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# IMPLEMENTATION OF THE BOLONIA PROCESS IN CANARY ISLANDS

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From time to time, it's a good idea for medical educators to step back and take a look at whether we're doing our best to meet our responsibilities to our students and society. Given the current push to expand the Bologna process in Europe, now is clearly such a time. It would be tragic if we failed to seize this opportunity for improvement and, unfortunately, I think that Bologna can be considered a missed opportunity or --- to say the least --- we're not taking full advantage of it. Medicine is the "latecomer" or "the subject in parentheses" in the Bologna Process. It may be that Medicine does not need to take any special actions, given that it matches the Bologna template so conveniently. However, the ongoing reforms have prompted us to think deeply about what we have been doing so far and what we should start doing from now on. So, I see the Bologna reforms as an occasion to think over our job and how we can improve it.

The medical school's primary contribution to the education of physicians is to ensure that when students graduate they possess a set of attributes that all physicians should have in order to meet their responsibilities to individual patients and to the society at large, once they enter practice, regardless of their ultimate career choice. So, first we focused on the objective of getting competent doctors –i.e. have acquired knowledge, skills, attitudes and behaviors- in all the basics necessary to undergo their residency and begin research projects and, perhaps, become educators. Given the nature of residency training, the general professional education of the physician provided by medical schools is the best time to embed those attributes in all physicians.

We started by defining what "competence" means to us. We asked other institutions and stakeholders to participate, as well as postgraduate tutors. We were particularly interested in the input of postgraduate tutors because it is unwise for the university to ignore the specialized training period. The poorly coordinated transitions across the

educational “continuum” –from medical school (the responsibility of the Ministry of Education) to residency and then to practice (both the responsibilities of a different ministry in Spain, the Ministry of Health)- are seen to pose additional obstacles to innovations that might otherwise optimize learning and perhaps shorten the duration of formal education. This is a central problem: how can medical school, residency, fellowship and practice be linked intelligently?

To address recognized shortcomings in traditional models of medical education, our medical school has updated its curriculum. We have incorporated different problem-based modes of instruction, designed an integrated curriculum for clinical disciplines and introduced the students to clinical practice early in their academic careers. We endeavor to ensure that our students become familiar with critical subject matter not yet sufficiently incorporated in the former curriculum, for example, the role of non-biological determinants of illness, health implications of cultural diversity, international cooperation, professionalism, etc. We are also trying to extend some educational methods to teach clinical disciplines, emphasizing interactive large-group presentations, in which the teacher coaches the students rather than “talking at them”. We are underscoring the importance of problem solving and self-directed, life-long learning, as well as the creative use of web-based learning and experiential learning. I must remark that we have found a resistance to change, and students have not always welcomed the reforms which Bologna brings. As in other aspects of social and political life, we are now facing the paradox of a conservative youth and a more progressive adult generation.

The current clinical training provided by medical schools continues to reflect a very traditional view of what medical students need to learn about clinical medicine before they graduate and enter their residency training. To create an early and powerful clinical immersion experience, our students spend significant amounts of time in clinical settings. This involves five days a week from the third year until the sixth year. We are placing more emphasis on community settings as “classrooms” for educating future physicians. Students need to gain an understanding of the critical roles played by other health professionals and the general approaches that can be employed to improve healthcare quality in both the inpatient and ambulatory care arenas. Taking advantage of other degrees in our Faculty, we prepare our students to work effectively as members of

inter-professional teams. This is increasingly desirable given the widely-acknowledged advantages of developing inter-disciplinary teams in clinical practice, especially to care for patients with chronic illnesses. Medical students must understand that they will be involved in the care of a large number of patients with chronic illnesses regardless of their specialty; therefore, medical schools must redesign the approaches used in providing clinical education to ensure that graduating students understand the challenges involved in caring for these patients over time.

We are now working on the redefinition of "university hospital". This is a very complex issue that has to be approached from different perspectives. The Spanish Conference of Deans of Medical Schools is working on a specific proposal that covers legal, administrative and educational requirements for a hospital to be considered a teaching hospital. The typical obstacle to overcome is that medical schools and hospitals often have different cultures and ways of working. These differences need to be acknowledged, confronted and managed, within a context of trust and respect, not because the individual partners are equivalent in size, scope or resources, but rather because respect grows from an appreciation for the unique contribution each could offer the other. The financial model university hospitals are based on and managed by also needs re-examination. The clinical time of the professor will need to be brought out to ensure it is adequate for clinical supervision, instruction and tutorials. If physicians wish to teach, they must complete a series of faculty development workshops and then have their productivity standards for patient care reduced so they can teach effectively.

Research is an integral part of the whole six-year curriculum. We are involved in research training of undergraduate students to produce future academic physicians committed to conducting medical research. All of our students have to present an original research work in English, in front of a panel of professors before graduating. That is going to pose some difficulties because recruiting qualified instructors, preceptors or facilitators to conduct and supervise a pretty high number of research works every year will be a huge challenge.

For this new curriculum to succeed, assessment must be expanded, transformed and aligned with educational objectives throughout the trajectory of the educational process. Assessment of formal knowledge, clinical performance, and professional formation

should be examined in the context of competencies, and assessment of competencies requires different methods of evaluation. Clinical reasoning, communication skills, procedural skills and professionalism can be assessed in practice settings and by using simulations and objective structured clinical exams as the one the National Conference of Deans for all the Spanish Medical Schools is preparing.

We are particularly concerned about the educational climate in our medical school because the quality of the educational environment reflects the quality of the curriculum. In addition, the learning environment is an important determinant of behavior, academic achievement, course satisfaction and aspirations. Medical students acquire their professional identities and norms of behavior not nearly as much from exhortations into the classroom as they do from observing how respected role models interact with, patients, staff, outside entities and themselves. Too often what students observe serves to foster cynicism rather than to reinforce the avowed values of professionalism. The cognitive dissonance between what we say we believe and what we actually do is damaging to the developing physician.

As for mobility, even though the main purpose of the European Higher Education Area is convergence and harmonization of curricula content and degrees throughout Europe to create circulation of students and professionals, this goal is far from being reached. The explicit aims to achieve study abroad for 20% of European students and to balance inter-country flows are undermined by current trends. What we see is a tension between freedom and autonomy, and standardization. Freedom of the universities to set their own goals should continue, but these goals should not prevent mobility of students among universities. I wonder whether Bologna enhances mobility through transparency, harmonization and credit transfer, or whether it restricts mobility by imposing tight degree program structures, leaving no room for studying abroad. Multilingualism and the current financial crisis add to difficulties in implementing mobility. Make medical education more alike in Europe is, of course, a means to facilitate circulation and employability. So, what we need is to work on a European core-curriculum and on establishing the competencies and learning objectives for every educational stage, and, above all, trust among participating countries.

Quality assurance is at the heart of a European Higher Education Area, and not only that but a mutually shared criteria and methodologies on quality assurance. These common criteria have not been fully developed. It would be a good idea to commission independent experts such as the AMEE (Association for Medical Education in Europe) for this task. Common standards for quality improvement would allow us to get a common accreditation system for Medical Schools in Europe and would provide a reliable instrument to keep high quality educational standards and to compare performances among different Medical Schools.

In conclusion, the underdevelopment of the so-called Bologna process is evident in medical education. For the most part, the adopted changes altered the organization of the curriculum and some pedagogical strategies to enhance student learning. It did not, however, delineate the specific attributes all physicians should possess, and it did not come up with educational programs to accomplish that goal. We need to think about the social responsibility and mission of our medical schools so we can bring our program into better alignment with societal needs and expectations. The government should increase the investment to support innovations and research in health professions education; otherwise we will keep doing what we have been doing up to now. Implementation of curricular innovations seems particularly restrained or threatened in Spain due to lack of funding and a certain chronic apathy of national bodies in medical education. As a consequence, and in spite of the fact that all the Spanish Faculties have made a great effort to bring in new teaching and learning paradigms, we are at risk of introducing just little more than cosmetic modifications to our medical curricula.

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