

Could Portugal design a unique accreditation programme for Portuguese medical schools? The answer is yes.

Roger Thomas, MD, Ph.D, CCFP, MRCGP
Professor, Department of Family Medicine, University of Calgary
Cochrane Collaboration Coordinator

Executive Summary

Portugal could examine the systems in other European countries or in Canada and the US for accrediting undergraduate medical education to decide if Portugal would like to design its own system or adopt some aspects of other systems.

The Liaison Committee on Medical Education assesses the 125 medical schools in the USA and 17 in Canada every five years, and their methods are presented here.

Portugal could be unique in accreditation by ensuring that students: 1. focus on the needs of individual patients by learning patient-focused care, and that the entire medical system they work in is patient-centred; 2. learn how medical errors originate, and their learning and the medical system are designed to minimise medical errors; 3. have daily access to updated clinical information through a hand-held computer; and 4. know how to treat all common medical problems uniformly using clinical practice guidelines; and 5 have the literature searching and appraisal skills to assess the quality of guidelines.

Your train is just pulling into the train station in Paris (or another city in Europe) and you have spent a pleasant night sleeping in your bed on the train. You now look forward to spending five days accrediting a French (or other European) medical school and talking with those colleagues. You wonder when they come to visit you where you would enjoy taking them in Portugal. Imaginative? No.

In this article we will answer five questions:

1. Why bother to accredit your undergraduate programmes?
2. Are there negatives to accreditation?
3. Are there models Portugal could adapt?
4. Are there additional qualities Portugal could add to an accreditation programme that would make the Portuguese style unique?

5. What could be the next steps?

Dr. Thomas was invited by the Portuguese Society for Medical Education on 19 April 2005 to present his views on how the integrated Liaison Committee on Medical Education accredits the 125 medical schools in the US and 17 in Canada. This article adds further thoughts to that presentation.

1. Why bother to accredit your undergraduate programmes?

The entire process of international peer review of research and publications is intended to ensure that international standards prevail in research so that we may use the results from other universities and countries with confidence in the care of patients. The Liaison Committee in the US accredits all 125 US and 17 Canadian medical schools, and thus their graduates can do electives or take up residencies in any field in either country and be competitive in applications.

If Portugal accredited its medical schools using international teams it would be an important step forward for the Bologna initiative.

2. Are there negatives to accreditation?

There are two possible negatives. It is quite a lot of work to get ready for an accreditation visit, mainly the self-study to assemble the documents ahead of time. However, assessors always say: "don't give me any more than I can read on the plane," and will complain about massive indigestible appendices and reports you didn't bother to summarise neatly. So if you distribute the work among colleagues and keep your assessment dossier concise and short but answer all their questions they will be very happy.

The second negative could be that individuals may feel that negative information about them has been divulged. I have never seen this happen, and I have never seen an accreditation report mention a person by name. Instead, the accreditors' Report will comment that a programme needs improvement, and will identify the aspects that could benefit by attention. However, Portugal is a small country with much competition required to move up in the medical world (true everywhere) so why not let your discrete European colleagues visit and return home 1000 km. away, and you won't see them again for five years?

3. Are there models Portugal could adapt?

I was asked to describe precisely how the Liaison Committee on Medical Education accredits the 125 Undergraduate Medical Programmes in the US and the 17 in Canada. This Committee has been functioning very smoothly for many years to the general satisfaction of the medical schools in North America. They

have put thousands of hours of committee work into designing accreditation documents and routines, and rather than begin from a blank page Portugal might wish to use or adapt some of their work.

It would be a good idea also for Portugal to examine the accreditation processes in, for example, the UK, France, Holland, Germany or Scandinavia, and compare them with the description of the North America system which now follows to see which is most carefully developed and also suited for the Portuguese situation.

Symmetry is not necessary: Portugal could design its own system or even one for individual schools and e.g. ask the French or English or Dutch to use it to assess their Portuguese medical school; and the other European schools could ask Portuguese accreditation teams to use their own assessment documents.

Most of the rest of the article will now be devoted to a detailed presentation of exactly what the Liaison Committee does.

The medical school to be visited completes a Self-Study document. Usually most of the hard work of improving programmes that everyone knew needed some attention will have been completed in the two years previous to the visit.

The team of five accreditors visits for about five days (there will be a US accreditor on visits to most Canadian schools and vice-versa). The advantage of the visit is that there is usually a very experienced Programme Director, former Dean or Associate Dean who understands exactly the difficulties of running a complex medical programme with changing faculty to high standards. There are usually few surprises and everything is very polite and low-key. They are realistic and give good advice.

The Committee on its accreditation visits assesses five components of the functions and structure of a Medical School.

I. The Institutional Setting (with 15 separate components numbered IS 1-15)

II. The Educational Program for the MD degree (ED 1-48)

- A. Educational Objectives
- B. Structure
 - 1. General Design
 - 2. Content
- C. Teaching and Evaluation
- D. Curriculum Management
 - 1. Roles and Responsibilities
 - 2. Geographically Separated Programs
- E. Evaluation of Program Effectiveness

III. The Medical Students (MS 1-37)

IV. The Faculty (FA 1-14)

V. Educational Resources (ER 1-12)

I will just comment on individual items which I think are particularly important or helpful.

The Institutional Setting

The committee is particularly interested in how schools define their goals and missions because, for example, schools which serve a large rural or disadvantaged population will need to structure themselves to accomplish these goals. The Committee also wants to be sure the achievement of the defined goals is tested in precise outcome measures, and that there is no separation between the basic science and clinical faculty.

IS 1 Define and periodically reassess short-term and long-term goals to successfully accomplish the institutional mission. Frame goals in measurable outcomes

IS 15 Those skilled in basic sciences must maintain awareness of their disciplines to clinical problems, and clinicians must maintain awareness of contributions of basic sciences to clinical problems.

The Educational Program

The Committee is keen for schools to use national norms to assess their achievements. There is a realisation that students now need to learn a wide range of professional skills and behaviours that are patient-centred, and there has been a new emphasis on providing structures to help students achieve these, as exemplified in these two reports, one from each of the US and Canada which set out detailed expectations.

ED 1 National norms should be used for comparison of student achievement of educational goals, and faculty will use the school's educational objectives in designing their courses

ED 1A The school must demonstrate achievement of the general competencies of physicians by how they achieve AAMC's Medical School Objectives Project or Can MEDS 2000

Studies show that patients spend little time in hospital compared to twenty years ago, and that students need to rotate through many specialty clinics to see the same number and variety of illnesses as twenty years ago. The committee wants

to be sure that all students see the same number and variety of patients, and that all faculty are competent.

ED 2 Each course or clerkship must specify:

- *the numbers and types of patients students must see to achieve the learning objectives*
- *major diseases students should encounter*
- *extent of student interaction with patients*

ED 8 Faculty at each site must:

- *be sufficiently knowledgeable to provide effective instruction*
- *have a clear understanding of the educational objectives and the evaluation methods to achieve the objectives*

ED 13 Clinical instruction must include the important aspects of

- *Preventative*
- *Acute*
- *Chronic*
- *Continuing*
- *Rehabilitative*
- *End-of-life care*

ED 21 All instruction must stress the need for students to be concerned with the total medical needs of their patients

The Committee is interested in schools using a wide variety of measures of student learning, in encouraging self-learning, and in innovative research on education. The Committee knows that it is important to have formative evaluations to guide students as well as final evaluations, and that it is often difficult to persuade all faculty to complete formative evaluations in a timely manner.

ED 26 The school must establish:

- *A system to evaluate student achievement using a variety of measures of knowledge, skills, behaviours and attitudes*
- *A system of evaluation to foster self-initiated learning*

ED 9 In view of the increasing pace of discovery of new knowledge and technology, the LCME encourages experimentation to increase the efficiency and effectiveness of medical education

ED 30 Directors of all courses and clerkships must implement a system of formative and summative evaluation

The heart of an effective medical programme is the system of oversight committees that collect information about progress in all the aspects of student

learning, collate the information and take action with frequent and regular follow-up to improve programmes that need strengthening.

ED 33 An effective central curriculum authority will:

- *Contain faculty with expertise in curricular design, pedagogy and evaluation methods*
- *Evaluate program effectiveness by outcomes analysis using national standards*
- *Monitor the content in each course and omissions*
- *Review the objectives, pedagogy and student evaluation of individual course and clerkships*
- *Document in the minutes of committee meetings to the faculty governance committees and deans that these activities took place and show the committee's findings and recommendations*

The Committee wants to know that evaluations of courses by students lead to changes and improvements where needed, and that there are clear standards for faculty conduct in regard to students.

ED 47 Schools must consider student evaluations of their courses and an appropriate variety of outcome measures

MS 32 Each school must develop and publicise the standards of conduct for the teacher-learner relationship and develop written standards for addressing violation of those standards

Faculty

The Committee wants to be sure that faculty have skills in curriculum design and evaluation, and that faculty participate in faculty development.

FA4

- *Faculty should be able to design the learning activities and evaluation methods of their courses consistent with the school's objectives*
- *Community physicians should be:*
 - *effective teachers*
 - *serve as role models*
 - *provide insight into contemporary methods of providing patient care*
- *There should be documented compliance of faculty in professional development activities related to teaching and evaluation*
- *There should be evidence that faculty members' knowledge of their discipline is current*

Blumberg (2003) similarly identifies the main themes in the Liaison Committee visit as assessing educational outcomes, deep learning, the acquisition of

information, evidence-based practice, professional behaviours, communication skills and interpersonal skills as a team member.

Dr. Nuno Sousa asked after the presentation what evidence there was that accreditation improved the quality of medical education. I undertook a literature search and contacted the Director of the Liaison Committee, who e-mailed me that the last assessment was by Dr. Kassebaum in 1997, who was the LCME Secretary. The up-to-date information on how accreditations change medical schools is presumably in their files, and there is an opportunity for a publication for anyone who wishes to summarise the files. The experience of participants in the Accreditation Process is that there is a lot of activity for about two years before an accreditation visit to make sure that all programmes are up to standard.

4. Are there additional qualities Portugal could add to an accreditation programme that would make the Portuguese style unique?

Portugal could adopt some or many of the approaches of the Liaison Committee.

Portugal could also consider issues that will become increasingly important over the next ten years in how both the public and governments assess the quality of medical care. I briefly identify five issues.

1. Ensure the entire medical system is focused on the needs of individual patients by teaching patient-focused care rather than focusing education on diseases and the career structures of health professionals

Epstein (2002) reviewed ways in which professional conduct and patient-centred care could be taught to students. Among the suggestions are the use of standardised patients with probing questions by the teacher about the understanding of the case, deep reading about the whole area after the case, followed by more questions about the student's clinical reasoning; exercises to assess the students ability to search, appraise and use the medical literature; assessments of students by patients; and unannounced standardised patients who present during regular clinics.

Egnew (2004) has a good form for assessing how patient-centred a student's encounter with a patient is. It includes building rapport, opening the discussion and establishing the foci, gathering information, understanding the patient's perspective, sharing information, reaching agreement and common ground on problems and plans, and providing closure.

Stewart (2000) demonstrated that 315 patients of family physicians who received patient-centred care had better recovery from their complaints ($p = .02$), better scores on the mental health dimension of the SF-36 two months later ($p = .05$)

and they received fewer diagnostic tests ($p = .05$) and referrals ($p = .01$) in the following two months.

2. Teach medical students how medical errors originate, and design both their learning and the medical system to minimise medical errors.

Two recent Canadian studies demonstrate the frequency and potential seriousness of medical errors. Baker (2004) showed that adverse events were documented in the charts of 7.5% of patients admitted to a sample of Canadian hospitals, death occurred in 20% of the patients with adverse events, and 37% of these events were preventable. Cornish (2005) showed that 54% of 151 patients admitted to a Toronto hospital had a medication discrepancy compared to their medications before admission, and that 39% of the discrepancies had the potential to cause moderate to severe discomfort or clinical deterioration.

3. Ensure every health professional has daily access to updated clinical information through a hand-held computer.

There are at least five widely available clinical information programmes for hand-held computers. For example, Infotriever from the University of Michigan has teams of reviewers assessing the quality and relevance of publications and sends daily and monthly clinical summaries of key publications that could affect how one cares for patients. Some programmes have advantages in sending daily updates or warnings about new drug interactions or side effects.

4. Ensure students are taught to know how to treat all common medical problems uniformly using clinical practice guidelines

Access to updated Clinical Practice Guidelines (CPGs) is free. The Canadians, the UK and the Dutch in particular have developed very practical guidelines. Despite criticisms that doctors don't like to use guidelines, they are usually a good first summary of the literature that would take one week to search the literature and critically assess.

Examples of guidelines are:

The United Kingdom Handbook of United Kingdom and European guidelines for primary and shared care: <http://www.eguidelines.co.uk>

The Netherlands: www.espald.org/english/cientifica/guias/guiaae.asp

The Canadian Medical Association guidelines www.cma.ca

The Alberta Medical Association www.albertadoctors.org (or available on a CD if you write them – look up their address on the above website)

The Canadian Society of Obstetricians and Gynecologists www.sogc.org [very authoritative guidelines on maternal and fetal medicine]

The US National Guideline Clearinghouse www.guideline.gov [a wide range from all over the world – you have to sort through them]

5. Teach students the literature searching and appraisal skills to assess the literature and the quality of guidelines. We find in Canada that the percentage of students entering residency with some literature searching skills is improving, but it varies according to their medical school of origin, and the skill level should be uniformly high. I have prepared a Power Point on literature searching, which is available at this website at the University of Minho.

<http://ecs2004.ecsaude.uminho.pt/ecs2004/recursos.html>

Any problems with access, please contact Sr. Jorge Freitas at the Medical Education Unit [jmfreytas@ecsaude.uminho.pt]

5. What could be the next steps?

If the Portuguese medical schools decided to collaborate in assessing the quality of accreditation guidelines and their relevance to Portugal they could each take a country and correspond with them, perhaps combining a visit with their next conference there. You could start with the Liaison Committee on Medical Education for the US and Canada which has an excellent website, with assessment documents and a reading list at www.lcme.org

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