

## Education in Internal Medicine

# A new direction for medical education in Ireland?

Paul Finucane<sup>a,\*</sup>, John Kellett<sup>b</sup>

<sup>a</sup> *Medical School Development, University of Limerick, Limerick, Republic of Ireland*

<sup>b</sup> *Mid-Western Regional Hospital, Nenagh, Ireland*

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### Abstract

In recent years, new concepts of educational theory and practice have stimulated new approaches to medical education in many countries. For various reasons, medical education in Ireland has been slow to change such that there are now increasing concerns about educational standards. In addition, Ireland currently produces too few doctors and is therefore highly dependent on overseas doctors to maintain its health service. The responsible agencies are finally about to address these problems through a major expansion of medical education coupled with a strong agenda for educational reform. While the reform process will clearly be influenced by the experience of other countries, Ireland now has a great opportunity to take innovation in medical education a step further. For example, there is now an opportunity to develop new strategies to ensure the social accountability of medical education, to increase its community orientation and to foster interprofessional teaching and learning.

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### 1. Background

From a historical perspective, innovations in medical education tend to happen in pulses, with long periods of relative stagnation interspersed with short bursts of creativity and upheaval. In the past 100 years, two revolutions in medical education stand out. The first resulted from the Flexner Report in 1910, which placed a new emphasis on the scientific basis for medical practice [1]. Almost 60 years later, a second revolution was begun at the then new medical school at Canada's McMaster University, when it applied modern concepts of adult learning to medical education, using a range of strategies, most notably problem-based learning (PBL) [2]. It took some 10 years for the ripple effect from McMaster to be felt elsewhere in the world and some 25 years before this ripple developed into a wave of reform that brought with it new methods of student selection, curriculum design, student assessment, staff development and programme evaluation.

Such reforms continue to impact on medical education in developed and developing countries alike [3].

For varied and complex reasons, the wave of reform in medical education has been slow to reach Ireland. A chronic under funding of medical education partly explains this phenomenon. For many years, third level education in Ireland has been mainly state-funded and the harsh economic climate of the 1980s brought about major cuts in educational funding that have yet to be reversed. For almost 30 years, medical schools have had to direct their energies at survival rather than at innovation. While successive Irish governments capped the number of places for indigenous medical students, there has been no restriction on recruitment of overseas fee-paying students. One particular survival strategy was for Irish medical schools to open their doors to overseas students such that by 2003, these constituted 62% of the new student intake and generated 83% of student-related income [4].

Attitudes of complacency may also have contributed to educational inertia and, despite a lack of supporting evidence, it has been asserted repeatedly that Ireland “can be justly proud of the history and quality of its medical education” [5].

\* Corresponding author. Tel.: +353 61 202695; fax: +353 61 330027.

E-mail address: paul.finucane@ul.ie (P. Finucane).

The erosion of confidence in the quality of Irish medical education gathered momentum in the late 1990s and early 2000s, following a series of accreditation visits to all five medical schools by the statutory regulatory body, the Irish Medical Council. Though such accreditation visits had occurred previously, they had been infrequent and low-key affairs whose findings had never been made public. By contrast, the Medical Council visits of 2001 and 2003 were both rigorous and highly structured, adopting the quality assurance standards of the World Federation for Medical Education (WFME) [6]. Furthermore, for the first time the Medical Council publicly reported its findings. Both Medical Council reports were critical of educational standards and the 2003 report highlighted a continuing decline in standards over time. The Council was particularly concerned about the quality of clinical training and considered that many training sites had reached the limit of their capacity. Collectively, the Medical Council reports presented a compelling case for urgent educational reform [4,7].

At the same time, a long-neglected shortage of medical manpower was finally beginning to receive national attention [8]. For many years, Ireland had produced too few indigenous doctors and had difficulty in retaining those that it did produce. As a consequence, the Irish health service had become highly reliant on overseas doctors to the extent that by year 2000, almost half of all Non-Consultant Hospital Doctors (NCHDs) in Irish hospitals were overseas trained [9]. This presented Irish medical schools with a complex amalgam of problems — the need to produce more indigenous doctors at a time when educational standards were sub-optimal and in decline, when the capacity for clinical teaching had been reached and when they were critically dependent on the fees generated by a large number of overseas students.

## 2. Taking action

Two government departments – Health and Children and Education and Science – are responsible for Irish medical education. In the past, the resolution of problems has often fallen between both stools. The Medical Council reports of 2001 and 2003 roused the key stakeholders, including the relevant government departments, the five medical schools and the Medical Council itself to take coordinated action. Crucially, the Department of Finance also became involved. The outcome was a government decision to set up a working group to examine the status of basic medical education in Ireland and to advise on its future direction. At the same time, another working group was convened to advise government on postgraduate education. Both working groups reported in 2005. Known colloquially by the surnames of the respective working group chairs, the Fottrell Report (on basic medical education) and the Buttimer Report (on postgraduate medical education) will determine the direction of medical education in Ireland for many years to come [5,10].

The Fottrell Report recommends that the intake of Irish/EU students into medical schools be more than doubled and

that this increase be phased in over a 4-year period. It further recommends that, ultimately, some 40% of all school places be for graduate students. Currently, the five Irish medical schools only offer school-entry programmes, into which a small number of graduates are also admitted each year. While the Fottrell report justifies the graduate-entry model on the basis of widening access to medical education and of reducing student attrition, this approach will also provide a different funding model as graduate students, unlike their undergraduate counterparts, will be liable for course fees.

Most of the recommendations of the Fottrell Report concern the need for educational reform and a need to move away from didactic teaching and rote learning towards more innovative approaches based on modern concepts of adult education. It advocates for more student-centred and self-directed learning and for teaching in small group settings as occurs in problem-based learning (PBL). Like others, it calls for a better balance between hospital-based and community-based teaching [11], noting that currently only 1–2% of Irish medical education occurs in the primary care setting. The Report also notes that interprofessional teaching and learning in the health sciences is currently almost non-existent and calls for initiatives in this area.

The Fottrell Report has a particular emphasis on clinical training and echoes many of the concerns previously expressed by the Medical Council. These centre on the lack of clear educational outcomes for clinical training, its poor structure and the variable quality of its delivery. Furthermore, Irish medical schools currently depend on hospital-based consultants, who have no contractual obligation to teach, to supervise the great bulk of clinical training. With the ever-increasing demands of service delivery, their voluntary efforts are in decline. The Report recommends that clinical training be ‘professionalised’ by introducing teaching contracts, processes to ensure the quality of teaching and opportunities for staff development.

## 3. Threats and opportunities

Medical education is under pressure in most countries, arising from factors as diverse as increasing service demands on clinical teachers, the need for shared teaching among different health-related disciplines, the need to incorporate modern educational principles and technologies, adapting to changing societal views of health and disease and the demand for health professionals to be more accountable [12]. While dealing with these pressures will tax all countries, the problems currently facing Ireland are particularly challenging. Although a positive outcome cannot be guaranteed, the two key ingredients for success do, however, appear to be present, namely an acceptance by the principle stakeholders of the need for reform and a financial commitment by government to the reform process. The increased numbers of medical school places will involve a competitive tendering process, with the expectation that the successful bidders will best combine educational innovation with cost-effectiveness.

With such an approach, meaningful educational reform appears inevitable. The only real uncertainty is whether the reform of medical education in Ireland will confine itself to copying what has been achieved elsewhere or will attempt to break new ground, perhaps in such important areas as ensuring social accountability [13], having a far greater community orientation, and fostering interprofessional teaching and learning [14]. Time will tell.

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