by institutions and their staff and students to the Bologna process, implementation will be difficult if not impossible. In the case of medicine it is just as important to involve the profession and other stakeholders, especially representatives of the health care delivery system, the ministry responsible for health and/or education, regulatory bodies, professional organisations etc. Implementing the Bologna objectives in medical education can not be decided by Ministers of higher education alone.

The two cycles. This development within the Bologna process can cause problems in several ways and important questions are: Will it be possible to maintain the long, integrated one-tier programme if preferred or should basic medical education be divided into the two main cycles? If medical education is based on two cycles should the undergraduate degree after 3 or 4 years (180 or 240 ECTS credits) in medicine provide immediate access to employment?

It is hard to point at occupations where an ‘unfinished’ study of medicine is an obvious qualification. A bachelor degree in medicine could be a stepping stone to further studies leading to a masters degree for instance in biology, in public health, dentistry, etc. and could possibly with a short (½ - 1 year) supplementary education in management, media, educational studies etc. qualify the bachelor in medicine for positions in the pharmaceutical industry, in public relations, newspapers and TV specialising in health issues and as teachers in educational programmes for other health personnel. However, medical education is costly and most countries need the medical doctors they can afford to educate. To divert the students from the path to a full medical qualification must be regarded as a debatable educational policy. To finalize medical

studies with a bachelor degree should be a rare exception, but could be an opportunity only for the few drop-outs from medicine.

If employability of a bachelor in medicine has priority, the curriculum for the first 3-4 years (180-240 ECTS credits) will have to be planned accordingly, hereby jeopardizing the efficiency and/or the quality of the full programme in medicine. Especially, it could be harmful by reinforcing the traditional sharp division between an early pre-clinical or basic biomedical part followed by the clinical part of the medical programme. One of the most widespread and irreversible international trends in quality improvement of medical education is integration of the basic biomedical disciplines and the clinical disciplines, hereby subordinating the teaching/learning of the basic biomedical disciplines to their present and future application in clinical practice.

Finally, it should be noted that the introduction of the 'new' masters degree in some countries can cause problems because of unclear relations to existing terminology and other degrees, their content (e.g. a thesis) and the professional status.

Countries and medical schools should for the time being be allowed to opt out regarding the two-cycle system and continue having the long (6 years/360 ECTS credits or more) integrated programme or alternatively to establish the first cycle as the first part of the medical programme without planning for special use or employability of the bachelor.

Concluding remarks

The organisations strongly urge the countries and the ministers responsible for higher education to make decisions of fundamental importance to medical education only with the necessary evidence for action and with involvement of the medical schools, their staff and students, and the stakeholders, primarily the profession and the health care system.