EU Harmony

The education of Irish doctors must be seen within a European context. Given the imperatives of the streamlining of professional qualifications across Europe and of the desire under the Bologna Declaration to build a common system of qualifications, the proposed government changes to the undergraduate system of education threaten the harmony of Ireland's medical education system within the EU.[18]

The Bologna Declaration and the reform process flowing from it represent an opportunity for Ireland to follow a common European system of third level education.

Diversity of Intake

The opportunity to achieve diversity is available within the context of an undergraduate system. Diversity will occur within the Irish education system as soon as it is a value which informs the design of the second level curriculum. Undergraduate medical school entry is not a threat to diversity. However, the prospect of introducing an aptitude test to the Leaving Cert for selection to the undergraduate programme has the potential of exacerbating pressure on students and creating a new 'grinds' industry.

IMO Rejects Graduate-Only Entrance to Medical School

The IMO rejects the proposition that the interests of healthcare, patients, and practitioners will be optimised by a graduate-only entry system.

The point's race is caused by restricting the number of places available in certain professional courses such as medicine, pharmacy and architecture. Demand outstrips supply and creates a point's race. Transferring entry to graduate-only level will merely move the point's race from the Leaving Certificate to primary degree examinations. Contrary to the statement of 'concern' about the progressive distortion of second level education by the very high points requirements of a number of third level courses, particularly Human and Animal courses (Health Sciences)',[19] undergraduate entry to medical school is not the cause of the point's race; it has no adverse effect *per se* on second level education. The broadness of the second level curriculum is directly affected by public policy regarding same.

It would be naïve to presume that prospective medical students in the second level cycle would be any less focused or less dedicated because they wish to read medicine as a graduate then the person sitting beside them wishing to read law or architecture as an undergraduate. The likely outcome of moving to graduate-only entry would be a significant rise in the points for science courses. The desired goal of changing the nature of second level education would not be obtained.
While the provision of graduate entry places by UCD and the Royal College of Surgeons will provide a diverse group of students the opportunity to study medicine, it raises the problem of creating a second point's race. Not only will students need to pass their Leaving Certificate but, after an undergraduate degree, sit the GAMSAT or something similar. Alternative suggestions that students might enter medicine *via* an interim two-year period of undergraduate science would carry the same fallacies.

There also is the issue of funding the second degree. As of yet, the government has not said what subvention, if any, will be provided to graduate students. The reality is that, unless any subvention is provided, the goal of social diversity is unlikely to be met.

Graduate-Only Entry: a Disincentive to Women?

If Ireland moves to a graduate-only entry system, students would enter medical school at twenty one or twenty two, delaying earliest qualification age as specialists until the mid-thirties. Given the fact that more than 50% of medical students are female, graduate entry accentuates already considerable career planning difficulties. This problem was already alluded to in the section above on weaknesses of the system. A graduate-only entry system would deny female doctors the flexibility to qualify fully as specialists before they take time out of their careers to have a family. In this context, the IMO believes that graduate programmes should be established in addition to undergraduate programmes.

Mature Commitment / Suitability to a Medical Career

Advocates of graduate entry to medical school have argued the case on 'the basis that selection for the health profession at school leaving age requires that individuals must make this important decision at a less mature age than is desirable.'[20] No evidence has been adduced to support this statement. All second level students must make decisions affecting their careers at the same time. There are no grounds to suggest that those selecting medicine are any less mature than those choosing humanities or engineering. In fact the HEA's 2001 report, *A study of Non-Completion in Undergraduate University Courses*[21] states that, after law, medicine had the lowest non-completion rate averaged over all relevant universities. This would indicate that students entering medical school in Ireland have made a conscious and well thought-out decision to pursue their chosen career.

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Difficulties arise after graduation for Irish medical students due to the disorganised career structure and poor prospects that junior doctors have historically faced i.e. doctors in pursuit of specialist training. These have been addressed in other *fora* such as the Implementation Group of the Task Force on Medical Staffing and the Medical Education and Training Group**.**

Graduate Entry – Qualification Timelines

Comments made in a HEA press release, dated 6th November 2003, to the effect that graduate medical entry, starting in 2007, would supply specialists in time for the expansion of the consultant workforce by 1,700, demonstrates a poor understanding of the length of time required (7-10 years) to produce a specialist. The first consultants from the 2007 entry would become available only in 2020 or 2021. The question remains, in the meantime, where are the extra consultants going to come from? It is naïve to presume that graduates who have trained abroad will automatically return to Ireland. While the Bologna Declaration aims to build a common system of professional qualifications across Europe, this will take a number of years to be implemented. Under current conditions, the health service will be forced to employ consultants trained in systems designed to fulfil the needs of other countries.

IMO Recommendations

1. *The IMO recommends the following improvements to the undergraduate medical education system;*

a) An increase in the overall number of medical school places at undergraduate level open to Irish / EU citizens.
b) An increase the proportion of the overall number of places allocated to students coming from within the Irish education system. The IMO recommends the removal of the 'cap' on Irish /EU student places.
c) Funding for medical student places comparable to international standards.
d) Comprehensive lifelong career planning for the medical profession in order to prevent loss of human capital from the healthcare system.
e) Proper remuneration for Consultant trainers and protected time for training for both Consultants and NCHDs.

2. *The IMO rejects any proposal to introduce a graduate-only entry system to the medical profession for the following reasons;*

a) Within the context of the European Union, undergraduate medical entry is the norm (Ref: Bologna Declaration).
b) International experience demonstrates that graduate entry does not significantly increase diversity of intake.
c) Undergraduate entry to medical school is not the cause of the points' race or any adverse affects on second level students; the cause of these problems lies in the inadequate supply of state-funded third level places in medicine for Irish / EU students.
d) The issues regarding lack of diversity of intake should be addressed by reform of the second level education curriculum.
e) Female participation in the medical workforce will be adversely affected by a graduate only entry system.

3. *Ireland needs to increase the number of fully funded places open to Irish/EU entrants substantially.*

4. *Ireland needs a properly funded world class medical education system, open to talent which will enhance the standards of patient care.*

1 Sixth International Medical Workforce Conference Report, Canada, 2003 (publisher Health Canada) and Australia Medical Workforce Committee, *International Medical Workforce Collaborative*, Fifth International Medical Workforce Conference Report, at http://www.healthworkforce.health.nsw.gov.au/amwac/amwac/5th_conf.html
2 Postgraduate Medical and Dental Board figures show that in 2001, 55% of Irish medical graduates were female and in 2003, 53% of Irish NCHDs were female. For 8 consecutive years, between 1994 and 2001, there were more Irish female than Irish male graduates – in 2002, according to the PGMDB's fourth report, almost 62% of Irish undergraduates were female. The HEA *Fourth survey of access to higher education* report also found that the number of women enrolling in medical sciences more than doubled between 1992 and 1998 and stated that medicine has "attracted a disproportionate number of female students".
3 Due to the fact that many female graduates drop out or reduce their hours as a result of family commitments, the number of places need to increase as well as improvements in the flexibility of working and training contracts are needed.
4 Professor Patrick Fottrell *et al.*, (2006) *Medical Education in Ireland; a New Direction.*
5 Central Applications Office
6 Ref: British Council at www.educationuk.org subject sheets:- medicine
7 Indecon, *The Cost of Medical Education in Ireland*. 2005
8 The Medical Council, *Statement on Undergraduate Medical Education*, 1997.
9 Fottrell et al., p.2
10 Fottrell et al, p.5
11 Fottrell et al, P. 18
12 Fottrell et al, p.3
13 Fottrell et al, p.5
14 Report of the National Task Force on Medical Staffing, June 2003
15 Dr. Jane Buttimer *et al.*, P. 4.
16 Irish Times July 25th 2000.
17 Fottrell, P. 6.
18 Fottrell, P. 8
19 Bologna Declaration, 19/6/1999. The Ministries of Education of the EU, EEA, and other European countries agreed at Bologna to work toward a common system of academic degrees and common methods of assessment to ensure student mobility and easy international recognition of third level qualifications across Europe.
20 Leo Kearns, *Study into Alternate Methods of Entry in to Health Sciences Professional Courses at Third Level,* (Dublin, 2003) published by the HEA, Executive Summary 1.1, p.14
21 HEA (2003) p.14
22 Mark Morgan *et al.*

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IMO Position Paper on Medical Schools

August 2006

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IMO Position Paper on Medical Schools

Overview

The IMO believes that four factors are currently causing significant difficulties for the Medical School system and for the profession as a whole:

1) Insufficient funding for medical education and training both at undergraduate and postgraduate level in Ireland.
2) The absolute number of student places is too low in relation to the current and future personnel requirements of the sector.
3) The arbitrary 'cap' on the number of places for Irish/EU students at 305 remains in place and restricts intake to approximately 315 *i.e.* there are too few places being funded for Irish/EU candidates.
4) The lack of a clearly defined medical career structure and body such as central training authority within which to situate undergraduate medical education and postgraduate training and its effect on retention of graduates.

These factors are of primary importance in order to improve the quality of the educational experience and professional training at third level and meet the demands of a rapidly changing health care service.

Health Service Reform

The health service reform recommended in recent reports will have consequences for the entire continuum of medical education, training and practice from undergraduate to consultant level. Implementation of the reform will create the need for a greatly increased number of doctors which will enhance patient care.

There are a number of reasons why an increase in the level of overall places is needed;

- The shortening of the working week as a result of implementing the European Working Time Directive (EWTD) will require a larger number of doctors.
- The projected increase in the number of consultants that would be needed nationally to implement the Hanly report recommendations on consultant provided service.
- The current and impending shortage of primary care specialists in the country.
- Globalisation of medical profession and migration of doctors, which presents both an opportunity and challenge to the medical manpower planning.[1]
- Current projections which show an increase in the proportion of female doctors in the profession. Work patterns relating to family commitments (such as maternity leave, part-time work, etc) are more common amongst female practitioners. The change in gender balance within the profession is therefore likely to place greater pressures on the workforce as a whole. The higher the proportion of female doctors to male doctors, the higher the absolute number of doctors that will be needed.[2] Consequently medical schools will need to alter significantly the structure and delivery of both education and training.
- The publication of the findings of the Fottrell and Buttimer working group reports on undergraduate and postgraduate education.

Too few opportunities for Irish students at Entry Level

Irish/EU students account for a disproportionately low number of places compared to non-EU students. The Fottrell Report has recommended an increase of places for EU students from 305 to 725. This increase is to be phased in over four years with 60% of the increase to be allocated to undergraduate places and 40% to postgraduate places. Undergraduate training will take five years and graduate training four years.[3]

While first preference applications for medicine via the Central Applications Office (CAO) are currently rising, the number of places available in Irish colleges has remained almost static. The following table shows the steady rise in the number since 2001.

No of students applying through the CAO to study medicine as their first choice

Year	No. of Applications
2001	1399
2002	1561
2003	1834
2004	2098
2005	2095

Source: CAO[4]

The IMO firmly believes that the increase in student numbers should be sourced from Irish/EU student applications. The UK system has put in place a 7.5% cap on non-EEA entrants to medical school.[5]

The effect of the preferential treatment in return for high fees for non-EU students *via* opportunities at undergraduate level and the relatively low level at which the 'cap' for Irish/EU student entrants is set is twofold:

- **It creates a shortage of places in medical school for Irish/EU students** in proportion to a very high and growing demand as seen in the above table.

- **It creates an emigration of talent and loss of return on educational investment –** the Irish medical system suffers the loss of potential expertise, as Irish students exit the system, to follow different careers or take up opportunities presented to them to become doctors in other countries. If graduates fail to return, the Irish Government loses the return on investment made in their second level education.

Acute Under-funding of Undergraduate Medical Education in Ireland

The chronic under-funding of undergraduate medical education in Ireland needs to be addressed. Scottish medical schools receive four times greater funding per student from the state compared with universities in the Republic. Medical schools in the Republic received between €7,135 and €9,000 per EU student per year compared with €36,430 for medical students in the University of Glasgow and €34,976 in Queens, Belfast.[6]

Inadequate funding of the undergraduate medical education and training system by the Irish Government helps to reinforce a system of dependence on Non-EU students to fund Ireland's medical education system. The IMO believes that this situation is untenable and unfair.

The nature of funding will not allow for small group, tutorial teaching because teaching resources have not kept pace with the total rise in student numbers. If undergraduate education is moving away from didactic teaching toward tutorial methods, it will require many more teachers and more resources.

The chronic funding situation also needs to be addressed in the context of the Medical Council's recommendations on curriculum reform. The Medical Council demanded an urgent review of funding needs to take place if the curriculum reform process is to be effective.[7] The Fottrell Report has treated the issue and outlined the scale of the resource allocation required.

NCHD Training (Clinical)

The announcement by the Department of Health and Children in February 2006 that it would provide €200 million in funding for medical education is very welcome. However, IMO research among the medical schools in Ireland has highlighted another area of chronic under-funding; NCHD Clinical Training. The Medical Council's *Review of Medical Schools of Ireland* emphasised the critical lack of training capacity to cater for an increased amount of students. The Fottrell report noted that 'radical reform of clinical training provision and capacity is an absolute precondition for any increase in overall numbers of medical students.' [8]

Within the current NCHD training system, junior doctors depend on consultants for vocational training. This is delivered without adequate remuneration of the consultants who hold teaching posts. Equally important, though often overlooked, is the fact that there is no protected time for this training for NCHDs and consultants. This results in prolonged and less structured training for NCHDs. Fottrell has noted the work of the Medical Council and stated trenchantly that 'the overwhelming majority of clinical education is provided by consultants, registrars and SHOs who do not have a specific academic contract and provide teaching services on a voluntary basis.'[9]

Fottrell estimated that funding voluntary teaching comes to €8,500 per student per year[10]. In the absence of current non-EU students' fees, even existing training programmes could not be maintained.

Intern posts must be increased by between 150-300 places to cope with the increase in student numbers.[11] Clinical training capacity will need to cater for between 760 to 2000 graduates.[12] There is an urgent requirement for structured training programmes that can be assessed and evaluated.

Poor Workforce & Career Planning and Structures

The IMO believes that better career planning is required to insure that the numbers in medical education and training adequately reflect the future of service requirements. This is particularly pertinent in light of the planned health reforms. As the Hanly report itself points out, medical training is intertwined with service provision.[13] The report also reflects the awareness that integrated planning of training and workforce numbers is essential to ensure that service deficits are avoided and that training numbers reflect future service requirements.

For many people in education and training it is difficult to see evidence of such planning. The IMO believes that there are currently serious 'choke points' in the system, which make it difficult for medical students to know where their education and training will lead them. These include;

1) Lack of comprehensive manpower analysis and long term planning.
2) Lack of clarity in the relationship between post-graduate speciality training, career structure and permanent employment opportunities.
3) Lack of clarity in the relationship between post-graduate speciality training and increasing numbers of NCHD posts which are of a service nature.
4) Lack of clear career paths due to all of the above.

The IMO believes that lack of co-ordination and planning in the system has contributed to the following problems:

- A reduction since 1984 in the number of Irish nationals applying for NCHD posts;
- A marked increase in the emigration pattern of Irish medical graduates, particularly male graduates.

The IMO conducted its own *National Benchmark Survey* in 2001. The survey found that 31% of respondents said they would not choose medicine again if they had the opportunity of starting their careers over. Particularly relevant was the greater number of female practitioners (36%) compared to male practitioners (29%) who stated that they would not choose medicine again.

However by contrast, the IMO noted in its submission to the Health Strategy that many young doctors are attracted by properly structured training schemes in Britain where consultant posts are more closely matched to training posts. The MET report recommends the independent and expert evaluation of the training value of all NCHD posts[14]. NCHDs are more confident of securing a consultant post once they successfully complete their training.[15]

The Fottrell report highlights the need for a greater focus on the logistics and co-ordination involved with aligning clinical training and curriculum objectives, student allocation and clinical capacity[16]

The IMO commends the Department of Health and Children and the Department of Education for the publication of the Fottrell Report, but believes they need to work together with other stakeholders to ensure the anticipated service delivery needs are reflected right back through the system of education, training, and recruitment. In particular, given the proposed reform of the hospital system and the ongoing shortage of general practitioners in the country, those with the responsibility for planning need to consider the appropriate relationship between numbers in the medical education and training system and anticipated future demand for consultants & GPs.

As previously argued, this will require change at two different points in the process.

1) More places at undergraduate level
2) More accredited training places at post-graduate level leading to a specialist certification.

The importance of putting the appropriate changes and structures in place in order to educate, train, retain and motivate medical staff into the future cannot be underestimated and should not be overlooked in a review of any aspect of the medical education and training system. There is a need to match training posts with consultant posts which would provide clear career paths for medical students and eradicate problems currently faced by the HSE.

The Case for Graduate Entry

The IMO supports the notion of graduate entry to the medical profession within the context of a comprehensive policy on diversity in education. Fottrell recommends a phased increase in the number of under-graduate / graduate places to the ratio of 60:40 over a four year period.[17] The method for entry will include the completion of an appropriate test (e.g. MCAT, GAMSAT, UMAT or equivalent derivative) by candidates with an honours primary degree.

In 2006, the first Graduate Entry Programmes came into operation in Ireland. The UCD School of Medicine and Medical Science plans to introduce a four-year programme in medicine by means of the GAMSAT that will be open to holders of honours degrees. The Royal College of Surgeons has fifty places open to EU and Non-EU graduates who have obtained a minimum of a 2.2 honours degree and have a knowledge of science. Unlike UCD, the GAMSAT is not yet mandatory for entry to the RCSI Graduate Entry Programme.

The IMO believes that the example of the UK, Canada, and Australia suggests that the role for graduate level entry lies in providing an additional, complementary, route of entry to medicine.