



SITE VISIT

at

**THE CAIRO UNIVERSITY, FACULTY
OF MEDICINE**

**Final Report of the WFME External
Evaluation in December 2004**

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INTRODUCTION

The invitation

The contact between the Faculty of Medicine, Cairo University and the World Federation for Medical Education (WFME) was made during the 2003 World Conference: “Global Standards in Medical Education for Better Health Care”, held in Copenhagen, Denmark, March 15-19, 2003. Following a Self-evaluation Study, the Cairo University Faculty of Medicine, facilitated by the Medical Education Development Centre (MEDC) Office, in 2004 forwarded an invitation to WFME to make an external evaluation based on the Self Study.

Purpose of visit

The purpose of the visit was to review the Faculty of Medicine at Cairo University on the background of the Self Study conducted by the Faculty of Medicine in 2004, which uses the WFME Global Standards for Quality Improvement of Basic Medical Education as a benchmark. The combination of the Self Study and the Site Visit by external reviewers from WFME is part of the national project on quality assurance and accreditation of medical schools in Egypt.

Although the Self-Study Report only deals with the basic medical education dimension of the WFME Standards (with some modifications), the review by the visitors will also include the quality development aspects.

It should be emphasised that WFME is not an accrediting agency. However, WFME is highly interested in contributing to the testing of the value of the WFME Standards, and, as a part of the WHO-WFME Strategic Partnership, to the improvement of medical education with regard to the issue of accreditation of medical education institutions and programmes.

Presentation of site-visit team

Dr. Hans Karle, president of the World Federation for Medical Education, is a haematologist at the University of Copenhagen and former chairman of the Danish Specialist Board for many years. He has done evaluations of medical schools in Sweden and Turkey. Professor Leif Christensen, Senior Advisor to the WFME, is a sociologist, former Dean of the Faculty of Social Sciences, former Prorector of the University of Copenhagen and former Head of Administration of Studies, Faculty of Health Sciences, University of Copenhagen. He has done evaluation of programmes and projects of education in Eastern Europe and Turkey. Dr. Jørgen Nystrup, Senior Advisor to the WFME, is a psychiatrist, associate professor at the University of Copenhagen, Postdoctoral Fellow in Medical Education at the University of Rochester, New York, former advisor for health professionals education for the Minister of Higher Education in Denmark.

The strengths of the team are (a) knowledge of the WFME Global Standards Programme including the Standards in Basic Medical Education, (b) expertise in international medical education subjects, (c) experience in teaching and especially in organisation and administration of medical education, and (d) experience from previous site visits.

The most obvious weakness of the team is lack of experience in matters related to educational traditions of medicine in the region, i.e. the culture, socio-economic conditions and practice.

Conditions for the review

The limitation of time allocated clearly meant restrictions, and the review only included a small number of the many departments involved in the medical education programme. This remark is especially relevant regarding the clinical sector of the Faculty of Medicine. This situation implies the risk of bias in selection of visited departments.

The material provided before the visit included the Self-Study Report.

The following material was received during the visit:

- Annexes 1 – 20 to the Report (Annex 21 missing)
- Course specifications
- Course material and textbook in biochemistry
- Core curriculum in paediatrics
- Internal medicine course syllabus

Altogether, the material was found sufficient, although we would have preferred to receive the Annexes to the Self-Study Report before the visit.

Most medical schools are in a state of dynamic change, the Cairo Faculty of Medicine not least due to the recent activities of the MEDC, which meant that changes had taken place between finalising the Self-Study report and the site visit (appendix 1).

Before the visit, some comments to the Self-Study Report were forwarded by the experts (appendix 2).

Observed prerequisites

The team noticed that a number of important areas of decision were beyond the jurisdiction and direct responsibility of the Faculty of Medicine. This included:

- the intake of students, number as well as qualifications
- national (governmental) curricular requirements, including duration of study periods and specific elements.

THE SITE VISIT

The programme for the visit is included (appendix 3).

Notes are included from meetings with senior faculty members (appendix 4) and medical students (appendix 5).

On location a preliminary report was delivered to the senior faculty staff. The presentation of the report is included (appendix 6).

THE EXTERNAL EVALUATION

This part of the report is organised in the same way as the Self Study, following the WFME Global Standards in Basic Medical Education.

1. Mission and Objectives

1.1 STATEMENTS OF MISSION AND OBJECTIVES

Basic standard:

*The medical school **must** define its mission and objectives and make them known to its constituency. The mission statements and objectives **must** describe the educational process resulting in a medical doctor competent at a basic level, with an appropriate foundation for further training in any branch of medicine and in keeping with the roles of doctors in the health care system.*

The statements of mission and goals are comprehensive and describe an educational process likely to result in a competent medical doctor.

Missions are formulated partly as a medical school mission (quoted in the Self Study) and in seven broad goals for the educational outcome of the students. These goals are comparable with international standards. Each course has formulated more detailed objectives or intended learning outcome. It is unclear for the visitors whether these course-specific objectives in total present a clear picture to the faculty and the students of the educational process resulting in a competent medical doctor.

Major problems or weaknesses are related to a rather limited participation of stakeholders in the formulation of mission and objectives and the demonstrated lack of knowledge of the mission and goals among staff and students. However, the site-visit team is aware of corrective actions following the self-study (e.g. focus groups from the syndicate, the Ministry of Health and students).

The visitors must endorse the suggested corrective actions, primarily actions to disseminate information on mission and objectives among staff and students and involvement of a wider range of stakeholders. Regarding the information, it is recommended to divide the efforts between, on the one hand new students and new staff, and on the other hand already admitted students and existing staff, as the need for information is different and the opportunities for reaching the target groups are different.

Quality development:

*The mission and objectives **should** encompass social responsibility, research attainment, community involvement, and address readiness for postgraduate medical training.*

The seven broad goal statements underline the importance of the topics mentioned. However, the visitors noted a lack of specifications of the role of the medical doctor in the Egyptian health care system and considerations of the disease patterns in Egypt.

1.2 PARTICIPATION IN FORMULATION OF MISSION AND OBJECTIVES

Basic standard:

*The mission statement and objectives of a medical school **must** be defined by its principal stakeholders.*

Regarding involvement of stakeholders, the visitors strongly recommend participation of representatives of the students and of the profession and health care system. The involvement of stakeholders can be seen as a motivating factor and can be expected to have a positive impact on learning and development of competencies.

Quality development:

*Formulation of mission statements and objectives **should** be based on input from a wider range of stakeholders.*

In the Self-Study Report, it is noted that neither the Ministry of Health nor the Medical Syndicate received a copy of the mission, goals and objectives once formulated. To fulfil the WFME Quality Development Standards, these parties should be involved in the process of formulating the documents. Even wider audiences like patients or representatives from the public or religious communities might be considered as stakeholders.

1.3 ACADEMIC AUTONOMY

Basic standard:

*There **must** be a policy for which the administration and faculty/academic staff of the medical school are responsible, within which they have freedom to design the curriculum and allocate the resources necessary for its implementation.*

The Law for Universities Regulation seems quite clearly to delegate some responsibility to the Faculty Council and to the Departmental Council. However, according to the Self-Study Report there seems to be a conflict of interest between some departments and the strivings of the Faculty Council to change curricular matters.

Regarding the academic autonomy, the visitors have the impression that national regulations are rather detailed and severely limit the freedom for the medical school to design the curriculum, and especially restrict the possibilities for the medical school to allocate the resources necessary for its implementation.

The visitors recommend a dialogue with the government regarding a change of the balance between national regulations and the responsibility of the medical school for the quality of medical education.

Quality development:

*The contributions of all academic staff **should** address the actual curriculum and the educational resources **should** be distributed in relation to the educational needs.*

It is difficult for the visitors to get a clear picture of the balance between single departmental interest in curricular shares and their balanced contribution to the curriculum seen from an educational viewpoint. On the other hand, there is an indication of interest in being more involved since many staff members according to the Self Study consider their degree of participation in curricular matters to be inadequate. This need might be met in creating a broader curriculum committee with subcommittees. The curriculum committee should have the power and authority over the whole curriculum and over the departments in teaching matters. The curriculum committee should have the power and authority over the whole curriculum and over the departments in teaching matters.

1.4 EDUCATIONAL OUTCOME

Basic standard:

*The medical school **must** define the competencies that students should exhibit on graduation in relation to their subsequent training and future roles in the health system.*

The general objectives of the faculty call for graduates to be broadly educated with an appropriate foundation for further practice in any field of medicine, including general practice (family medicine), residency programs for medical, surgical, laboratory or other specialities, and career choices in medical research, public health medicine or health service administration. In addition, it is specified that the graduates should have competencies in knowledge, clinical skills, communication, awareness of social and community contexts of health care, ethics and professional behaviour and life-long learning.

This list of competencies seems quite adequate.

Quality development:

*The linkage of competencies to be acquired by graduation with that to be acquired in postgraduate training **should** be specified. Measures of, and information about, competencies of the graduates **should** be used as feedback to programme development.*

Although described in general, a major weakness according to the Self-Study is the lack of specification of the educational outcome by defining the competencies that students should exhibit on graduation in relation to their subsequent training and future roles in the health system.

Evaluation of the graduates' competencies, which could be used as a feedback to program development, is only randomly taking place.

Concluding remarks regarding AREA 1

In the area of Mission and Objectives, important developments have taken place since the preparation of the Self-Study Report and before the Site Visit. Extensive work is initiated comprising specification of learning objectives and description of course plans. This action is fundamental and the results will have impact on several other areas of the medical programme as a whole.

The Site Visit confirmed the conclusions of the Self Study, regarding the strengths as well as the weaknesses, in relation to the basic standards of the WFME Global Standards.

The basic standards in this area are fulfilled or partly fulfilled. Shortcomings are being addressed.

Quality Development is possible within several standards.

2. Educational Programme**2.1 CURRICULUM MODELS AND INSTRUCTIONAL METHODS****Basic standard:**

*The medical school **must** define the curriculum models and instructional methods employed.*

The undergraduate program consists of a 6 ½ year curriculum organised by discipline and delivered by basic and clinical-science faculty. Three years are preclinical, three years clinical, followed by a 12-months preregistration training before being licensed to practice medicine.

The curriculum utilizes a variety of instructional methods, including lectures, tutorial classes, practical training in the lab and clinical inpatient and outpatient rounds, student and faculty seminars in some courses, and computer-assisted learning in only one course (the biochemistry course).

Teaching times are almost always in the morning. Half of the contact hours in the preclinical years are spent in practical activities (lab, museum and dissecting room). Two thirds of the contact time in the clinical years is spent in patient-related activities.

The Site-Visit Team got the impression that there were no dissection exercises with real corpses, and the anatomical museum seemed quite insufficient in both quantity and quality to provide the students with anything but scanty and historical examples of anatomy and pathological anatomy.

The Self Study discusses the importance of self-directed learning. To that end the Site-Visit Team agrees with both students and faculty that the library facilities are insufficient and not encouraging for that purpose.

The Self Study points out that the amount of private tutoring is a problem. In order to make this less attractive, additional workshops on teaching skills might foster a more general dynamic interchange between lectures and self-directed learning. This might create more dialogue (student activation) during the teaching sessions. Furthermore, clinical-skills lab training, both quite early as a motivating subject and during the clinical clerkships, might enhance the skills-training aspect of the education. During the Site Visit, it was discussed whether skills-lab equipment should be placed centrally or decentralised at relevant departments. There is probably no easy answer to that. A very sophisticated skills-lab might be so expensive that a centralised solution is preferable. Decentralised equipment can more easily be integrated in the curriculum. In both cases, the major problem with skills-labs is the maintenance and manpower support.

Quality development:

*The curriculum and instructional methods **should** ensure that students have responsibility for their learning process and **should** prepare them for lifelong, self-directed learning.*

It is an interesting phenomenon that all teaching and learning material is in English. Although this decision could be disputed from a national health care perspective there is no doubt that this stimulates and open up possibilities for lifelong learning both on an individual (journals, textbooks, internet) and on a collective basis, stimulating the interest and widening the possibilities of attending international conferences, thus serving continuing professional development purposes.

In general, the Site-Visit Team finds the organisation of instructional methods and the heavy load of end-of -the-year examinations counterproductive to independent learning. An experimental solution to this could be the establishment of independent learning programmes for selected parts of the student body.

Since the organisation of the faculty is strongly departmentalised, it is difficult for the students to study integrated subjects or subjects not taught in the normal curriculum. Furthermore, it requires a strong curriculum committee with some ruling power over the curriculum to insist on both horizontal and vertical integration.

2.2 SCIENTIFIC METHOD

Basic standard:

*The medical school **must** teach the principles of scientific method and evidence-based medicine, including analytical and critical thinking, throughout the curriculum.*

Having a classical, traditional curriculum model with separation of preclinical sciences and clinical sciences, one may conclude that the students will get a basic and strong science base for their medical study. One may define this science base as rooted in the natural sciences.

In the Self Study, it is emphasised that the students in the third year are introduced to a specific course on principles of scientific methods. They learn basic study design and the principles of medical statistics in an abstract form.

In order to increase the focus and awareness of evidence-based medicine the Medical Education and Development Centre (MEDC) is launching a series of workshops enhancing faculty skills in this area.

Quality development:

*The curriculum **should** include elements for training students in scientific thinking and research methods.*

A few especially gifted students (we assume) are given the chance to engage in small research projects already in their preclinical years. They may author or co-author a small scientific article or they get the chance to present their work at the annual faculty day for presentation of student research.

In order to foster self-experienced research activity and deepen the understanding of scientific method, many schools around the world demands one or more times during the study period a compulsory elective assignment of the student. Such assignments can vary from small write-ups as part of course teaching to more demanding literature reviews or small supervised experiments or evaluation of clinical phenomenons or elementary comparisons of the result of different clinical treatment modalities. If the writing has a magnitude of a treatise it might be considered exempting the student from regular yearly examination in the particular subject.

2.3 BASIC BIOMEDICAL SCIENCES

Basic standard:

*The medical school **must** identify and incorporate in the curriculum the contributions of the basic biomedical sciences to create understanding of the scientific knowledge, concepts and methods fundamental to acquiring and applying clinical science.*

This principle seems very important in the curriculum model at the Faculty of Medicine, Cairo University. Given the huge number of students, one may, however, doubt the deeper level of understanding in the individual student. Even given the fact that the faculty staff at the preclinical

departments do their utmost in illustrating their teaching with clinical examples, it is difficult to imagine that the physicians in any large numbers will be able to conduct clinical scientific research upon graduation.

Quality development:

*The contributions in the curriculum of the biomedical sciences **should** be adapted to the scientific, technological and clinical developments as well as to the health needs of society.*

It is the impression of the Site-Visit Team that this is indeed so at the Faculty of Medicine, Cairo University.

2.4 BEHAVIOURAL AND SOCIAL SCIENCES AND MEDICAL ETHICS

Basic standard:

*The medical school **must** identify and incorporate in the curriculum the contributions of the behavioural sciences, social sciences, medical ethics and medical jurisprudence that enable effective communication, clinical decision making and ethical practices.*

These disciplines are clustered in community and public health, forensic medicine and medical psychology. In public health and community courses, students study the basics of health administration and communication. It is quite a heavy theoretical course amounting to 128 hours of lecturing in year five. Communicable and non-communicable disease prevention is part of the epidemiology course. Preventive aspects of different diseases are taught by the faculty as part of any disease management plan. Medical ethics and jurisprudence are integrated in the forensic medicine course.

The students complain about lack of applicability of the current medical psychology course.

Quality development:

*The contributions of the behavioural and social sciences and medical ethics **should** be adapted to scientific developments in medicine, to changing demographic and cultural contexts and to health needs of society.*

This is a constant challenge to disciplines in medical curricula to bridge between academic theory and societal needs. Even if the behavioral sciences teach this, current research imprint on the study plans is weak.

2.5 CLINICAL SCIENCES AND SKILLS

Basic standard:

*The medical school **must** ensure that students have patient contact and acquire sufficient clinical knowledge and skills to assume appropriate clinical responsibility upon graduation.*

The clinical courses cover a broad spectrum of clinical disciplines. The duration of the clerkship period seems sufficient. Due to the huge number of students it might be difficult to secure experiential clinical training for each student. However there seems to be an abundance of clinical cases in the Cairo area. Some of the patients in private hospitals are reserved for postgraduate training although the experience from other medical schools around the world suggests that hospitals serving medical students are highly esteemed and patients feel proud to tell their story to a medical student. The Self Study calls attention to the fact that: “Students are allowed to take history from patients and perform physical examinations. However, they are not allowed to write in patients’ records, prescribe treatment or request investigations”. The Site-Visit Team finds this in total accordance with clinical teaching for students all over the world. These necessary restraints on function does not prevent active engagement in clinical care – even if the students are performing a supplementary (parallel) medical record, which is not a legal part of the health care system, but an educational tool.

The Site-Visit Team feels that there might be some cultural inhibitions in opening up clerkships for full-time student engagement obeying the above rules. The formulations in the Self Study and our interviews suggest that the students are too much observers with too few clerkship demands.

The Site-Visit Team also feels that clinical skills might not be sufficiently assessed, and not sufficiently rehearsed, for example in clinical-skills labs.

Quality development:

*Every student **should** have early patient contact leading to participation in patient care. The different components of clinical skills training should be structured according to the stage of the study programme.*

Early clinical exposure is virtually missing in the present curriculum, both in terms of motivating elements and in terms of integration with the preclinical sciences.

Many models for early clinical exposure exist on the international stage.

2.6 CURRICULUM STRUCTURE, COMPOSITION AND DURATION

Basic standard:

*The medical school **must** describe the content, extent and sequencing of courses and other curricular elements, including the balance between the core and optional content, and the role of health promotion, preventive medicine and rehabilitation in the curriculum, as well as the interface with unorthodox, traditional or alternative practices.*

The content, extent and sequencing of the courses and other curricular elements are clearly described at the faculty, both generally and in examples of separate course material in different disciplines.

The Site-Visit Team saw beautiful brochures with course descriptions containing objectives and learning guides in both pediatrics and biochemistry.

Although the Self Study states that most of the faculty agrees that electives are very beneficial and should be part of the curriculum, it is not possible with the current overloaded and examination-heavy curriculum. We support the Self Study which suggests the following corrective actions:

- Decreasing the theoretical load of the curriculum and putting more time for clinical applications and student-directed learning sessions
- Dividing basic science courses into semesters to decrease student workload.
- Planning for elective studies in the curriculum to encourage students to engage in in-depth study of areas of interest and to identify students with specific interests.

Quality development:

*Basic sciences and clinical sciences **should** be integrated in the curriculum.*

This is only beginning to be discussed. Preclinical sciences use clinical examples in the teaching programme, and clinical faculty refer to preclinical sciences in their teaching. No systematic efforts are in action in terms of integrated teaching, symposia or integrated exams.

2.7 PROGRAMME MANAGEMENT

Basic standard:

*A curriculum committee **must** be given the responsibility and authority for planning and implementing the curriculum to secure the objectives of the medical school.*

It is only since January 2003 that a curriculum committee has been formed as the faculty body responsible for the management of the curriculum.

The terms of reference are rather comprehensive, but the Self Study points out that the actual situation is that departments have the autonomy to define their course contents, to decide on teaching and assessment methods within the frame defined by the faculty regulations and to give feedback directly to the Faculty Council without Curriculum Committee approval.

Quality development:

*The curriculum committee **should** be provided with resources for planning and implementing methods of teaching and learning, student assessment, course evaluation, and for innovations in the curriculum. There **should** be representation on the curriculum committee of staff, students and other stakeholders.*

The Curriculum Committee at the Faculty of Medicine, Cairo University has no financial autonomy and no independent budgetary lines. Neither is student representation secured.

The committee is headed by the associate dean of student affairs and education. Other members include:

- The director and the vice-director of the medical education and development centre

- Four professors from basic science courses
- Six professors from clinical courses
- Educational experts
- Teacher representatives

As corrective actions, the Self Study suggests that the Curriculum Committee should have student members and members from the Ministry of Health. At least these parties should be invited regularly, the opinion is. In addition, adequate links between the Curriculum Committee, course directors, and departmental councils should be established. Horizontal links between courses taught in the same year could be useful as well as vertical links between basic and clinical sciences to provide integration.

2.8 LINKAGE WITH MEDICAL PRACTICE AND THE HEALTH CARE SYSTEM

Basic standard:

*Operational linkage **must** be assured between the educational programme and the subsequent stage of training or practice that the student will enter after graduation.*

A very well organised and structured preregistration house-officer training programme lasting 12 months after the six years of basic medical education exists. Two specialties can be chosen as electives during the period.

Complaints have been made that graduates are not well enough prepared for entering this phase of postgraduate training. Neither is compulsory training in primary care (in community hospitals or clinics) required.

As corrective actions, the Self Study suggest that students are encouraged to spend more time in community hospitals and clinics, particularly if they are going to work as general practitioners after the end of the year. We support this proposal.

Quality development:

*The curriculum committee **should** seek input from the environment in which graduates will be expected to work and **should** undertake programme modification in response to feedback from the community and society.*

It is difficult for the Site-Visit Team to evaluate whether this process takes place. We assume it does take place on an overall basis through dialogues with the Ministry of Health and the World Health Organisation. However, systematic interaction between the University and Hospital Owners is probably not conducted on a regular basis and seems insufficient to provide systematic feedback.

Concluding remarks regarding AREA 2

The curriculum model of the Faculty of Medicine at Cairo University is quite traditional with a rather firm division between preclinical sciences and clinical sciences. Seen as a whole, a variety of instructional methods are employed. Computer-assisted learning is emerging. Networking between students and between students and faculty is only possible through the internet. No intranet with teaching schedules, teaching assignments, etc., has been developed. Almost all teaching takes place in the morning. It seems an insufficient use of both student and teacher time. The Self Study does say that the amount of private tutoring is a problem. In order to make that less attractive more workshops on teaching skills might foster a more general dynamic interchange between lectures and self-directed learning.

The fact that all teaching and learning is conducted in English could be disputed from a national health care perspective, but it certainly opens up an international stage for lifelong learning.

The heavy load of “end-of-the-year examinations” seems counterproductive to independent learning incitements for the students.

Since the organisation of the faculty is strongly departmentalised, it is difficult for the students to study integrated subjects.

The training in research methodology only takes place for a few specially gifted students. However, the curriculum is strongly based on science and research results. New initiatives to enhance evidence-based medicine are taken by the MEDC. In many international schools, a compulsory elective written assignment, or small treatise, is required in order to foster an experience in the use of research.

The content of the curriculum seems quite in accordance with most schools in the world. This implies both basic biomedical sciences, behavioural and social sciences and medical ethics as well as clinical sciences and skills.

Concerning clinical teaching it might be difficult to secure experiential clinical teaching for each student. The Site-Visit Team got the impression that clinical skills might not be sufficiently assessed and not sufficiently rehearsed, for example in clinical-skills labs.

The Site-Visit team agrees with the Self Study that it is desirable to:

- Decrease the theoretical load of the curriculum and devote more time to clinical applications and student-directed learning sessions
- Divide basic science courses into semesters in order to decrease student workload
- Plan for elective studies in the curriculum in order to encourage students to in-depth study of the area of interest, and to identify students with specific interests, would add to quality improvement

Concerning programme management, the crucial question seems to be the composition and competence of the curriculum committee. The present committee originates from 2003, but it is not able to fulfill neither the Basic nor the Quality Development Standards of WFME.

In the area of “Linkage between Medical Practice and Health Care”, systematic interaction between the University and the Hospital Owners is probably not regular and insufficient to provide systematic feedback

All in all, the Basic Standards within this area are partly fulfilled; the Quality Development Standards are barely fulfilled.

3. Assessment of Students

3.1 ASSESSMENT METHODS

Basic standard:

*The medical school **must** define and state the methods used for assessment of its students, including the criteria for passing examinations.*

From deliberations with the Dean, senior faculty, students and staff from MEDC as well as meeting individual chairmen from various departments, we may conclude that examinations in the medical school plays a major role in qualifying for becoming a doctor.

With the huge number of admitted students per year – beyond the control of the Medical Faculty itself, there is no possibility of establishing personal teacher/doctor mentorship, except in rare cases. Quality control must be based on examinations.

We understand that the most commonly used method of examination is written short-answer essays as well as general written essay examinations. In general, the examinations are required yearly throughout the medical study (6 ½ years). The yearly examinations are based on the major disciplines taught during the year, meaning that the student may have to sit for several examinations per year. Surprisingly, each student may enroll for the examination an unlimited number of times. This is in contrast to most places in the world where there is a limited number of examination possibilities in order to exert quality control – even when students are highly selected from the beginning. They may not be suited as doctors despite excellent intellectual and social capabilities.

In the clinical disciplines oral examinations are required. In the presentation of the Core Curriculum of Pediatrics several other evaluation methods are outlined: Assignments, case studies, project reports, structured clinical examinations, observations with checklists, portfolios. From interviews with students and from own investigations we might conclude that these examination methods are being developed but in no way are substitutes for the traditional written and clinical oral examinations. In all likelihood only a few students as part of the classroom teaching are giving the chance to be evaluated by these methods. Furthermore, it is stated that students during the course should be evaluated through formative assessment.

We were given no evidence that systematic pass/fail criteria were formulated as for example blueprints for written examinations. Not to speak of any relationship between examination questions and stated missions and objectives.

The examination methods as well as the content of the questions are put in the hands of the individual departments and its chairman, who in a very responsible way create each examination in collaboration with his or her senior staff members.

Quality development:

*The reliability and validity of assessment methods **should** be documented and evaluated and new assessment methods developed.*

No assessment unit as such with medical educators and psychometricians exists, neither linked to the Deans Office nor to MEDC – despite the huge number of examinations having to be constructed and corrected each year. Given this fact, we must conclude that very little testing of reliability or validity of the examinations takes place.

During the deliberations with both senior faculty and representatives from the students an eagerness was heard to have new assessment methods implemented. The students in particular found the clinical oral examinations very subjective and time-wise biased. Even the Senior Faculty Members missed general guidelines or objective criteria amalgamated in the oral clinical examinations. This should be regarded in the perspective, that the clinical experience of each student during their clerkships could be quite limited.

A serious discussion around formative examinations, instead of summative examinations, was conducted with the emphasis on the learning perspectives of formative examinations, maybe encouraging the students to in-depth studies. The heavy emphasis on summative examinations forces the students to focus on the core content of the medical curriculum. The vicious circle then becomes studying to pass the examinations, not studying to start lifelong learning. Through the student interviews, it became clear that many students wanted more written formative assignments being able to use their computers that they had in order to interact with the internet anyway. It was discussed whether students could not be given schedules for teaching and formative assignments through a university based intranet connection.

3.2 RELATION BETWEEN ASSESSMENT AND LEARNING

Basic standard:

*Assessment principles, methods and practices **must** be clearly compatible with educational objectives and **must** promote learning.*

With a higher priority given to missions and objectives at the Medical Faculty, the bridge to examination questions and methods is within sight. The results of the examinations should on the other hand provide a feedback to the objectives and in that way influence the teaching content.

With increasing emphasis on the objectives, it seems important to bear in mind that medical students graduate from a university, so that both objectives and exams should meet, not only requirement at the low end of intellectual taxonomy such as recall of knowledge but should challenge the students at a higher taxonomical level such as problem solving. Given the huge amount of resources put into the examination system as a whole, more attention should be given to

taking advantage of the knowledge acquired in the examination process for learning purposes through feedback mechanisms.

Quality development:

*The number and nature of examinations **should** be adjusted by integrating assessments of various curricular elements to encourage integrated learning. The need to learn excessive amounts of information **should** be reduced and curriculum overload prevented.*

Not only do examinations guide the learning of the student, it also inhibit individual learning and in-depths studies – in general counteracting the attitude of life long learning as an individual responsibility for each doctor and doctor to be. The more examinations the less time for studies. Many examinations also create a need for examination-gearred classroom teaching which again leaves the student with too little time for individual reading and studies.

Even if students tend to favor exams right after the end of teaching in a discipline, real life and transfer of learning requires integration of disciplines to problem solving in real life. Of particular importance is the integration of preclinical knowledge in clinical functions – if preclinical sciences shall have relevance in addition to academic virtues. This is the major argument for constructing and requiring integrated examinations joined by integrated teaching sessions.

Concluding remarks regarding AREA 3

The heavy emphasis on summative "end-of the year" examinations forces the students to focus on the core content of the medical curriculum. The vicious circle then becomes to survive the examinations, not to start life long learning. Given the huge amount of resources put into the examination system as a whole, more attention should be given to taking advantage of the knowledge acquired in the examination process for learning purposes through feedback mechanisms.

The process of suggested corrective actions will include also a revision of methods of student assessment linking requirements and examination to the learning objectives.

In the area of Student Assessment, the WFME Global Standards at the basic level are partly fulfilled. There is a lot of room for quality improvement.

4. Students

4.1 ADMISSION POLICY AND SELECTION

Basic standard:

*The medical school **must** have an admission policy including a clear statement on the process of selection of students.*

Quality development:

*The admission policy **should** be reviewed periodically, based on relevant societal and professional data, to comply with the social responsibilities of the institution and the health needs of community and society. The relationship between selection, the educational programme and desired qualities of graduates **should** be stated.*

4.2 STUDENT INTAKE

Basic standard:

*The size of student intake **must** be defined and related to the capacity of the medical school at all stages of education and training.*

Rules for admission are determined by the Ministry of Higher Education. The size of the student intake is determined by the Supreme Council for Universities. Admission is determined solely by high school degrees of the applicants, who are always ranked among the highest degrees. The school is clearly aware of the fact that this selection method, which in combination with unlimited access to re-examinations results in a low drop-out rate of only about 5 %, will not always lead to graduates capable of practicing medicine.

Additional selection methods (use of advanced level marks in biology from high school, a national admission examination testing other qualifications such as communication skills, language, attitude and interests or personal interview) will have limited influence compared to resource requirements and will create new problems regarding objectivity.

Quality development:

*The size and nature of student intake **should** be reviewed in consultation with relevant stakeholders and regulated periodically to meet the needs of community and society.*

The fact that the Ministry of Higher Education through the Supreme Council for Universities determine the student intake should not completely prevent the faculty in formulating an admission policy, which could be a basis for negotiations and reviews with the government about balance between resources and student number.

The Self Study report states that the current policy does not comply with social responsibilities and health needs, and it is not reviewed periodically based on societal or professional data.

Measured by the number of students (9,500) and the yearly intake of medical students (self-evaluation report: 1,200-1,400; information during site visit: 800-1,600) Cairo University Medical Faculty is among the largest in the world. Although there is no clear relationship between the number of students and the quality of education, the volume of students, which is determined outside the faculty by the Supreme Council for Universities based on traditional principles of free access to higher education and not by needs of the society for medical doctors, sets limits for reform initiatives.

The only solution to the volume problem, which exceeds the capacity of the faculty and which is clearly reflected in the teaching and learning conditions (see area 6), will be to regulate the number

of students in accordance with the needs for medical doctors in the society, either by using institutional numerous clausus or by introducing stop-examinations after the first or second semester. Division of students in smaller groups or clusters (like student societies used in some colleges around the world) would probably have limited effect concerning the pre-clinical basic sciences, but could be used in connection with inclusion of new teaching hospitals in the clinical study period. Extensions of working hours for teachers will probably be met with resistance, and other suggested corrective actions mentioned in the Self-Study look like actions which might risk lowering the quality of teaching.

4.3 STUDENT SUPPORT AND COUNSELLING

Basic standard:

*A programme of student support, including counselling, **must** be offered by the medical school.*

A program for student support is offered and conducted through the Youth Care Office, which is supervised by the vice dean for student affairs. It includes social, financial, sports, arts and literature activities. Health services are available at the students' hospital which is affiliated to Cairo University

Quality development:

*Counselling **should** be provided based on monitoring of student progress and **should** address social and personal needs of students.*

The Self-Study points out that student support and counselling is clearly inadequate regarding academic support, career guidance and personal counselling. A high percentage of students find this situation unsatisfactory. The visitors got the same impression when meeting the group of students.

4.4 STUDENT REPRESENTATION

Basic standard:

*The medical school **must** have a policy on student representation and appropriate participation in the design, management and evaluation of the curriculum, and in other matters relevant to students.*

The faculty does not have a clear policy on student representation in relevant committees and participation in design, management and evaluation of the curriculum and other relevant matters.

Quality development:

*Student activities and student organisations **should** be encouraged and facilitated.*

Although described in general, a From the meeting with students, the visitors can confirm, that students feel that their opinions are not being taken into consideration. We also got the impression that adequate representation of students could easily be organised by the Student Scientific Society (S.S.S.). The students seemed very motivated for such a development.

The visitors, who have very positive experiences from Scandinavia, very strongly support the suggested corrective actions in the Self-Study Report.

Concluding remarks regarding AREA 4

The basic standards in this area are partly fulfilled. Initiatives must be taken in order to control the student volume in accordance with resource allocations. Student counselling is not systematized. Involvement of student representatives in curricular matters is strongly advised.

5. Academic staff/faculty

5.1 RECRUITMENT POLICY

Basic standard:

*The medical school **must** have a staff recruitment policy which outlines the type, responsibilities and balance of academic staff required to deliver the curriculum adequately, including the balance between medical and non-medical academic staff, and between full-time and part-time staff, the responsibilities of which **must** be explicitly specified and monitored.*

The range and balance of teaching skills required to deliver each course in the curriculum is determined by the departments.

Beyond setting the number of required staff members, the faculty, the faculty council and the curriculum committee obviously has limited influence on recruitment of the academic staff, which is governed by the University law and regulated by the department councils. Staff promotion, which early in the career depends on scientific and professional activities but later on seems to follow a simple pattern of seniority, is regulated by the Supreme Council of Universities. Most teachers are recruited from Cairo University Medical Faculty graduates. Teaching capability is not mentioned in the Self-Study Report as a qualification and there is no policy for recognising and rewarding outstanding teaching contributions.

Almost all faculty members hold full time appointments in the basic science or clinical departments. In reality, according to the Self-Study Report and confirmed by staff members, most of the faculty are in practice working part-time in the departments.

Quality development:

*A policy **should** be developed for staff selection criteria, including scientific, educational and clinical merit, relationship to the mission of the institution, economic considerations and issues of local significance.*

All promotion is regulated by the Supreme Council of the Universities, taking into consideration the scientific, ethical, and professional competencies. These competencies are evaluated by the department councils. There is no specific mentioning of teaching competencies. But clinical skills and experiences seem to be a normal professional competence, which may elicit academic promotion.

5.2 STAFF POLICY AND DEVELOPMENT

Basic standard:

*The medical school **must** have a staff policy which addresses a balance of capacity for teaching, research and service functions, and ensures recognition of meritorious academic activities, with appropriate emphasis on both research attainment and teaching qualifications.*

There is no definite policy for recognising and rewarding outstanding teaching, except on specific occasions such as faculty or departmental conferences.

At the start of their academic career, all new staff members receive a three-week course, a workshop on teaching methodology.

Regarding staff influence on the curriculum and teaching conditions there is academic staff representation in all department councils and committees of the faculty.

There is no promotion line based on teaching qualifications solely.

Quality development:

*The staff policy **should** include teacher training and development and teacher appraisal. Teacher-student ratios relevant to the various curricular components and teacher representation on relevant bodies **should** be taken into account.*

With an academic staff of approximately 2770 full-time members, the teacher-student ratio of about 1:3 seems adequate, even favorable, but as mentioned above the realities are different due to a considerable amount of work outside the medical school. Furthermore, the Self-Study Report indicates, and this is also the impression of the visitors from discussions with staff members, that the distribution of academic staff is not always fully taking teaching obligations into consideration, thus leaving some disciplines in a more favorable situation than others. There seems to be no problem regarding medical educational background of the teaching staff, a phenomenon now being prominent in many medical schools worldwide.

Teacher training is now becoming a significant activity at the faculty, and the Medical Education Development Centre has taken an important initiative in arranging and conducting workshops in teaching methodology, curriculum development and assessment. So far, about ¼ of the staff have attended these workshops, and the majority of teachers still think they need teacher development support.

Concluding remarks regarding AREA 5

The basic standards in this area are partly fulfilled, and important initiatives to amelioration have been taken.

The visitors strongly endorse the suggested corrective actions outlined in the Self-Study Report.

6. Educational resources

6.1 PHYSICAL FACILITIES

Basic standard:

*The medical school **must** have sufficient physical facilities for the staff and the student population to ensure that the curriculum can be delivered adequately.*

According to the information in the Self-Study Report, many square meters of large lecture halls and smaller halls as well as classes for small group sessions are available. The visitors only had the opportunity to see a minor part of the teaching rooms. Some were nice with adequate audio-visual equipment, but we also took part in a teaching session, where the obviously competent lecturer without adequate microphone system and somewhat primitive overhead illustrations had to compete with the noise from the nearby train traffic.

The library facilities for students are insufficient. First of all, there is a lack of space in comparison with the high number of students, but also the access to textbooks, journals and other teaching material seems insufficient.

Staff access to libraries and computers seems better from the few observations we had. Office facilities for staff members were only demonstrated in few cases at senior level (head of department) and we understand from the Self-Study Report that this is a great problem, especially in the clinical departments.

Quality development:

*The learning environment for the students **should** be improved by regular updating and extension of the facilities to match developments in educational practices.*

Annually, each department should evaluate the different facilities. Departments can correct deficiencies through reallocating and optimizing the use of their resources. Additional needs are forwarded by the department chair to the dean. There are budgets for construction, equipment and education.

Student access to computers and internet facilities is generally insufficient at the institution.

The Site-Visit Team was presented for recreational facilities for the students such as cafeterias and a field for sport activities.

6.2 CLINICAL TRAINING RESOURCES

Basic standard:

*The medical school **must** ensure adequate clinical experience and the necessary resources, including sufficient patients and clinical training facilities.*

The visitors had the opportunity to see only one department in pediatrics. The visit was concentrated on meeting staff members, visiting lecture rooms, the neonatal department and a newly established, not finished skills lab. However, the Self-Study Report reveals greater problems regarding capacity for clinical training at the medical school. On the other hand, large numbers and a great variety of patients are obviously available for clinical training in the affiliated hospital departments, including outpatient clinics, although the Self-Study Report claims sub-optimal student-patient contact.

Quality development:

*The facilities for clinical training **should** be developed to ensure clinical training which is adequate to the needs of the population in the geographically relevant area.*

The clinical rotation program in the various specialties seems adequate. We were informed about, but did not visit community-based health facilities used in the clinical training. The use of skills laboratories, simulated patients and facilities for communication skills seem to be only at the beginning.

6.3 INFORMATION TECHNOLOGY

Basic standard:

*The medical school **must** have a policy which addresses the evaluation and effective use of information and communication technology in the educational programme.*

We have already dealt with this theme under subarea 6.1. Obviously, the faculty has no defined policy regarding use of information and communication technology (ICT) in the educational programme, and although at least most student have personal computers and some skills in using ICT, there is a great need for modern ICT facilities and training of both teachers and students.

Quality development:

*Teachers and students **should** be enabled to use information and communication technology for self-learning, accessing information, managing patients and working in health care systems.*

The visit team strongly supports the suggested corrective actions in the Self-Study Report.

6.4 RESEARCH

Basic standard:

*The medical school **must** have a policy that fosters the relationship between research and education and **must** describe the research facilities and areas of research priorities at the institution.*

The medical faculty possesses considerable research facilities, of which some laboratories were demonstrated for the site-visit team. The faculty staff and a high number of postgraduate students are engaged in research. According to the Self-Study Report, research activities are lacking funding opportunities.

Quality development:

*The interaction between research and education activities **should** be reflected in the curriculum and influence current teaching and **should** encourage and prepare students to engagement in medical research and development.*

Students are only to a very limited degree involved in research projects, and only about 10 % of students believe they have acquired research skills.

There seems to be a lack of institutional research policy and also of a lack of interaction between research and education.

6.5 EDUCATIONAL EXPERTISE

Basic standard:

*The medical school **must** have a policy on the use of educational expertise in planning medical education and in development of teaching methods.*

Use of educational expertise is a novelty at the medical faculty, and the Medical Education Development Centre (MEDC) is, in spite of limited personnel and resources, conducting many types of activities, now also more systematic training programmes in the form of workshops as described above. However, there is still no formulated policy on the use of educational expertise, and responsibility for appropriateness of instructional methods is presently placed in the single department councils.

Quality development:

*There **should** be access to educational experts and evidence demonstrated of the use of such expertise for staff development and for research in the discipline of medical education.*

MEDC is staffed with faculty members who have the knowledge, interest and experience in medical education development. The centre provides major contributions to education and staff development in addition to supporting staff in organising conferences and scientific events, designing publications and presentations.

In addition to this invaluable system it should be considered to employ a few fulltime educational experts either on a permanent basis or in temporary contracts – not least to support the immense professional challenge of organising valid and reliable assessments of students.

6.6 EDUCATIONAL EXCHANGES

Basic standard:

*The medical school **must** have a policy for collaboration with other educational institutions and for the transfer of educational credits.*

Quality development:

*Regional and international exchange of academic staff and students **should** be facilitated by the provision of appropriate resources.*

Although the Faculty has a number of relations to other educational institutions, the links and especially the exchange programmes are insufficient taking the high number of teachers and students into account. Especially, there have not been any traditions for student exchange programmes or mechanisms to recognize electives completed outside the medical faculty, especially not within an international cooperation agreement.

The recommendations outlined in the suggested corrective actions are endorsed by the site-visit team.

Concluding remarks regarding AREA 6

Altogether, the description in the Self-Study Report of qualitative and quantitative deficiencies with respect to physical facilities seems correct. We understand that not only financial factors but also inappropriate allocation and utilisation of physical facilities are responsible for this situation. The suggested corrective actions seem reasonable, including the increase of the relatively low tuition fees, the last with the proviso that recruitment of students is continued from the same social classes as presently.

Subarea 6.1 is not fulfilled at the moment, and necessary corrections seem difficult under the present circumstances, especially regarding student number and resource allocation.

In general the basic standard in subarea 6.2 is fulfilled, but some of the suggested corrective actions should be supported.

The standard of subarea 6.3 is not fulfilled, and initiatives to improve the situation and circumvent the financial and other practical obstacles are highly needed.

The basic standard of subarea 6.4 is partly fulfilled, but the relationship between research and education could be strengthened.

The basic standard of subarea 6.5 is partly fulfilled by the existence and functions of MEDC.

At the moment, the basic standard of subarea 6.6 is not fulfilled.

The Site-Visit Team endorses the suggested corrective actions formulated in the Self-Study Report.

7. Programme Evaluation

7.1 MECHANISMS FOR PROGRAMME EVALUATION

Basic standard:

*The medical school **must** establish a mechanism for programme evaluation that monitors the curriculum and student progress, and ensures that concerns are identified and addressed.*

The Self-Study is comparatively brief and firm regarding the programme evaluation or rather the lack so far of systematic evaluation of the programme. It is noted as a weakness that a mechanism for programme evaluation that monitors the curriculum is not accessible to the faculty as such. Each course is monitored by the various departments through different types of course evaluation.

Quality development:

*Programme evaluation **should** address the context of the educational process, the specific components of the curriculum and the general outcome.*

No general plan or method is yet in place for picking up these data and their interrelation.

7.2 TEACHER AND STUDENT FEEDBACK

Basic standard:

*Both teacher and student feedback **must** be systematically sought, analysed and responded to.*

In the Self Study it is noted as a weakness that teacher and student feedback is not systematically sought, analysed and responded to and finally that the principal stakeholders are only involved to a limited extent in programme evaluation. Apparently, in the Self Study this area is regarded as primarily characterised by weaknesses and lack of fulfilment of the basic WFME standards.

Quality development:

*Teachers and students **should** be actively involved in planning programme evaluation and in using its results for programme development.*

Noted as strengths in the Self Study is the awareness of the importance of involvement of teachers and students in programme evaluation as well as the involvement of the department council, especially in course evaluation.

7.3 STUDENT PERFORMANCE

Basic standard:

*Student performance **must** be analysed in relation to the curriculum and the mission and objectives of the medical school.*

Student performance is carefully recorded in the books of the Medical Faculty, but there is no evidence that these data are subjected to analysis or put in any relationship to individual course evaluations.

Quality development:

*Student performance **should** be analysed in relation to student background, conditions and entrance qualifications, and **should** be used to provide feedback to the committees responsible for student selection, curriculum planning and student counselling.*

This is a very ambitious WFME sub-area standard that is rarely met in medical schools. Nevertheless, given the high quality of societal resources provided by the medical students there is an obligation on the universities to take ultimate care of that resource and through such monitoring improve the admission process and the curriculum.

7.4 INVOLVEMENT OF STAKEHOLDERS

Basic standard:

*Programme evaluation **must** involve the governance and administration of the medical school, the academic staff and the students.*

Through the Site Visit it was obvious that the governance and administration of the school were aware of the necessity to improve this process. This was also stated in the Self Study report.

Quality development:

*A wider range of stakeholders **should** have access to results of course and programme evaluation, and their views on the relevance and development of the curriculum **should** be considered.*

The Site-Visit Team had meetings with the Minister of Higher Education, representatives from the Regional Office of WHO and representatives of the National Accreditation Committee. Through these encounters there could be no doubt that the quality of medical education is of interest and concern to a wide range of stakeholders.

Concluding remarks regarding AREA 7

The basic standards in this area are fulfilled except the standard on student performance. Implementation of the plan for corrective action must be given high priority.

The Site Visit partly confirmed the conclusions of the Self Study. In our preliminary written comments on the Self Study Report we wrote “The report from the Self Study is well-structured and well-written. It includes a brief section on the methodology used in the Self Study, documenting the basis for the study. However, the outstanding feature of the report is the profound analysis, the frankness in the discussion of strengths and weaknesses as well as the precise statements on suggested corrective actions.” The Self-Study Report documents a competent programme evaluation, including teacher and student feedback and involvement of other stakeholders and also

some directions for future follow up on evaluation and improvement. The visitors must endorse the proposal to establish a special committee to be in charge of programme evaluation.

In the Self-Study, it is noted as a weakness that data on student performance is not used efficiently. This was confirmed during the site visit and also that analysis of student performance has so far not been addressed. The report states the plans for corrective actions, the data to be collected and their use. The visitors strongly recommend that this plan be implemented.

8. Governance and Administration

8.1 GOVERNANCE

Basic standard:

*Governance structures and functions of the medical school **must** be defined, including their relationships within the University.*

The governance structure and function is clearly described in the Self-Study report.

Quality development:

*The governance structures **should** set out the committee structure, and reflect representation from academic staff, students and other stakeholders.*

The curriculum committee established in the year 2003 is composed of the associate dean of student affairs and education, the director and staff of the Medical Education Development Centre in addition to representatives of the main departments involved in the education of undergraduate students.

Comparing with other medical schools it puzzles the Site Visitors that MEDC staff is heavily represented in the curriculum committee instead of serving as a kind of civil servant back-up function for a representative curriculum committee – not exceeding 20 members - elected of both staff and students.

8.2 ACADEMIC LEADERSHIP

Basic standard:

*The responsibilities of the academic leadership of the medical school for the medical educational programme **must** be clearly stated.*

This seems to be the case.

Quality development:

*The academic leadership **should** be evaluated at defined intervals with respect to achievement of the mission and objectives of the school.*

There is a relatively short period of deanship followed also by a shift of vice deans. This has democratic virtues, but the continuity of the business might suffer. The invitation to perform an international Site Visit is an example of wanting to be evaluated at may-be defined intervals or at least periodically.

8.3 EDUCATIONAL BUDGET AND RESOURCE ALLOCATION

Basic standard:

*The medical school **must** have a clear line of responsibility and authority for the curriculum and its resourcing, including a dedicated educational budget.*

A basic problem, mentioned also in the discussion of mission and objectives, is the limitations of the autonomy of the medical faculty, especially in the governance of and the responsibility for the medical curriculum and its resourcing. Coming from a state-controlled educational system, the visitors could recognize the impact of state control and must consider medical education in Egypt to be highly regulated.

The visitors can only recommend a dialogue with the university and the ministry as an attempt to obtain some degree of deregulation and transfer of authority and responsibility to the medical faculty.

Quality development:

*There **should** be sufficient autonomy to direct resources, including remuneration of teaching staff, in an appropriate manner in order to achieve the overall objectives of the school.*

It appears to the visitors that with the newly established curriculum committee there is a possibility for the Faculty Council to allocate economic resources to that committee to support educational development, strengthening the objectives of the school.

8.4 ADMINISTRATIVE STAFF AND MANAGEMENT

Basic standard:

*The administrative staff of the medical school **must** be appropriate to support the implementation of the school's educational programme and other activities and to ensure good management and deployment of its resources.*

The administrative staff and management are regarded as sufficient in number, but it is stated as a point of weakness that most of the non-academic supporting staff is inefficient and lacks the necessary skills. The suggested corrective action that the administration should take active steps to increase the skills of the non-academic staff is an obvious and effective measure.

Quality development:

*The management **should** include a programme of quality assurance and the management should submit itself to regular review.*

Again this external review is an example of administrative quality assurance.

8.5 INTERACTION WITH HEALTH SECTOR

Basic standard:

*The medical school **must** have a constructive interaction with the health and health-related sectors of society and government.*

The constructive interaction with the health sector is somewhat limited as it takes place at higher levels partly outside the medical school. The visitors strongly endorse the suggested corrective actions both to have representatives of the ministry of health and the profession (the syndicate) as members of the faculty council and/or to organise regular meetings between representatives of the medical faculty and of the health and health-related sectors of society and government.

Quality development:

*The collaboration with partners of the health sector **should** be formalised.*

The advantages for a medical school of involving a wider range of stakeholders are often the opportunity to obtain support, establish cooperation and alliances, etc.

Concluding remarks regarding AREA 8

The basic standards in this area are fulfilled or partly fulfilled. Lack of fulfilment is for some standards outside the control of the medical school, i.e. aspects of standards related the autonomy of the medical school. The limited interaction with the health sector is being addressed.

The Site Visit confirmed the conclusions of the Self Study regarding strengths and weaknesses in relation to the basic standards of the WFME global standards. Governance structures and functions including relationships within the university are defined as well as the responsibilities of the academic leadership for the medical programme. However, some problems are connected with the present structures.

Major problems seem to be related to the departments, the lack of effectiveness of the department councils due to the present size and composition of the councils and the quick turnover of department heads. The visitors endorse the proposed corrective actions, changes in the department councils to obtain a smaller and more representative group and introduction of requirements regarding departmental planning to counter the turnover.

9. Continuous Renewal

Basic standard:

*The medical school **must** as a dynamic institution initiate procedures for regular reviewing and updating of its structure and functions and **must** rectify documented deficiencies.*

The Self-Study and the activities already initiated as a result of the Self Study is clearly the beginning of a process of continuous self-review and quality improvement of the medical programme. The plans are to combine a quality assurance system with continuous monitoring and annual reviewing of selected processes with regular strategic reviews (5 year intervals) of all aspects, programmes and services of the faculty. The review is to be followed by strategic planning addressing deficiencies and development needs.

It is a well conceived plan in accordance with conditions and needs of the medical school. Also, it is the firm belief of the visitors that it is possible to execute the plan. At meetings during the site visit the visitors were impressed by the competence and enthusiasm of the staff connected with the MEDC which will have to play a leading role in the process.

Quality development:

*The process of renewal **should** be based on prospective studies and analyses and should lead to the revisions of the policies and practices of the medical school in accordance with past experience, present activities and future perspectives. In so doing, it **should** address the following issues:*

- *Adaptation of the mission and objectives of the medical school to the scientific, socio-economic and cultural development of the society.*
- *Modification of the required competencies of the graduating students in accordance with documented needs of the environment graduates will enter. The modification shall include the clinical skills and public health training and involvement in patient care appropriate to responsibilities encountered upon graduation.*
- *Adaptation of the curricular model and instructional methods to ensure that these are appropriate and relevant.*
- *Adjustment of curricular elements and their relationships in keeping with developments in the biomedical sciences, the behavioural sciences, the social sciences, the clinical sciences, changes in the demographic profile and health/disease pattern of the population, and socio-economic and cultural conditions. The adjustment shall assure that new relevant knowledge, concepts and methods are included and outdated ones discarded.*
- *Development of assessment principles, and the methods and the number of examinations according to changes in educational objectives and learning goals and methods.*
- *Adaptation of student recruitment policy and selection methods to changing expectations and circumstances, human resource needs, changes in the premedical education system and the requirements of the educational programme.*
- *Adaptation of recruitment and staffing policy regarding the academic staff according to changing needs of the medical school.*
- *Updating of educational resources according to changing needs of the medical school, i.e. the student intake, size and profile of academic staff, the educational programme and contemporary educational principles.*
- *Refinement of the process of programme monitoring and evaluation.*

- *Development of the organisational structure and management principles in order to cope with changing circumstances and needs of the medical school and, over time, accommodating to the interests of the different groups of stakeholders.*

The visitors recommend that the role of MEDC in relation to the dean, the faculty council, the curriculum committee, to departmental heads and councils is considered and specified. Especially, the involvement of the students in the process should be decided. Finally, it is very important that resources are dedicated to the expansion of activities, e.g. intensified information activities and the monitoring of the process of change, especially of student performance.

Concluding remarks regarding AREA 9

The medical school has embarked on a process of continuous reviewing and updating of its structure and functions. This standard is fulfilled.

FINAL REMARKS

The site-visit team want to express its admiration of the efforts of the Self-study Task Force, which has demonstrated great energy, constructive work, openness and preparedness for change. This resulted in a very important report, characterised by criticism combined with fairness and loyalty to the institution. The group seems deeply devoted to quality improvement of the institution.

The Site-visit Team supports the conclusion in the Self-study Report:

- The undergraduate curriculum needs major reform as the current curricular components, teaching and assessment methods do not adequately fulfill our mission
- The faculty staff needs more training in curriculum planning, teaching and assessment methods in order to be able to deal with the forthcoming curriculum changes.
- The resource allocation process should be adequately revised in order to ensure enough resources for the educational reform process.
- The educational program needs comprehensive repeated evaluation in order to ensure continuous improvement and self correction.
- The student admission policy needs to be revised in order to secure validated criteria for selecting students highly efficient and able to cope with medical education and its related stress.

In addition, the Site-visit Team wants to emphasize the following recommendations:

- Strengthening the Curriculum Committee
- Development of ITC in medical education
- Improved interaction between Research and Education
- Establishment of an integrated curriculum
- More emphasis on clinical training
- Higher student involvement in faculty matters

Facing a significant reform process, the Faculty of Medicine at the University of Cairo can count on important factors such as:

- A large academic staff with, in general, high academic qualifications
- A highly competent and motivated MEDC staff
- Access to a huge number and variety of patients
- Generally high capability and motivation of students
- A long tradition of medical education
- Institutional pride.

APPENDICES

1. Developments Between the Final Self-Evaluation Report and the Site Visit. Information from the Medical Center (MEDC).

1-2 Focus groups has been done with the students and syndicate where mission and ILOs were discussed and subjected to minor changes.

1-4 ILOs were also revised and subjected to minor changes.

Faculty development is now more developed and obligatory for promotion...

A new program for faculty development in EBM has started aiming at basic EBM and advanced EBM for tutors.

Psychiatry and psychology courses are revised and more patient exposure started.

Medical Ethics course has been designed and implemented on 1st year.

Course specifications for all courses are being worked on and intended to be finished by the end of January 2005

Attendance of faculty members skill workshops is now essential for promotion.

Faculty is giving financial and moral support for activities at MEDC.

Number of staff members working at MEDC has increased and we are planning for the attainment of two of them academic degrees in medical education.

A quality assurance committee affiliated to curriculum committee has been established but still need to be activated.

2. Some Advance Comments on the Self Study Report

(Sent by the external experts before the visit)

The following preliminary comments are based on the Self-Study report with figures 1 – 54. Annex 1 – 21 are not received.

General remarks

The report from the self study is well-structured and well-written. It includes a brief section on the methodology used in the self study, documenting the basis for the study. However, the outstanding

feature of the report is the profound analysis, the frankness in the discussion of strengths and weaknesses as well as the precise statements on suggested corrective actions.

The conclusions

In a brief summary five critical areas of strategic importance for the improvement of the medical programme at Cairo University are identified (a major reform of the curriculum, staff development, resource allocation, quality assurance and admission policy).

The major reform of the curriculum, of teaching and assessment methods as suggested in the sections on corrective actions are in line with recent international trends in improvement of medical education. In this connection, the strategic importance of revision of the resource allocation process in order to ensure resources for the educational reform process must be emphasised. To increase small group teaching will require more small class rooms and more teachers, self-directed learning and use of ITC will require extension of library and IT facilities etc.(p. 12 & p. 32). Taking into account the size of the medical faculty at Cairo University these reforms will put a heavy burden on the financial resources. Careful planning and specification of priorities will be necessary.

Besides advocating supplementary criteria for selection of students to medical education, it is not clearly stated how the admission policy and selection procedure could be changed. Many medical schools under similar admission systems as the Medical Faculty at Cairo University with results at the end of secondary education as the selection criteria voice the same dissatisfaction with the system and look for alternative or supplementary procedures. Often interviewing the students as it is done in UK and USA is regarded as a solution. However, without the tradition of interviewing the applicants training of staff in the techniques of interviewing as well as the actual interviewing are extremely resource-demanding (p. 26). Cost and benefits should be assessed.

Based on the data and the conclusions in several subsections of the report (e.g. 2.7) one would have expected strengthening the authority of the recently formed curriculum committee to be one of the critical areas. It seems that the Medical Faculty at Cairo University share a major educational problem with many other well-established, large and strongly research-based medical schools all over the world: The conflict between the responsibility for the medical programme as a whole and the academic autonomy of the individual departments. Most likely it is a fundamental requirement for quality improvement of the programme in basic medical education that – as stated – the curriculum committee get more authority in planning and directing curriculum changes (p. 20 & p. 23).

Other remarks

Despite many efforts acquaintance with and *knowledge about the mission of the medical school and the objectives for the programme* are very limited both among staff and students. Continuation and extension of the information activities is important. Furthermore, the medical school should consider including issues such as mission and objectives in the staff development activities especially in the teaching methodology workshops. For a successful process of change and improvement of the medical programme a shared sense of direction, of mission and objectives among all involved will be necessary. This is most likely just as important as strengthening the leadership, the curriculum committee as well as leadership at the departmental level.

It could possibly be argued that the *assessment methods* used today are not compatible with the objectives but to a reasonable degree are compatible with actual course content and teaching

methods. Simultaneous changes in teaching and assessment are called for. However, in any case the lack of faith in the validity and reliability of the assessment methods is a serious problem and as pointed out needs immediate attention and improvement.

Apparently the graduates lack confidence in their *ability to communicate with patients*. Partly this problem seems to be overcome during the PRHO year. However, this lack of confidence at the beginning of the PRHO year can seriously hamper learning and performance. Consequently, many medical schools have developed courses in communication coordinated and more or less integrated with clinical courses and clerkships, especially courses in clinical skills and/or with courses in medical psychology and medical sociology. (Several such courses are described and discussed in the journals and in conference proceedings). The medical school should consider introducing formal training in communication.

A lack of *academic counselling and supervision* of the students is noted. Improvement in this area should possibly be seen in a broader context and in general attempt to integrate the students more into the academic environment and extend the contact between staff and students. Contact between students and staff is important for the professional socialization and has been shown to increase performance and reduce drop-out.

Final remarks

On the one hand, the report and results of the self-evaluation seems to support the selected strategy, to concentrate on the basic standards as benchmarks. In all essentials the medical school seems to fulfil or partly fulfil the basic standards (It should be noted that some standards may be regarded as not relevant in an evaluation of a medical school for instance when a school is not in a position to decide due to present rules and regulations e.g. to relate the intake of students to the capacity of the school). On the other hand, the report indicates that some quality development standards are fulfilled or partly fulfilled. A systematic evaluation of the medical programme at Cairo University in relation also to the quality development standards could have produced interesting results and useful information for the preparation of an action plan.

3. Site-Visit Schedule

December 4:

Reception. Members of the Self-Study group were present for introductory purpose.

December 5:

Meeting with the Minister of Higher Education, Mr. *Amro Salama*.

Meeting with the Dean, Prof. Dr. Madiha Khattab

Seminar: Accreditation and quality improvement of medical education:

WFME presentations and discussion

Meeting with National Assurance and Quality Commission and representative from WHO EMRO.

December 6:

Meeting with Senior Faculty Members and high committee of Curriculum Development.

Meeting with Self-Study team. Review of Corrective actions:

Pilot Postgraduate Self-Study discussion

Review of Annexes by Site Visit Team

December 7

Visit to the Department of Pediatrics:

Teaching Class in Pediatrics (Lecture Room), neuromuscular diseases

Meeting with Senior Academic Staff of Pediatric Hospitals (Teaching plan and material)

Visit to clinical round and tutorial

Visit to Neonatal ward

Meeting with students (10-12, including one from focus group)

Visit to Undergraduate Library

Visit to Postgraduate Library

Meeting with Academic Staff of Department of Biochemistry (Teaching plan and material)

Visit to IT Learning facilities (20 PC'es), department library (not for education purposes), visit to Lecture (data supported) (50-60 students), Visit to Teaching Lab

Visit to research lab for molecular biology – demonstration of equipment and presentation of projects

Visit to Anatomical Museum (outdated learning material) (dissection courses not provided)

Demonstration of MEDC activities: (1) EBM course for teachers, (2) Virtual anatomy, (3) Symposium in Medical Ethics (External teacher)

Preparation of preliminary report by Site-Visit Team

December 8

Preparation of preliminary report by Site Visitor team

Meeting with senior staff. Presentation of Preliminary report and oral feedback

Meeting with MEDC Staff. Discussion of MEDC and WFME collaboration. Discussion of strategic planning of MEDC activities

4. Meeting with senior faculty members

The Self Study documents that, at the present time, the Faculty of Medicine at the University of Cairo consists of 37 departments, 42 specialized units, 2773 faculty members, 9423 undergraduate students, and 3732 postgraduate students.

The yearly intake of students in 2004 was 1200 students. This number may vary from year to year depending on decisions in the Ministry of Education. Some budget allocations follow an increase of the intake. Students from secondary schools with the highest school marks are admitted within the allowed quote. The Medical Faculty has very little say in this process. It was said that the ideal number of students seen from the point of view of the Medical Faculty would be 320. It was also said that although the number of admitted students per year was very high, the number of faculty was also high, allowing a teacher/student ratio of 1:3.

The overall failure rate at the faculty was very low, about 5%, partly due to very competent and motivated students but also due to an examination system allowing the students an unlimited number of chances to pass the examinations every 6 months. It is estimated that 80% of the students will fulfill their study in the stipulated 6 ½ years, but some will continue for 8 may be 10 years or more. Quite constantly, the failure rate in each examination is around 20%.

Given the high number of students the quality assurance of the product was the system of assessment, almost solely examinations. Partly different types of written examinations, mostly long essays, but also short essays and multiple-choice questions. In addition the faculty conducted oral examinations both in theoretical disciplines and at clinical examinations. Both amongst the senior faculty members and amongst the students, dissatisfaction was expressed regarding the oral examinations. They were not regarded reliable enough and sometimes very subjective. A suggestion was raised to produce written guidelines for examinations, including guidelines for the structure of a clinical case based examination.

Following the Self Study, the Mission and Objectives of the school had been revised through a process involving more stakeholders than before. Neither the efforts of making them widely known amongst faculty and students nor the process of making them publicly known were yet satisfactory. Some important steps had been taken to initiate an update of course specifications making them reflect intended learning outcome in line with the objectives. It was thought that this process would improve the relevance and the connection between the examination questions, the content and the objectives.

A fairly new development was the constitution of a curriculum committee. All department heads (16) had a seat on this committee. Various models for the constitution of curriculum committees were discussed. One model was a small representative group on an elective basis being able to negotiate with departments not represented, but also being freer to get an overall perspective of the curriculum. It was noted that in some countries the chairman was specifically appointed by the dean. In many countries, students are represented on an elective basis, both on the faculty council and on the curriculum committee. The importance of the curriculum committee having a budget on its own was emphasised by the Site-Visit team.

5. Meeting with a group of medical students during their pediatric clerkship

Twelve students were present along with the Site-Visit team. The atmosphere of the meeting was from the very beginning frank and open. All the students participated in the debate. Immediately the question of examinations came up. The students felt that the assessments of the school need to be developed. “We only tend to focus on what give us high ranks”, it was said. Only memory, not skills or other competencies were tested, it was said. Most examinations were of the long essay type. Many of the students studied the USLME, and found in there more problem oriented questions. Almost unanimously it was said that studies beside the core curriculum was a waste of time. The expression ‘Exam horror’ was used. Generally it was felt, that the written examinations were fair, but that the oral examinations were unfair.

There was a general need to be more directly motivated for studies, instead of just preparing for the next examination.

During the clerkships there was a wish to become more involved in the treatment/management plan of individual patients.

The English language is not seen as a problem. However it could be difficult to communicate and translate the technical terms when dealing with patients in Arabic as a physician

Many felt there was a curriculum overload in the first three years. “ It is huge”, was the expression. Not until the clinical phase it is understood what is relevant. Also there was a substantial part of the curriculum, that was repeated in different disciplines.

There were no specific courses in communication skills. It was learned through the trial and error method. Using role/play and video-feedback was mentioned as a possibility given the large number of medical students.

Dialogue teaching was rare. Mostly questions were only allowed at the end of each lecture. Only one textbook was mandatory.


Most students had their own laptop computer, but these were not connected through the internet to the university. No use was required for study purposes. They rarely got written assignments. The present group of students would very much like more written assignments and participation in research projects, particularly if this was reflected in marks or alternative marks. Research projects existed, but only for very few students.

It was revealed that a quite active committee existed amongst the students interested in medical education. This committee was called The Student Scientific Society, and was connected to the IFMSA. The body was not invited to elect members to neither the Curriculum Committee, nor the Faculty Council. The students present were interested in more student involvement in curriculum planning.

The students did not need to earn money through work during their studies. Almost all were supported by their parents. They also normally lived at home. For students coming from outside Cairo, student hostels exist.

6. Presentation of preliminary report

The Medical Faculty
The University of Cairo 2004



Site Visit – Preliminary Report

by
Hans Karle, Leif Christensen, Jorgen Nystrup, WFME


The Medical Faculty
The University of Cairo 2004



Site Visit

Issues to be dealt with

The Medical Faculty
The University of Cairo 2004



Preamble

- Purpose of visit
- Strengths and weaknesses of the visitors
- General impression
- Conditions for the review
- External influences
- Basic strengths of the faculty
- Review report

Mission and Objectives

- ⌘ Widened debate and revision
- ⌘ Still widely unknown
- ⌘ New process with course specification
- ⌘ Examinations linked to objectives
- ⌘ Relation to the function as physician

Curriculum

- ⌘ Governed by exams
- ⌘ Overload
- ⌘ Poor integration
- ⌘ Departmentalised (fragmented?)

Core and Option

- ⌘ Self directed study
- ⌘ Electives
- ⌘ In-Depth options
- ⌘ Life long learning incentives
- ⌘ Space to study instead of preparing an examination
- ⌘ Responsibility for own learning

Teaching Methods

- ⌘ Dynamic change between lectures, small group teaching and self-directed learning
- ⌘ More dialogue (student activation)
- ⌘ Skills lab
- ⌘ Private teaching

Research

- ⌘ Written assignments
- ⌘ Compulsory reviews/write-ups (scientific methods on own experience)
- ⌘ Student research conference

Curriculum Committee

- ⌘ Task delegation from Faculty Council
- ⌘ Smaller representative elected group
- ⌘ Student representation
- ⌘ Budget responsibility
- ⌘ Possibility for coordination

Assessment

- ⌘ Improved examinations
- ⌘ More than examinations (reports)
- ⌘ Fewer examinations – particularly orals
- ⌘ Integrated examinations
- ⌘ Real formative examinations
- ⌘ Less based on memorizing facts

Number of students

- ⌘ Imposed problem
- ⌘ Teacher/Student ratio 1/3
- ⌘ A resource
- ⌘ Greater student involvement on all levels
- ⌘ Student clusters

Clinical Education

- ⌘ Sufficient number of patients
- ⌘ Early patient contact
- ⌘ More hospitals involved
- ⌘ More “hands-on” experience
- ⌘ Involvement of the Primary Care Sector
- ⌘ Integrated lectures

Physical Facilities

- ⌘ Many square meters available
- ⌘ Library insufficient
- ⌘ Lack of reading and discussion places
- ⌘ No IT network between students and faculty
- ⌘ Generally more IT facilities in teaching rooms needed

Change-Management Mechanisms

- ⌘ Role of MEDC vis a vis the Faculty Council, curriculum committee, and the departments
- ⌘ Relation to national quality assurance and accreditation committee
- ⌘ Strategic planning and programme evaluation
- ⌘ Monitoring of curriculum
- ⌘ Monitoring of exams
- ⌘ Student involvement