



The Association of Medical Schools in Europe

Declarations on Policy and Practice for medical schools in Europe

The Association of Medical Schools in Europe (AMSE) was founded in 1979, and creates a forum for European Medical Faculties to share experiences in the fields of education, research and management. AMSE seeks to stimulate co-operation between Medical Schools in Europe and to initiate and sustain relations with other professional, governmental and non-governmental organisations in education, research and health care.

AMSE is primarily concerned with the leadership and management of medical schools, and the question of how to run the medical school, and how to manage its relationship with the university hospital and other health-care partners. AMSE is also interested in the political and economic context in which the medical school works to fulfil its mission of medical education and medical research.

This collection brings together all the declarations and policy papers agreed by the Association of Medical Schools in Europe since 2007.

AMSE organises regular conferences on topics of particular interest to deans, heads of school and other staff members of medical faculties. These conferences normally produce a declaration summarising policy recommendations arising from the conferences.

AMSE believes that these policy recommendations are of value to medical faculties, universities, regulatory agencies, and all concerned with the management and funding of medical schools and faculties.

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**AMSE Annual Conference
Senate of the Parliament of the
Czech Republic, Prague
7 October 2016**

AMSE – Prague declaration on quality assurance in medical education

The Association of Medical Schools in Europe (AMSE) promotes and develops the co-operation between medical schools in Europe and is dedicated to enhance and ensure the quality of their activities. Medical schools have the duty to give a solid training on basic education in order to provide to students the right instruments and development pathways which allow them to then make informed and responsible choices for their careers ranging from clinical practice to research, teaching, management and inter-professional activities.

The AMSE conference 2016 was held in Prague under the auspices of the Speaker of the Senate of the Parliament of the Czech Republic on 7 October. The main topic of the conference, that gathered participants and speakers from 13 different countries (Austria, Belgium, Croatia, Czech Republic, France, Georgia, Germany, Hungary, Lithuania, Romania, Slovakia, Slovenia and Sweden), was “Challenges of doctor mobility in a changing Europe – Standards and recognition for patient safety.”

As of today, European countries have different medical curricula (e.g. duration of training, type, format and number of examinations, outcomes of training, etc.). The European countries often apply different quality assurance systems in their medical educations, they rely on different accreditation agencies, or at worst they are not accredited at all.

At the beginning of the 3rd millennium and at the time of automatic recognition of physician´s license in the EU – which warrants the employability of a physician – AMSE points to the necessity to establish a common European quality management system for medical education. The main objectives are assurance of the quality of medical education delivered by medical schools/universities, and the mobility of medical students and physicians across Europe, with the final main goal to safeguard the health of the population.

AMSE stresses the necessity to introduce a common accreditation standard meeting the European Standards and Guidelines (ESG) of the European Higher Education Area and the standards for Basic Medical Education (BME) of the World Federation for Medical Education (WFME). This standard goes beyond the current European Directive (2013/55/EU) which only specifies that medical education should at least last for 5 years and 5.500 hours under the supervision of a university. In future, this standard should be fulfilled by all medical schools in WHO Europe.

AMSE also points to the need of a common, high quality, optimised accreditation process for all European medical schools which is supported and accepted by the European Parliament, European quality organisations, accreditation agencies and medical schools.

AMSE is highly active in putting these initiatives forward and seeks the support of European medical schools, students, professors and educators in medicine on this important matter.



**AMSE Joint Symposium with the
German Medizinische Fakultätentag,
Berlin, Germany
13 – 14 September 2014**

AMSE – BERLIN CONSENSUS PAPER

The AMSE (Association of Medical Schools in Europe) 2014 conference, organised in collaboration with the German Association of Medical Faculties (MFT Medizinischer Fakultätentag), was held in Berlin, Germany, September 13 – 14, 2014.

The background of the AMSE-MFT joint symposium was the "uncontrolled" increase of public and private medical schools, franchise-cross-border models of medical schools, differences in medical programmes, in quality assurance procedures and in the automatic recognition of physician licenses across Europe according to the EU Directive 2005/36/EC and EU Directive 2013/55/EU. Competent and well known speakers from different stakeholders such as medical education, deans of medical schools from different countries, academic hospitals and regulatory authorities, accreditation experts and WHO-Europe presented their data and ideas and more than 50 delegates from 18 different countries had stimulating and lively discussions.

The outputs of the meeting which were agreed by all participants were as follows:

- The **study of medicine** is an **academic scientifically-based programme** and medical schools and affiliated hospitals have to guarantee an appropriate academic scientific infrastructure.
- The **development of technology** especially communication technology, the economic crisis, integrative processes in Europe (European Union) and globalization in general inevitably influence medical education. Many new developments mark the evolution of the medical school now in the beginning of the 21st century. Distance learning via the internet, 'e-learning', has become increasingly popular in recent years. It offers an opportunity to gain a qualification and experience a full university education while continuing in employment or other daytime responsibilities. However when it comes to practical medical training where is the limit?
- **Internationalisation** and mobility of medical students is becoming more and more intensive.
- **Uncontrolled growth** of medical schools, public and private, and franchise-cross-border models of medical schools, sometimes of doubtful quality, may erode standards and may damage health care. They may disrupt policy on the managed and good quality development of medical education and health care.

- **All involved stakeholders** should stay in closer touch in the future and improve their communication.
- We must build a closer collaboration with **politicians** and **EU-policy**.
- We need **Europe-wide standards** for medical education programmes, medical schools, franchise-cross-border models of medical schools and academic hospitals.
- Based on these standards we need **Europe-wide valid quality assurance procedures**.
- **Recognition of physician licences** should be based on these approved standards and adequate language, knowledge and skills tests.

AMSE must and will take a leading initiative in these proposed outputs in order to ensure that we are not at risk in the future.



**AMSE Annual Conference
University of Ljubljana School of
Medicine, Ljubljana, Slovenia
16 – 18 June 2011**

AMSE – Ljubljana declaration on the Staff of the Medical School

A medical school is not defined by its history, or by its buildings and facilities, or by its management. A medical school is primarily its people. Without good staff and students, a medical school will fail.

Therefore, the most important task for those who run a medical school, under the leadership of the dean, is the recruitment and continuing support of staff and students. In particular, it is essential to recruit, motivate, reward and retain excellent staff. This is also important in view of the challenges facing medical education in the future.

Academic staffing matters, in total, are an important part of the autonomy of the university. The specific issues in the medical school, in the particular settings in which teaching and research take place, are the questions of parity and equity with the health care system. The medical school must maintain its academic mission, while at the same time working together with its health care partners in the delivery of education, clinical care, and research in the facilities that they share.

Academic clinical staff provide clinical care, and leadership and innovation in the health care system, in addition to their responsibilities in teaching and research. Teaching and research are essential for the quality and development of health care.

There are difficulties in the recruitment and retention of clinical academic staff in medical schools, because of inadequate recognition and reward of these multiple responsibilities. **In particular, the circumstance in many countries, where a disparity exists between salaries and conditions of work for clinical staff of the medical school and salaries and conditions that are available for their colleagues in the health care system, is not tolerable.**

Governments, medical regulatory authorities, medical professional associations, and other responsible bodies, in close dialogue with medical schools, must ensure that conditions and salaries for academic clinicians are always considered together with, and matched to, health care system salaries and conditions of work. There are examples of good practice in many European countries.

The environment in which medical school staff work must provide good and secure facilities, satisfactory working conditions, and a sympathetic, positive and academic ethos. Salaries, and conditions of employment, must reflect all the responsibilities in clinical work, teaching, research and in management. Academic staff must have the equipment and technology they require, which must be up-to-date, and they must be supported in their personal and professional development.

Reward must be related to the entirety of the activity of the academic, but must also be related to performance. Planning of work in the domains of teaching, clinical work, research, and other activities must be clear, and must be honoured both by the staff member and by those to whom he or she is responsible. Time agreed for research and teaching must be assured. Greater responsibility and commitment of time must be matched by financial reward.

This planning of the job will normally require tripartite agreement between the individual academic, the management of the medical school, and the management of the relevant clinical service or facility, irrespective of the detailed configuration of the clinical service. This will not apply in structures where the health care and the medical school administration are combined.

The definition of the plan of work for the individual academic must be associated with a system of regular appraisal, and a personal development programme, including mentoring, and feedback on performance. Staff must be supported in the development of their teaching, clinical and research skills. The plan of work must include realistic targets to be met. Staff who persistently fail to meet realistic targets, for example, in teaching, or in clinical performance, should not be retained.

In non-clinical departments of the medical school, all conditions of work must be such that medically qualified staff as well as non-medical staff are attracted into basic science teaching and research. Conditions must be such that medical and non-medical staff work together equitably. This is important not just in basic sciences but also in translational medicine and science.

Reliable data on the numbers and levels of clinical academic staff in medical schools are essential in planning and development of medical education, research, and clinical work. The practice of the Medical Schools Council annual survey in the United Kingdom is commended.

In summary, the recruitment, reward and retention of medical school clinical academic staff requires:

- **Adequate and protected time for teaching, research, and personal development. This should be tailored to the individual talent and annually monitored and discussed**
- **Equitable conditions of employment and reward, related to the plan of work and performance of the individual academic**
- **A supportive, well-resourced academic and clinical environment**

Academic medical staff, both clinical and pre-clinical, must be valued for their multiple contributions. A medical school leads, within its parent university, in the engagement of society with the academic mission of the university. The academic staff of the medical school lead in essential education and training of medical and paramedical professionals, in high-quality and innovative health care, and in research which often jointly with other scientific, technological and social science schools of the university.

All these activities are essential for the creation of future generations of doctors, for the good of society as a whole. The present situation in some jurisdictions is putting this future at immediate risk.



**AMSE Annual Conference
Charité – Faculty of Medicine,
Berlin, Germany
10 – 12 June 2010**

The following Policy on the Bologna Process and Medical Education was agreed by the AMSE General Assembly at its meeting on 12 June 2010

- AMSE endorses the purpose of the Bologna declaration and supports the policy that medical education, as a part of higher education, should be fully involved in the Bologna Process.
- When implementing the Bologna objectives in medical education, the specificity of medical curricula and the current situation of European medical schools must be considered.
- Most Bologna action lines are in accordance with current practices and reforms in medical schools, but implementation of action line two (“adoption of a system essentially based on two cycles”) can have serious implications for the quality of medical education if not done with care and with regard to best practice in medical education.
- AMSE proposes that medical schools should not be obliged to adopt the two cycle structure and be allowed to continue to have a long, integrated, one-tier structure for basic medical education.
- AMSE urges countries and governments, if making decisions of fundamental importance to medical education in Europe, to do so based on the necessary evidence and in dialogue with medical schools and their stakeholders (including students), and with the interests of patients and society paramount.

AMSE accepts that the central requirement for undergraduate medical education remains the obligation under Directive 2005/36/EC of the European Parliament and of the Council of the European Union, with later amendments. The Directive requires (at Article 24) that “Basic medical training shall comprise at least six years of study, or 5,500 hours of theoretical and practical training provided by, or under the supervision of, a university.”

This requirement, together with continuing quality improvement of medical courses measured against agreed national and international standards; and with development and improvement in the definition of teaching outcomes, curricula, educational methods and assessment techniques, is of greater importance than the introduction of any two-cycle model.



**AMSE Annual Conference
University of Zagreb, School of
Medicine, Zagreb, Croatia,
4 – 6 June 2009**

AMSE – Zagreb declaration on the Role of the Medical School in Postgraduate Education

The postgraduate role of the medical school extends into clinical, specialist and research education. In all these, the medical school is a partner of the health-care system, and of the profession. This three-way partnership depends, for success, on mutual respect, communication and collaboration. This partnership also includes support from ministries both of health and of education, and society at large.

The statutory responsibilities in all aspects of postgraduate work may vary within and among different jurisdictions: but the principles of involvement are common to all. Medical schools across Europe recognise and welcome their postgraduate roles and responsibilities, notwithstanding any local variations in funding and regulatory arrangements.

In the continuum of medical education, good alignment of pre-graduate (undergraduate) and postgraduate education is essential. The transition of graduates from the educational system to the health-care system must be understood, structured and managed. The medical school must work with its partners – and be involved by its partners - in the arrangements for relevant internships, foundation programmes, and the like.

Today's society is asking that doctors be scientifically-based, possessing on the one hand theoretical knowledge and clinical skills, and on the other hand, skills in communication, human understanding and other competencies, in order to work in a patient-focussed, safe and effective environment. The medical school and its partners must understand at which time or times in undergraduate and postgraduate education knowledge, skills and attitudes are best acquired.

Medical School involvement in residency and specialist programmes is also essential. Specialist education must be delivered, in part, in an academic environment where learning processes and teaching excellence should be accountable to appropriate academic authority and to society at large. Provision of postgraduate training should be rewarded in a way that supports innovation and provides incentives for excellence. Selection into residency and speciality programmes should be a joint responsibility of all partners, including the medical school.

Funding of postgraduate medical education must be fair, transparent and adequate, and there should be no financial disincentive to institutions in the provision of good postgraduate education. Individual postgraduate students should be fairly remunerated whether pursuing a clinical career or an academic clinical career.

Clinical postgraduate trainees should have the opportunity for further research education, in order better to understand the basis of clinical practice and of its development. Research training during clinical training should be organised and properly funded. The possibility of integrating PhD programmes in medicine into postgraduate clinical studies should be offered, in order to shorten the total duration of the entire education, and at the same time improve the quality because it would enable a better integration of clinical research into clinical practice.

AMSE endorses the work of ORPHEUS in development of standards for research training in medical schools and faculties, and supports the position paper from the Aarhus meeting of ORPHEUS (<http://www.orpheus2009.org/>) about standards for PhD education.

The role of the mentor in postgraduate clinical and research education is vital. Mentor and mentee must work together as partners, and feedback between them is of particular importance. Training and professional development of mentors must be supported.

Quality assurance is vital to the improvement of postgraduate education and is a paramount collective responsibility of the academic community, health-care system, regulatory authorities and government.

Assessment methods and standards must be defined and documented, particularly workplace methods of assessment. Feedback should be encouraged and developed. Appropriate involvement of all partners, including academic partners, in assessment processes is necessary.

In conclusion, the medical school has responsibility in all aspects of postgraduate clinical, specialist and research education. It must work with its partners in order to promote quality in postgraduate work, and excellence in the future of medical research, education and care.



**AMSE Annual Conference,
University of Barcelona, Faculty of
Medicine, Barcelona, Spain
5 – 7 June 2008**

AMSE – Barcelona Declaration on Quality Assurance in the Medical School

The Association of Medical Schools in Europe (AMSE) wishes to support the development of a coherent and strong set of processes for quality assurance and quality improvement in medical schools across Europe. Medical schools will only fulfil their responsibility to society, and their duties to their students and staff, if quality assurance systems are strong, effective, and fit for purpose.

Quality assurance is essential for all aspects of the academic work of the medical school (whether in the public or private sector): including basic and clinical undergraduate medical education, postgraduate medical education and specialist clinical training, continuous professional development as well as research including research training and PhD studies.

AMSE recognises that standards and processes for quality assessment and quality assurance are often authoritative and efficient, but not uniformly so. AMSE is fully supportive of an academically-developed independent system of accreditation, quality assurance and quality improvement of medical education and research, and also supportive of quality assurance and improvement of the related health-care system. The standards used should be based on common European criteria, together with local specifications as needed. AMSE and the World Federation for Medical Education developed European specifications to the WFME global standards, for this purpose.

Independence in these processes means that the authority for quality assurance must be external to the individual medical school and genuinely representative of stakeholders. However, externality and independence must be associated with self-evaluation and with:

- expertise: these are peer review processes
- interaction: there must be constructive and open dialogue between the quality assurance agency and the medical school
- objectivity: the standards must be set dispassionately and must be defensible
- transparency: the process and outcome must be open and publicly available
- freedom from any conflict of interest.

There must be emphasis on medicine-specific criteria. The range of academic work in the medical school, and the interaction with the health care system, means that the application of general quality assurance processes for higher education, without specific modification, may not be adequate.

In considering medicine-specific criteria, the quality of the eventual performance of the graduate, as a doctor for clinical practice, is the measure that is of critical importance to society. Assurance of clinical competence at graduation will be essential, achieved through academic and scientific knowledge, professionalism, ethics, attitudes and skills.

In countries where postgraduate medical education and specialist clinical training are the responsibility of the health care system or the profession, and not of the medical school, there must be good communication and transition processes between the quality assurance system for the medical school and the related processes in the postgraduate system.

AMSE can act as a vehicle through which good practice across Europe, and more widely, can be shared. In the development of Quality Improvement programmes for medical schools in Europe, the following principles and proposals for good practice could prove helpful:

- **Dialogue between medicine-specific quality assurance agencies and agencies with a responsibility for general quality assurance** in higher education should be promoted: AMSE is considering a workshop for interactive discussion and development of this topic.
- Such a workshop will also promote development of **common goals in quality assurance agencies, a common language and common understanding of terminology** and processes across Europe, and promotion of understanding of the terminology.
- Recognising that there are varied models and systems for quality assurance in Europe, **development and implementation of systems that are appropriate for local need** is admissible, provided standards and processes are of the necessary core quality.
- **Interaction** between peer reviewers and the medical school is essential. **Exchange of ideas** is indispensable in the enhancement of quality.
- Promotion and development of a **quality culture** for the entire medical school and its partners is an essential goal, in particular because medical students must understand and adopt this culture for life-long learning.
- **Medical students** are the future of medicine and the medical profession, and should all be **active partners** in discussion and agreement of our quality improvement processes in education. Self-assessment and self-directed quality improvement by students should be required.



**AMSE Annual Conference,
New University of Lisbon, Faculty of
Medicine, Lisbon, Portugal,
14 –16 June 2007**

AMSE – Lisbon Declaration on the relationship between Medical Schools and Healthcare Systems

The Association of Medical Schools in Europe (AMSE) recognises that there is a common set of issues across Europe relating to the relationship between Medical Schools and the health systems in which they operate.

Closer working between Medical Schools and University Hospitals is essential, involving dialogue between Deans and Chief Executives. Clear clinical and clinical academic leadership of affiliated hospitals is required.

The tensions identified between Medical Schools and their affiliated hospitals include differences in time frame: a hospital must meet its targets, where diagnosis and treatment must be made in hours, days or weeks as required; a Medical School has a perspective of years and decades, educating students for a lifetime of evolving clinical practice, and supporting research that may not demonstrate its significance for many years. Financial challenges are important: the budget of the hospital is always much greater than that of the Medical School. There are problems for institutions caused by the lack of communication over policy between Ministries for Health and for Education, or equivalent.

Medical Schools must strive to form close ties with all affiliated organisations in the health care system in which they operate, appreciating the wide range of settings in which the student must train, in order to gain the diversity of experience necessary to develop as a well-rounded, competent doctor.

The provision of experience and training for students in Primary Care settings allows them to develop an understanding of the full spectrum of disease seen in the community, complementing experience from the specialised cases treated in a tertiary hospital setting. Through affiliation with a Medical School, Primary Care practices, and other organisations, gain in prestige and a potential increase in patient volume. Practitioners themselves gain opportunities for continuing professional development. Such incentives could be outlined to General Practices by Medical Schools seeking to establish teaching and research networks in Primary healthcare. The development of relationships between Primary, Secondary and Tertiary centres and the Medical School, benefits the community in which these organisations are based, leading to inward investment in research and development and so an increase in the wealth, and ultimately health, of the local population.

Teaching and research in community settings and within University Hospitals should be seen as the essential components of medical education: the two complementary sides of the same coin.

Medical Schools must recognise and plan for the training needs of the 21st Century doctor, providing the skills to allow these healthcare professionals to adapt to changing patterns of disease, of healthcare provision, evolving patient expectations, and so preparing them for future healthcare challenges.

Students themselves are changing, not only in relation to their technological proficiency on entrance to Medical School but also in respect of their attitudes and values. Models of medical training should recognise this and seek to harness such developments.

AMSE is fully supportive of an independent system of accreditation and quality assurance of medical education in all settings, including medical schools, teaching hospitals and other healthcare settings, and of efforts to drive up standards of medical education. AMSE, with the World Federation for Medical Education (WFME), is to build on success in leading the Quality Assurance taskforce under MEDINE 1, by taking a lead in MEDINE 2, and will further explore issues relating to Quality Assurance at its Annual Conference in Barcelona, 2008.

AMSE can act as a vehicle through which best practice across Europe, and more widely, can be shared. In developing relationships with University Hospitals and Primary Care, the following principles could prove helpful:

- Clear **leadership** from Medical School Deans in relation to strategy and policy in the development of teaching strategies and other areas of mutual interest, including research, in affiliated organisations, both hospitals and community services.
- The need to develop a **common set of goals and objectives** in partnership with these affiliated bodies.
- Obligatory **involvement** of the Medical Faculty in appointments for staff at affiliated healthcare providers.
- Recognising that, although Europe may have much to learn from models internationally, for example in North America and other parts of the world, Medical Schools should not seek simply to impose external models on European structures, but to **develop and implement systems that are appropriate for local need**.
- Effective high-level **communication** between the Medical School and its healthcare partners, with appropriate **cross-representation** on the relevant governing bodies
- Assuring mentors and tutors in all organisations are well-trained and fully qualified, and that there is strong Quality Development and **Quality Assurance** of their role, and of education and of other activities.